
Constructing Bridges of Support: School Counsellors' Experiences of Student Suicide

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ABSTRACT

School counsellors are professionals with specialized training in personal counselling who work in school settings. They are usually the front-line school personnel required to deal with youth suicide. Despite the important roles of school counsellors, there is little research that explores the experiences of school counsellors who have lost clients to suicide. In this study, seven school counsellors were individually interviewed, and data were analyzed using a basic interpretative qualitative method informed by grounded theory. Themes related to training and practice standards, support resources, and self-care were identified by participants as critical to personal well-being and continued effective professional functioning. Personal and professional implications are discussed.

RÉSUMÉ

Les conseillers scolaires sont des professionnels ayant une formation spécialisée en counseling personnel travaillant en milieu scolaire. Ils sont habituellement le personnel scolaire de première ligne à qui il est demandé de traiter le suicide d'un jeune. Malgré le rôle important qu'ils jouent, peu de recherches examinent le vécu des conseillers scolaires qui ont perdu des clients par suicide. Sept conseillers scolaires ont été interviewés individuellement, et les données ont été analysées en utilisant une méthode d'interprétation qualitative de base informée par une théorie à base empirique. Les participants ont identifié les thèmes liés aux normes de formation et de pratique, aux ressources de soutien, et aux auto-soins d'une importance critique pour le mieux-être personnel et la continuation d'un fonctionnement professionnel efficace. Les répercussions aux plans personnel et professionnel sont discutées.

In Western countries, suicide ranks between the fifth and tenth most common cause of death (Berman, Jobes, & Silverman, 2006). For children and adolescents in Canada, suicide is one of the top three leading causes of death (Statistics Canada, 2003). Between the ages of 15 and 19, youth are more likely to commit suicide than to die from disease (Statistics Canada); when adolescents look at their reflections in the mirror, they see one of the greatest dangers they will face. Aside from the family, the school has the most contact with young people during their formative years (Sofronoff, Dalglish, & Kosky, 2005). This places school counsellors in a unique position to address students' mental health needs. School counsellors are one of the professional groups who work closely with at-risk children and adolescents (Allen et al., 2002), facing youth suicide as frequently as other groups of mental health professionals (Borders, 2002).

Although there are similarities with other mental health professions, school counselling is a unique discipline (Borders, 2002) involving the provision of

multiple counselling relationships including personal, social, educational, and career counselling (Erford, 2003). The primary difference between professional counsellors working in school settings and other mental health providers is setting, not professional skill set (Lambie & Williamson, 2004). The role of school counsellors has changed in magnitude in recent years; consequently, they now encounter the same issues faced by counsellors in other settings, including “bullying, bereavement, family divisions, substance abuse, physical, sexual and emotional abuse, sexual and racial harassment, unwanted pregnancy, and isolation” (Barwick, 2000, p. 1).

As the needs of the student population and society have changed, so too have the training requirements and role definitions of school counsellors (Lambie & Williamson, 2004). While school counsellors previously focused on guidance, their role has expanded to include personal counselling (Barwick, 2000). They are expected to be knowledgeable in the areas of human growth and development, social and cultural foundations, the helping relationship, group work, career and lifestyle development, and professional orientation (Sink, 2005). What currently distinguishes teachers functioning as school counsellors from professional school counsellors is the level of specialized training they have received. Until the late 1980s school counsellors had to be certificated teachers but required neither training nor certification in counselling (Robertson & Paterson, 1983). The requirements have changed in recent years, as many school boards in British Columbia, Alberta, and Ontario, for example, now expect school counsellors to have professional training at the graduate level in educational psychology or other related fields (Alberta Education, 2007; British Columbia School Counsellors’ Association, 2006; Ontario School Counsellors’ Association, 2007).

Regardless of how well-trained clinicians may be or the setting in which they practice, losing clients to suicide is difficult (Grad & Michel, 2005) and is often experienced on both a personal and professional level (Berman et al., 2006). Consequently, when clinicians do not process their experiences of client suicide in a healthy way, they may find their professional work unfulfilling, unsatisfying, and compromised in addition to feeling the personal impact of the loss (Fox & Cooper, 1998). Typically this experience is referred to as *burnout*.

