

School Counselors' Experience of the Impact of Student Suicide:

A Qualitative Narrative

Stacy Bowman

The College at Brockport

Acknowledgements

Table of Contents

Abstract

This article focuses on the effects that a student loss to suicide has on school counselors. It is unfortunate that this profession places counselors at a high risk for experiencing the loss of a student to suicide as they work closely with at-risk students on a daily basis. In this study, a qualitative narrative method was used to explore the personal and professional impact resulting from the suicidal experience. Recommendations are made to help school counselors cope with such an overwhelming tragedy.

School Counselors' Experience of the Impact of Student Suicide:
A Qualitative Narrative

The suicide of a loved one causes one to question the value and meaning not only of life in general but of their own individual lives. It is believed that “the isolation, secrecy, and disconnection become the survivors’ legacy” (Alexander, 1991, p.1). Reflection on the reality that a person chooses to end their own life often leaves one ill at ease, regardless of your relationship with them. For counselors, failure to anticipate and prevent suicide may result in feelings of personal failure and professional self-doubt (Foster & McAdams, 1999).

It is an ill-fated reality that schools must endure the impact of sudden deaths on their student populations. In fact, over the last 35 years, suicide among young people has increased at alarming rates: 300% for males and 230% for females (Johnson, 1999; World Health Organization, 1991) which is higher than any other age group. With this knowledge, it is probable that school counselors will encounter the tragedy of student suicide at some point in their professional career (Parsons, 1996). The school counseling profession faces the awesome responsibility of suicide prevention and intervention but what happens when those strategies fail? Christianson and Everall (2009) investigated this and found that there is limited research on the impact that suicide has on psychiatrists, psychologists, and psychotherapists and that no research has been conducted on how school counselors felt after losing a student to suicide. Clark and Goldney (2000) study supported this as they drew on a large number of studies that examined the impact of suicide from a research and clinical perspectives. They found substantial research that focused on the impact it had on survivors that included parents,

adolescents, siblings, spouses, families, friends, and psychotherapist but found that studies that compared school counselors' experience were non-existent (Wertheimer, 2001). This is perplexing considering that research indicates that school counselors experience youth suicide as frequently as others in helping professions (Borders, 2001; Christianson & Everall, 2007). Similarly, Fox and Cooper (1998) reported finding a wealth of information for professionals on how to assess suicidal risk and suggestions for prevention yet argued that sparse attention was paid to the impact of threatened and completed suicide on the clinician.

A student's suicide is an unspeakable tragedy and school counselors may personally feel the impact of such a devastating act on a multitude of levels. It is a "singular act with plural effects" (Parsons, 1996, p.77) that may unleash a variety of emotions. Research denoted that a complex and lengthy set of emotive responses including, but not limited to, guilt, blame, and denial (Lafayette & Stern, 2004) as well as anger, betrayal, sadness, shame and embarrassment (McAdams & Foster, 2002) can be felt after losing a student to suicide. With this knowledge, the overarching objective of this research is to identify areas, both personally as well as professionally, in which school counselors are affected by student suicide and determine the extent of the personal and professional impact.

Typically, it is assumed that the school counselor will calm, explain, heal, and cope with the aftermath of a student death (Stefanowski, 1990). Often, they work with the student's family, other students in the district, as well as the faculty. Yet, the question remains as to how they manage the struggle with their own emotions. Research shows that experiencing the suicide of a client is stressful, and for a sizeable number, the event

has a substantial impact on their professional and personal lives (McAdams & Foster, 2002). Unfortunately, there is little research to support this as most studies focus on prevention. Little attention has been given to what happens when preventative measures fail. It is also shown that a limited number of counselors seek professional help in coping with their loss as they equate seeking help with failure (Christianson & Everall, 2009; McAdams & Foster, 2000). To obtain a comprehensive understanding of their sentiments, the primary researcher contends that the most effective way to achieve this was by allowing counselors who have experienced a recent student suicide in their district the opportunity to provide a detailed account of their recollections. With hope, these findings will serve as a guideline for future research and provide appropriate recommendations on sources for support for school counselors who experience student suicides.

In this investigation, the primary researcher explored the impact of student suicide on school counselors by enabling those, who recently experienced a suicide in their district, to recount their experience in an environment in which they were at ease exploring their feelings. The majority of research to date focuses on the impact it has on parents, siblings, and students yet little is known about how school counselors are impacted. The prevalence of suicide in today's student population suggests that a plan may be needed to help school counselors' cope with the tragedy. It is the intention of the primary researcher that this investigation will provide knowledge of various aspects of their lives most crucially affected by the suicide so that appropriate resources for support can be utilized. Furthermore, it is with hope that the research will help school counselors' face this difficult and multifaceted problem and create the awareness for further research so that a meaningful solution may be found. The research questions framing this study

were: 'What are the emotional implications for school counselors' after a student commits suicide?', 'How are they impacted professionally', and 'What sources of support are they using to cope with the tragedy?'

Review of the Literature

Youth suicide is a national epidemic that claims an increasing number of lives each year. According to Kirk (1993), suicide completed individually, in pacts, and in geographical clusters is increasing as youth view ending their lives as a solution to ending their pain. Suicide defies "the cherished notion that all human life is sacred, challenges the value of life itself, and places a question mark over the taboos against the taking of one's own life" (Wertheimer, 2001, p. 3).

Over the years, numerous attempts by lawyers, doctors, novelists, poets, philosophers, and theologians have been made to compartmentalize and categorize suicide, in hopes of desensitizing the tragedy of it (Wertheimer, 2001). That is rather alarming considering that "it is universally recognized that handling a client's suicide is one of the most important, if not most difficult, function a therapist performs" (Fox & Cooper, 1998, p.144). It begs the question why plentiful attempts are made to downplay the tragedy rather than address the seriousness of it. Suicide has often been a word that is avoided. Obituary notices skirt around the truth, using evasive phrases such as "died suddenly" or "sudden illness" (Alexander, 1991). This review of the literature will attempt to unveil the mystery surrounding this taboo topic and provide its readers with a comprehensive understanding of the incidence of youth suicide, risk factors associated with causation, and the impact that suicide has on school counselors. It additionally focuses on suggested prevention, intervention, and postvention measures currently used

by professionals. The effectiveness and well as ineffectiveness of the aforementioned strategies are explored.

Statistics

The alarming number of young individuals who take their own lives is stupefying. The occurrence of adolescent suicide has increased drastically over the last twenty years. In fact, it has become the third leading cause of death in the United States for persons under the age of 24 (Berman, Jobes, & Silverman, 2006; Cross, T., Cassady, C., Miller, K., 2006; Lester, 1993; U.S Department of Health and Human Services, 2007). It is a sad reality that mass media attention typically concentrates on sensationalism similar to the Columbine tragedy, yet few are aware that an increasing number of children are taking their own life more now than any other time in American history (Portner, 2001). Mauk and Gibson (1994) denote that one child (ages 5-24) commits suicide every 33 hours and one (ages 15-24) commits suicide every one hour and 48 minutes. With this knowledge, they argue that youth suicide is a grave public health challenge that does not receive the attention and degree of national priority it deserves. When comparing the incidence of suicide with that of homicide, suicide is a greater killer, by far. In fact, for every two deaths by homicide in the U.S. there are three deaths due to suicide (U.S Department of Health and Human Services, 2007).

