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Series Preface

Tony Rousmaniere and Alexandre Vaz

We are pleased to introduce the Essentials of Deliberate Practice series of training books. We are developing this book series to address a specific need that we see in many psychology training programs. The issue can be illustrated by the training experiences of Mary, a hypothetical second-year graduate school trainee. Mary has learned a lot about mental health theory, research, and psychotherapy techniques. Mary is a dedicated student; she has read dozens of textbooks, written excellent papers about psychotherapy, and receives near-perfect scores on her course exams. However, when Mary sits with her clients at her practicum site, she often has trouble performing the therapy skills that she can write and talk about so clearly. Furthermore, Mary has noticed herself getting anxious when her clients express strong reactions, such as hopelessness, skepticism about therapy, or becoming very emotional. Sometimes this anxiety is strong enough to make Mary freeze at key moments, limiting her ability to help those clients.

During her weekly individual and group supervision, Mary's supervisor gives her advice informed by empirically supported therapies and common factor methods. The supervisor often supplements that advice by leading Mary through role-plays, recommending additional reading, or providing examples from her own work with clients. Mary, a dedicated supervisee who shares tapes of her sessions with her supervisor, is open about her challenges, carefully writes down her supervisor's advice, and reads the suggested readings. However, when Mary sits down with her clients, she often finds that her new knowledge seems to have flown out of her head, and she is unable to enact her supervisor's advice. Mary finds this problem to be particularly acute with the clients who are emotionally evocative.

Mary's supervisor, who has received formal training in supervision, employs supervisory best practices, including the use of video to review supervisees' work. She would rate Mary's overall competence level as consistent with expectations for a trainee at Mary's developmental level. But even though Mary's overall progress is positive, she experiences some recurring problems in her work. This is true even though the supervisor is confident that she and Mary have identified the changes that Mary should make in her work.

The problem with which Mary and her supervisor are wrestling—the disconnect between her knowledge about psychotherapy and her ability to reliably perform psychotherapy—is the focus of this book series. We started this series because most therapists experience this disconnect, to one degree or another, whether they are beginning trainees or highly experienced clinicians. In truth, we are all Mary.

To address this problem, we are focusing this series on the use of deliberate practice, a method of training specifically designed for improving reliable performance of complex skills in challenging work environments (Rousmaniere, 2016, 2019; Rousmaniere et al., 2017). Deliberate practice entails experiential, repeated training with a particular skill until it becomes automatic. In the context of psychotherapy, this involves two trainees role-playing as a client and a therapist, switching roles every so often, under the guidance of a supervisor. The trainee playing the therapist reacts to client statements, ranging in difficulty from beginner to intermediate to advanced, with improvised responses that reflect fundamental therapeutic skills.

To create these books, we approached leading trainers and researchers of major therapy models with these simple instructions: Identify 10 to 12 essential skills for your therapy model where trainees often experience a disconnect between cognitive knowledge and performance ability—in other words, skills that trainees could write a good paper about but often have challenges performing, especially with challenging clients. We then collaborated with the authors to create deliberate practice exercises specifically designed to improve reliable performance of these skills and overall responsive treatment (Hatcher, 2015; Stiles et al., 1998; Stiles & Horvath, 2017). Finally, we rigorously tested these exercises with trainees and trainers at multiple sites around the world and refined them based on extensive feedback.

Each book in this series focuses on a specific therapy model, but readers will notice that most exercises in these books touch on common factor variables and facilitative interpersonal skills that researchers have identified as having the most impact on client outcome, such as empathy, verbal fluency, emotional expression, persuasiveness, and problem focus (e.g., Anderson et al., 2009; Norcross et al., 2019). Thus, the exercises in every book should help with a broad range of clients. Despite the specific theoretical model(s) from which therapists work, most place a strong emphasis on pantheoretical elements of the therapeutic relationship, many of which have robust empirical support as correlates or mechanisms of client improvement (e.g., Norcross et al., 2019). We also recognize that therapy models have established training programs with rich histories, so we present deliberate practice not as a replacement but as an adaptable, transtheoretical training method that can be integrated into these existing programs to improve skill retention and help ensure basic competency.

About This Book

This book in the series is on self-directed violence (SDV) assessment skills and includes a series of exercises designed to increase therapist competency in assessing and treating clients who are making statements or engaging in a range of behaviors that fall under the SDV umbrella, including potentially fatal suicidal ideation and behaviors as well as nonfatal thoughts and behaviors that fall more under the self-injury description. SDV assessment skills are critical for all therapists to have in their toolbox because when a client enters a therapist office, we can never fully know whether they will utter or report SDV statements and behaviors. SDV assessment skills require that the practitioner pay attention to the specific content questions aimed at assessing the client's risk level while processing issues to help gain client cooperation and honesty. Most professionals can ask

a checklist of questions, but the art of effective SDV assessment requires understanding the client's motivation to engage openly in the therapeutic process and knowing how to handle difficult or life-threatening responses. Practicing SDV assessment skills, with ongoing feedback, is needed to build, strengthen, and increase confidence with these crucial skills. This allows clinicians not only to tend to the clinical needs of their clients but also to meet legal and ethical responsibilities as they relate to certain SDV scenarios.

In this book, we adopt deliberate practice methods to support experiential—learn by doing—training opportunities. The described methods and stimuli can facilitate practicing a range of important SDV assessment skills. In addition, this text supports fine-tuning the “how” of intervention delivery, conducted in a flexible manner across diverse clinical scenarios. Importantly, this book is not intended to replace core coursework and exposure to foundational SDV theory, interviewing skills, and legal and ethical responsibilities. Rather, its purpose is to augment other common training components.

