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The use of Core Competencies in Suicide Risk Assessment and Management in Supervision: A  
Feminist-Narrative Approach

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### Abstract

Therapists-in-training receive limited training in how to perform suicide risk assessment and management. This task is generally left for clinical supervision. In fact, one-to-one supervision is the most critical element in helping supervisees become skilled at assessment and management of suicide risk. This article proposes the use of the Core Competencies for Suicide Risk Assessment and Management (Suicide Prevention Resource Center, 2006), using feminist and narrative family therapy perspectives. This approach is meant to foster competence and confidence necessary for supervisees to perform suicide risk assessment and management. Specific tools for supervision are provided.

**KEYWORDS:** suicide, supervision, narrative therapy, feminist therapy, supervisor, supervisee competency, assessment, confidence

The Use of Core Competencies in Suicide Risk Assessment and Management  
in Supervision: A Feminist-Narrative Approach

Suicide is one of several high-risk situations therapists must deal with. Though not an everyday occurrence, clients presenting with suicide risk are a fairly common occurrence for mental health professionals. While the suicide rate in the general population is 12 per 100,000, the prevalence of suicide in psychiatric populations is 60 per 100,000 (Meichenbaum, 2005). Moreover, it is estimated that one in every two psychiatrists and one in every six psychologists will experience a patient's completed suicide in their careers (Meichenbaum, 2005). While client suicide risk does not make distinctions based on therapist experience, it is beginning therapists that generate more concern. The impact of client suicide on practitioners is intense, including reactions such as shock, self-blame, guilt, and shame. Moreover, the impact of client suicide can be even more severe on clinicians-in-training, with the amount of training received having an inverse relationship with the amount and duration of distress experienced (Rudd, Cukrowicz, & Bryan, 2008).

Although client suicide risk is a constant concern for mental health practitioners, studies show that graduate students receive little training on how to manage these situations. In one study of over 200 pre-doctoral psychology interns, findings indicate that only 50% of the sample reported being formally trained in managing such situations through their academic training programs (Dexter-Mazza & Freeman, 2003). This is a concerning estimate for clinical supervisors, considering that supervisees practice under a clinical supervisor's license, leaving a tremendous burden of responsibility on supervisors' shoulders. With that responsibility in mind, this article will explore the current best practices in managing client suicide risk and approaching supervision of new therapists regarding the issue of suicide risk assessment and management.

More specifically, this article will explore the use of the Core Competencies for Suicide Risk Assessment and Management (CCSRAI; Suicide Prevention Resource Center, 2006) using feminist and narrative family therapy perspectives. The CCSRAI provides structure to the training of supervisees in suicide risk assessment and management. The feminist-narrative approach emphasizes a postmodern feminist perspective, with focus on issues of power, language, and context. From that perspective, supervisors tend to adopt a collaborative approach to supervision, challenging assumptions, attending to intersections of multiple systems of oppression, and modeling behaviors and practices that follow ethics guidelines (AAMFT, 2006) while also encouraging supervisees to develop their own style and approach to treatment and suicide assessment and management. The main goal is that, with the combination of the CCSRAI and the use of a feminist narrative approach to supervision, supervisees will gain competence and confidence in their approach to suicide prevention and management.

### *Suicide and Best Practices*

Client suicide risk is a clinical scenario that, once encountered, calls for immediate action, following standard protocol. The common protocol used when a client discloses suicide ideation is for clinicians to follow a line of questioning exploring client intent (generally as a scaling question), whether there are available means to suicide, risk factors (previous attempts, substance use, impulsivity, gender, age, stress), and protective factors (reasons to live, support; Bryan & Rudd, 2006). From that assessment, clinicians may either invite clients to develop a safety plan (when risk is present, but low) or follow a plan of voluntary or involuntary hospitalization (when risk is higher, such as the presence of hopelessness, finds no reasons to live for, and has access to means to suicide). This general protocol appears to be clear, simple, and easy to follow.

