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# Trauma-Informed Risk Communication for Self-Directed Violence: A Supervision Model for Counselor Education

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**Keywords**
Counselor education, risk communication, self-directed violence, supervision model, trauma-informed.

**Abstract**

This teaching practice brief presents a counselor education supervision model to support counselors-in-training serving clients experiencing self-directed violence, such as non-suicidal self-injury and suicidal ideation. The current model emerged from previously published grounded theory research on counselor-in-training needs for intervening on self-directed violence resulting in two key themes: (1) two forms of supervisory support are needed: logistical and emotional, and (2) supervisors are reported to exhibit a concerning spectrum of skill with both, impacting trainees. This brief is intended to translate these findings into practical supervision recommendations. Supervisors who intentionally provide attuned logistical and emotional support scaffold the clinical competencies necessary for counselors-in-training to both seek timely help for intervening in self-directed violence and protect themselves from compassion fatigue. Therefore, trauma-informed risk communication, informed by relevant research, is described. Limitations and future directions are discussed.

## INTRODUCTION

Someone dies by suicide every 40 seconds (Ritchie et al., 2015). Global rates of suicide have been on the rise for decades, while the standardized age of death has dropped (Naghavi & Global Burden of Disease Self-Harm, 2019). For the last two decades, suicide was a top ten cause of adult death in the United States until alcohol-related deaths and COVID-19 bumped it down to the top twelve; it is still top two for adolescents and young adults (Garnett et al., 2022; Martinez-Ales et al., 2022). Pre-pandemic non-suicidal self-injury (NSSI) had high prevalence rates among adolescents (17.2%), young adults (13.4%), and adults (Swannell et al., 2014). NSSI rates then skyrocketed among youth during the pandemic (Schwartz-Mette et al., 2023; Zetterqvist et al., 2021). Therefore, counselors-in-training (CITs) *must* learn to skillfully address NSSI, suicidal ideation (SI), and suicide attempts (SA) within a reliable and responsive supervisory chain-of-command.

Unresolved trauma, particularly developmental/relational trauma, is often implicated in these forms of self-directed violence (Bryan, Grove, & Kimbrel, 2017; NAMI, 2020; Ralph et al., 2006; Sitnik-Warchulska & Izydorczyk, 2018; Steeg et al., 2023). There have been calls for an integrated public health response to address not just the SDV symptoms that result in clinical crises, but the unresolved and often transgenerational trauma that escalates into SDV when left untreated (Decker et al., 2018; Stone et al., 2023). Counselor education and training needs to lead this charge for large scale prevention.

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**Purpose Statement**

The literature related to training CITs on skillfully assessing and treating unresolved trauma that often drives SDV as a coping mechanism is limited, and the research that does exist shows there is a concerning gap in training for SDV assessment and intervention (Cureton et al., 2021; 2018; Jacoby et al., 2024; Tyler et al., 2024). Such gaps can lead to CITs falling back on what is comfortable and familiar, which for many can be *avoidance*. Furthermore, anecdotal evidence gathered from practicum and internship faculty suggests that current digital native counselors-in-training are beginning to turn to AI large language model sites to seek guidance for such situations when they do not feel confident turning toward their supervisor for help. Given the lack of empathy or skill in tracking non-verbal communication inherent in machine learning tools, counselor educators and supervisors must intentionally make themselves safe resources for counselors-in-training who need help.

Research into CIT self-efficacy with SDV continues to demonstrate an increased need for structured education and training (Cureton et al., 2021; 2018; Tyler et al., 2024) and coherent trauma-informed supervision models that contain CIT stress while facilitating skillful intervention (Kim et al., 2024). Cureton and colleagues have found that that recent CACREP graduates who are both confident and skilled at intervening on SDV had structured, scaffolded pre-professional suicide training in their programs, followed up by structured, scaffolded supervision that systematically expanded their skillset within a co-regulating supervisory relationship (2021). The current authors aim to systematize CACREP programs and sites' methods to do so by presenting a training and supervision model for trauma-informed risk communication for SDV based on our grounded theory research. This teaching practice brief operationalizes specific steps for counselor educators and clinical supervisors to take to implement such scaffolding in an emotionally regulating manner.