Thank you for including us in your journey toward psychotherapy expertise. Now let's get to practice!

Introduction and Overview of Deliberate Practice in Assessing Self-Directed Violence

Self-directed violence (SDV) touches the lives of families and communities across the world in devastating ways, manifesting in forms ranging from self-harm and suicide attempts to completed suicide, claiming someone's loved one every 11 minutes. In the United States, more than 49,000 people died by suicide in 2023 (Centers for Disease Control and Prevention, 2025), representing not just a statistic but tens of thousands of grieving families, friends, and communities. Behind each number is a person who was struggling—perhaps a parent, a teenager, a veteran, or a colleague—and whose emotional and psychological pain (Williams, 1997) led them to harm themselves in ways that can have lasting or fatal consequences.

What makes this tragic choice even more heartbreaking is that many instances of SDV could be prevented with proper intervention. Yet when people in crisis reach out for help, they often encounter mental health professionals who, despite their best intentions, lack adequate training in recognizing and responding to SDV. Clinicians report substantial gaps in their suicide prevention knowledge and training (Kene et al., 2019; Labouliere et al., 2021), meaning that at the moment when someone needs lifesaving care the most, their therapist may not have the specialized skills to address the full spectrum of self-harmful behaviors.

As prominent suicide researcher David Jobes (2023) has emphasized, the assessment of risk for SDV is a complex and dynamic process. Our sincere hope is that this book will help to fill the gap by supporting SDV skill development of new and experienced therapists alike. Research has shown that specific suicide training improves trainees' reports of confidence in working with a client who is suicidal (Oordt et al., 2009). The stakes could not be higher: Ensuring that every mental health professional has the tools and knowledge to recognize warning signs and deliver evidence-based interventions for SDV isn't just about improving clinical practice—it's about saving the lives of people who matter deeply to someone.

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Deliberate Practice in Assessing Self-Directed Violence, by R. Scholz, S. R. Hall, B. Van Brunt, A. Vaz, and T. Rousmaniere
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Like you, each of us authors entered the field with a passion for helping people and making a difference. At the same time, however, we didn't enter the mental health field because we wanted to focus on working with self-directed forms of violence. Yet, as many discover throughout their training and experiences, our paths unfolded, and we each found ourselves in places we might have never imagined when we started out. For example, my (Robert Scholz's) initial experiences in crisis mental health began as a graduate intern at a college counseling center, on a community crisis team and during initial professional experiences doing crisis work with children and teens. I vividly recall some of those first experiences where clients expressed various forms of self-directed thoughts of violence, including thoughts of suicide, desires to self-mutilate and cut, and descriptions of previous attempts of suicide. Whether as a beginner or later as a more experienced therapist, these moments remain filled with emotion and a heightened sense of responsibility.

I (Robert Scholz) am thankful for the early in-house and continuing education trainings I engaged in and for the supervisors who stayed on the phone with me late into the evenings or spent extra hours of supervision preparing me for these conversations. As the number of assessments increased, my confidence and skill set improved, which led me more into the field of crisis response and risk management. Drawing from our counseling, coaching, teaching, and training experiences, we want others in the profession to learn how to become empathic and effective surveyors of risk when faced with a client in crisis. We each hope that this book helps you learn and enhance your craft with SDV.

A brief trigger warning for readers of this text. Having taught graduate students, licensed professionals and paraprofessionals for more than 3 decades, we have appreciation for the fact that many readers have their own lived experiences of SDV, whether that be from their own challenges or those experiences by friends, family, neighbors, or clients. Given that this book contains discussions of suicide, self-harm, and mental health struggles, which may be distressing or triggering for some, please proceed with caution. You and your mental well-being are important, so consider whether you are in the right state of mind or space to engage with this content, as well as who can support you and what you might need if you decide to move forward and engage in this learning process.

This invitation for self-reflection is essential because you never know whether or when your next client or student will be suicidal. Oordt et al. (2005) found that one in five psychologists and one in two psychiatrists experienced patient suicide. We believe that you can and should be prepared to address suicide and suicidality with competence and confidence. Competence begins with understanding your own attitudes, beliefs, and values. Throughout this book, we will intermittently ask you to check in with yourself and to notice, accept, and manage your thoughts, emotions, and behavioral impulses. Working with clients who are suicidal is emotionally activating. Becoming comfortable with suicide as an issue in counseling is a developmental process that takes time and practice. One way of looking at the content of this book is as an exposure experience that will improve your ability to self-regulate when facing crisis situations as a counseling professional. We appreciate your investment in yourself and in this essential work.

Overview of the Deliberate Practice Exercises

The main focus of the book is a series of 10 exercises that we have included because they represent relevant best practices in the assessment of SDV. The first 10 exercises each represent essential SDV assessment skills. The last two exercises are more comprehensive, consisting of an annotated SDV assessment skills transcript and improvised mock therapy sessions that teach practitioners how to integrate all these skills into more expansive clinical scenarios. Table 1.1 presents the 10 skills that are covered in these exercises.

Throughout the exercises, trainees work in pairs under the guidance of a supervisor and role-play as a client and a therapist, switching back and forth between the two roles. Each of the 10 skill-focused exercises calls for a specific skill and consists of multiple client statements grouped by difficulty—beginner, intermediate, and advanced. For each skill, trainees are asked to read through and absorb the description of the skill, its criteria, and some examples of it. The trainee playing the client then reads the statements, which present varying degrees of content often heard by clinicians who are working with clients experiencing thoughts of SDV. The trainee playing the therapist then responds in a way that demonstrates the appropriate skill. Trainee therapists will have the option of practicing a response using the one supplied in the exercise or immediately improvising and supplying their own.

