

“I Honestly Would Not Have Known What to Do”: An Exploratory Study of Perspectives on Client Suicide Among Vocational Rehabilitation Support Staff

OMEGA—Journal of Death and
Dying
0(0) 1–18

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DOI: 10.1177/0030222817739215

journals.sagepub.com/home/ome



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Abstract

Despite the high prevalence of suicide both overall and among people with disabilities in particular, little research has explored suicide in the context of the vocational rehabilitation (VR) system or in counseling support staff in general. We analyzed the responses of 14 VR support staff who responded to an open-ended qualitative prompt regarding their experiences with suicide training and competency. Key themes included a perceived lack of and desire for more training regarding

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suicide, seeking and receiving suicide training outside of VR, and a perceived lack of resources for working with suicidal clients. Responses also underscored the heavy emotional impact of working with these clients, especially when one feels unprepared to do so. These results suggest that it is important to provide VR support staff with resources and training for addressing suicide in their client populations.

Keywords

suicide, suicide competency, vocational rehabilitation, disability, support staff

In 2015, over 44,000 people died by suicide in the United States, making it the 10th leading cause of death for that year (Drapeau & McIntosh, 2016). Additionally, there are approximately 25 suicide attempts for every death by suicide (Drapeau & McIntosh, 2016). The rate of deaths by suicide in the United States also increased 24% from 1996 to 2014 (Curtin, Warner, & Hedegaard, 2016), indicating that suicide is a large and growing health crisis that needs to be addressed.

People with disabilities—those with a chronic physical or mental health impairment that limits one or more major life activities—have been identified as particularly high-risk group for suicide (Giannini et al., 2010; Lund, Nadorff, & Seader, 2016; McConnell, Hahn, Savage, Dube, & Park, 2015; Pompili et al., 2011). This increased and elevated risk has been found both when people with disabilities are examined as a broadly defined group (Lund et al., 2016; McConnell et al., 2015) as well as when specific disability groups are examined separately. For example, researchers have found that this elevated risk for suicidality exists in such diverse disability groups as people with psychiatric disabilities (Lund et al., 2016), people with multiple sclerosis (Giannini et al., 2010; Pompili et al., 2011), people with autism spectrum disorders (Segers & Rawana, 2014), people with spinal cord injury (Giannini et al., 2010), and people with Huntington's Disease (Wetzel et al., 2011).

Although disability is also associated with increased rates of depression and depressive symptoms (Giannini et al., 2010; Lund et al., 2016), researchers have found that controlling for depression alone does not fully account for the increased suicidality among people with disabilities (Lund et al., 2016; McConnell et al., 2015). Similarly, controlling for combined anxiety and depression diagnoses (Dennis et al., 2009; McConnell et al., 2015) and socioeconomic factors (McConnell et al., 2015) cannot fully explain the higher suicidality in people with disabilities, suggesting that disability may be a risk factor for suicidality itself. This may be in part attributable to attitudinal factors, such as the belief that disability makes suicide more acceptable or permissible (Lund, Nadorff, Winer, & Seader, 2016) as well as the cumulative and pervasive social, logistical, attitudinal, and physical barriers that may make life overall

more difficult for many people with disabilities (Smart, 2008) and thus increase their vulnerability to suicidal thinking.

