



1997

Risk Factors Associated with Suicide Probability in HIV Positive and AIDS Patients

Kenneth W. Jackson
Loyola University Chicago

Follow this and additional works at: https://ecommons.luc.edu/luc_diss



Part of the [Psychology Commons](#)

Recommended Citation

Jackson, Kenneth W., "Risk Factors Associated with Suicide Probability in HIV Positive and AIDS Patients" (1997). *Dissertations*. 3674.

https://ecommons.luc.edu/luc_diss/3674

This Dissertation is brought to you for free and open access by the Theses and Dissertations at Loyola eCommons. It has been accepted for inclusion in Dissertations by an authorized administrator of Loyola eCommons. For more information, please contact ecommons@luc.edu.



This work is licensed under a [Creative Commons Attribution-Noncommercial-No Derivative Works 3.0 License](#).
Copyright © 1997 Kenneth W. Jackson

LOYOLA UNIVERSITY OF CHICAGO

RISK FACTORS ASSOCIATED WITH SUICIDE PROBABILITY
IN HIV POSITIVE AND AIDS PATIENTS

A DISSERTATION SUBMITTED TO
THE FACULTY OF THE GRADUATE SCHOOL
IN CANDIDACY FOR THE DEGREE OF
DOCTOR OF PHILOSOPHY
DEPARTMENT OF COUNSELING PSYCHOLOGY

BY

KENNETH W. JACKSON

CHICAGO, ILLINOIS

JANUARY 1997

Copyright by Kenneth W. Jackson, 1997

All rights reserved.

ACKNOWLEDGEMENTS

Albert A. Agresti Ph.D. Chairperson of my dissertation committee. I wish to express my sincere appreciation for the considerable patience you have extended to me as my guide to the world of research. This project developed out of my curiosity and your expertise to assist me in clarifying my objectives. It has been an interesting journey, including frustration, paralysis, and the excitement you expressed with the results of the study.

Marilyn Susman Ph.D. Member of my dissertation committee. I wish to thank you for your willingness to participate in this study by offering your perspective which clarified the objectives of the study. Additionally, I am grateful for your direction which facilitated the data collection process.

Ronald Morgan Ph.D. Member of my dissertation committee. I am grateful for your availability and direction in guiding me through the initial design and development of this research project. Your encouragement of my ability to accomplish this project has returned me to the pursuit of the goal on many occasions.

Claranne Weinert Ph.D. I want to express my appreciation for her permission to use the PRQ85 to assess the social support component of this

project. This instrument has provided valuable data which has contributed to the usefulness of this project.

James L. Jonsson Ph.D. My Friend, for his vision to see in me what others could not see and the encouragement and the belief that I had something useful to say.

This project has developed out of a need, perhaps an urgency to understand the lives of numerous friends who have lived with HIV and died from AIDS. As each of them may be represented somehow in the responses of others who participated in this study, the representative portrait of people living with HIV and AIDS does not foreshadow the individual memory of the individuals who have touched my life.

ILLUSTRATIONS

	Page
FIGURE 1. Johnson, R.A., <i>Mandorla</i> , 1991	37

TABLES

Table I Demographic Information	119
Table II Correlation Coefficients BHS & SPS	121
Table III Stepwise Multiple Regression BHS	122
Table IV Stepwise Multiple Regression SPS	123
Table V t-tests	124
Table VI Correlation Coefficients PRQ85 & Violence	126
Table VII Correlation Coefficients Sub-tests	127
Table VIII Correlation Coefficients PRQ85	128
Table IX Correlation Coefficients Demographics and Questionnaire	129

APPENDICES

Appendix I Demographic Questionnaire	130
Appendix II Peer Questionnaire	145
Appendix III Peer Questionnaire (Spanish)	148
Appendix IV Alpha Tables	150

ABBREVIATIONS

BDI **Beck Depression Inventory**

BHS **Beck Hopelessness Scale**

PRQ **Personal Resource Questionnaire**

SPS **Suicide Probability Scale**

TOT **Total**

BHS

Loss Mot **Loss of Motivation**

Feeling **Feeling about the Future**

Hopeless **Hopelessness**

Future **Feelings about the Future**

PRQ

UN **Urgent Needs**

Integrat **Integration**

Recipro **Reciprocity**

SPS

Hless **Hopelessnes**

SID **Suicide Index**

Neg Self **Negative Self-Image**

CONTENTS

Acknowledgements	iv
List of Illustrations	vi
Tables	vii
Abbreviations	ix
Abstract	xii
Chapter I (Introduction)	1
Chapter II (Literature Review)	10
Chapter III (Method)	48
Chapter IV (Results)	61
Chapter V (Discussion)	75
References	92
Vita	148

ABSTRACT

Since the identification of the Human Immunodeficiency Virus (HIV) and AIDS, the epidemic has received considerable attention. Medical researchers have directed their attention to finding a cure, and the social scientists involvement in education and prevention programs. Thus far medical researchers have focused on finding a vaccine to improve the quality of life for AIDS patients. As we now enter the second decade of the AIDS epidemic, the profession of psychology also needs to focus it's attention to the healing of the social consequences that is associated with the AIDS epidemic. The stigma, isolation discrimination, and depression associated with AIDS persists and may contribute to the hopelessness and the suicides of many people with HIV or AIDS.

Social constructions have an influence on the individuals in our society. AIDS continues to elicit a negative image and a negative attitude for a majority of people in society. Judgements are frequently made due to the pre-existing negative attitudes toward the marginalized groups of society that are at greatest risk for HIV infection and AIDS. These marginalized groups include gay men, IV drug users, ethnic and racial minorities, and women. Membership in

one or more of these groups is associated with increased stress due to experiences of prejudice, discrimination, and violence. These factors place individuals with already compromised immune systems at great risk for negative health outcomes.

This study attempts to identify how depression, social support, locus of control, pre-existing discrimination, violence and the stigma of AIDS increase the risk of suicide in HIV+ individuals and people with AIDS. Additionally this study will explore those factors having a social component which contribute to the increased risk of suicide in HIV+ people and people with AIDS.

CHAPTER I

INTRODUCTION

AIDS (Acquired Immunodeficiency Syndrome) has been closely associated with the gay community since the early stages of the epidemic and continues to be closely associated with it. However, it should be noted that HIV infection has also been present in women as well as in heterosexual men from the start of the epidemic (Chin, 1991).

Early in the epidemic, only the gay community developed strong social support programs to combat the social impact of AIDS. Thus, any person struggling with AIDS had very little choice but to rely on the gay community for support in dealing with the disease. Paradoxically, even if the AIDS patient is gay, he may find that his individual needs and concerns are not fully served by the gay community's social support programs, because he may not feel included in the socially constructed image of homosexuality that the gay community reflects back to him. Although the socially constructed and reflected image seems hauntingly clear, it is only two-dimensional. Consequently much of what the patient feels as "himself" may be different from that image reflected and acknowledged in the gay community.

The generally unacknowledged incompleteness of the reflected image, which is made up of individual characteristics and accepted social attitudes and behaviors, presents special difficulties for members of the gay community. The incomplete constructions may be contributing to questions of personal identity and social integration, as well as to factors related to perceived hatred and discrimination. These constructions may lead to the gay community and the gay individual participating in the hate and discrimination because of self-loathing. Pharr (1988) discussed the generally accepted viewpoint which permits the overt expression of homophobia in society. This commonly accepted view removes the individual's sense of safety from verbal and physical attack. Even more destructive is internalized homophobia, because it is often invisible and may result in an erosion of the person's self-concept, dignity, and ability to function (Slater, 1993). According to Slater (1993), "Internalized homophobia is a result of external or societal homophobia, whether it is aimed specifically at the youth or only present in the youth's environment" (p.188). Gonsiorek (1988) described internalized homophobia as the process of incorporating biases against homosexuality that are evidenced in the social world of gays, lesbians, and bisexuals. Individual expression may range from self-doubt to overt self-hate.

The non-mirroring of individual personal characteristics and aspects in the socially constructed gay community is a common problem among gay and lesbian people. In a discussion of lesbian and gay development, D'Augelli (1991) identified lesbians and gays as a hidden population on many college campuses, evidenced by their invisibility in the curriculum. Stigmatized in early life by heterosexual constructions of homosexuality, and confined since coming out by gay definitions of homosexuality, gay individuals may find that the stigma of AIDS adds yet another obstacle for them to overcome in their effort to be accepted and integrated into the social structure at large (Herek & Glunt, 1988; Shilts 1987).

The relationship of an individual to other members of society is often stressful even in ideal circumstances. The presence of any chronic illness or a family history of suicide have been reported to be hallmark risk factors for potential suicide (Dublin, 1963). For gay and lesbian people, the additional factor of AIDS compounds the stress by intensifying the difficulties between individual and social structures. As a result, people living with AIDS are more likely to complete suicide than people living with other life threatening diseases (Rundell, Thomason, Zajac, & Beatty, 1988; Pierce, 1987).

Characteristic responses to stress are considered to be more reliable indicators of suicide potential than the nature or intensity of the stress. HIV

infection and AIDS adds a further set of stressor variables to the personal factors already established in the individual's organization of suicide ideation and potential for completion of suicide. Because of this, it has been possible to develop characteristic profiles of individuals most at risk for suicide. Yet there has been no systematic attempt to develop a profile of potentially suicidal HIV/AIDS patients that take these additional variables into account. Thus therapists and care-givers may be currently unable to provide the same appropriate understanding and intervention to AIDS patients as that which is routinely provided to other terminally ill and/or suicidal patients.

SOCIAL SUPPORT

Psychological factors such as personality, life style, and social environment have been shown to influence conditions related to an individual's health or risk of illness (Antonovsky, 1979). Using diverse subject groups, Leavy (1983) found that reduced social support or an absence of social support is associated with an increased risk for psychological distress.

Thus, although there appears to be evidence that social support is an important factor related to health and illness, exactly what is meant by "social support" is difficult to pinpoint (Vaux et al., 1986). The diverse conceptions of what constitutes adequate social support (Green, 1992; Sarason, Sarason,

Potter, & Antoni, 1985) have caused the development of several different types of instruments to measure social support (Green, 1993).

For example, in a factorial confirmation study to examine various dimensions of social support, McCormick, Siegert, & Walkey (1987) found five distinct dimensions of social support. Although not exhaustive, the five dimensions include non-directive support, directive guidance, and tangible assistance from the Inventory of Socially Supportive Behaviors (ISSB) (Barrera, Sander, & Ramsay, 1981), network size, and satisfaction from the Social Support Questionnaire (SSQ) (Sarason, Levine, Basham & Sarason, 1983).

In an overview of the theoretical considerations related to social support, Green (1993) reviews social support literature in terms of different aspects of social relationships, including:

- (a) the existence, quantity and type of interpersonal relationships (network structure or social interaction);
- (b) the functional content of these relationships (emotional, psychological, tangible or informational support);
- and (c) the perceived quality or adequacy of this support (p. 89-90).

Studies have shown that existing social support systems may be taxed when a person is diagnosed with a chronic illness (Bloom & Spiegel, 1984,

Peters-Golden, 1982). The role of social support in chronic illnesses and terminal illness management has been linked with other psychological resources in assisting the patient to cope with the illness and promote recovery (Madge & Marmot, 1987; Wortman & Dunkel-Schetter, 1979; Wortman, 1984). In cases of HIV disease, social support may be reduced because of the social stigma associated with the disease (Kowalewski, 1988).

Living and coping with AIDS reportedly produces many psychosocial difficulties (Zich & Temoshok, 1987). One's ability to cope with life's difficulties may be an influencing factor in the availability of social support (Wortman, 1984). In a study of three methods of coping, active behavioral coping was found to be related to higher self-esteem and a more positive affective state, and avoidance coping was found to be related to lower self-esteem and higher levels of depression (Namir, Wolcott, Fawzy & Alumbaugh, 1987; Wolf et al., 1991). Individuals using avoidance coping expressed greater concerns related to their health, friends, self, and existential issues. HIV-infected adults who utilize purpose and meaning for explanations of their life circumstances with good social support reportedly have higher self-esteem and lower levels of anxiety (Linn, Lewis, & Kimbrough, 1993). Other studies link social support with less anxiety and depression in various populations (Flannery, 1989; Turner, 1981).

The profound psychosocial impact that AIDS produces has prompted numerous authors to write about the need for social support groups, social support, the problems of isolation, and social discrimination (Christ, Wiener & Moynihan, 1986; Coates, Temoshok & Mandel, 1984; Green & Miller, 1986; Morin & Batchelor, 1984; Watkins, 1988). In a study of social support and adjustment, Holohan & Moos (1982) reported that decreased available support was related to increased psychosomatic complaints.

In a study designed to examine how asymptomatic HIV-positive men cope with the threat of AIDS, Lesserman, Perkins, and Evans (1992) found that positive coping strategies included adoption of a fighting spirit, reframing experiences to maximize personal growth, seeking social support and developing a plan of action. Helpless coping was associated with a non-fighting spirit, while less personal growth was related to dysphoria, lower self-esteem and denial was related to higher levels of depression, anger, and increased helplessness. Additionally, the investigators reported that satisfaction with one's social support and involvement in the AIDS community were related to healthy coping strategies.

Promoting adaptive coping skills, utilizing existing positive social support, mobilizing coping strategies, or finding support networks should be encouraged by health care providers (Lesserman et al., 1992). The need for

varying support networks may be crucial for some gay men who may be more dependent on the gay community for support than they are on their families (Namir et al., 1987).

This research was designed to develop a characteristic profile of AIDS patients who might be most at risk for suicide. It is hoped that this profile will serve as a starting point for further empirical testing and refinement in the delivery of services in clinical and/or non-clinical settings.

Several agencies in a midwestern state which provide services related to HIV and AIDS participated in this study by distributing the research packets to HIV+ and AIDS patients. The participants were asked to complete a battery of inventories which assess intrapsychic and psycho-social constructs. The instruments used included: The Beck Depression Inventory, The Personal Resource Questionnaire (PRQ 85), Internal versus External Control of Reinforcement, The Suicide Probability Scale, The Beck Hopelessness Scale and a demographic questionnaire which included questions about violence.

Distribution of the packets was done by the agency employees. Consent forms were returned to the participating agency in pre-paid envelopes and the research materials were returned by mail to the researcher in pre-paid business envelopes. At no time did the researcher know the identity of the participants and the participants did not know the identity of the researcher.

Due to the sensitivity and nature of the study, coding allowed the researcher to contact the agency by protocol number should intervention be deemed necessary. The agency was identified as the source for intervention due to the ongoing established relationship that the agency has with the participant.

CHAPTER II

LITERATURE REVIEW

The Acquired Immunodeficiency Syndrome (AIDS) epidemic has been categorized as consisting of three separate epidemics (Mann, 1988). The first epidemic (the process of HIV infection) had a silent, unidentified beginning sometime during the mid 1970's and continued undetected by health officials until 1981. The second epidemic was that of identification and description of symptoms associated with the disease. The third epidemic consisted of the social, cultural, and political responses to the people affected by HIV and AIDS. To date, this third epidemic has received less attention than the other two (Morin, 1988). This study was designed to examine the impact that the third epidemic has had on the personal lives of those living with HIV disease and AIDS.

It is probably fair to say that the third epidemic is based, at its core, on a social reactions to the pathology of AIDS. Issues associated with this third epidemic include fear and irrational actions, discrimination, and stigma.

Public fear about personal security has fueled the debate for mandatory testing,

in the hope of finding a quick fix to a long-term, complex problem (Batchelor, 1988; Morin, 1988). The Presidential Commission on the Human Immunodeficiency Virus exposed information regarding the many flaws in the reaction of society and the health care system to persons with HIV and other disabilities. Foremost among these flaws has been the obstacle of discrimination. This finding prompted Admiral James D. Watkins, Chair of the Presidential Commission on Human Immunodeficiency Virus Epidemic, to state in the *Report of the Presidential Commission on the Human Immunodeficiency Virus Epidemic* that discrimination on the basis of HIV status should be prohibited (Watkins, 1988). Backer, Batchelor, Jones, and Mays (1988) in their introduction to the Special Issue on Psychology and AIDS in the *American Psychologist* stated that "AIDS holds up a mirror to all that does not work in our health care system (and our society) and psychology (we) is (are) included in that reflection" (p. 836).

Unfortunately, the findings and recommendations of the Presidential Commission on the HIV Epidemic have gone virtually unheeded. Discrimination has continued (Batchelor, 1988) in the form of cruelty, refusal to provide treatment, and inadequate service provision for people with AIDS. Little attention has been paid to the national, state and local programs specifically designed to reduce stigma and decrease the frequency of incidents

of discrimination and violence (Morin, 1988). Stigmatization of people with AIDS and engaging in high-risk behaviors continue due to the lack of trust in doctors, scientists, and public education efforts to provide information about AIDS and its transmission process (Herek, & Capitanio, 1994). The AIDS epidemic has produced an unprecedented degree of public fear (Ostrow, 1988). In a backlash of fear, voters have passed state constitutional amendments and local ordinances denying homosexuals (gays, lesbians, and bisexuals) legal safeguards for the equal protection of their human rights. Gay men have been hit disproportionately hard by the AIDS epidemic, and the public's perceived association of being gay with having AIDS has prompted a number of reactive measures (Mann, 1988, Morin, 1988) to insure individual safety from infection.

Discrimination has been at the center of the AIDS epidemic and must be addressed before we move forward in our treatment of HIV infected people (Watkins, 1988). The process of successfully implementing educational programs aimed at reducing discrimination and violence against people with HIV infection has been thwarted by the fact that the incidence of infection and disease is disproportionate among already stigmatized groups within the United States (Herek, 1984). Discrimination continues to add to the stigma associated with HIV and infection. In a study examining public reactions to AIDS,

Herek, & Capitanio (1993) found that AIDS-related stigma remains a serious problem in the United States as we enter the second decade of the epidemic.

