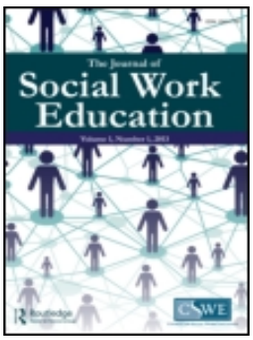

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YOU CAN'T RECOVER FROM SUICIDE: PERSPECTIVES ON SUICIDE EDUCATION IN MSW PROGRAMS

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Suicide is a profound worldwide public health problem that has received increased attention in recent years. The major federal response, the National Strategy for Suicide Prevention, calls for more suicide education for mental health professionals, including social workers. Little is known about the amount of suicide education in MSW curricula nationwide. This study presents quantitative findings from 2 national surveys of MSW deans and directors and of MSW faculty on suicide education and qualitative findings from a series of faculty focus groups. Results suggest that MSW students receive 4 or fewer hours of suicide education in graduate school, and most deans and faculty do not have plans to increase suicide content. Barriers include lack of faculty expertise, crowded curricula, and other educational priorities. Implications are discussed.

SUICIDE IS A SIGNIFICANT worldwide public health problem that causes widespread loss, trauma, and suffering. According to the Centers for Disease Control and Prevention, suicide is the 10th leading cause of death in the United States and the third leading cause of death for young people ages 15 to 24; in 2009, there were 36,909 suicide deaths (American Foundation for Suicide Prevention, 2012). The 2009 overall rate of suicide was 12/100,000 population, the highest it has been since 1995 (American Foundation for Suicide Prevention, 2012). In addition to completed suicides, it is estimated that close to one million U.S. residents make attempts each year and that approximately 650,000 people seek treatment in emergency rooms after suicide attempts (Maris, Berman, & Silverman, 2000; U.S.

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Department of Health and Human Services, 2001). A far-reaching problem that affects millions of Americans each year, suicide has not received the attention focused on other public health problems of a similar magnitude (Knox, Conwell, & Caine, 2004; Nock, Borges, Bromet, Cha, Kessler, & Lee, 2008).

Surgeon General David Satcher of the U.S. Public Health Service issued a major *Call to Action to Prevent Suicide*; shortly thereafter, the U.S. Department of Health and Human Services developed and launched a national public health strategy for suicide prevention (U.S. Department of Health and Human Services, 1999). The strategy's key recommendations focused on broadening public awareness of suicide, strengthening clinical intervention and population-based prevention approaches used by professionals, and advancing the science of suicide prevention (U.S. Department of Health and Human Services, 2001). Although the science of suicide prevention and intervention is still evolving, the National Strategy for Suicide Prevention has identified the importance of more professional training in current best practices for all mental health professionals, including social workers (U.S. Department of Health and Human Services, 2001).

Social Work and Suicide Education

With more than a half million practicing social workers in the United States, workforce studies show an increase in social work practice in health and mental health and indicate that the majority of social workers now work in health or mental health care settings (Ruth et al., 2008; Whitaker, Weismiller, Clark, & Wilson, 2006). Over the past 20 years, social work has grown in prominence as a mental health profession, and social workers are now the nation's largest providers of mental health treatment services, providing approximately 70.0% of mental health services (Joe & Niedermeier, 2008; Manderscheid et al., 2004). Social workers appear to encounter suicidal clients regularly; according to a national survey of NASW members, 93% of randomly sampled social workers responded that they had worked with suicidal clients at some point, and 87.1% had worked with a suicidal client in the past year (Feldman & Freedenthal, 2006). In another national survey, some 55% of a randomly drawn NASW sample of mental health social workers had experienced a client suicide attempt during their careers, and another 31% had experienced a completed client suicide (Sanders, Jacobson, & Ting, 2008). Although no systematic or large-scale studies of social work students exist, more than half of students (58.2%) surveyed at a large urban school of social work described the prevalence of suicide and suicidal behavior as "extensive" among clients in their agencies (Ruth, Sasportas, Beville, & Muroff, 2008).

Despite the widespread exposure of social workers to the issue of suicide, scholarly professional literature on suicide in social work journals and by social workers is sparse; one systematic review of 29 of the profession's major journals from 1980 to 2006 revealed that less than 1% of total articles related generally to suicide (Joe & Neidermeier, 2006). Of particular concern is the lack of suicide prevention scholarship focused on multicultural issues or at-risk populations, such as African Americans, Latinas, elders, or LGBT populations (Joe, Canetto, & Romer, 2008; Joe &

Neidermeier, 2008; Range et al., 1999). It is widely believed that professional journals exert a powerful effect on professions, establishing the issues to be proactively addressed and providing the current evidence base for guiding practice (McMahon & Allen-Meares, 1992; Van Voorhis & Wagner, 2001). Thus, suicide's absence from the profession's literature poses significant problems for social work practitioners, scholars, and students. However, the relative lack of social work literature on suicide occurs in the larger context of suicide prevention and intervention research, which remains underdeveloped across the helping professions (Linehan, 2008).

