Article

OMEGA—Journal of Death and Dying
0(0) 1–16

DOI: 10.1177/0030222818783933
journals.sagepub.com/home/ome
SAGE

"It's Awful When We Get It Wrong": An Exploratory Qualitative Study of Vocational Rehabilitation Counselors' Perspectives on Suicide

Emily M. Lund[1,2], Jared C. Schultz[2], Katie B. Thomas[3], Michael R. Nadorff[4,5], Dalia Chowdhury[7], and Kate Galbraith[6]

Abstract

Despite the high prevalence of suicide among people with disabilities, little research has explored suicide in the context of the vocational rehabilitation (VR) system. We analyzed the responses of 27 VR counselors who responded to an open-ended qualitative prompt regarding their experiences with suicide training and competency. Key themes included a desire for more training on suicide and the experience of seeking and receiving suicide training and experience outside of VR. Responses also underscored the heavy emotional impact of working with suicidal clients, especially when one feels unprepared to do so. These results suggest that it

[1]Department of Community Psychology, Counseling, and Family Therapy, St. Cloud State University, MN, USA
[2]Department of Special Education and Rehabilitation, Utah State University, Logan, UT, USA
[3]Clement J. Zablocki VA Medical Center, Milwaukee, WI, USA
[4]Department of Psychology, Mississippi State University, Starkville, MS, USA
[5]Baylor College of Medicine, Houston, TX, USA
[6]Utah State Office of Rehabilitation, Salt Lake City, UT, USA
[7]University of North Texas, Denton, TX, USA

Corresponding Author:
Emily M. Lund, Department of Community Psychology, Counseling, and Family Therapy, St. Cloud State University, 720 4th Avenue S., St. Cloud, MN 56301, USA.
Emails: emlund1@stcloudstate.edu; emily.m.lund@gmail.com

is important to provide VR counselors with resources and training for addressing suicide in their client populations.

Keywords
suicide, vocational rehabilitation, counselors, disability, rehabilitation counseling

Suicide is a major public and mental health issue; 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), and there are approximately 25 suicide attempts for every death by suicide (Drapeau & McIntosh, 2016). Furthermore, the rate of deaths by suicide increased 24% from 1996 to 2014 (Curtin, Warner, & Hedegaard, 2016), indicating that suicide is still a health crisis that needs to be addressed. Although suicide affects individuals across all sociodemographic groups, some groups are at higher risk for suicide thoughts, attempts, or deaths than others (Drapeau & McIntosh, 2016).

People with disabilities have been identified as one such high-risk group (Giannini et al., 2010; Lund, Nadorff, & Seader, 2016; McConnell, Hahn, Savage, Dube, & Park, 2015; Pompili et al., 2011) across all types of suicidality (i.e., ideation, attempts, and deaths). This increased or elevated risk has been consistently noted in both people with disabilities as a broadly defined group (Lund et al., 2016; McConnell et al., 2015) and for specific disability groups, including people with psychiatric disabilities (Lund, Nadorff, et al., 2016), multiple sclerosis (Giannini et al., 2010; Pompili et al., 2011), autism spectrum disorders (Segers & Rawana, 2014), spinal cord injury (Giannini et al., 2010), and Huntington's disease (Wetzel et al., 2011). The exact mechanism underlying the link between suicidality and disability is unclear, but researchers have found that controlling for depression alone, either via symptoms or diagnosis, cannot fully account for the increased rate of suicidality among people with disabilities (Lund et al., 2016; McConnell et al., 2015), nor can controlling for combined anxiety and depression diagnoses (Dennis et al., 2009; McConnell et al., 2015) or socioeconomic factors (McConnell et al., 2015). This suggests that disability may be a risk factor for suicidality itself, above and beyond the general increased risk for depression seen in people with disabilities (Lund et al., 2016).

As counseling professionals who work with individuals with disabilities, vocational rehabilitation (VR) counselors may be an important resource in recognizing and responding to suicidality among people with disabilities. Addressing suicidal and self-injurious behaviors is within the scope of practice for rehabilitation counselors (Commission on Rehabilitation Counselor Certification, 2016). In addition, there is an increasing push to train both professionals (Schmitz et al., 2012) and paraprofessionals and community members (Condron et al., 2015; Isaac et al., 2009) on basic suicide risk assessment and referral as part of comprehensive

gatekeeper training initiatives (Condron et al., 2015; Isaac et al., 2009) and professional development (Schmitz et al., 2012).