There is a growing emphasis on training a large number of individuals, including paraprofessionals like vocational rehabilitation (VR) support staff (i.e., paraprofessionals who directly interact with clients in VR settings but do not provide direct and independent counseling services) on basic suicide risk assessment and referral as part of comprehensive gatekeeper training initiatives (Condrón et al., 2015; Schmitz et al., 2012). Such trainings have been found to increase rates of appropriate referrals of high-risk or suicidal individuals by paraprofessionals (Condrón et al., 2015), and widespread gatekeeper training has even been shown to reduce suicide rates (Isaac et al., 2009). Providing training on key suicide assessment and crisis intervention competencies may help paraprofessionals and others better identify to respond to individuals who are showing warning signs of or openly stating suicidal intent. Additionally, suicide is a highly emotional topic for many people, and even professionals often bring a vast array of intense personal and professional experiences, biases, fears, and misconceptions into their work with suicidal clients, some of which may negatively influence their clinical responses (McHale & Felton, 2010; Saunders, Hawton, Fortune, & Farrell, 2012). For example, individuals who do not have a good understanding of suicide warning signs or referral options may not know if or how to respond when a client shows “red flags” for suicide (Condrón et al., 2015). Alternately, other individuals may panic when a client mentions suicide or self-injury and respond in a manner that is punishing or inconsistent with the client’s level of risk (Saunders et al., 2012). Training on suicide can help make individuals, including paraprofessionals like VR support staff, more comfortable and competent in working with and responding appropriately to clients who are at risk for or engaging in self-injurious or suicidal behavior.

Due to the increased risk of suicide among people with disabilities, VR support staff may be important frontline individuals in responding to clients who are suicidal or engaging in other self-injurious behaviors. However, the research addressing suicide in VR specifically and rehabilitation counseling in general has been extremely limited. Hunt and Rosenthal (2000) found that concerns related to client suicide were the most commonly cited death-and-dying-related concern cited by rehabilitation counselors, suggesting both a need for and critical lack of training in this area. Furthermore, Hunt and Rosenthal (1997) found that less than a quarter of rehabilitation counseling trainees in their study reported receiving any training on death and dying-related issues at all. However, over four fifths felt that such training was important or very important. A recent study of suicide competency in VR counselors found that counselors were willing to work with suicide clients and did so somewhat frequently but generally did not feel that they were competent in basic suicide assessment or crisis intervention (Lund, Schultz, Nadorff, Galbraith, & Thomas, 2017a). Although we

are not aware of any studies examining suicide-related competencies and experiences in VR support staff, specifically in a study using the same dataset as the present study, we found that over four fifths of VR support staff surveyed ($n = 93$) reported working with suicidal clients and that almost two fifths related doing so once a year or more (Lund, Schultz, Nadorff, Galbraith, & Thomas, 2017b).

Given the complex, critical, and life-threatening nature of suicide, the increasing recognition of the importance of universal training in basic suicide assessment and intervention, and the limited research on suicide competency in rehabilitation counseling in general and VR support staff in particular, it is important to understand support staff's thoughts on and experiences with suicide in VR settings. Such knowledge may allow for VR administrators to better understand the roles, functions, experiences, and needs to VR support staff as they relate to working with suicidal clients. Additionally, our findings in this population may help inform suicide-related experiences and roles in support staff populations in other clinical and counseling settings. Thus, we conducted an exploratory qualitative analysis of State/Federal VR support staff's perspectives regarding suicide in VR settings.

Method

Recruitment

We drew participants from a larger study on suicide knowledge, experience, and competency in the public (State/Federal) VR system. Participants were recruited via e-mails sent by administrators in participating state to their rehabilitation counselors and support staff. The recruitment e-mail stressed that participation in the study was anonymous, confidential, and voluntary and that participation or lack thereof would not affect participants' employment with VR. Interested participants could then click a link to review the letter of information and complete the survey, which was hosted on a secure, university-based Qualtrics server. All study procedures and materials were approved by a university institutional review board prior to data collection.

As part of this study, participants completed measures related to demographic information (i.e., age, gender, years worked in rehabilitation counseling, educational background, state where they were employed exposure to suicide, and self-injury through family and friends), experience working with clients who express thoughts and behaviors related to suicide and nonsuicidal self-injury (NSSI), and training received, if any, on suicide and NSSI; measures related to suicide and NSSI-related knowledge; and measures related to perceived comfort and competency related to working with assessing and intervening with potentially suicidal clients. More information on the larger study can be found elsewhere (e.g., Lund, Schultz, & Nadorff, 2017; Lund, et al., 2017a,

2017b). A total of 122 support staff completed some or all of the survey. However, only 93 support staff participants had complete data on all suicide competency measures, including the one with the open-ended item (a general open prompt for “comments” related to participant experiences with and thoughts on suicide and suicide competency) from which the data for the current analyses were extracted (Lund et al., 2017b).