Although professional and clinician education on suicide is crucial to the national strategy, research on suicide education within the professions is also sparse; most existing studies on clinician education in suicide were conducted on psychologists or psychiatrists, not on social workers (Grandin, Yan, Gray, Jamison, & Sachs, 2001; Sanders et al., 2008). At best, the issue of suicide prevention education has garnered modest attention within social work education; consequently, little is known about content or quality of suicide prevention and intervention training received by social workers, either in MSW programs or after graduation (Ruth et al., 2008; Sanders et al., 2008). In one of the few studies to inquire about the training of social workers, less than a quarter of a national sample of NASW members had received any formal training in suicide prevention, and most of the 598 respondents indicated their training had been inadequate (Feldman & Freedenthal, 2006). In comparison, a survey of doctoral psychology interns found that approximately 50% received formal training in their graduate programs, with an emphasis on four areas of training: crisis intervention, assessment, prevention skills, and postvention (Dexter-Mazza & Freeman, 2003). Suicide education among social work students, however, has generally not been studied: In a small study of 116 MSW students and field supervisors at a large urban school of social work, 40% of advanced students reported feeling "somewhat or very unprepared," and 23% reported they had not received any suicide education in their MSW program (Ruth et al., 2008). In that same study, 73% of 117 field supervisors surveyed strongly agreed that teaching their MSW interns about suicide was important, but 43.9% reported that they did not feel "well enough prepared" to do so (Ruth et al., 2008). We must begin to understand whether and to what degree suicide education is integrated into social work education, so that the national strategic training objectives for reducing suicides may be achieved.

Suicide Education Assessment Project and Suicide Education Enhancement Project

As part of a larger 3-year initiative to increase interest and education on suicide prevention in the MSW program at Boston University, an urban northeastern school of social work with a multimethod educational focus, the researchers conducted three research studies on understanding suicide education in the social work profession. The Suicide Education Assessment Project (SEAP) and the Suicide Education Enhancement Project (SEEP) focused at both the national and state levels, using qualitative and quantitative methods. The purpose

of the National Deans/Directors Survey (NDDS) was to gain a broader understanding of the suicide education in MSW education nationally from deans' perspectives, and the National MSW Faculty Survey (NMFS) sought to understand the views of faculty members. The Massachusetts MSW Faculty Focus Group study used qualitative focus group inquiry to gain a more grounded and thorough understanding of faculty perceptions of and experiences with integration of suicide education into MSW curricula. The Institutional Review Board approved these studies.

NDDS

Methods

We constructed a sample of all U.S. MSW program deans and directors from a Council on Social Work Education (CSWE) list of accredited and accreditation-in-process MSW programs in 2008 (N=208). All deans and directors were invited to participate by e-mail letter, which included a link to an anonymous online survey with 31 questions on suicide education within MSW programs. Participants provided their research consent online. The survey included questions on the amount and type of academic activities and curriculum content related to suicide prevention and intervention, as well as questions related to general attitudes, experience, and knowledge of suicide. The entire sample received $20 gift cards to encourage consideration to participate. We sent follow-up e-mails twice, and the survey remained active for 60 days. The response rate for completed surveys was 25.9% (n=54). All data were analyzed in SPSS.

The sample included 14.8% (n=8) deans, 55.9% (n=33) directors, 27.1% (n=16) professors, and 32.2% (n=19) curriculum committee chairs or other administrator roles; some respondents held more than one role. The average time at their respective institutions was 8.3 years (SD=7.1, maximum=32 years), and time in current position was 4 years (SD=3.9, maximum=20 years). The institutions with which these deans and directors were affiliated were 14.8% (n=8) rural, 9.3% (n=5) suburban, and 70.4% (n=38) urban. Additionally, they were 72.2% (n=39) state-funded, 22.2% (n=12) private, and 13.0% (n=7) religious-affiliated. Furthermore, 59.3% (n=32) offered a BSW, and 37.0% (n=20) offered a doctoral degree in social work.

Findings

Almost all deans and directors (90.7%, n=49) reported that suicide education was included in the MSW curriculum, with 57.4% (n=31) of respondents estimating that their students received four or fewer hours of suicide education. Most deans and directors (85.2%, n=46) noted that suicide education was not required of MSW students in their programs, and only 1.9% (n=1) reported that their program offered a specific course dedicated to suicide prevention education. Additionally, although 61.1% (n=33) stated that suicide education was integrated through students' MSW field education internships, no dean reported that his or her school's program provided suicide training to field instructors, and 53.7% (n=29) reported that their programs provided no continuing education or professional development courses in suicide education. Most

deans and directors, when asked to rank the suicide education preparation of their MSW students on a scale from 1 to 10 (*very limited preparation* to *extensive preparation*) ranked students at a 4 (*moderately limited preparation*). Despite this appraisal, 83.3% of respondents did not have plans to increase suicide education in the curriculum (n=45), even though most agreed that the education was "somewhat" or "very" important (72.2, n=39). Most (75.9%, n=41) reported that their program "was about equal to other social work programs" on the inclusion of suicide education. The greatest barriers to suicide education cited by deans and directors included "lack of faculty expertise" (35.2%, n=19), "lack of room in the curriculum" (40.7%, n=22), and "other training priorities" (40.7%, n=22).