## LITERATURE REVIEW

### Training Standards

Since 2009, CACREP standards have required programs to prepare CITs to effectively serve clients with SI and NSSI. However, CITs continue to report that their CACREP programs did not teach them to assess or intervene in SI, SA, or NSSI (Cureton et al., 2021; 2018; Jacoby et al., 2024). Cureton and colleagues summarize the problem as an "inexistence, small amount, poor placement in programs' curricula; vagueness of training content; ineffectiveness of training methods; and inconsistency across programs" (Cureton et al., 2021). Programs may introduce the concept of risk, and perhaps discuss case studies, but do not routinely scaffold assessment and intervention skills development through supervised in-class role-play or require final skills assessment of pre-professional suicide training (Cureton et al., 2021; 2018; Jacoby et al., 2024).

Because CITs often provide outreach to underserved clients, they may be among the first to empathize with clients' emotional suffering, ranging from stress to distress to unbearable *psychache* (Cheng et al., 2021; Pachkowski et al., 2019), a term coined by suicidologist Edwin Shneidman describing the "hurt, anguish, soreness, aching, psychological pain in … the mind" (Shneidman, 1993). considered to drive SDV. CITs are understandably overwhelmed by this new life-protecting responsibility, compounded by the need for discernment and trauma-informed pacing to effectively perform risk assessments, rule-outs, and evidence-based interventions, all while maintaining rapport. Such work-related anxiety and inexperience can lead to clinical errors and ineffective use of supervision, increasing the risk of danger to clients, as well as burnout and compassion fatigue in practitioners (Davies et al., 2021; Davis, 2019; Novoa, 2021; *SAMHSA*, 2021). Counselor educators, supervisors, and CITs can also have a personal history with SDV that may impact their response to these clinical presentations, in addition to the social stigmas and taboos that shut down effective communication about them. Several CITs from around the United States stated in our grounded theory research that self-directed violence was not taught *at all* in their CACREP

programs because it was too uncomfortable for faculty to discuss (Jacoby et al., 2024). This discomfort signaled to CITs that they should figure out what to do on their own.

**Assessment and Treatment Considerations**

Currently, there is no identified single best practice for treating NSSI, and assessment measures are undergoing validation (Westers et al., 2023; 2016). The NSSI-AT, SNSI, and SOARS models are used in emergency room screenings and have been suggested for use by mental health professionals (Whitlock & Purington, 2013). Dialectical Behavior Therapy (DBT) is considered a well-established intervention (Kothgassner et al., 2020) it is time-intensive to inculcate to fidelity. A pilot study on the Cutting Down Programme (Kaess et al., 2020) found it reduced symptoms by 50%, making it more effective than treatment-as-usual, which in this study was a combination of Cognitive Behavior Therapy, DBT, and psychodynamic approaches. Meta-analyses of randomized controlled trials suggest that increasing distress tolerance through body-based emotional regulation skills, combined with enhanced prosocial support, is necessary to reduce symptom presentation in both the short and long term (Asarnow et al., 2021; Kothgassner et al., 2020). Best practices for suicide prevention and intervention include comprehensive wraparound support from pre-postvention (CDC, 2022). These common factors must be operationalized as *risk communication* and safety planning to prepare CITs effectively.

As CACREP graduates continue to report this foundation is not always provided, supervisors need to provide these resources and training at onboarding. It is generally not appropriate for trainees to retain outpatient clients with NSSI and ongoing SI or SA, given their restricted availability and scope of competence; however, accurately identifying the needs and making appropriate referrals to full-time counselors within a network of care is. Rural or globally placed trainees often work in areas where there is no available referral network to facilitate a warm hand-off (Intervention, 2023), and thus must receive ongoing supervisory support in distress tolerance and safety planning.

**Pathway from Grounded Theory Themes to Supervision Framework**

The current authors' previously published grounded theory research (Jacoby et al., 2024) identified four themes central to CITs' needs to effectively serve SDV clients: Supervision Facilitation, Secure Base Provision, Clinical Identity Development, and Sufficient Preparation.