Incidence Suicide rates among 15-19 year old Americans have tripled over the past 15 years sparking the U.S Department of Health and Human Services to implement specific federal health objectives yet failure to meet these objectives has led to reestablished goals for the year 2010 (Berman, Jobes, & Silverman, 2006; Cross, T., Cassady, C., Miller, K., 2006; U.S Department of Health and Human Services, 2007). The

National Violent Death Reporting System indicated that significant upward departures from modeled trends in 2004 were identified and reported for females aged 10-14 years and 15-19 years and males aged 15--19 years (see Table 1 for suicide rates for youths and young adults aged 10-24, by age group, method, sex, and year). The largest percentage increase in rates from 2003 to 2004 was among females aged 10-14 years (75.9%), followed by females aged 15-19 years (32.3%) and males aged 15-19 years (9.0%). In absolute numbers, from 2003 to 2004, suicides increased from 56 to 94 among females aged 10-14 years, from 265 to 355 among females aged 15-19 years, and from 1,222 to 1,345 among males aged 15-19 years. Rates of suicide among adolescents aged 15-19 years were so high that they accounted for approximately half of all suicides those over the age of 19(National Violent Death Reporting System, 2005).

Related Behavior The U.S Department of Health and Human Services (2007) reported that 14.5% of students in grades 9-12 seriously considered suicide in the previous 12 months (18.7% of females and 10.3% of males), 6.9% of students reported making at least one suicide attempt in the previous 12 months (9.3% of females and 4.6% of males) and 2.0% of students had made a suicide attempt that resulted in an injury, poisoning, or an overdose that required medical attention (2.4% of females and 1.5% of males). They added that, for 15 to 24 years old, there were approximately 100-200 attempts for every completed suicide.

Limitations Although a vast amount of statistics on child suicide was obtained, they varied considerably. One reason for this were the differing comparative dates and definitions of childhood; some defined a child under the age of ten while others used fourteen (Stefanowski-Harding, 1990). Research has also evidenced that many suicides

are undercounted because adolescent death by suicide is often concealed and documented as accidental (Mauk & Gibson, 1994; Stefanowski-Harding, 1990). According to the Suicide Prevention Center of Los Angeles, it is estimated that 50% of the deaths documented as accidental are, in reality, suicides (McGuire & Ely, 1984; Stefanowski-Harding, 1990). Due to these classification errors, official mortality data for suicide could be significantly higher. Nonetheless, as Crook (2003, p.18) stated “statistics only give us the numbers we need to establish the problem, and can be useful to grab the attention of those who have no idea that suicide is so insidious”. Those numbers are ineffectual for trying to depict why children commit suicide or what helping professionals can do about it. There is a clear-cut need to go further than any set of numbers can take us such as looking into some of the underlying factors.

Educational Barriers

Despite the amount of training or preparation for client suicide, nothing can eliminate the pain endured throughout the experience. However, programs can and should minimally prepare students for the reality of encountering clients with suicidal ideation (McAdams & Foster, 2002). As it stands, professional training for a suicidal crisis is briefly touched upon in graduate studies and this minimal emphasis does not match magnitude of the crisis as a reality in practice (McAdams & Foster, 2002). Some argue that training programs for counseling focus on suicide just enough to prepare counselors for the initial crisis yet lack intervention as well as postvention education (Stefanowski-Harding, 1990; McAdams & Foster 1999). They felt that preparation for client suicide is a prerequisite for coping with it and that more in-depth instruction is needed to educate counselors regarding the possibility of client suicide. An examination

of standards set by the Council for Accreditation of Counseling and Related Educational Programs found their standards for clinical training “do not specify supervisory responsibilities for a mental health emergency such as client suicide” (Foster & McAdams, 1999, p.1). It is reasoned that increased preparation and experience with the topic can positively affect student development by leading to a decrease in death related anxiety (Christianson and Everall, 2009; Foster & McAdams, 1999; Maples, et al, 2005; Mauk & Gibson, 1994; Parsons, 1996).

They believed that greater preparation for coping with client suicide that included education regarding the possibility of client suicide, its impact on survivors, and the process of personal and personal recovery should be incorporate into training programs. Myers and Hutchinson (1994) concurred and added that it should not only be incorporated into academic course work but clinical training as well in order to illustrate a sound message of its impact on counselors. In addition, it is reported that mental health professionals are poorly trained in dealing with the aftermath of such a tragedy (Christison & Everall, 2009; Dexter- Mazza & Freeman, 2003). In sum, the vast majority of research implies that preparation for client suicide is a prerequisite

Contributing Factors

Efforts toward pinpointing a single cause of suicide are futile as there is no one factor. “Suicide is more like a multicolored tapestry that must be unraveled strand by strand to better understand how it happens and what can be done to thwart it” (Portner, p8.) Research indicates that there are underlying risk factors that cause children to be more susceptible to taking their own life and that they are drastically different from those of suicidal adults (Maples, Packman, Abney, Daugherty, Casey, & Pirtle, 2005; Crook,

2003; Goodyer, 1995; Johnson, 1999). Crook (2003) believes that suicide is a threat to every child and adds they do not have to be “special”, have a mental illness, or have obvious tribulation to be vulnerable. Research has examined various factors contributive to the growing phenomenon of adolescent suicide. For youth, this is an unstable time period as struggle through the transitional period of childhood to adulthood battling physical, emotional, and hormonal changes (Maples et al, 2005). Johnson (1999) stated that a combination of factors converge in adolescence leaving youth at a point where suicide seems to be the only escape. He added that the period of adolescence, in itself, is complex and full of risks. This time period is a challenge for youth as they try to establish their individual identity. It is characterized by puberty, transition of schools, and cognitive maturation (Goodyer, 1995). In addition, changing physical characteristics, lack of experience in social and sexual roles, changing friendships, and evolving family dynamics may contribute as well (Crook, 2003).

Lester (1993) found that lack of a solid family unit, deficiency of clear-cut goals, diminished self esteem, lack of role models, and the breakdown of communication between peers and parents may play a part. He added that domestic violence, increasing divorce rate, and destruction of the family unit were other possible causes (Lester, 1993). According to Johnson (1999), a major factor in the majority of teen suicides is loss of hope. He views hopelessness as a reflection of depression and deems that as a classic predictor of suicidal ideation.

Depression According to Kirk (1993), depression is the most worthwhile topic to explore when attempting to search for the explanation of suicide. He stated that regardless of age, severe depression is the driving force behind self-destruction yet

adolescents are at a higher risk because their age makes them more vulnerable to an array of depressive disorders. For this reason, the prevalence of depression increases significantly throughout adolescent years (Goodyer, 1995). Research indicated that there may be something unique about adolescence and that stressors faced during this developmental period trigger the onset of depression (Davidson & Linnoila, 1991; Goodyer, 2001). In a study of suicide attempters conducted by Withers and Kaplan (1987), it was found that three-quarters of the adolescents sampled were significantly depressed (Kirk, 1993). In contrast, other studies indicated that not all depressed adolescents are suicidal (McWhirter & Kigin, 1988; Kirk, 1993). They argued that although depressive profiles can be linked to suicidal tendencies, it does not automatically lead to suicidal behavior.

Berman, Jobes, and Silverman (2006) purported that suicidal adolescents do not present in such a way that would lead clinicians to automatically assess risk for depression. Johnson (1999) indicated that adolescents show their despair differently than adults and for that reason is often overlooked. He reported that sadness among youth often results in acting out behaviors including, but not limited to, skipping school, failure to comply with adults, and a general tendency poor academic performance. Goodyer (2001) referred to this as masked depression. He asserted that that these depressive equivalents can be mistaken as school phobia. Giffin (1980), on the other hand, reported indicators very similar to adult depression. She stated that depressed adolescents express apathy, changes in sleep habits, loss of interest in previously enjoyed hobbies, abrupt behavioral changes, social withdrawal, and impulsive or uncharacteristically erratic behavior (Johnson, 1999)

Abuse Numerous studies have documented that many suicidal adolescents have a history of sexual and/or physical abuse. It was indicated that high school students that attempted suicide had a history of more physical beatings, rape and sexual abuse than those of their peers (Davidson & Linnoila, 1991; Goodyer, 1995; Lester, 1993; Smith & Crawford, 1986). It is reported that children living in abusive homes are at risk for feelings of general hostility, unhappiness, confusion, and disgust (Kirk, 1993). He added that if this abuse occurred during the child's younger years, these negative feelings may be repressed and resurface during puberty. Suicide can serve as the escape they are looking for when abuse is seemingly intolerable and inescapable. The abuse leads to a greater likelihood of suicide because it increases the probability of becoming psychiatrically disturbed in general (Lester, 2003). However, despite his theory, he found that there are no studies published that have reported less suicidal thoughts by those who have been abused when compared to peers of the same age that had not suffered any form of abuse.