NMFS

Methods

The authors constructed a national MSW faculty sample from a CSWE list of accredited and accreditation-in-process MSW programs (n=213). All faculty (full-time, part-time, adjunct, and visiting professors) listed on U.S. websites in 2009 were included (N=4727). The recruitment e-mail invitation included a link to an online anonymous survey containing 51 questions on suicide education in MSW programs and to an online consent form. Similar to the NDDS, the instrument was modified to better capture specific faculty issues, along with attitudes, beliefs, and training on suicide education in MSW curricula. Schools where faculty e-mail addresses were not listed were contacted twice and asked to send the invitation e-mail to all faculty members. The NMFS remained active for 3 months. Participants who provided their e-mail address at the end of the survey were entered into a lottery to win a $100 gift card. We sent the recruitment e-mail three times; the response rate was 11.6% (n=551). All data were analyzed in SPSS.

The sample included 10.9% (n=60) full professors, 26% (n=143) associate professors, 30.9% (n=170) assistant professors, and 27.7% (n=153) adjuncts and visiting professors. The average time at their respective institutions was 8.8 years, and the average time in their current position was 6.3 years. The faculties' institutions were 13.6% (n=75) rural, 21.8% (n=120) suburban, and 63.0% (n=347) urban. Additionally, they were 71.0% (n=391) state-funded, 24.0% (n=132) private, and 9.26% (n=51) religious-affiliated (respondents could chose more than one). Furthermore, 71.7% (n=395) offered a BSW, and 52.5% (n=289) offered a doctoral degree in social work.

Findings

Some 69.1% of faculty (n=381) endorsed suicide education to MSW students as "very" or "exceptionally important," and the majority (73.3%, n=404) reported that it was included in their MSW programs. Approximately half (48.6%, n=268) of faculty members estimated that students received four or fewer hours of suicide education. The majority indicated either that suicide education was not required in their programs (60.8%, n=335) or that they did not know whether it was required (25.4%, n=140). Approximately 59.9% (n=330) reported that their MSW program was "about equal

to other social work programs" on the topic of suicide education. Some 43.2% (*n*=238) affirmed that they were very interested in the topic of suicide; however, only 14.5% (*n*=80) endorsed suicide as a primary "research" interest for any faculty members in their institutions, including themselves. Some 59.2% of faculty members (*n*=326) "strongly agreed" that they would feel comfortable teaching about suicide in their courses, and another 22.1% (*n*=122) "moderately agreed." Despite a stated comfort level, fewer than half (47.2%, *n*=260) reported more than eight hours of suicide education in their own careers. Although 83.8% (*n*=462) agreed that teaching about suicide is a shared responsibility between field educators and classroom-based instructors, with both classroom and field-based components, 50.1% (*n*=276) reported that their program, school, or department did not provide suicide education training for field instructors or supervisors, nor was it included in continuing education or professional development activities (21.1%, *n*=116). Most faculty members responded either that they did not know whether there were plans to include more suicide education (46.6%, *n*=257) or that there were no plans to include more suicide education at their schools (40.7%, *n*=224). Their explanations for this finding echo the deans' and directors' responses: "lack of room in the curriculum" (34.8%, *n*=192), "other priorities" (33.8%, *n*=186), and "lack of faculty expertise" (29.4%, *n*=162). These findings, particularly the reasons given for not including suicide education in the curriculum, raised additional questions about the specific nature of the obstacles to integrating suicide education into MSW curricula.

Faculty Focus Group Project

Methods

SEEP/SEAP conducted a series of five 2-hour focus groups with MSW faculty members in four locations throughout Massachusetts during 2008 and 2009. A statewide MSW faculty sample was constructed from a CSWE list of accredited and accreditation-in-process MSW programs (*n*=8). The authors invited by e-mail all MSW faculty members across Massachusetts to participate in a focus group meeting, using a sample constructed from university websites (*N*=381); programs that did not list faculty e-mails were contacted twice and asked to send the invitation e-mail directly to their faculty.

The groups were facilitated by two MSW faculty members experienced in qualitative methods and knowledgeable about suicide. All groups were audiotaped and professionally transcribed. Faculty participants received subject payments of $40 gift cards. A semi-structured interview format was used with open-ended questions that focused on the following issues: (1) participant motivations for dealing with the issue of suicide, (2) perspectives on the importance of suicide education to social work education, (3) views on suicide education content in the curriculum, (4) perceptions of student preparation regarding suicide education, (5) recommendations for integrating suicide education across the curriculum, and (6) observations of the profession's response to suicide.