Participants were included in the present analysis if they identified as support or line staff and responded to the open-ended question regarding suicide training and competency. We excluded participants whose responses to the open-ended item simply indicated that they did not have any comments (i.e., “no” or “n/a”). Fourteen participants met these inclusion criteria and were included in the present analyses.

Participants

Demographic information is provided in Table 1 and is also summarized here. Of the 14 participants, nine (64.3%) worked in Texas, three (21.4%) worked in Utah, one (7.1%) worked in Idaho, and one (7.1%) worked in South Dakota. Thirteen (92.9%) were women and one (7.1%) was man. The mean age was 55.46 years ($n = 13$, $SD = 8.06$), with a range of 45 to 69 years.

Participants had worked in rehabilitation counseling for an average of 16.71 years ($SD = 9.351$; range = 3–31 years). We did not collect information on the

Table 1. Participant Demographics.

Gender	Female: 92.9% (13) Male: 1 (7.1%)
State of employment	Texas: 64.3% (9) Utah: 21.4% (3) Idaho: 7.1% (1) South Dakota: 7.1% (1)
Highest degree attained	Associates degree or less: 78.6% (11) Bachelor's degree: 7.1% (1) Master's degree: 14.3% (2)
Certifications and licenses	Licensed clinical social worker: 7.1% (1) Enrollment specialist credential: 7.1% (1) Administrative assistant credential: 7.1% (1)
Suicide training received	Received training on both nonsuicidal self-injury and suicide: 35.7% (5) Received no training: 64.3% (9)
Friend or family member suicide exposure	Yes: 71.4% (10) No: 28.6% (4)

specific client populations, if any, that the participants worked with, although a few participants did provide this information in their open-ended responses, as noted in the Results section. In terms of education, 11 (78.6%) had associate's degrees or less, 1 (7.1%) had a bachelor's degree, and 2 (14.3%) had master's degrees. In terms of certification or licensure, one (7.1%) was a licensed clinical social worker, one (7.1%) held an enrollment specialist credential, and one (7.1%) held an administrative assistant credential. Five (35.7%) had reported receiving training on both NSSI and suicide, while the remaining nine (64.3%) reported receiving no training on either of these topics.

All of the 13 participants who responded to the item regarding frequency of working with clients who express suicidal thoughts or behaviors reported that they did indeed work with these clients. Six (42.9%) reported that they did so less than once a year, one (7.1%) reported that they did so about once a year, five reported (35.7%) reported that they did so every few months, and one reported that they did so approximately once a month. Additionally, 10 participants (71.4%) reporting having a friend or family member who "attempted or completed" suicide.

As part of the larger study, participants completed the Suicide Competency Assessment Form (SCAF; Cramer, Johnson, McLaughlin, Rausch, & Conroy 2013), which is a self-report measure of perceived competency in both 10 core suicide assessment and intervention competencies and overall suicide competency. It demonstrated excellent psychometric properties in VR support staff (Lund et al., 2017b). Possible total scores on the SCAF range from 10 to 40, with higher scores representing greater competency and possible scores on the single-item ratings of overall suicide competency range from 1 to 8, with higher scores again representing greater perceived competency. We have provided participants' scores on the SCAF in order to provide some contextual information on their perceived overall competency in assessing and intervening with suicidal or potentially suicidal clients.

Of the 14 participants included in this study, 12 had complete data for the SCAF total score and 12 completed the overall suicide competency rating item. The 12 participants with complete SCAF data had a mean total score of 19.33 ($SD = 8.93$, range = 10–37). Of 12 participants who completed the overall suicide competency rating item, five (41.7%) rated themselves in the "unacceptable" range, four (33.4%) in the "working toward competency" range, two (16.7%) in the "competent" range, and one (7.1%) in the "advanced competency" range. The mean overall competency rating was 3.00 ($SD = 2.05$, range = 1–7).