It is estimated that in this country, 51% of adults diagnosed with AIDS have contracted the disease through behaviors associated with homosexuality (CDC, 1994a). The behavior of sharing of needles among people using intravenous drugs is believed to account for an additional 21% of HIV transmission (CDC, 1994a).

In a discussion on the individual and social reactions to AIDS, Herek & Glunt (1988) stated:

Because of the dialectical relation between cultural ideologies and individual attitudes, any attempt to eradicate AIDS-related stigma must target both levels. AIDS-education programs must be designed not only to impart information to individuals but also to reduce the stigma attached to AIDS. Public policy not only must respond to the technical issues of treatment and prevention but also must help to establish clear social norms of respect and compassion for HIV-infected persons (p. 889).

MINORITIES

There is considerable controversy within American society as to whether gays and lesbians constitute a minority. Oppression has been defined by Goldenberg (1978) as a state of being in which a person is deprived of some human right or dignity and is or feels powerless to do anything about it. Earlier, Wirth (1945) provided a detailed definition of minority based on the concept of oppression. Wirth defined a minority as:

... a group of people who, because of physical or cultural characteristics, are singled out from the others in society in which they live for differential and unequal treatment, and who therefore regard themselves as objects of collective discrimination (p. 347).

According to the Wirth definition of minority, blacks and hispanics have been socially acknowledged as minorities. For gays and lesbians, their experience in society parallels the criteria which identify groups as minorities, however acceptance as a minority status has not occurred. This is a difficulty because of the social climate for gays and lesbians but more importantly because of AIDS being identified as a gay disease and the powerlessness within society to be accepted.

The misperception that AIDS is a gay white male disease has been commonly held by many ethnic minority groups and society at large. This

belief has created a false sense of security which has resulted in a lack of risk reduction behaviors in ethnic minority groups. This belief has been a dangerous one because transmission of the virus can take place without risk reduction behaviors (Evans, 1988). Black and hispanic women comprise only 21% of all U.S. women, yet 77% of AIDS cases among women in 1994 occurred among blacks and hispanics (CDC, 1995). Minority groups unevenly affected by AIDS include the gay and bisexual male community, intravenous drug users and their sexual partners, hemophiliacs, racial and ethnic minority groups (Poppen & Reisen, 1994), and adolescents (Holmes, 1991; Longshore, 1990). A closer look at Goldenberg's (1978) definition of oppression has at it's core an individual meaning. Minority, according to Wirth (1945) incorporates the collective of individuals but has at it's core the concept of oppression. Oppressed individuals feel powerless to change the social situation, individuals in a minority group are invisible because of social collective blurring. The history of oppressed groups has created difficulties in identifying their needs and also limitations in their access to medical and psychosocial services (Land, 1994).

While there has been a steady increase of AIDS in ethnic minority groups since the beginning of the epidemic (Evans, 1988). On the other hand, according to the Center for Disease Control (1993a; 1994a) gay or bisexual

male contact accounts for over 50% of AIDS cases, reflecting a decrease in AIDS cases for this group. However, according to recent CDC (1994a) reports, "men who have sex with men continued to account for the largest proportion (44 percent) of all (new) cases reported among adults/adolescents" (p.5). It is important to note that some men who have sex with men do not consider themselves gay. These data appear to counter the common belief that HIV/AIDs is a gay disease.

The second most common mode of HIV transmission is through intravenous drug use, which accounts for 34% of all cases and continues to increase (CDC, 1993b). Intravenous drug use is now considered the most likely mode of the spread and increase of AIDS (Longshore, 1990). An increase of 44% has been noted in heterosexual modes of transmission, accounting for over 7% of all cases reported, up from 5% since the beginning of the epidemic. Blood transfusion as a mode of HIV transmission has declined and represents less than 2% of AIDS cases. AIDS cases of hemophiliacs and perinatal infants each represent approximately 1% of all cases.

Blacks and Latinos in the United States are reported to be six times and three times, respectively, more likely to account for AIDS cases than white Americans (CDC, 1994a; Selik, Castro, & Pappaioanou, 1988). The risk for

acquiring AIDS in the heterosexual community is estimated to be ten times greater for African-Americans and four times greater for Latinos than for their white counterparts (Aral & Holmes, 1991). Among African-American women, the risk of AIDS is eight times greater than that of their white counterparts (CDC, 1994a; Land, 1994).

African-Americans and Hispanics make up a sizeable portion of the AIDS cases in the United States. Most have been linked to gay or bisexual behavior or intravenous drug use (Peterson & Marin, 1988). Schuster (1992) discusses the demographic variations of drug-related HIV populations as they relate to research and prevention. According to Schuster, whites represent 80% of the total United States population, blacks represent 12%, and Hispanics represent 6% of the population. Whites account for 73% of AIDS cases among gay and bisexual males, 76% among hemophiliacs and blood transfusion recipients, and 30% of cases among intravenous drug users. Their black counterparts account for 44% of cases among intravenous drug users, 62% of heterosexual contact cases, and 58% of perinatal cases. Hispanics account for 26% of intravenous drug transmission cases.

Mitchell (1989) reported that women accounted for nearly 7% of all AIDS cases reported. In the current CDC information (1995) sources it was reported that women now represent 18% of all AIDS cases. African-

American women account for more than 50%, with nearly 20% identified as Latina and hispanic. More recently, reports estimate that women of color constitute 72% of all women infected with HIV, with 53% among African-Americans and 20% among Latinas (Land, 1994). Of all AIDS cases reported among women in 1994, 77 percent occurred among black and Hispanic women (CDC, 1995).

Adolescents (13-19 years) now account for 0.5% of all AIDS cases (CDC, 1994a). Concern about this population is warranted, however, because although this is a small percentage, the long incubation period of HIV suggests that many AIDS cases reported between 20 and 29 years of age and into the early 30's were probably contracted during the teenage years (Center for Disease Control, 1993a; 1994b).

As noted earlier, the AIDS epidemic in American society has an established history of disproportionately affecting already marginalized groups, particularly gay men. Few would argue that the additional layer of stigma associated with AIDS for gay men and other marginalized groups (Herek, & Glunt, 1988) is built on a strong foundation of preexisting stigma.

Awareness of the epidemic of AIDS in American society has been associated with the groups hardest hit by the disease. Early mass media coverage of AIDS introduced Americans to the disease by referring to AIDS as

the Gay Plague (Ver Meulen, 1982). In *AIDS and Its Metaphors*, Sontag (1989) stated: "plague is the principal metaphor by which the AIDS epidemic is understood" (p.44) and "plagues are invariably regarded as judgments on society" (p.54). Additionally Bruhn (1989, p. 455) referred to AIDS as " an epidemic of fear". Fineberg, (1988, p. 128) refers to a plague as "a condition that is literally as well as morally contagious". Prior to international agreement to identify the retrovirus HIV, the causative agent associated with AIDS, a proposed name for the syndrome was Gay-Related Immune Deficiency (GRID) (Shilts, 1987). Thus, continued marginalization due to the incidence of AIDS has provided further distinction of "in" groups and "out" groups. People in "out" groups with AIDS bear an additional burden of societal hostility when they are in most need of understanding and social support (Herek & Glunt, 1988).

PSYCHO-SOCIAL OUTCOMES

A diagnosis of AIDS elicits psychological events that are very much associated with a need to confront inevitable fatality. Tross and Hirsch (1988) and Morin and Batchelor (1984) report that a diagnosis of AIDS triggers many existential depressive symptoms which include dysphoric mood, hopelessness and helplessness, anhedonia, and abandonment or rejection sensitivity.

Suicidal ideation is common because many people with AIDS have watched friends die of AIDS. They would prefer suicide or passive euthanasia as reasonable alternatives to experiencing a slow deteriorating course of disease and death (Tross & Hirsch, 1988). Suicide ideation among women is reported to be a concern in providing adequate counselling services (Sherr et. al. 1993). Suicide among infected women may be a concern at the time of diagnosis, symptom presentation, and during the final stages of the disease (Ybarra, 1991).

Coming to terms with death and dying appears to be cyclical in nature, and is marked by heightened distress around a significant medical crisis (Christ & Wiener, 1985). The psychological difficulties experienced by women are extreme with reported similarities to the trauma experienced by gay men at the beginning of the epidemic (Miller, 1987; Miller, Weber & Green, 1987). The initial diagnosis of AIDS is frequently experienced as an episode of acute distress. As one progresses to an acceptance of the diagnosis, existential psychological issues of accepting imminent death, dealing with regret over lost future plans, sustaining hope and meaning in life, and dealing with depression become intertwined with the progression of AIDS (Tross & Hirsch, 1988).

As the AIDS epidemic progressed, early reports of psychological ramifications related to the disease acknowledged the emotional reactions

commensurate with a diagnosis of such seriousness (Morin, & Batchelor, 1984). Psychological reactions exhibited after a diagnosis of HIV or AIDS typically include an expressed:

fear of death and dying , guilt, fear of exposure of life-style, fear of contagion, loss of self- esteem, fear of loss of physical attractiveness, fear of decreased social support and increased dependency, isolation and stigmatization, loss of acceptance and financial status, concerns and confusion over options for medical treatment, and the overriding sense of gloom and helplessness associated with a degenerative illness (Morin, Charles, & Malyon, 1984, p. 1288).

Existential concerns include life and death, boundaries, loneliness, helplessness, and facing one's own mortality (Morin, Charles, & Malyon, 1984). May and Yalom (1984) perceive the existential conflict regarding death as being between the individual's awareness of inevitable death and the simultaneous wish to continue to live.

Given the social climate, the social condemnation that people with AIDS encounter is understandable in that the groups presenting early in the epidemic were gay, bisexual, or IV drug users (Morin, & Batchelor, 1984). The social stigma attached to this disease for gay men also raises psychological

issues for significant others (Morin, & Batchelor, 1984) ranging from overidentification by gay peers to disclosure of sexual orientation to families.

For women with HIV or AIDS, family issues focus on concerns about children and about personal and social support (Sherr et al., 1993). The impact of a diagnosis of AIDS produces a profound impact on friends and family of the infected individual (Frierson & Lippmann, 1987; Wolcott, 1986) with the first psychological event of AIDS on family and friends beginning with grief (Lippmann, James, & Frierson, 1993). AIDS is about multiple losses as Hoffman (1991) reports:

The progression of HIV infection is associated with deterioration (physical and neurological), changes in day-to-day functioning, loss of employment, stigma, and in many cases, exposure of one's life-style around the issues of sexuality and/or drug use. It is about the loss of one's health, vitality, sensuality, and career and most profoundly, the letting go of the future as one had envisioned it" (p. 468).

A negative future expectation or sense of hopelessness has been shown to be a powerful cognitive organization in the development of suicidal behavior (Beck, 1967; Beck, Steer, Kovacs, & Garrison, 1985; Bonner & Rich, 1987, 1991; Schotte & Clum 1982, 1987). Beck suggests that hopelessness is a powerful cognitive schema that is otherwise dormant unless activated by

environmental stress (Beck, 1967; Beck, Rush, Shaw & Emery 1979; Beck, Steer, Kovacs & Garrison, 1985). Beck's (1967, 1984) cognitive model of depression identifies negative views of self, others, and the future as dysfunctional cognitive processes that place one at increased risk for depression and suicide.

It has been argued that increased stress related to major life transitions has an adverse effect on immunity (Kiecolt-Glaser, & Glaser, 1988) and that distress would have its greatest impact on the immune systems of persons whose immune systems are already compromised. The role of stressors such as traumatic negative life events (e.g., serious illness, loss of job) has received much attention in the research on the etiology and increasing hopelessness leading to suicidal behavior (Bonner & Rich, 1987, 1991; Schotte & Clum, 1982, 1987).

Living with HIV and AIDS can be associated with living with unresolved grief, and frequently with depression (Dilley, Ochitill, Perl, & Volberding, 1985; Frierson, & Lippmann, 1988). Clinical levels of depression have been reported to be common in persons with HIV infection and AIDS (Perry et al., 1990; Woo, 1988). Rational suicide may be viewed as a viable option for some patients (Lippmann, James, & Frierson, 1993) who

want to avoid extraordinary life support measures (Frierson, & Lippmann, 1986; Lippmann, Frierson, & Shaltout, 1988).

With the progression of the disease, there may be evidence and symptoms of peripheral and central nervous system damage, which may include AIDS dementia complex as evidenced by motor, cognitive and behavioral dysfunction (Navia, Jordan, & Price, 1986). Bridge (1988) reviewed the literature on AIDS and HIV central nervous system disease and argued that HIV infection is a neuropsychiatric disorder as well as an immunologic disorder. This argument is based on the observation that neuropsychiatric symptoms develop secondarily to a direct HIV infection of the brain (Gartner, Markovitz, & Markovitz; 1986; Ho, Rota, & Schooley, 1985; Koenig, Gendelman, & Orenstein, 1986; Navia et al. 1986; Stoler, Eskin, & Benn, 1986) and that cognitive, motor and affective symptoms can be present before a diagnosis of AIDS (Navia et al. 1986).

Morin, Charles, and Mayon (1984) described the fear that is ever present within the gay male community with respect to the threat of AIDS. Morin, and Batchelor (1984) have described "The Worried Well" in a study of AIDS anxiety among gay men. They are medically asymptomatic but develop psychological symptoms as a response to their increased risk for infection. This overidentification by gay men may be understood from the concept of

situational distress, in that the stressful event causes distress for almost everyone found in the situation (Nichols, 1986; Parkes, 1971; Weiss 1976).

We may be able to understand the psychological difficulties which arise from a diagnosis of AIDS by looking at some of the psychosocial difficulties experienced by gay men and lesbians in their coming out process. This process is pertinent because for a gay man or lesbian diagnosed with AIDS, intense emotions are revived about facing, accepting and telling others about their medical condition, and this may be experienced as a "second coming out" for gay people (Nichols, 1983).

RELATED LIFE EVENTS

The process of coming out is experienced as an "Act of Love" for many gays and lesbians in that they see it as a way to completely share themselves (Eichberg, 1991). Participation as a full member of society is sought by breaking the concealment of one's homosexual identity through the disclosure of one's sexual orientation. As one identifies oneself as homosexual, society (in the form of family, friends and institutions) places the individual into a group previously categorized as "protected" in terms of functioning with only partial rights and participation in society to some limited degree (Saunders & Valente, 1987).

Saunders and Valente (1987) reported that many societies identify children, criminals, the sick and the handicapped as protected groups. Full participation is lost when individuals are identified by behaviors or characteristics which limits their participation in society. By labeling homosexuality as an illness, society legitimizes limited participation for those persons fitting this label.

Isolation and estrangement are not the objectives of the individual who discloses a homosexual identity. The overall aim of coming out, or the full disclosure of one's identity, is for full integration into the social structure. This integration provides the individual with reciprocal access to social support networks. Social support as explained by Weiss's (1974) model of relational functioning consists of the following components: (a) a possibility for attachment and intimacy; (b) being socially integrated; (c) an expression for nurturing behavior; (d) an acknowledgement of individual worth and personal achievements; and (e) adequate informational, emotional, and material assistance.

The process of self-identification of being gay and the coming out experience is progressive in that it leads individuals from group support into an unknown arena. For most, the new sense of identity is overshadowed by being a member of a stigmatized group that is often disenfranchised from

mainstream social supports. According to a report from the Center for Population Options (1992), lesbian, gay and bisexual youth:

...face tremendous challenges to growing up physically and mentally healthy in a culture that is almost uniformly anti-homosexual...they often face increased risk of medical and psychosocial problems, caused not by their sexual orientation, but by society's extremely negative reaction to it. Gay, lesbian and bisexual youth face rejection, isolation, verbal harassment and physical violence at home, in school and in religious institutions (p. 1).

For minority persons, the identification of being gay also removes many from those minority social institutions which had provided social support. This break from the mainstream community or from minority social support system leaves many HIV positive individuals and people living with AIDS without social supports and psychological protection from symptoms of distress (Schneider, Farberow, & Kruks, 1989).

Among HIV positive individuals, distress symptoms such as depression and hopelessness, loneliness, lack of perceived control over AIDS risk and AIDS related life events have been found to be associated with reporting of suicidal ideation (Marzuk, 1991; Schneider, Taylor, Hammen, Kemeny &

Dudley, 1991). Suicidal behavior can be expected in groups with a high concentration of illness, death, and loss (Schneider et al., 1991).

The relationship between homosexuality and suicidal behavior was explored in a study by Schneider and colleagues (1989). The findings clearly document the process of social support deterioration experienced by recently suicidal gay men and lesbians. Findings indicate that many suicidal gay men and lesbians view social supports as rejecting of their sexuality, yet these social supports are greatly depended upon and are viewed as being critically important.

During a suicidal phase, the gay man may increase his alienation from potential sources of support. Because of the sense of perceived rejection by social supports, possible sources of new support may also be viewed as potentially rejecting. The gay man who makes a suicide attempt may be closeted at the time or may have experienced rejection as a result of self-identification as being gay in the coming out process. Being closeted and/or rejected for coming out frequently elicits psychological stress and the suicidal gay male may make a suicide attempt during this stressful event, as a result of his relative isolation or in the fear (or actual experience) of rejection from potential social supports (Schneider et al, 1989).

Testing for the HIV antibody is frequently accompanied by mild to moderate psychological distress (Catalan, 1990). For those individuals testing positive, psychological distress with short-term or long-term implications may be evidenced. The range may include adjustment reactions of despair, grief, guilt, anxiety, and/or depression. More serious forms of distress may include suicide, which are frequently experienced by those individuals with multiple psychosocial stressors. These multiple psychosocial stressors include social isolation and alcohol abuse, and are seen in those for whom denial is a primary defense mechanism or in those who perceive themselves as victims (Rundell et al., 1988).