All interviews were analyzed using Atlas.ti software by a team of one researcher and two graduate assistants with degrees in

public health and social work. The analysis began with a "read-through" of the transcripts three times. This was followed by an inductive stage of open coding (Charmaz, 2006; Glaser & Strauss, 1967), followed by focused coding. Similar codes were grouped together under more general categories and labeled in order to identify initial common themes. Transcripts were then reviewed using axial coding (Charmaz, 2006; LaRossa, 2007; Miles & Huberman, 1994); coding was refined, and relevant quotes were extracted. Finally, senior members of the SEAP/SEEP team completed a last review of the transcripts, evaluating the coding scheme against the data.

Findings

A total of 18 faculty members participated; the number of participants in each group ranged from two (n=2) to five (n=5), with a mean of four (n=4). The sample was 66.7% (n=12) female and 66.7% (n=12) White. Adjuncts and visiting professors accounted for 33.3% (n=6) of participants; some 22.2% (n=4) were assistant professors and 22.2% (n=4) were associate professors. The remaining 22.2% (n=4) were full professors. The average number of years teaching was 18.2 (SD=8.4; range 7 to 31 years). Most traditional social work departments were represented: clinical, macro, human behavior, research, and policy. The sample included six of the state's eight MSW programs. The institutions with which these faculty were affiliated were 44.4% (n=8) urban and 55.6% (n=10) suburban, and none were rural. Additionally, they were 16.7% (n=3) state-funded, 83.3% (n=15) private, and 5.6% (n=1) religious-affiliated. Furthermore, 38.9% (n=7) were from institutions that also offered a BSW degree and 61.1% (n=11) that offered a doctoral degree in social work.

Six significant themes were identified: (1) the complexity and diversity of motivations for participation, (2) social work role in prevention, (3) insufficient student preparation in suicide education in social work programs, (4) explanations for why MSW programs lack suicide education, (5) making the commitment to integrate suicide education, and (6) faculty recommendations for moving forward.

Complex motivating factors for participation. Faculty participated in the focus groups for various reasons. One participant suggested the gravity of suicide had catalyzed his attendance:

> Well, you can never recover from suicide, right? It's kind of the final statement. Maybe there's an opportunity to intervene in a way somewhere along the line where people will be able to come back from life situations that they find themselves in. Suicide, it's so final. (Focus Group 2)

Several others cited a need to raise general awareness of the issue, as well as a personal sense of responsibility as educators to students who will become the "frontline workers" of the future. Others cited a desire to support colleagues' research on suicide, but others welcomed the opportunity to collaborate across schools on an important issue. One seasoned clinical professor noted a desire to learn more about prevention:

> I have spent about 30 years as a clinician in a community mental health

> center. Part of my interest was the focus on prevention, and that's something I know far less about, since I feel like I'm more often responding to an acute crisis, and I have a lot of suicidal kids in my client load right now. I'm interested to learn more about prevention. (Focus Group 1)

Social work role in prevention. Participants observed that a prevention focus should cut across all departments—macro, clinical, policy, and research—because social workers move within and between systems. The unique role social work could play in suicide prevention was described in this way:

> I see social work being extremely well positioned to engage in prevention efforts, because we work with teachers . . . physicians . . . nurses. And we have these capacities to understand systemic intervention pathways and prevention pathways. That is not true across all clinical professions. (Focus Group 1)

There was broad agreement that MSW education prepares social workers to understand issues at multiple levels of practice and that social workers had the potential to be effective suicide preventers and interveners; one participant remarked, "Social workers are . . . on the front lines, but also, our training is broad. And there's a whole policy advocacy piece of this" (Focus Group 3).

Insufficient suicide education in social work curricula. Some faculty observed that suicide education content was not really "owned" by any specific department within MSW programs. The reality, several participants offered, is that it is not adequately covered anywhere in the curriculum. One participant observed, "Where should [suicide] live in a curriculum? . . . 'Oh, it doesn't belong here, it belongs over there.' Sort of like, 'No, it's not my purview'" (Focus Group 2).

Others noted that a student's field placement determines whether students get any suicide education: If they are placed in a field setting where they are required to conduct suicide assessments, they will receive some training on this issue. Said one professor, "The sense that a lot of people have is that [suicide training is] something that you kind of pick up. Practice wisdom . . . by osmosis" (Focus Group 4).

Professors expressed concern that students are exposed to suicidal clients, even in first-year field placements, and that schools can no longer "protect" students from exposure to suicidal clients, making suicide education especially critical: "Our students are actually seeing a lot of clients who are suicidal, whereas . . . a long time ago . . . we might have protected their caseload from that population; that's not really happening anymore" (Focus Group 1).

One research faculty member used the following metaphor: "I say to my students all the time, 'I think you get thrown in without your swimmies.' I really do" (Focus Group 5).