After each client statement and therapist response couplet is practiced several times, the trainees will stop to receive feedback from the supervisor. Guided by the supervisor, the trainees will be instructed to try statement–response couplets several times, working their way down the list. In consultation with the supervisor, trainees will go through the exercises, starting with the least challenging and moving through to more advanced levels. The triad (supervisor–client–therapist) will have the opportunity to discuss whether exercises present too much or too little challenge and adjust up or down depending on the assessment.

TABLE 1.1. The 10 Self-Directed Violence Assessment Skills Presented in the Deliberate Practice Exercises

BEGINNER SKILLS	INTERMEDIATE SKILLS	ADVANCED SKILLS
1. Exploring the meaning of client statements 2. Assessing precipitating factors 3. Asking scaling questions 4. Exploring and encouraging social support	5. Safety planning 6. Working with ambivalence 7. Using self-directed violence assessment measures	8. Providing rationales for focusing on self-directed violence 9. Responding to ruptures in the therapeutic alliance 10. Communicating therapist boundaries and responsibilities

Trainees, in consultation with supervisors, can decide which skills they wish to work on and for how long. Based on our testing experience, we have found practice sessions last about 1 to 1.5 hours to receive maximum benefit. After this, trainees become saturated and need a break.

Ideally, SDV learners will both gain confidence and achieve competence by practicing these exercises. *Competence* is defined here as the ability to perform an SDV assessment skill in a manner that is flexible and responsive to the client. Skills have been chosen that are considered essential to best practices in assessing SDV and that practitioners often find challenging to implement.

The skills identified in this book are not comprehensive in the sense of representing all one needs to learn to become fully competent in the assessment of SDV; however, they will, we hope, provide a solid foundation for newer therapists and add to the existing skills of more experienced therapists. We expect some of the more advanced skills to be more challenging for those new to the field. After describing the goals of the book and who can benefit from it, a brief description of the deliberate practice methodology and of SDV is provided to explain how we have arrived at the union between them.

The Goals of This Book

The primary goal of this book is to help trainees achieve competence in core SDV assessment skills. Therefore, the expression of that skill or competency may look somewhat different across clients or even within sessions with the same client.

The SDV deliberate practice exercises are designed to achieve the following:

1. Help therapists develop the ability to apply the skills in a range of clinical situations.
2. Move the SDV skills into procedural memory (Squire, 2004) so that therapists can access them even when they are tired, stressed, overwhelmed, or discouraged.
3. Provide therapists in training with an opportunity to exercise SDV assessment skills using a style and language that is congruent with who they are.
4. Provide the opportunity to use SDV assessment skills in response to varying client statements and affect. This is designed to build confidence to adopt skills in a broad range of circumstances within different client contexts.
5. Provide therapists in training with many opportunities to struggle and then correct their less skilled response based on feedback. This helps build confidence and persistence, particularly in a critical skill area that often raises therapist anxiety and feelings of incompetence.

Finally, this book aims to help trainees discover their own personal learning style so they can continue their professional development long after their formal training has concluded.

Who Can Benefit From This Book?

This book is designed to be used in multiple contexts, including in graduate-level courses, supervision, postgraduate training, and continuing education programs, and for trainers and trainees from different cultural backgrounds worldwide. The term *trainee* in this

book is used broadly, referring to anyone in the field of professional mental health who is endeavoring to acquire and improve their SDV assessment skills. This book is applicable for those who are training at all career stages, from beginning trainees, including those who have never worked with real clients, to seasoned therapists. All exercises feature guidance for assessing and adjusting the difficulty level to target the needs of each individual learner more precisely. It assumes the following:

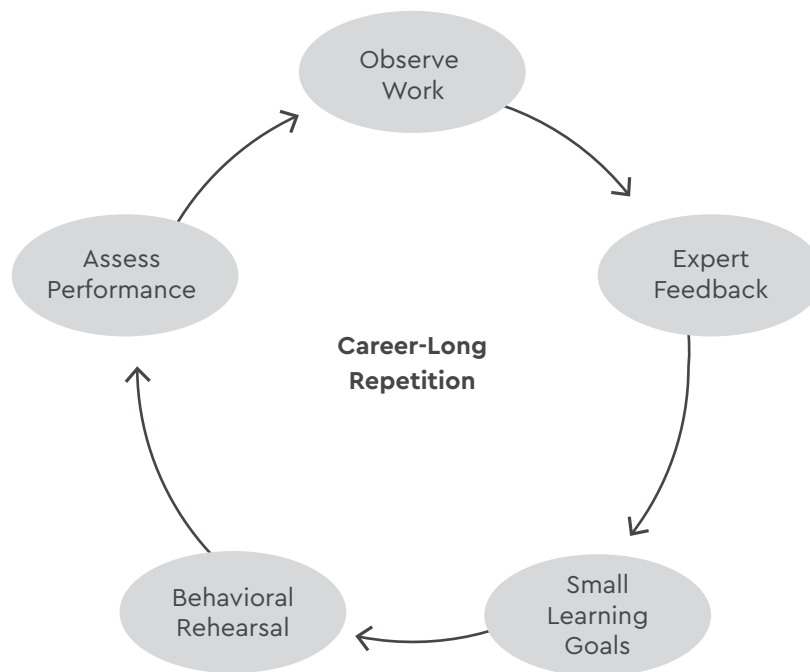
1. The trainer is knowledgeable about and competent in the assessment of SDV.
2. The trainer is able to provide good demonstrations of how to use SDV assessment skills across a range of therapeutic situations. This can occur via live role-play and/or video; trainers should have access to examples of SDV assessment skills being demonstrated through psychotherapy videos.
3. The trainer is able to provide feedback to students regarding how to craft or improve their application of SDV assessment skills.
4. Trainees will have accompanying reading, such as books and articles, that explain the theory, research, and/or importance of learning each particular SDV assessment skill. Recommended reading for each skill is provided in the sample syllabus (Appendix C).

