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# SUICIDE RESILIENCY IN PEOPLE WITH HIV

by

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# ABSTRACT

*Suicide Resiliency in People with HIV* is a phenomenological study into the experiences of people living with HIV who have considered suicide and who are no longer suicidal. This study addressed the following questions: “What are the experiences of people with HIV who consider suicide?” and “What helped them to be resilient to suicide?”

These questions are important as suicide is a significant concern for people living with HIV. An increase in suicidal thinking is first evident when a person seeks an HIV diagnosis and continues to be high throughout the course of the disease. HIV is associated with a number of factors that are independently associated with suicide. This includes: pain, stigma and discrimination, isolation, cognitive impairment, and depression.

This study involved semi-structured interviews with six individuals who were living with HIV and who had previously attempted suicide. The results were analyzed using NVivo and major themes identified. The main themes that emerged from the interviews have been grouped into four major sections: Suicide, Stressors, External Resources, and Coping.

This study also includes a theological reflection on the Book of Job. A number of similarities between the experiences of the co-researchers in this study and the experience of the character of Job in the Book of Job are explored.

The information relating specifically to suicide in this study supports much of the previous research on suicide. This study provides indications about the kinds of interventions that will be helpful to those with whom we work as counsellors.

# ACKNOWLEDGEMENTS

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# CHAPTER 1: INTRODUCTION

In 2001, I began working in a group home for people living with HIV. In working with the residents, I learned that many people living with HIV are creative, intelligent, funny, and caring. I also found that many of the people I worked with were in a great deal of psychological pain, and many described feelings of suicide. However, as I began to study suicide, I was surprised to learn that most illnesses are not associated with an increased rate of suicide. An Australian study found that those with physical illnesses were more likely to die due to an accident than due to suicide. It also found that HIV was one of only two exceptions to this. (Ruzicka, Choi, and Sadkowsky, 2005, p. 339)

In this study, I use the term HIV as opposed to HIV/AIDS or AIDS. While HIV and AIDS are often used interchangeably there is a medical distinction between the two which is based on an individual's viral load and illness history. Therefore, the term HIV/AIDS is not accurate because not all individuals who have HIV also have AIDS. Many professionals in this field state that a distinction between the two terms no longer provides an accurate description of an individual's current state of health.

Through my experience working in the field of HIV, I witnessed some of the extremes that can accompany this illness. I saw people struggle with chronic pain, constant fatigue, and diarrhea. Despite the lengthy course of the HIV disease, there are intermittent periods of relative health followed by periods of illness. The course of the illness, as well as death, is therefore unpredictable. Beyond the physical symptoms, I also saw people who developed dementia, and I saw others—also living with the illness—fear that this might be their future. I saw many trying to cope with rejection by friends and

family, social stigma, discrimination, and loss of employment, social status, and hope for the future.

After witnessing all of the uncertainty and pain that can be a part of HIV, it was not difficult for me to comprehend why some individuals might consider suicide. It was difficult, though, to understand the incredible resiliency that some individuals displayed. The bare facts were simple. Most of those I met did not commit suicide. Most found a reason to live and created meaning in their lives.

I wondered what it is about people's experience with HIV that leads them to feel suicidal, to find the ability to live, and to subsequently transform their lives. This led me to study the factors that increase resiliency to suicide among people with HIV. I was aware that some of these factors might include personal elements such as beliefs, values, or vision of the future. It might also include outside resources such as supportive family members, friends, or a sense of community.

Suicidal thinking is extremely common among people infected with HIV. Various studies have been done to ascertain the relative rate of suicidal thinking in this population. A number of studies have found extraordinarily high rates of both suicidal thinking and suicide attempts among people with HIV (Marzuk and Mann 1988, Krentz, Kliewer, & Gill 2005, Schneider et al. 1991, Jud & Mitch 1996, Cooperman & Simoni, 2005) Despite the incredibly high rate of suicidal ideation in this population, the majority of people with HIV do not choose to end their own lives. They find ways to cope with the pain (both physical and psychological) in their lives. Research is necessary to find the resiliency factors that apply to members of this population in order to correctly assess suicide risk and to serve members of this community more effectively.

Thus, my research questions are: “What are the experiences of people with HIV who consider suicide?” and “What helped them to be resilient to suicide?”

Referring to resiliency, I use the definition suggested by Everall, Altrows, and Paulson (2006), who describe it as “an adaptive process whereby the individual willingly makes use of internal and external resources to overcome adversity” (p. 462). This adaptive process draws on many different elements, including beliefs, activities, and life changes. This also includes reaching out to others to help cope with adversity.

Since research into suicide resiliency among people with HIV is limited, a qualitative approach seemed most appropriate to explore these questions as it focuses on understanding the human experience. Chapter 2 reviews the relevant literature around HIV and suicide. Chapter 3 describes the rationale for choosing a phenomenological research method as well as the methodology used in this study. Chapter 4 presents the data from this study. Chapter 5 is a theological reflection, applying the findings of this research study to the book of Job, looking for similarities. Finally, Chapter 6 is a discussion of the discoveries of this study.

# CHAPTER 2: LITERATURE REVIEW

In researching suicide resiliency in people living with HIV, I began by researching suicide. I read summaries of issues related to suicide and of research already conducted. I then turned to articles that focused specifically on suicide in people living with HIV. This was done by using the PsychInfo database on the University of Alberta Library Web site as well as the EBSCO host database. I used the following keywords: “HIV and suicide,” “HIV and depression,” “HIV and AIDS,” “suicide resiliency,” and “suicide prevention.” I also used the citation list in articles found using this method to locate other articles.