*Supervision Facilitation* was positively operationalized by CITs as regularly scheduled weekly face-to-face clinical (not just administrative) supervision, enhanced by ad hoc crisis supervision as necessary for risk assessment and stabilization. CITs were provided a clear communication protocol to access their supervisors between scheduled meetings, with a phone tree chain-of-command in case the assigned supervisor was not physically available to provide live supervision. Group supervision provided an intentional use of shared time, balanced by active containment of more monopolizing trainees seeking attention for individualized needs and proactive direction for common CIT administrative and clinical needs. Supervision Facilitation, when negatively operationalized by CITs, consisted of irregular prioritization of the weekly individual/triadic face-to-face clinical supervision; group or individual/triadic supervision over-indexed toward administrative responsibilities; no clear chain-of-command to contact in case an assigned supervisor is not available for live supervision; and emotionally aggravating supervision due to supervisor limitations suggestive of crisis or trauma incompetence and/or compassion fatigue (Jacoby et al., 2024). Group supervision concerns centered on unstructured processes, over-indexing toward primarily administrative responsibilities, and/or an aggravating waste of time due to monopolizing trainees getting the bulk of attention for individualized needs.

*Secure Base Provision* was positively operationalized by CITs as a physically and emotionally available individual/triadic supervisor who was reliably calming and supportive while both anticipating and providing for CITs' needs related to risk assessment and intervention (Jacoby et al., 2024). Such supervisors normalized CIT anxiety and stress related to client risk, proactively provided written policies

for risk assessment and intervention, and patiently reinforced risk communication processes in an iterative fashion. Such supervisors abstained from micromanaging, but were responsive to bids for help. Such supervisors consistently embodied a welcoming and supportive attitude, were graceful regarding requests for reassurance, and used therapeutic self-disclosure regarding their own learning and mistakes. Secure Base Provision was negatively operationalized by CITs as a supervisor who was not reliably available physically or emotionally, who was aggravating when needed for crisis or other supervisory needs, and who was perceived as micromanaging on one end, or dismissive on the other (Jacoby et al., 2024). Such supervisors tended to silence bids for help and reassurance through shame and other symptoms of impatience, or conversely, projected their own anxiety about loss of control by micromanaging.

*Clinical Identity Development* was positively operationalized by CITs as a growing sense of authority and responsibility related to delivering clinical crisis care (Jacoby et al., 2024). CITs with well-supported foundations tended to have a positive attitude about their readiness to serve high-acuity clients and willingness to seek help within their chain-of-command. Well-supported CITs tended to express positive attitudes about seeking continuing education to specialize in various modalities for high-acuity clinical presentations, reflecting a growth mindset. Clinical Identity Development was negatively operationalized by CITs as a chronic sense of overwhelm with responsibility related to clinical crisis care (Jacoby et al., 2024). Poorly supported CITs tended to have a negative assessment of their counselor education programs and supervision, as well as high-acuity clients. Poorly supported CITs with this negative assessment of the role questioned their choice of professional training and did not want to seek continuing education for high-acuity clinical presentations, resulting in a fixed mindset.

*Sufficient Preparation* was positively operationalized by CITs as feeling appropriately, not overly, confident in their crisis competence (Jacoby et al., 2024). CITs with sufficient preparation knew what processes their sites expected them to follow for risk assessment and intervention, and whom to call under what circumstances. They felt healthfully entitled to call their supervisors for help when needed, and able to regulate themselves under a broad range of clinical crises because they knew help would be available when needed. Sufficient Preparation was negatively operationalized by CITs as feeling exceedingly anxious about common clinical crises, unsure how to start or proceed with assessment or intervention, unwilling to ask for help for a variety of reasons, and considering abandoning the licensure track.

In sum, CITs cannot safely learn NSSI/SI work through exposure alone. They need attuned supervisors, clear procedures, repeated iterative practice, and soothing support for their own emotional activation. When these needs are fulfilled proactively by validating supervisors and systems, CITs are more likely to operate within scope without succumbing to compassion fatigue because they will ask for and receive appropriate help when needed. This requires that counselor educators and supervisors have patience for repeatedly teaching culturally and developmentally responsive risk communication skills for all the clients their trainees serve.