However, a suicide assessment can be more than asking the right questions. In fact, it is not uncommon for clients and therapists to avoid the issue due to discomfort or fear, leading the suicide risk assessment to end prematurely (Rudd et al., 2008). A suicide risk assessment also depends on therapist-specific and relationship-specific factors, such as therapist's knowledge and confidence (Rudd et al., 2008), and working alliance (Meichembaum, 2005). In sum, even though the standard protocol is clear, the assessment of suicide risk is an anxiety-provoking task for both therapist and client, which in turn can hinder the effectiveness or the thoroughness of the assessment.

More recently, specific core competencies to aid practitioners in performing a satisfactory suicide assessment have been proposed (Suicide Prevention Resource Center, 2006). These core competencies indicate more than a course of action; they invite therapists to be self-reflective and explore their role in the assessment process.

The core-competencies approach has proven to be helpful in promoting effective training in suicide management; in fact, research indicates that core-competence training can alter clinicians' confidence in assessing and managing clients with suicide risk, along with helping clinicians incorporate specific behavioral changes in day-to-day practices that can make their clients safer (Oordt, Jobes, Fonseca, & Schmidt, 2009). Furthermore, when comparing the use of core competencies as an ongoing discussion versus one-time training (seminar or workshop format), ongoing training proved to be a superior modality with greater improvements in therapists' general interview and assessment skills (Morriss, Gask, Battersby, Francheschini, & Robson, 1999). One-to-one supervision was considered the most critical element in helping supervisees become skilled at assessment and management of suicide risk (Reeves, Wheeler, & Bowl, 2004). Given these findings, it appears that clinical supervision can be the ideal setting for

training and developing skills useful in suicide management. Effective training in suicide assessment needs to be a priority, considering that insufficient knowledge and training in that capacity may expose clients, therapists, and supervisors to undue risk.

*A feminist-narrative supervision approach as a way of fostering professional competence in new therapists*

Feminist family therapy and narrative therapy are based on similar foundations of social constructionism and social justice. Both feminist and narrative approaches emphasize the influence of social context as the framework to understanding human behavior, with a commitment to facilitating equality and challenging assumptions that disadvantage certain groups and benefit others. Based on social constructionist ideas, both narrative and feminist therapists see every person's personal and interpersonal realities as constructed through interaction with other human beings and institutions (Freeman & Combs, 2003; Wheeler, Avis, Miller, & Chaney, 1989). From that standpoint, there is not one "Truth" but multiple truths constructed from the context where people are immersed, creating individual social realities. Such realities influence meanings in people's lives (Freeman & Combs, 2003).

For feminist therapists, special emphasis is placed on social context, sharing of power in the therapeutic relationship, considering issues from a social justice viewpoint, and recognizing multiple systems of oppression or privilege operating in people's lives (Wheeler et al., 1989). For narrative therapists, their knowledge and professional selves are in a process of constant development. Therapists take a stance of "not-knowing," in that therapists must learn their clients' reality, as well as their needs, and what life direction they wish to pursue. The focus of treatment is not on "fixing problems" but on thickening narratives that do not sustain problems. From a narrative approach, much attention is paid to language, which is seen as constituting our

world and beliefs. Therefore, change involves a change of language (Freeman & Combs, 2003; White & Epston, 1999).

Supervision from a feminist-narrative perspective is focused on collaboration and respect between supervisor and supervisee, privileging both as sources of knowledge. During supervision sessions, the supervisor asks questions that can thicken the therapist's narrative about their work with clients challenging existing assumptions, particularly attending to assumptions that privilege certain groups over others, including but not limited to race, gender, sexual orientation, socio-economic status, or immigration status. The supervisor explores with the supervisee their use of language about their clients, questions surrounding therapist's interventions (landscape of action), meanings (landscape of consciousness), unique and preferred outcomes, and questions of relative influence (Freeman & Combs, 2003).