Measure

We analyzed qualitative responses to an open-ended item regarding participants' experiences or thoughts on suicide. In addition to the quantitative items on

suicide assessment competency mentioned earlier, the SCAF (Cramer et al., 2013) provides a blank space entitled “comments (optional)” in which participants can write their thoughts about suicide competency and training. Responses to that open-ended item were the source of our qualitative data for these analyses.

Data Analysis

We utilized a grounded theory for our data analysis. Grounded theory is an inductive emergent hypothesis approach that is centered on building, not testing, theory (Glaser, 1998; Strauss & Corbin, 1990). The first step of grounded theory is coding of key themes via open reading of the data. As such, two investigators identified key themes after closely reading the data and discussed any differences to reach consensus on the key themes. After this consensus-building process, a total of eight themes were identified: (a) a lack of training on suicide, (b) a desire for more training on suicide, (c) perceived lack of resources used to address suicide, (d) receiving training and suicide outside of VR, (e) obtaining skills via experience rather than training, (f) not working with or only referring suicidal clients, (g) differentiating NSSI and suicide, and (h) sharing one’s experiences with suicidal individuals, either personally or professionally.

Coding and Interrater Agreement

After the eight themes were identified, two authors independently coded all 14 responses dichotomously regarding whether or they not they contained content relevant to each theme. We then calculated percent agreement for each theme and for the data overall. This method has been used in other research drawing from short qualitative responses to an online survey (e.g., Lund, Andrews, & Holt, 2016). Because some quotes captured multiple themes and some quotes are used to illustrate more than one theme in the Results section.

Based on the suggestions of Graham, Millanowski, and Miller (2012) for interrater agreement (IRA) in coding artifacts (i.e., preexisting content), we set an IRA benchmark of 75% or higher. The number of disagreements and percent IRA for each theme and the data overall can be seen in Table 2. All but one theme-level percent agreement was above 75% and all but two were at or above 85%. Given the small number of responses ($n = 14$) and the high overall agreement of 83.9%, we decided to retain the one theme with 71.4% theme-level agreement. The number of disagreements per code was generally low (range = 1–4), with only two themes having more than two disagreements. Because of the generally low number of disagreements, the ratings of one coder were used to calculate the percentage of responses that contained each theme.

Table 2. Interrater Agreement.

Theme	Number of disagreements	Percent agreement
No training on suicide	4	71.4
Desire for suicide training	2	85.7
Perceived lack of suicide-related resources	2	85.7
Received training outside of VR	2	85.7
Obtained skills through experience	1	92.9
Does not address suicide/only refers clients	2	85.7
Differentiates NSSI and suicide	2	85.7
Discusses personal/professional experiences with suicide	3	78.6
Overall	18	83.9

Note. NSSI = nonsuicidal self-injury; VR = vocational rehabilitation.

Results

Lack of Training on Suicide

Three participants (21.4%) cited a lack of training on suicide. One participant simply noted, “I have no training in this field.” Another noted that they had no knowledge of suicide but also had never had a suicidal client that they were aware of, stating, “I can’t say [anything] about suicide. Thanks to God I have no one who tried to [die by] suicide.” A third participant noted the impact of not having had training on suicide when working with someone who is in immediate suicidal crisis:

We have not been trained, and I have had people call and proclaim that they are on a table with a towel around their neck that is tied to something above and about to jump off. [W]e handled it just fine with no training on our part, but we had two lines going for over an hour until police arrived. It should never take that long for our agency to get to [the] point of getting police involved.

Desire for Additional Training

Four participants (28.6%) reported wanting more training on suicide. One participant noted that such training would be helpful for their clients and for VR as whole, saying “I am interested in training in this area. I want to learn and help. I want to better serve our division and consumers.” Similarly, another participant emphasized the importance of such training for fulfilling the

support staff role:

I feel that [VR] has not provided the proper training for support staff on suicide. I have had more than one client that has wanted to do self-harm, not wanting to live. . . I feel that [VR] does need to implement some sort of training in order for us to provide proper care.