However, there has been almost no research addressing suicide training and competency in either VR specifically or rehabilitation counseling in general. In a study on client death in general, Hunt and Rosenthhal (1997) found that only 23% of the 160 rehabilitation counseling trainees who responded to the study reported receiving any training on death-and-dying-related issues. However, 83% felt that such training was important or very important. Furthermore, 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 in their study, and that there were 39 client deaths by suicide reported among the 151 participants. In a study using the same data set as this study, we found that 55% of rehabilitation counselors reported working with suicidal clients once a year or more (Lund, Schultz, Nadorff, Galbraith, & Thomas, 2017).

Suicide by its very nature tends to be a stressful and emotional topic even among professionals (Saunders, Hawton, Fortune, & Farrell, 2012). 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 (Saunders et al., 2012). In addition, concerns about the legal implications of working with suicidal clients may cause people to react in a manner that is not consistent with the actual level of risk presented (Saunders et al., 2012). Alternatively, individuals who do not have a good understanding of suicide risk or referral may not know how to screen for suicidality or to refer appropriately when an individual demonstrates risk for suicide (Condron et al., 2015). Given the complex nature of suicide and the limited research on suicide competency in both VR and rehabilitation counseling in general, it is important to understand rehabilitation counselors' thoughts on and experiences with suicide. Such knowledge may allow for the provision of better regarding assessing, working with, and referring suicidal clients. To help further that knowledge, we conducted a qualitative analysis of the perspectives of State/Federal VR counselors' perspectives regarding suicide in VR settings.

Method

Recruitment

Participants were recruited as part of a larger study on suicide knowledge, experience, and competency in the State/Federal VR system (Authors, in press). State VR offices were recruited via assistance from regional technical assistance centers, and recruitment e-mails were sent to rehabilitation counselors and support staff in participating state VR offices. All procedures were approved by the university institutional review board prior to data collection. The recruitment e-mail stressed that participation in the study was anonymous,

confidential, and voluntary and that participation or lack thereof would have no effect on participants' employment with VR. Interested participants could then click a link to review the letter of information and complete the survey. All data collection took place on a secure university-based Qualtrics server, and no identifying information was collected. Participants were included in the present analysis if they identified as rehabilitation counselors (as opposed to support staff) and responded to the open-ended question regarding suicide training and competency. Of the 223 counselor participants in the larger study, 27 (12.1%) provided responses to the qualitative item and thus were included in the present analyses.

Participants

Of these 27 participants, 18 (66.8%) worked in Texas, 4 (14.8%) worked in Idaho, 3 (11.1%) worked in Utah, and 2 (7.4%) worked in South Dakota. Fifteen (55.5%) were women, and 12 (44.4%) were men. The mean age was 46.81 years ($n = 40$, standard deviation [SD] = 12.21), with a range of 25 to 71 years.

Participants had worked in VR for an average of 9.04 years ($SD = 7.75$; range = 0–21 years). Twenty-five (92.6%) held masters degrees, one held a doctorate, and one held a bachelors degree. Eleven (40.7%) were certified rehabilitation counselors, three were licensed professional counselors or licensed mental health counselors, two were licensed addiction counselors, and one was a licensed clinical social worker. Twelve (44.4%) had received training on both nonsuicidal self-injury (NSSI) and suicide, four (14.8%) had received training on suicide only, and one (3.5%) had received training on NSSI only. The remaining 10 (37.0%) reported receiving no training on either of these topics.