Consistent with findings on common methods of feminist family therapy supervision (Prouty, Thomas, Johnson, & Long, 2001), the supervision approach proposed here may take two main approaches: collaborative or hierarchical. Collaborative supervision is the primary approach to supervision, by fostering competence, honoring multiple perspectives, contemplating options, making collaborative call-ins, and mutual feedback. During these interactions, the supervisor generally takes a guiding but reflective role, allowing the supervisee to draw from their already existing knowledge and develop confidence in the competencies that they bring to the therapeutic and supervisory relationship. When necessary, considering the supervisee's developmental level and the general risk assessment of the situation, the supervisor may take a hierarchical stance, offering directives, modeling, or making directive call-ins. Considering the need to constantly train and evaluate supervisees in their ability to provide effective suicide risk assessment and management, and that the goal of supervision is to generate clinicians that are



capable of self-supervision (Todd, 2002), it is proposed here that the feminist-narrative approach can be a valuable approach in fostering the competence and confidence necessary for supervisees' professional development, and more specifically, in the issue of suicide management.

### *Implications of the use of the core competencies in supervision*

The proposed core competencies in suicide assessment and management (Suicide Prevention Resource Center, 2006) comprise seven competencies that are meant to assist therapists and clinical supervisors in their suicide risk assessment training. The seven competencies include: attitudes and approach to suicide, understanding suicide, collecting accurate assessment information, formulating risk, developing services and a treatment plan, managing care, and understanding legal and regulatory issues related to suicidality. An exploration of each of the core competencies is beyond the scope of this article, but a list of the core competencies can also be found in Appendix 1. Rudd et al. (2008) suggest that these competencies can be translated into three main tasks for the supervisory relationship: addressing self-awareness and understanding of suicidality, ensuring content mastery, and monitoring and refining skill acquisition. The following sections describe vignettes of supervision challenges and brief examples of how these tasks can be accomplished in supervision from a feminist-narrative approach.

#### *Addressing Self-Awareness and Understanding of Suicidality*

One of the foundational skills necessary to successfully manage suicidality indicated by the core competencies is to explore therapists' attitudes and approach to suicide. Self-reflection and an examination of the supervisee's own biases about suicide fits well within the feminist framework, as one of the main tasks of feminist supervision is enhancing self- and social

awareness (Wheeler et al., 1989). While this task is crucial in family therapy training in general, it is an essential task to suicide assessment training, because any discomfort or anxiety over issues related to suicide can lead the assessment to end prematurely. During this task, supervisor and supervisee explore emotional reactions to suicide, past experiences, preconceived ideas and personal beliefs, and the potential impact of these reactions and ideas to the therapist's performance in suicide risk assessment and management. During the exploration of these topics, the supervisee has an opportunity to self-evaluate on where they stand on the issue of suicide. The focus turns to the therapist, rather than the client. The main goals for this task are: (a) assess the supervisee's assumptions and reactions to the topic; (b) assess their level of understanding of how these assumptions affect assessment and treatment; and (c) develop goals for how supervisee would like to address suicide assessment in the future.

*Case Example.* A novice supervisee seeks supervision for a case. The novice supervisee presents the case, a female client in her late thirties, whose relationship was terminated shortly before their wedding. The client demonstrates symptoms of depression, and in the words of the supervisee, is "suicidal." The supervisee is anxious about the situation, and is having difficulties empathizing with the client, who is described as someone who is "thinking about killing herself because she got dumped." This can be a challenging situation in which the supervisor has an opportunity to explore with the supervisee the first task of the core competencies for suicide risk assessment and management. The supervisor addresses several relevant points while meeting with the supervisee. The first task is to address with the supervisee the role of language and provide an opportunity for reflection about the effect of language in approaching the client.

*Supervisor:* "I noticed that you refer to the client as a 'suicidal' client. Did you notice that? Can you tell me a little about that choice of words?"

*Supervisee:* “I think that is how we all discuss cases, us students. You know, maybe it is a way to identify our clients: ‘my suicidal client,’ ‘my borderline client,’ ‘my depressed client.’ I think it is a way of simplifying things.”

*Supervisee:* “So, you are saying that it is perhaps done to facilitate discussions. Can you think of any drawbacks to that terminology?”

*Supervisee:* “I think it may box the client in a category, and it kind of negates everything else they might be; you know, the client may not always be in that state, but when we talk about it that way, we end up making it more static, like they have always been and always be in that suicidal state.”