While the literature on burnout has expanded since its introduction in the 1970s, it still comprises three components: exhaustion, depersonalization, and reduced efficacy (Maslach, Schaufeli, & Leiter, 2001). Clinicians experiencing burnout may find that they become ineffective helpers unless they seek services for themselves; however, few seek professional assistance in processing the loss of their clients (McAdams & Foster, 2000) despite the recognition of its benefit. Counsellors may be reticent to seek professional services because they equate seeking help with a failure to heal themselves (Everall & Paulson, 2004). For professionals who routinely encounter the “occupational hazard” of client suicide (Chemtob, Bauer, Hamada, Pelowski, & Muraoka, 1989, p. 419), mental health professionals remain poorly trained and ill prepared for the aftermath of such an event (Dexter-Mazza & Freeman, 2003). Additionally, it seems that few training programs provide

adequate training in suicide prevention, intervention, or postvention (McAdams & Foster, 2002), specifically in self-care following the death of a client.

Limited research has focused on the impact of client suicide on mental health professionals including psychiatrists, psychologists, nurses, and psychotherapists, and the consensus among researchers is that the existing literature is not comprehensive (Hendin, Pollinger Haas, Maltsberger, Szanto, & Rabinowicz, 2004; McAdams & Foster, 2000). In a study conducted by Kendrick and Chandler (1994), 93% of the school counsellors sampled had worked with students expressing suicidal ideation, yet they received little to no preparation in their training programs to help them cope with a potentially fatal eventuality (Allen et al., 2002). Despite the significant number of school counsellors who deal with suicidal youth, research has not been conducted on the experiences of those who have lost clients in this manner. With a clearly defined need for such a study, this research was guided by two questions: "What are school counsellors' experiences of client suicide?" and "What impact did the participants feel client suicide had on their lives?" The results presented will focus on training, support, and related issues that affected participants' reactions to their clients' suicides.

METHOD

The purpose of this research study was to gain an in-depth understanding of school counsellors' experiences of client suicide from their perspective. The goal of qualitative research is to understand and identify the meaning of a particular experience from the perspective of study participants through description and interpretation (McLeod, 2001; Merriam, 2002). Since little is known about the research question, a qualitative approach was deemed to be appropriate.

In this study, grounded theory was chosen as an appropriate methodology as it provides a structure to explain how people behave in the context of a specific experience or phenomenon (Glaser & Strauss, 1967). Through an inductive examination of data, grounded theory is designed to both describe and explain subject areas that may be difficult to access using traditional research methods. In addition, it provides clear techniques and procedures of data collection and data analysis that help illuminate meaning making and the underlying processes that are identified by participants (McLeod, 2001).

Procedure

Ethics approval was obtained from the University of Alberta Faculties of Education and Extension Research Ethics Board. Potential participants were recruited from across the country through listserv e-mails, newsletters, personal contacts and a website. Those interested in participating contacted the researcher, and an orientation to the study was provided via telephone. The nature and purpose of the study, confidentiality, anonymity, and right to withdraw from the study at any time without penalty were explained. Potential participants who met the inclusion criteria and expressed an interest in further participation were mailed consent

forms that they signed and returned by mail. Individual in-depth telephone interviews were then scheduled at a mutually convenient time.

Two interviews, each between one and two hours in length, were digitally recorded and transcribed into text for analysis. The aim of the interviews was to elicit participants' experiences of their clients' suicides. Semi-structured interview questions included: "How did you find out about your client's suicide?" "What supports were available to you following the suicide?" and "What was it like to work with the next client who presented with suicidal ideation?" The transcribed interviews were sent to participants for verification of accuracy. In all cases, clarification or additional information was provided that was incorporated into the analysis.