A MODEL OF ASSESSMENT AND INTERVENTION

Hoffman's (1991) discussion of the special characteristics of seropositivity takes into account individual differences and differences in environments. Understanding the importance and devastating effect of a seropositive diagnosis is the underpinning of the first component of the model. The relevance of this is due to the chronic, progressive nature of HIV infection, the stigma, timing, and how these special characteristics limit the responses that a HIV infected person may make.

The model was developed from an understanding that there are six-stages of disease progression. The six stage process of HIV disease is best understood as a continuum with risk behavior at one end of the continuum and stage six being the development of AIDS. The responses that a client can make throughout the disease progression are discussed with awareness that due to the chronic, catastrophic features of the disease, individuals may not be able to maintain or regain equilibrium over the course of the life transitions stemming from progression of the disease.

In her work with HIV positive and AIDS patients, Hoffman (1991) constructed a model for understanding and working with the emotional, social, and psychological needs of these clients. The model consists of four components which are helpful for the clinician in assessment and in guiding the counseling process. The first component includes the special characteristics of seropositivity. This is an important and necessary aspect of understanding the impact of HIV infection on the client. This component underscores that a diagnosis of seropositivity is limiting and most likely catastrophic to nearly all (if not all) who receive it--and that there are events that are experienced to some degree by nearly everyone who is infected. (p. 470).

The first component includes the stigma closely associated with seropositivity and AIDS. The final, special, or limiting characteristic of HIV infection is the time in life when individuals are diagnosed or become ill. Overall, AIDS has impacted a relatively young group, who may be developmentally unprepared to deal with the extraordinary losses associated with HIV disease and AIDS.

The second component of the model was designed to focus on social supports. It is reported to be useful in the assessment process and in providing intervention through examining the interpersonal and the institutional support structures currently operating in a client's life. HIV infected individuals receive the most help in dealing with physical and psychological symptoms from their interpersonal support systems. Hoffman discusses the less stable institutional social supports which change as the individual's involvement in these relationships change. Included in these institutional sources of support are employment, religious or spiritual supports, and community agencies.

The third component of the Hoffman model involves an understanding of the initializing characteristics of HIV seropositivity. This may involve the identifying source, timing, onset and progression of symptoms, role change, and stage of emotional reaction to the disease. Incorporated in the Hoffman model is the need for individuals to know how they contracted the disease, and

the impact that a life-threatening disease at one's most productive and contributing time in life has had on their life. Assessing the degree of distress as it relates to the uncertainty yet progressive nature of the disease, and role changes surrounding multiple losses are included in this component.

Imbedded in the third component is Nichols' (1983, 1986) four-stage model of emotional reaction. The four stages involve initial crisis, early deterioration, acceptance, and preparation for death. Hoffman suggests another stage be included before the preparation for death stage. She suggested adding a stage identified as "adjusting to long-term progressive illness" (p. 483).

The final component of the Hoffman assessment model involves examining the individual characteristics of the client which may influence the progression of HIV disease. Assessment of several categories needs to occur. These include, a person's psychosocial competence, the individual's self-esteem, and a person's self-efficacy as this influences a person's success or failure in handling transitions. Also addressed in this component of the model is cognitive appraisal. Responses to HIV infection are varied, contingent on attributional style and appraisal of future threat and challenges (p. 485).

One of the major issues that Hoffman attends to in this component involves gender and gender role identity. Concerns may range from

emotional experiences derived from coming out and gender identity for gay men to gender identity for heterosexual men and women due to the high incidence of AIDS in gay men. The importance of assessment in women is discussed because of the various concerns which do not affect men. These include concerns surrounding dependent children, the transmission process and/or role loss for women with no children. It should be noted that there is a disproportionate incidence of AIDS in minority and racial groups in the United States. This concern involves the client's access to health care and social services.

An important feature of the fourth component is the awareness that changes in health may affect work, energy, social confidence, and body image. Since the identification of AIDS, advances in treatment have recognized categories related to disease progression based on an individual's state of health. These categories now include asymptomatic, symptomatic, and having AIDS.

Lastly, in the fourth component, attention is given to life style and cofactors of HIV infection. The issue here is how life style factors are related to immune functioning. Assessing a client's illicit drug use, alcohol and cigarette use, infections with sexually transmitted diseases, and repeated

infections with common viruses are all relevant in terms of immunosuppression and the risk for infection or deterioration.

With this assessment model of HIV/AIDS infection as an inter-related network, Hoffman (1991) expands into the realm of counseling strategies and explores the challenges that may present in the course of treatment for client and therapist alike.

The Hoffman model identifies and assesses the myriad of physical, social, psychological and emotional concerns that HIV/AIDS patients encounter in the process of HIV disease. The model provides a framework in which systematic assessments may be made of the stressors that one may encounter that contribute to a higher risk of suicide.

SUICIDE

Durkheim (1951) provided a useful framework for understanding social influences on the potential for suicide among the members of a given society. Durkheim argued that collective representations of a societal nature are different in character from the representations of those of the individual. Although the basis of a society is made up of individuals, the combination of these individuals creates the "psychical existence" of a new entirety, which

consequently has its own manner of thinking and feeling. The association of individual consciousness, when combined to form something new, actually alters something in the world. Durkheim bases his conclusion on the proposition that the social whole is qualitatively different than the sum of its parts.

Durkheim recognized that differences exist between individual representations and collective (social) representations. Social states of mind are considered to be qualitatively different from individual states of mind and are in a sense exterior to individuals. The number of suicides in a society is relatively stable, and Durkheim argued that this is due to the influence of a common cause which dominates and survives the individual persons involved. The force which is transmitted to the suicidal individual is external to each of them.

This force, in the form of its collective representations, has an existence of its own; it is as real as any other cosmic force and has an influence on individuals from without. Rotter (1966) acknowledged the importance that Durkheim placed on the concept of alienation as it relates to internal-external control on a group level. Durkheim argued that this cosmic force is evidenced by the uniformity of the effect as evidenced in the stable suicide rate in a society. This view does not, however, explain the increased

rate of suicide within the gay community or those living with HIV disease or AIDS unless these individuals are understood to comprise a social entity alienated from the society at large.

The principle of uniformity may, however, be applied to the consistency of higher rates of suicide within the gay community. Durkheim (1951) discussed the nature of these forces as existing within a moral order. He stated that "except for individuals, there is no other moral order of existence in the world but society, they (the forces) must be social" (p. 309).

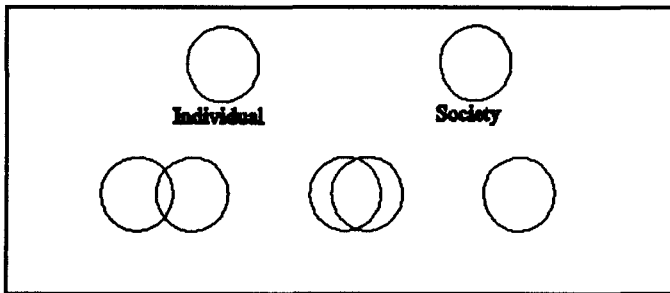
According to Durkheim, the kind of suicide discussed here would be classified as anomic suicide. *Websters New World Dictionary* (1982) defines anomic as, "Without law; lack of purpose, identity or ethical values in a person or in a society; rootlessness." Anomy has at its core the lack of presence of the collective representation within the individual.

To understand what Durkheim may have intended, an explanation or interpretation is necessary. An explanation which utilizes Durkheim's concepts can be found in the discussion of the mandorla which is found in *Owning Your Own Shadow*, (Johnson, 1991). The discussion proceeds from an understanding that mandorla is the almond shape that is created when two circles partly overlap. This symbol signifies the overlap of opposites. The pair of opposites that Durkheim talks about in referring to anomie is society

and the individual. The goal of mandorla is that the two circles will become entirely overlapped so that one sees that there was only one circle all along.

"The two circles are only the optical illusion of our capacity- and need- to see things double", (Johnson, 1991, pg. 109).

Figure 1



This explanation can be applied to Durkheim in terms of the need to keep things double and the social forces which prevent enough of the individual to be present in society and society to be present in the individual. The problem develops for the gay or lesbian individual when the amount of overlap is small or shrinking. With small overlap the problem for the individual becomes a problem of existence in society.

So, according to Durkheim, the external collective forces of a society have an effect on the individuals within that society. The regularity of the suicide rate within any society may be explained by: "the definite currents

impelling its inhabitants with a definite force...to behavior of every sort likely to involve those in trouble" (Durkheim, 1951, pg.306).

Durkheim further discussed the transmission process for social phenomena. It is purely social in that it is passed from one individual to another. He discussed the special nature of the transmission process of suicide. Suicide is a phenomenon that is transmitted from individual to individual, and to a nearly equal number of individuals. Given that transmission is to an equal number of persons, Durkheim perceived that the transmission process involves something other than mere individuals. The inference that we can make from Durkheim is that suicidal individuals experience an interruption or alienation from established social representations. This may be experienced as separation or alienation from social support. This process may occur as a result of experienced rejection or disempowerment for full autonomous functioning in a socially recognized fashion.

Turning to theory, we may gain some insight and explain the ensuing process of rejection, limited participation, and possible estrangement of social supports. This is to say that the individual's perception of his homosexual being will not be mirrored by his social support structures (family, friends, schools or religion). The basic problem is that this non-mirroring (internalization of unreflected experiences and behaviors) will be organized

from a rejecting position and introjected as a bad self (Jacobson, in Greenberg & Mitchell, 1983).

Accepting and understanding one's identity as a homosexual within the social climate of the United States parallels one's acceptance and understanding of oneself as a potential target of bias and the threat of violence. As social supports become estranged and new ones are yet to be formed, a young gay man or lesbian woman may be victimized by violence. Documented increased violence against young lesbians and gay men often includes social, verbal, physical and sexual violence (Comstock, 1991; Freiberg, 1987; Herek, 1989; National Gay and Lesbian Task Force, 1988, 1990; Schaecher, 1989; Whitlock, 1988). Other reports show an increase in violence toward adult gay men and lesbians (Berrill, 1985, 1992; Herek, 1989; Herek & Glunt, 1988; National Gay and Lesbian Task Force Policy Institute, 1991).

Anti-gay violence was described by Herek (1992) as "a logical, albeit extreme, extension of the heterosexism that pervades American Society" (p. 89). Governmental exclusion of alternative ways of living further increases the likelihood of violence. Since the advent of AIDS, presidential administrations prior to 1993 perpetuated discrimination. An example was the publication of the controversial U.S. Department of Health and Human Services' *Report of the Secretary's Task Force on Youth Suicide*, (U.S.

Department of Health and Human Services, 1989). Slater (1993) reported that a controversy had surrounded the discussion of the increased risk of suicide for lesbian and gay youths, which may be three times that of heterosexual youths. It was believed that discussing homosexual persons in a government report was not consistent with the focus of "traditional family values." The release of the report was accompanied by a disclaimer to clarify that the appearance of homosexual references did not constitute government support. Slater (1993) states that: "Clearly the United States government at that time was willing to allow the deaths of lesbian and gay youths from suicide in order to suppress information which might have been useful in alleviating such tragedies (p. 179).

Gibson (1989, p. 3) suggests that the increase in suicide among gay and lesbian youths results from "a society that discriminates against and stigmatizes homosexuals while failing to recognize that a substantial number of its youth are gay or lesbian in orientation." Violence toward gay and lesbian youths may also manifest itself as violence toward self in the form of suicidal behavior (Gibson, 1989; Hunter & Schaefer, 1990; Savin-Williams, 1994). Risk for suicide increases for those who have interrupted social ties (Dublin, 1963). Self-violence in the form of suicide has been found to be two to seven

times more likely among gay men and lesbians women than heterosexual comparison groups (Bell, 1978; Jay, 1979, Saghir, 1973).

Hunter (1990) reviewed charts of the first 500 youths seeking services in 1988 at the Hetrick Martin Institute, a community based agency in New York City that provides social services primarily for gay and lesbian youth and their families. Over forty percent of those involved in programs there reported experiencing violent physical attacks, with 46% of the violence being gay related. Suicide ideation was found among 44% of those experiencing violent physical attacks, with 41% of the females and 34% of the males having made suicide attempts since the violent attacks.

Gala et al (1992) found two periods for increased risk of suicide in HIV+ and AIDS patients. The first period spans the first 6 months after HIV diagnosis and the second high risk period is after 3 years from diagnosis. Suicide rates were found to be 17 to 36 times higher for individuals who were diagnosed with Acquired Immunodeficiency Syndrome (AIDS) (Hull, Sewell, & Wilson, 1985, Kizer et al., 1988). In a United States study of men with AIDS aged 20-59, Marzuk (1988) reported a 36% increase in the risk for suicide as compared to men of the same age group who did not have AIDS and a 66% increase as compared to the general population. In the Natural History of AIDS Psychosocial Study, some form of suicide ideation was reported in 27%

of the HIV positive and HIV negative men who were at risk for developing AIDS (Schneider, Farberow, & Kruks, 1991).

Currently, there is growing popular acceptance of suicide and euthanasia, but it is restricted to cases of incurable disease, terminal illness or debilitating pain (Fujimura, Weis & Cochran, 1985). In a study attempting to determine whether attitudes about suicide were influenced by the type of illness, Deluty (1988-1989a) provided results that indicated that college students did not judge all suicides to be the same. The study showed that students considered suicide more favorable in the face of terminal illness, as compared to severe psychiatric illness, and their evaluation of suicide in response to chronic physical pain was also more favorable (albeit not always significantly so) than for psychiatric illness.

In a follow-up study by Deluty (1988-1989b) the previous findings were replicated using a college age sample. In addition to the variables in the first study, the variables of age and gender of the individual suicide client and the gender of the evaluator were part of this study. The results of the study indicated that these new variables are related to the acceptability of suicide. For example: suicide by elderly persons is perceived to be significantly more acceptable than suicides by middle aged persons. Female evaluators rated suicide as being significantly more foolish, more wrong, less permissible, and

less acceptable than male evaluators. Martin and Range (1991) conducted a study of undergraduate students and found similar results. The respondents supported the view that people with incurable diseases should be allowed to complete suicide in a dignified manner. That is to say that the results of the study showed more tolerance of suicide if the victim is suffering great pain. It should be noted that the study was done with disease diagnosis as an independent variable (cancer and AIDS were the diseases compared in the study). The results indicated that people were more tolerant of suicide if the patient had AIDS than if he or she had terminal cancer because of the social stigma that frequently accompanies AIDS.

The growing acceptance of suicide in the case of AIDS was the groundwork for an argument for rational suicide (Werth, 1992). Controversy over what constitutes rational suicide has prompted authors (Choron, 1972; Humphry, 1987; Siegel, 1986) to develop criteria for rational suicide. The idea of rational suicide is closely connected with the AIDS epidemic (Glass, 1988; Smith, 1989). Siegel (1986) outlined the characteristics of a rational suicide as follows:

- (1) the individual possesses a realistic assessment of his or her situation,
- (2) the mental processes leading to his or her decision to commit suicide are unimpaired by psychological illness or severe

emotional distress, and (3) the motivational basis of his or her decision would be understandable to the majority of uninvolved observers from his or her community or social group (p. 407).

Werth (1992) proposes that, in cases of AIDS patients, if an argument for rational suicide can be determined according to criteria, the role of the counseling psychologist should shift from the traditional role of prevention of suicide to that of allowing suicide. In an article highlighting professional and individual concerns for counseling psychologists, Rogers and Britton (1994) express concerns with the position that Werth (1992) proposed about rational suicide and AIDS. Their concerns are focused on three areas. The first concern is with the assumptions drawn by Werth (1992) that there is a growing acceptance for suicide for terminally ill people and the elevated suicide rate among people with AIDS. The second concern involves questioning the rationality criteria for acceptance of suicide in certain cases and the social implications that sanctioning suicide in these cases would have. Thirdly, their concern raises the issue of the abandonment of a traditional counseling psychology perspective in such a rationale.

The professional role in preventing suicide has been clearly built into General Principle E, Social Responsibility, of the "Ethical Principles of Psychologists and Code of Conduct" (American Psychological Association

[APA], 1992). The center of the principle is the concept to do no harm. This has been incorporated as a professional role which includes prevention of a client doing harm to oneself. This is further clarified in the Ethical Standard 1.14 Avoiding Harm. This standard refers to reasonable steps to be taken to avoid harming the client and to minimize harm that is foreseeable and unavoidable. Szasz (1986) opposes assuming this responsibility. Szasz (1976) argues that since a person's life is his or her own, then he or she has the right to complete suicide (p. 137). He advocates the principle of the autonomy of the client and views suicide prevention as incompatible with therapeutic procedures.

Considering the controversy surrounding HIV/AIDS and the general discomfort of discussions about suicide, the study to be described in what follows was designed as an attempt to explore social, intra-personal and inter-personal relationships between HIV/AIDS and suicide. This study was anchored within the context of the professional and popular literature related to various life issues of the gay community in the U.S. primarily because of the close association with AIDS to the gay community. Various studies and authors were cited in an attempt to systematically explore the social components of the gay experience in the U.S. which include topics of breaks

in social ties, confronting stereotypes, disillusionment with self, grief and loss, violence of a social nature and violence toward self.

A review of the literature indicated that there is a significantly higher rate of suicide among gays, lesbians, and bisexuals in the U.S. Research and theories suggest various reasons to account for this fact. The variables which may contribute to the high suicide rate among gays, lesbians, and bisexuals are included within the context of this study. It is hoped that this research will document relationships that exist among factors that people living with AIDS experience that may be similar to the factors contributing to the higher incidence of suicide among gays, lesbians, and bisexuals.

The higher incidence of suicide among people with HIV/AIDS raises questions as to what variables are contributing to the increase. The variables assessed in this study will hopefully be useful in evaluating people living with HIV/AIDS and serve as a guide into the intervention of the psychosocial treatment of HIV disease and AIDS.

This study was designed to explore a number of variables which may be related to hopelessness and suicide probability. Included in the study are variables of an intrapsychic nature such as depression and locus of control for reinforcement. An effort will also be made to explore the relationship that

violence and various aspects of social support may have with hopelessness and suicide probability.