A third participant mentioned the value of continuous and updated training on suicide, noting “[I] always feel that there is more to learn and update [and am] very open to refresher courses and perspective training.” The fourth participant simply stated that they valued such training, noting that “it would be helpful to get training on dealing with suicidal clients.”

Obtained Training Outside of VR or Obtained Skills Through Experience

Three participants (21.4%) mentioned that they had obtained training on suicide outside of VR and two participants (14.2%) mentioned gaining skills related to suicide assessment and intervention through experience, rather than formal training. Because both of these themes address non-VR-related training and because only two participants’ responses addressed obtaining skills through experience specifically, we have combined discussion of these two themes in order to avoid unnecessary repetition or extremely short subsections.

One participant discussed gaining skills both through experience and outside training:

I have had basic training over the years, but the majority of my skills have been obtained through experiences at work. I also have knowledge and skills by study and volunteering with [the National Alliance on Mental Illness] as well as being a care taker and family members with several mental illnesses and have been on the verge of an attempt at suicide.

Another participant mentioned that they had training and experience with suicide through a volunteer role, stating “I am currently [a liaison] for the [Regional] Chapter of Bikers Against Child Abuse and have on occasion had to deal with suicide and self-injury issues.” Similarly, a third participant stated that they had outside training on suicide and felt that this experience had been vital to performing their role in VR:

I have had more than one client that has wanted to do self-harm, not wanting to live if it had not been for my Life Coaching training that I had outside of [rehabilitation counseling]. I honestly would not have known what to do with the clients.

Perceived Lack of Resources for Addressing Suicide

Four responses (28.6%) addressed the theme of a perceived lack of resources for addressing suicide. Three of these participants mentioned this lack of resources as affecting client care. For example, one participant noted, “I believe we encounter more and more individuals and miss the warning signals,” while another noted, “I have had more than one client that has wanted to do self-harm, not wanting to live . . . I honestly would not have known what to do with the clients. I feel [VR] does need to implement some sort of training in order for us to provide proper care.” Similarly, a third participant indicated that, although the agency was able to resolve a crisis situation without training or resources, the lack thereof made the process more drawn out and stressful than it needed to be:

[W]e handled it just fine with no training on our part, but we had two lines going for over an hour until police arrived. It should never take that long for our agency to get to [the] point of getting police involved.

The fourth participant noted how the lack of resources can affect the availability of referral and follow-up care:

VR does not counsel in clinical settings, so it is different than a mental health clinic where you usually have teams to refer to. Nor do most cities have a mental health [emergency room], such as [the one that] opened up [in a large city] this week, with new resources.

Experiences with Suicide and Differentiation Between NSSI and Suicide

Four responses (28.6%) referenced participants’ own personal and professional experiences with suicide and self-injury and two (14.3%) differentiated between NSSI and suicide. Because the responses that specifically mentioned NSSI generally dealt with participants’ experiences working with clients with NSSI and because only two participants’ responses addressed NSSI specifically, we have combined discussion of these two themes in order to avoid unnecessary repetition or extremely short subsections.

Some of the responses highlighted the highly emotional and stressful nature of working with clients who are suicidal or who engage in self-injury, as shown the following response:

I have had people call and proclaim that they are on a table with a towel around their neck that is tied to something above and about to jump off. [W]e had two lines going for over an hour until police arrived . . .

This participant also noted how a lack of training could leave support staff feeling helpless when working with clients who disclosed thoughts or behaviors related to self-harm. The participant further stated, “Also, I have had two profiles in [my] 23.5 years here that have told me they cut [themselves]. I have had no training. I only can tell the VR [counselor].” Similarly, another participant stated, “I believe we encounter more and more individuals and miss the warning signals.”

In contrast to these feelings of frustration or helplessness, one participant mentioned their well-developed strategy for working with suicidal clients:

I have a reference sheet [that] I keep under my telephone that has a checklist of what to do, how to remain calm, listen, be empathetic patient, and accepting and it lists what questions to ask, and it gives a mental health phone [number] to connect me, the suicidal caller and the [Division] of Mental Health with a three-way call to refer them to an expert.