Deliberate Practice in Psychotherapy Training

How does one become highly skilled in their professional field? What is trainable and what is simply beyond our reach, due to innate or uncontrollable factors? Questions such as these touch on our fascination with highly skilled performers and their development. A mixture of awe, admiration, and even confusion surround people such as Mozart, Mary Cassatt, Leonardo da Vinci, or more contemporary top performers such as the painter Frida Kahlo, basketball legend Michael Jordan, and chess virtuoso Garry Kasparov. What accounts for their consistently superior professional results? Evidence suggests that the amount of time spent on a particular type of training is a key factor in developing competence in virtually all domains (Ericsson & Pool, 2016). "Deliberate practice" is an evidence-based method that can improve performance in an effective and reliable manner.

The concept of deliberate practice has its origins in a classic study by K. Anders Ericsson and colleagues (1993), who found that the amount of time practicing a skill and the quality of the time spent doing so were key factors predicting mastery and acquisition. They identified five key activities in learning and mastering skills: (a) observing one's own work, (b) getting expert feedback, (c) setting small incremental learning goals just beyond the performer's ability, (d) engaging in repetitive behavioral rehearsal of specific skills, and (e) continuously assessing performance. Ericsson and his colleagues termed this process deliberate practice, a cyclical process that is illustrated in Figure 1.1.

Research has shown that lengthy engagement in deliberate practice is associated with expert performance across a variety of professional fields, such as medicine, sports, music, chess, computer programming, and mathematics (Ericsson et al., 2018). People may associate deliberate practice with the widely known "10,000-hour rule" popularized by Malcolm Gladwell in his 2008 book *Outliers*, although the actual number of hours

FIGURE 1.1. Cycle of Deliberate Practice

Note. From *Deliberate Practice in Emotion-Focused Therapy* (p. 7), by R. N. Goldman, A. Vaz, and T. Rousmaniere, 2021, American Psychological Association (<https://doi.org/10.1037/0000227-000>). Copyright 2021 by the American Psychological Association.

required for expertise varies by field and by individual (Ericsson & Pool, 2016). This, however, perpetuated two misunderstandings. First, that this is the number of deliberate practice hours that everyone needs to attain expertise, no matter the domain. In fact, there can be considerable variability in how many hours are required.

The second misunderstanding is that engagement in 10,000 hours of work performance will lead one to become an expert in that domain. This misunderstanding holds considerable significance for the field of psychotherapy, where hours of work experience with clients has traditionally been used as a measure of proficiency (Rousmaniere, 2016). Research suggests that the amount of experience alone does not predict therapist effectiveness (Goldberg, Babins-Wagner, et al., 2016; Goldberg, Rousmaniere, et al. 2016). It may be that the quality of deliberate practice is a key factor.

Psychotherapy scholars, recognizing the value of deliberate practice in other fields, have called for deliberate practice to be incorporated into training for mental health professionals (e.g., Bailey & Ogles, 2019; Hill et al., 2020; Rousmaniere et al., 2017; Taylor & Neimeyer, 2017; Tracey et al., 2015). There are, however, good reasons to question analogies made between psychotherapy and other professional fields, like sports or music, because by comparison psychotherapy is so complex and free-form. Sports have clearly defined goals, and classical music follows a written score. In contrast, the goals of psychotherapy shift with the unique presentation of each client at each session. Therapists do not have the luxury of following a score.

Instead, good psychotherapy is more like improvisational jazz (Noa Kageyama, cited in Rousmaniere, 2016). In jazz improvisations, a complex mixture of group collaboration, creativity, and interaction are coconstructed among band members. Like psychotherapy, no two jazz improvisations are identical. However, improvisations are not a random collection of notes. They are grounded in a comprehensive theoretical understanding and technical proficiency that is only developed through continuous deliberate practice. For example, prominent jazz instructor Jerry Coker (1990) listed 18 skill areas that students must master, each of which has multiple discrete skills, including tone quality, intervals, chord arpeggios, scales, patterns, and licks. In this sense, more creative and artful improvisations are actually a reflection of a previous commitment to repetitive skill practice and acquisition. As legendary jazz musician Miles Davis put it, "You have to play a long time to be able to play like yourself" (Cook, 2005, p. 112).

The main idea that we would like to stress here is that we want deliberate practice to help therapists using SDV skills become themselves. The idea is to learn the skills so that you have them on hand when you want them. Practice the skills to make them your own. Incorporate those aspects that feel right for you. Ongoing and effortful deliberate practice should not be an impediment to flexibility and creativity. Ideally, it should enhance it. We recognize and celebrate that psychotherapy is an ever-shifting encounter and by no means want it to become or feel formulaic. Strong therapists mix an eloquent integration of previously acquired skills with properly attuned flexibility. The core SDV psychotherapy responses provided are meant as templates or possibilities, rather than "answers." Please interpret and apply them as you see fit, in a way that makes sense to you. We encourage flexible and improvisational play!