Culture The desire to be liked and accepted is common among teens (Davidson & Linnoila, 1991). Often times, they struggle trying to find the niche that they fit in. "The social group is one of the teen's most important cultural groups; to feel that they belong among peers means that they see their place in culture" (Crook, 2003, p38). Along with this ethnic and religious considerations also play a role. While they long to be accepted by their peers it is challenging to hold onto that piece of their traditional culture. Often times, there is a considerable difference between teen culture expectations and those values set by their ethnic culture. They strive to be separate from adults but the "isolation

that may ensue from the process creates a sense of loneliness and rejection that may become very difficult to deal with” (Crook, 2003, p.39)

Media Evidence suggests that media portrayal of suicide may lead to suicide contagion especially when they are sensationalized and glorified (Davidson & Linnoila, 1991; Stack, 2005). He cited a study conducted by Phillips and Carstensen (1986) and reported a direct relationship between the amount of media sensationalism and an increase in suicide for those in the reporting area. They conducted similar research and found an increase in youth suicide immediately following the airing of television movies that illustrated suicide and focused on lives of troubled and suicidal adolescents (Kirk, 1993). This sadly places school counselors in a compromising position as they search for that delicate balance that appropriately responds to the grief felt by peers yet does not increase suicide risk for vulnerable students. According to Kirk (1993), when a suicide is reported sensationally, young individuals that are currently experiencing feelings of hopelessness may be influenced toward greater desolation. He states that when a pathogen is presented to a vulnerable population, the likelihood of contagion increases. Counselors are faced with adolescents that view suicide as an end to their problems rather than an end to their existence and reporting such horrific events only fosters self-destructive behavior (Portner, 2001).

Wertheimer (2001) found several examples in history of imitative or “copycat” suicides which, on occasion, reached epidemic proportions. There is an unprecedented growth in mass media means, particularly the internet, which enables youth the opportunity to obtain questionable information regarding suicide. They have the ability

to view, fictional and factual portrayals of suicide which can have the potential of serving as a catalyst for imitative acts (Wertheimer, 2001).

Stress It is assumed that individuals are equipped with internal and social resources to effectively manage stress. Unfortunately, Kirk (1993) found that many adolescents are plagued with an increasingly stressful world without proper modeling or support to provide them with effective coping mechanisms. His research indicated that adolescents largely differ in their ability to cope in the face of chronic and constant stress. He stressed their tolerance depends upon a number of variables that include genetic predisposition, temperament, learning/conditioning, environmental issues, and perhaps even luck. However, he added that despite these variables, youth perception of the stressor coupled with availability of supports and resources are imperative for properly determining how an adolescent will respond to any stressful situation.

Sexuality Sources indicate that gay youth represent a significant percentage of adolescents that attempt or complete suicide (Crook, 2003; Johnson, 1999; Kirk, 1993). In fact, current data indicate that suicide appears to be the leading cause of death for the young homosexual population (Kulkin, Chauvin, & Percle, 2000). Gibson (1989) deemed that homosexual adolescents were two to three times more likely than their heterosexual peers to attempt suicide indicating that 30% of the completed suicides each year are completed by homosexual youth.

According to research, society is a major contributing factor in the suicide rates of young homosexuals as these young individuals are negatively impacted by attitudes, stereotypes, and the norms of our society (Gibson, 1989; Kulkin, Chauvin, & Percle, 2000). These adolescents are commonly rejected by friends, family and several religious

institutions resulting in feelings of estrangement and detachment from society. Gay youth of both sexes are more susceptible to suicide as they face greater social discrimination, depression, isolation, low self-esteem and violence than do their peers (Johnson, 1999; Rofes, 1983).

School environment compounds adjust problems for homosexual adolescents as they are faced with physical and verbal abuse (Kirk, 1993). He added that gay youth not only experience rejection from the peers but often times their parents as well which may double their sense of isolation.

Exceptional Children According to Stefanowski-Harding (1990), children with learning disabilities as well as those that are intellectually superior face a greater risk of suicidal ideation than do their peers. She cited a pilot study conducted by the Los Angeles Suicide Prevention Center that examined suicides of youth age fourteen and younger and reported that 50% of the deaths were children who had been diagnosed with a learning disability (LD). Likewise, they conducted a similar study that evidenced 33% of those investigated had behavior disorders and 36% had learning disabilities (Stefanowski-Harding, 1990). To further investigate the hypothesis that LD plays a part in adolescent suicide, suicide notes from 267 adolescent suicides were analyzed for spelling and handwriting errors (McBride & Hazel, 1997). Their study confirmed that 89% had significant deficits in spelling and handwriting that were similar to those of the adolescents with LD. These data signify a strong correlation between learning disabilities and adolescent suicide. As a result, they purported that routine screening for learning disabilities in school systems may help prevent further needless and heartrending deaths.

Cross (1996), originally believed that given the limited data available, one could not ascertain whether the incidence of suicide among gifted adolescents was different than in the general population of adolescents. However, since that time, a variety of studies of gifted students have been carried out in an attempt to shed light on their suicidal tendencies (Cross, Cassady & Miller, 2006; Johnson, 1994; Neihart, 1999; Peterson, 1993). The majority of findings yielded that adolescents with above average IQ's may be more vulnerable to psychological distress and suicidal tendencies than the average student because it is challenging for educators to create an appropriate educational setting and instructional type that best meets their needs. In contrast, others argued this and stated their study was "one of very few in the field that provides direct evidence that gifted adolescents are no more likely to engage in suicide ideation than the general population of adolescents" (Cross, Cassady & Miller, 2006, p. 13). They gathered participants from a state public residential academy for academically gifted juniors and seniors in high school and administered the *Suicide Ideation Questionnaire (SIQ)*. They evidenced that after critical factors identified in the SIQ were analyzed it was revealed that this group of high-ability youth did not demonstrate elevated rates of suicidal ideation.

Role of School Counselors

In the past twenty years, several programs that address suicide prevention, intervention, and postvention are now offered in schools (Crook, 2003). She stated that often times, these responsibilities are often delegated by the administration onto school counselors rather than where it properly belongs; spread throughout the staff. However, literature indicates that few clinical training programs have specific plans or models for

responding to client suicide (Foster & McAdams, 1999). They added that practically no information is available on the amount of attention that counselor education programs place on client suicide.

Prevention “Inasmuch as most suicidal behaviors are multicausal and multifactorial in etiology, so must the preventative interventions themselves be multifocal in terms of the behaviors and etiological agents they are designed to target” (Berman, Jobs, & Silverman, 2006, p.296). For reasons unknown, “there are fewer emotional buoys floating around for children to grab onto, so more of them plummet to the bottom, unless someone, somewhere has taught them how to swim” (Portner, 2001, p.9). Considering that children spend over 1000 hours in school each year, teachers and counselors are in a unique position to toss out that buoy when they notice the signs of an impending suicidal crisis (Johnson, 1999). In order to do so, obtaining knowledge of risk factors, educating teachers to recognize the warning signs, and collaboration among school, community, and family in educating students about the risk of suicide is essential (Maples et al, 2005; Johnson, 1999).