CHAPTER III

METHOD

Participants:

Agencies in several midwestern states that provide information about prevention of HIV, support groups for living with HIV, and information about medication and drug trials were contacted for participation in this study. Data collection occurred over a 10 month period of time. Disinterest in this study and lack of response excluded agencies from participation.

In order to be included in the study, all participants must have had a HIV positive status and/or a diagnosis of AIDS. The sample consists of male and female respondents, 18 years of age or older, who received services from the agencies sampled.

The HIV +/AIDS participants were asked to complete a battery of inventories. In addition, two other people, closely associated with each participant, were asked to complete a questionnaire that was designed to assess similar categories as those put to the HIV +/AIDS respondents. The two

persons who completed the index about the HIV+ participant must have had a relationship with the participant that would include knowledge of their health status and behaviors that may indicate consideration of suicide in the subject. The person might be a lover, roommate, immediate family member, and or other primary care-giver.

Procedure:

It should be noted that the study included a double blind design. The researcher did not know the identity of the participants and the agencies involved did not have access to the responses of the participants. However, due to the sensitivity of the instruments used in the investigation, if any of the participants in the research scored high on any of the depression or suicide probability scales, the participant was informed that the researcher would contact the participating agency by protocol number and report the finding to the agency. The rationale for this procedure involved the possible need for intervention which the agency could provide because of the ongoing established relationship with the participant.

The purpose of the study was to identify those factors that are related to hopelessness and the probability of suicide among HIV+/AIDS individuals

from the time of diagnosis and over the course of the disease. Factors related to hopelessness and the probability of suicide were determined through a series of self-assessment procedures. The factors assessed included depression, locus of control, victimization by violence, and social support. Hopelessness was assessed using the Beck Hopelessness Scale (BHS). The probability for suicide was assessed using the self-report Suicide Probability Scale (SPS). Other factors explored in the study included: the possible relationship among being treated stereotypically and hopelessness and suicide probability, the relationship among one's value in society and hopelessness and suicide probability, and the relationship among the importance of religion and hopelessness and suicide probability.

Distribution of the research instruments was conducted by the case workers at the participating agencies. The battery of instruments was distributed in packets which contained instruments to assess social support, locus of control, depression, hopelessness, and the probability of suicide. Each potential participant received three packets containing these instruments. The potential participants were asked to respond to the set of instruments included in packet #1 and return them in the pre-paid business mailer that was included. A consent form was also included in the packet in a separate envelope. A pre-paid envelope addressed to the participating agency

accompanied the consent form. In an effort to reduce confusion for the participant, corresponding color label dots were placed on the instruments and the business mailer, indicating to the participant that the color matching items were to be returned by mail to the researcher. Different coordinating color dots were placed on the consent form and agency envelope, indicating that these items were to be matched and returned to the agency.

As noted above, the potential participants were asked to request that two peers respond to another set of instruments (packets 2 and 3) on behalf of the HIV+/AIDS individual. Included in each of these packets was a consent form, a pre-paid envelope with coordinating color dots in which to return the correct form to the agency, a questionnaire, a business size envelope with coordinating color dots in which to return the instruments to the researcher.

The comparative responses to the dependent variable measures were used to determine if the terminal status of HIV positive individuals and/or people living with AIDS (using a male and female sample) were related to hopelessness and at-risk suicidal behaviors.

Instruments:

The Suicide Probability Scale (SPS; Cull & Gill, 1982) is a self-report questionnaire designed to assess individual attitudes and behaviors that may shed light on risk of suicide. The 36 item scale takes between 5 and 10 minutes to complete. The SPS provides a global index for the risk of suicide among HIV positive individuals and people living with AIDS. The instrument appears to be highly reliable. The Alpha coefficient on study samples was reported to be .93 and the test-retest reliability coefficient was reported to be .94. These provide positive support for the use of the instrument (Cull, & Gill, 1982) . Content validity was assessed by using item analysis, criterion validity was estimated by comparing responses of those individuals who attempted suicide with the responses of those who did not attempt suicide, and construct validity was assessed by comparing scores on the SPS with scores on other instruments that measure suicide risk. Sub-scales of the SPS were designed to assess hopelessness, suicide ideation, and hostility.

The Beck Hopelessness Scale (BHS; Beck, Weissman, Lester & Trexler, 1974) was designed to measure an individual's negative expectations about the long-range and short-range future. This scale assesses hopelessness

as a possible indicator for suicide risk. The scale consists of 20 true-false items and takes about five to ten minutes to complete. It is reported in the manual that internal consistency is excellent with coefficients ranging between .82 and .93 with a mean coefficient of .87 (Beck, & Steer, 1988). Stability estimates in the manual are reported to be lower with a mean of .67. This estimate may raise some questions with respect to the stability of the construct of hopelessness, but the validity evidence discussion presented in the manual provides some support for content, concurrent, discriminant, and predictive validity. Sub-scales of the BHS were designed to assess: Feelings about the future, Loss of motivation, and Future expectations.

The Beck Depression Inventory (BDI). Originally designed by Beck and associates in 1961 (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961), the BDI was designed to measure severity of depression in persons already diagnosed as depressed. Revised as a short questionnaire (Beck, & Beamesderfer 1974), its current use includes clinical settings and research. The BDI consists of 21 items with four options per item. It is estimated that it will take the average person five to ten minutes to complete the BDI.

The BDI has been found to be predictive of suicidal behavior (Emery, Steer, & Beck, 1981 ; Lester & Beck, 1975). In a number of studies with

non-psychiatric samples, test-retest reliability estimates were reported to range from .60 to .90. Internal consistency estimates of .81 have been reported for non-psychiatric subjects (Beck, Steer, & Garbin, 1988). Beck's review (1988) includes a list of studies supporting the concurrent and construct validity of the instrument. High mean correlations were documented between the BDI and clinical ratings of depression in psychiatric populations (.72) and with normal populations (.60).

The Personal Resource Questionnaire (PRQ 85) (Weinert, 1987) is a self-administered tool designed to assess social support. The instrument focuses on three factors: Factor I, Intimacy and Assistance; Factor II, Reciprocity of Support; and Factor III, Integration and Affirmation. The PRQ 85 requires approximately fifteen minutes to complete. Ongoing validity and reliability studies lend strong support for the use of the PRQ 85 as a measure of social support. Several researchers reported Cronbach's alpha to be in the range from .87 (Muhlenkamp, 1985, in Weinert, 1987) to .90 (Catanzaro, 1986, in Weinert, 1987) for the total scale with an alpha range of .62 to .68 for the Nurturance sub-scale. Evidence of construct validity for this instrument was obtained by correlating the scores on this measure with scores from instruments measuring depression and anxiety. Norbeck, Lindsey, and

Carrieri (1983) found that the strength and direction of correlations was consistent with the construct of social support. Sub-scales of the PRQ 85 were designed to assess: Urgent needs; Social support satisfaction; Intimacy; Reciprocity; and Integration.

Internal versus External Control of Reinforcement

The Rotter (1966) is a self-administered 29 item, forced choice instrument designed to assess whether a person perceives a reward as being contingent on his or her own behavior or independent of it. The time requirement for completion of the instrument is estimated to be between 5 and 10 minutes. An externally controlled person would perceive reinforcement as following some action but not being entirely contingent upon that action. An internal controlled person would perceive an event as being contingent on their own behavior or on their relatively permanent characteristics. Internal consistency estimates have been reported to be relatively stable with a range of .65 to .76 (Rotter, 1966). Test-retest reliability estimates range from .60 to .83 for a 1 month interval and .49 to .61 for a 2 month interval (Rotter, 1966).

Demographic Questionnaire:

This instrument was designed by the researcher in an effort to collect specific information relevant to the study about each participant. Included in this instrument are questions related to age, race, marital status, sexual orientation, religion, education, and employment status. Imbedded in the instrument are 8 questions that were designed to assess the participants victimization by violence. There are 7 questions related to health status. There are also 8 questions about social support. Two of the social support questions were open ended and provided the participants the opportunity to tell their stories. One of the social support questions was designed to assess the participants perceived value in society and another question was designed to assess whether the participants feel that they have been stereotyped by society.

The Demographic questionnaire that the participant completed included the following information about the participant: involvement in counseling; degree of involvement in the gay community/AIDS community; degree of involvement and / or experience with the terminally ill; demographic information; number of losses: number of friends who are HIV+, number of friends who have died from AIDS. The questionnaire also included items related to a history of violence, health status, and social support.

The questionnaire that the two friends completed was designed to collect information about the participant from the perspective of a peer who was close to them. There were six questions on the instrument and is intended to mirror the categories assessed in the battery of instruments completed by the participant. Included were questions related to social support, amount of time spent together, the participants mood (specifically depression), expectations about the future, and comments or discussion about suicide as a way to solve the participants problems.

Design and Analysis:

The **Independent Variables** included the scores on: the Rotter Internal External Locus of Control instrument (a measure used to determine the degree that an individual organizes his or her world from an external locus of control); The Beck Depression Inventory (a measure to determine the degree that an individual is depressed); and The Personal Resource Questionnaire (PRQ 85), a measure used to determine the size, nature, utilization, and satisfaction with social support).

Additionally, information was gathered within the contest of a demographic questionnaire that was used to assess the differential influences of

gender, race, current living setting, and exposure to violence in the respondents views of the future.

Dependent Variables:

There are two Dependent variables included in the study. The Suicide Probability Scale and the Beck Hopelessness Scale were used to assess hopelessness and suicide.

Research Questions:

The study was designed to address the following research questions:

1. Is there a relationship between depression and hopelessness?
2. Is there a relationship between locus of control and hopelessness?
3. Is there a relationship between social support and hopelessness?
4. Is there a relationship between violence and hopelessness?
5. Is there a relationship between depression and suicide?
6. Is there a relationship between locus of control and suicide?
7. Is there a relationship between social support and suicide?
8. Is there a relationship between violence and suicide?
9. Is there a relationship among depression, locus of control, social support, violence, and hopelessness?

10. Is there a relationship among depression, locus of control, social support, violence, and suicide?
11. Are the hopelessness scores lower for those who reside in an urban/suburban area than those who live in rural and small towns?
12. Are people who live in urban/suburban areas at lower risk for suicide than those who live in rural and small towns?
13. Are people who have achieved higher levels of education less hopeless than those who have not achieved higher levels of education?
14. Are people who have achieved higher levels of education at less risk for suicide than those who have not achieved higher levels of education?
15. Do people who feel valued by society experience less hopelessness than people who feel unvalued by society?
16. Are people who feel valued by society at less risk for suicide than people who feel unvalued by society?
17. Do people who are accepted for who they are experience less hopelessness than people who are stereotyped?
18. Are people who are accepted for who they are at less risk for suicide than people who are stereotyped?

An important component of the research design involved the participation of two friends or family members whom the participant selected

who would fill out a six question questionnaire. The return rate of this component was so small that it's inclusion in the study was abandoned.

CHAPTER IV

RESULTS

The current study includes 50 HIV-positive and AIDS patients in a metropolitan and suburban area in a mid-western state. There were only 42 males and eight females who completed the research materials, representing an 18 percent return rate. One agency destroyed 10 packets of the research materials citing disinterest by the African American male population that it serves. With a slow return rate, the researcher contacted other out of state agencies. These agencies declined to participate, citing that the questions about violence due to sexual orientation would be offensive to the population that they served.

The mean age was 38 with a range of 22-62. The racial ethnic diversity of the sample consisted of 62 percent Caucasian, 24 percent African American, eight percent hispanic, and six percent other. Over 50 percent of the sample lived in a large city, 20 percent lived in a suburban setting, 28 percent lived in medium sized cities, small towns, and rural settings.

The sexual orientation of the sample included 70 percent gay or lesbian, 22 percent heterosexual, six percent with a bisexual orientation.

Eighty-six percent of the sample was "out" with respect to their sexual orientation. The educational profile of the sample showed that 54 percent of the sample were high school graduates; 14 percent had earned an associates degree, and 30 percent had earned a bachelor degree or higher.

Thirty four percent of the participants expressed a very positive outlook for their future and 23 percent expressed a very negative outlook for their future. Thirty-four percent of the sample stated that they felt under valued by society. Seventy-four percent said that they had managed to develop a social support network that included five or more people. Counseling services were reportedly used to some degree by 60 percent of the sample. A summary of the demographic data is presented in TABLE I.

An examination of the results indicated that HIV +/-AIDS patients are mild to moderately depressed. There was also evidence that the participants were externally controlled. Overall, the results of the study indicated that the participants are satisfied with their perceived social support. According to information yielded by an examination of the Beck Hopelessness Scale, 34% of the respondents were in the score range that is classified as suicide attempters; 22% of the respondents were in a range classified as major depression. Mean scores on the Suicide Probability Scale for normals was found to be 44.9 (Cull & Gill, 1982). The mean for this sample was 57.0.

Cull and Gill report a mean for suicide attempters as 84.0. In this study, 8% of the total sample scored above the mean of 84.0. Sixty-eight percent of the sample reported being the target of attack in some form. Comparing the mean scores of normals on the Suicide Probability Scale sub-scales with the scores of the sample, 46% of the respondents were found to be more hopeless, 28% experienced more suicidal ideation, 24% had a greater negative self-image, and 22% had a greater hostility than the scores reported for normals. Alpha values for the instruments used in this study fell within the published ranges (see APPENDIX IV). Of particular note, the findings related to the PRQ85 were found to be consistent with prior research. The alpha for this study was in the high range.

The Pearson Product-Moment correlations between all variables, the Suicide Probability Scale, and Hopelessness are presented in TABLE II. The first research question of the study was directed at the documentation of a relationship between depression and hopelessness. The Pearson Product-Moment coefficient of .7368 with $p \leq .01$ supports the existence of a relationship. The second research question focused on the relationship between locus of control and hopelessness. The Pearson Product Moment correlation of .4390 with $p \leq .01$. indicates that external locus of control was related to hopelessness. The third research was addressed at determining the

possibility of a relationship between social support and hopelessness. The Pearson Product Moment correlation of $-.4557$ with $p \leq .01$ indicated that there was a relationship between perceived social support (PRQ11TOT) and hopelessness. The fourth research question asked if there was a relationship between violence and hopelessness. The relationship between violence and hopelessness was also found to be significant with a Pearson Product Moment correlation of $.3136$ with $p \leq .05$.

The fifth research question was focused on the relationship between depression and suicide. Depression was found to be significantly related to suicide probability ($r = .7063$, $p \leq .01$). The sixth research question was directed at documenting the existence of a relationship between external locus of control and suicide. The external locus of control cognitive style variable was found to be related to suicide ($r = .4318$, $p \leq .01$). The relationship between social support and suicide was addressed in question seven. PRQ urgent needs (social support) was found to be related to suicide ($r = .3706$, $p \leq .01$). The eighth question was targeted at determining a relationship between violence and suicide. Violence was found to be significantly related to suicide ($r = .3096$, $p \leq .05$). These findings are presented in TABLE II.

The ninth question was directed at determining the existence of relationships among depression, locus of control, social support, and

Hopelessness. A multiple regression procedure was applied to the data set. The following variables were used in the stepwise entry: depression (BDI) scores; Rotter internal external locus of control scores; and social support PRQ85TOT scores. The sub-scales from these instruments were included in the analysis. The sub-scales included: SPS hopelessness; PRQ85 intimacy; PRQ85 reciprocity; PRQ85 integration; PRQ85 urgent needs; SPS negative self; SPS suicide ideation; and SPS hostility.

A stepwise linear regression procedure was used to predict hopelessness using the sub-scales of the Suicide Probability Scale as independent variables. Depression accounted for 52% of the variance, hopelessness (sub-scale of SPS) accounted for an additional 11% of the variance, and reciprocity, (a sub-scale of social support PRQ85) accounted for an additional 4% of the total variance. Results of the regression analysis are presented in TABLE III-A.

A stepwise linear regression procedure was used to predict hopelessness using the total score of the Suicide Probability Scale as an independent variable, three predictor variables were identified. The total score of the SPS accounted for 53% of the variance, depression accounted for an additional 8% of the variance, and reciprocity (a sub-scale of social support PRQ85) accounted for an additional 5% of the total variance. These findings are presented in TABLE III-B.

Question ten was targeted at documenting a relationship among depression, locus of control, social support, and suicide. A stepwise linear regression procedure was used to predict suicide. Using the sub-scales of the Beck Hopelessness Scale, three predictor variables were identified. Loss of Motivation (sub-scale of BHS) accounted for 50% of the variance, depression accounted for an additional 13% of the variance, and social support PRQ85 urgent needs accounted for an additional 7% of the total variance. These findings are presented in TABLE IV-A.

A stepwise linear regression procedure was used to predict suicide probability. Using the Beck Hopelessness total score as an independent variable, three variables were found to be predictive of suicide probability. Hopelessness (BHSTOT) accounted for 53% of the variance, social support PRQ85 urgent needs accounted for an additional 10% of the variance, and depression accounted for an additional 4 % of the total variance. Results of the regression analysis are presented in TABLE IV-B.

In addition to the series of Pearson Product Moment Correlation analyses, t-tests were used to determine if there were any demographic differences between the various groups. TABLE V is a summary of the t-values. Question eleven was directed at determining if there were any differences in the hopelessness scores based on a persons place of residence.

For the variable Hopelessness, the t-value for living situation was found to be significant, $p \leq .05$ level. Group 1 consisted of people living in urban and suburban areas and group 2 consisted of people living in rural areas, small towns and medium cities. The possibility of suicide risk based on a persons place of residence was addressed in question twelve. No significant difference was found.

Question thirteen was focused in documenting a difference for hopelessness scores across educational level. Significant differences were found ($p \leq .05$) between high school graduates and college graduates. Question fourteen was directed at determining if there were any differences in suicide risk across educational level. The results of a 2 tailed t-test indicate that there were significant differences for these groups.