Simulation-Based Mastery Learning

Deliberate practice uses simulation-based mastery learning (Ericsson, 2004; McGaghie et al., 2014). That is, the stimulus material for training consists of "contrived social situations that mimic problems, events, or conditions that arise in professional encounters" (McGaghie et al., 2014, p. 375). A key component of this approach is that the stimuli being used in training are sufficiently similar to real-world experiences that they provoke similar reactions. This facilitates *state-dependent learning*, where professionals acquire skills in the same psychological environment where they will have to perform the skills (Fisher & Craik, 1977). For example, pilots train with flight simulators that present mechanical failures and dangerous weather conditions, and surgeons practice with surgical simulators that present medical complications. Training in simulations with challenging stimuli increases professionals' capacity to perform effectively under stress. For the psychotherapy training exercises in this book, the "simulators" are typical client statements that might actually be presented in the course of therapy sessions and call on the use of the particular skill.

Declarative Versus Procedural Knowledge

Declarative knowledge is what a person can understand, write, or speak about. It often refers to factual information that can be consciously recalled through memory and often is acquired relatively quickly. In contrast, procedural learning is implicit in memory, and "usually requires repetition of an activity, and associated learning is demonstrated

through improved task performance" (Koziol & Budding, 2012, pp. 2694). Procedural knowledge is what a person can perform, especially under stress (Squire, 2004). There can be a wide difference between their declarative and procedural knowledge. For example, an "armchair quarterback" is a person who understands and talks about athletics well but would have trouble performing it at a professional ability. Likewise, most dance, music, or theater critics have a high ability to write about their subjects but would be flummoxed if asked to perform them.

The sweet spot for deliberate practice is the gap between declarative and procedural knowledge. In other words, effortful practice should target those skills that the trainee could write a good paper about but would have trouble actually performing with a real client. We start with declarative knowledge, learning skills theoretically and observing others perform them. Once learned, with the help of deliberate practice, we work toward the development of procedural learning, with the aim of therapists having "automatic" access to each of the skills that they can draw on when necessary.

Self-Directed Violence Psychotherapy and Assessment Skills

Unlike some of the other deliberate practice books, this text offers a set of skills aimed at improving performance in a specific skill domain—SDV—rather than in a theoretical orientation. Let us turn to a little foundational background on SDV and SDV assessment skills to help contextualize the skills of the book and how they fit into the greater training model.

Background on Self-Directed Violence

The term *self-directed violence* was primarily developed by the CDC as part of a collaborative effort to address the lack of uniform definitions in the field. Given the "considerable confusion about how to define the phenomenon," the CDC proposed standardized terminology for SDV to "improve communication among researchers, clinicians, and others working in this important area" (Crosby, Ortega, & Melanson, 2011, p. 11). This framework has been adopted by various organizations, including the VA system, and is used in national efforts to help track and inform prevention, research, public health, and intervention efforts, as well as in clinical practice guidelines (Crosby, Ortega, & Melanson, 2011).

We join these efforts in choosing to use the term *self-directed violence* over *suicide* for this book because it is a much broader and more useful term. If someone says "suicide," they're really only talking about deaths by suicide, but the reality is that there's a whole spectrum of self-harm behaviors that researchers and clinicians need to study and understand. Although we recognize other terminology is equally valid in the field, such as threats to self and suicidal and self-injury ideation, we decided the SDV framework best fit the purposes of this book.

More specifically, SDV is defined as behavior that is self-directed and deliberately results in injury or potential injury, and it can be broken down into suicidal and nonsuicidal categories. Thus, SDV captures everything from suicide attempts and nonsuicidal self-injury to other forms of intentional self-harm, giving therapists the ability to assess for a more complete range of what a client may be experiencing. This clarity and inclusiveness are important

because different types of self-harm often need different approaches when it comes to treatment and prevention. With that said, we've chosen to share the 10 skills in this book that are relevant to any type of SDV.

When we focus our attention on suicide specifically within this broad SDV framework, we want to state up front that suicide is a complex problem that isn't always predictable. In the words of well-known researcher Dr. Craig Bryan (2022), suicide is a "wicked problem" because it doesn't always behave predictably, has wide-ranging impacts, and is hard to assess accurately. In writing this book, we recognize that much remains unknown about why some people attempt or complete suicide. While in some cases there were clear precursors leading up to a suicide attempt, in others there were no signs, and the behavior appears to have emerged quickly. Contrary to popular opinion and well-accepted "facts" in the field of suicide, not everyone (or even the 80%–90% often cited by well-regarded suicide prevention programs) who attempts suicide has a major mental illness or has been thinking about suicide for a significant period of time (Jobes, 2023). Although clearly this does describe the experience of many suicide attempters or completers, we also recognize that there are a wide range of individual, relational, neurological, and systemic factors that are part of the equation in an individual's decision to engage in suicide and other forms of SDV.

Preparing for Conversations About Self-Directed Violence

Given the complexity of SDV, therapists need to devote significant time to preparing for encounters with clients experiencing thoughts of SDV, as they would with other types of emergency preparations. This preparation often begins the first semester of graduate school and continues throughout one's career. Unfortunately, as noted by the American Foundation for Suicide Prevention (2024), "There are no nationally set standards or guidelines requiring mental health professionals to be trained to address and treat suicidal ideation and behavior in their patients, either during education and certification or during their professional career" (p. 1).

We hope this book helps fill this training gap. As noted by Sommers-Flanagan and Sommers-Flanagan (2021), because there is no way you will know whether or when you will have a suicidal client, ongoing skill development is crucial. With practice and training, when you are faced with an unexpected suicidal crisis, you are prepared to respond. Entering into conversations about SDV requires the appropriate educational knowledge, specific SDV skills training, a knowledge of the laws regarding confidentiality, and a plan for self-care, particularly after high-intensity conversations or as you are managing clients with chronic suicidality. We briefly discuss each of these key preparation areas next, followed by an overview of the 10 SDV deliberate practice skills you will be learning in this book.