**Presentation of New Position: Trauma-Informed Risk Communication**

*Risk communication* transcends risk assessment (Soper et al., 2022). Soper and colleagues posit in the pain-brain evolutionary theory that “all intellectually competent humans carry the potential for suicide” given sufficient distress (Soper et al., 2022). Once people have the developmental capacity to perceive that they can stop their pain by killing themselves, there remains a non-zero risk that they may do so given sufficient psychological suffering. Soper and colleagues postulate that risk communication engages compassionately with psychache while facilitating healthy protective factors, which they conceptualize more specifically as (1) the *fenders* of a benign worldview (often spiritual/religious, in addition to psychodynamic defenses and pleasurable pursuits) that keep emotional homeostasis slightly above a neutral resting point, and (2) *keepers* (anti-suicide responses to intense/chronic pain) that tether

a person to the world. Evolution and sociological reinforcement have installed many of these defenses for psychological pain that can be leveraged, but chronic psychache can override these fenders and keepers, leading to SI and SA, as well as NSSI, in an attempt to reduce the psychache.

*Trauma-informed risk communication* requires advanced clinical skills to leverage and expand upon these fenders and keepers. Intervention and treatment planning require exquisite sensitivity to the developmental and relational stressors that impinge on the client's ability to find relief from suffering with less harmful means. All interventions must be performed while maintaining the client and family system within their *window of tolerance*, so that overwhelming, painful emotions do not escalate the imminency of crisis (Corrigan et al., 2011).

Updated guidelines encourage professionals to initiate ongoing risk communication from intake forward through clinical interviews, assessments, and continually adjusting safety planning within a responsive support network (aka collaborative assessment and management of suicide (CAMS) and crisis response planning (CRP). Such comprehensive approaches are found to be more effective than enhanced treatment-as-usual (Bryan, Grove, & Kimbrel, 2017; Bryan, Mintz, et al., 2017; CAMS-Care, 2023; Elliott & Henninger, 2020; McCutchen et al., 2022; Santel et al., 2020). Trauma-informed risk communication begins with informed consent, normalizing direct discussion about SI and NSSI in the exceptions to confidentiality while gathering a list of emergency contacts. When clients cannot identify at least three (ideally five) sober, responsive adults to call in case of emergency, some pre-existing risk factors are evident at intake (*SAMHSA*, 2021), to be discussed consistently in supervision and addressed via linkage throughout treatment.

## Training and Supervision Model

### Common Factors Discrimination Model as Applied to Risk Communication Training

Crunk and Barden (2017) have summarized meta-analyses of counseling and supervision models to state that tailoring supervision to the needs of each supervisee supports the quality of each relationship (counselor-client, and supervisor-counselor). Supervisors may best serve supervisees and clinical populations by centering attunement and relational skills development over specific intervention approaches as they navigate the various roles of counselor, teacher, and consultant. Research on attachment in supervision suggests that both the supervisor and supervisee experience a bi-directional interaction pattern in the intensive professional relationship, which can be informed by both beneficial and problematic developmental patterns when either is distressed (Hiebler-Ragger et al., 2021). Secure functioning in the supervisory relationship is therefore an aspiration to elicit the most coherent professional response to clinical crisis in the CIT while also protecting them from burnout and compassion fatigue (Hiebler-Ragger et al., 2021).

Secure functioning in the supervisory relationship is operationalized by the CIT reliably turning to the more experienced supervisor when the CIT is unsure what to do, and directly seeking the appropriate help necessary without added emotional duress due to fear of reprisal, a sense of being a burden, or learned helplessness because the supervisor will not know what to do and will react defensively toward the CIT (Jacoby et al., 2024). Secure functioning in the supervisory relationship is further operationalized by neither the CIT nor the supervisor engaging in avoidance, dismissive, or over-reactive behaviors related to the stress of client crises. Secure functioning by the supervisor therefore requires consistent and reliable physical presence and emotional responsivity, with logistical knowledge of what to do in the scenarios presented, and willingness to seek further help when necessary. Secure functioning in the supervisory relationship results in a realistic self-assessment of when the CIT needs help, and consistent scaffolding of the skills necessary to increasingly manage more components of client risk assessment and intervention, without over-attributing an inappropriately inflated sense of competence in the CIT. With sufficient repetition, this reliable logistical and emotional support becomes internalized in the CIT, and

they are increasingly able to perform the steps necessary to keep clients safe while honoring autonomy and beneficence.