*Supervisor:* “Good point. So, perhaps you would like to attend more to the language you use to describe the client, focusing on perceptions of the problem as separate from the client, such as: you have a client presenting with ‘suicidal ideas,’ not a ‘suicidal client?’”

*Supervisee:* “Absolutely. I never thought about it that way.”

*Supervisor:* “So, I see that you are anxious about meeting this client, and maybe a big part of that is the fact that the client contemplates suicide. So, do you mind if I ask about your views on suicide? What are your personal theories about why people *Supervisee:* “I think I am really afraid of talking about it. I am afraid of addressing it with clients, because I am afraid that they will say that they have thought about it. And then I won’t know what to do. I think I feel very vulnerable in those situations, because I think ‘who am I to try to talk anyone out of anything?’”

*Supervisor:* “So there is a lot of discomfort and uncertainty about what you can do in those situations. If you have a client presenting with suicidal ideation, what do you think

are the contributing factors that brought them to this idea of suicide as a real possibility for them?”

*Supervisee:* “I have a hard time connecting with them, because it sounds like to me they are at a level of desperation that I have never experienced, so I feel like I am at a loss. I think that’s why I can’t empathize with her. I don’t know what to do.”

*Supervisor:* “That feeling of helplessness comes again. When that feeling of helplessness comes in, how does it affect your relationship with your client?”

*Supervisee:* “I freeze. I just don’t know what to do, what to say. I am sure I am not that helpful to the client.”

*Supervisor:* “Helplessness makes you feel stuck. In some ways, you and your client may be sharing the same feeling. So, what would be your ideal way of conceptualizing suicide? How do you want to respond to clients who present with suicidal thoughts?”

*Supervisee:* “I would like to be able to shut off all the fears and the concerns that I have at that moment, and to just be able to be with my client. Well, I don’t know that I can not be fearful, but at least to be able to function. My fears really get in the way and I can’t think. If someone is telling me something like that, and I have a deer-in-the-headlight look, it might come across as judgment to my client. I think if I can calm down and not feel so overwhelmed, I will be able to think better too and come up with something to say.”

*After the session, supervisee seeks supervisor and reflects back on the session:*

*Supervisee:* “I was still nervous in session, but I was able to offer the client more empathy today. I think talking about it helped, in the sense that I am more self-aware and I am able to regulate my emotions better. I would notice myself drifting off because of

my concerns, or feeling my breathing was getting faster, and then I would bring myself back. I think I need more time, but I am more hopeful.”

Consistent with the first task of the core competencies for suicide risk assessment and management, these opening questions explored the therapist’s views and behaviors, what impact those views have on treatment, and the supervisee’s goals. Other important behaviors to include in the supervisory agenda is instilling the concern and need for thorough suicide risk assessment with all incoming clients, including reassessment and monitoring with current ongoing cases. One way of demonstrating this priority is asking supervisees to always include information on risk factors when presenting cases in supervision, regardless of the presenting concern. Many times, supervisees may underestimate the presence of suicide ideation, if the client does not bring a presenting concern that might lead the supervisee to believe that an assessment is warranted (e.g., client presenting with depressive symptoms, grief and loss, or other signs of hopelessness). The challenge is to incorporate a suicide assessment to the supervisee’s standard clinical practice, rather than performing an assessment only in situations when the supervisee feels like there might be a reason to further assess suicide risk. The constant questioning about the issue and the reiteration of its importance is meant to demonstrate concern and the seriousness of the issue at hand. More caution and the understanding of the importance of such assessment is likely to better prepare supervisees to manage risky situations than approaching suicide as an unlikely occurrence under their watch. The role of the supervisor is to role model, in a persistent and collaborative manner, an attitude of concern and competence.