Several participants raised the issue of how the lack of training affects student anxiety levels:

> When I ask students in the first week of class: "What's your biggest fear? . . . What's your worst case scenario?"—it's

> always the same. "My client's going to tell me they want to kill themselves or kill somebody else." That is their biggest fear of what is going to walk in the door their first week. (Focus Group 1)

Finally, students not only may emerge unprepared to assess suicidal behavior or to intervene with suicidal individuals but may lack training to advocate on behalf of suicidal clients within the mental health system. One longstanding community practitioner observed,

> I think that there's sometimes a disconnect between what people learn in social work school and the real world. You talked about how to deal with insurance companies and manage care. That's not something we talk about in social work school. [Students] need to learn these skills to advocate. (Focus Group 3)

Explanations for why MSW programs lack suicide education. Stigma emerged as a major thematic explanation for suicide's absence in the MSW curriculum. Several faculty members identified stigma as a significant barrier to discussion of the topic among faculty and, in turn, discussed how that affected the curriculum. One faculty member recalled that when she was in school, "We didn't talk about it. It was a dirty word" (Focus Group 3). Another noted,

> I think the profundity of the stigma continues. I mean, I can't tell you how many clients I've had who have family members who have committed suicide, and no one identifies it as a suicide. There are the cryptic things in the obituary about died suddenly. This veil of silence falls upon everyone. I mean, it's heartbreaking. (Focus Group 1)

One participant made the connection between faculty anxiety, lack of expertise, and suicide's absence:

> I think sometimes faculty members are anxious because the stakes are so high that they don't want to teach something they don't know very well. Because what if they get it wrong, or get it superficial or say something that a student takes the wrong way? (Focus Group 1)

Another theme emerged related to frustration with the crowded, "jammed" MSW curriculum and the impact that this has on integrating any new content: "I never feel satisfied. I mean we cram so much into the syllabi, and we're trying to do so much. You can't do it all" (Focus Group 1).

Another professor observed how this pressure influences her teaching of foundation year content: "I always feel like when I teach first-year practice that I'm rushing students through a very plentiful buffet. It's like telling them to eat a little bit of everything, but quickly; there's no time to digest" (Focus Group 2).

Several faculty participants discussed how competing research and pedagogical interests affected the attention given to any one topic:

> My experience is you go to a training, you get inspired, and you do it. And then you go to another training, you get inspired, and you do that instead. We'd be jazzed about suicide for a year, and then the next year, we'd be jazzed about something else. (Focus Group 4)

Finally, participants emphasized the lack of connection between field and classroom, where faculty and field instructors each assumed the other addressed suicide education. Faculty participants observed that suicide education is not consistently taught in either the MSW classroom or the field setting. One adjunct faculty member stated, "As a field advisor, I know that they're not talking about it in supervision in the field agencies. . . . I don't know where it's being covered" (Focus Group 5).

Making the commitment to integrate suicide education. Participants emphasized the need for faculty commitment and buy-in, as well as the importance of being "intentional," in addressing suicide. One said, "We have to be more intentional about where we put it in the curriculum. And I agree that I think it should not be infused. I think it should be in very specific places where this is going to happen" (Focus Group 5).

Several participants noted that the first step toward integration of suicide education is that faculty must embrace its inclusion in the curriculum. At least one school realized some success with integrating suicide education initiatives:

> Everyone embraced it—this is part of what we need to do. There was no discussion about what were the obstacles, but rather how can we actually improve and support the efforts to try to incorporate. . . . Right across the table, everyone really rolled up their sleeves. (Focus Group 2)

Some observed that colleagues endorsed the idea of suicide education integration but that issues of comfort and expertise arose:

> We haven't had any trouble getting verbal buy in, but in terms of whether it really carried over into some kind of substantial and competent teaching of the subject? I'm not being critical. I just think a lot of people don't have the expertise. (Focus Group 1)

With few exceptions, participants across schools noted that suicide education, if it exists, is usually contained within clinical practice courses. One faculty member from a state-funded MSW program described integrating suicide education into their human behavior, mental health policy, and research courses; another professor from a private university noted that suicide education was included in a course on refugees and immigrants. However, most agreed that a more systematic strategy was needed to frame and elevate suicide as a larger public health issue. One experienced macro professor observed,

> In macro practice, we don't, that I know of, really deal with it in a significant way. So I'm here to learn how we can address it more effectively, and how to look at some of the macro level

issues and prevention strategies. (Focus Group 5)

Faculty recommendations for moving forward. Many participants endorsed the idea that infusion of suicide education across the curriculum would require a long-term, sustained effort, and they offered numerous suggestions. Most agreed that "one shot" training was insufficient. Observed one professor, "I mean, it just feels like it's the kind of thing you need over and over and over again" (Focus Group 1). Some felt the social work curriculum could be streamlined to make room for suicide education, eliminating repetition in other areas. Another faculty member observed that despite its complex nature, suicide education was essential to social work education: "You need to have all of these pieces surrounding suicide and assessing risk and having a comfort level to talk about ideation. I do think the particular issues surrounding suicide . . . are really fundamental skills" (Focus Group 2).