Participants

Seven of 13 prospective participants met the study criteria: (a) is/was a school counsellor; (b) lost a personal, not academic, counselling client to suicide; and (c) received training in educational psychology or a counselling-related field. Four men and three women representing four provinces in both rural and urban settings were selected. Counselling experience ranged from 15 to 31 years.

Data Analysis

Interview transcripts were loaded into the qualitative program ATLAS.ti 5.0. The program allowed for highlighting and selecting specific quotations, and searching for key words, ideas, and concepts. Initially, interviews were analyzed individually. Each transcript was read and reread in its entirety to capture the full content of the participants' narratives. Meaning units were identified from segments of the interview and codes were attached to identified quotes. Following within-case analysis, code families were created between cases to determine the similarities and differences between participants' experiences. Throughout the analysis, the meanings of all categories were compared and contrasted both within and across participants' experiences. Using a constant comparative method (Glaser & Straus, 1967; Merriam, 2002), major themes were identified across cases and linked together into higher-order categories representing related ideas. After reorganizing, collapsing, and exploring all linkages and patterns between the categories, main and subsequently higher-order core categories appeared. Core categories became central in the hierarchical structure that emerged. Referring back to participants' interviews and connecting the identified themes to the literature provided further rationale for the inclusion of themes.

FINDINGS

With increasing mental health concerns among school-aged children and continued budget cutbacks to community mental health services, school counsellors are becoming increasingly responsible for providing mental health services to the student body (Atkinson & Hornby, 2002; Lockhart & Keys, 1998). As "it has been

estimated that up to 50% of completed suicides were in treatment at the time of their death” (Berman et al., 2006, p. 348), school counsellors will likely encounter a student suicide, if not a client suicide, during their career. Thus, preparation for such an occurrence has become increasingly important.

Participants in this study did not believe they were adequately prepared for their experiences of client suicide. Themes related to national training and practice standards, support resources, and self-care highlighted areas of minimal preparation. As national training and practice standards have not been developed, participants felt professionally ill-equipped to deal with the aftermath. Further, they reported having few if any colleagues with whom to consult. Participants were not encouraged to seek support when dealing with the aftermath of client suicide nor were support resources easily accessible. The lack of emphasis placed on support made self-care strategies challenging to develop and implement.

National Training/Practice Standards

With no national directive, significant differences in school counsellors’ training, practice, and responsibility exist. Without parameters around the profession, school counsellors’ role definition has continued to evolve. Participants described how their responsibilities have expanded over time without an increase in resources:

The job is just becoming more busy and I’m not sure it’s just the population. I think it’s the nature of cutbacks and dwindling resources.

I’m finding that we don’t have as many resources in the community as we used to... We are dealing with a lot of mental health issues that really don’t necessarily fit our mandate.

Expansion of the school counselling role has not been met with additional training or preparation despite the identified need:

Having a situation where a student is suicidal and dealing with that requires some professional skill and knowing what the role is, knowing what your boundaries are, knowing that you’ve got people around you that know what’s going on.

Inconsistencies between best practice and current practice were noted. In terms of the professional training required to counsel in schools, one participant commented: “My definition of what’s adequate and what’s happening are different.” Another stated:

What I see happening now is the training programs are shorter. They seem to have much less practicum time, they’re putting people in schools to do practicums where they’re basically throwing them into school to do the job and having a fellow counsellor kind of oversee them, but not the same kind of intense focus on the counselling process.

Further gaps between best practice and current practice in the post-intervention process were identified. While the experiences of school counsellors differed, all either assumed or were expected to assume the key role in developing, managing, and implementing the postvention protocol. Participants described their experiences and their reactions to the postvention process:

My first reaction was “Oh my God, nobody knows what to do here, and nobody is doing the right thing.” School was going to start on the Monday and I thought, “We have to have a plan before the kids come back.” We didn’t even know what staff members knew.

I wrote a script for what the staff could say to the students and I got pamphlets and handouts on grief and suicide and warning signs. I got a bunch of stuff together and got together with a couple of the teachers who were close to her and felt that we needed to do something. I arranged for a crisis debriefing session. I’d never done one before. I realize now that we should have gotten some outside help to do this, but I didn’t know that then.

