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Giving up on giving up : stories of people who were previously suicidal : a project based upon an independent investigation

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Giving Up on Giving Up: Stories of People Who were Previously Suicidal

Abstract

This qualitative study explores the role of hope and spirituality in those lives of people who were previously suicidal. Eight formerly suicidal women were asked a series of questions regarding their suicidal ideation, their suicidal belief system, suicidal behavior, and their thoughts on the role of hope and spirituality in their lives. Participants' answers revealed the strength these women have.

Major findings suggest that hope and spirituality play a huge role in helping people through desperate times. Almost all but one of the participants said that hope gave them the inspiration to carry on. The one person who said she did not believe in hope said it was because it meant not living in the moment; she needed to be future oriented. All participants said they rely on some form of spirituality. They all reported that spirituality is what gives them strength to go on and keeps them from wanting to try and end their lives again.

The findings did support the previous literature. There are implications for social work practice such as informing clinicians on what works with working with suicidal clients. Additionally, a strong rapport between the clinician and the client was instrumental in the eyes of the client.

GIVING UP ON GIVING UP: STORIES OF PEOPLE WHO WERE PREVIOUSLY SUICIDAL

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

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CHAPTER I

INTRODUCTION

The project is an exploratory study about people who have had histories of suicidality and no longer experience suicidal ideation. I am particularly interested in how the concepts of 'hope' and 'spirituality' have impacted the shift from the presence of suicidal ideation to experiencing none. The research question at hand is: How have 'hope' and 'spirituality' impacted a person who has a history of suicidal ideation to reject the notion of suicide as an option?

Approximately 900,000 people die every year by suicide, according to the Encyclopedia of Social Work (2009). This number of deaths by suicide is alarming. This is a massive population of people who have been in so much emotional pain that they ultimately came to the belief that suicide was their only way out. Recent statistics show that between 18 and 36 suicide attempts occur for every completed suicide. Many mental health professionals do not even know how many people have suicidal urges and do not act on these thoughts (Encyclopedia of Social Work, 2009)

Not everyone who is depressed becomes suicidal. There are many reasons, or even a combination of reasons as to why a person might become depressed. Some of these reasons include traumatic life experiences such as the death of a loved one, certain diseases or medicines, substance abuse, hormonal changes, or family history of depression. Sometimes the cause of depression is unknown. More often it is a

combination of genetic, psychological, and environmental factors that bring on a depressive episode (Retrieved on October 16, 2009, from (http://www.nimh.nih.gov/health/publications/depression/complete-index.shtml#pub1).

Whatever the circumstances, depression may also be caused by an imbalance of neurotransmitters in the brain. Normally, these “chemical messengers” help nerve cells communicate with one another by sending and receiving messages. Neurotransmitters may also influence a person's mood. In the case of depression, the availability of the chemical messengers is low, so nerve cells can't communicate effectively (Retrieved October 16, 2009, from http://www.nimh.nih.gov.)

Depression is considered to be the most common mental illness. According to Casey, Dunn, Kelly, Lehtinen, Dalgard, Dowrick, Ayuso-Mateos (2008), depression is a prevalent disorder, affecting 12% annually, which is approximately 20 million people. Depression is under treated and under diagnosed. Only 20% with recent episodes have been treated and 40% with lifetime symptoms have received treatment (Casey et al.) (2008). Since World War II, there has been a decreased age of onset. This change in age of onset is because of the change in times and views on suicide. This change has been from later teens to earlier in teen years. The ratio for depression is one male to every two females (Casey et al.) (2008). Sometimes people who have a depressive episode end up becoming suicidal.

Yet, there is hope for the suicidal client. There are various treatment techniques including therapy and medication. Additionally, according to recent literature, hope and spirituality play a critical role resulting in a positive outcome from suicidal thinking and behaviors. Goldney (1998) writes that hope plays a huge role in being an instrument in

keeping one alive. This hope can carry a person through tough times even when things seem grim. Kramer (2002) notes that sometimes people who have been suicidal lack a full commitment to meaningful and sustainable life goals that bring satisfaction and provide ongoing hope for the future.

Another form of a client's strength is their access to spiritual faith. Spiritual faith helps foster and sustain a commitment to life. There is a positive relationship between spirituality and mental health. According to Kramer (2002), spiritual beliefs can serve as a buffer against depression and, by association, suicide. Additionally, some people may use religion or spirituality as a source of comfort.

More information gathered from first hand reports from formerly suicidal people who have been helped by hope and spirituality may help other people who are still struggling with effective coping strategies and overcoming feelings of hopelessness. Learning about the role of hope and spirituality may help mental health professionals to build their knowledge as to what is effective in working with suicidal clients. The overarching purpose of this study is to gather first hand information about the role of hope and spirituality in the lives of people who have left a state of hopelessness and have continued rejecting suicide as an option. The sample for this exploratory study aimed to recruit 12-15 individuals who have had no suicidal ideation for at least one year.

CHAPTER II

LITERATURE REVIEW

Introduction

The central question for this study is: How have ‘hope’ and ‘spirituality’ impacted a person who has a history of suicidal ideation to reject the notion of suicide as an option? In order to situate this study in existing literature, current studies will be reviewed that deal with the reasons people commit suicide. The previous literature on topics such as depression epidemiology, depression causes, depression symptoms, and treatments for depression will be reviewed. I will then move on to discuss suicidality epidemiology, symptoms of suicidality, the role of hope, and spirituality.

Depression Epidemiology

According to the National Institute of Mental Health (2009), one of the most predictive conditions for suicide is untreated depression; and depression is the most common mental illness. Depression's impact is pervasive, affecting social, biological, and individual functioning.

The first modern American general population epidemiological surveys that included information about depression were carried out in the late 1950s with the Midtown Manhattan study and the Stirling County study (Rennie, 1962 & Leighton, 1963). These studies reached across America. These early surveys were dimensional screening scales of nonspecific psychological distress and were used to pinpoint

respondents with likely mental disorders.

These researchers, Rennie and Leighton, focused on getting a global measure of depression rather than individual diagnoses. The screening in these tests assessed depressed mood. From these data it was possible to make rough estimates about the prevalence and correlates of depressive disorders because the screening scales assessed depressed mood and other symptoms.

Kessler & Wang (2009) noted that, "In later surveys, variants on the screening scales used in the Midtown Manhattan and Stirling County studies were generally used without clinical follow-up. Scale scores were sometimes dichotomized to define cases of mental disorder based on external standard of a clinically relevant cut point." (p. 5). These scores allowed researchers to structure diagnostic interviews for use in community surveys in the 1970's.

Today there are many diagnostic tools that assess depression. For example, Kesller & Wang (2009) mentioned the Primary Care Evaluation of Mental Disorders (PRIME-MD). Community surveys that diagnose depression in people using symptom-screening scales find up to 20% of adults report depressive symptoms during recall periods between 1 week and 6 months. Point prevalence estimates for Diagnostic Statistical Manual (DSM) Major Depression in surveys that use structured diagnostic interviews are considerably lower (Kessler & Wang, 2009).