Across schools, participants noted that MSW programs should ensure that all faculty and field instructors, as well as students, are trained in suicide education. One remarked, "I feel like if we're really going to do it right, we're going to hit everybody who interacts with our students, who then interact with our clients, and have ongoing support" (Focus Group 1).

Participants made suggestions about how to teach about suicide; some observed that role play and experiential exercises are critical components of suicide education. According to one,

> You can't just say, "Alright we're going to do suicide assessment and I'm going to cover these eight things." You actually have to make the students practice. You have to make them interview each other and have the words come out of their mouths while feeling the anxiety while they're doing it. (Focus Group 1)

Faculty recommended the use of first-person narratives, including the professors' own experiences working with suicidal clients, and the stories of suicide survivors as especially beneficial to student learning. Some noted the utility of case studies for teaching about suicide across the curriculum and for helping to disperse "ownership" across departments. One macro professor pointed out that even though macro students may not work with individuals, they can shift the focus in a case study to "How does our community get some kind of prevention program started, or a program for survivors?" (Focus Group 5).

Finally, professors described the complex and cross-cutting nature of suicide as especially relevant to helping schools of social work break out of departmental "silos." Indeed, some faculty participants extended the "silos" metaphor to include cross-school and school–agency collaboration. One faculty member stated, "Sharing resources and sharing ideas . . . works [and] keeps our programs vibrant. And to be in our own little silos, not exactly my style. So, I'm in favor of the collaborative approach" (Focus Group 1).

One faculty member identified it as an opportunity to better link practice and the academy:

> One thing that would be very useful would be to have more dialogue between schools and the agencies, for

> us to understand better what the various types of agencies need or don't need and where they're at, and deal with these issues. It'll help us to get a better sense for where the major gaps are. (Focus Group 4)

Discussion

These studies make a meaningful contribution to mapping the issue of suicide education for social work. These are the first national surveys and focus groups investigating this topic, and the findings help answer some basic questions surrounding the training of graduate social workers in suicide education.

The research findings suggest that social work deans, directors, and faculty view suicide as an important educational issue. However, the amount of suicide education in MSW programs appears limited, with both faculty and deans or directors reporting that most students receive four or fewer hours of suicide education during their MSW programs. This amount is consistent with the Feldman and Freedenthal (2006) research, where practitioner respondents reported similar amounts of suicide education, and it raises significant questions about the adequacy of social work education on a public health issue of great magnitude. Both faculty members and deans and directors identified numerous and similar barriers to its integration: a crowded curriculum, lack of faculty expertise, stigma, and the pressure to cover many other current topics in social work education. Although respondents suggested many ways for how suicide education could be integrated into MSW programs, our data suggest that this is not a priority for most schools; most respondents reported no plans to increase content on suicide, despite agreement on its relevance. Thus it appears that, despite its gravity, suicide has yet to emerge as a broadly pressing issue in social work education.

Limitations

This research was exploratory and has several limitations. The survey response rates were modest. Participants with greater interest in suicide possibly responded at higher rates to the surveys; thus, selection bias may have affected the data. In addition, it is possible that faculty members, deans, and directors responded to questions related to the importance of teaching about suicide with socially desirable answers because admitting lack of knowledge or interest in a topic as serious as suicide might be problematic for social work leaders. Thus, response bias might have affected the findings as well. Selection and social desirability bias might have influenced the focus groups; sample sizes were small, and those who attended were probably the most committed to the issue of suicide education. In addition, because the focus groups were geographically limited to one northeastern state, these findings may reflect regional bias. In other states, the issue of suicide may well garner more or less attention and focus.

Implications

Still, trends suggest that social workers play a central role in suicide prevention and intervention, as noted by the National Strategy for Suicide Prevention (U.S. Department of Health

and Human Services, 2001). This role may grow if the profession's presence in mental health continues to expand. Moreover, societal focus on suicide as a public health problem is accelerating and will probably continue given the increases in the rates (Knox et al., 2004). Therefore, social work educators must provide professionals-to-be with an education that prepares them for competent practice in suicide prevention and intervention by responding to the challenges of integrating suicide content, even in a crowded curriculum.

With leadership, barriers can be overcome; faculty findings in particular point to the value of intentional school-wide commitment and sustained focus as key elements to successful integration and to reducing the almost unconscious stigma associated with suicide. Of consequence, too, is the promotion of faculty comfort and expertise in the teaching of suicide prevention and intervention. Anxiety related to lack of training affects faculty as well as practitioners, as our findings suggest, and can influence willingness to deal with suicide in the curriculum.