Attachment research has whittled down to Secure Base Provision as the key element that predicts whether or not the developing individual will turn to and seek help in good timing from the more developed individual, and whether the logistical and emotional support offered by the more developed individual will be perceived as helpful and soothing, rather than agitating (Woodhouse et al., 2020). Hiebler-Raggler and colleagues synthesize the challenge (Woodhouse et al., 2020). Although individuals with a secure attachment cope with stressful experiences either by actively seeking support or by utilizing mental representations of previously received support, hyperactivating strategies (AX) involve demanding care (Mikulincer & Shaver, 2003), worry and rumination (Cassidy, 1994). Conversely, deactivating strategies (AV) involve a strong need for self-reliance (Mikulincer & Shaver, 2005) and high levels of unconscious distress (Shaver & Mikulincer, 2002).

Results of Crunk and Barden's meta-analysis indicated that specific attachment to the supervisor was a significant predictor of the supervisory alliance and group climate, and essential as a stress-holding container for CITs. CITs are most likely to evolve toward more reliable independent practice when they can count on Secure Base Provision of logistical and emotional needs from their primary supervisor as they adjust to the demands of clinical crisis assessment and intervention. This, in turn, makes it possible for CITs to "return to exploratory system behaviours (e.g., learning new techniques) ...difficulties in this process may occur when insecure attachment in the supervisee impairs their ability to profit from supervision but also when the supervisor is unable to provide appropriate caregiving" (Crunk & Barden, 2017). The current authors posit that insecure attachment and/or insufficient support and training in the supervisor impairs their ability to reliably embody secure base provision for CITs, but that practicing the logistical and emotional support domains can successively approximate secure base provision for high-acuity crises. The current authors acknowledge that clinical systems often contain structural challenges that impede the supports supervisors need to reliably embody secure base provision, and these isomorphic shortcomings cannot always be overcome by individual supervisors within the system.

Our grounded theory research operationalizes Secure Base Provision for trauma-informed risk communication, encompassing both High Emotional Support/Availability and High Structure/Scaffolded Guidance domains, and is countered by signs of Low Emotional Support/Availability and Low Structure/Scaffolded Guidance domains. These domains arose out of CIT reports regarding their perceptions of quality of support from their CE faculty, clinical supervisors and sites (Jacoby et al., 2024). CITs with the most realistic self-assessment of competencies to effectively manage clients with SDV stated that their faculty, sites and supervisors proactively provided clear expectations of whom to contact for support, and how, throughout risk communication assessment and intervention. These CITs who reported feeling safe and appreciated by their faculty, sites and supervisors reported low internal and external barriers to reaching out for that help in good timing, in a way that helped clients feel that asking for help is a wise and reasonable choice. These CITs reported using supervision to process the predictable emotional stress of needing to intervene directly on SDV and systematically growing in their confidence regarding how to effectively assess and intervene on SDV by staying open to learning new intervention methods.

Our grounded theory research also identified concerning patterns reported by poorly supported CITs regarding their CE programs and training sites not anticipating or providing for their clinical skills development needs related to SDV assessment and interventions. The absence of proactive introduction or development of risk communication skills in CE programs was sometimes compensated for by training sites, but sometimes not (Jacoby et al., 2024). Commonly, CE programs did not introduce any structure for assessing or intervening on SDV. Often, when they did, it was a minimal theoretical introduction, with no structured skills development that could lead to muscle memory when stressed. CITs only realized this gap when they launched to placement and met clients who were engaging in SDV, which was often