Kessler & Wang (2009) also noted that, "The discrepancy between the high prevalence of symptoms in screening scales and the comparatively low prevalence of depressive disorders means that many people have subsyndromal depressive symptoms" (p.6). These results suggest that depression is under treated and under diagnosed.

Many community surveys report a 12-month prevalence of depression. Lifetime estimates of major depression in the US surveys have ranged widely from as low as 6% to as high as 25% (Kessler & Wang, 2009). This figure suggests that more than 30 million adults in the U.S. have met the criteria for a diagnosis of Major Depressive Disorder (MDD) at some point in their life. More women than men will experience depression at some point of their lives. However, there has been an increase in rates of depression over the past two decades. According to Kessler & Wang (2009), the rates are very high and they note that the World Health Organization (WHO) ranked depression as the most burdensome disease in the world in terms of total disability-adjusted life years.

Depression has been found to be associated with poor physical health, high rates of cardiac problems, and higher rates of smoking. There is also a high economic cost of depression. Depression has been and is still a prevalent disorder in the United States.

According to Barnhofer & Crane (2009), the high rates of depression as a disability are projected to increase by the year 2020. One concerning factor is that most individuals who suffer from one episode of depression end up experiencing it again. According to Barnhofer & Crane (2009), it is assumed that after a person's first episode they will have a 50% chance of a depressive episode to occur again. And after having a second episode, the probability of a depressive episode occurring again is even higher. Researchers speculate that there are many factors affecting why a person becomes depressed.

Depression Causes

There are many reasons, or even a combination of reasons, why a person might become depressed. According to the National Alliance of Mental Illness (NAMI), these include traumatic life experiences such as the death of a loved one, certain diseases or medicines, substance abuse, hormonal changes, or a family history of depression. Sometimes the cause of depression is unknown. According to NAMI, more often it is a combination of genetic, psychological, and environmental factors that bring on a depressive episode.

Although there is no consensus as to the causes of depression, it is well known that socio-economic and cultural changes can affect mental health (Fu & Parahoo, 2008). In one study performed by Fu & Parahoo (2008), they found that their participants perceived the causes of their depression as being mainly social and cultural in origin. The main identified causes were stress in marital relationships, conflict in extended families, changes in life circumstances, and early life experiences.

Fu & Parahoo (2008) conducted a quantitative study of people over 65 years and found a positive correlation between depression and physical illness, life events and socio-demographic factors. In another quantitative study by Fu & Parahoo, the following predictors for depression were identified in older people: having a respiratory disease, poor cognitive function, poor social support network, dissatisfaction with living situation, perception of poor health status, and perceived income inadequacy.

Many theorists have tried different approaches to try to understand the origins of depression. For instance, some of these theories focus on personal characteristics; others look at genetics and biological functioning, and on social environment.

Researchers have speculated for years, that environmental factors play an important role in depression. Fu & Parahoo (2008) wrote, "Depressed individuals, clinicians, and theorists commonly assume that depression is ultimately intertwined with the stressors and strains of people's social worlds" (p. 340).

Researchers are also looking at the role of genetics in depression and they are applying methodologies to search for the sequence of gene variations that increases ones risk of developing disorders or traits. Fu & Parahoo (2008) write, "On a clinical level, the conceptualization of phenotypes for genetic studies rest on four lines of research. The most important of these is the family and twin studies that established modern psychiatric diagnostic criteria based on specific signs symptoms, and longitudinal course" (p. 165). These categories were relevant because of the results of elevated risks in relatives and twins.

Fu & Parahoo (2008) wrote about twin studies that suggest that gene susceptibility accounts for 40-50% of major depression disorder in the population at large, although "heritability might be higher in clinically identified probands" (p. 165). Adoption studies also support genetic factors: "Studies of Major Depression Disorder (MDD) in families have been inconclusive about how it is inherited, but multiple genes likely interact to increase an individual's susceptibility" (p. 168).

According to Fu & Parahoo (2008), genetic studies that can detect risk-altering locus depend in part on how much the locus increases the risk of disease in the population. This is commonly measured as relative risk (RR), the risk of disease in the first-degree relatives of ill probands divided by the risk in the general population. Three characteristics of MDD probands have generally been shown to predict a larger increase

in risk to their relatives: recurrent episodes, earlier age at onset; and severity, as indexed by the number of MDD criteria endorsed by each subject (Fu & Parahoo, 2008).

According to Fu & Parahoo (2008), "The single most studied variant is 5-HTTLPR, a 44 base pair insertion-deletion polymorphism in SLC6A4. Almost all studies have analyzed counts or genotypes for the two alleles defined by the presence or absence of the insertion sequence." (p. 169). Fu & Parahoo (2008) write that, "

> S Alleles produce fewer transporter molecules that bind less serotonin, and this should decrease reuptake capacity. Many antidepressants block the same reuptake site, and these drugs have adverse effects on mood, anxiety, cognition, and behavior. Thus, it is reasonable to predict that this DNA variant will have significant effects on mood and behavior. (p. 169).

Heterogeneous conditions that are grouped together under the construct of clinical depression are biopsychosocial disorders and usually have multifactorial causality. There are, more often than not, many reasons why a biopsychosocial disorder occurs. Fu & Parahoo (2008) write,

> Two basic tenets are: (1) Clinical forms of depression comprise a related yet heterogeneous group of syndromes associated with disturbances of the brain systems that regulate the normal processes of mood, cognition, and appetitive behavior; and (2) Most—if not all—forms of depression involve dysfunctional adaptations of the brain systems that regulate adaptations to stress. (p. 188).

Fu & Parahoo (2008) added that, "Responses to stress, aging, and neurobiological sequelae of recurrent depression are almost inextricably interwoven, and many individuals experience a shift in predominant symptoms and response to treatment over

time" (p. 207). Usually during youth and young adult life, a significant stressor will trigger the onset of the first depressive episode. This relation is stronger with those individuals with a strong genetic disposition. Fu & Parahoo (2008) state, "This association isn't as true for later life individuals with a history of recurring depressive episodes; however, in concert with the increasing prevalence of state-dependent neurobiological abnormalities" (p. 207). Furthermore, later life diseases of the brain heighten vulnerability to depression.

A developmental psychopathology perspective begins with consideration of developmental processes. It is important to know the time that an adverse experience did occur. Timing is important for two reasons. According to Fu & Parahoo (2008), "First, it [timing] is informative in terms of children's stage-salient needs at the time of exposure, which might be disrupted as a result of adverse experiences. Second, consideration of timing allows one to take into account the potential advantage of developmental accomplishments that children might have achieved prior to any disruption associated with adverse experiences" (p. 249).

According to Fu & Parahoo (2008), early experiences may link with the emergence of depression and other outcomes, including healthy outcomes, by following different pathways. Even if depression is the ultimate outcome, the particular pathways may relate to the relative degree of involvement of cognitive, socioemotional, representational, or biological domains in the depression that emerges.