The number of persons living with HIV in Canada is increasing rapidly. Each year, thousands of people are diagnosed with HIV, joining those that were diagnosed the year before (Public Health Agency of Canada, 2007).

> Approximately 58,000 Canadians were estimated to be living with HIV infection. This number will likely increase as new infections continue and survival improves due to new treatments, which will mean increased future care requirements. An estimated 2,300 to 4,500 new infections occurred in Canada in 2005. (p. 5)

Those who have been diagnosed may face many difficulties, including physical health concerns, medications, employment issues, relationships concerns, stigma, and isolation. It is perhaps due to these difficulties that the rate of suicidal behaviour is higher in people living with HIV.

## *Definitions*

These definitions are based on Maris, Berman, and Silverman (2000), *Comprehensive Textbook of Suicidology,* and the Canadian AIDS Treatment Information Exchange (2009), *Managing Your Health: A Guide for People Living with HIV*:

**AIDS**

AIDS (acquired immune deficiency syndrome) is a disease of the human immune system caused by HIV. When a person is diagnosed with one of the serious illnesses or cancers which are “AIDS-defining,” the person is then said to have AIDS.

**ASO**

ASO is an acronym which stands for AIDS Service Organization, dedicated to providing services to people living with HIV.

**CD4**

CD4 is a specific type of white blood cell crucial to co-coordinating the immune system. CD4 cells are infected and killed by HIV. The CD4 cell count is a measure of the strength of an individual’s immune system (in healthy individuals, this is generally between 500 and 1,500 cells per cubic millimetre).

**Completed suicide**

Completed suicide is a death arising from an act inflicted upon oneself with the intent to kill oneself.

**HIV**

HIV (human immunodeficiency virus) is a virus that attacks the immune system, resulting in a chronic, progressive illness that leaves people vulnerable to opportunistic infections and cancers.

**HIV+**

HIV+ indicates a person who is seropositive for HIV.

**Parasuicidal behaviour**

Parasuicidal behaviour is a nonfatal act in which an individual deliberately causes self-harm.

**PLWHA**

PLWJA is an acronym that stands for people living with HIV and AIDS (PHA is an alternate acronym).

**Seronegative**

An individual who does not have HIV is said to be seronegative.

**Seropositive**

Seropositive is another way of describing the presence of HIV in an individual. An individual who is seropositive has immunological evidence of infection indicated by a positive blood serum reaction. This is sometimes shortened to "positive."

**Suicidal ideation**

Suicidal ideation is thinking about suicide or intending suicide without an explicit act. These can vary from nonspecific to specific thoughts, or even to the intention with a plan but without action.

**Suicidology**

Suicidology is the scientific study of suicide and its prevention, including the study of completed suicides, nonfatal attempts, and self-destructive behaviours and attitudes.

**Suicide attempt**

A suicide attempt is when someone intentionally injures oneself with the intention of dying but does not die.

**Suicide resiliency**

Suicide resiliency generally refers to factors that prevent an individual from attempting or completing suicide.

**Viral load**

Viral load is a measure of the amount of HIV in the blood, calculated by estimating the virus amount in a sample. It is an indication of the severity of the infection: generally, the higher the viral load, the faster HIV will damage an individual's immune system.

*Suicide and HIV*

Suicidal thinking is extremely common among people infected with HIV. Various studies have been done to ascertain the relative rate of suicidal thinking in this population. A number of studies have found extraordinarily high rates of both suicidal thinking and suicide attempts among people positive for HIV. One study by Marzuk and Mann (1988) found that the risk of suicide in men with HIV was 36 times higher than in men of the same age who were seronegative.

A study of the cause of death in people living with HIV in southern Alberta found that of those deaths not attributed to HIV, 7% were due to suicide and an additional 29% to drug overdoses (Krentz, Kliewer, & Gill, 2005, p. 99).

*HIV Diagnosis*

An increase in suicidal thinking is first evident when a person seeks an HIV diagnosis. A third of the people who sought HIV testing reported suicidal thinking. Among those who received a negative test result, the rate of suicidal thinking decreased by 50 % (Perry, Jaconsberg, & Fishman, 1990). For those who tested positive, the prevalence of suicidal thinking remained high. “A 27.1% and 16.3% prevalence of suicidal thoughts was found 1 week and 2 months later, respectively” (Schneider et al., 1991). This elevated rate is still present six months after diagnosis (Jud & Mitch, 1996).

A study by Cooperman and Simoni (2005) of HIV+ women in New York City also found that suicidal thinking and actions frequently followed an HIV diagnosis.

> As predicted, suicidal ideation was high: 78% reported suicidal thoughts since their HIV diagnosis, and 26% of the women in this sample reported a suicide attempt since diagnosis. (p. 153)

This rate of suicidal thinking and behaviour is startling. The study also indicated that the increase in suicidal behaviour was associated with the HIV diagnosis. This was evident in the timeframe of the attempts, as Cooperman and Simoni (2005) note:

> Among those who attempted suicide, most made their first attempt soon after their HIV diagnosis, with 42% acting within the first month and 27% within the first week (Bellini & Bruschi, 1996). In addition, there was a spike in suicide attempts around the period of the one-year anniversary of diagnosis. (p. 153)

This study also asked participants if they considered their suicide attempt to be connected to their diagnosis. Sixty-three percent stated that their suicide attempt was very much related to their diagnosis; 23% stated that it was partly related; and 14% stated that it was

not at all related (Cooperman & Simoni, 2005, p. 153). The period immediately following an HIV diagnosis appears to be a time of increased suicidal thinking and behaviour.