surprising for them (Jacoby et al., 2024). CITs then had a concerning mix of experiences in seeking supervisory support to help these higher-acuity clients. Those CITs sometimes recognized when CITs from other programs appeared to have more SDV skills training, and more reliably knew what to do. CITs then had to rely on their internalized processes for seeking help. Those who had learned helplessness about authority figures' reliability for emotional support tended to avoid help-seeking, and acknowledged they did not really know what to do to help clients with SDV. Some had more willingness to seek help even when they wondered if they were a burden, while others reported not seeking help. The range of self-assessment of competence was of particular concern, as CITs with less experience and support tending to rely on themselves more than a reasonable clinician would. The authors therefore offer the following structure and support model to help systems and supervisors identify what changes are necessary to move supervision and agency response toward more Secure Base Provision.

Figure 1. <Trauma-informed risk communication supervision structure and support quadrants>

| **Installing Insecurity** | |
|---|---|
| ***Low Emotional Support/Availability***<br>Supervisor is Dismissive, Micromanaging, does not Anticipate or Provide for Needs (Reactive)<br>Ad Hoc On-Call Crisis Supervision destabilizes client/s and/or counselor<br>Negative Association, Afraid to Ask for Help<br>Supervisor leaks stress on CIT (overwhelmed) | ***High Emotional Support/Availability***<br>Supervisor is Attuned, Empathic, Anticipates and Provides for Needs (Proactive)<br>Ad Hoc On-Call Crisis Supervision is Helpful<br>Positive Association in spite of Challenges/Growing Edges<br>Supervisor does not leak stress on CIT |
| **Efficacy Impacted by Emotional Support/Availability** | |
| ***Low Structure/Scaffolded Guidance***<br>FTF Individual/Triadic Supervision is not Scheduled or Upheld on Weekly Interval<br>Chain-of-Command for Crisis Response is not Explicit or Available<br>Live Supervision/shadowing not offered for demonstration/training<br>Group Supervision is crisis-driven, reactive, and/or administratively focused<br>Site's assessment process and documentation are not provided as part of onboarding, CITs must learn expectations as they go with negative feedback en route | ***High Structure/Scaffolded Guidance***<br>Weekly FTF Individual/Triadic Scheduled and Upheld Consistently<br>Chain-of-Command for Crisis Response is Explicit and Available<br>Live Supervision to Take Over/Shadow as Necessary<br>Group Supervision is Clinically Focused with guided use of time for all to benefit<br>Site's preferred assessment process and documentation is provided at onboarding.<br>Forms and charting expectations are explicit and scaffolded during supervision. |

CITs reflecting on working with clients engaging in SDV may perceive their training as falling all in one column, or a mix of the columns and rows (Jacoby et al., 2024). CITs who perceive High Emotional Support/Availability and High Structure/Scaffolded Guidance tend to feel more realistically capable, open to learning more assessment methods and interventions, and are motivated to keep growing in skills and leadership. They demonstrate a more realistic self-assessment of their scope of competence, willingness to seek timely help, collaboration within the chain-of-command, and positive attitudes about working

with high-acuity clients. This exhibits *Compassion Satisfaction*, the personal satisfaction one feels in watching clients improve and benefit from skillful service that leads to ongoing motivation and growth in the clinician. There is no inappropriate amount of confidence present, as no such overcompensation is required to cope.

CITs who perceive Low Emotional Support/Availability and Low Structure/Scaffolded Guidance tend to exhibit some laissez-faire beliefs and practices regarding seeking consultation and training, initiating continuing education, or reflecting deeply on supervision practices with high-acuity clients. They demonstrate a vague self-concept regarding the scope of competence, low willingness to seek timely help, low interest in collaboration within the chain-of-command, vague attitudes about working with high-acuity clients, and hopelessness regarding improvement of supervision at the site (Jacoby et al., 2024). This is *Compassion Fatigue,* the growing inability to effectively serve one's population due to ongoing overwhelm. This systemic mutual disengagement and avoidance is rife with liability risk.