Question fifteen was directed at determining if there were any differences in the hopelessness scores based on how valued a person feels by society, or how unvalued a person feels by society. Significant differences with $p \leq .001$ were found between groups with low to not feeling valued at all by society and the high value groups. Question sixteen was directed at determining if there was any difference for suicide based on how valued a person feels by society, or not feeling valued by society. A significant

difference with $p \leq .01$ level was found between these same groups on the Suicide Probability Scale.

Question seventeen was targeted at determining if there were any differences in hopelessness scores based on being accepted for who you are, or on being stereotyped. Significant differences were found between groups who reported few or no people who accepted them as a person and not as an AIDS stereotype and groups who reported that they had five or more people who accepted them. The dependent variable Hopelessness was significant with $p \leq .01$ level. The last question addressed if there was any differences in the suicide probability scores between being accepted as a person, or being stereotyped. These differences were found to be significant with $p \leq .001$ level.

In addition to the 18 research questions posed, a more fine grounded analysis of the data is presented below related to on the sub-scales of the instruments used. The more fine grounded analysis of the data sets should increase our understanding of the relationships among locus of control, social support, violence, hopelessness, and suicide.

The correlation coefficients among depression, locus of control, suicide, hopelessness, social support, and violence are presented in TABLE VI. Violence was found to be significantly related depression ($r = .4393$, $p \leq$

.01), suicide ($r = .3096, p \leq .05$), hopelessness ($r = .3136, p \leq .05$), and perceived social support ($r = -.3241, p \leq .05$). The negative correlations suggest that average to moderately high perceived social support is negatively related to hopelessness and suicide probability. Thus, this suggests that average to moderate perceived social support serves as a possible buffer against hopelessness and the probability of suicide.

The perceived social support score (PRQ11TOT) is the total score of the PRQ85. The PRQ85 instrument packet and user guide establishes a mean score range between 112.3 and 149.2. The mean score for this sample was found to be 135.9. Perceived social support PRQ11TOT was found to be significantly related to depression ($r = -.3803, p \leq .01$), suicide ($r = -.3714, p \leq .01$), external L.O.C. ($r = -.4242, p \leq .01$), and hopelessness ($r = -.4557, p \leq .01$).

The sub-scales of the PRQ85 were found to be negatively correlated with suicide (SPS) (see TABLE VII). The correlation coefficients for the sub-scales were as follows: Intimacy ($r = -.4803, p \leq .01$), and Integration ($r = -.4612, p \leq .01$). The opportunity for Reciprocity was found to be negatively correlated with the SPS ($r = -.3087, p \leq .05$). The sub-scales of Hopelessness (BHS) were found to be correlated with the Suicide Probability Scale (SPS) (see TABLE VII). The (SPS) was positively correlated with Loss of

motivation ($r = .6698$, $p \leq .01$), Future expectations ($r = .6486$, $p \leq .01$), and Feelings about the future ($r = .5150$, $p \leq .01$).

The sub-scales of Hopelessness (BHS) presented in TABLE VII were found to be negatively correlated with social support. Significant correlation coefficients were found among the variables: Loss of Motivation ($r = -.4885$, $p \leq .01$), Future expectations ($r = -.3077$, $p \leq .01$), and Feelings about the future ($r = -.2943$, $p \leq .05$).

The sub-scales of the social support instrument (PRQ 85) were found to be negatively correlated with hopelessness. Intimacy was correlated with hopelessness ($r = -.5223$, $p \leq .01$), Reciprocity ($r = -.4713$, $p \leq .01$), and Integration ($r = -.5542$, $p \leq .01$). These findings are presented in TABLE VII.

These results suggest that depression and external locus of control are related to hopelessness. Additionally, perceived social support was found to be negatively related to hopelessness. Most researchers have defined stressors in terms of major traumatic negative life events. According to Beck's cognitive theory, stress is hypothesized to lead to suicidal behavior through the influences of hopelessness (Beck, 1967; Beck, Rush, Shaw, & Emery, 1979; Beck, Steer, Kovacs, & Garrison, 1985; Bonner & Rich, 1987, 1991).

Part I of the PRQ85 measure of social support presents 10 life situations in which an individual may need assistance. The situations are associated with various negative life events such as relationship problems, financial problems, health problems and career problems. An examination of the correlations for the 10 situations designed to assess Suicide Probability and Hopelessness indicated that the 10 life situations were negatively related to Suicide Probability and Hopelessness. The correlations for each situation, depression, locus of control, social support, and violence are presented in TABLE VIII.

Situation 1 was found to be significantly correlated with all of the variables; depression ($r = -.4261, p \leq .01$), suicide ($r = -.5098, p \leq .01$), hopelessness ($r = -.4066, p \leq .01$), and violence ($r = -.3769, p \leq .01$). Situation 2 was found to be significantly correlated with depression ($r = -.3797, p \leq .01$), suicide ($r = -.3942, p \leq .01$), external locus of control (L.O.C.) ($r = .3956, p \leq .01$), and hopelessness ($r = -.4795, p \leq .01$). Situation 3 was found to be significantly correlated with suicide ($r = -.2984, p \leq .05$), depression ($r = -.3858, p \leq .01$), external L.O.C. ($r = -.4987, p \leq .01$), and hopelessness ($r = -.4493, p \leq .01$). Situation 4 was found to be significantly correlated with violence ($r = -.3493, p \leq .05$), depression ($r = -.4777, p \leq .01$), suicide ($r = -.4090, p \leq .01$), external L.O.C.

($r = -.4154$, $p \leq .01$), and hopelessness ($r = -.4724$, $p \leq .01$).

Situation 5 was found to be significantly related to external L.O.C. ($r = -.3170$, $p \leq .05$), and hopelessness ($r = -.3519$, $p \leq .05$). Situation 6 was found to be significantly related to depression ($r = -.3105$, $p \leq .05$), suicide ($r = -.3000$, $p \leq .05$), hopelessness ($r = -.3519$, $p \leq .05$), and violence ($r = -.4084$, $p \leq .01$). Situation 7 was found to be significantly related to violence ($r = -.2941$, $p \leq .05$), depression ($r = -.4711$, $p \leq .01$), suicide ($r = -.4303$, $p \leq .01$), and hopelessness ($r = .5111$, $p \leq .01$). Situation 8 was found to be significantly related to depression ($r = .2969$, $p \leq .05$), suicide ($r = -.4131$, $p \leq .01$), and hopelessness ($r = -.3702$, $p \leq .01$).

Situation 9 was found to be significantly correlated suicide ($r = -.2964$, $p \leq .05$), and external L.O.C. ($r = -.3153$, $p \leq .05$), hopelessness ($r = -.3734$, $p \leq .01$). Situation 10 was found to be significantly correlated with suicide ($r = -.3305$, $p \leq .05$), depression ($r = -.4734$, $p \leq .01$), external L.O.C. ($r = -.3999$, $p \leq .01$), hopelessness ($r = -.5024$, $p \leq .01$), and violence ($r = -.3618$, $p \leq .01$). A summary of the correlation coefficients are presented in TABLE VIII.

A post hoc correlation analysis was also conducted on the demographic data set. The following correlation coefficients were found between the demographic variables: perceived social support and value by society ($r =$

.4976, $p \leq .01$), perceived social support and the number of illnesses experienced ($r = .4027$, $p \leq .01$), and the number of other HIV/AIDS patients known and the number of other HIV/AIDS patients known who have died ($r = .6851$, $p \leq .01$), age and the number of HIV/AIDS patients known who have died ($r = .3095$, $p \leq .05$), a persons physical health and how closely they follow an established health plan ($r = .2804$, $p \leq .05$), and physical health and number of illnesses experienced ($r = -.3266$, $p \leq .05$), positive future and the number of HIV/AIDS patients known ($r = .2873$, $p \leq .05$), positive future and number of HIV/AIDS patients known who have died ($r = .3262$, $p \leq .05$), negative future and a persons value by society ($r = .3123$, $p \leq .05$). For a summary of the correlation coefficients of the demographic variables, see TABLE IX.

As noted earlier, included in the demographic questionnaire were two open ended questions. Not all of the responses given are included in the discussion section. The responses were categorized into related groups or themes and a single response was include which captured the essence of the theme of that category. Several themes emerged. These themes will be discussed in Chapter 5.

In summary, a number of significant relationships were found among the psycho-social variables, hopelessness, and suicide probability. Depression,

an external locus of control, a reduction or break in social support, as well as a history of being victims of violence were found to be related to both hopelessness and suicide probability. The place of residence had an influence on hopelessness. Differences in educational level appear to influence hopelessness and suicide probability. Differences existed between groups treated like individuals compared to those being treated stereotypically. There were differences in hopelessness and suicide probability between groups being valued or not being valued.

Most notably, differences of whether a person is treated like a person or stereotype appear to have a profound influence on a person's probability of suicide and hopelessness. Related to this, differences between being valued by society or not valued by society seemed to have some influence on hopelessness and suicide probability.

The best fit predictive model for hopelessness included depression and aspects of social support. The best fit predictive model for suicide probability included hopelessness. Also included in the predictive model were depression and urgent needs (an aspect of social support related to degree of stress and problem solving).

CHAPTER 5

DISCUSSION

Several agencies in a mid-western state, providing HIV and AIDS counseling and support services in a metropolitan area participated in this study. One agency with services within the state participated by mailing the instruments to their clients. It should be noted that the sample included in this study represented only 18% of the total number of research packets distributed. This small return rate may be due to the social sensitivity of the research. The family and friends component of the research design may have decreased the willingness of some to participate. Other possible explanations may be that it was too threatening, and the reservation of the gay community to examination.

Research related to the window of opportunity for suicide among HIV+/AIDS patients indicates that the greatest risk is during the first six months of diagnosis (Gala et al., 1991). In this study there were no participants in this 3-6 month category. It remains unclear as to what occurs during this high risk period that would elicit fallout from the network of

service provision. Recently diagnosed and asymptomatic HIV+ individuals may see themselves as victims of the virus. In terms of their connection with the social support networks, they may react adversely because they don't see themselves in the same way as members of the social support groups who are battling incessant infections. Their lack of identification is an obstacle for them to make a committed connection to the social groups so early in their process of HIV infection.

The sample of HIV+/AIDS patients included in this study were found to be mildly to moderately depressed on average. There was also evidence that this sample shared an external locus of control cognitive style. Overall, the sample of HIV+/AIDS patients appeared to be satisfied with their perceived social support system. However, 40% of the respondents reported that they did not belong to a group where they felt important or got sufficient social support. This discrepancy may be explained by understanding that participants may be aware of the social support available but do not participate as members of the social support networks. Another explanation may be that they rely on one another as a means of support but do not feel that they would be accepted in the social support networks available to others.

The external locus of control cognitive style which the sample of HIV+/AIDS patients displayed in this study may present difficulties and

disappointments for them in their daily lives. A strong relationship was found between an external locus of control and social support. For this sample, an external locus of control was found to be related to perceived social support which is less available, to higher levels of hopelessness, and a higher risk of suicide.

One of the difficulties they may experience is related to their reliance on validation from external sources to define who they are. The complications which this presents are numerous. With an external locus of control, one may rely on reinforcement from social supports which may not be forthcoming. This appears to be related to Durkheim's understanding of the alienation process. According to Durkheim, the collective force is external to the individual and with an external reinforcement, alienated individuals may be at risk for receiving a dangerous collective representation.

From the perspective that social support involves a balance of contributing and receiving, for many HIV/AIDS patients, the opportunity to participate in this type of relationship may be diminished. Specifically, the negative social support correlation coefficients found in the study suggest that the balanced relationship of this view of social support involving intimacy, reciprocity and integration may be unmet for this sample of HIV+/AIDS patient. A person with an external locus of control places reinforcement of

their value outside of themselves. The sense of not being valued may be experienced in terms of being treated as a stereotype and not as an individual. This is very similar to Saunders and Valente, (1987) who portrayed society as placing groups into "protected" categories which removes the individual from participating fully in the society. For the HIV+/AIDS patients in this study, a strong relationship was found between social support (their network of people who love them and are available to help them) and their sense of hopelessness. An examination of the data also indicated that there was a strong relationship between social support and their risk for suicide.

Many social factors contribute to placing a HIV+/AIDS patient at risk for suicide. Social support may be diminished through loss of employment, dissatisfaction with religious institutions, and the death of other HIV/AIDS patients who have become major sources of support.

The post hoc analysis of the data set indicated that an individual's perceived social support is related to the social value of that individual. The results of this study also revealed that perceived social support is related to the number of illnesses that an individual experiences. In addition, an individual's value to society was found to be related to a negative future expectation. With social support diminishing, illnesses escalating over the course of HIV infection and AIDS, a person will probably experience urgent needs. Urgent

needs that develop and are unmet, may be experienced as stress which increase the risk for suicide. This interpretation is supported by Beck (1967) who reported that stress is one factor that produces increased levels of hopelessness and raises the risk of suicidal behavior.

There are several possible explanations for the failure of the family and friends questionnaire. One may be that the participant did not want to ask the person out of respect for their time. Another possible reason may be that disclosure of their HIV status has not occurred and the instructions on the questionnaire stated that the study was about HIV and AIDS. It is also interesting to note that on several of those that were complete, there were extreme differences in the information shared by the family members or friends. A possible cause for this discrepancy may be that information assessed in the questionnaire has not been shared with all of the participants family or friends and the questions may have elicited discussions which the participant did not want to have at this time.

As society perceives a person's value as being diminished, a pessimistic, dark, uncertain future may begin to permeate the individuals daily routine. A relationship was found between low social value of the person and negative expectations about the future. A complicating factor to this process appears to involve being victimized by violence. Making sense of violence

associated with one's sexual orientation is difficult for the victim because it occurs in a society which rationalizes the cause and permits such violence to occur. This view is similar to views reported by Slater, (1993) and Savin-Williams, (1994). A strong relationship was found between violence and reduced social support, violence and hopelessness, and violence and suicide probability.

Weiss's (1974) model of social support involving relational functioning includes the following concepts: (a) the possibility for attachment and intimacy; (b) social integration; (c) expression of nurturing behavior; (d) acknowledgement of individual worth and personal achievements; and (e) adequate informational, emotional and material assistance. However it should be noted that the data from this study suggests that those aspects of social support are not a part of the lives of HIV/AIDS patients. The attachment, intimacy, and nurturing aspects of this model are elusive to the HIV/AIDS patient due to the social distance created by discrimination and fear of contagion by the disease. They are further jeopardized by a history of external validation for personal worth and value which many of the respondents utilize that is now complicated by rejection, deterioration, and stigma.

Complicating the utility of the Weiss model and its application to this sample is the issue of understanding social support and the relationship with

violence. At the core of the Weiss model is the concept of reciprocal access to the social support network. With this in mind, difficulties would arise from the necessity for individuals to function with these social support expectations and the reality of what they actually get.

Hopelessness has been implicated in a variety of psychopathological conditions including suicide, (Beck, 1967). The view of suicide as a viable option has aspects of hopelessness that contribute to the development of suicide. Bonner and Rich, (1991) found that people come to view suicide as the only option when faced with no way to solve a crisis and having a future expectation that things will not improve. The data indicate that for this population, living with HIV/AIDS, negative feelings about the future, loss of motivation and a vague future are related to suicidal risk. Strong correlations were found between the hopelessness sub-scales and social support and suicide. Specifically, as one experiences negative feelings about the future, loss of motivation, uncertainty about the future, and perceived social support is less available. Negative feelings about the future, and loss of motivation and uncertainty about the future were found to be related to suicide probability.

Werth (1992) stated that with consideration to the physical and psychosocial aspects of AIDS, a realistic assessment of the patient's life may actually move the client closer to choosing suicide as a favored option.

Schneider (1991) stated that suicidal thoughts in response to the threat of AIDS may be a successful maneuver to control existential threats. Nietzsche provided some insight into this with his observation that: "The thought of suicide is a great consolation; by means of it, one gets successfully through many a bad night" (in Shneidman, 1984, p. 322). This approach to understanding an individual's attempt to resolve an otherwise hopeless situation is hopeful in that it is an assessment of viable options available in response to a death sentence.

With 70% of this sample self-identified as gay or lesbian, several interesting insights into their lives as HIV+/AIDS patients have surfaced. This is a group of resourceful and resilient individuals. In lieu of a diminishing social support network, a majority of HIV/AIDS patients appear to have a core group of family, friends or peers with whom they are connected. They interact with members of this core family who apparently treat them as a whole person and not with the stereotypical misgivings of social rhetoric.

Forty-seven percent of this sample viewed organized religion as an important aspect of their lives. It is interesting to note that between Catholic and Protestants, 15% of Catholics reported that religion was very important whereas 62% of Protestants reported that religion was very important in their lives. Some clarity on this disparity may be understood from the perspective

of organization. There has been a long vocal history within the Catholic church which has condemned homosexuality. However, similar condemnation exists in many Protestant Churches. An explanation must have roots elsewhere. The Catholic church is a worldwide system of organization with one man (the pope) who is viewed as the authority on spiritual life. It is a system of organization similar to that of a social order. Deviation from what the agreed upon authority states is cause for non-inclusion and exclusion. For many gays and or lesbians, their experience is that of non-inclusion.

Functioning from a position of disempowerment may be cause for a sense of frustration and discouragement and may lead to living out a spiritual life of entrapment, caught between identifying one-self as Catholic but not welcome to express one-self among Catholics.

The importance of religion however, for many HIV/AIDS patients is another dysynchronous event in their lives. For many people in our society, religion and reconciliation occur in the later stages of life. AIDS has affected a generation who deals with the whole life cycle in an accelerated fashion. This dysynchronous accelerated life cycle involves issues of assessing one's mortality, loss of health, loss of employment, loss of future, and for many the loss of friends to HIV/AIDS.