Perhaps other changes within the social work academy, such as reducing practice experience requirements for social work educators (e.g., 2 years post-MSW mandatory, to 2 years post-MSW recommended, to 2 years of pre- or post-MSW practice experience) and the growing chasm between social work research and practice, are also affecting general faculty readiness to teach about suicide (Johnson & Munch, 2010). However, faculty development activities, fellowships, and other creative methods for engaging faculty in knowledge and skills development may successfully address the situation. Strengthening faculty interest in suicide research, currently low, could be another important direction for including suicide education. Social work research, with its nuanced understanding of social determinants and ecological factors, could make distinctive contributions to the developing field of suicide research.

Although the MSW curriculum is jampacked, social work educators may respond affirmatively to identified gaps in MSW education. For example, the widely documented inadequacy of training in gerontological knowledge, skills, and competencies has been successfully addressed through a multitude of profession-wide initiatives; the visibility and integration of geriatric social work within social work education has notably increased (Hooyman & Tompkins, 2005; Kropf, 2002; Rosen, Zlotnick, & Singer, 2002; Sisco, Volland, & Gorin, 2005). Substance abuse underwent a similar integration process over the past three decades from initial identification as an overlooked issue to deliberate integration of education and skills development for both faculty and students (Amodeo & Litchfield, 1999; Gassman, Demone, & Albilal, 2001). This pattern of problem identification, gradual recognition, sustained efforts to educate the academy, and ultimate integration of valuable new content into curricula is well established and may be replicated for the crucial social health issue of suicide.

Social work educators must respond to a multitude of social concerns clamoring for inclusion in the curriculum; however, the profundity and extent of suicide and suicidal behavior cannot be overstated. As one of our

participants noted, there is no "recovery" from suicide, and some indications suggest that the already unacceptable rates are increasing. Both the prolonged recession and the protracted wars in Afghanistan and Iraq may be exacerbating suicide and suicidal behavior in some populations (Bagley, Munjas, & Shekelle, 2010; Kaplan, Huguet, McFarland, & Newsom, 2007; Stack, 2000; Tanielian & Jaycox, 2008). Suicide both deserves and requires the attention of social work education. Social workers, as frontline mental health professionals, are often the first place distressed individuals and families turn for help during times of emotional distress. Leadership is needed now to address the unevenness and gaps in the education of graduate social workers so that they emerge competent in suicide prevention and intervention and are prepared to engage in research, advocacy, and leadership on this major health issue.

References

American Foundation for Suicide Prevention. (2012). *Facts and figures: Suicide rate over 16 years.* Retrieved from http://www.afsp.org/index.cfm?fuseaction=home.viewPage&page_id=04EA1254-BD31-1FA3-C549D77E6CA6AA37

Amodeo, M., & Litchfield, L. (1999). Integrating substance abuse content into social work courses: Effects of intensive faculty training. *Substance Abuse, 20*, 5–16.

Bagley, S. C., Munjas, B., & Shekelle, P. (2010). A systematic review of suicide prevention programs for military and veterans. *Suicide and Life-Threatening Behavior, 40*(3), 257–265.

Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis*. London, UK: Sage.

Dexter-Mazza, E. T., & Freeman, K. A. (2003). Graduate training and the treatment of suicidal clients: The students' perspective. *Suicide and Life-Threatening Behavior, 33*, 211–218.

Feldman, B. N., & Freedenthal, S. (2006). Social work education in suicide intervention and prevention: An unmet need? *Suicide and Life-Threatening Behavior, 36*, 467–480.

Gassman, R. A., Demone, H. W., & Albilal, R. (2001). Alcohol and other drug content in core courses: Encouraging substance abuse assessment. *Journal of Social Work Education, 37*, 137–145.

Glaser, B. G., & Strauss, A. L. (1967). *The discovery of grounded theory: Strategies for qualitative research*. Chicago, IL: Aldine.

Grandin, L. D., Yan, L. J., Gray, S. M., Jamison, K. R., & Sachs, G. S. (2001). Suicide prevention: Increasing education and awareness. *Journal of Clinical Psychiatry, 62*(Suppl. 25), 12–16.

Hooyman, N. R., & Tompkins, C. J. (2005). Transforming social work education [Guest editorial]. *Journal of Social Work Education, 41*, 371–377.

Joe, S., Canetto, S. S., & Romer, D. (2008). Advancing prevention research on the role of culture in suicide prevention. *Suicide and Life-Threatening Behavior, 38*, 354–362. doi:10.1521/suli.2008.38.3.354

Joe, S., & Niedermeier, D. M. (2006). Preventing suicide: A neglected social work research agenda. *British Journal of Social Work, 38*, 507–530. doi:10.1093/bjsw/bcl353

Joe, S., & Niedermeier, D. M. (2008). Social work research on African Americans and suicidal behavior: A systematic 25-year review. *Health and Social Work, 33*, 249–257.

Johnson, Y. M. , & Munch, S. (2010). Faculty with practice experience: The new dinosaurs in the social work academy? *Journal of Social Work Education, 46*, 57–66.