#### *Content Mastery*

The main task with the content mastery portion of the core competencies is increasing the supervisee’s confidence in assessment by increasing knowledge about suicide, risk/protective

factors, statistics, and procedures. While supervisees are expected to have basic knowledge about suicide risk assessment and management, it is important to convey to the supervisee that acquisition of knowledge is ongoing. Supervisees should be encouraged to seek out new resources that could be helpful in increasing competence. The supervisor can offer resources, but supervisees should be strongly encouraged to develop their own resource archive. The goal is empowering the supervisee through knowledge, and encouraging and guiding supervisees' search for knowledge is part of the feminist model of supervision (Prouty et al., 2001). Actively pursuing resources rather than passively receiving them is proposed here as more fitting for the professional development of therapists in order to reach independent thinking and empowerment.

*Case Example.* A supervisee approaches the supervisor's office outside of their supervision session. The supervisee will have to do an emergency intake in a couple of hours in which the client has been threatening suicide. The supervisee is anxious and wants help in preparing for that assessment. The supervisee reports feeling unsure about what forms or information to take to the session and is playing out situations of the possible scenarios and the decisions will need to be made. It is clear that the supervisee's anxiety is leading to feelings of helplessness and feeling unprepared for the appointment.

The main goals for this task are: (a) privilege the knowledge supervisee already has, encouraging independent thinking; (b) encourage continuous accumulation of knowledge, actively engaging supervisees in searching for knowledge; and (c) model an attitude of confidence and calm, allowing supervisee to problem-solve and retrieve information that they already have but which may be blocked due to anxiety.

*Supervisor:* "You are anxious about what to do with this client. Let's think about the case, and tell me what you believe it is necessary to happen during that intake."

*Supervisee:* “Well, I need to assess for suicide, and then make a decision in terms of whether or not to direct the client for hospitalization, or sign a no-suicide contract, that kind of thing.”

*Supervisor:* “Ok, so how do you assess? Can you demonstrate what your assessment would look like?”

*Supervisee:* “Yes, so I would ask during the interview if there have been any time when they have considered suicide. If they respond yes, I’ll ask when, and how, and maybe scale to see how sure/unsure they were about it.”

*Supervisor:* “Right. And then?”

*Supervisee:* “Then assess reasons to live. Maybe ask what would make them feel more or less strongly about it.”

*Supervisor:* “Right. What is the attitude you want to have in that interview?”

*Supervisee:* “I just want to be calm.”

*Supervisor:* “I understand it is a difficult situation, particularly because we need to rely on our clinical judgment and we may need to assert our need to protect our clients. I know you are very collaborative in your approach to clients, how do you feel about the idea that client safety is non-negotiable and you may need to enforce that with your client?”

*Supervisee:* “I think it will be hard. But it may also be a way to demonstrate that we care about clients. I mean, you can present that in a tone of control or in a tone that demonstrates care.”

*Supervisor:* “It sounds like it fits with you to have that discussion in a caring way. So, did you notice that you knew all the answers about how to approach this? I would encourage

you to start developing a protocol to that can help you incorporate suicide risk assessment in sessions for intakes and ongoing cases. This may a good way for you to become more involved with the subject and it would be excellent practice. Lastly, would you like to spend a few minutes revising documentation and how to document your assessment in your case notes?"

*After the session, supervisee assessed the situation:*

*Supervisee:* "It went well, and the client was able to identify a safety plan and we have a session tomorrow. I talked to the client about the need to continue talking about suicidal thoughts and continue assessing, and really emphasized safety. I think the best way to go about this is to make it part of every session, and perform a brief assessment, maybe ask the client to scale suicidal thoughts, intent, or plan. Making it a matter-of- fact topic rather than a taboo will be better for me and better for the client."

This is a process of active search for resources and thinking about how the suicide risk assessment can be modified and made to fit the supervisee's current practice. Simultaneously, as it has come up in this case example, it is important to explore the therapist's empathy for the client, and discuss the possibility for the therapist to develop empathy for the suicidal wish (Orbach, 2001). Such empathy is helpful in reconciling the conflict between the client's desire to eliminate psychological pain and the therapist's desire to prevent suicide (Rudd et al., 2008). If the conflict between the death wish and the desire to help is not resolved, the product is an adversarial relationship rather than a collaborative one, though research findings indicate that collaborative relationships are more helpful in such cases (Bryan & Rudd, 2006).