*Suicide High Throughout Illness*

This increased rate of suicidality is not limited to the period following diagnosis, but continues to be high throughout the course of the disease. A study of suicide attempts among PLWHAs in France found that "individuals who had been diagnosed for a longer period of time were also associated with higher frequencies of SA [suicide attempts]" (Préau et al., 2008, p. 919).

This study also found that those who were healthier were less likely to have attempted suicide: "With respect to clinical variables, individuals with undetectable viral load as well as those with CD4 cell counts above 200 reported significantly lower rates of SA" (Préau et al., 2008, p. 919). A low viral load and high CD4 cell count are associated with health in PLWHAs. Other research has found that "higher levels of suicidal thinking has been reported by HIV+ persons who are experiencing physical symptoms, especially pain, as compared to those who are asymptomatic" (Kelly et al., 1998).

Not all illnesses are associated with an increased rate of suicide. Many illnesses—even terminal illnesses—are actually associated with a reduced risk of suicide. Brown, Henteleff, Barakat, and Rowe (1986) found that "77% of the terminally ill who were questioned in a hospice setting had never wished for death to come early" (Maris, Berman, & Silverman, 2000, p. 354). However, certain illnesses have been correlated to a higher rate of suicide, as Maris, Berman, and Silverman (2000) note:

We know that 30–40% of all suicides have some significant *physical illness*. Diseases that have been found to be related to suicide include epilepsy, malignant

> neoplasms, AIDS, gastrointestinal problems, and musculoskeletal disorders (e.g., arthritis and chronic lower back pain), among others. (p. 83)

In order to understand why some illnesses may increase the likelihood of suicide while others do not, commonalities between those illnesses that are associated with increased suicidality were studied and common features identified. A summary of the characteristics these illnesses share was compiled by Maris, Berman, and Silverman (2000).

> Characteristics of Physical Illnesses That May Predispose One to Suicide
>
> 1. Chronic in nature—lasts over time
> 2. Debilitating—interferes with activities of daily life
>    i. Poor health
>    ii. Disruptive to daily life
>    iii. Limitations in range of motion or activity
> 3. Painful—unresponsive to treatment
> 4. Deteriorating over time; downhill course
> 5. Embarrassing—socially isolating
> 6. Stigmatizing to society
> 7. Cognitively impairing—affects judgment, memory, insight, orientation, abstraction
> 8. Apathy and decreased motivation
> 9. Dependency—on others, medications, regiments
> 10. Irritability
> 11. Inability to adjust or cope to the illness
> 12. Life-threatening complications (p. 344)

Of these characteristics, at least nine of the twelve are associated specifically with HIV (1–7, 9, and 12). It is therefore not surprising that several studies have found that suicidal thinking is extremely common in people living with HIV. In particular, pain, stigma, and cognitive impairment are significant factors.

*Pain and HIV*

Pain is a characteristic that is associated with increased suicidal thinking or behaviour. In a study of veterans: "the presence of severe chronic pain was associated with increased risk for suicidal ideation" (Thompson et al., 2006, p. 152). While not immediately apparent, HIV is associated with considerable pain, as Marcus, Kerns, Rosenfeld, and Breitbart (2000) note:

> The high prevalence of pain in patients infected with HIV/AIDS is now well established. Estimates have been reported to range from 30% to over 90% … respondents described an average of 2–3 concurrent pains at a time which was comparable to descriptions of pain among patients with cancer. (p. 260)

Clearly, pain is a concern for people living with HIV. This pain could arise from symptoms or from medication side effects. Causes of pain include: osteopenia, osteoporosis, pancreatitis, lactic acidosis, peripheral neuropathy, as well general muscle aches and joint pain (CATIE, 2009, pp. 155–163).

*Stigma and Discrimination and HIV*

Stigma and discrimination are, unfortunately, a common experience for those living with HIV. We often discuss the experience of stigma and discrimination for those living in areas in which HIV is endemic such as Sub-Saharan Africa or the Caribbean, but those who live in low-HIV prevalent areas such as Canada and the United States also

report frequently experiencing discrimination. A study by Zukoski and Thorburn (2009) of people living with HIV in Oregon confirms this.

> Our findings indicate that people living with HIV in low-HIV prevalence areas experience stigma and discrimination in both community and health care settings. In their day-to-day lives, participants described feeling socially isolated and rejected by friends and family. These descriptions highlight the relational nature of stigma and how rejection by loved ones is especially perceived to be damaging. (p. 269)

Stigma and discrimination appear to be a daily experience for many people living with HIV, and have been associated with a higher rate of suicidal thinking and behaviour, as described by Préau et al. (2008).

> Reporting having suffered from HIV discrimination by family, friends, at work, or by sexual partners were all associated with SA [suicide attempt]. More precisely, the level of SA was 44% among those HIV discriminated by relatives (versus 18% [for HIV negative]; $p<0.001$), 42% among HIV discriminated by friends (versus 19%; $p<0.001$), 36% among HIV discriminated at work (versus 20%; $p<0.001$) and 32% among those HIV discriminated by sexual partners (versus 20%; $p<0.001$). (p. 919)

Stigma and discrimination are common for those living with HIV and those who experience these are also at a greater risk of suicide.