I knew it was crazy. I was so angry. I felt this whole thing was out of control. It just feels like ... it’s crazy that I’m doing this. But there was nobody else who was stepping up to the plate to do it. I needed to do it.

To deal effectively with the post-intervention process, participants expressed interest in having standard protocols to follow, including access to crisis teams:

I could have used another counsellor from one of the other schools to talk to me.

I could have used our district psychologist to come and talk to me. I was too in shock, myself, to initiate that.

What I needed at that point was for someone to say, “Are you doing okay? What was the first thought you thought of right now? Are you able to go home and sleep tonight?”

While one participant was able to access a crisis team, it did not have the training to adequately support her:

What the counsellors said when we were going through this process was that they felt I wasn’t debriefed properly. That was something that probably psychologically affected me for a long time. My first reaction was “I’m going to be tough, no it was fine.” And then I thought, “I’m not helping anybody else by saying I was fine” because there were times when I just didn’t have the energy to deal with kids.

Support Resources

Structured support for bereaved counsellors was identified as a significant deficit in current training programs. According to one participant, “You can read all the literature, you can talk to all sorts of people, but I think the most important thing is that you need supports in place.” As personal needs and emotional experiences following a suicide were never formally or informally addressed at an institutional level, participants were unsure whether they were supposed to have such an emotional reaction or, as one participant stated, whether they were even “allowed to grieve.” Participants revealed their common experience of feeling afraid when they had to navigate the process alone:

I don’t think anybody would be different in the amount of aloneness you feel about it all ... It would have been nice to have somebody to guide me through all of that.

The principal was a very supportive man, but he wasn’t a trained counsellor or anything. Basically, I had to handle it on my own.

Only two participants received personal counselling to help them process their losses; they both talked about the important roles their counsellors played in the

healing process. One participant reported, “He was really good, and he supported how I was handling everything. He checked out my supports to make sure that I had other people to talk to.” The other commented, “An incredible support system was put into place and I was very, very happy to have someone work with me through this.” Support of friends and colleagues, while helpful, did not replace the support of a professional. Some participants reflected on their experiences of having either no or limited professional support:

I had a fiancé and I had one roommate, so they gave me whatever support they could, but they weren't professionals either. They were teachers, but they weren't trained in dealing with grief or anything like that.

I had no one, no. I believe if I would have, my grieving process would have been much quicker.

I spent a good portion of the year seeing a career counsellor because I wasn't sure I wanted to stay in this job. I wasn't sure the supports were in place for me professionally.

Of the five participants who did not receive professional counselling, two thought they should be able to work through their losses alone. One did not reach out for support but would have accepted help had it been offered. He talked about counselling himself through his healing process and spoke about how difficult it had been to engage in self-therapy. Another participant was concerned there might be professional repercussions for seeking personal services. The final participant believed she worked through her grief by talking with colleagues, friends, and family. Although participants constructed their own support systems to the best of their ability, only one was encouraged to access personal counselling services.

Self-Care

Participants endorsed integrating self-care into training programs so that it could become part of a healthy professional identity for counsellors who were working in demanding, stressful, high-intensity environments. They were able to identify several global self-care strategies they implement. However, when asked to specify what self-care strategies they used to help them through their experience of client suicide, participants readily acknowledged the barriers they encountered:

I had to be strong for everybody else right? I had to be strong for the students and I had to put my grieving aside so I could do that.

Sometimes we get too busy or involved in other people's problems to deal with our own. I think that's probably the nature of the beast.

I was dealing with so many other issues, but when I did do what I needed to do and I did it right, I felt that was able to help me quite a bit.

As participants continued to work in their chosen field after their experiences of client suicide, further discussion centred on the long-term impact of that experience:

It did affect me, I had a lot more sick days. In afterthought, I think it probably influenced me quite a great deal in a physical aspect.