This study was targeted at an examination of the relationship between social convention and the lives of people on it's fringe. In doing so, information gathered from HIV/AIDS patients has been utilized to inform society about the whole of society. Gays and lesbians and HIV/AIDS patients are a part of the whole of society and most of them want to be able to see themselves reflected in the mirror of society. As members of society, they are given voice to describe their perspective of the society in which the live.

What they have told us (society) about who we are is from a position of abandonment and rejection and an urgency to experience inclusion and see themselves as embraced and integrated into the whole image which by definition, society reflects. Included in the research instruments were two questions which may shed some light on the current relationship that HIV/AIDS patients have with themselves and the relationship that they have with society. Question 28 and 29 were open ended questions: (When I look into the mirror as a gay person and or person with AIDS, what society tells me to see is: When I look into the mirror as a gay person and or person with AIDS, what I see is:). The responses to these questions were revealing and rather dramatic.

Some of the responses that respondents gave to question 28 included: a ghost; something that is not really there; a ghostly look, a death mask; In

general, I feel that society would just like to see me fade away; Someone who should be ashamed; A negative image; Society tells me to see something useless and worthless.

Some of the responses that respondents gave to question 29 included:

A loving human being; A vibrant healthy productive member of society; A good person who tries to be considerate of others and tries to help others less fortunate; Someone who is afraid of the future; A loving caring person, who accepts life on life's terms.

The multiple layers of loss, and the many variables included in this study appear to impact on the development of hopelessness and suicide in the lives of HIV+/AIDS patients. Often overlooked, the results of this study provide some support for the notion that society plays a significant role in the identification, communication and development of suicide in individual members of it's society. This concept is consistent with the Durkheim theory of suicide, specifically Anomic suicide. Durkheim has defined Anomic suicide whereby an individual member of society is identified as of no value, and the interactions that society has with that individual communicates that it would be acceptable to complete suicide to retain the established social value.

The instruments used in this study were selected because of the user friendly nature of their design. Consideration of the health status of the

sample under study was the guide in instrument selection. The instruments are good measures with sound psychometric properties. The constructs which are assessed in the study are independent of one another. The findings of the study are clinically useful and can be useful for non-clinical care givers. The implications of this study provide a framework for developing programs addressing the social ills which have become clearly delineated in reaction to HIV/AIDS. Continued research in this area is needed.

It is recognized that there are a number of limitations in this study. Overall, the study was designed as a descriptive study to give voice to those living with HIV and AIDS in our society. This goal has not been fully accomplished. Perhaps the greatest limitation to this study is the small response rate of 18%. This may be attributable to the lack of clarity of the instructions, the cumbersome nature of the coding procedures, and perhaps being overwhelmed by the tasks to be included. Another contributing factor to the small response rate may be related to the design which asked for two friends to complete questionnaires about their relationship. This may have reduced the willingness to participate in the study because it may have been perceived as threatening. Future research is needed to replicate the study with a larger sample. Future research in this area may consider using a sample of convenience in terms possibly eliciting greater participation in the study.

Another limitation to the study may have been the resistance of the gay community to examination. The history of the AIDS epidemic in the United States and the social backlash against people with AIDS may explain the resistance as it related to the double blind nature of the study.

Several useful findings have surfaced from this study. The first involves concern over the lack of participants in the critical 3-6 month time period. As noted earlier, this has been identified as a crucial time for HIV+ individuals. It is uncertain as to what occurs during this critical time period. This may reflect the fact that the recently diagnosed HIV+ patient is not involved in the social support network of the participating agencies. Another possible explanation may be that the social support network is not accurately addressing their needs and they do not get integrated into the network.

Hoffman (1991) built a model of assessment from the awareness that HIV/AIDS is about loss. That is to say that a sense of hopelessness may develop from the multiple layers of loss that HIV+/AIDS patients experience. Living with HIV is considered to be dysynchronous with a normal life span. Contributing to one's sense of hopelessness about self and life are: awareness of no breakthrough cure; multiple illnesses occur before re-establishing equilibrium from the last illness; loss of employment; and multiple losses of life among HIV/AIDS peers.

The four components of the Hoffman model include assessing: (1) stigma; 2) social support; (3) stage of disease; and (4) individual characteristics of the individual patient. Looking at the three variable model used to predict hopelessness in this study, depression appeared as something to be considered that is clearly related to Hoffman's model. Reciprocity was found to be another predictive variable. Social support assessment is the second component of Hoffman's model. Hopelessness has been shown to be a predictor of suicide intent and behaviors (Beck, 1985). The findings throughout this study confirm this relationship.

In terms of the Hoffman model, it may be important to get a history of the person's exposure to victimization by violence. It appears that it would be important to assess physical, sexual, social and psychical violence against the person in an effort to understand the impact that overt and perceived acts of violence have on the person. This should be done within the framework of assessing support and resiliency as it relates to hopelessness and suicide probability among HIV/AIDS patients.

In the predictive model of suicide probability using hopelessness and the hopelessness sub-scales, hopelessness accounted for 53% of the variance in predicting suicide probability. This relationship is similar to what Beck (1985) found. Social support in the form of urgent needs appears to be related to

Hoffman's component two and depression appears to be related to the individual characteristics of the patient found in component four of her model.

By examining the sub-scales of the Hopelessness scale (BHS), a closer look is provided. Loss of motivation accounts for 50% of the variance in predicting suicide probability. Loss of motivation, a sub-scale of the Hopelessness scale may be a response to life circumstances related to the stage of disease the individual is in. This finding appears to be reflective of Hoffman's third component. Depression was also found to be predictive and appears to be similar to component four. Finally, urgent needs were found to be a predictive variable (a sub-scale of social support) and seems to be related to Hoffman's second component.

It is striking to note that Hoffman's first component is missing in this predictive model. The first component of Hoffman's model assesses stigma associated with HIV disease and AIDS. A possible explanation for this missing component may be that stigma involves a closer look at the relationship between the individual and the society in which he or she lives.

If that be the case, then the question involves the relationship between society and the individual. Specifically: What does society contribute in the development of an individual member of that society being at risk for suicide in an HIV +/- AIDS population? A look beyond the obvious will be explored

by keeping in mind that the complementary message which society communicates may target those who are not valued. This twist of communication takes place when there are advantages for certain categorical members of a society. The antithesis of this is that those who are not in the valued category are in a position of disadvantage.

Variables known to be related to the risk of suicide were examined in this study. Additionally, questions were raised with respect to the relationship between societal factors and an individual's risk for hopelessness and suicide. The results of the study have shown that there is a strong relationship between various aspects of social support and suicide probability. For those working with HIV+AIDS patients, it seems to be important to assess the level of social support in an effort to reduce their risk of suicide and to improve the quality of their lives.

Although direct information has been collected from HIV+/AIDS patients, this study proceeded from an understanding that they are members of our society and their perception of society is a valid perspective of the whole of our society. With this in mind, the data presented here can be useful in designing and addressing the social aspects of this disease. This may be accomplished by providing programs that target the social milieu in which AIDS exists. Such programs may include issues about discrimination as

evidenced by violence against gays, lesbians, and AIDS patients. The notion of virtually equal rights under the law, exclusion from religious institutions, and the social valuing of individual differences compared with devaluing as evidenced in stereotyping which does not listen to description but chooses to define are issues that need to be carefully addressed and studied.

Although an aside to this study, future research into the role that religion plays in the life cycle of HIV/AIDS patients is needed. Included in such a study, it would be important to assess the relationship between religious order ie. (society) and the impact on development of a positive or negative attitude about one's future.

REFERENCE

- American Psychological Association. (1992). Ethical Principles of psychologists and code of conduct. American Psychologist, 47, 1597-1611.
- Antonovsky, A. (1979). Health, stress and coping. San Francisco, Jossey-Bass.
- Aral, S. & Holmes, K. (1991). Sexually transmitted diseases in the AIDS era. Scientific American, 264, 62-69.
- Backer, T.E., Batchelor, W.F., Jones, J.M., & Mays, V.M. (1988). Introduction to the special issue: Psychology and AIDS. American Psychologist, 43, 835-836.
- Batchelor, W.F. (1988). AIDS 1988: The science and the limits of science. American Psychologist, 43, 853-858.
- Beck, A.T. (1967). Depression: Clinical, experimental and theoretical aspects. New York: Harper & Row.
- Beck, A.T. (1984). Cognition and Therapy. Archives of General Psychiatry, 41, 1112-1114.

Beck, A.T., & Beamesderfer, A. (1974). Assessment of depression: The depression inventory. In P. Pichot (Ed.), Psychological measurements in psychopharmacology: Vol 7. Modern problems in pharmacopsychiatry (p. 151-169). Basel, Switzerland:Karger.

Beck, A.T., Rush, A.J., Shaw, B.F., & Emery, G.(1979). Cognitive therapy of depression. New York: Guilford Press.

Beck, A.T. & Steer, R.A. (1988). Beck Hopelessness Scale (manual). San Antonio, TX: Psychological Corporation.

Beck, A.T., Steer, R.A., Kovacs, M., & Garrison, B. (1985). Hopelessness and eventual suicide: A 10 year prospective study of patients hospitalized with suicide ideation. American Journal of Psychology, 142, 559-563.

Beck, A.T., Steer, R.A., & Garbin, M.G. (1988). Psychometric properties of the Beck Depression Inventory: Twenty-five years of evaluation. Clinical Psychology Review, 8, 77-100).

Beck, A.T., Ward, C.H., Mendelson, M., Mock, J., & Erbaugh, J. (1961). An inventory for measuring depression. Archives of General Psychiatry, 4, 561-571.

Beck, A.T., Weissman, A., Lester, D., & Trexler, L. (1974). The measurement of pessimism: The hopelessness scale. Journal of Consulting and Clinical Psychology, 42, 861-865.

Bell, A.P., & Weinberg, M.S. (1978). Homosexualities: A study of diversity among men and women. New York: Simon and Schuster.

Berrill, K.T. (1985). Anti-gay violence and victimization. New York, New York: National Gay and Lesbian Task Force.

Berrill, K.T. (1992). Anti-gay violence and victimization in the United States: An overview. In G.M. Herek & K.T. Berrill (Eds.) Hate Crimes: Confronting violence against lesbians and gay men (p. 19-45). Newberry Park, CA: Sage Publications Inc.

Bloom, J.R., & Spiegel, D. (1984). The relationship of two dimensions of social support to the psychological well-being and social functioning of women with advanced breast cancer. Social Science and Medicine, 19, 831-837.

Bonner, R.L., & Rich, A.R. (1987). Toward a predictive model of suicidal ideation and behavior: Some preliminary data in college students. Suicide and Life-Threatening Behavior, 17, 50-63.

Bonner, R.L., & Rich, A.R. (1991). Predicting vulnerability to hopelessness: A longitudinal analysis. The Journal of Nervous and Mental Disease, 179, 29-32.

Bridge, T.P. (1988). HIV-1: Neuropsychiatric manifestations and their treatment. (Review). Psychopharmacology Bulletin, 24 (3), 320-324.

Bruhn, J.G. (1989). Counseling persons with a fear of AIDS. Journal of Counseling and Development, 67, 445-457.

Catalan, J. (1990). Psychiatric manifestations of HIV disease. Bailliere's Clinical Gastroenterology, 4, 547-562.

Center for Disease Control. (1986). Acquired immunodeficiency syndrome (AIDS) among blacks and hispanics -United States. Morbidity and Mortality Weekly Review, 35, 655-666.

Center for Disease Control. (1993a). Update: Acquired Immunodeficiency Syndrome-United States, 1992. Morbidity and Mortality Weekly Report, 42, 547-551.

Center for Disease Control. (1993b). Facts about drug use and HIV/AIDS. HIV/AIDS Prevention, September, 1993. Atlanta: CDC.

Center for Disease Control. (1994a). HIV/AIDS Surveillance Report: Year end report, 6.2. Atlanta: CDC.

Center for Disease Control. (1994b). Facts about adolescents and HIV/AIDS. HIV/AIDS Prevention, December, 1994. Atlanta: CDC.

Center for Disease Control. (1995). Facts about women and HIV/AIDS. HIV/AIDS Prevention, February 13, 1995. Atlanta: CDC.

Center for Population Options. (1992). Lesbian, gay and bisexual youth: At risk and underserved. Washington, DC: Author.

Chin, J. (1991). Current and future dimensions of the HIV/AIDS pandemic in women and children. The Lancet, 336, p. 221-224.

Choron, J. (1972). Suicide. New York: Scribner.

Christ, G.H., & Wiener, L. (1985). Psychosocial issues for AIDS. In V. Devita, Jr., S. Hellmann, & S. Rosenberg (Eds.), AIDS (p.275-297). Philadelphia: Lippincott.

Christ, G.H., Wiener, L., & Moynihan, R.T. (1986). Psychosocial issues in AIDS. Psychiatric Annals, 16, 173-179.

Coates, T.J., Temoshok, L., & Mandel, J. (1984). Psychosocial research is essential to understanding and treating AIDS. American Psychologist, 39, 1309-1314.

Comstock, G.D. (1991). Violence against lesbians and gay men. New York: Columbia University Press.

Cull, J.G., & Gill, W.S. (1982). Suicide Probability Scale (SPS)

(manual) . Los Angeles, CA: Western Psychological Services.

D'Augelli, A.R. (1991). Teaching lesbian and gay development: A pedagogy of the oppressed. In W.G. Tierney (Ed.), Culture and ideology in higher education: Advancing a critical agenda (p. 213-233). New York: Praeger.

Deluty, R.H. (1988-1989a). Physical illness, psychiatric illness, and the acceptability of suicide. Omega: Journal of Death and Dying, 19, 79-91.

Deluty, R.H. (1988-1989b). Factors affecting the acceptability of suicide. Omega: Journal of Death and Dying, 19, 315-326.

Dilley, J.W., Ochitill, H.N., Perl, M., & Volberding, P.A. (1985). Findings in psychiatric consultations with patients with acquired immune deficiency syndrome. American Journal of Psychiatry, 142, 82-85.

Dublin, L. (1963). Suicide: A sociological and statistical study. New York: Ronald Press.

Durkheim, E. (1951). Suicide: A study in sociology. New York: The Free Press.

Eichberg, R. (1991). Coming out: An act of love. New York: Penguin Group.

Emery, G.D., Steer, R.A. & Beck, A.T. (1981). Depression, hopelessness, and suicidal intent among heroin addicts. International Journal of the Addictions, 16, 425-429.

Evans, P.E. (1988). Minorities and AIDS. Health Education Research, 3, 113-115.

Feinberg, H.V. (1988, October). The social dimensions of AIDS. Scientific American, p. 128-134.

Flannery, R.B., & Wieman, D. (1989). Social support, life stress, and psychological distress: an empirical assessment. Journal of Clinical Psychology, 45, 867-872.

Freiberg, P. (1987, September 1). Sex education and the gay issue: What are they teaching about us in the schools? The Advocate, 42-48.

Frierson, R.L., & Lippmann, S.B. (1986). AIDS in Kentucky. Journal of the Kentucky Medical Association, 84, 487-494.

Frierson, R.L., & Lippmann, S.B. (1987). Psychologic implication of AIDS. American Family Physician, 35, 153-159.

Frierson, R.L., & Lippmann, S.B. (1988). Management and treatment of AID-related depression. Clinical Advances in the Treatment of Psychiatric Disorders, 2, 1-3.

Fujimura, L.E., Weis, D.M., & Cochran, J.R. (1985). Suicide: Dynamics and implications for counseling. Journal of Counseling and Development, 63, 612-615.

Gala, C., Pergami, A., Catalan, J., Riccio, M., Durbano, R., Musicco, M., Baldeweg, T., Invernizzi, G. (1992). Risk of deliberate self-harm and factors associated with suicidal behavior among asymptomatic individuals with human immunodeficiency virus infection. Acta Psychiatrica Scandinavica, 86, 70-75.

Gartner, S., Markovits, P., & Markovitz, D.M. (1986). Virus isolation from and identification of HTLV-III/LAV-producing cells in brain tissue from a patient with AIDS. Journal of American Medical Association, 256, 2365-2371.

Gibson, P. (1989). Department of Health and Human Services. Gay male and lesbian youth suicide. In Report to the secretary's task force on youth suicide, Vol.3: Prevention and intervention in youth suicide (p. 110-140). Washington D.C.

Glass, R. M. (1988). AIDS and suicide. Journal of the American Medical Association, 259, 1369-1370.

Goldenberg, I.I. (1978). Oppression and social intervention. Chicago: Nelson-Hall.

- Gonsiorek, J.C. (1988). Mental health issues of gay and lesbian adolescents. Journal of Adolescent Health Care, 9, 114-122.
- Green, G. (1992). A review of the literature on social support and health with special reference to HIV. MRC Medical Sociology Unit Working Paper, 34.
- Green, G. (1993). Editorial review: social support and HIV. AIDS Care, 5, 87-104.
- Green, J., & Miller, D. (1986). Hospital counseling: Structure and training. In J. Green & D. Miller (Eds.) The Management of AIDS Patients. (187-194). London: MacMillan Press.
- Herek, G.M. (1984). Beyond "homophobia": A social psychological perspective on attitudes toward lesbians and gay men. Journal of Homosexuality, 10, 1-21.
- Herek, G.M. (1989). Hate crimes against lesbians and gay Men: Issues for research and policy. American Psychologist, 44, 948-955.
- Herek, G. M. (1992). The social context of hate crimes: Notes on cultural heterosexism. In G.M. & K.T. Berrill (Eds.) Hate crimes: Confronting violence against lesbians and gay men (p. 89-104). Newberry Park, CA: Sage Publications Inc.

Herek, G.M., & Capitanio, J.P. (1993). Public Reactions to AIDS in the United States: A second decade of stigma. American Journal of Public Health, 83, 574-577.

Herek, G.M., & Capitanio, J.P. (1994). Conspiracies, contagion, and compassion: Trust and public reactions to AIDS. AIDS Education and Prevention, 6(4), 365-375.

Herek, G.M., & Glunt, E.K. (1988). An epidemic of stigma: Public reaction to AIDS. American Psychologist, 43, 886-891.