Johnson (1999, p.28) depicted a prime example of recognizing warning signs as he portrayed a scenario of an honor student who suddenly was unable to concentrate in class, began failing all subjects, expressed sadness in artwork and writing and turned in the following poem two days prior to his suicide.

I was through a woods the other day
And I saw tiny flowers sitting among the brush,
and I wondered as to their cause, for it seemed so small,
they have colors that are so perfect

that I wondered how such colors could come about.
But is it needed for everything to be explained,
Rather than to marvel at its beauty?
It is the cause of a tiny flower to shed light, how so ever small,
Upon a world of opulent darkness
Yet I am no bigger than the flower, and I wonder,
Could it not be the meaning of life?
And I came to think that flower was indeed a wiser thing
To be so selfless and not to fight
Selfless and rendering when being picked.
Beauty that is above all beauty,
And silence that is above all understanding,
And, in my view, an understanding that is above all inherent to man.
It quietly stands unwanting to move, yet on and giving to all those that
pass by.

It is the responsibility of school staff to recognize verbal and nonverbal indicators similar to those of the aforementioned child. Typically, it is the after the death of a student that districts become motivated to implement organized suicide prevention, intervention, and postvention plans (Crook, 2003). Unfortunately, this is already after the loss of one life and the rising prevalence of suicide in youths clearly indicates that the time is now for implementing preventative measures (Johnson, 1999). He added that it is essential that administration and staff recognize and act on the fact that suicide poses a clear threat to their student population.

Criticism currently surrounds the prevention of suicide in schools as incidence rates continue to rise. According to Goodyer (1995, p243), "there is an abundance of literature on sociological, psychological, and biological aspects of suicide but a scarcity of studies on the development and evaluation of well-structured programs and schemes for treatment and prevention". It is reported that many schools utilize one-time workshops for suicide awareness (Lester, 1993). It is intended that workshops and seminars will not only educate students but the staff as well as they are forced to examine their own attitudes toward suicide (Crook, 2003). Unfortunately, programs like these are typically not evaluated and when they are, reveal ineffectiveness (Lester, 1993). Shaffer and co-workers (1988) evaluated some of these programs and showed that they did not change the students attitudes toward the management of suicide, or whether students would seek out counseling if they felt they were in crisis (Lester, 1993). To support this, a study of 1,000 students in New Jersey was conducted in 1997 to evaluate several widely used programs and indicated that there was no evidence that the didactic instruction did not alter the attitudes of those student's who viewed suicide as a reasonable solution to their problems (Pornter, 2001). Furthermore, the study evidenced that student's that were previously contemplating suicide were more distressed after the exposure of lessons. In general, there is little empirical evidence that indicates which suicide prevention strategies are most effective with children (Berman et al., 2006). Conversely, evidence does specify approaches that are not effective that include scare tactic approaches and health-awareness programs that focus solely in suicide prevention (Berman et al., 2006; Shaffer et al., 1991).

Another suggested approach was creating peer groups for suicide prevention (Herring, 1990; Johnson, 1999). These groups are expected to foster positive peer relationships and aim to educate peers on how to properly intervene with at-risk friends Johnson (1999).

Whether or not a student will attempt suicide can never be known for certain but the ability to recognize behaviors of students showing suicidal ideation, the interpersonal skills necessary to help those students, and the knowledge of appropriate referral services is essential. Crook (2003) upheld the belief that the most critical aspect of suicide prevention among youth is recognition by the government and health officials that teen suicide is a legitimate problem. She added that an awareness of the problem would lead to funding for much needed research and treatment programs but until that time, school counselors will continue to uphold an awesome responsibility.

Intervention Professional judgment must be exercised when students are at risk for a potential suicide attempt. Often times this can be a delicate situation as unwarranted responses such as hysterical phone calls to parents and/or emergency services as well as physical restraint of students, are detrimental to students as well as the credibility of school counseling programs (Remley & Sparkman, 1993). Instinctively taking extremist steps to prevent a suicide without first determining that such steps are unwarranted is viewed as unprofessional.

Postvention Prevention of suicide is ideal, but not always reality. "A teenager's suicide is an overwhelming event in the life of a school, but school must continue" (Johnson, 1999, p.57). Having a plan alleviates some stress associated with coping with the aftermath. Ideally, schools should have staff trained to deal with crisis situations.

Studies indicate that it is helpful to establish working arrangements with mental health facilities so that additional support can be provided for immediate crisis intervention (Lester, 1993). As with the causes of suicide, there is no one single course of treatment in postvention (Parsons, 1996). There are numerous guidelines that are expected to ease the grieving process. The literature indicates that a common postvention approach is one adapted from the American Association of Suicidology (Maples, et al, 2005; Mauk & Gibson, 1994; Parsons, 1996).

1. Plan in advance of any crisis.
2. Select and train a crisis team.
3. Verify report of suicide from collaboration with the medical examiner, police, and family of the deceased.
4. Do not dismiss school or encourage funeral attendance during school hours.
5. Do not dedicate a memorial.
6. Do contribute to a suicide prevention effort on behalf of the schools or the community.
7. Do contact the family, apprise them of the schools intervention efforts and assist with funeral arrangements.
8. Do not release information in a large assembly or over the intercom system. Disseminate information in informal meetings with individual groups of students, faculty, and parents.
9. Follow the suicide victim's classes throughout the day to provide opportunity for discussion and counseling.
10. Arrange for counseling rooms in the school building and provide individual

and group counseling.

11. Collaborate with media, law enforcement, and community agencies.

12. Points to emphasize with media and parents: prevention, no one thing or person is to blame, help is available.

13. Provide counseling or discussion opportunities for the faculty.

The aforementioned suggestions are designed to keep as much dignity and privacy for the deceased child and his/her family as well as helping staff and students cope with the devastation (Crook, 2003).

. **Liability** Although it is a natural tendency to worry about legal liability, typically it is only those who lack appropriate skills or are negligent in their care of students that are held accountable (Remly & Sparkman, 1993). There are varying state liabilities, immunity statutes, and given circumstances surrounding a suicide that determines who is held liable (Maples, Packman, Abney, etc, 2005). School counselors have a vast array of ethical and legal responsibilities that includes reporting the possibility of a premeditated suicide attempt. The danger of hurting oneself is an exception to the ethical confidentiality obligation typically used when working with minors. Legal liability ends when the counselor notifies parents or authorities that a particular student is at risk and appropriate actions to prevent the attempt are in place. With regard to liability, Kirk (1993, p.107) listed the following as a guideline for intervention that should provide firm legal footing for the affected district yet stressed that legal guidelines may vary from state to state and that certain districts within states may have different statutes or guidelines.

1) School personnel are not responsible for the suicide death of a student

unless they aided and abetted the student in death during a period of obvious suicidality.

- 2) When a student is assessed as or suspected of being suicidal, the parents or guardians must be informed about the assessment and the actions being taken to alleviate or treat the vulnerability.
- 3) When an employee or consultant to the school system becomes aware of the possibility of suicidal ideation in a student, he or she should consider immediate assessment or intervention
- 4) The rules of confidentiality can be broken when information suggests that a student is suicidal is obtained.
- 5) All communication, conversations, and actions taken with regard to the assessment, intervention, and referral of a suicidal student should be documented and reported.
- 6) When the suicide process is accurately assessed, regardless of risk level, the student should be referred to a therapist or clinic.