*HIV and Isolation*

One of the first people to study and write extensively about suicide was the French social philosopher Émile Durkheim (1897–1951). He hypothesized that “suicide

varies inversely [negatively] with the degree of social integration of the social group of which the individuals forms a part" (Maris, Berman, & Silverman, 2000, p. 44). This hypothesis appears to have merit.

> Social involvement of all sorts tends to reduce suicide potential and social isolation or living alone tends to increase the risk of suicide. In one study 42% of suicidal depressives lived alone as opposed to only 7% of nonsuicidal depressives (Maris 1981). In Chicago research, 50% of completed suicides had no close friends compared to only 20% of nonfatal suicide attempters. (Maris, Berman, & Silverman, 2000, p. 81-82).

Research seems to indicate that the more we are connected to others, the lower the risk of suicide.

People living with HIV appear to be more isolated. This may be due to a loss of employment, family support, or relationships, as Rokach (2000) notes.

> Seventy-five percent of AIDS patients reported that they live alone (Christ, Wiener, & Moynihan, 1986). In many cases, patients may not have an ongoing intimate relationship, or they have reported that their partner died of the disease (Nokes & Kendrew, 1990). The individual frequently loses both a job and the social contacts associated with employment. In many cases, alienation from the self and society intensifies the pain of loneliness (Cherry & Smith, 1993). (p. 286)

A study of the social networks of people living with HIV found that social networks were greatly limited and seemed to rely on professional support rather than family or friends (Lichtenstein, Laska, & Clair, 2002).

> The social networks of the men and women alike usually consisted of support persons (buddy or support groups, care teams). Few participants enjoyed an active social life now that they were ill, and even fewer had kept in contact with old friends and activities. Social networks had narrowed through stigma or illness, and volunteers and support groups were relied upon to fill the void. (p. 36)

This increased isolation may play a role in the increase of suicide in people living with HIV. They may be isolated due to stigma and discrimination, loss of employment, loss of relationships, or because of the illness itself.

*Cognitive Impairment and HIV*

One of the characteristics of illnesses associated with an increased rate of suicide is cognitive impairment. HAD (HIV-associated dementia) has been seen in people living with HIV (Skinner et al., 2009).

> HAD is an AIDS-defining illness and approximately 20–40% of untreated AIDS patients acquire the diagnosis, while in populations receiving HAART [highly active antiretroviral treatment] the estimated prevalence of HAD is 10%, although recent studies suggest that neurocognitive impairment progresses despite HAART. (pp. 246–247)

While the rate of HAD may only be 10% in those receiving antiviral medication for HIV, a more mild form of cognitive impairment, NCI (neurocognitive impairment), is quite prevalent (Atkinson, 2010).

> Milder forms of NCI may be more common, and researchers in the United States are taking an in-depth look at this issue in the CHARTER (CNS HIV Antiretroviral Therapy Effects Research) study. Their results, released this past

> summer, indicate that the rate of NCI was 52% among 1,555 middle-aged HIV-positive volunteers—with 21% having mild impairment, 29% moderate, and 2% severe. (p. 22)

This rate of cognitive impairment indicates that loss of cognitive function is a real concern for those living with HIV. Given the connection between cognitive impairment and a higher risk of suicide, this is also significant when considering suicide risk in people living with HIV.

*Depression and HIV*

There is little doubt that those who commit suicide are in intense psychological pain. In everyday conversation, we refer to those who commit suicide as those who have reached their "breaking point." This may be more than a figure of speech. Suicide has been found to be highly correlated with depression. "It has been estimated that about 15% of hospitalized depressed patients eventually commit suicide, and that roughly two thirds of suicides have a primary depressive disorder" (Guze & Robins, 1970, in Maris, Berman, & Silverman, 2000, p. 80).

For those living with HIV, depression may be a concern. Research has indicated that people living with HIV have a higher rate of depression (Himelhoch & Medoff, 2005).

> Depression is highly prevalent among individuals receiving medical care for HIV with lifetime prevalence of depression among HIV-positive individuals reported to range from 22–45%. This compares with lifetime prevalence of depression among HIV-negative individuals, which is reported to be approximately 15%. (pp. 813–814)

A lifetime prevalence of 22–45% seems considerable. However, this may underestimate the number of PLWHAs who experience depression. A Canadian study by Williams et al. (2005) found that the rate of depression among people living with HIV was over 50%. "Of 297 PHAs participating in the study, 54.2% ($n$ = 161) scored ≥ 21 on the CES–D scale (The Center for Epidemiologic Studies depression scale), indicating depression" (p. 125). With this increased rate of depression, it is hardly surprising that an increase in the rate of suicide is also present in people living with HIV.

*Alcohol and Drug Use in PLWHAs*

The use and abuse of drugs and alcohol are significant risk factors for suicide. Alcohol and drug use appear to be both a proximal and a distal cause of suicide. It is a proximal cause as many of those who commit suicide are under the influence of drugs or alcohol when they kill themselves (Merrill, Milner, Owens, & Vale, 1992).

> The proportion of patients that had drunk alcohol prior to the attempt (males 54%, females 41%) concurs with the findings of other studies (males 44–67%, females 17–45%). Most patients were admitted to hospital in the evening and those that had been drinking had usually done so within an hour or so of self-poisoning. (p. 87)

These statistics indicate that the use of drugs and alcohol is extremely common just prior to a suicide. However, the use of alcohol and drugs is not merely confined to the moments just before a suicide.