I'm not going to lie to you, it hurts me even to this day. The raw emotions are there and, I mean, I still go for walks in the evening.

In the flash, I see the head, I see the blood, and it basically snaps me awake. And by that time I'm usually sweating like a pig and then I'm up. Now, my wife has learned, I have shared this story with her so she wouldn't be frightened. She had to know about [him], I wanted her to know about [him] so that when I had these flashes, these relapses, she knew what was going on.

Again, I think that eventually I had to understand that there is no control in a lot of those situations and in that whole process that I had to take ownership of myself and let everything else go I think was important. That ceremony that I had in my backyard where I took all of [her] letters and basically said prayers and burnt them up, that really helped me understand and work through that.

When sharing what keeps them in the school counselling context, participants described the importance of taking an active role in their own healing process. Two participants become involved in developing curricular content and providing workshops for school counsellors. They reflected on why they chose this public forum:

I think it's very, very important because prior to that there were no guidelines or direction in how to deal with something like that. It was very healing for me to be a part of that committee, though.

I think it's important information for other people to have, that these are some of the things that can happen, that you don't have control of the situation when the student's not with you. I think it's important that we share those experiences with others.

Others identified more private means of self-care activities:

I take care of myself and take quiet time for myself. I do all of the things that I know I'm supposed to do to look after myself. I have a therapist that I've seen on and off over the years. I haven't seen her for a couple of years, but I know she's there in case I ever need to go back and see her. I'm not hesitant to get help if I need help.

Even if I just get out there and just walk. Just become one with nature is what I try to do to clear my head, and look around and look at the beauty of the world to take my mind off the ugliness of suicide.

DISCUSSION

Client suicide has a profound personal and professional impact on mental health professionals. Unfortunately, training programs have not adequately prepared school counsellors to deal with client suicide. Without national standards of practice and training in place, school counsellors are ill prepared to manage this crisis. With appropriate and accessible support resources, the impact of client suicide need not result in the inability to function personally or professionally. Debriefing through professional, supervisor, and peer support as well as the practice of self-care have been identified as critical support resources.

School counsellors have identified suicide as the most stressful client issue they encounter (Jewell, 2005); however, most graduates of counselling programs receive little training in suicide prevention or intervention, and no training in

postvention (Dexter-Mazza & Freeman, 2003; Westfeld et al., 2000). In most professional disciplines, guidance in the form of ethical codes is used to work through the ethical decision-making process. Psychologists refer to the *Canadian Code of Ethics for Psychologists*, counsellors certified by the Canadian Counselling Association (CCA) follow the *CCA Code of Ethics*, but school counsellors do not have consistent national guidelines to consult when working with suicidal clients. Some provincial school counselling associations have drafted their own ethics codes, while others follow their provincial teaching codes.

To complicate the matter, inconsistent standards for professional training continue to exist across the country. Due to a counsellor shortage in Newfoundland and Labrador, teachers have been assigned counselling positions without professional training (Cooper, 2004). The Manitoba School Counselling Association reported, "School counsellors are essentially clinicians, working with almost no safety net ... with little or no supervision" and are asking to be "adequately trained and supported" (Robertson & Boxer-Meyrowitz, 2004, p. 17). In British Columbia, litigation against untrained counsellors motivated many districts to require that new school counselling appointees hold a master's degree (Easton, 2004). The few national constants, as reported by school counselling associations across the country, seem to be that budgetary cutbacks to mental health services have resulted in school counsellors assuming more of a mental health role, large counsellor-student ratios (1:500, 1:693; 1:1200), and access to fewer community resources (Butler, 2004; Cooper; Donovan, 2004; Easton; Robertson & Boxer-Meyrowitz).

Times of crisis are not times when counsellors should learn about post-intervention protocols. The purpose of a crisis intervention plan is to provide comprehensive, carefully constructed procedures that allow for the skillful management of an emergency or urgent situation by school personnel who have clearly defined roles (King, 2001). Counsellors indicated the need to be part of a team that works with the school community to facilitate healing; they should not be required to shoulder that responsibility alone (King, 1999).