According to NAMI, whatever the life circumstances a depressed person faces, depression is caused by an imbalance of neurotransmitters in the brain. Normally, these "chemical messengers" help nerve cells communicate with one another by sending and

receiving messages. They may also influence a person's mood. In the case of depression, the availability of the chemical messengers is low, so nerve cells can't communicate effectively. Sometimes when a person becomes depressed they exhibit an array of symptoms including becoming suicidal.

Depression Symptoms

According to the Diagnostic and Statistical Manual (DSM - IV-TR), a person suffering from a major depressive episode often describes his or her mood as depressed, sad, hopeless, discouraged, or “down in the dumps.” Additionally, the DSM (2000) describes common symptoms of depression as sadness or "empty" feelings. A person may feel helpless and worthless. Other symptoms include “irritability, restlessness, and decreased energy” (p. 356). Furthermore, there may be loss of interest or pleasure (DSM-IV-TR, p. 349). According to Fu & Parahoo (2008), “An episode is defined as having a certain number of symptoms for certain duration. Although the exact values for these variables may defer depending on the study, researchers have generally followed the standards of the DSM” (p. 23)Even when a person’s depression goes into remission, he or she may have some continuing symptoms. Depression is not necessarily present at all times. Fu & Parahoo (2008) clarify,

> A remission, conceptually, is the point at which an episode ends. It is defined by a period of time in which an individual no longer meets criteria for the disorder. Such a remission can be partial or full. In partial remission, an individual still has more than minimal symptoms. Full remission is defined as the point at which an individual no longer meets criteria for the disorder and has no more minimal symptoms. (p. 23).

According to Barnhofer and Crane (2009), “For individuals with depression, negative thinking pervades views of the personal past, the current self and the personal future while lack of interest and anhedonia reduce engagement in activities that used to be experienced as enjoyable” (p. 221). Barnhofer and Crane added that, “These psychological symptoms are accompanied by disregulations in a number of physical systems, with symptoms such as fatigue and difficulties concentrating undermining the ability to deal actively with the challenges of everyday life” (p. 221). The authors also noted that usually people experience their depression as painfully discrepant from their typical day's functioning and in response people attempt to cope in ways that often cause them to remain passive and have a tendency to engage in either avoidance or repetitive and analytical, ruminative thinking, which further increase the likelihood of deteriorations in mood" (p.221). In a significant number of cases the hoplessness associated with this condition escalates into suicidal ideation and behavior. Antypa, Van der Does, & Penninx (2010) note,

> Suicidal ideation is the most stable symptom of depression across episodes. This relative stability may be brought about by increased cognitive reactivity to sad mood during periods of remission. The idea is that a network of depressive cognitions, which include siuicidal ideation, becomes strengthened with each episode of depression. Consequently, the whole network may be more easily reactiviated, for instance by an episode of low mood. And this is a problem given the prevalence of suicides and number of attempted suicides. (p.46)

Suicidality Epidemiology

When a client reports that he or she is feeling unsafe with his or her own thoughts, this can be worrisome for the therapist. Sometimes a therapist will react on a continuum, doing nothing to urging hospitalization. Murray (1972) writes that it is hard to assess the risk for suicidal clients because professionals could not possibly know how many people have attempted or thought about suicide. According to the DSM, "Up to 15% of individuals with severe Major Depressive Disorder die by suicide" (p. 371).

According to the Encyclopedia of Social Work (2009), "Worldwide, approximately 900,000 people die by suicide every year. The average suicide rate internally [the U.S.] is 15 per 100,000 and rates are three times higher in several eastern European countries. Suicide ranks the 11th cause of death in the United States and the third leading cause among adolescents."(p.1) There have been efforts to reduce the number of suicides by identifying risk factors, prevention, and intervention programs. Society has struggled over time to understand why suicide occurs. That is why it is important to study reasons why one may consider suicide and take into account the means available to suicidal people. Suicide is self-inflicted intentional death. More people try to commit suicide with intent on dying but fail. Thus there are larger numbers of individuals who attempt to commit suicide but do not succeed.

Suicide rates are thought to be underreported. Sometimes it is difficult to determine if a person actually intended to die. Thus, actual numbers are hard to determine. One reason it may be difficult to determine is that only a few people actually leave a note. No one really knows why a person ultimately decides to kill him or herself. Usually there are symptoms of suicidal ideation before a person attempts suicide.

Suicide Symptoms

There are many reasons why a person may consider suicide as an option, including many risks. Some potential risk factors are as follows:

- New and unfamiliar environment
- Difficulties adjusting to new demands and different work loads
- Lack of adequate social and coping skills
- Academic and social pressures
- Feelings of failure or decreased performance
- Sense of alienation and lack of social support
- Family history of mental illness (Retrieved on August 15 2009, http://en.wikipedia.org/wiki/Major_depressive_disorder (Depression, 2010, p. 1).

Sometimes there are co-morbid disorders that exist in addition to depression. For instance, a study by Panagioti & Gooding & Tarrier (2009) examined the relationship between posttraumatic stress disorder and suicide. There had not been much focus about this relationship in recent literature. Panagioti, et al. concluded, "Overall, there was a clear relationship between PTSD and suicidal thoughts and behaviors irrespective of the type of trauma experienced" (p. 471).

Suicidal behaviors can take on many forms. There is suicidal ideation which is may be as detailed as a formulated plan, without the suicidal act itself. Although most people who experience suicidal ideation do not commit suicide; and some go on to make completed suicide attempts. The following are reasons why a person may consider suicide - some warning signs:

- Someone looking for ways to kill him/herself by seeking access to firearms, available pills, or other means
- Someone talking or writing about death, dying or suicide, when these actions are out of the ordinary for the person

- Hopelessness
- Rage, uncontrolled anger, seeking revenge
- Acting reckless or engaging in risky activities, seemingly without thinking
- Feeling trapped – like there's no way out
- Increased alcohol or drug use
- Withdrawing from friends, family and society
- Anxiety, agitation, unable to sleep or sleeping all the time
- Dramatic mood changes
- Expressing no reason for living; no sense of purpose in life (Retrieved on August 15 2009, http://en.wikipedia.org/wiki/Major_depressive_disorder (Depression, 2010, p. 1).

Rudd (2006) wrote a book that described the assessment and management of suicidality. He first discusses how the language and terminology used can be a method of intervention in and of itself. Styron (2007) writes of his own despair struggling with depression and that it took him to the brink of suicide. Styron gives a powerful description of the insanity that is behind the thinking of someone who has been engulfed with depression. Furthermore, he offers an account of what it is like to recover from the depths of madness.

Bernhardt (2002) describes his own experience with depression and suicidal thoughts. He could note understand why and what was happening to him as he sunk into a terrible depression and had suicidal urges. Most people who are suicidal are depressed too.

Treatment for Suicidal Clients

There are many effective strategies for the treatment of suicidal people. First of all, it is important that people are given the opportunity to say that they are struggling in the most comfortable setting available. Rudd (2006) suggests setting up a safe atmosphere so that a client can disclose if he or she is having suicidal thoughts. Rudd's book can be used as a tool to educate helping professionals when assessing risk for potential suicide.