Alcohol and drug abuse can also be considered a distal cause of suicide. It is not simply while intoxicated that alcohol and drugs affect the rate of suicide. Those who

abuse drugs and alcohol are also more likely to commit suicide in general. ( Maris, Berman, & Silverman, 2000).

> Illicit drug abusers have high rates of completed suicide (Grinspoon, 1986). Abusers who suicide are typically between 20 and 40 years old, male, multiple drug abusers (including concurrent alcohol abuse—Roy and Linnoila [1986] found that typical alcoholic suicide had a mean age of 47 years and, on average had been alcoholic for 25 years) and have comorbid diagnoses of depression, borderline personality disorder, or psychosis. (p. 301)

As with many of the risk factors related to suicide, simply using drugs or alcohol is not sufficient to increase the risk of suicide, but in the presence of other factors, it seems to exacerbate other risk factors.

The recreational use of drugs is connected with HIV infection. The use of injection drugs is one of the most prevalent routes of HIV transmission in Canada. “Of the 31,197 cumulative positive HIV tests in adults reported to PHAC [Public Health Agency of Canada] with exposure category information since reporting began in 1985 to December 31, 2006, 17.0% were attributable to injecting drug use” (Public Health Agency of Canada, 2007, p. 10). This means that a higher number of people who use drugs contract HIV. In addition, the use of drugs may increase the risk of sexual risk-taking. “Under some circumstances, crack use may result in trading sex for drugs, heighten sexual desire, and enervate protective intentions” (Schilling et al., 1991, p. 685).

Alcohol use has also been studied in connection with HIV. A study by Robert et al. (2009) of women living with HIV in the United States found a high rate of problematic alcohol use.

> Subjects were 2,770 HIV positive women recruited from 6 U.S. cities who participated in semiannual follow-up visits in the Women's Interagency HIV Study from 1995 to 2006. Hazardous alcohol consumption was defined as exceeding daily (≥4 drinks) or weekly (>7 drinks) consumption recommendations. Over the 11-year follow-up period, 14–24% of the women reported past-year hazardous drinking, with a slight decrease in hazardous drinking over time. (p. 1025)

Whatever the reason for this association, increased use of alcohol or drugs—along with other risk factors—may be connected to the increased rate of suicide and suicidal behaviour.

*Other High-Risk Groups*

Other studies have challenged findings that an HIV diagnosis increases the rate of suicidal thinking. Those who receive an HIV diagnosis often belong to other high-risk groups. When the rate of suicidal thinking (and behaviour) is compared to equivalent high-risk groups, the findings are more ambiguous.

Some studies continue to find a higher rate of suicidal thinking, deliberate self-harm, and suicide attempts in HIV+ persons, while other studies have failed to find a significant difference. They have found that other factors such as sexual orientation (Perry, Jaconsberg, & Fishman, 1990), a history of deliberate self-harm (Van Haastrecht et al., 1994), childhood trauma (Roy, 2003, p. 42), and a history of psychiatric disorders (Gala et al., 1992) are better predictors of suicidality than HIV status.

Within-group comparisons investigating suicidal thinking and behaviour seem to confirm that those who are HIV+ are more likely to attempt suicide and report more

suicidal ideation than a matched sample. This has been found in the majority of high-risk groups, including gay and bisexual men, intravenous drug users (Grassi et al., 2001), and women (Cooperman & Simoni, 2005).

There are a number of hypotheses regarding the cause of this increase in suicidal ideation and acts. Robertson, Parsons, van der Horst, and Hall (2006) outline three of the most prominent hypotheses.

> Possible etiologies include: 1) multiple psychological stressors, including loss of physical health and well being, social isolation due to death of friends or fear of contagion, societal reaction to the disease, and loss of income due to physical illness; 2) the possibility that persons who are depressed behave in ways that put them at risk for acquiring HIV; and 3) central nervous system (CNS) effects of HIV. (p. 1)

It is also possible that these factors coexist in some people. Whatever the cause, this increase in suicidality indicates that more research into the treatment of suicidal thoughts and actions in people with HIV is essential.

*Suicide Resiliency*

While some research on suicide resiliency has been done, it appears that people with HIV have unique resiliency factors. For example, employment is considered to be a protective factor in a suicidal individual. However, it appears that employment may actually increase the risk of suicide in people with HIV. Having children has also been found to reduce the risk of suicide, but this does not appear to generalize to people with HIV. Cooperman and Simoni (2005, p. 152) found that the presence of children was correlated with an increase in suicidal ideation. Rather than providing the factors that

help people with HIV to be resilient to suicide, this research highlights our lack of information related to suicide resiliency in people with HIV.

People living with HIV experience multiple stressors that are associated with an increased risk of suicide. An HIV diagnosis appears to be related to an increase in suicidal thinking and behaviour, and living with this illness is associated with pain, cognitive impairment, and isolation. In addition, people living with HIV appear to be more likely to experience depression, and have higher rates of problematic alcohol and drug use. It also appears that those factors considered to be protective against suicide in the general population may not be helpful to those living with HIV.