Two participants also mentioned their experiences with suicidal individuals outside of VR. One participant stated, “I have provided suicide prevention in the community with bartenders and hair stylist[s].” Another mentioned their experiences with family members who were suicidal, saying, that they had gained experienced with and knowledge of suicide through assisting “family members with several mental illnesses and have been on the verge of an attempt at suicide.”

Do Not Encounter Suicide or Only Refer Suicidal Clients Elsewhere

Three responses (21.4%) mentioned that respondents either did not work with suicidal clients frequently or only referred suicidal clients elsewhere, rather than engaging with them further. One participant simply noted that they had never had a client who attempted or died by suicide. Another noted that their exposure to suicidal clients was likely due to the nature of their caseload (“Working recently with a deaf caseload, have had very little involvement with mental disabilities”). It is worth noting that these participants may have worked with clients who were experiencing suicidal thoughts but were not aware of it. The third participant highlighted how simply referring suicidal clients can be a barrier when the community lacks resources to which to refer them:

Things change. VR does not counsel in clinical settings, so it is different than a mental health clinic where you usually have teams to refer to. Nor do most cities have a mental health [emergency room], such as [the one that] opened up [in a large city] this week, with new resources.

Discussion

In this study, we examined the qualitative responses of 14 VR support staff who participated in a study regarding suicide and self-injury-related knowledge and competency. Participants frequently reported a lack of training on suicide and a desire for more training and resources to use when working with suicidal clients, especially those who are in immediate suicidal crisis. Some participants noted the highly stressful and emotional experiences of working with clients who are in acute suicidal crisis, suggesting that VR support staff, even though they are not counseling or mental health professionals, would benefit from being trained on how to best work with clients who are experiencing thoughts or behaviors related to suicide and self-injury. Furthermore, multiple participants noted that the training on and experience with working with individuals who are in suicidal crisis that they had obtained outside of VR had been helpful in their role as VR support staff. This further suggests that training on basic suicide assessment and crisis intervention may be useful and important for VR support staff.

Implications for Practice and Training

The role and responsibilities of VR support staff in relation to suicide is largely unexplored area. Our results suggest that VR support staff do indeed interact with and work with clients who they know to experience thoughts and behaviors related to suicide. Moreover, some support staff may be directly involved with clients who contact VR offices in a state of immediate suicidal crisis, such as answering the phone when a client who is making threats of suicide calls. Despite this, most participants in our present analyses reported not having ever received any training on suicide and some of those who did report having received such training did so outside of the VR system. These findings are similar to those of Hunt and Rosenthal (1997, 2000), who found that training on client death in general was lacking among rehabilitation counseling professionals and trainees and that suicide was a major area of concern. It also is in line with the findings that training on suicide is lacking among many physical and mental health professionals, especially those who do not work in dedicated mental health settings (Schmitz et al., 2012). Like Hunt and Rosenthal (1997, 2000), we also found that participants in our study were generally very open to receiving training on suicide, often seeing such skills as vital to maintaining client safety and well-being at their jobs. A gatekeeper training program (e.g., Applied Suicide Intervention Skills Training (ASIST; Ramsay, Tanney, Tierney, & Land, 1999); SafeTALK (LivingWorks, 2010), Question, Persuade, Refer (QPR; Quinnett, 1995), may be appropriate and beneficial professional development training to provide to VR support staff. Many communities are increasingly making such trainings available to community members via public health departments, colleges and universities, secondary schools, and community mental health offices

for a minimal fee. State VR offices could contact community agencies to help locate a local trainer and arrange a training of their office staff.