Modeling calm and confidence to the supervisee is very important, in expectations that their anxiety about the issue will be reduced, and that they will be able to think more clearly,



retrieving the knowledge that they already have about the topic as well as identifying areas that need more attention. Privileging the knowledge the supervisee already has is essential, instead of adopting a stance of providing the information to the supervisee without reflection. Consistent with feminist supervision, the supervisor adopts a curious and supportive stance (Prouty et al., 2001), stimulating supervisee's confidence and retrieval of already existing knowledge.

Developing a personal approach to a suicide assessment makes the process more individualized while still including the important elements of a suicide risk assessment. Such an approach gives supervisees a sense of mastery, as they are actively working on their own professional development. While many supervisees feel that they have the basic knowledge to manage such situations from what they have learned from their training programs, the content mastery task is focused on increasing knowledge, helping supervisees interact with the literature, rethinking practice, and actively pursuing integration.

#### *Refining Skill Acquisition*

This next phase calls for supervisors to continue assessing supervisees' development in terms of suicide assessment, management, and prevention, regardless the stage of professional development of the supervisee. The task of refining skill acquisition means continuously reviewing new knowledge acquired and adjusting strategies as needed. At this stage, the previous two tasks are revisited, and new information is gathered based on supervisee's experiences in their practice and their own personal reflections. It would be essential to review the meaning of successful experiences with the supervisee and provide feedback on their work. Main goals for this task are: (a) reassess supervisee's development regarding the subject matter and (b) identify areas for improvement or expand knowledge about the subject.

*Case Example.* During supervision, a supervisee presents a case of a client who has been in treatment for a few sessions and shares with the supervisor that the client commented on suicidal ideation during their last meeting. This supervisee has had a few experiences with suicide risk assessment and management and is notably concerned, but demonstrates less anxiety about the case that day. This supervisee has been working on developing a protocol of suicide risk assessment and management and has implemented it successfully.

*Supervisor:* “After using your knowledge and protocol with a few clients, how have your views on suicide and clients presenting with the issue changed?”

*Supervisee:* “I think it has improved, and I can say I am better prepared about what to do in those situations, after all these experiences. I feel a lot more competent in taking cases, knowing that I can be present with my client, I can work with them in those situations.”

*Supervisor:* “Do you recall your initial approach, your gut reaction to the topic a few months ago?”

*Supervisee:* “Yes, I felt very insecure. I believe the word we used was helpless. I did not feel it was my place, or that there was nothing I could offer to the client.”

*Supervisor:* “And do you feel you have anything to offer now?”

*Supervisee:* “I think I do now. I have seen some pretty awesome things with clients. And I think I know a lot more about it too, so I have more to offer. I hope my clients have a better experience with me now.”

*Supervisor:* “What does that mean about you as a therapist?”

*Supervisee:* “That I am turning into a decent therapist! I mean, I have a lot to learn, but it is nice to see that I can overcome problems and I actually believe that I can do some good now.”

*Supervisor:* “Good. So how is your protocol working for you? What else regarding suicide would you like to discuss?”

*Supervisee:* “I heard about some books about suicidality that I wanted to take a look at, to see if I can improve my work in that area. I also heard about a session that will be presented at our national conference that will be about suicide assessment. I am curious to hear if there is anything new or different ideas about it. I think I also would like to talk more about boundaries with clients. I think it is difficult for me to establish those with some clients, particularly if they present with suicidal thoughts.”

Honoring the social constructionist epistemology, this is a time of reassessing and revisiting the process from the supervisee’s perspective and making adjustments and assessing the efficacy of the protocol and their performance from their perspective. At this time, the supervisees are guiding their own professional development and may feel a sense of mastery that was not experienced prior to exploring the issue. This is also a good opportunity to provide feedback on the supervisee’s endurance throughout the process and give the supervisee an opportunity to stop and reflect on their performance and growth. Throughout the supervisory relationship, the three tasks of self-awareness, content mastery, and refining skills are constantly reevaluated in an ongoing conversation that continues to evolve and build confidence and competence. This protocol is applied regardless of the supervisee’s experience level, in order to increase the effectiveness of the supervisee’s training in suicide risk assessment and management.