All participants reported that they worked with clients who expressed suicidal thoughts or behaviors. Five (18.5%) reported that they did so less than once a year, six (22.2%) reported that they did so about once a year, and eight (29.6%) did so every few months. The remaining eight participants (29.6%) reported working with suicidal clients once a month or more. In addition, 16 participants (59.3%) reported 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, & Conroy 2013), which is a self-report measure of perceived competency in 10 core suicide assessment and intervention competencies as well as overall suicide competency. It demonstrated excellent psychometric properties in rehabilitation counselors (Lund, Schultz, & Nadorff, 2017). We have provided information on the participants' self-ratings of their suicide assessment and intervention competency in order to provide context to their qualitative responses. The 27 participants included in this study had a mean SCAF total score of 26.26 ($SD = 8.16$, range = 15–40) out of a possible score range of 10 to 40. Twenty-six participants

also had data for the SCAF overall perceived suicide assessment competency item. Of those 26, 6 (23.1%) rated themselves in the ''unacceptable'' range (1–2), 8 (30.8%) in the ''working toward competency'' range (3–4), 9 (34.6%) in the ''competent'' range (5–6), and 3 (11.5%) in the ''advanced competency'' range (7–8). The mean overall competency rating was 4.04 ($SD = 2.16$, range = 1–8).

Measure

We analyzed qualitative responses to an open-ended item regarding participants' experiences or thoughts on suicide. The SCAF (Cramer et al., 2013; Lund, Schult, & Nadorff, 2017) provides a blank space entitled ''comments (optional)'' in which participants can write their thoughts about suicide competency and training. We analyzed all responses left in that space except those that simply indicated that the participant did not have any comments (i.e., ''no'' or ''n/a''). In total, the responses contained 988 words and comprised just over two single-spaced pages. Response lengths ranged from 9 words to 155 words, with only one response containing fewer than 14 words.

Data Analysis

For our analysis, we utilized grounded theory, an inductive emergent hypothesis approach that is aimed at building, rather than testing theory (Glaser, 1998; Strauss & Corbin, 1990). Grounded theory begins with the coding of key themes via open reading of the data. As such, two investigators independently identified key themes after closely reading the data and discussed any differences to reach consensus on the key themes. After this consensus building process, the same two authors independently coded all 27 responses dichotomously regarding whether or not they fit each theme. Because all but one of the items that were coded as ''obtained skills through experience'' were also coded as ''obtained training outside of VR,'' the two themes were combined in order to reduce redundancy. This was agreed on by consensus of the investigators who had originally identified the themes via open coding. This resulted in a total of seven codes: (a) a desire for more training on suicide, (b) a perceived lack of resources used to address suicide, (c) receiving training and suicide outside of VR and through experience, (d) not working with or simply referring suicidal clients, (e) having out of date training or education on suicide, (f) differentiating NSSI and suicide, and (g) sharing one's experiences with suicidal individuals either personally or professionally.

Because of the relatively short nature of the responses, we calculated inter-rater agreement (IRA) at both the level of each theme and overall. This method has been used in other research drawing from short qualitative responses to a survey (e.g., Lund, Andrews, & Holt, 2016). As seen in Table 1, both overall and theme-level agreements were within the 75% to 90% range suggested by that is

Table 1. Interrater Agreement.

Theme	Number of disagreements	Percent agreement
Desire for suicide training	3	88.9
Perceived lack of suicide-related resources	1	96.3
Received training outside of VR/obtained skills through experience	4	85.2
Does not address suicide/only refers clients	3	88.9
Feels training or skills are outdated	1	96.3
Differentiates NSSI and suicide	4	85.2
Discusses personal/professional experiences with suicide	4	85.2
Overall	20	89.4

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

often considered "acceptable" in content analysis IRA (Graham, Millanowski, & Miller, 2012). All theme-level agreements were at or above 85%. Overall agreement was 89.4%. Thus, both our overall and theme-level IRAs were acceptable or better. Because the number of disagreements per code was generally low (1–4 disagreements per theme), the ratings of one coder were used to decide which responses represented each theme, with the exception to one clear miscoding in NSSI differentiation and one clear miscoding outdated skills and experience. To provide a conservative estimate of IRA, these two changes were not reflected in our IRA calculations.

Results

Received Training on Suicide and Self-Injury Outside of VR and Through Experience

Thirteen participants (48.1%) reported receiving training on suicide outside of VR or through experience. Many of these participants mentioned having received training at other jobs. For example, one participant noted, "Previous to my current employment, I worked as a crisis clinician and have dealt with numerous suicide attempts," while another noted, "I have over 9 years [of] experience working with people with mental health issues through a public community agency." Other examples include a participant who "worked at our local [mental health agency] [where] one of [the] assigned duties was to be on the Crisis Intervention Team rotation," a participant with prior experience working on an assertive community treatment team, a participant who had worked with suicidal patients in the emergency room, a participant who had received training on suicide through previous employment with Adult Protective Services, and a

participant who worked with clients who were suicidal or engaging in NSSI in their second job at a private practice.