Ho, D.D., Rota, T.R., & Schooley, R.T. (1985). Isolation of HTLV-III from cerebrospinal fluid and neural tissues of patients with neurological syndromes related to the acquired immunodeficiency syndrome. New England Journal of Medicine, 313, 1493-1497.

Holmes, M.D. (1991). Editorial: AIDS in Communities of Color. American Journal of Preventive Medicine, 7, 461-463.

Holohan, C.J., & Moos, R.H. (1982). Social support and adjustment: Predictive benefits of social climate indices. American Journal of Community Psychology, 10, 403-415.

Hoffman, M.A. (1991). Counseling the HIV-infected client: A psychosocial model for assessment and intervention. The Counseling Psychologist, 19, 467-542.

Hull, H.F., Sewell, C.M., Wilson, J. (1985). The risk of suicide in persons with AIDS [letter]. Journal of the American Medical Association, 260, 1881.

Humphry, D. (1987). The case for rational suicide. Suicide and Life-Threatening Behavior, 17, 335-338.

Hunter, J. (1990). Violence against lesbian and gay male youths. Journal of Interpersonal Violence, 5, 295-300.

Hunter, J. & Schaecher, R. (1990). Gay and Lesbian youths. In M. Rotheram-Borus, Bradley, J., & Oblensky, N. (Eds.), Planning to Live: Suicidal Youths in Community Settings, Tulsa: The University of Oklahoma Press.

Institute of Medicine. (1994). J.D. Auerbach, C. Wypijewska, & H.K. Brodie. (Eds.) (1994). AIDS and Behavior: An integrated approach. Washington, DC: National Academy Press.

Jay, K., & Young, A. (1979). The gay report: Lesbians and gay men speak out about sexual experiences and lifestyles. New York: Simon and Schuster.

Jacobson, E. (1983). Chapter 10. In Greenberg, J. R., Mitchell, S. A. Object Relations in Psychoanalytic Theory. Cambridge, Harvard University Press.

Johnson, R.A. (1991). Owning Your Own Shadow: Understanding the Dark Side of the Psyche. San Francisco, Harper.

Kiecolt-Glaser, J., Glaser, R. (1988). Major life changes, chronic stress, and immunity. In Bridge, T.P., Mirsky, A.F., & Goodwin, F. K. (Eds.) Psychological, Neuropsychiatric, and Substance Abuse Aspects of AIDS. Raven Press, New York.

Kizer, K.W., Green, M., Perkins, C.I., Doebbert, G., & Hughes, M.J. (1988). AIDS and suicide in California [Letter to the editor]. Journal of the American Medical Association, 260, 1881.

Koenig, S., Gendelman, H.E., & Orenstein, J.M. (1986). Detection of AIDS virus in macrophages in brain tissue from AIDS patients with encephalopathy. Science, 213, 1089-1093.

Kowalewski, M.R. (1988). Double stigma and boundary maintenance: how gay man deal with AIDS. Journal of Contemporary Ethnography, 17, 211-228.

Land, H. (1994). AIDS and women of color. Families in Society: The Journal of Contemporary Human Service. Milwaukee, WI: Families International Inc.

Leavy, R.L. (1983). Social support and psychological disorder: a review. Journal of Community Psychology, 11, 3-21.

Lesserman, J., Perkins, D.O., & Evans, D.L. (1992). Coping with the threat of AIDS: The role of social support. American Journal of Psychiatry, 149, 1514-1520.

Lester, D., & Beck, A.T. (1975). Suicidal intent, medical lethality of the suicide attempt and components of depression. Journal of Clinical Psychology, 31, 11-12.

Linn, J.G., Lewis, F.M., Cain, V.A., & Kimbrough, G.A. (1993). HIV-illness, social support, sense of coherence, and psychosocial well-being in a sample of help-seeking adults. AIDS Education and Prevention, 5, 254-262.

Lippmann, S.B., Frierson, R.L., & Shaltout, T. (1988). AIDS: What is the psychiatrist to do? American Journal of Preventive Psychiatry and Neurology, 1, 14-16.

Lippmann, S.B., James, W.A., & Frierson R.L. (1993). AIDS and the family: implications for counselling. AIDS Care, 5, 71-78.

Longshore, D. (1990). AIDS education for three high-risk populations. Evaluation and Program Planning, 33, 67-72.

Madge, N., & Marmot, M. (1987). Psychosocial factors and health. Quarterly Journal of Social Affairs, 3, 81-134.

Mann, J.M. (1988). AIDS: A global strategy for a global challenge. Impact Science, 38, 163.

Martin, S.K., & Range L.M. (1991). Extenuating circumstances in perceptions of suicide: Disease diagnosis (AIDS, cancer), pain level, and life expectancy. Omega: Journal of Death and Dying, 22, 187-197.

Marzuk, P.M. (1991). Suicidal behavior and HIV illness. International Review of Psychiatry, 3, 365-371.

Marzuk, P.M., Tierney, H., Tardiff, K., Gross, E.M., Morgan, E.B., Hsu, M., & Mann, J.J. (1988). Increased risk of suicide in Persons with AIDS. Journal of the American Medical Association, 259, 1333-1337.

May, R., & Yalom, I. (1984). Existential psychotherapy. In R.J. Corsini (Eds.), Current Psychotherapies (3rd ed., p. 354-391). Chicago, IL: F.E. Peacock.

McCormick, I.A., Siegert, R.J. & Walkey, F.H. (1987). Dimensions of social support: A factorial confirmation. Journal of Community Psychology, 15, 73-77.

Miles, S.H., & August, A. (1990). Courts, gender and the "Right to Die". Law, Medicine and Health Care, 18, 85-95.

Miller, D. (1987). Living with AIDS and HIV. London, McMillan.

Miller, D., Weber, J., & Green, J. (1987). The Management of AIDS Patients. London, McMillan.

- Minkoff, H.L. & Dehovitz, J.A. (1991). Care of women infected with the human immunodeficiency virus. Journal of the American Medical Association, 266, 2253-2258.
- Mitchell, J.L. (1989). Drug abuse and AIDS in women and their affected offspring. Journal of the National Medical Association, 81, 841-842.
- Morin, S.F. (1988). AIDS: The challenge to psychology. American Psychologist, 43, 838-842.
- Morin, S.F., & Batchelor, W.F. (1984). Responding to the Psychological Crisis of AIDS. Public Health Reports, 99(1) p. 4-9.
- Morin, S.F., Charles, K.A., Malyon, A.K. (1984). The psychological impact of AIDS on gay men. American Psychologist, 39, 1288-1293.
- Namir, S., Wolcott, D.L., Fawzy, I., & Alumbaugh, M. J. (1987). Coping with AIDS: Psychological and health implications. Journal of Applied Social Psychology, 17, 309-328.
- National Gay and Lesbian Task Force (1988). Anti-gay violence and victimization in 1988. Washington, DC: Author
- National Gay and Lesbian Task Force (1990). Anti-gay violence, victimization and defamation in 1989. Washington, DC: Author.

National Gay and Lesbian Task Force Policy Institute. (1991). Anti-gay/lesbian violence, victimization and defamation in 1990. Washington, DC:

Author.

Navia, B.A., Jordan, B.D., & Price, R.W. (1986). The AIDS dementia complex: 1. Clinical features. Annals of Neurology, 19, 517-524.

Nichols, S.E. (1983). Psychiatric aspects of AIDS. Psychosomatics, 24, 12.

Nichols, S.E. (1986). Psychotherapy and AIDS. In T.S. Stein & C.J. Cohen (Eds.), Contemporary perspective on psychotherapy with lesbians and gay men (p. 202-239). New York: Plenum.

Norbeck, J., Lindsey, A., & Carrieri, V. (1983). Further development of the Norbeck Social Support Questionnaire. Nursing Research, 32, 4-9.

Ostrow, D.G. (1988). Models for understanding the psychiatric consequences of AIDS. In Bridge, T.P.; Mirsky, A.F.; & Goodwin, F.K. (Eds.), Psychological, Neuropsychiatric, and Substance Abuse Aspects of AIDS. Raven Press, New York.

Parkes, C. M. (1971). Psychosocial transitions: A field for study. Social Science and Medicine, 5, 101-115.

Perry, S., Jacobsberg, L., & Fischman, B. (1990). Suicidal ideation and HIV testing. Journal of the American Medical Association, 146, 556-557.

- Perry, S., Jacobsberg, L.B., Frances, A., Bobo, J., & Jacobsberg, B.K. (1990). Psychiatric diagnosis before serological testing for the human immunodeficiency virus. American Journal of Psychiatry, 147, 89-93.
- Peters-Golden, H. (1982). Breast cancer: varied perceptions of social support in the illness experience. Social Science and Medicine, 16, 483-491.
- Peterson, J.L. & Marin G. (1988). Issues in the prevention of AIDS among black and hispanic men. American Psychologist, 43, 871-877.
- Pharr, S. (1988). Homophobia: A weapon of sexism. Inverness, CA: Chardon Press.
- Pierce, (1987). Underscore urgency of HIV counseling: Several suicides follow positive tests. Clinical Psychiatry News, October, p. 1.
- Poppen, P.J., Reisen, C.A. (1994). Heterosexual behaviors and risk of exposure to HIV: Current status and prospects for change. Applied and Preventive Psychology, 3, 75-90.
- Rogers, J.R., & Britton P.J. (1994). AIDS and rational suicide: A counseling psychology perspective or a slide on the slippery slope. The Counseling Psychologist, 22, 171-178.
- Rotter, J.B. (1966). Generalized expectancies for internal versus external control of reinforcement. Psychological Monographs: General and Applied, 80, 1-28.

Rundell, J., Thomason, J., Zajac, R., & Beatty, R. (1988).

Psychiatric diagnoses and attempted suicide in HIV infected USAF personnel.

IV International Conference on AIDS. Stockholm, Abstract 8595.

Saghir, M.T., & Robins, E. (1973). Male and Female Homosexuality:

A comprehensive investigation. Baltimore: Williams and Wilkin.

Sarason, I.G., Levine, H.M., Basham, R.B., & Sarason, B.R. (1983).

Assessing social support: The Social Support Questionnaire. Journal of

Personality and Social Psychology, 44, 127-139.

Sarason, I.G., Sarason, B.R., Potter, E.H., & Antoni, M.H. (1985).

Life events, social support and illness. Psychosomatic Medicine, 47, 156-163.

Saunders, J.M., & Valente, S.M. (1987). Suicide risk among gay

men and lesbians: A review. Death Studies, 11, 1-23.

Savin-Williams, R. (1994). Verbal and physical abuse as stressors in

the lives of lesbian, gay male and bisexual youths: Associations with school

problems, running away, substance abuse, prostitution, and suicide. Journal of

Consulting and Clinical Psychology, 62, 261-269.

Schaecher, R. (1989, Winter). Stresses on lesbian and gay adolescents.

Independent School, 29-35.

- Schneider, S.G., Farberow, N.L., & Kruks, G.N. (1989). Suicide behavior in adolescent and young adult gay men. Suicide and Life-Threatening Behavior, 19, 381-394.
- Schneider, S.G., Taylor, S.E., Hammen, C., Kemeny, M.E., & Dudley, J. (1991). Factors influencing suicide intention in gay and bisexual suicide ideators: Differing models for men with and without Human Immunodeficiency Virus. Journal of Personality and Social Psychology, 61, 776-788.
- Schotte, D., & Clum, G. (1982). Suicide ideation in a college population: A test of a model. Journal of Consulting and Clinical Psychology, 50, 690-696.
- Schotte, D., & Clum, G. (1987). Problem-solving skills in suicidal psychiatric patients. Journal of Consulting and Clinical Psychology, 55, 49-54.
- Schuster, C.R. (1992). Drug abuse research and HIV/AIDS: a national perspective from the US. British Journal of Addiction, 87, 355-361.
- Seligman, M.E.D., Abramson, L.Y., Semmel, A., & von Baeyer, C. (1979). Depressive attributional style. Journal of Abnormal Psychology, 88, 242-247.

Selik, R.M., Castro, K.G., Pappaioanou, M. (1988). Racial and ethnic differences in the risk of AIDS in the United States. American Journal of Public Health, 78, 1539-1545.

Sherr, L., Petrak, D., Melvin, T., Davey, L., Glover, L., & Hedge, B. (1993). Psychological trauma associated with AIDS and HIV infection in women. Counselling Psychology Quarterly, 6, 99-108.

Shilts, R. (1987). And the band played on: Politics, people and the AIDS Epidemic. New York: St. Martins Press.

Siegel, K. (1986). Psychosocial aspects of rational suicide. American Journal of Psychotherapy, 40, 405-418.

Slater, B.R. (1993). Violence against lesbian and gay male college students. Journal of College Student Psychotherapy, 8, 177-202.

Smith, K. (1989). AIDS suicide: Ultimate choice or desperate act? AIDS Patient Care, 3, 20-22.

Sontag, S. (1989). AIDS and its metaphors. Toronto: Collins.

Stoler, M.H., Eskin, T.A., & Benn, S. (1986). HTLV-III infection of the central nervous system. Journal of the American Medical Association, 256, 2360-2364.

Szasz, T. (1971). Ethics of Suicide. Antioch.

Szasz, T. (1976). The ethics of suicide. In Wolman, B.B., Between Survival and Suicide. New York, New York, Gardener Press.

Szasz, T. (1986). The case against suicide prevention. American Psychologist, 41, 806-812.

Tross, S., & Hirsch, D.A. (1988). Psychological distress and neuropsychological complications of HIV infection and AIDS. American Psychologist, 43, 929-934.

Turner, R.J. (1981). Social support as a contingency in psychological well-being. Journal of Health and Social Behaviour, 22, 357-367.

United States Department of Health and Human Services. (1989). Report of the secretary's task force on youth suicide. MD: Author.

Vaux, A., Phillips, J., Holly, L., Thomson, B., Williams, D. & Stewart, D. (1986) The social support appraisals scale (SS-A): studies of reliability and validity. American Journal of Community Psychology, 14, 195-219.

Ver Meulen, M. (1982, May 31). The Gay Plague. New York Magazine.

Watkins, J.D. (1988). Responding to the HIV epidemic: A national strategy. American Psychologist, 43, 849-851.

- Webster's New World Dictionary (1982). New York: Simon & Schuster.
- Weinert, C. (1987). A social support measure: PRQ 85. Nursing Research, 36, 273-277.
- Weiss, R.S. (1974). The provision of social relationships. In Z. Rubin (Ed.), Doing unto others. Englewood Cliffs, N.J.: Prentice Hall.
- Weiss, R.S. (1976). Transition states and other stressful situations: Their nature and programs for their management. In G. Caplan & M. Killilea (Eds.), Support systems and mutual help. New York: Crane & Stratton.
- Werth, J.L. (1992). Rational suicide and AIDS: A consideration for the psychotherapist. The Counseling Psychologist, 20, 645-659.
- Whitlock, K. (1988). Bridges of respect: Creating support for lesbian and gay youth. Philadelphia: American Friends Service Committee.
- Wirth, L. (1945). The problem of minority groups. In R. Linton (Ed.), The science of man in the world crisis. New York: Columbia University Press.
- Wolcott, D.L. (1986). Psychosocial aspects of Acquired Immune Deficiency Syndrome and the primary care physician. Annals of Allergy, 57, 95-102.

Wolf, T.M., Balson, P.M., Morse, E.V., Simon, P.M., Gaumer, R.H., Dralle, P.W., & Williams, M.H. (1991). Relationship of coping style to affective state and perceived support in asymptomatic and symptomatic HIV-infected persons: implications for clinical management. Journal of Clinical Psychiatry, *52*, 171-173.

Woo, S.K. (1988). The psychiatric and neuropsychiatric aspects of HIV disease. Journal of Palliative Care, *4*, 50-53.

Wortman, C.B. (1984). Social support and the cancer patient: conceptual and methodological issues. Cancer, *53*, 2339-2359.

Wortman, C.B. & Dunkel-Schetter. (1979). Interpersonal relationships and cancer: a theoretical analysis. Journal of Social Issues, *35*, 120-155.

Ybarra, S. (1991). Women and AIDS: Implications for Counseling. Journal of Counseling and Development, *69*, 285-287.

Zich, J., & Temoshok, L. (1987). Perceptions of social support in men with AIDS and ARC: relationships with distress and hardiness. Journal of Applied Social Psychology, *17*, 193-215.

TABLE I
DEMOGRAPHIC INFORMATION

Gender	male	42
	female	8
Sexual Orientation		
Sexual Orientation	heterosexual	11
	bisexual	3
	gay/lesbian	35
Living Setting		
Living Setting	large city	26
	medium city	6
	suburban	10
	small town	4
	rural	4
Open about Sexuality		
Open about Sexuality	not open to many	3
	not some/others	4
	open many	24
	very open all	19

TABLE I (CONTINUED)
DEMOGRAPHIC INFORMATION

Education	some high school	1
	high school/GED	14
	some college	13
	2 yr. Assoc. Arts	7
	BA	10
	MA	3
	graduate school	2
Race/Minority		
Race/Minority	African American	12
	Asian American	2
	Caucasian	31
	Puerto Rican	3
	Other Hispanic	1
	Native American	1
Religious Affiliation		
Religious Affiliation	Protestant	18
	Catholic	15
	Jewish	1
	None	5
	Other	9

TABLE II

Correlation Coefficients
Correlation Analysis used to assess BHS & SPS

	SPS TOT	Hopeless BHS
BDI TOT	.7063**	.7368**
SPS TOT	1.000	.7276**
EXTERNAL TOT	.4318**	.4390**
BHS TOT	.7276**	1.000
PRQUN	.3706**	●
PRQ11 TOT	-.3714**	-.4557**
VIOLENCE TOT	.3096*	.3136*

2 TAILED * - $p \leq .05$ ** - $p \leq .01$ ● - Not Significant

TABLE III A
STEPWISE MULTIPLE REGRESSION TO PREDICT HOPELESSNESS
WITH SUB-SCALE SPS AS INDEPENDENT VARIABLE

	R SQUARE	F	B
BDI TOT	.52	49.4	.21
SPS HLESS	.63	38.3	.23
RECIPRO	.67	29.3	- .16
CONSTANT			3.6

TABLE III B
STEPWISE MULTIPLE REGRESSION HOPELESSNESS
WITH TOTAL SPS AS INDEPENDENT VARIABLE

	R SQUARE	F	B
SPS TOT	.53	51.2	.12
BDI TOT	.61	35.9	.18
RECIPRO	.66	28.2	- .18
CONSTANT			2.14

TABLE IV A
STEPWISE MULTIPLE REGRESSION TO PREDICT SUICIDE
PROBABILITY WITH SUB-SCALES HOPELESSNESS AS I.V.