Another important idea is increasing protective factors such as involving the family in strategic planning, developing goals such as problem-solving skills, and adaptive communication skills. Fiske (2008) quotes Barber: "The best form of suicide prevention may be as simple as putting time or distance between the impulse to die and the weapon at hand" (p. 103). Additionally, other suggestions in working with suicidal clients include providing the basic needs for a person, such as safety, food, warmth/cooling, water, sleep, or medical attention.

According to Rutter, Freedenthal, & Osman (2008), in a review of 41 suicide instruments, 95% of the assessed were strictly negative, pathological-related, or deficit-related factors such as substance abuse, hopelessness, or depression. However, looking only at pathology and other suicide risk factors it does not take into account strengths and resilience that helps keep people alive.

Suicide assessment should include an assessment of protective factors, which according to Rutter et al., (2008) are factors that dissuade a person from considering suicide as an option: "Protective factors are those variables that allow a person to defend against suicidal behaviors" (p. 114) such as hope and spirituality. There are internal and external protective factors. An example of an internal protective factor is hope and an external protective factor could be a strong support network.

Cognitive therapy has been one form of treatment modality that has been viewed as effective. Kuyken (2009) writes, "Hopelessness has a central role in cognitive theories of depression, and consistently predicts suicide attempts and suicide completion" (p. 305). If hopelessness is addressed, it decreases chances of a person trying to commit suicide.

Mindfulness-based therapy may reduce thought suppression in previously suicidal people. A study performed by Hepburn, Crane, Barnhofer, Duggan, Fenell, & Williams (2009) found mindfulness-based cognitive therapy significantly reduced self-reported attempts to suppress. Hepburn, et al. write, "Mindfulness has been described as paying attention in a particular way: on purpose, in the present moment and nonjudgmentally"(p. 224). The core of mindfulness is to teach people to recognize and disengage from mind states characterized by self-perpetuating patterns of ruminative, negative thought. Fiske (2009) states that, "The main aim of MBCT is to teach patients to take a different perspective on thinking and awareness itself. By consistently practicing bringing awareness to the present moment experience, participants shift into a mode of functioning that is incompatible with the self-focused and analytical cognitive processes that perpetuate depressive states" (p. 224). This mode goes from a doing mode to a state of being.

Dialectical Behavior Therapy (DBT) is a type of therapy that has been proven useful in working with suicidal clients. According to Kerr, Muehlenkamp, & Larsen (2009), DBT was developed to work with people with Borderline Personality Disorder (BPD). Individuals with BPD are known to have high rates of suicide attempts. DBT targets areas of disregulation and gives a person hope.

Hope

Hope is a powerful tool in preventing suicide. Even just the slightest glimmer of hope is helpful in working with someone who is suicidal. All a person needs is a little bit of hope to hold on to, to get through tough times. Without hope a suicidal person has

little to no reason to continue living.

According to Kuyken (2004), hopelessness has a central role in cognitive theories of depression, and is one consistent predictor of suicide attempts and suicide completion. Furthermore, there is direct evidence that hopelessness predicts cognitive therapy outcome, in terms of early termination of therapy. This is partly because theories of therapy change suggest that "remoralization" is a critical first phase of change. Kuyken (2004) found that patients whose level of hope is responsive to early interventions make more rapid and pronounced improvements during "real world" cognitive therapy.

Another way to instill hope in the suicidal client is to contact the local suicide prevention center. Even though such contact may be anonymous, this interaction can provide hope for that individual. At suicide prevention centers, a person can connect with other individuals who have been through similar experiences.

Kramer (2002) wondered,, "Are the occasional thoughts of suicide useful defenses against the trials of living or do they represent the first steps toward succumbing to a tide of thoughts and feelings whose ultimate end is self-annihilation?" (p.241) According to Kramer (2002),

> Suicide victims frequently perceive gaps in the degree to which important aspects of their experience have been recognized by others, become alienated from these experiences themselves, feel that their truth is not authenticated by others, believe that the structure of their lives does not allow for workable solutions, and lack full commitment to meaningful and sustainable life goals, that bring satisfaction and provide ongoing hope for the future. (p. 241).

Kramer (2002) notes that, "Suicide is a complex human problem that defies any

singular explanation. Yet, in-depth analyses of particular cases of suicide reveal common psychological processes that propel the individual toward the final, devastating decision." (p. 241). One of the things a person is lacking is the hope that things will get better. A sign that there still may be hope is when a person with suicidal ideation is talking with their therapist. There remains some possibility that some problem solving options may be considered.

Smith (2009) writes that "Solution-focused questions function as a 'tap on the shoulder' in therapeutic conversations **a**bout suicide. They draw suffering people's attention to more positive or constructive aspects of their lives and experiences. Often these aspects have been ignored— 'untapped'—in preoccupation with the sources and details of pin and perturbation" (p.21). Many people get hope through their spirituality.

Spirituality

Some people attribute acceptance of major life events to spirituality. Spirituality has been **a**round for centuries. "Spirituality can refer to an ultimate reality or transcendent dimension of the world; an inner path enabling a person to discover the essence of his or her being" (http://en.wikipedia.org/wiki/Spirituality, 2010, p#1)or the "deepest values and meanings by which people live. Spiritual practices, including meditation, prayer and contemplation, are intended to develop an individual's inner life; such practices often lead to an experience of connectedness with a larger reality: a more comprehensive self; other individuals or the human community; nature or the cosmos; and/or the divine realm." (http://en.wikipedia.org/wiki/Spirituality, 2010, p#1)). Spirituality is often experienced as a source of inspiration or orientation in life. It can

encompass belief in immaterial realities and/or experiences of the immanent or transcendent nature of the world. Spirituality can mean different things for different people.

Taliaferro & Rienzo, Pigg, Miller, & Dodd (2009) explored spiritual well-being **a**nd whether it is related to reduced suicidal ideation. Findings from this study suggested that existential well-being was **a**n important factor associated with lower levels of suicidal ideation **a**mong college students. According to Maselko, Gilman, & Buka (2009),

> A growing body of empirical evidence suggests that, overall, religiosity and spirituality are correlated with better psychological health. Persons who attend religious services report fewer depressive symptoms and, among those who are depressed, experience shorter time to remission of symptoms. Religiosity and Spirituality may be protective factors for mental health through several pathways, both social and psychological. For example, social isolation is a major risk factor for depression and belonging to a religious community is often an important source of social integration. Religious teachings and beliefs provide a coherent framework within which to interpret life's events and this may lead to a higher sense of meaning, coherence, and sense that life has a larger purpose. (p. 1009).

The inability to make meaning out of life's experiences is a risk factor for psychological health problems and spirituality may protect against this risk. Preliminary evidence suggests that existential well-being may be more important for mental health although the evidence is not consistent according to Maselko, Gilman, & Buka (2009).

Maddi, Brow, Khoshaba, & Vaitkus (2006) state that, “Spirituality leads a person to think in terms of a higher order of functioning that emphasizes honesty, justice, courage, altruism, and other values, thus facilitating transcendence of experiential specifics through efforts to improve functioning and search for positive meaning in life” (p. 148). Therefore, if an individual is searching for positive meaning then it leaves little or no room to ruminate about ending ones own life.