Coping Strategies

Research shows that a lack of resources impact school counselors' ability to process their emotions (Christianson & Everall, 2009). Other mental health professionals practice in settings that allow for psychological autopsies, supervisory consultation, and debriefing with team members after a suicide (McAdams & Foster, 2000; Christianson & Everall, 2009). Shockingly, this is not the case for school counselors' as their studied reported that participants rarely had the opportunity for post-suicide processing.

McAdams and Foster (2002) reported findings from their study and found that resources examined for coping and recovery from client suicide were beneficial.

Formal Research indicated that counselors should not hesitate in obtaining personal therapy after experiencing such a tragedy yet found that many decline as they equate it with personal inadequacy or professional failure (McAdams & Foster, 2002). They looked at sixty-six professional counselors across the nation who had a client in their primary care commit suicide and found that only a small number of respondents sought professional help while the remainder displayed hesitance. Attending the memorial service or funeral

Informal

Obtain support from colleagues and mentors

Personal support system family and friends

Impact on counselors

It is believed that the process of understanding and incorporating the effects of suicide into therapists' personal and professional lives is similar to recovery from trauma (Lafayette & Stern, 2004). Initial reaction is likely to be intense. Menninger (1991) adds that with any traumatic experience, the suicide of a patient can be representative of disaster to the therapist. He deemed this calamity may include loss suffered on personal and professional levels.

Personal Suicide results in a complex and lengthy set of emotional responses including, but not limited to, guilt, blame, and denial (Lafayette & Stern, 2004) as well as anger, betrayal, sadness, shame and embarrassment (McAdams & Foster, 2002). Parsons (1996) felt that many experience countless hours of anguish, destructive self-doubt, and

several other debilitating effects. Trying to understand why can preoccupy survivors for months, even years, as they seek to answer the question of 'why' in a multitude of ways (Wertheimer, 2001).

Denial is almost inevitable when confronted with the news of a suicide. According to Alexander (1991), the mind instinctively recoils and refuses it as it plays out other possible scenarios such as murder or mere accident. Denial is often verbalized by phrases such as, "It's not true!" or, "It can't be!" and has the potential to become so strong that the person may faint or lose consciousness (Pretzel, 1976). According to Wertheimer (2001), this oration of disbelief serves to protect them from feelings that may be too overwhelming to face immediately. The suddenness of it makes it difficult to accept the reality of it of the death, not to mention the actuality that it was intentional (Alexander, 1991).

Another common feeling is blame, sometimes referred to as "survivor guilt" (Johnson, 1999). This natural tendency is clouded by a number of unanswered questions such as, "Did I miss the signs?", "Was there more I could have done?" or "Did I fail to meet their needs?" It is common for counselors to believe they should have done more even when all proper steps toward prevention were made. Wertheimer (2001) stated that whatever the guilt is about, the end result is the same with an unending list of 'if-only'. He added that the guilt never really goes away. Often, they will reach into years gone by and obsessively recount "all the sins of commission and omission that were perpetrated against the deceased" (Pretzel, 1976, p140).

Following denial and guilt are typically feelings of anger. According to Johnson (1999), anger can be a positive motivator as it sometimes prompts the redirection of

energy toward life-affirming activities of the promotion of suicide awareness and prevention. However, it can also be disparaging if the anger leads to other negative subsequent feelings. Wertheimer (2001) purported that anger may be directed toward themselves or felt somatically through physical symptoms. It is possible to bury anger and believe that it is hidden from one's consciousness only to appear in a disguised form such as dreams. Tekavcic-Grad and Zavasnik (1992) as cited in Wertheimer (2001, p 234) relate the following dream as an example:

A woman, whose daughter died by suicide a year ago, visits the cemetery once or twice a day and finds this comforting. In the dream she goes to the cemetery and finds the grave has been damaged. There are traces of horse shit everywhere and the gravestone had been torn down. She is in shock and feels devastated.

According to a longitudinal study conducted by Brown (1987), these effects can be long lasting as psychiatrists that he surveys still remembered the name of the suicide victim and details regarding the death 30 years later (Lafayette & Stern, 2004). In some cases, more serious pathologic reactions to the suicide of a client such as melancholia, atonement, and narcissistic avoidance have been reported (Maltzberger, 1992; McAdams and Foster, 2002).

Professional There has been little investigation regarding the professional impact of youth suicide for those in the helping profession. Psychological autopsies can be performed to help those affected work through doubts of professional competence and what they might have been missed that felt like a lethal mistake (Christianson & Everall, 2009). Regrettably, they found that although these autopsies are a common practice in the

medical field, they are very uncommon in the school system. They add this is because the “resources have not been made available for school counselors’ to create an atmosphere of learning and processing” (Christianson & Everall, 2009, p.164). Results of their study indicate these autopsies may be beneficial to school counselors’ as they found the majority of participants questioned their professional competence after the loss of a student. They added the suicide made them challenge their self-perceptions as they admittedly entered the counseling profession with the belief that they could help young individuals. Several respondents displayed frustration by their lack of control and felt victimized by “the system”. Counselors are in a position to effect change yet there are circumstances beyond their control when they follow the necessary channels only to find that preventative measures ended there. For example, one respondent said “I carried a lot of anger for the system. If she had gotten the help that she needed when she should have gotten it, she might still be alive” (Christianson & Everall, 2009, p.160). Others in the study feared being held accountable and faced with litigation while others felt that the school, including faculty and students, would blame them. They held the fear that they would no longer be trusted.

One counselor reported that “if I cared about my clients enough, they would be safe; that everyone can be helped by the right sort of help; that if I ask the right questions or say the right things that I will keep my clients safe” (Rycroft, 2005, p.89). Sadly she learned after fifteen years in the field that client suicide was not just something that happened to others and was left challenging and confronting her own limitations. She was also in question of her professional competence as she asked herself the following questions (Rycroft, 2005, p. 90)

What does it mean that a therapist cannot keep a client safe from the will to die?

What sort of therapist am I?

Am I toxic?

Don't let me near people at risk: They won't be safe with me

From her experience she learned that from a professional standpoint, the experience of losing a client to suicide forces one to face death as a reality and that it is important to be mindful of that in the therapeutic practice.

Additional studies confirmed similar findings and found that respondents felt ashamed, responsible, inadequate, and fearful of legal consequences (Lafayette & Stern, 2004). They found that those with more than one experience with suicide had lower levels of guilt, social withdrawal, and loss of self-esteem. A study by Fox and Cooper (1998) that interviewed clinicians after loss of a client to suicide evidenced feelings of fear with regards to appearing fraudulent or inept in the eyes of their colleagues. They also found indicated feelings of hurt and doubt about their competency as a professional.

Method

Participants

Participants were selected from a midsize, rural public school district in the Eastern United States. The selected individuals all work as school counselors. Initially, eight individuals, six women and two men, were invited to participate in this study; however five declined as a result of time constraints. Those willing to participate orated

that despite the sensitive nature of the research objective, the desire to participate was driven by the need for research in the area.

Procedure

Using a qualitative narrative approach, self-reported stories were collected in a semi-structured interview of ninety minutes in length. These interviews were performed in an open-ended manner and held in the office of the primary investigator. The course of action for the semi-structured interviews was based on a series of established questions created by the primary researcher (See Table 2). This method was chosen to ensure consistency across the self reported stories while also allowing room for personal reflection. Upon completion, data was analyzed for recurring themes to depict short as well as possible long term effects. Interviews were taped and the responses transcribed so that an item analysis could be performed.

Table 2

Interviewing Outline

- I. Introduction
(The primary researcher will briefly review the informed consent form and remind the participant that their participation is voluntary and that they may choose to quit at any time. To prevent possible premature exhaustion of interviewees, the primary researcher will avoid immediate use of emotionally laden questions)

Approximate time: 15 minutes

1. Do you have any questions before we get started?
2. Tell me a little bit about yourself.
3. How long have you been in the counseling profession?
4. What is your most memorable experience?
5. What do you feel is the hardest part about being in the helping profession?