CITs who perceive High Emotional Support/Availability and Low Structure/Scaffolded Guidance tend to be willing to ask for more help when necessary but exhibit longer-term low confidence about what to do with high-acuity clients. They demonstrate a general sense of limits to their scope of competence but lack a clear understanding of what or how to improve in assessments or interventions. CITs in this category have a generally positive assessment of supervision, but lower self-efficacy (Jacoby et al., 2024). Their attitude toward skills development may be more reactive to client population needs, rather than proactive with a sustained growth mindset. However, because this interaction pattern creates a willingness to ask for help, they are more likely to seek ad hoc crisis supervision as needed. Supervisors must therefore position themselves as on-call for a longer training period than those who also scaffold structured guidance toward skillful independent practice.

CITs who perceive Low Emotional Support/Availability and High Structure/Scaffolded Guidance tend to want to work more independently but have a sense of self-efficacy. They have a more negative assessment of supervision but internalize an expanded sense of scope of competence (Jacoby et al., 2024). They are unlikely to ask for help within the chain-of-command unless a situation clearly exceeds their scope of competence, which can lead to attribution errors and liability risks. The clear order of operations to follow with high-acuity clients reduces ambivalence and anxiety about what to do when; however, the emotional discharge and cost of caring without sufficient emotional support may wear these clinicians down, resulting in negative morale and high turnover.

**Description of Innovation**

The authors recommend steps for counselor educators to integrate into their course design, and for supervisors to further scaffold with iterative practice. We suggest acknowledging that many CITs' lives have been touched by trauma, suicide, and/or NSSI; that trauma and crisis work is inherently activating; and that engaging in ongoing personal counseling is essential to cope with these stressors throughout our careers. (1) Provide open-source handouts to CITs the week before the quarter or site placement begins. The Suicide Prevention App (ISDI, 2019); My3 App; a safety planning guide and warning signs; language about suicide (IRMI, 2021); (Suicidology, 2019); guidelines for Crisis Response Planning and Collaborative Assessment and Management of Suicide; NSSI-AT; the SOARS model; and a crisis supervision safety protocol are all linked in references. (2) During in-class and supervision role-plays, have CITs reference their handouts and use additive empathy to guess at and be willing to be corrected about the unmet psychological needs that underlie the emotional pain being revealed. Stay with this pain (Shook, 2019), listening for and bracketing signs of hope that may be leveraged later. (3) For suicide assessment skills practice, have CITs ask directly, "How many times a day are you thinking about killing yourself? Is it about 10-20? 20-50? More than 100?" Do not allow euphemisms for the word "kill"; this avoidance of the severity can signal an inability to hear the truth (Shneidman, 1993). (4) For NSSI skills practice, have CITs state directly, "Sometimes when people are struggling like you are right now, they hurt themselves

without trying to kill themselves. Do you ever do that? Cut, scratch, burn, or hit yourself?". (4) Have CITs wait calmly for a response, practice reflective listening, and validate the unmet needs and painful affect. Have them engage perseverative thinking with a calm face and body while inviting clients to share their self-annihilation fantasies and/or self-harming rituals. The goal is to demonstrate the capacity to hear the painful truth and reduce client isolation with pain, thus piercing the suicide trance. (5) Guide CITs to go slowly and do nothing to try to "cheer up" the client, or rush to safety planning (Shneidman, 1993; Soper et al., 2022). Instead, have them stay with the client in their painful affect for at least 30 minutes. Then gently assess if the client can access hope for a better future. (6) With mock client, collaboratively follow safety planning intervention: (1) identifying individual warning signs; (2) identifying and employing internal coping strategies; (3) using social supports as distractions; (4) contacting trusted family or friends to help; (5) contacting specific mental health services; (6) reducing access to lethal means (Stanley & Brown, 2012). (7) When clients cannot identify hope or practice sufficient soothing from internal and external resources, have CITs demonstrate seeking the appropriate level of supervisory support for client safety, including the client whenever possible to protect rapport. If the client presents a flight risk with the added attention of a supervisor, seek supervisory help out of earshot of the client. Provide an overview of the expectations for how a warm hand-off is performed if a referral up is indicated.