Simonson (2007), writes that “Individuals who think about suicide but do not feel suicidally hopeless tend to be less religious and can therefore entertain thoughts of suicide unabated by religiousness” (p. 951). Sometimes people with strong religious backgrounds feel its wrong to entertain thoughts of suicide and this serves as a protective factor. According to Yoon & Lee (2007),

> Especially significant has been an increase in empirical research linking religiosity/spirituality to physical health, emotional and psychological well-being, and quality of life among older adults. Despite methodological limitations and heterogenity in religious measure, findings of previous empirical studies point consistentently, though not unanimously, to a positive effect of religion on health and psychological well-being among elderly individuals (p. 282).

Yoon & Lee have documented a strong positive reltionship between religious involvement and coping behaviors in response to negative life events. An inverse relationship between levels of depression and the levels of social support has been shown in a number of studies.

Yoon & Lee (2007) reported that, “Religious involvement and spiritual committment have been positively associated with an array of subjective well-being

indicators such as greater lifesatisfaction, decreased depressive symptoms, optimism, less anxiety, and better emotional adjustment among older adults" (p. 284). Becoming part of something helps a person feel connected and busier.Yoon & Lee (2007) added that,

> Religious involvement may have a positive effect on health perceptions and act as a buffer against the negative impact of phsyical and emotional problems. Recent research on the relationship between religious faith and depression has generally found that religiosity is associated with lower levels of depression. As a coping mechanism, relgious faith and religious/spiritual practices function to ease the grieving or bereavement process for many individulas who may be at risk for depression due to experiencing exceptional circumstances. Among the elderly, relgious and spiritual involvement among people experiencing stressful events is significantly associated with lower levels of anxiety (p. 284).

And lower levels of anxiety decreases the chances for suicidal ideation.

According to Yoon & Lee (2007), "Indeed, spirituality is typically shaped by a community of individuals who share similar values and experiences and religion has therefore been considered a mechanism of social integration" (p. 284). Yoon & Lee (2007) add about religious individuals "Their faith appeared to operate as a stress buffer, distress deterrent, or stress suppresssor" (p. 294). They were able to rely on their faith which helped ease their stress.

Thus, it is clear that depression is a significant problem and suicide attempts are symptoms. Yet studies of those who are suicidal but who do not commit suicide show that there are ways to treat including spirituality and hope.

Summary

Depression and suicidality are serious matters. As noted before, depression and suicide are not synonymous; but occasionally someone who is depressed may have thoughts of wanting to commit suicide. There can never be a sure way of keeping someone from committing suicide but there are protective factors and treatment modalities that have been proven beneficial for someone who is suffering from depression and or suicidal thoughts. I plan on further investigating this phenomenon. The following chapter entitled Methodology will explain my plan in detail.

CHAPTER III

METHODOLOGY

The central question of this study is: How have 'hope' and 'spirituality' impacted a person who has a history of suicidal ideation to reject the notion of suicide as an option? The study is qualitative in design, which allows one to understand a subjective experience because narrative data is gathered via interviews and observations. The experiences of people who no longer have suicidal ideation comprise the sample for this study. The study method is inductive using semi-structured open-ended interviews. The design is exploratory because it is designed to explore a little researched topic. This study will be looking at common themes that emerge from participants' stories about being previously suicidal, yet are now able to successfully stay away from the option of suicide when their lives become difficult.

Sample

Inclusion criteria for participation in this study were that sample recruits needed to be between 21 and 64 years old. Adults who had a prior history of suicidal ideation present as less vulnerable than children or elders and may have been better able to give a retrospective narrative. Individuals of any ethnicity, gender, relationship status, and socioeconomic status qualified for participation. People who have experienced hope as having had an impact on their suicidal behavior were asked to participate as well as those people who had been positively impacted by a spiritual experience. Participants needed to

be able to speak English. Participants had to have been suicidal at some point in the past, but not in the past year. I included clients who might have become depressed in that one-year period but did not turn to old thought patterns of considering suicide. Clients must have had a therapist. Participation was not limited to one particular geographical area.

Exclusion criteria included people who are under the age of 21 and those over the age 64. Additionally, anyone who had not been previously suicidal was excluded. Another reason for exclusion was someone who has entertained suicidal ideation in the past year. Furthermore, those who did not speak English were excluded. If someone was severely depressed they were excluded from the study. I screened people by asking them if they are depressed. If they admitted they are depressed, I asked more questions to gauge their level of depression.

The target sample for this study was between 5-6 participants. However, a total of 8 participants who met the selection criteria were interviewed.

Ethics and Safeguards

The information gathered during this study will remain confidential. All data is stored in a locked cabinet during this project. I am the only one able to access this information. There were no identifying names on the tapes. The tapes were kept secure for a minimum of three years as required by federal law. I will continue to keep data secure beyond that for as long as needed. When the data are no longer needed, they will be destroyed. The results of the study were disseminated in the form of a thesis and may be published in a professional journal or presented in professional meetings. The information that emerged from the findings may be of value to social workers and other mental health professionals to better understand how to provide quality services for

people with suicidal ideation.

Risks for participation were that a person might have experienced uncomfortable feelings when recalling difficult experiences from the past. Any question that an interviewee found to be especially uncomfortable was omitted or, if they wished, the interview was terminated. In the cases where this occurred, participants were advised to contact their therapist. A list of mental health resources was given to each interviewee. Benefits to the participant included the opportunity to discuss feelings, perceptions, and thoughts related to their past suicidal ideation. .

Data Collection

The recruitment process began with calls to various agencies or clubhouses and asking to speak with the director. An explanation of the study was given and then permission to hang a flier was obtained. I then got a written statement from the agency stating that they give me permission to hang the flier in their clubhouse or agency. This document was submitted along with other recruitment materials to the Smith College School for Social Work (SCSSW) Human Subjects Review Committee. Formal data collection began upon receipt of an approval letter from the SCSSW Human Subjects Review Committee.

Interview Guide

I developed questions that varied from asking them if they have been suicidal to question regarding their relationship with hope and spirituality. For example, I asked about if they have tried to commit suicide before, if so, what method did they use. Another question was what role did hope play and what role did spirituality play in

decreasing thoughts of suicide.

Data Analysis

Once all eight interviews were conducted, the data was manually transcribed from audiotape by the interviewer. To insure confidentiality names were left out on the transcription and each interview was assigned a code number.

I reread each transcript to look for similar themes. I organized the data by color, coding similar themes. I went throughout the material and sought out material that was similar and grouped them together. All answers were grouped together under themes such as depression, suicidal ideation, suicidal belief system, hope, and spirituality. Therefore, I went through each category and wrote in all their answers so they would be together.

Discussion

I expected to find that hope and spirituality both play a role in rejecting the notion of suicide. I was surprised to find that one participant did not believe in hope as an influence. One limitation was that I only had a small sample and their answers were subjective. This study may have implications for theory and/or practice. For instance, all of the participants talked about their connection to their therapist and how important that was to them.