Other participants noted that their skills related to suicide assessment and crisis intervention primarily came via working with friends and family members who were engaging in self-harm or in suicidal crisis. For example, one participant commented, "most of my knowledge on these subjects comes from my education and from educating myself after dealing with suicidal and self-injurious behaviors with friends and family." Another participant openly attributed their skills in this area to experience working with such clients rather than training, stating, "I'm sure I have been trained but cannot think of the training. I have more on the job experience as training." In addition, other two participants cited their experience as with trainers with suicide gatekeeper training programs as the source of their suicide-related knowledge and skills. Because training on suicide was sought and obtained outside of VR, the onus for seeking and paying for training was placed on counselors. One participant stated that "all of my specialized trainings have been received [through] programs I have paid for myself, not as part of my state [VR counselor] job."

Desire for Additional Training

Seven participants (25.9%) reported wanting more training on suicide and self-injury. For example, one participant stated, "There really does need to be more training done regarding this particular topic, especially for those working in my own profession." Some participants noted that participating in the study had made them more aware of the gaps in their one knowledge and training. One said, "I wish I have more training on this. I will definitely educate myself more as I feel very incompetent throughout this survey." Similarly, a second participant noted, "I don't believe I have adequate knowledge in this assessment but would like to learn more." Notably, another participant's response underscored the vital importance of suicide training, stating, "Please, get us more training on this. It's awful when we get it wrong."

One participant acknowledged that they had received prior training but still felt like they would benefit from more training in the area. Likewise, a second participant reported that they believed that training would be beneficial even though they felt like their agency had a solid crisis protocol in place:

> Our clients are stable and on medication once they arrive. When or if they discuss suicide automatically we inquire if they are on their meds and then contact 911 for transport to psychiatric evaluation through county. However, formal training would be absolutely wonderful as an empowerment tool as well as directing ourselves to be able to give and seek good resources to be on hand.

Another participant listed specific suggestions for training content specific to VR employees:

> I would be interested in knowing: (1) what percentage of public VR counselors encounter consumers who are at risk for suicide; (2) which disabilities increase a consumer's risk of suicide; (3) which disabilities when combined (two or more) are likely to increase the consumer's risk of suicide; [and] (4) which limitations are likely to increase the consumer's risk of suicide.

Experiences With Suicide

Five responses (18.5%) referenced participants' own personal and professional experiences with suicide and self-injury. Some of these experiences, even if infrequent, were highly emotional, as shown this response from a participant:

> In my 23 years with [VR], I have only had on consumer who was suicidal. We were talking on the telephone and she wanted to kill herself. I was able to get her mom on my cell phone to call for an ambulance, which saved her life. I never left the telephone with her until help got there.

Other participants mentioned experience with suicide via other jobs, volunteer positions, or via assisting friends or family members in crisis. One participant commented on both their personal and professional experiences with suicide, stating:

> I have occasionally had a client that has attempted suicide or self-mutilation but it has usually been after the fact—the client was referred to [VR] for assistance with obtaining employment rather than treatment. I have had two family members commit suicide; one made several, what appeared at the time, to be attention getting attempts, [and] the other [gave] no indication that I am aware of.

Do Not Encounter Suicide or Simply Refer Suicidal Clients Elsewhere

Five participants (18.5%) commented that they do not encounter or very rarely encounter suicidal clients or that they do not engage with those clients beyond referring them elsewhere for mental health treatment. One participant stated, ''My job duties are not normally directed towards suicide prevention. Normally, individuals are referred to a qualified professional.'' One participant specifically said that they do not frequently work with suicidal clients due to having a deaf/hard of hearing caseload but noted that their colleagues who work with other VR populations might do so more frequently.

Two participants indicated that they still believe that training would be helpful, even though they mostly address suicidality through referrals:

> In my current job, I don't see myself being the person who would create a treatment plan and treat a person who has suicidal or self-injurious thoughts and behaviors. However, I could be doing that in the future. In my current job, I think training in the other factors above would be very helpful so I can do my best to help someone who is having suicidal or self-injurious thoughts and behaviors and refer them to other professionals where I am not competent . . . I don't mean I am dealing with that in my office at the frequency I reported, but I know several of my current and past clients have those thoughts and behaviors.