Education

Therapists complete specialized training in suicide risk assessment, intervention techniques, and crisis management during their graduate programs and continuing education. They learn to recognize warning signs, understand risk factors, and (ideally) master evidence-based assessment tools and protocols. Learning about suicide assessment and intervention is a career-long process and requires therapists to update their knowledge

base and practice their skills regularly. We encourage trainees to seek out more comprehensive texts to supplement this skill-building resource.

Competent therapists practice specific communication techniques for these sensitive conversations: learning how to ask direct questions about suicidal thoughts without increasing risk, how to balance empathy with clinical assessment, and how to deescalate crisis situations. Role-playing exercises and supervised practice help build confidence and competence. Therapists familiarize themselves with crisis resources, hospitalization procedures, and legal requirements. They develop clear safety protocols and maintain updated lists of emergency contacts, crisis hotlines, and psychiatric facilities.

Part of deliberate practice for assessing SDV is having the appropriate forms printed out ahead of time. Assessments measures, safety plans, and numbers for local crisis teams/hospitals should be easily accessible. In clinic settings where prelicensed clinicians are practicing, we strongly recommend that a protocol is established that includes how and when to triage a case with a licensed supervisor and/or when a more experienced clinician should assist in the risk assessment. We cannot emphasize clinic safety planning enough. Sharp items and toxic materials, such as bathroom cleaners or other items, should be locked away and be out of reach of all clients. Although rarely necessary, clinician safety planning should also be put in place, which could include items such as a panic button or emergency words.

Legal and Ethical Requirements

Therapists working with suicidal clients must navigate complex ethical and legal responsibilities that prioritize client safety while respecting autonomy. The duty to protect overrides confidentiality when there is imminent risk of self-harm, requiring therapists to take reasonable steps to prevent suicide, which may include involuntary hospitalization, notifying emergency contacts, or involving law enforcement. Ethically, therapists must balance respect for client self-determination with their professional obligation to preserve life, conduct thorough risk assessments, document their clinical reasoning and interventions, maintain appropriate competence in suicide risk management, and ensure proper consultation and supervision. Additionally, therapists should be familiar with their local emergency procedures, understand the criteria for involuntary commitment in their jurisdiction, and maintain clear documentation of all assessments and interventions related to suicide risk.

Self-Care and Support Systems

In summarizing critical points about working with suicidal clients, Sommers-Flanagan and Sommers-Flanagan (2021) emphasized the role of self-awareness, self-care, and support. As you enter and continue working in the field, they advised that you must remain highly aware of how your attitudes, beliefs, and values influence your work and prepare for how working with suicidal clients is emotionally activating. It's critical to have outlets to process sessions of work with suicidal clients, as well as learn how to regulate yourself when working with a high-risk client. Severely depressed and agitated clients can be exhausting to sit with, so having a clinician restoration plan is crucial to recovery from these sessions. Most therapists participate in regular supervision or consultation groups, or they have professionals in their networks with whom they can discuss difficult cases, receive guidance, and process the emotional toll of working with suicidal clients. Finding these

sources of support is crucial to a therapist's well-being and maintaining a sound ethical and legal clinical practice.

Most important, therapists need to learn ways to manage the impact of listening to someone talk about SDV and the level of hopelessness that sometimes exists within these conversations. Some clinicians have a hard time shutting off client statements or find themselves thinking well beyond the workday about whether a client is safe. While these are common reactions to high-intensity conversations, we encourage therapists to have a variety of self-care strategies that allow them to decompress and maintain a healthy distance from their work with clients experiencing SDV.

Categorizing the Self-Directed Violence Assessment Skills

We have included 10 SDV assessment deliberate practice exercises in this text. Although foundational, as noted earlier, these are not an exhaustive list of all skills and techniques used in working with clients exhibiting SDV-related symptoms. The 10 skills are categorized as either beginner, intermediate, or advanced. Within each of the 10 exercises, the difficulty of the client statements therapists will respond to increases, so the further you get into each exercise, the more you may experience challenges to grow your skills. These 10 exercises represent key SDV assessment skills, while also reinforcing the importance of empathic, client-centered, and active listening skills.

The beginner exercises (Exercises 1–4) include skills designed to increase understanding of client statements, the precipitants of SDV thoughts, and the level of social support a client has in place at the time of the assessment. Each of these beginner exercises begins by prompting the therapist to reflect back an initial client statement to demonstrate understanding and build connection. Exercise 1 guides the therapist to ask a specific question to clarify the meaning of a possible concerning client statement. Exercise 2 guides the therapist to explore what events may have triggered or led up to an increased level of emotional distress. The use of scaling questions, whereby therapists ask clients to rate their level of subjective distress on a scale of 1 to 10, is taught in Exercise 3. Finally, Exercise 4 helps therapists examine the level of social support a distressed client might have and whether an identified supportive person could be available in the event the client's SDV thoughts increase outside of sessions.

Three intermediate exercises (Exercises 5–7) are related to more challenging skills commonly needed in conversations with clients experiencing SDV thoughts. Exercise 5 involves having a collaborative conversation with clients about safety planning, as well as suggesting possible ways that they could enhance their safety. Many clients experiencing SDV thoughts have mixed feelings about wanting to hurt themselves, thus Exercise 6 assists therapists to develop skills to help respond to client ambivalence. The intermediate section concludes with Exercise 7, which focuses on learning how to introduce assessment tools and measures to the client. As we'll discuss shortly, such measures are an empirically supported practice that assist and enhance a therapist's understanding about the nature and severity of clients' SDV thoughts to inform their assessment, safety planning, and interventions.