CHAPTER IV

FINDINGS

This study set out to gather data about the role of hope and spirituality in previously suicidal people. In face-to-face interviews, eight people who were previously suicidal were asked questions regarding their history of suicidal ideation and the role that hope and spirituality played in their lives. The interview guide consisted of eight questions.

The findings are divided into six sections. Section one presents the demographic characteristics of the participants. Section two contains what was discussed about suicidal ideation. Section three illustrates the participants' suicidal belief system. Section four describes the participants' suicidal behavior. Sections five and six contain the participants' responses about role of hope and spirituality respectively.

The results suggest that hope and spirituality have a positive influence on deterring one from seriously considering suicide as an option. All participants talked about hope having an impact on their lives and said that without hope they would be suicidal today. All subjects talked about having a relationship with some form of higher power or God. Some were closer and more connected to that source than others.

Demographic Characteristics

The sample consisted of eight women. Respondents' ages ranged from 27 to 58 at the time of the interview. The participants were in the three age categories selected 27-37 (N=3); 38-48 (N=4); and 49-59 (N=1).

The majority of the interviewees self identified as White or Caucasian. All eight women said they were White with the exception of one who said she considers herself White but she is of mixed races.

Six out of eight participants are employed. One woman is a full time student and the other is considered disabled but volunteers her time at a soup kitchen and a library. Another one of the participants said she was on disability but works part time. Two of the women work in the human services field while another woman is a psychotherapist. Another woman is a nurse and the last woman is a delivery person.

All eight interviewees said that they had been diagnosed with at least one mental illness. Six reported they have been diagnosed with depression while the other two said they were diagnosed with bipolar disorder. Two were diagnosed with anxiety. Three were diagnosed with PTSD (post traumatic stress disorder). Two were diagnosed with binge eating. One had a diagnosis of OCD (obsessive compulsive disorder). One person had a diagnosis of trichotillomania (pulling ones hair) and dermatillomania (picking at one's skin) and BPD (borderline personality disorder). There was also one person diagnosed with dissociative disorder.

Suicidal Ideation

In the second section of the interview guide, the participants were asked, “Can you describe when you first began to have thoughts of suicide?” Six out of eight participants said they started having suicidal ideation when they were in their early teens. One participant was only 9 years old when she started having thoughts of wanting to end her life. Another participant was in her late teens and the other participant was in her thirties.

One interviewee answered the question by saying "I always felt that I was burdensome to my parents. I thought I was defective. Those beliefs were paralyzing to me. I wanted not to feel that pain anymore and suicide seemed to be the answer for me." Most participants talked about not wanting to feel the pain anymore. Another person recalled that her first thoughts of suicidal ideation were triggered by a break up. This woman recalled:

> My first thoughts were, maybe around 14 and I remember it was over a breakup of a relationship I was in with somebody for a couple of years. Then after the breakup I think it really hit me when I found out that he is with somebody else and I like even though I think I initially broke up with him even though once I knew he had somebody else like I just couldn’t live with the thoughts of him being with somebody else.

The next question asked was, “What was it like for you to have thoughts of suicide?” This question provoked all sorts of responses. For instance, one woman said "So, it might have been a little bit comforting to think that it is really hard right now but someday I might be able to do that (commit suicide) because I think I was always kind of

afraid to do it." Knowing that there could be a way out was reassuring to her even though she was scared of actually committing the act.

The majority of these women were in 12-step recovery programs and they all had therapists. Therefore, it appears that many have done a lot of personal work. One woman said,

> I think it is really disconcerting and it really frustrates me because like, umm, you know I feel like I try so hard to do all this work I would always go back to having that ideation. So, it was always like upsetting and frustrating at times. It was frustrating because I felt like dying after I would try so hard to not feel like that. And at the same time, I would be frustrated with myself for not doing it, you know, so yeah I think that's it.

Another participant stated, "I was hurt, lonely, and I just wanted the thoughts in my head to stop." So this woman admitted that the thoughts occurred often and she would get tired of hearing these thoughts over and over again.

The emotional pain seemed unbearable for these women. "It was painful; I just wanted to not be in so much pain. I was tired of the stress and trauma and I had no hope or answers. I didn't see a way out of my pain." Most women felt like they were disconnected from their life. As one woman said, "I felt dissociated as if I was living a dream. It became clear to me that depression is a deep dark abyss that one could get sucked into and lost forever."

The next question in this section of the interview guide was "How often did you have suicidal thoughts?" The word that sums up how frequently the participant's experienced suicidal ideation was "often". Once these women started having thoughts,

they became flooded with intrusive, obsessive thoughts. Furthermore, most women stated that these thoughts did not go away. One participant recalled, "Like it never, thoughts never fully went away but it depended on what was going on in my life."

Suicidal Belief System

The first question in this section asked, “Did you consider suicide to be an option for you?” All of the interviewee’s answered “yes.” One respondent said, “When the emotional pain was too much to endure, I felt that it was the only way to relieve it”. All of the women talked about not being able to withstand the emotional pain that they were feeling. Therefore, killing themselves so they did not have to feel the pain seemed like a logical answer at the time. Another woman said, “It was not so much I wanted to die. I just didn’t want to feel the pain anymore.” This proved to be a common theme among the women.

One woman noted that many people see suicide attempts as a means of getting attention. This participant agreed that, in some cases, this may be true; but there also must be a lot going in their life.”They need help and figure the only way they can get the help they need is by trying to kill themselves.” This women added, “You know, I've heard of people that attempt suicide are looking for attention and I feel like I can understand that for sure. But for me, at that moment, I just didn't want to be here anymore, it wasn't for attention.” Most of the women discussed not really wanting to die but needing a break from the pain..

Suicidal Behavior

The next question was, “Have you ever tried to commit suicide?” All but one of the respondents said they have tried at least once to commit suicide. Many tried multiple times. One woman made three serious suicide attempts.

The woman who never tried to commit suicide said, “And I think like I have had a lot of experience with therapy and recovery. I probably - in the back of my mind - I probably have this notion that tomorrow might be a better day”. This participant did admit that she had thought often about ending her life but was too afraid. Her father ended up killing himself so she always had this notion of how her suicide would impact others. She did not want to put others through what she went through with her father.

A follow up to this question was, “If yes, can you share the experience and how the attempt impacted your subsequent suicidal ideation?” One participant said, “Out of all the attempts, I can't even say that they were attempts because I knew that I wouldn't die. But I needed help and I knew that they were cries for help. But there was one time that I did take an overdose of something that I knew could kill me.”

One women mentioned that depression can push people away. She said, “Um, well, I think, um, I well, probably I certainly wasn't thinking of how it would effect the people around me. And I didn't think there were people around me at that point.” All the women experienced depression as an isolating place.

Another woman spoke about people not taking her suicidality seriously, “My parents never got me help or took my suicide attempts seriously. Their inaction reinforced my desire to commit suicide. If they didn’t take my life seriously, then why should I take my life seriously? I thought.”