Consistent with prior research (McHale & Felton, 2010; Saunders et al., 2012), several participant responses highlighted the sheer stress and emotionality that is inherent in working with clients who are in suicidal crisis. Because suicide can literally be a matter of life and death, those who work directly with individuals who are suicidal may feel considerable responsibility and anxiety regarding keeping that individual alive as well as extremely complex guilt if that client does indeed die by suicide (Knox, Burkard, Jackson, Schaack, & Hess, 2006). Additionally, individuals may have personal or familial experiences with suicide that affect their responses to suicidal clients and how they cope with the situation afterwards. Good supervision is essential in assisting professionals, trainees, and others in the aftermath of a suicidal crisis (Knox et al., 2006) and requires strong understanding of suicide on the part of the supervisor. Thus, providing training to counselors and administrative supervisors who are working with support staff who have or may later work with clients who are in suicidal crisis may be beneficial in ensuring that these situations are addressed in sensitive manner that is both personally responsive and legally and ethically appropriate.

Limitations and Directions for Future Research

One limitation of this study is the small, self-selected sample. Only 14 support staff participants provided responses to the qualitative item. This limited the breadth of experiences and opinions that we captured. In addition, individuals who took the time to respond to both the overall survey and the qualitative item specifically may have particularly strong feelings about or notable or memorable experiences with suicide. Thus, these experiences and opinions may not necessarily be representative of the general population of VR support staff. Relatedly, the generalizability of the study is limited by the fact that we did not use a national sample and that almost two thirds of participants worked in one state (Texas). This study should be replicated with a larger and more geographically diverse sample in order to verify the generalizability of our findings. Such a study may also elucidate potential differences in support staff roles and responsibilities regarding suicide between different states. Additionally, our sample was almost entirely female; although this may reflect the overall under-representation of men in counseling and related fields (e.g., Association of Psychology Post-doctoral and Internship Centers, 2011; Lund, Andrews, & Holt, 2014; Wong, Chan, Da Silva Cardoso, Lam, & Miller, 2004), it still limits our ability to generalize our findings to and detect any differences among male support staff.

Another limitation is that our qualitative prompt asked participants for their general “comments” on suicide competency and training. The lack of a more

direct, targeted question or questions may have reduced the focus and depth of participant responses. Although a broad, general prompt may be useful given the novel and exploratory nature of this study, researchers may wish to replicate and expand on this study by using questions that more specifically target certain experiences, beliefs, and competencies related to suicide. Relatedly, the text-based entry may have increased the response effort and thus decreased the length of participant responses. Finally, the anonymous, cross-sectional nature of this survey—although potentially helpful with regard to the highly stigmatized nature of suicide (Knox et al., 2006)—did not allow us to ask follow-up questions or use probes to clarify, enhance, or expand on participants' responses. Thus, researchers should expand on this study using other methods of data collection, such as face-to-face interviews, that allow for follow-up, probing, and verbal instead of text-based responses.

Additionally, future research should examine the roles, responsibilities, and experiences of support staff in other clinical and counseling settings to see if and how their experiences vary from those reported by support staff in VR. The State/Federal VR system is somewhat unique in that it employs counselors to address psychosocial issues related to disability, employment, postsecondary education, and community integration but does not provide direct clinical mental health counseling. Thus, individuals who elect to work as support staff in VR settings may have less initial interest or training in suicide and mental health in general than those who chose to work in dedicated mental health settings like university counseling centers or community mental health centers. On the other hand, support staff in more clinical mental health-related settings may have more readily available support for addressing such issues due to the high concentration of dedicated mental health clinicians available for consultation and assistance. Thus, additional research should be conducted on how support staff in other settings respond to and address client and patient suicidality.

Conclusion

In this study, we explored support staff members' thoughts and experiences regarding suicide in the State/Federal VR system. We found that VR support staff do work with clients who are suicidal as part of the roles and responsibilities of their job but that many lacked and desired training on working with suicidal clients and believed that such skills were vital to better ensuring the staff and well-being of their clients. The responses also underscored the emotional intensity of working with clients who are in immediate suicide crisis. VR administrators may consider providing additional training for their staff, including support staff, on working with suicidal clients. Additionally, administrators in other counseling settings may consider providing support and training on suicide to clinical support staff in addition to counselors.

Acknowledgments

We would like to express our gratitude to the state vocational rehabilitation offices, regional technical assistance centers, and support staff who participated in this study.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) received no financial support for the research, authorship, and/or publication of this article.

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