### *Conclusion*

The supervisory role includes several demands, but few are as important as the responsibility for keeping clients safe. In order to fulfill the commitment to safety, clinical

supervision has an important role in providing continued training to therapists, as training in graduate programs is limited. Ongoing training, particularly in the form of one-to-one supervision, is the most beneficial approach to developing skills in suicide risk assessment and management (Morriss et al., 1999; Reeves et al., 2004).

Using the three basic tasks of the core competencies suggested by Rudd et al. (2008)—self-awareness, content mastery, and refining skill acquisition—it is proposed here that supervisors engage in an ongoing conversation with supervisees about suicide assessment, further refining supervisees' skills, easing supervisees' anxiety surrounding suicide assessment and management, and increasing confidence in their knowledge and skills. The underlying task of supervision can generate confidence by providing opportunities for supervisees to reflect on their own work, assess their strengths and weaknesses, their growth, and develop the ability to self-supervise (Todd, 2002). Investing time and energy in suicide risk assessment and management is expected to generate more skilled therapists who can provide well-rounded assessments, in that supervisees are capable of establishing a good working alliance with clients—demonstrating empathy with clients in their pain in a context of genuine care and concern—but who are ultimately committed to preserving clients' safety as a priority. Future research should focus on further exploring the effects of supervision “as usual” compared to supervision focused on core competencies in situations where there is suicide risk. In addition, qualitative studies of clients' experiences in suicide risk assessment are needed to explore the perceptions of therapists' approach to suicide.

In sum, responsible practice should be take precedence both in clinical practice and supervision. Clients trust our work as mental health providers to be nothing less than theoretically, empirically, and ethically sound. The clinical supervisor is not only liable for their

supervisee's clients but is also responsible for the formation of competent clinicians through supervision. Furthermore, gatekeeping to the profession is one of our responsibilities as supervisors (AAMFT, 2006), and one of the ways we further assess and evaluate supervisees is through their reactions and actions in a risk-laden situation. Through formal training, self-of-the-therapist discussions, and modeling constant awareness and sensitivity to risk concerns, clinical supervisors can better prepare supervisees to engage in clinical work with confidence, caution, and responsibility.

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## APPENDIX 1

Core competencies for the assessment and management of individuals at risk of suicide

A. Working with individuals at-risk for suicide: Attitudes and approach

1. Manage one's reactions to suicide.
  - a. Become self-aware of emotional reactions, attitudes, and beliefs related to suicide.
  - b. Understand the impact of clinicians' emotional reactions, attitudes, beliefs on the client.
  - c. Tolerate and regulate one's emotional reactions to suicide.
  - d. Obtain professional assistance.
2. Reconcile the difference (and potential conflict) between the clinician's goal to prevent suicide and the client's goal to eliminate psychological pain via suicidal behavior.
  - a. Understand that suicidal thinking and behavior "makes sense" to the client when viewed in the context of his or her history, vulnerabilities, and circumstances.
  - b. Accept that a client may be suicidal and validate the depth of the client's strong feelings and desire to be free of pain.
  - c. Understand the functional and useful purpose of suicidality to the client.
  - d. Understand that most suicidal clients suffer from a state of mental pain or anguish and loss of self-respect.
  - e. Maintain a nonjudgmental and supportive stance.
  - f. Voice authentic concern and true desire to help the client.
  - g. View each client as an individual with his or her own unique set of issues and circumstances and someone the clinicians seeks to understand thoroughly within the



client's own mini-culture (family and community context) rather than a stereotypic "suicidal client."

3. Maintain a collaborative, non-adversarial stance.

a. Listen thoroughly to attain a shared understanding of client's suicidality and goals.

b. Communicate that helping to achieve resolution of the client's problem(s) is paramount.

c. Obtain informed consent.

d. Create an atmosphere in which the client feels safe in sharing information about his or her suicidal thoughts, behaviors, and plans.

e. Share what you know about the suicidal state of mind.

f. Honestly express to the client why it is important that the person continue to live.

g. Work with the client and do not abandon him or her.

h. Be empathic to the suicidal wish.