There are a number of ways that these women tried committing suicide. One person sat in a garage with the engine running hoping to die from poisoning. Another tied a belt around her neck and tried hanging herself. One drank bleach and ended up having her stomach pumped. A few women cut their wrists. Additionally, several women took an overdose of pills.

Hope

A question was asked regarding hope, “How has hope impacted your thoughts of suicide?” Overall, the subjects reported that hope had a huge impact on their life. One participant said, “Hope has been really key to me. Hope, I don't hope that things will get better anymore. I believe that they are better. But I did have to think that there was hope before I could believe things could get better.”

Another woman reported, “It [hope] has made my thoughts of suicide nonexistent. They are nonexistent today. So I have hope and I have resources in my life that I use daily instead of resorting back to that being an option ‘cause it's not.” Hope played a role in this woman’s life by taking away the option of killing herself.

The women spoke of hope as in believing that tomorrow may be better. One interviewee noted, “Well I think hope has - I think hope was always there a little bit. Or else I probably would have - maybe or maybe not - but I think there is that tiny little voice or shed of light that is saying you shouldn't do it because tomorrow might be better”.

One woman's view that varied from the others was she believed there is no such thing as hope. She said "Um, I understand it as living in the moment. If you can be in the moment, you are not hoping about the future and you are not reliving the past so you are hopeless."

Spirituality

For many women, spirituality played a huge role in deterring them from suicidal actions. One participant stressed that, "Spirituality is essential". Another woman said, "The stronger my faith is in a Higher Power that is, a "Corrective" patent that I am a precious child of God, the less likely I am to feel suicidal." This woman equates the feeling of being a child of God as a factor that lessens the chances she will try to hurt herself.

A third participant stated, "I am sure I didn't have any spirituality when I had thoughts of suicide." For the most part, these women believed that they could not feel spiritual when they were suicidal.

Most of the participants felt that a belief in a higher power was a major factor in deterring a person's compulsion to end one's life. One woman said, "It is not an option because I see my life as really precious and I have time and experience that all problems are temporary and that my Higher Power will get me through." Furthermore, the more one values life, the less one thinks of killing themselves.

Summary

In summary, I found these women to be incredibly resilient. Not everyone who has been suicidal is able to continue with his or her life ideation free. Additionally, some people end up taking their own lives and don't get another chance at life. These women had a lot of different challenges but were similar in many ways too. Next chapter will discuss what are common themes and differences in these women's lives.

CHAPTER V

DISCUSSION

Overall, the findings of the study confirmed that hope and spirituality can impact a person who has a history of suicidal ideation to reject the notion of suicide as an option. Hope and spirituality have played an important role in keeping these women from suicidal thoughts and actions for at least a year.

This Discussion chapter matches the outline in the Findings chapters so that the comparison with the previous literature follows the flow of the interview guide. Section one presents the demographic characteristics of the participants. Section two contains what was discussed about suicidal ideation. Section three illustrates the participants' suicidal belief system. Section four describes the participants' suicidal behavior. Sections five and six contain the participants' responses about role of hope and spirituality respectively. Then, the implications for social work practice is presented. The final section contains some recommendations for future research.

*Sample Demographic*s

The demographics of the people interviewed varied and some were similar to samples in previous studies regarding people that have suicidal ideation and attempted suicide. The literature suggests that more women have failed attempts at committing suicide while more men are successful at ending their lives (Suicide- Encyclopedia of social work, 2010, p. 3). In this study, the sample was comprised of women..

The age of onset for females usually occurs in young adulthood (Suicide- Encyclopedia of social work, 2010, p. 3) which is consistent with the sample for this study with the exception of one woman who started having severe depressive symptoms when she was in her thirties. Whites are the second highest racial category for committing suicide (Suicide- Encyclopedia of Social Work, 2010, p 3). All of the participants in this study were White. The majority of the sample were working and in a helping profession.

Suicidal Ideation

It was not surprising to discover that almost all of the participants this study started having suicidal ideation at young ages. This is consistent with the previous literature which notes that the suicide rate among children and adolescents have risen faster than the world population as a whole. (Encyclopedia of Mental Disorders, http://www.minddisorders.com/Py-Z/Suicide.html. Typically, the teen years are a difficult time for adolescents because of the changes they are experiencing both physically and emotionally. Additionally, hearing the trauma that these women went through is an added stressor that may have triggered some of the women's response to turn towards suicide as an option. Literature suggests people start thinking about suicide at an early age.

The interviewees' experience with suicidal ideation was described as very painful and difficult. Their life got so bad that suicide seemed like it was the only option for them at the time. All participants described their thoughts as loud, obsessive, and intrusive. All of the women talked about having bouts of feeling safe for a period of time then something would trigger them and they started to have suicidal thoughts again.

Sometimes these bouts of suicidal thinking could last for long periods of time. Other studies are in concurrence with the picture that these women painted of what their lives were like when they were suicidal. For example, Antypa & Williem Van der Does & Penninx (2009) conducted a study where they found that depression cognitions become strengthened with each episode. Feelings of hopelessness also increased.

Suicidal Belief System

The suicidal belief system was dominant in all responses. All people who were interviewed said that they considered suicide as an option for them. Although all of the women felt fear, suicide was still an option for them. Comparatively, not everyone who suffers from depression becomes suicidal according to Casey at el (2007). Major depression brings with it a lot of symptoms, suicidality being one.

Suicidal behavior was a common theme among the women. All but one had attempted suicide. They talked about the attempts as scary experiences that have affected their lives forever. The one person who didn't try to commit suicide had thought long and hard about it. Previous studies show that many people attempt suicide every year. For example, suicide- the encyclopedia of social work (2010) states that it is estimated that 18-36 suicide attempts occur for every completed suicide attempts in adults and the estimated rates are even higher for adolescents.

Hope and Spirituality

Hope and spirituality according to the literature has a positive quality on one's life. According to Ellison & Fan (2008), they found that spirituality taps into positive well being (p. 247). In the examples of the interviewees they too had a good experience with hope and spirituality. Hope has diminished thoughts of ending one's life. However,

there was one interviewee who viewed hope differently. She saw it as a negative thing because it is future orientated. There is also some literature out there that is along those same lines. For instance, Zimbardo & Boyd (2008) wrote, "Hope is the expectation of positive outcomes of one's present actions at some time in the future." (p.152) Spirituality has been a preventative means to escape from suicidal ideation.

In summary, a lot of my findings are concurrent with the literature. Several studies describe the classic symptoms of depression which the participants in this study all confirmed.. However, these depressive symptoms got bad enough that each person thought that ending his or her life would be the answer.

Implications for Clinical Practice

The findings impact clinical practice by adding more narrative information for clinicians on what has worked for clients in the past and what they find helpful in the future. A strong therapeutic alliance has been key in the stories of many of the women. Most of the women spoke of finding hope from their therapists. They felt listened to and cared for and knew that the therapist wasn't going to give up on them. Furthermore the pain that they have suffered has motivated them to find a source outside themselves that would help them in time of need and always. Thus, many of them turned to spiritual guidance, which they feel has helped them with taking away the obsession to commit suicide.