- II. Emotional Impact Assessment

Approximate time: 30 minutes

1. Tell me a little bit about your relationship with Hector.
2. How did you become aware of the suicide?
3. What was your initial reaction?
4. How do you feel this tragedy has affected you?
5. How did you address your own grief?

III. Professional Impact Assessment

Approximate time: 30 minutes

1. What have you learned from this experience?
2. Describe the obligations you faced.
2. Do you place blame on anyone for his death?
3. Tell me how this has strengthened/weakened your role as a counselor.
4. Has this experienced changed your desire to work in a school system?

IV. Conclusion

Approximate time: 15 minutes

1. We have about fifteen minutes left and I am wondering if there is any thing else you would like to share?
2. What was this process like for you?
3. Are there any questions you have for me?

*** Interview questions were created by the primary researcher.

Data analysis

This study used an interpretive phenomenological analysis (IPA). Developed by Jonothan Smith, this experiential qualitative approach is often used in psychology, human, health and social sciences research (Smith, Flowers, & Larkin, 2009). It was chosen with the hope that a new perspective regarding the research question may be obtained. After transcribing the data, I reviewed the text intensively, and coded it for insights into the participants' experience of the suicide. As numerous codes emerged, I began to look for patterns within them. IPA refers to these patterns as themes that display

recurring patterns of ideas, thoughts, and feelings. The analysis yielded four major themes which described the personal and professional impact of student suicide on school counselors'. These themes were summarized and backed up with direct quotes from participants.

Results

Discussion

“His statements were so abstract and any counselor that worked with him would tell you that. He never really gave a concrete indicator. He was so bright and so careful about the way he talked about things. He would say things like “I just want to get out of here”, “I need to get away”, and I found myself doing several risk assessments with him but he always had the unique ability of taking away that abstract. But for some reason there was always that question mark”.

“I had two days of tears where I worked with his brother's, got them clothes for the funeral, took them to pick out flowers, went to the funeral and after that I think I was a little numb. I just felt like I had no more to give. My friends were concerned because normally I talk, talk, and talk about things but this was different. I kind of compartmentalized it for awhile and threw it away until I was ready to talk about it”.

“This experience just adds to the horrible list of things that I have had to go through as a counselor. It has made me look closer at all the other kids who are really going through a

struggle. It has made me reach out more to the community so that I become a more familiar face for those to reach out to me who know of children in pain that I might not have the knowledge of”.

My initial reaction was shock. Tears started coming down my face and I ran into the house because I was a bit embarrassed. I felt the need to collect myself. It was a horrible realization that it had occurred”.

“The real anger I think was directed toward the agencies. Those children should have been placed in foster care many years ago. We tried to set up a safe situation for him and his brothers”.

“I have found myself using a more cognitive based approach. I have done a ton of the emotional stuff over the years and eventually you reach a stand still. I guess I didn't realize it until now but yeah that is when the change in my approach occurred”.

“We deal with so many kids in pain; more than ever before. I want to be able to get to some of these kids and talk about opening the door to some alternative ways of thinking. I use a more futuristic approach. It's important to acknowledge their pain but more important to let them know it won't last forever”.

“As far as blame goes, I really think his mother needs to take some accountability. She was a very poor mother and I don't mean monetarily. Between the drug and alcohol

abuse and numerous boyfriends in and out of the house, the children were neglected physically and emotionally. There was speculation of both physical and sexual abuse but, as always, came back unfounded by Child Protective Services”.

“He had a love/hate relationship with his mother and despite his anger towards her; he was very protective and guarded on the information that he was willing to share”.

“Since this experience, I find myself guiding kids a little more which has always been taboo in terms of counseling but I firmly believe that I can't just use a Rogerian based approach anymore. In a school institution we are educating and part of that educational process is helping a child think about their emotions, think about the way they are behaving, and think about alternatives. The cognitive approach that I was talking about earlier helps them get over that “woe is me” syndrome and allows them to see that there is a different way of thinking.”

“I don't know why but there are times when I kind of drift and wonder what he's doing. I can close my eyes and see visions of him sitting on the porch like I could pull up and talk to him. Other times, I see him in this office, right where you are sitting now and remember the good times we had. He would draw, he was an amazing artist and we would laugh”.

“It was a combination of shock and sadness. I shouldn't say shock because I knew something horrible was going to happen to this family. I guess I was just really quiet for

awhile, very internal and stayed to myself. There was a tremendous amount of grief and sadness”

“Losing a young boy who had so much to give and so much to offer made me appreciate life and the time that we have on this earth. It made me want to, more than ever, help the other kids I see in pain and get them to look at the positives in their lives and really evaluate the happy events.

“I kept telling myself that I had the swine flu. I was completely down for at least five days”.

“I knew that I had done all that I could for him but I doubted my ability to help the surviving kids. I worked closely with him and all of his brothers for years in fact I spent two hours with his brother the actual day he killed himself. My connection to the family was huge and went above and beyond what I typically give. My biggest concern now was them. I wondered; how can I do this? How can I sit with them? How can they trust me?”

Limitations

Although the findings of this study are informative with respect to how school counselors' experience student suicide, it is imperative to acknowledge several limitations. Due to the modest sample size of the study, a larger participant pool could increase the likelihood of generalizing the findings. In addition, a more diverse sample could provide very different results as the study included only Caucasian participants from a rural school district. The primary researcher proposes that future research include participants from various cultures and backgrounds. It was also noted that all participants were in the school counseling profession for a period of time that exceeded ten years.

There could be a significant difference in results if a comparison study were conducted that examined seasoned counselors to those new to the profession.

“Counselors have such a high degree of responsibility and it’s such a helpless feeling to be in a position where the information you are given is so sad you know that a kid is caught in family situation and there is nothing you can do but give them the tools necessary to cope. It’s just the way the system works. Over and over again calls were made to Child Protective Services yet nothing was done. No matter how many times we made reports, nothing happened”.

I was angry, very angry. As much as you fear things happening, there is sort of an attitude like oh we are just going on and on and then something like this just hits you in the face. I really feel there was a let down and injustice for him. We did everything we could for him, from a school perspective, from a counselor’s perspective, no stone was left unturned. That was comforting and I do not think any responsibility lies with us. The real anger is really aimed towards the people in the agencies who didn’t do anything. I mean these children should have been placed in foster care many, many years ago and they did not acknowledge that these children were in pain, at risk of being killed, killing themselves and certainly for getting involved with pretty dangerous stuff as far as drugs go”.

“I have a greater awareness of that line that we are walking and it’s the kind of thing where you have something happen and things go along for awhile as normal and you get

that wake up call. Gradually things get back to normal and you start thinking everything is going to be okay and then you get another wake up call”.

“It still burns. There is still that feeling there”

Attended the calling hours and funeral and made ourselves visible for all the children.

It shows people the real seriousness of what we do and it shows people that we are needed. When a tragedy happens, it's all about the counselors at that point. We help people develop coping skills and work through their pain.

Life is fragile and you really have to take everything seriously and I think this has made me hyperaware of kids that need extra support. Unfortunately the lessons sometimes are, no matter what you do it may not really make a difference.

It was a good thing to reflect. I think I am often diving from one thing to the next and I don't always get that chance to reflect. I am always moving on before I get the chance to really process and as much we talk about things, to sit back and sort of process it and have the ability to go back and look at it from a different perspective was very helpful.