# CHAPTER 3: METHODOLOGY

## *Rationale*

My research seeks to understand the experiences of people who are living with HIV and who consider suicide. Qualitative research methodology offers the preferred approach to understanding human experience. “Qualitative research methods are used to understand some social phenomena from the perspectives of those involved, to contextualize issues in their particular socio-cultural-political milieu, and sometimes to transform or change social conditions.” (Glesne, 2006, p. 4)

I selected a phenomenological approach because, in the words of Thomas H. Schram (2006): “Phenomenological questions are targeted towards understanding the meaning of lived experience and the essence of a particular concept or phenomenon” (p. 100). I was seeking to understand the heart, or the core, of living with HIV and considering suicide. My hope was that at the end of this project, I would feel that “I understand better what it is like to experience that” (Schram, 2006, p. 99), and will have made a contribution to the understanding of others.

## *Selection of Co-Researchers*

A phenomenological study requires that people recruited to participate in this study be those who have lived the experience being investigated. Accordingly, individuals living with HIV who have considered suicide in the past were recruited for involvement in the study. These individuals are referred to as “co-researchers.” Because I was partly interested in exploring how individuals worked through this experience, it was also important that co-researchers not be suicidal at the time.

Studying suicide is extremely difficult, as those who die by suicide are tragically no longer available, so those that attempt suicide and survive are often used as models. As the focus of this study was to explore both HIV and the experience of considering suicide, it was essential that all volunteers both be living with HIV and have attempted suicide at least once. As I was also interested in how people are able to overcome feelings of suicide, not being suicidal at the time was important, as mentioned above.

In order to recruit interested individuals, posters were printed indicating that a research project was seeking people living with HIV and willing to share past experiences with suicidal feelings or suicide attempts. These posters were distributed to various non-profit agencies that serve people living with HIV. I also attended groups for people living with HIV at which I described the research project and invited interested individuals to contact me.

Seven individuals expressed interest in being involved and were interviewed for this project. There were five men and two women. Four of the seven co-researchers were aboriginal and three were Caucasian. All were independent adults between 36 and 50 years of age. All were asked if they were currently considering suicide, and all stated that that they were not. These co-researchers reported that they had been HIV+ for between 8 and 20 years. All indicated that they were connected with one of two ASOs

*Data Collection*

The primary mode of data collection in this study involved conducting, digitally recording, and transcribing in-person interviews with each co-researcher. Interviews were held at the HIV Edmonton offices. Before the start of each interview, I thanked all participants for their willingness to be involved and share their experiences. The co-

researchers were given the opportunity to read and sign a consent form. In order to accommodate those individuals with low literacy, I also read aloud the consent form to each. While discussing possible risks of participating in this study, which included feeling emotionally distressed, I asked each co-researcher to name someone I should call if I had concerns about their emotional state during or following the interview.

Interviews were semi-structured, and prior to meeting with the co-researchers, the intended questions were tested. I did this by meeting with a friend who had attempted suicide eight years ago. Based on this testing, none of the interview questions were changed. During the interviews with co-researchers, additional questions were asked to clarify or expand upon responses given, and questions were omitted if I felt that the co-researcher had already answered the intended question. Interviews were approximately a half-hour in length.

At the end of the interview, all co-researchers received a $25 grocery store gift card as thanks for their participation. This was not indicated on the posters, and potential co-researchers were not told of this prior to their involvement.

All interviews were digitally recorded and transcribed. All transcriptions were done by me in my home. All recordings and notes were locked up when not in use and the computer files were password-protected. One of the interviews could not be transcribed due to a recording problem.

After the transcriptions were completed, the remaining six co-researchers were contacted and each was given their copy of the transcription record. They were given the opportunity to correct any errors and provide any additional information they felt was

missing or important. Strauss and Corbin (1998) suggest this as a way of validating this kind of study.

> Another way to validate is to actually tell the story to respondents or ask them to read it and then request that they comment on how well it seems to fit their cases. Naturally, it will not fit every aspect of each case because the theory is a reduction of data, but in the larger sense, participants should be able to recognize themselves in the story being told. (p. 159)

In two cases, this was not possible. Several attempts were made to contact these two individuals. However, one individual had moved and the other's telephone had been disconnected. Messages were left for them at the agency (where they were involved) but no responses were received.

When the transcripts had been vetted by the co-researchers (with the exception noted) I looked for themes among the personal accounts. By identifying repeated themes, I noted common elements in their experience that helped prevent these people from committing suicide.

*Data Analyzing Procedures*

During the interviews, I sought to elicit lived experiences related to suicide, including stories, anecdotes, and past experiences. I was also interested in discussing the co-researchers' current views and beliefs about suicide. I conducted a thematic analysis by searching for themes in the interviews. Each line of each transcription was coded based on major themes (called nodes in NVivo), and many lines were coded on several different relevant nodes. These themes and their frequency were also recorded.

Themes were added as they emerged from the text of the transcription, rather than using predetermined themes. This type of coding is described by Kathy Charmaz (2003).

> We create codes as we study our data. We do not, or should not, paste catchy concepts on our data.… Unlike quantitative research that requires data to fit into preconceived standardized codes, the researcher's interpretations of data shape his or her emergent codes. (p. 258)

This was done by using QRS NVivo 8 software, which recorded the number of times a theme occurred (references) as well as the number of co-researchers (sources) who mentioned a particular theme.

After all lines of the transcripts were coded, I examined the data a second time. I re-examined all of those themes (nodes) that had been referenced less than 10 times or had fewer than four sources. When re-examining them, I considered if they could fit into other nodes or if they represented a new theme or idea.

I also re-examined two large nodes ("Family" and "Peers"), which contained a large number of references—some that were positive and some negative. These were re-examined and divided into two separate nodes. After again re-examining the data, I organized it into "tree" nodes (a term used in NVivo 8). This organized the nodes, connecting those that were closely related.