4. Make a realistic assessment of one's ability and time to assess and care for the client as well as for what role the clinician is best suited.

## B. Understanding suicide

1. Define basic terms related to suicidality.

2. Be familiar with suicide-related statistics.

3. Describe the phenomenology of suicide.

4. Demonstrate understanding of risk and protective factors.

a. Ask questions about suicide-related risk and protective factors during assessment.

b. Consider risk and protective factors when formulating risk.

c. Incorporate modifiable risk and protective factors into treatment and services planning.

- d. Consider risk and protective factors when managing suicidal clients.
5. Collecting accurate assessment information.
    - a. Integrate risk assessment for suicidality early on in a clinical interview, regardless of the setting in which the interview occurs, and continue to collect assessment information on an ongoing basis.
    - b. Elicit risk and protective factors.
    - c. Elicit suicide ideation, behaviors, and plans.
    - d. Elicit warning signs of imminent risk of suicide.
    - e. Obtain records and information from collateral sources as appropriate.
    - f. Formulate risk.
  6. Make a clinical judgment of the risk that a client will attempt or complete suicide in the short and long term.
    - a. Integrate and prioritize all the information that has been collected.
    - b. Assess the client's motivation to minimize risk and motivation to exaggerate risk.
    - c. Assess acute/imminent suicidality.
    - d. Assess chronic/ongoing suicidality.
    - e. Consider developmental, cultural, and gender-related issues related to suicidality.
  7. Write the judgment and the rationale in the client's record.
  8. Developing a treatment and services plan.
  9. Collaboratively develop an emergency plan that assures safety and conveys the message that the client's safety is not negotiable.
  10. Develop a written treatment and services plan that addresses the client's immediate, acute, and continuing suicide ideation and risk for suicide behavior.

- a. Address key modifiable risk and protective factors.
  - b. Specify the setting and frequency of managements for specific periods of time: immediate, acute, continuing care, maintenance, and resolved suicidality.
  - c. Identify a range of treatment alternatives.
  - d. Develop a plan collaboratively with the client, family members, and significant others.
11. Coordinate and work collaboratively with other treatment and service providers in an inter-disciplinary team approach.
12. Manage care.
13. Develop policies and procedures for following clients closely, including taking reasonable steps to be proactive.
- a. Motivate and support clients in getting them a referral source to their next treatment/management session.
  - b. Engage in collaborative problem-solving with the client to address barriers in adhering to the plan and revise the plan as necessary . . . session by session.
  - c. Assure that the client, family, significant others, and other care providers are following through on agreed-upon actions.
  - d. Address the outcome of each referral.
  - e. Develop and implement follow-up procedures for all missed appointments.
  - f. Be available between appointments.
  - g. Arrange for clinical coverage when clinician is unavailable.
  - h. Assure continuity of care and follow-up contact with all suicidal clients who have ended treatment.
14. Follow principles of crisis management.

- a. Take a problem-solving approach.
- b. Maintain a matter-of-fact demeanor.
- c. Perceive crises as opportunities for growth.
- d. Know that crises are short-lived.
- e. Neither punish nor reinforce suicidal behaviors.

15. Document the following items related to suicidality:

- a. Informed consent
- b. Information that was collected from a bio-psycho-social perspective
- c. Formulation of risk and rationale
- d. Treatment and services plan
- e. Management
- f. Interaction with professional colleagues.
- g. Progress and outcomes.

16. Understand legal and ethical issues related to suicidality.

17. Understand state laws pertaining to suicide.

18. Understand legal challenges that are difficult to defend against as a result of poor or incomplete documentation.

19. Protect client records and rights to privacy and confidentiality following The Health Insurance Portability and Accountability Act of 1996 that went into effect April 15, 2003.

The Core Competencies in Suicide Risk assessment and management: Implications for Supervision (Suicide Prevention Resource Center, 2006), were reproduced from the article *Core competencies in suicide risk assessment and management: Implications for supervision*, by Rudd et al. (2008).