I was very sad and very angry at the system. It was one of those situations where we always anticipated something bad was going to happen. He was one of our CPS cases that we were so emotional about to begin with. We had this kid in a situation that was just

horrific and he was begging to be taken out of the situation and begging for someone to help him. We had this whole history where we tried to set up a safe circumstance for him and his brothers as well and it was just a tragic end to years of frustration.

Suicides are the most difficult things for a counselor. He was so bright and so aware.

I cried. I talked to my husband and the other counselors. I think in our profession talking to other people is the only way to get through.

I keep all of his things hanging up. I think of him and I pray for him. I have faith that really helps me through.

I learned that I need to have a level of acceptance that there is no way to really ever know or predict that that is what's going to happen. It doesn't change the fear that I have for kids heading to the high school. I have this constant worry that, at some point, they are going to decide they can't do it anymore.

I can't get the visuals of his artwork out of my head. It was very powerful.

I had to call the teachers that I knew were close to him. I had to counsel the girls that found his body. It was very traumatic and awful for them and I know it is something that they will never forget. So many of the groups that I run have students in them that were very close to him and they struggled with the idea that he was murdered. We had to wade

through all that even though I knew he had committed suicide based on the autopsy reports yet it didn't change the fact that these kids were filled with fear.

I am very discouraged that "the system" didn't hear his voice. As counselors, we try to be their voice and it is so hard to see their pain and feel so powerless. I am so angry because CPS still holds the power to help that whole family and still have not done a thing.

References

- Alexander, V. (1991). *Words I thought I would never speak: Stories in life in the wake of a suicide*. New York: Lexington Books.
- Berman, A., Jobes, D., & Silverman, M. (2006). *Adolescent suicide: Assessment and intervention*. Washington DC: American Psychological Association.
- Borders, L. (2002). School counseling in the 21st century: Personal and professional reflection. *American School Counselor Association*, 5, 180-185.
- Christianson, C., & Everall, R. (2009). Breaking the silence: School counsellors' experiences of client suicide. *British Journal of Guidance & Counselling*, 37, 157-168.
- Crook, M. (2003). *Out of the darkness: Teens and suicide*. Vancouver B. C.: Arsenal Pulp Press.

- Cross, T. (1996). Examining claims about gifted children and suicide. *Gifted Child Today, 18*, 3, 46-48.
- Cross, T., Cassady, C., Miller, K. (2006) Suicidal ideation and personality characteristics among gifted adolescents. *Gifted Children Quarterly, 50*, 295-301.
- Cvinar, J. (2005). Do suicide survivors suffer social stigma: A review of the literature. *Perspectives in Psychiatric Care, 41*, 14-21.
- Davidson, L., & Linnoila, M. (1991). *Risk factors for youth suicide*. New York: Hemisphere.
- Dexter-Mazza, E., & Freeman, K. (2003). Graduate training and the treatment of suicidal clients: The student's perspective. *Suicide and Life Threatening Behavior, 33*, 2, 211-218.
- Fincham, B., Scourfield, J., & Langer, S. (2008). The impact of working with disturbing secondary data: Reading suicide files in a coroner's office. *Qualitative Health Research, 18*, 853-862.
- Foster, V., & McAdams, C. (1999). The impact of client suicide in counselor training: Implications for counselor education and supervision. *Counselor Education & Supervision, 39*, 22-34.
- Fox, R., & Cooper, M. (1998). The effects of suicide on the private practitioner: A professional and personal perspective. *Clinical Social Work Journal, 26*, 143-157.
- Gibson, P. (1989). Gay male and lesbian youth suicide. *Report to the Secretary's Task Force on Youth Suicide, 3*, 110-142. Washington, D.C.: U.S. Department of Health and Human Services.
- Goodyer, I. (1995). *The depressed child and adolescent: Developmental and clinical*

perspectives. Cambridge: University Press.

Herring, R.(1990). Suicide in the middle school: Who said kids will not? *Elementary School Guidance and Counseling*, 25, 129-137.

Huntington, D., Bender, W. (1993). Adolescents with learning disabilities at risk? Emotional well-being, depression, suicide. *Journal of Learning Disabilities*, 26, 3, 159-166.

Jellinek, M., Bostic, J., & Schlozman, S. (2007).When a student dies. *Educational Leadership*, 65, 78-82.

Johnson, W. (1999). *Youth suicide: The school's role in prevention and response*.
Bloomington, Indiana: Phi Delta Kappa Educational Foundation

Kulkin, H., Chauvin, E., Percle, G. (2000). Suicide among gay and lesbian adolescents and young adults: A review of the literature. *Journal of Homosexuality*, 40, 1-29.

Kirk, W. (1993). *Adolescent suicide: A school based approach to assessment and intervention*. Champaign, Illinois: Research Press.

Lafayette, J., & Stern, T. (2004).The impact of a patient's suicide on psychiatric trainees: A case study and review of the literature. *Harvard Review of Psychiatry*, 12, 49-55.

Lalor, J., Begley, C., & Devane, D. (2006).Exploring painful experiences: Impact of emotional narratives on members of a qualitative research team. *Journal of Advanced Nursing*, 56, 607-616.

Lester, D. (1993). *The cruelest death: The enigma of adolescent suicide*. Philadelphia: The Charles Press Publishers.

- Lindqvist, P., & Lars, K.(2008). In the aftermath of teenage suicide: A qualitative study of the psychosocial consequences for the surviving family members. *Urban BMC Psychiatry*, 8, 1-7.
- Maples, M., Packman, J., Abney, P., Daugherty, R., Casey, J., & Pirtle, L. (2005) Suicide by teenagers in middle school: A postvention team approach. *Journal of Counseling & Development*, 83, 397-405.
- Mauk, G., & Gibson, D.(1994). Suicide postvention with adolescents: School consultation practices and issues. *Education & Treatment of Children*, 17, 468-484.
- McAdams, C, Foster, V. (2002). An assessment of resources for counselor coping and recovery in the aftermath of client suicide. *Journal of Humanistic Counseling, Education & Development*, 41, 232-241.
- McBride, H., Siegel, L. (1997). Learning disabilities and adolescent suicide. *Journal of Learning Disabilities*, 30, 6, 122-130.
- McGuire, D., & Fly M. (1984). Child suicide. *Child Welfare*, 1, 17-26.
- McAdams, C, Foster, V. (2000). Client suicide: Its frequency and impact on counselors. *Journal of Mental Health Counseling*, 22, 107-122.
- McMenamy, J., Jannette, M., Jordan, J., & Mitchell, A. (2008).What do suicide survivors tell us they need? Results of a pilot study. *Suicide & Life-Threatening Behavior*, 38, 75- 389.
- Menninger, W.(1991).Patient suicide and its impact on the psychotherapist. *Bulletin of the Menninger Clinic*, 55, 216-228.
- Mitchell, A., Gale, D., Garand, L. & Wesner, S. (2003).The use of narrative data to

- inform the psychotherapeutic group process with suicide survivors. *Issues in Mental Health Nursing*, 24, 91-107.
- Miyabayashi, S., & Yasuda, J.(2007). Effects of loss from suicide, accidents, acute illness and chronic illness on bereaved spouses and parents in Japan: Their general health, depressive mood, and grief reaction. *Psychiatry & Clinical Neuroscience*, 61, 502-508.
- Myers, M., & Fine, C.(2007). Touched by suicide: *Bridging the perspectives of survivors and clinicians suicide & life-threatening behavior*, 37, 119-126.
- Neihart, M.(1999). The impact of giftedness on psychological well-being: What does the empirical literature say? *Roeper Review*, 22, 10–17.
- Parrish, M., & Tunkle, J.(2005). Clinical challenges following an adolescent's death by suicide: Bereavement issues faced by family, friends, schools, and clinicians. *Clinical Social Work Journal*, 33, 81-102.
- Parsons, R. (1996). Student suicide: The counselor's postvention role elementary school *Guidance & Counseling*, 3, 77-81.
- Peterson, E., Louma, J., & Dunne, E.(2002).Suicide survivors' perceptions of the treating clinician. *Suicide & Life-Threatening Behavior*, 32, 158-167.
- Portner, J. (2001). *One in thirteen: The silent epidemic of teen suicide*. Beltsville, Maryland: Robins Lane Press.
- Pretzel, P.(1972).*Understanding and counseling the suicidal person*. New York: Abingdon Press.
- Ratnarajah, D., & Schofield, M.(2008).Survivors' narratives of the impact of parental suicide. *Suicide & Life-Threatening Behavior*, 38, 618-630.