The advanced skills in Exercises 8 through 10 also center attention on the therapist–client relationship. This is essential, as a recent systematic review revealed that flexible weaving of SDV assessment in session conversations not only enhanced safety but also benefited the therapeutic alliance (Huggett et al., 2024). Accordingly, Exercise 8

teaches therapists psychoeducation and framing skills to help explain to clients why there is a need to make SDV a focus of therapy. For example, after an SDV crisis has passed, some clients wonder why therapists must still check in about this content area, and Exercise 8 provides therapists an opportunity to learn how to address these concerns in a relational manner. In other cases, ruptures may occur in the therapeutic alliance around discussions of SDV, such as when crisis intervention takes precedence over daily therapy topics. Exercise 9 helps therapists learn how to address and move toward repairing the relationship so that productive therapeutic work can continue.

Finally, Exercise 10 focuses on how therapists can talk with their clients about therapeutic boundaries. It offers opportunities to learn how to set appropriate boundaries around therapist availability and explain the rules around confidentiality, particularly as they pertain to SDV thoughts and behaviors. We consider this skill challenging because therapists who work with suicidal clients report that they give more of themselves and are more emotionally available to be able to hear and hold their client's pain (Waddington, 2021); as such, we therapists need practice setting boundaries to take care of ourselves.

A Note About Vocal Tone, Facial Expression, and Body Posture

Given the importance of the therapeutic relationship with any client, but especially when working with clients experiencing SDV symptoms, the therapist's tone is just as crucial as the content of what is said. A clinician's tone of voice determines whether their expression comes across as a reflection, question, or confrontation. Likewise, body language serves as another form of expression, and clinicians should ensure their non-verbal cues align with their verbal communication. Clinicians should maintain an open and curious posture, avoiding closed-off body language like crossed arms, while giving clients space to think and process their reactions. Although eye contact norms differ among individuals and cultures, clinicians should avoid prolonged staring, which can feel forced or aggressive. Creating pauses in conversation is essential, allowing clients time to respond to clinician statements. When clinicians rush to fill silence by immediately asking questions after reflections, they deny clients the opportunity to share their perspective. These pauses may initially feel uncomfortable for new clinicians, but they typically become more natural with practice.

The Role of Deliberate Practice in Self-Directed Violence Assessment Training

Although various forms of SDV are widely considered a significant public health problem, required training in SDV, or specifically suicide prevention, is only mandated in 12 U.S. states (American Foundation for Suicide Prevention, 2024). Trainings that fulfill the required obligation vary widely in terms of content and method of delivery, and many do not include real-time opportunities to practice intervention skills. This book will provide trainees with a template of how to improve their SDV assessment skills with actual practices.

Throughout this text, you will have the opportunity to blend best practice and evidence-based SDV assessment practices with the deliberate practice training model. Ultimately, we believe these skills will raise therapists' level of competence in this critical area of

practice and in return save lives and continue to maintain a high level of therapeutic rapport with clients. You will also see how skills learned in deliberate practice books on specific therapeutic approaches (e.g., motivational interviewing [MI], dialectical behavior therapy [DBT]) are related to the deliberate practice of assessing for SDV.

Deliberate practice with SDV also complements other well-established training methods. In brief, these include clinical interviewing skills and techniques (see additional discussion in the next section), such as direct inquiry about suicidal thoughts (avoiding myths about "planting the idea"); assessment of ideation, intent, plan, means, and past behavior; and MI skills. Also relevant are risk formulations (e.g., static vs. dynamic risk; chronic vs. acute risk; see Exercise 2 on assessing precipitating factors) and use of standardized tools (e.g., Columbia-Suicide Severity Rating Scale [C-SSRS], SAFE-T, ASQ). Moreover, it works well with evidence-based models of crisis intervention (e.g., safety planning vs. no-suicide contracts; means restriction counseling) and therapy models with suicide-specific protocols (e.g., cognitive behavioral therapy for suicide prevention, DBT, collaborative assessment and management of suicidality [CAMS], brief interventions, and follow-up contacts).

Interviewing Skills

Helping clients open up about the challenging subject of suicide and other forms of SDV requires a delicate balance of maintaining or establishing a therapeutic relationship, while also asking SDV-related questions. This therapeutic "dance" requires interviewers to maintain a calm, collaborative, and warm stance, even when clients may hesitate to open up or they become reactive. Concurrently, therapists need to gain comfort in moving forward with a structured interview protocol such as the CAMS. This approach emphasizes the importance of therapeutic connection alongside the use of measures designed for accurate assessment, and then safety planning with a client.

We highly recommend readers consider training in MI as a framework for having these sometimes challenging and difficult conversations. The four tasks of MI—engaging, focusing, eliciting, and planning—offer therapists useful ways to think about how they talk about SDV with clients.

Engaging involves the basic tenets of the therapeutic alliance, whereby clinicians spend time building trust, get to know the person (outside of their suicidal behavior), and establish the goals for the assessment. You should be aware that this task continues throughout the interview.¹ As the interview moves into more sensitive material, there are times where the interviewer will need to fall back into a more relational stance, empathizing with the pain, fear, or frustration the client might be feeling.