**Instructional Strategy**

Building on the sequenced introduction of the innovation above, counselor educators can predict that CITs will require redirecting support to overcome social and religious taboos related to addressing SI and NSSI directly. Ferguson et al. (2022) noted that formal risk assessment and management processes could be experienced as disempowering because life context and personal decision-making are mediated by clinical appraisal. Demonstrating sensitivity to key predictors of SI helps CITs slow down their data collection process to stay in respectful emotional contact with clients; *hopelessness* indicates imminency of threat (Wolfe et al., 2019), while *thwarted belongingness* and *perceived burdensomeness* contribute to hopelessness (Roeder & Cole, 2019). Embodying a collaborative tone also requires practice and redirection when CITs are either too directive (i.e., hiding behind their role as assessors) or non-directive (i.e., staying in a supportive, passive, humanistic stance rather than shifting into active crisis management).

**Assessment of Student Learning**

To assess CITs' learning on NSSI and SI, the authors propose two assignments for the Crisis and Trauma Counseling class. The first assignment is a final skills demonstration video focused on trauma-informed risk communication outcomes and includes three components. Component one is a general demonstration of trauma-informed pacing, tone, prosody, proxemics & oculesics (i.e., attuned mimesis with body language and eye contact), to build rapport with the client within their window of tolerance. Component two is drawing out the crisis level of severity by following what the mock client has privately decided to present, mimicking what happens in real sessions. Component three concludes with CITs demonstrating risk communication and initiating supervisory support and/or safety planning as indicated.

The second assignment is a reflection paper that makes explicit the CIT's awareness of areas that require both supervisory and personal therapeutic support. The instructor reviews the final video and accompanying reflection paper for signs of self-awareness and ethical management of power, privilege, and cultural humility, as well as adherence to trauma-informed care and crisis protocols as outlined.

**Implications for Counseling**

The 2009 CACREP standards made explicit that programs became accountable for providing suicide training in core classes, while the 2016 standards articulated that programs were responsible for training students in suicide prevention models, strategies, and risk assessment procedures (2017). However, current students are still launching into practicum without understanding how to assess or intervene

effectively (Jacoby et al., 2024). The 2024 CACREP standards state that programs *must* assess student learning of procedures for assessing and responding to the risk of aggression or danger to others, self-inflicted harm, and suicide; and include emergency procedures in written supervision agreements.

### Limitations and Future Research

Further experimental research and validation are needed to determine if statistical significance with clinical implications might be achieved by this training and supervision model. Pre-and-post-testing of how effectively faculty and CITs engage in trauma-informed risk communication would help clarify which components are most essential (Tyler et al., 2024). Chu et al. (2017) center culturally competent assessment practices in training CITs to assess for suicide; faculty and supervisors are encouraged to utilize the Multicultural and Social Justice Counseling Competencies (Ratts et al., 2016) to validate any tools used.

Lastly, assessments are needed to determine the ability of CITs to perform emotionally regulated risk communication, intervention, and chain-of-command activation in a timely manner. The question, "How do we track crisis intervention growth in counselor education and supervision?" is posed. It is currently challenging to fully assess the comprehension of CITs when working with clients who exhibit NSSI, SI, and SA. We recommend integrating skills-focused assessments (i.e., role-playing, fishbowls, video case studies) and reflection journals to evaluate student comprehension and increase self-reflection for clinical skills with these populations.

## CONCLUSION

Due to the prevalence rates of SDV, all CITs need to be prepared to effectively assess and intervene within a chain-of-command to keep clients and sites safe. Current grounded theory research suggests that CACREP programs do not consistently prepare CITs for this responsibility. Supervisors must anticipate CITs' needs for high logistical and emotional support, as these clinical presentations can activate the fear response, which may reduce the coherence of the clinical response. Faculty and clinical supervisors who embody secure base provision via clear standard operating procedures, chain-of-command directives, and comprehensive co-regulation of emotional responses increase the likelihood that CITs will seek them out at the right time when help is needed for SDV and other high-acuity clinical presentations. Consistent scaffolded logistical support can systematically increase CITs' scope of competence toward more independent practice, while consistent emotional validation can protect CITs from burnout and compassion fatigue.

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