> Our clients are stable and on medication once they arrive. When or if they discuss suicide automatically we inquire if they are on their meds and then contact 911 for transport to psychiatric evaluation through county. However, formal training would be absolutely wonderful as an empowerment tool as well as directing ourselves to be able to give and seek good resources to be on hand.

Differentiation Between NSSI and Suicide

Four participants (14.8%) differentiated between NSSI and suicide in their responses. Mostly, these differentiations were simply surface level (e.g., specifically mentioning clients who had "suicidal or self-injurious thoughts" or having taken "courses in graduate school which addressed the topic of suicide and self-injury"). One participant mentioned training related to self-injury specifically in their response, stating, "I have had training on self-injurious behaviors." Another participant related knowledge specific to self-injury: "Self-harm doesn't always relate to suicide—[it is] often expression of pain."

Perceived Outdated Training or Knowledge and Lack of Resources

One (3.7%) participant mentioned a perceived lack of resources for addressing suicide in VR settings, stating that training would be good as it would allow counselors to "be able to give and seek good resources to be on hand." Similarly, three participants (11.1%) mentioned that they had suicide training but felt that their knowledge or skills in this area may be outdated. One participant noted, "We were all required to take courses in graduate school which addressed the topic of suicide and self-injury, but I do feel the need for continued update[d] training on something this important." Another participant noted that their training on this topic came from a previous position 20 years ago and thus may not be up-to-date. Finally, a third participant noted that their training

was somewhat old, but they still felt that they could effective handle a crisis, thanks in part to using the skills in other settings:

> I was a certified Applied Suicide Intervention Skills Trainer through LivingWorks at one point. I have a hard of hearing case load and don't have the opportunity to use these skills as much as my colleagues. I am not aware of the latest suicide prevention and intervention techniques but remain confident in my skills. I use these skills more in my volunteer activities with women and children who have been abused, particularly sexual abuse.

Discussion

In this study, we examined the qualitative responses of 27 VR counselors who participated in a study regarding suicide and self-injury-related knowledge and competency. Participants frequently reported getting training on and experience with this topic outside of the VR setting. However, many also reported that they would want additional training on addressing suicide and working with suicidal clients. Some participants highlighted highly emotional and stressful experiences when working with suicidal clients or other individuals, and even participants who noted that they just refer suicidal clients for treatment elsewhere or rarely encounter suicidal clients in their current position often noted that additional training on this topic would be welcome. Overall, the results suggest a desire and need for current and up-to-date training on suicide among counselors and support staff working for the State/Federal VR system.

Implications for Practice and Training

Our results are in line with the findings of Hunt and Rosenthhal (1997, 2000) regarding training and experiences with client death in general in rehabilitation counseling. Namely, our results highlight both a desire for additional training in addressing suicidality in VR settings. Furthermore, many participants specified that their training and education on suicide had occurred outside of their duties and training in VR. Instead, participants frequently discussed that their suicide-related knowledge and training was received as part of non-VR-related work experiences or as a result of their own initiative to seek suicide gatekeeper training as an individual. Despite the reported lack of suicide-related training offered by VR, however, participants often reported that the knowledge and skills that they learned during this training was applicable and useful in their work in VR. This suggests that suicide-related training, such as a gatekeeper training program or another clinical professional development program, might be appropriate and beneficial professional development training to provide to VR counselors. Several such programs exist, including Applied Suicide

Intervention Skills Training (Ramsay, Tanney, Tierney, & Land, 1999), SafeTALK (LivingWorks, 2010), and Question, Persuade, Refer (Quinett, 1995). In addition, agencies can work with universities or mental health agencies to develop more advanced training for those wanting or needing more clinical skills in suicide assessment. Preliminary research has found that even brief training can lead to large increases in suicide knowledge and self-assessed competency in clinicians (Cramer, Bryson, Eichorst, Keyes, & Ridge, 2016).