As trust is built and the interview continues, the interviewer will *focus* the conversation and cue the client that they'll be shifting to talk about suicide/SDV. If not completed before, at the conclusion of the interview the interviewer should briefly review the limits of confidentiality and encourage honesty as a way for the client to maintain autonomy. Although hospitalization is always a possible outcome of an interview about suicide/SDV, it has been our experience that more times than not, if a client is engaged and working with a clinician collaboratively, safety planning can occur and a client can

1. When "interview" and "interviewer" are used in MI and in this subsection, therapists can substitute terms such as "session" or "assessment" for "interview" and "therapist," "counselor," or otherwise for "interviewer" to fit their context and practice.

remain at home. Giving the client a heads up about the shift in the interview can prepare the client to talk about suicidal content.

The *focused* part of the interview might involve the use of measures such as the C-SSRS or ASQ, or a structured interview guide that ensures the important specific questions are asked so that an appropriate assessment of risk can be obtained. Current ideation, planning, access to means, and reasons for living or dying are crucial areas of focus. It's important to ask about both current behavior and historical data of suicidal behavior because one of the best predictors of future attempts is previous attempts of suicide.

The task of *eliciting* uses open-ended questions and complex reflections to draw out the client's perspective on the various aspects of their suicidal or SDV ideation, what they believe would help, who could support them, what would reduce their risk, and what they want to do. When a client says "I'd be better off dead," it's up to the interviewer not to overreact but to explore with the client what they meant to communicate from their comment. They can inquire whether it was merely a statement about wanting to escape the frustration of a situation or something more serious, like a suicidal thought, and then engage the client in planning. Taking a curious or eliciting stance enables the client to clarify vague statements and provide the interviewer with more insight into their statement.

The final task in suicide assessment involves *planning*. In this task, interviewers summarize findings and suggest a path forward based on the clinical data. In this part of the assessment, the interviewer elicits ideas from the client and significant others (if relevant) about how to increase protective factors and reduce risk factors. A written safety plan, such as that developed by Stanley and Brown (2012), provides the client and therapist with a written summary of agreed upon coping skills and support resources.

Within any given interview a therapist might find themselves moving back and forth between these four tasks depending on the client's willingness to disclose honestly and safety plan.

In sum, unlike some of the other deliberate practice books, this text offers a set of skills aimed at improving performance in a specific skill domain, rather than in a practice theory or with a specific client population. Our work draws from the vast fields of suicide and risk assessment but also incorporates skills consistent with humanistic therapies, such as MI and emotion-focused therapy. Our hope is to assist newer clinicians in gaining a foundational skill set that they can use whenever faced with a client making utterances of SDV.

Overview of the Book's Structure

This book is organized into three parts. Part I contains this chapter and Chapter 2, which provides basic instructions on how to perform these exercises. We found through testing that providing too many instructions up front overwhelmed trainers and trainees, and they skipped past them as a result. Therefore, we kept these instructions as brief and simple as possible to focus only on the most essential information that trainers and trainees will need to get started with the exercises. Further guidelines for getting the most out of deliberate practice are provided in Chapter 3, and additional instructions for monitoring and adjusting the difficulty of the exercises are provided in Appendix A.

Do not skip the instructions in Chapter 2, and be sure to read the additional guidelines and instructions in Chapter 3 and Appendix A once you are comfortable with the basic instructions.

Part II contains the 10 skill-focused exercises, which are ordered based on their difficulty: beginner, intermediate, and advanced (see Table 1.1). They each contain a brief overview of the exercise, example client–therapist interactions to help guide trainees, step-by-step instructions for conducting that exercise, and a list of criteria for mastering the relevant skill. The client statements and sample therapist responses are then presented, also organized by difficulty (beginner, intermediate, and advanced). The statements and responses are presented separately so that the trainee playing the therapist has more freedom to improvise responses without being influenced by the sample responses, which should only be turned to if the trainee has difficulty improvising their own responses. The last two exercises in Part II provide opportunities to practice the 10 skills within simulated psychotherapy sessions. Exercise 11 provides a sample psychotherapy session transcript in which the SDV assessment skills are used and clearly labeled, thereby demonstrating how they might flow together in an actual therapy session. Trainees are invited to run through the sample transcript with one playing the therapist and the other playing the client to get a feel for how a session might unfold. Exercise 12 provides suggestions for undertaking mock sessions, as well as client profiles ordered by difficulty (beginner, intermediate, and advanced) that trainees can use for improvised role-plays.

Part III contains Chapter 3, which provides additional guidance for trainers and trainees. Whereas Chapter 2 is more procedural, Chapter 3 covers big-picture issues. It highlights six key points for getting the most out of deliberate practice and describes the importance of appropriate responsiveness, attending to trainee well-being and respecting their privacy, and trainer self-evaluation, among other topics.

Three appendixes conclude this book. Appendix A provides instructions for monitoring and adjusting the difficulty of each exercise as needed. It provides a Deliberate Practice Reaction Form for the trainee playing the therapist to complete to indicate whether the exercise is too easy or too difficult. Appendix B includes a Deliberate Practice Diary Form that can be used during a training session's final evaluation to process the trainees' experiences, but its primary purpose is to provide trainees a format to explore and record their experiences while engaging in additional, between-session deliberate practice activities without the supervisor. Appendix C presents a sample syllabus demonstrating how the 12 deliberate practice exercises and supporting material can be integrated into a wider SDV training course. Instructors may choose to modify the syllabus or pick elements of it to integrate into their own courses.

Downloadable versions of this book's appendixes, including a color version of the Deliberate Practice Reaction Form, can be found in the "Resources" tab at <https://www.apa.org/pubs/books/deliberate-practice-assessing-self-directed-violence>.