Kaplan, M. S., Huguet, N., McFarland, B. H., & Newsom, J. T. (2007). Suicide among male veterans: A prospective population-based study. *Journal of Epidemiology and Community Health, 61*, 619–624.

Knox, K. L., Conwell, Y., & Caine, E. D. (2004). If suicide is a public health problem, what are we doing to prevent it? *American Journal of Public Health, 94*, 37–45.

Kropf, N. P. (2002). Strategies to increase student interest in aging. *Journal of Gerontological Social Work, 39*, 57–67.

LaRossa, R. (2007). Qualitative methods in sociology. In J. D. Ballard & V. Jensen (Eds.), *Teaching qualitative methods: A collection of syllabi and instructional materials*. Washington, DC: American Sociological Association.

Linehan, M. M. (2008). Suicide intervention research: A field in desperate need of development. *Suicide and Life-Threatening Behavior, 38*, 483–485. doi:10.1521/suli.2008.38.5.483

Manderscheid, R. W., Atay, J. E., Male, A., Blacklow, B., Forest, C., Ingram, L., . . . Ndikumwami, A. (2004). Highlights of organized mental health services in 2000 and major national and state trends. In R. W. Manderscheid & M. J. Henderson (Eds.), *Mental health, United States, 2002* (DHHS Pub No. [SMA] 3938, pp. 243–279). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Maris, R. W., Berman, A. L., & Silverman, M. M. (2000). *Comprehensive textbook of suicidology*. New York, NY: Guilford Press.

McMahon, A., & Allen-Meares, P. (1992). Is social work racist? A content analysis of recent literature. *Social Work, 37*, 533–538.

Miles, M. B., & Huberman, A. M. (1994). *Qualitative data analysis: An expanded sourcebook.* London, UK: Sage.

Muhr, T. (2000). Increasing the reusability of qualitative data with XML. *Forum: Qualitative Social Research, 1*(3).

Nock, M. K., Borges, G., Bromet, E. J., Cha, C. B., Kessler, R. C., & Lee, S. (2008). Suicide and suicidal behavior. *Epidemiologic Reviews, 30*, 133–154. doi:10.1093/epirev/mxn002

Range, L. M., Leach, M. M., McIntyre, D., Posey-Deters, P. B., Marion, M. S., Kovac, S. H., . . . Vigil, J. (1999). Multicultural perspectives on suicide. *Aggression and Violent Behavior, 4*, 413–430.

Rosen, A. L., Zlotnik, J. L., & Singer, T. (2002). Basic gerontological competence for all social workers: The need to "gerontologize" social work education. *Journal of Gerontological Social Work, 39*, 25–36.

Ruth, B. J., Sasportas, K., Beville, K., & Muroff, J. (2008, October). *Suicide prevention/intervention training in social work education: Mapping the training issues*. Paper presented at American Public Health Association Annual Meeting, San Diego, CA.

Ruth, B. J., Sisco, S., Wyatt, J., Bethke, C., Bachman, S. M., & Markham Piper, T. (2008). Public health and social work: Training dual professionals for the contemporary workplace. *Public Health Reports, 123*(Supplement 2), 71–77.

Sanders, S., Jacobson, J. M., & Ting, L. (2008). Preparing for the inevitable: Training social workers to cope with client suicide. *Journal of Teaching in Social Work, 28*, 1–18.

Sisco, S., Volland, P., & Gorin, S. (2005). Social work leadership and aging: Meeting the demographic imperative. *Health & Social Work, 30*, 344–347.

Stack, S. (2000). Suicide: A 15-year review of the sociological literature. Part I: Cultural and economic factors. *Suicide and Life-Threatening Behavior, 30*, 145–162.

Tanielian, T., & Jaycox, L. (Eds.). (2008). *Invisible wounds of war: Psychological and cognitive injuries, their consequences, and services to assist recovery*. Santa Monica, CA: RAND Corporation.

U.S. Department of Health and Human Services, Public Health Service. (1999). *The Surgeon General's call to action to prevent suicide*. Washington, DC: Author. Retrieved from http://profiles.nlm.nih.gov/ps/retrieve/ResourceMetadata/NNBBBH

U.S. Department of Health and Human Services, Public Health Service. (2001). *National strategy for suicide prevention: Goals and objectives for action*. Rockville, MD: Author. Retrieved from http://store.samhsa.gov/shin/content/SMA01-3517/SMA01-3517.pdf

Van Voorhis, R., & Wagner, M. (2001). Coverage of gay and lesbian subject matter in social work journals. *Journal of Social Work Education, 37*, 147–159.

Whitaker, T., Weismiller, T., Clark, E., & Wilson, M. (2006). *Assuring the sufficiency of a frontline workforce: A national study of licensed social workers. Special report: Social work services in behavioral health care settings.* Washington, DC: National Association of Social Workers.

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