The role of VR counselors as it relates to suicide have not been well-examined. Although VR counselors do, by definition, provide counseling services, they do not provide more in-depth mental health counseling, as was noted by several participants in this study. However, researchers have found that training even nonmental health professionals in the basics of suicide risk assessment and referral increases the number of referrals for more in-depth mental health and suicide assessment that those individuals than make (Condron et al., 2015), potentially saving lives. In addition, we found that participants in our study did indeed cite their experiences working with individuals who were experiencing or had experienced an acute suicidal crisis in VR settings and reported that they would like more training in working with these populations. Training VR counselors in how to respond in these crisis situations as well as how to assess and respond to any continued risk might increase the safety, comfort, and well-being of all those involved. Furthermore, training VR counselors in basic suicide assessment and crisis intervention could increase their ability to serve clients with histories of suicide attempts or ideation as a part of an interdisciplinary rehabilitation or treatment team.

Master degree programs in rehabilitation counseling should include training in basic suicide assessment and crisis intervention at both the preservice and practicum and internship levels. The recent merger of the Council on Rehabilitation Education and the Council for Accreditation of Counseling & Related Educational Programs may result in suicide-related training in preservice rehabilitation counselor education. For example, the current Council for Accreditation of Counseling & Related Educational Program (2016) education standards specifically mention ''suicide prevention models and strategies'' and ''procedures for assessing risk of aggression or danger to others, self-inflicted harm, or suicide'' in their required competencies, whereas the last set of Council on Rehabilitation Education (2011) standards only specified that rehabilitation counselors should have the ability to ''recognize and communicate a basic understanding of how to assess individuals, groups, and families who exhibit suicide ideation, psychological and emotional crisis.'' However, additional supports and training may still be needed to enhance the competencies of rehabilitation counselors who are already working in the field.

As would be expected based on the previous research (McHale & Felton, 2010; Saunders et al., 2012), several participants also highlighted the sheer stress and emotionality that comes with suicide and self-injury. Suicide is

literally a life and death issue and thus individuals who are working with suicidal clients, especially those who are in a state of immediate suicidal crisis, may feel immense pressure to keep a suicidal individual alive (Saunders et al., 2012) as well as considerable and complex guilt if that client does indeed die by suicide (Knox, Burkard, Jackson, Schaack, & Hess, 2006). In addition, as noted by some of our respondents, professionals may have personal experiences with suicide that may impact their professional feels about and reactions to suicidal clients. Good supervision is essential in assisting counselors 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 supervisors in supporting counselors who are working with suicidal clients may be helpful.

Limitations and Directions for Future Research

One limitation of this study is the small, self-selected sample. Only 27 counselor participants provided responses to the qualitative item, thus limiting the number and variety of experiences 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 that may not necessarily be representative of the general population of VR counselors. In addition, the generalizability of the study is limited by the fact that we did not use a national sample and that a majority of the respondents worked in one state (Texas). This study should be replicated with a larger, more representative sample in order to enhance the generalizability and depth of the results.

In addition, the study is limited by the fact that the qualitative prompt asked participants for their general "comments" on suicide competency and training. This lack of a more directive question may have reduced the focus and depth of participant responses. Although a broad, general prompt is useful for an exploratory study of this nature, researchers may wish to follow-up this study with items that more specifically target certain experiences, beliefs, and competencies related to suicide. Also, the anonymous, online nature of this survey—although potentially helpful with regard to the highly stigmatized nature of suicide (Knox et al., 2006)—prevented us from asking follow-up questions and providing prompts to clarify, enhance, or expand on participants' comments. Finally, the text-based entry may have increased the response effort and thus decreased the length of participant responses. Thus, it may be useful to replicate or expand on this study using other methods of data collection, such as face-to-face interviews.

Conclusion

In sum, this study provides an initial exploration of rehabilitation counselors' experiences with suicide in the State/Federal VR system. Participants' responses

highlighted a pervasive feeling of lack of preparation for working with suicidal clients and a desire for more training in this area. In addition, participants often sought out suicide training on their own, rather than having it provided through VR training and professional development. Finally, the responses also underscored the emotional intensity of suicide as both a clinical and personal phenomenon. VR counselors may benefit from additional training and supports regarding assessing and working with suicidal clients.

Acknowledgments

We would like to express our gratitude to the state VR offices, regional technical assistance centers, and VR counselors 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.