Social workers can use these findings to help their clients. For instance, knowing the warning signs of suicidality is helpful and therapists are especially urged to pay close attention to their client at this time. It can be sometimes frustrating to watch someone suffer who is or is not taking suggestions, knowing that there is not much a clinician can

do except to instill hope for the future.

Recommendations for Future Research.

There is a need for further research on what helps an individual make it through tough times without hurting him or herself. These women's stories may serve as hope and inspiration to other women and men who have been through similar experiences. Suicide is a major problem in the US it needs to be addressed. People, in general, need to be educated about mental illness and methods to help loved ones deal with their mental illness. The more people are educated on how to help the less alone a person may feel with their struggles.

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Appendix A

Screening Script

1.Would you currently consider yourself depressed? If so, how severe would you rate your depression?
2.Are you someone who used to entertain the thought of suicide and haven't had suicidal ideation for at least one year?
3. Are you currently in therapy?
4. Are you between the ages of 21 and 64?
5. Has your hope changed the way you think about suicidal ideation?

Appendix B

Informed Consent Form

Dear Participant,

My name is Tricia Fitzgerald and I am a graduate student at the Smith College School for Social Work, Northampton, Massachusetts. I am conducting this study to learn more about the impact of hope and spirituality as it relates to a previously suicidal person who now rejects having this ideation as an option. Specific use of the data is for a MSW thesis and presentation when the research is complete. Before agreeing to participate in this research study, it is important that you read the following explanation of this study. This statement describes the purpose, procedures, benefits, risks, discomforts, and precautions of the program. The research is also for possible publication.

Participation in the study involves completion of a short demographic data collection sheet and one interview, which will last no longer than one hour. To be included in the study, you must be between the ages of 21 through 64. Any ethnicity, gender, relationship status, and socioeconomic status qualify. All participants must have considered or attempted suicide in the past, but have not felt suicidal or made a suicide attempt for at least one year. All participants must have a therapist. It doesn't matter where the participants reside as long as they are in reasonable distance from the study area (Springfield, MA).

Exclusion criteria include people who are under the age of 21 and those over the age 64. Additionally, anyone who has not been previously suicidal is excluded. The interviews will be audio taped and later transcribed by me for the purpose of data analysis. The interviews will be conducted at a setting that is mutually agreeable to the participant and the researcher.

You may experience uncomfortable feelings when telling me about difficult experiences from the past. We can skip any questions you find to be especially uncomfortable or, if you wish, end the interview early. In the case that this should occur you may want to contact your therapist. I will provide a list of mental health supports. Benefits to you include the opportunity to discuss feelings, perceptions, and thoughts related to your past suicidal ideation. . Also, you will not be paid to participate in this research project.

The information gathered during this study will remain confidential in a locked cabinet during this project. I will be the only one able to assess this information. There will be no identifying names on the tapes. The tapes will be kept secure for a minimum of three years as required by federal law, and that I will continue to keep data secure beyond that for as long as I need them. When they are no longer needed I will destroy them. The results of the research will be published in the form of a graduate paper and may be published in a professional journal or presented in professional meetings. The information will help social workers, and others to better understand how to provide quality services for people with suicidal ideation.

Participation in this study is voluntary; refusal to participate will involve no penalty. Each participant is free to withdraw consent and discontinue participation in this project until April 15th. Additionally, you may refuse to answer any questions. All materials pertaining to you will be immediately destroyed should you choose to withdraw. Feel free to contact me by email or phone if you have any additional questions or wish to withdraw. Additionally, you may contact the chair of the Human Subjects Review Committee at (413) 585-7974 if you have any questions or concerns about the study.

YOUR SIGNATURE INDICATES THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.

Signature: Date:

Tricia Fitzgerald phone (413) 214-4418 email**triciafitz@yahoo.com**

You should keep a copy of this form for your records.

Thank you for your participation!

Appendix C

Referral Resources

BHN Crisis Stabilization (413)733-6661

BHN Liberty Street Clinic (413) 304 7100

Baystate Adult Behavioral Health (413) 794-7035

Behavioral Health (413) 686-8550

Center for Psych & Family Services (413) 739-0882

Gandara Mental Health (413) 736-0395

National Alliance on Mental Health (NAMI) (413) 786-9139

Northampton Crisis (413) 586-5555

Pioneer Valley Mental Health (413) 737-1426

Service Net (Northampton) (413) 585-1300

Appendix D

Giving Up on Giving Up: Stories of people who are no longer suicidal

Are you someone who used to entertain the thought of suicide? Come share your story on how you moved from contemplating suicide to no longer having suicide as an option.

Be part of an important research study!

You qualify if:

1. You are someone who used to entertain the thought of suicide and haven't had suicidal ideation for at least one year
2. You are currently in therapy
3. You are between the ages of 21 and 64

If you have answered Yes to all these questions, you may be eligible to participate in a research study about people who were once hopeless and suicidal and now have hope and aren't suicidal. Furthermore, if you've experienced a spiritual experience around suicidal ideation you are welcome to participate in this study. I will be conducting interviews lasting no longer than an hour.

The purpose of this study is to research what factors have been instrumental in not having suicide as a consideration anymore. There is no compensation for participating in this study. Benefits of this study are having a sense of contribution to the existing literature about how it is possible to live a life without suicidal ideation. Participants in this study will be confidential. The research may also be used for publication and presentation.

This research study is being conducted as part of a study as part of a thesis requirement from Smith College School of Social Work.

Please call Tricia Fitzgerald at (413) 214-4418 for more information

Appendix E

Appendix F

Appendix G

SMITH COLLEGE
School for
Social Work

Lilly Hall
Northampton, Massachusetts 01063
T (413) 585-7950
F (413) 585-7994

March 26, 2010

Tricia Fitzgerald

Dear Tricia,

You have done a fine job in revising your materials. We are able at this time to give final approval to your study.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Good luck with your project.

Sincerely,

Ann Hartman, D.S.W.
Chair, Human Subjects Review Committee

CC: Nora Padykula, Research Advisor

Appendix H

Questions
Giving Up on Giving Up: Stories of People Who Are No Longer Suicidal
Qualitative Research Questionnaire

Name
Date
Age
Gender
Race
Working status
Have you been diagnosed with a mental illness?

Research Questions

Suicidal Ideation

1. Can you describe when you first began to have thoughts of suicide?

2. What was it like for you to have thoughts of suicide?

3. How often did you have suicidal thoughts? How long did you have suicidal thoughts for? When did it end for you?

4. Can you share how this has shifted for you — going from experiencing suicidal ideation to no longer experiencing thoughts of suicide?

Suicidal Belief System

5. Did you consider suicide to be an option for you? If not, why not?

Suicidal Behavior

6. Have you ever tried to commit suicide? If not, why not?

- If yes, can you share the experience and how the attempt impacted your subsequent suicidal ideation?

- If yes, can you share how the experience impacted how you see suicide as an option?

7. How has hope impacted your thoughts of suicide? Seeing suicide as an option? What do you think about the impact of hope?

8. How has spirituality impacted your thoughts of suicide? Seeing suicide as an option? How would you describe your spirituality?