- Remly, T., & Sparkman, L.,(1993). Student suicides: The counselor's limited legal liability *School Counselor*, 40, 164-170.
- Richards, B. (2000). Impact upon therapy and the therapist when working with suicidal patients: some transference and counter-transference aspects. *British Journal of Guidance & Counselling*, 28, 325-337.
- Rofes, E. (1983). *I thought people like that killed themselves: Lesbians and gay men and suicide*. Grey Fox Press: San Fransico.
- Rycroft, P. (2005).Touching the heart and soul of therapy: Surviving client suicide. *Women & Therapy*, 28, 83-94.
- Sakinofsky, I. (2007). The aftermath of suicide: Managing survivors' bereavement *Canadian Journal of Psychiatry*, 52, 129-136.
- Sargent, M. (1984). Adolescent suicide: Studies reported. *Journal of Child and Adolescent Psychotherapy*, 1, 2, 49-50.
- Shneidman, E. (1996). *The suicidal mind*. New York: Oxford University Press.
- Shaffer, D., Garland, A., Gould, M., Fisher, P., & Trautman, P. (1988). Preventing teenage suicide. *Journal of the American Academy of Child and Adolescent Psychiatry*, 27, 675-687.
- Smith, K. & Crawford, S.(1986).Suicidal behavior among normal high school students. *Suicide and Life-Threatening Behavior*, 16, 313-325
- Smith, J. A., Flowers, P., & Larkin, M.(2009). *Interpretive phenomenological analysis: Theory, method, and research*. London: Sage.
- Stack S (2005). Suicide in the media: A Quantitative review of studies based on nonfictional stories. *Suicide and Life Threatening Behavior*, 35, 121-133.
- Stefanowski-Harding, S.(1990). Child suicide: A review of the literature and implications

- for school counselors. *Suicide & Life-Threatening Behavior*, 37, 328-140.
- Sveen, C., & Walby, F.(2008). Suicide survivors' mental health and grief reactions: A systematic review of controlled studies. *Suicide & Life-Threatening Behavior*, 38, 13-29.
- Tice, T.(1991).Child Suicide. *Education Digest*, 56, 39-47.
- Underwood, M., Dunne-Maxim, K., & Ahrens, R.(1995).Managing sudden violent loss in the schools. *Social Work in Education*, 17, 125-128.
- U.S. Census Bureau (2006). Statistical Abstract of the United States. Retrieved from <http://www.census.gov/compendia/statab/2006/files/index.pdf>
- Wertheimer, A. (2001). *A special scar: The experience of people bereaved by suicide*. New York: Brunner-Routledge.

American Foundation for Suicide Prevention
http://www.afsp.org/index.cfm?fuseaction=home.viewPage&page_id=1

Appendices

STATEMENT OF INFORMED CONSENT

The purpose of this research project is to identify areas in which school counselors are affected by student suicide and determine the extent of personal and professional impact. This research project is also being conducted in order for me to complete my master's thesis for the Department of Counselor Education at The College at Brockport.

In order to participate in this study, your informed consent is required. You are being asked to make a decision whether or not to participate in the project. If you want to participate in the project, and agree with the statements below, please sign your name in the space provided at the end. You may change your mind at any time and leave the study without penalty, even after the study has begun.

I understand that:

1. My participation is voluntary and I have the right to refuse to answer any questions.
2. I will be audio taped, and the researcher will transcribe the audio tapes. If any publication results from this research, I would not be identified by name.
3. There will be no benefits because of my participation in this project. There is a potential risk of emotional upset during the interview.
4. My participation involves being audio taped during an interview answering a series of open-ended questions. It is estimated that it will take 90 minutes to complete the interview.
5. A maximum of 7 people will take part in this study. The results will be used for the completion of a master's thesis by the primary researcher.

- 6. Data, audio tapes, and transcribed notes will be kept in a locked filing cabinet by the investigator. Only the primary investigator will have access to the tapes and corresponding materials. Data, audio tapes, transcribed notes and consent forms will be destroyed by shredding when the research has been accepted and approved.

I am 18 years of age or older. I have read and understand the above statements. All my questions about my participation in this study have been answered to my satisfaction. I agree to participate in the study realizing I may withdraw without penalty at any time during the survey process.

If you have any questions you may contact:

| | |
|--|---|
| Primary researcher | Faculty Advisor |
| Name: Stacy Bowman | Name: Thomas Hernandez |
| Phone Number: (716) 803-3039 | Counselor Education Department Phone Number : (585) 395-2258 |
| Email address: sbow0418@brockport.edu | Email address: thernandez@brockport.edu |

I agree to participate and understand that I will be audio taped.

Signature: _____ Date: _____

I agree to participate, but do not agree to be audio taped.

Signature: _____ Date: _____

Resources for Support

ORLEANS COUNTY

Group Name & Mailing Address:

Survivors of Suicide Orleans County Support Group

Regional Action Phone, Inc.

PO Box 281

Batavia, New York 14021

Contact: Holly (585) 703-2706 or

Dawn: (585) 698-4857, rapinc1@verizon.net

Meeting Place: Call for information.

Meeting Day(s)/Meeting Time: 2nd Monday of each month

Facilitated by: Peer

Charge: No

Newsletter: No

Counties Served: Orleans & Surrounding Area

GENESEE COUNTY

Group Name & Mailing Address:

Survivors of Suicide Genesee County Support Group

Contact: Ann and Ellen

(585) 344-2611 (9am-5pm), (585) 768-2540 (after 5pm), mhagenesee@2kj.net

Meeting Place: Call for information.

Meeting Day(s)/Meeting Time: 3rd Tuesday of each month

Facilitated by: Peer

Charge: No

Newsletter: No

Counties Served: Genesee & Surrounding Area

ERIE COUNTY

Life Transitions Center, Inc.

150 Bennett Road

Buffalo, NY 14227-1480

Group Name: Suicide Bereavement Support Group

Contact Person: Jen Henry

(716) 836-6460

Leadership Type: Prof

Meetings/Month: 1

Charges: No

Newsletter: No

Table 2: Compositional structure of IPA themes

Thematic level Code Theme One Code Theme Two Code Theme Three

Super-ordinate

theme

1. Judgement of issue 2. Comparison of issue 3. Personal understanding of issue

Master themes 1.1. Source of Judgement 2.1. Self – Self 3.1. Health

2.2. Self – Others 3.2. Coping

Sub categories 1.1.1. Attitudes 2.1.1. Past, Present, Future Self 3.1.1. Illness – Recovery

1.1.2. Prejudice

1.1.3. Discrimination

Sub Categories 1.1.1.1. Effect on Life 2.2.1. Inclusion – Distinction 3.2.1. Avoidance – Withdrawal

3.2.2. Education

3.2.3. Secrecy

Key: Code indicates thematic hierarchy

An investigation 'People don't understand': An investigation of stigma in schizophrenia using Interpretative Phenomenological

Analysis (IPA)