References

Commission on Rehabilitation Counselor Certification. (2016). *Code of professional ethics for rehabilitation counselors*. Schaumburg, IL: Author.

Condron, S. D., Garraza, L. G., Walrath, C. M., McKeon, R., Goldston, D. B., & Heilbron, N. S. (2015). Identifying and referring youths at risk for suicide following participation in school-based gatekeeper training. *Suicide and Life-Threatening Behavior*, *45*, 461–476.

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

Council on Rehabilitation Education. (2011). *CORE accreditation standards*. Schaumburg, IL: Author. Retrieved from http://www.cacrep.org/wp-content/uploads/2017/07/CORE-Standards-for-Rehabilitation-Counselor-Education-Programs.pdf

Cramer, R. J., Bryson, C. N., Eichorst, M. K., Keyes, L. N., & Ridge, B. E. (2016). Conceptualization and pilot testing of a core competency-based training workshop in suicide risk assessment and management: Notes from the field. *Journal of Clinical Psychology*. doi:10.1002/jclp.22329

Cramer, R. J., Johnson, S. M., Mclaughlin, J., Rausch, E. M., & Conroy, M. A. (2013). Suicide risk assessment for psychology doctoral programs: Core competencies and a framework for training. *Training and Education in Professional Psychology*, *7*, 1–11.

Curtin, S. C., Warner, M., & Hedegaard, H. (2016). Increase in suicide in the United States, 1999–2014 *(NCHS data brief, no. 241)*. Hyattsville, MD: National Center for Health Statistics. Retrieved from http://www.cdc.gov/nchs/data/databriefs/db241.pdf

Dennis, M., Baillon, S., Brugha, T., Lindesay, J., Stewart, R., & Meltzer, H. (2009). The influence of limitation in activity of daily living and physical health on suicidal ideation: Results from a population survey of Great Britain. *Social Psychiatry and Psychiatric Epidemiology*, *44*, 608–613.

Drapeau, C. W., & McIntosh, J. L. (2016). *U.S.A. suicide 2015: Official final data*. Washington, DC: American Association of Suicidology. Retrieved from http://suicideprevention.nv.gov/uploadedFiles/suicidepreventionnvgov/content/SP/CRSF/Mtgs/2018/2016_AAS_USA_data.pdf

Giannini, M. J., Bergmark, B., Kreshover, S., Elias, E., Plummer, C., & O'Keefe, E. (2010). Understanding suicide and disability through three major disabling conditions: Intellectual disability, spinal cord injury, and multiple sclerosis. *Disability and Health Journal*, *3*(2), 74–78.

Glaser, B. G. (1998). *Doing grounded theory: Issues and discussions*. Mill Valley, CA: Sociology Press.

Graham, M., Millanowski, A., & Miller, J. (2012). *Measuring and promoting inter-rater agreement of teacher and principal performance ratings*. Washington, DC: Center for Educator Compensation Reform, U.S. Department of Education, Office of Elementary and Secondary Education. Retrieved from http://files.eric.ed.gov/fulltext/ED532068.pdf

Hunt, B. H., & Rosenthal, D. A. (1997). Rehabilitation counselors-in-training: A study of their levels of death anxiety and their perceptions about client death. *Rehabilitation Education*, *11*, 323–335.

Hunt, B. H., & Rosenthal, D. A. (2000). Rehabilitation counselors' experiences with client death and death anxiety. *Journal of Rehabilitation*, *66*(4), 44–50.

Isaac, M., Elias, B., Katz, L. Y., Shay-Lee, B., Deane, F. P., Enns, M. W., & Sareen, J. (2009). Gatekeeper training as a preventative intervention for suicide: A systematic review. *Canadian Journal of Psychiatry*, *54*, 260–268.

Knox, S., Burkard, A. W., Jackson, J. A., Schaack, A. M., & Hess, S. A. (2006). Therapists-in-training who experience a client suicide: Implications for supervision. *Professional Psychology: Research & Practice*, *37*, 547–557.

LivingWorks. (2010). SafeTALK—Suicide alertness for everyone. Retrieved from http://www.livingworks.net/programs/safetalk/

Lund, E. M., Andrews, E. E., & Holt, J. M. (2016). A qualitative analysis of advice from and for trainees with disabilities in professional psychology. *Training and Education in Professional Psychology*, *10*, 206–213.