Supervisory support is critical for mental health professionals working through their experiences of client suicide (McAdams & Foster, 2002). Next to professional counselling, supervisory support has been cited as the most helpful resource for professional community counsellors, psychologists, and psychiatrists working through their loss experiences (Hendin, Lipschitz, Maltsberger, Pollinger Haas, & Wyncoop, 2000; McAdams & Foster, 2000; Richards, 2000). The availability of professional support or supervision from experienced clinicians provides a safety net that offers shared responsibility, guidance, and the opportunity for personal debriefing (McAdams & Foster, 2002). As participants noted, supervision is not typically available, as many school counsellors practice in isolation and/or without direct supervision (Lambie & Williamson, 2004).

The impact of working in stressful contexts can affect clinicians' mental and physical well-being (Arvay, 2001; Arvay & Uhlemann, 1996). Mental health professionals' well-being and susceptibility to burnout are mediated by a number of factors. A feeling of being overloaded, role ambiguity, lack of supervisory sup-

port, and inexperience are all variables that contribute to burnout (Maslach et al., 2001). Factors such as working with difficult clients, carrying a large caseload, and experiencing limited control over the work context also contribute to burnout (Arvey & Uhlemann). As illustrated by the participants in this study, these factors had a dramatic impact upon their experiences.

Self-care needs to be modelled, taught, and supported as a professional resource. It is neither a luxury nor an indulgence. While clinicians know that “developing strategies for self-care is an essential component of ongoing professional development that can sustain counselors and help them to avoid compassion fatigue, or burn-out” (Walshe-Burke, 2006, p. 96), they struggle to meet their self-care needs because they have been trained to care for others to the detriment of their own health. A high level of stress has the potential to compromise counsellors’ personal health and their professional abilities (Arvey & Uhlemann, 1996), yet self-care for clinicians working in the area of trauma has been overlooked in the research (Arvey, 2001).

RECOMMENDATIONS

National standards for training and practice that guide the services provided by school counsellors need to be implemented to facilitate consistency between school districts within and across provinces. Currently, school districts have considerable power in determining the role, training, and function of counsellors in their schools. To meet the needs of counsellors who have lost clients to suicide, school districts can ensure the following provisions are put in place: “(a) a supportive and nonblaming staff atmosphere that ensures that a range of feelings can be expressed and understood, (b) availability of a neutral consultant or consultation group, and (c) training to supplement prior training and experience with suicidal individuals” (Berman et al., 2006, p. 360). If these structures are proactively engaged, counsellors will have easier access to information, resources, support, and training.

As counsellors have assumed a mental health role in schools, supervision and collegial support need to be integral components of every comprehensive school counselling program (McMahon & Patton, 2001). For some professionals in school settings, peer support is more difficult to access because clinicians often practice independently (McMahon & Patton; Valente, 2003; Worden, 2002). Professional connections between counsellors, then, need to be fostered at the district level so that school counsellors, even in rural areas, have the opportunity to access peers and services for professional consultation and support.

School counsellors work in contexts that put them at increased risk for fatigue; therefore, protective measures need to be in place to assist them when facing personal and professional crises that result from their professional roles and responsibilities. Not all school counsellors are professionally trained. Counsellor training and continued professional development thus need to be high priorities for school districts, as additional experience and training seem to equate with more confident, as well as mentally and physically healthy, counsellors.

As the experiences of school counsellors who have lost clients to suicide had not been addressed in the literature, the purpose of this study was to give voice to those who had experienced the trauma of this event. The perspectives of these participants do not represent the experiences of client suicide for all school counsellors, but they do offer an opening for discussion, thought, introspection, and reflection. Certainly, further research in the area of school counsellors' experiences of client suicide is needed. Continued study of this relatively unexplored phenomenon will allow for a better understanding of both the personal and professional impact on professional school counsellors when a client commits suicide. Additional research will also provide a foundation upon which issues related to training and practice standards can be better explored.

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