Finally, I re-examined all of the references and considered if their best fit was in the current node or in another. I also examined references that were coded in more than one node, and attempted to eliminate multiple codes. Some references were still coded in more than one node at the end of this process.

# CHAPTER 4: RESULTS

This chapter begins with background information on the co-researchers, providing context for the results discussed later in the chapter.

## *Introduction of the Co-Researchers*

In order to maintain the confidentiality of those involved in this project, the names of the co-researchers have been changed and all information not essential for understanding their situation has been omitted.

### *Adam*

Adam is a Caucasian man in his forties. He is divorced and has two teenaged children who live with his extended family. He described his childhood as being extremely abusive both physically and emotionally—especially from his step-father. When he was a young adult, he spent six years in prison for drug-related charges. He currently uses marijuana, and has an addiction to heroin but has not used it in the last eight years. Eight years ago, he was in a common-law relationship. His partner died of a drug overdose. That was also when he learned he had HIV.

He has been homeless sporadically for the last ten years, and his income is from AISH (assured income for the severely handicapped). He lives with chronic pain from sciatica in both hips. He stated that he is not yet on HIV medication as he is relatively healthy. He is currently in a relationship but stated that he is unhappy as she is using drugs.

He said he was in his thirties when he was most suicidal. He attributed this to his childhood experiences of abuse. He was admitted to hospital because of his suicidal thinking and behaviour five times in two years. He stated that it was the death of his

common-law girlfriend that changed the way he saw suicide and came to value his own life.

He has received support from several counsellors and psychologists over the last eight years, and has been quite involved with agencies that serve people living with HIV.

*Brenda*

Brenda is an aboriginal woman in her early forties, with three children and a granddaughter. She stated that all her children have different fathers, and feels ashamed of this. She has been homeless for many years, and is currently at a long-term drug treatment centre for a crack addiction. She is currently four months clean and sober. Brenda described being close to her late father and that his death was part of what made her suicidal. She stated that her drug use and being diagnosed with HIV were also major factors in leading her to become suicidal.

Brenda attributed her current well-being to her drug treatment program, the support of professionals, and her faith. She said that she is now closer to her family and that this is helpful. She also stated that in the past, her friends were a negative influence on her life and that she has cut them out of her life.

*Chris*

Chris is a single Caucasian man in his late thirties with no children. He described his mother as manic-depressive and his father as being an abusive alcoholic. He stated that he was physically and sexually abused and never had anyone to talk to about the abuse. He said he used to get arrested and go to jail just to get a break from home. His first suicide attempt was when he was seventeen, and he said it was a result of family dynamics.

Chris was admitted to the hospital for suicidal thinking or suicide attempts several times after he left home. He stated that when he learned he had contracted HIV, he was considering suicide.

Chris stated that he is extremely uncomfortable around groups of people, and is unable to work as a result of this. He has frequently been homeless over the last 12 years, and has a history of drug use and excessive drinking.

He stated that after his last admission to the hospital crisis unit, a counsellor met with him. He appreciated this and decided to see her regularly afterward. He credited talking to his counsellor and his psychiatrist for his current well-being.

*Daniel*

Daniel is a Caucasian man in his late forties, and has been living with HIV for almost 20 years. He described an abusive childhood that involved being placed in foster care. Currently, he is not close to his family of origin or his foster family. He stated that his first suicide attempt was when he was 21 years old, and thoughts of suicide have occurred several times since then. He reported being in several romantic relationships in the past and being abusive towards these women. He has been arrested for this abuse, and has also spent time in prison for theft. Daniel credited a judge who chose to send him to a mental health facility rather than a prison as being one of the most helpful people in his life.

Daniel struggles with an addiction as well as a bipolar disorder. He has spent time in drug treatment centres and psychiatric institutions. He stated that much of the support he has received in his life came from professionals and agencies. He is currently

receiving support from a psychologist and a psychiatrist, and living in a housing program for people with mental health concerns.

As Daniel has been living with HIV for a long time, he reported losing many peers to HIV. He attributed some of his suicidal thinking to these multiple losses. Daniel has been homeless many times, most recently about three years ago.

Daniel credited much of his current well-being to his knowledge of psychology, to the support of professionals, and to his volunteer work. He described finding meaning in helping others in a variety of ways.

*Eric*

Eric is a single 50-year-old aboriginal man with no children. He described being separated from his siblings as a child, saying that they were often sent to different foster homes. Despite that, he reported being very close to his family now.

Eric considered suicide when he was first diagnosed with HIV. At the time, he was living on the streets of another major city, and he described his life as being centred on drugs. He stated that he considers much of his drug use to be suicide attempts, and he took a lot of risks hoping he would die. He said that part of what caused him to feel suicidal was the effect of the drugs he was using.

Eric acknowledged many people as being helpful to him, including professionals, support groups, and friends, but most importantly, his family. He stated that when he was suicidal, he was not in touch with his family and that they are now very important to his current well-being. He currently lives with his nephew and enjoys the company. Eric described finding meaning in helping others. He helped start an agency for people with HIV in another city, and he continues to try to help others when he can.

*Fran*

Fran is an aboriginal woman in her mid-forties with one child. She is currently in an eight-year-long relationship with a man who she stated, loves her unconditionally and whom she described as being very important to her. She described a childhood of sexual abuse and involvement with the child welfare system. Fran reported running away from her foster home in her teens due to ongoing abuse, living on the streets as a result.