Lund, E. M., Nadorff, M. R., & Seader, K. (2016). The relationship between suicidality and disability when accounting for depressive symptomology. *Rehabilitation Counseling Bulletin*, *59*, 185–188.

Lund, E. M., Schultz, J. C., & Nadorff, M. R. (2017). The factor structure, internal consistency, and convergent validity of two suicide assessment competency measures in vocational rehabilitation counselors. *Rehabilitation Counseling Bulletin*, *60*, 20–27.

Lund, E. M., Schultz, J. C., Nadorff, M. R., Galbraith, K., & Thomas, K. B. (2017). Experience, knowledge, and perceived comfort and clinical competency in working with suicidal clients among vocational rehabilitation counselors. *Rehabilitation Counseling Bulletin*, *60*, 54–63.

McConnell, D., Hahn, L., Savage, A., Dubé, C., & Park, E. (2015). Suicidal ideation among adults with disability in western Canada: A brief report. *Community Mental Health Journal*. doi:10.1007/s10597-015-9911-3

McHale, J., & Felton, A. (2010). Self-harm: What's the problem? A literature review of the factors affecting attitudes towards self-harm. *Journal of Psychiatric and Mental Health Nursing*, *17*, 732–740.

Pompili, M., Forte, A., Palermo, M., Stefani, H., Lamis, D. A., Serafini, G., . . . Girardi, P. (2012). Suicide risk in multiple sclerosis: A systematic review of current literature. *Journal of Psychosomatic Research*, *73*, 411–417.

Quinett, P. (1995). *Question, persuade, refer: Ask a question save a life [Booklet]*. Spokane, WA: QPR Institute.

Ramsay, R., Tanney, B., Tierney, R., & Land, W. (1999). ASIST (Applied Suicide Intervention Skills Training) trainer's manual. Calgary, Canada: LivingWorks Education.

Saunders, K. E., Hawton, K., Fortune, S., & Farrell, S. (2012). Attitudes and knowledge of clinical staff regarding people who self-harm: A systematic review. *Journal of Affective Disorders*, *139*, 205–216.

Schmitz, W. M., Allen, M. H., Feldman, B. N., Gutin, N. J., Jahn, D. R., Kleespies, P. M., . . . Simpson, S. (2012). Preventing suicide through improved training in suicide risk assessment and care: An American Association of Suicidology Task Force report addressing serious gaps in US mental health training. *Suicide and Life-Threatening Behavior*, *42*, 292–304.

Segers, M., & Rawana, J. (2014). What do we know about suicidality in autism spectrum disorders? A systematic review. *Autism Research*, *7*, 507–521. doi:10.1002/aur.1375

Strauss, A. L., & Corbin, J. (1990). *Basics of qualitative research: Grounded theory procedure and techniques*. Newbury Park, CA: SAGE.

Author Biographies

Emily M. Lund, PhD, CRC, is an assistant research professor at the National Research and Training Center on Blindness and Low Vision at the Mississippi State University and a former Assistant Professor in the Department of Community Psychology, Counseling, and Family Therapy at St. Cloud State University. Her research interests include interpersonal violence against people with disabilities, suicide and self-injury and disability, and the experiences of graduate students with disabilities..

Jared C. Schultz, PhD, CRC, is an associate professor at Utah State University. He currently serves as the Program Chair for the Rehabilitation Counseling program in the Department of Special Education and Rehabilitation.

Katie B. Thomas, PhD, is a clinical psychologist at the Clement J. Zablocki VA Medical Center in Milwaukee, WI. She has research interests in interpersonal trauma, emotion dysregulation, and self-harm behavior.

Michael R. Nadorff, PhD, is an assistant professor at Mississippi State University. His research focuses on the association between sleep disorders and suicidal behavior.

Dalia Chowdhury, PhD, is an assistant professor at University of North Texas, Denton. She works on violence and disability, suicide and trauma, addictions and co-occurring disorders. She is also interested in diversity and multicultural issues within rehabilitation.

Kate Galbraith, MRC, CRC, is a vocational rehabilitation counselor for the Utah State Office of Rehabilitation. Her interests include transition in young adults with disabilities.