	R SQUARE	F	B
LOSS MOT	.50	44.4	4.0
BDI TOT	.63	37.8	.68
PRQ UN	.70	34.3	2.0
CONSTANT			31.4

TABLE IV B
STEPWISE MULTIPLE REGRESSION SUICIDE PROBABILITY
WITH HOPELESSNESS TOTAL SCORE AS I.V.

	R SQUARE	F	B
HOPELESS	.53	51.2	1.7
PRQ UN	.63	38.2	2.1
BDI TOT	.67	29.7	.51
CONSTANT			27.0

TABLE V
COMPARISON OF BHS AND SPS BY CONTINUOUS
DEMOGRAPHIC VARIABLES

		n	BHS	p	SPS	p
GENDER	Male	42	6.6 ± 4.7	●	56.1 ± 15.0	●
	Female	8	6.8 ± 3.5		59.8 ± 17.3	
LIVING	Urban	36	5.8 ± 3.7	.05	55.4 ± 14.4	●
SETTING	Rural	14	8.9 ± 5.6		60.0 ± 17.2	
SEXUAL ORIENTATION	Hetero	11	5.3 ± 3.9	●	55.7 ± 17.5	●
	Gay/Lesbian & Bi	38	7.0 ± 4.7		56.8 ± 14.9	
SEXUAL ORIENTATION	Hetero & Bi	14	6.9 ± 5.2	●	60.1 ± 18.3	●
	Gay/Lesbian	35	6.6 ± 4.3		55.1 ± 14.0	
EDUCATION	High School	28	7.9 ± 4.9	.05	60.7 ± 15.3	.05
	College	22	5.0 ± 3.4		51.5 ± 13.7	

Mean ± S.D. reported; Signif set at ≤ 0.05 by t-test; ● - not significant

TABLE V continued
COMPARISON OF BHS AND SPS BY CONTINUOUS VARIABLES

		n	BHS	p	SPS	p
+ FUTURE	No Change	31	6.9 ± 4.6	●	56.2 ± 15.3	●
	+ Change	17	6.3 ± 4.7		58.3 ± 14.9	
- FUTURE	No Change	25	6.1 ± 4.5	●	56.7 ± 14.0	●
	- Change	23	7.3 ± 4.6		58.0 ± 16.4	
SOCIAL VALUE	Low	30	8.3 ± 4.6	.001	61.3 ± 15.1	.01
	High	19	3.9 ± 3.0		48.8 ± 12.3	
PERSON VS. STEREOTYPE	Few	24	8.5 ± 5.0	.01	63.7 ± 17.0	.001
	Many	25	4.8 ± 3.2		49.6 ± 9.40	
COUNSELING	Occasionally	30	7.3 ± 5.0	●	56.9 ± 17.1	●
	Frequently	20	5.6 ± 3.6		56.3 ± 15.9	
ILLNESSES	0-1	25	6.4 ± 4.4	●	54.5 ± 14.4	●
	2+ more	25	6.8 ± 4.7		58.8 ± 15.9	
DEAD	0-18	32	5.9 ± 4.5	●	55.4 ± 15.0	●
	19+	18	7.9 ± 4.3		59.0 ± 15.6	

Mean ± S.D. reported; Signif set at ≤ 0.05 by t-test; ● - not significant

TABLE VI
CORRELATION COEFFICIENTS

	PRQ11 TOT	VIOLENCE
BDI TOT	-.3803**	.4393**
SPS TOT	-.3714**	.3096*
EXTERNAL TOT	-.4242**	●
BHS TOT	-.4557**	.3136*
PRQ11 TOT	1.000	-.3241*
VIOLENCE TOT	-.3241*	1.000

2 TAILED * - $p \leq .05$ ** - $p \leq .01$ ● - Not Significant

TABLE VII
SUB-SCALE CORRELATION COEFFICIENTS

SCALES	PRQ TOTAL	SPS TOTAL	BHS TOTAL
BHS Hopeless	-.4557**	.7276**	
BHS Feeling	-.2943*	.5150**	
BHS Los Mot	-.4885**	.6698**	
BHS Future	-.3077**	.6486**	
PRQ Intimacy		-.4803**	- .5223**
PRQ Recipro		-.3087*	- .4713**
PRQ Integrat.		-.4612**	- .5542**

2 Tailed * - $p \leq .05$ ** - $p \leq .01$

TABLE VIII
CORRELATION COEFFICIENTS
CORRELATION ANALYSIS OF SOCIAL SUPPORT (PRQ85) & IV

	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10
BDI TOT	-.4261**	-.3797**	-.3858**	-.4777**	●	-.3105*	-.4711**	-.2969*	-.2964*	-.4734**
SPS TOT	-.5098**	-.3942**	-.2984*	-.4090**	●	-.3000*	-.4303**	-.4131**	●	-.3305*
EXTERNAL	●	-.3956**	-.4987**	-.4154**	-.3170*	●	●	●	-.3153*	-.3999**
BHS TOT	-.4066**	-.4795**	-.4493**	-.4724**	-.3519*	-.3519*	-.5111**	-.3702**	-.3734**	-.5024**
PRQ11 TOT	.3166*	.3407*	.4849**	.4151**	.3613*	.4364**	.3576*	.2834*	.4225**	.4790**
VIOLENCE	-.3769**	●	●	-.3493*	●	-.4084**	-.2941*	●	●	-.3618**

2 TAILED * - $p \leq .05$ ** - $p \leq .01$ ● - Not Significant

TABLE IX
CORRELATION COEFFICIENTS
CORRELATION ANALYSIS OF DEMOGRAPHIC VARIABLES AND QUESTIONNAIRE

	PRQ11 TOT	Q1	Q11	Q21	Q26	Q27	Q30	Q33	Q35	Q36	Q37
PRQ11 TOT											
Q1	•										
Q11	•	•									
Q21	•	•	•								
Q26	•	•	•	•							
Q27	•	•	•	•	•						
Q30	.4976**	•	•	•	•	-.3123*					
Q33	•	•	•	.2804*	•	•	•				
Q35	.4027**	•	•	-.3266*	•	•	•	•			
Q36	•	•	•	•	.2873*	•	•	•	•		
Q37	•	.3095*	•	•	.3262*	•	•	•	•	.6851*	

* - $p \leq .05$ ** - $p \leq .01$ • - Not Significant

Q1 - Age

Q11 - Importance Organized Religion

Q21 - Physical Health

Q26 - Positive Future

Q27 - Negative Future

Q30 - Value By Society

Q33 - Follow Health Plan

Q35 - Illness Experienced

Q36 - Other HIV/AIDS Patient Known

Q37 - Death of Other HIV/AIDS Patient Known

For complete information of item, see APPENDIX I

Appendix I

Please respond to the following questions with the appropriate type of response

(Provide information or **CIRCLE** an answer which applies to you.)

1. Age: _____

2. Gender: _____ male _____ female

3. Which of the following settings best describes where you are living now.

_____ large city _____ medium size city _____ suburban _____ small town

_____ Rural

4. Please indicate your sexual orientation: **CIRCLE**

1. Heterosexual only

2. Heterosexual mostly

3. Heterosexual somewhat more

4. Bisexual

5. Gay/Lesbian somewhat more

6. Gay/Lesbian mostly

7. Gay/Lesbian only

5. How open are you about your sexual identity?

1. not open to anyone
2. not open to many people
3. not open to some but open to others
4. somewhat open to people
5. very open to everyone

6. Marital status: _____

1. single never married
2. married (legally)
3. married (self-defined)
4. divorced
5. partner deceased or widowed
6. involved in monogamous relationship with significant other
7. involved in non-monogamous relationships

7. Length of time for marital status:

1. 1 month to 1 year
2. 1 to 3 years
3. 4 to 7 years
4. 8 to 10 years
5. more than 10 years

8. Education: Please CIRCLE highest number of years or highest degree:

1. some high school
2. high school
3. some college
4. 2 year college associate degree
5. bachelor's degree
6. master's degree
7. graduate school
8. doctorate (M.D., Ph.D., J.D., DDS., etc.)

9. What is your current employment status?

1. employed full time
2. employed part time
3. not employed but looking for work
4. not employed, not looking
5. other (specify) _____

10. Race: Please **CIRCLE** that which applies to you. Please make one selection.

1. African American
2. Asian American
3. Euro-American (Caucasian)
4. Mexican American
5. Puerto Rican
6. other Hispanic
7. Native American
8. other(specify)

11. How important is organized religion in your life?

unimportant 1 2 3 4 5 important

12. What is your religious affiliation or preference?

1. Protestant
2. Catholic
3. Jewish
4. Muslim
5. None
6. other _____ specify

13. To what extent were you the target of verbal insults in your school because of your sexual orientation?

1. never
2. less than once a year
3. at least once a year
4. at least once a month
5. at least once a week
6. every or almost every day

14. To what extent did verbal insults occur in your childhood home because of your sexual orientation?

1. never
2. less than once a year
3. at least once a year
4. at least once a month
5. at least once a week
6. every or almost every day

15. How frequently have verbal insults occurred at your job in the last year?

1. never
2. less than once a year
3. at least once a year
4. at least once a month
5. at least once a week
6. every or almost every day

16. To what extent has verbal abuse occurred in public places (on the street, at parties etc.) because of your sexual orientation?

1. never
2. less than once a year
3. at least once a year
4. at least once a month
5. at least once a week
6. every or almost every day

17. To what extent has your personal property been damaged or destroyed because of your sexual orientation?

1. never
2. less than once a year
3. at least once a year
4. at least once a month
5. at least once a week
6. every or almost every day

18. To what extent were you punched, kicked or beaten in your childhood home because of your sexual orientation?

1. never
2. less than once a year
3. at least once a year
4. at least once a month
5. at least once a week
6. every or almost every day

19. How frequently have you been punched, kicked or beaten at your job because of your sexual orientation?

1. never
2. less than once a year
3. at least once a year
4. at least once a month
5. at least once a week
6. every or almost every day

20. How old were you when you began to be punched, kicked or beaten in your childhood home because of your sexual orientation?

1. 8 year or younger
2. 9 to 10 years
3. 11 to 12 years
4. 13 to 14 years
5. 15 to 16 years
6. 17 to 18 years
7. did not occur

21. Health: Rate your current physical health condition: Please **CIRCLE** a number.

very poor 1 2 3 4 5 very good

22. How many cigarettes do you smoke per day? Please **CIRCLE** a response.

0 1to4 5to10 15to20 30to40 more than 40

23. How many alcoholic drinks do you have in a day?

0 1 2 3 4 5 6 or more

24. How frequently do you use non-prescription drugs?

1. never
2. at least once a year
3. at least once a month
4. at least once a week
5. at least once a day
6. more than once a day

25. When were you informed of your HIV + status?

1. within last 3 months
2. 3 to 6 months ago
3. 6 to 12 months ago
4. 12 to 18 months ago
5. 18 to 24 months ago
6. between 2 and 3 years ago
7. 3 to 5 years ago
8. 5 to 7 years ago
9. 7 to 10 years ago
10. more than 10 years ago

26. How would you say that HIV/AIDS has had positive expectations for your future?

no change 1 2 3 4 5 very positive

27. How would you say that HIV/AIDS has had negative expectations for your future?

no change 1 2 3 4 5 very negative

28. When I look into the mirror as a gay person and/or person with AIDS, what Society tells me to see is:

29. When I look into the mirror as a gay person and/or person with AIDS, what I see is: _____

30. To what degree do you feel valued by society at large?

not at all 1 2 3 4 5 completely

31. How many people close to you do you believe see and accept you as a total personality, rather than as a stereotypical AIDS patient or gay person?

no-one 1 2 3 4 5 more than 5

32. How many people can you discuss important things with without having to feel that you have to be careful of what you say and how you say it?

no-one 1 2 3 4 5 more than 5

33. To what degree would you say that you follow the health plan that has been established for you by your primary health provider? **Please CIRCLE a number.**

1. not at all
2. rarely
3. sometimes
4. most of the time
5. totally

34. To what degree do you utilize (ATTEND) the counseling services available to you? **Please CIRCLE a number.**

1. not at all
2. rarely
3. sometimes
4. most of the time
5. totally

Please provide a number for the next 3 questions.

35. How many illnesses related to HIV/AIDS have you experienced? _____

36. How many other people do you know who have HIV/AIDS illnesses?

37. How many people do you know who have died from HIV/AIDS or complications of HIV/AIDS? _____

Appendix II**Questionnaire B**

Please answer the following questions about the friend who gave you this questionnaire and asked you to complete it. Please answer as honestly and candidly as you are able, keeping in mind the way that you know your friend to be. The responses will not require a specific number but will require a rating on a scale. The scale will have words on either end to suggest degrees of intensity. Please respond by **CIRCLING A NUMBER ON THE SCALE** that refers to your friend as you know your friend to be.

1. How frequently does your friend confide/talk with you about things that are very important to him or her?

all the time 1 2 3 4 5 never

2. On a weekly basis, how frequently do you and your friend spend time together?

all the time 1 2 3 4 5 never

3. To what degree does your friend experience feelings of depression?

always optimistic 1 2 3 4 5 very depressed

4. How positive is your friend's outlook for a solution of his/her current life problems?

very positive 1 2 3 4 5 hopeless

5. To what extent does society value all of the current characteristics and current circumstances of your friend's life?

high value 1 2 3 4 5 total disregard

6. Does your friend state that he/she wishes to harm him/her-self (complete suicide) in an effort to control the difficulties or problems of his/her life?

frequently 1 2 3 4 5 never

Appendix III**Cuestionario B**

Por favor conteste las siguientes preguntas acerca del amigo(a) que le entrego este cuestionario. Por favor responda con honestidad y franqueza, teniendo en mente la forma de ser de su amigo(a). Sus respuestas requieren un rating en la escala que le sigue a cada pregunta. Las palabras a cada extremo de la escala indican grandos de intensidad. Por favor responda **CIRCULANDO EL NUMERO EL LA ESCALA** que mejor indique la forma de ser de su amigo(a).

1. Con que frecuencia confia o platica con usted acerca de las cosas que son muy importantes para el (ella)?

todo el tiempo 1 2 3 4 5 nunca

2. **Por Semana**, cuanto tiempo pasan juntos usted y su amigo(a)?

todo el tiempo 1 2 3 4 5 nunca

3. Hasta que grado experimenta su amigo(a) síntomas de depresión?

siempre optimista 1 2 3 4 5 síntomas de depresión

4. Que tan positiva es la actitud de su amigo hacia la posibilidad de solucionar sus problemas actuales?

muy positiva 1 2 3 4 5 sin esperanzas

5. Hasta que grado valora la sociedad las características y circunstancias de la vida de su amigo(a)?

alto valor 1 2 3 4 5 completo desinterés

6. Ha dicho su amigo(a) que desea hacerse daño (suicidarse) en un esfuerzo por controlar las dificultades/problemas de su vida?

con frecuencia 1 2 3 4 5 nunca

APPENDIX IV
ALPHA TABLE

SCALES	ALPHA
BDI	.8673
SPS	.8648
ROTTER	.7263
BHS	.8568
PRQ11 TOT	.9031
VIOLENCE	.7486

ALPHA TABLE

SUBSCALES	ALPHA
SPS Hopeless	.7466
SPS SID	.7510
SPS Neg Self	.4679
SPS Hostility	.5906
BHS Feeling	.7148
BHS Loss Mot	.8054
BHS Future	.6360
PRQUN	.5742
PRQ Intimacy	.8236
PRQ Reciprocity	.6288
PRQ Integration	.7508

KENNETH W. JACKSON**Department of Counseling Psychology****Loyola University Chicago**

Kenneth Jackson grew up in the Pocono Mountains of Northeastern Pennsylvania. He received his B.A. degree in Art Education from Marion College, Marion, Indiana in 1980. In 1989, he received his M.A. degree in Community and Family Counseling from Northeastern Illinois University, Chicago, Illinois. His Ph.D. is from the Department of Counseling Psychology at Loyola University Chicago, Chicago, Illinois.

Kenneth Jackson has worked in the area of chemical dependency with experience in an outpatient setting as well as an inpatient setting. He has also worked with an adolescent population in an inpatient setting. He also has worked as a Career Counselor at Loyola University Chicago. Kenneth Jackson also has experience working for a Community Mental Health agency and has worked as a volunteer for organizations providing support services to people with AIDS and their families.

DISSERTATION APPROVAL SHEET

The dissertation submitted by Kenneth W. Jackson has been read and approved by the following committee:

Albert Agresti, Ph.D., Director
Associate Professor, Counseling Psychology
Loyola University Chicago


Marilyn Susman, Ph.D.
Associate Professor, Counseling Psychology
Loyola University Chicago

Ronald Morgan, Ph.D.
Associate Professor, Educational Psychology
Loyola University Chicago

The final copies have been examined by the director of the dissertation committee and the signature which appears below verifies the fact that any necessary changes have been incorporated and that the dissertation is now given final approval by the committee with reference to content and form.

The dissertation is, therefore, accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy, (Ph.D.).

Sept. 18, 1996
Date


Director's Signature