She reported first feeling suicidal when she was fifteen, and again in her late twenties. Fran stated that she has attempted suicide at least three times—when she ran away from home, when her son was apprehended by child welfare, and when she learned that she had HIV. She described a history of abusive relationships and wondered if these were also suicide attempts.

Fran is currently struggling with an addiction to alcohol, and reported selling sex to purchase alcohol. She is currently waiting to get into a drug treatment program. She said the things most helpful to her are the support of her boyfriend, her brother, and her brother-in-law. She also reported that the support of professionals has been essential for her. She is currently seeing a therapist and taking antidepressant and antipsychotic medication. Fran also found that her native traditions and faith are important elements in her life.

*Overview of Results*

The main themes that emerged from the interviews have been grouped into four major sections: Suicide, Stressors, External Resources, and Coping. The section "Suicide" describes themes related to the co-researchers' suicide attempts and attitudes towards suicide. "Stressors" contains those elements that were described as negative or

contributing to feeling suicidal by the co-researchers. The section “External Resources” contains information about the people and places that were identified by the co-researchers as being helpful. Finally, “Coping” focuses on other factors the co-researchers found helpful. Table 1 shows the number of people who referred to a given theme (source) as well as the number of times it was mentioned (references). As previously mentioned, I use the terms parent node and child node, as they are used in NVivo 8.

Table 1

*Themes Identified and Their Frequency*

| Parent node | Child node | Sources | References |
|---|---|---|---|
| Suicide | | 6 | 54 |
| | Euthanasia | 2 | 7 |
| | Feelings about Suicide | 3 | 5 |
| | Long Suicide History | 4 | 5 |
| | Method | 6 | 33 |
| | Multiple Attempts | 6 | 21 |
| | Suicide Ideation | 6 | 18 |
| | Survival | 3 | 7 |
| Stressors | | 6 | 184 |
| | Isolation and Loneliness | 6 | 50 |
| | Drug Use | 6 | 40 |
| | Emotional Pain | 6 | 37 |
| | Childhood Experiences | 5 | 29 |
| | Negative Thinking | 6 | 19 |
| | Family | 5 | 18 |
| | Relationship Problems | 5 | 17 |
| | Death of Support Persons | 4 | 14 |
| | Peers | 4 | 13 |
| | Homelessness | 4 | 10 |
| | HIV Diagnosis | 6 | 9 |

| Parent node | Child node | Sources | References |
|---|---|---|---|
| | Legal Issues | 3 | 4 |
| | Mental Health Concerns | 3 | 3 |
| External Resources | | 6 | 180 |
| | Professional Support | 6 | 44 |
| | Family | 5 | 35 |
| | Agencies | 5 | 24 |
| | Friends or Peers | 4 | 11 |
| | Legal Intervention | 2 | 9 |
| | Emergency Treatment | 4 | 7 |
| | Not Wanting to Hurt Others | 4 | 7 |
| Coping | | 6 | 153 |
| | Change of Thinking | 6 | 57 |
| | Change of Situation | 6 | 25 |
| | Internal Resources | 6 | 23 |
| | Talking | 6 | 21 |
| | Faith and Spirituality | 5 | 20 |
| | Resolving Past Issues | 5 | 17 |
| | Search for Meaning | 4 | 16 |
| | Helping Others | 4 | 14 |
| | Medication | 5 | 12 |
| | Less Impulsive | 4 | 11 |
| | HIV Disclosure | 3 | 11 |
| | Future Oriented | 5 | 8 |
| | Progress Over Time | 4 | 8 |

*Suicide Themes*

A number of themes emerged when the co-researchers discussed their experiences with suicide. These fell into six categories:

1. Method
2. Multiple attempts

3. Past thoughts and feelings about suicide
4. Present thoughts and feelings about suicide
5. Future thoughts and feelings about suicide
6. Euthanasia

*Method*

While not asked what method was used during suicide attempts, all co-researchers referenced different suicide methods. Overwhelmingly, most references (10) were to overdoses—five of the six co-researchers attempted suicide by overdosing. Some mentioned prescription medications such as tranquilizers or sleeping pills, while others mentioned using illegal drugs. Some co-researchers found it hard to distinguish between their drug use and suicide attempts: “You don’t go out intentionally to kill yourself; but, really, you realize that that is a risk every time you use, right?” (Adam).

Both of the female co-researchers indicated that they had considered or had used cutting as a suicide method. One indicated that she cut her legs: “I subsequently cut my legs where my varicose veins are, trying to bleed that black blood so that I could die. And I took a knife and started cutting my legs in the bathtub so that I could bleed to death.” The other woman intended to cut her wrists. Another co-researcher stated that he burned his wrists so badly that he required skin grafts.

Two of the co-researchers indicated that they saw contracting HIV as an unconscious suicide attempt. One said: “I was diagnosed with HIV…. I thought, ‘Well, I guess I’ve finally killed myself.’” Another described her thinking before she learned she was HIV +: “If I do get afflicted with this HIV, then it was good enough for me that I’m going to die, and I can accept that and that almost is comforting.”

Two co-researchers also described self-neglect as a possible suicide attempt. Daniel stated that when he left his home and began living homeless in the river valley, he was trying to hasten his death.

> That was eight years ago. Oh God. I've lived in the river valley for two years homeless. I'd given up. I didn't care. I didn't pay bills, ripped off people, because I didn't care. I got sick—thank God, finally. It took that long, because I'm a chicken. I guess there is part of me that is somewhat spiritual, so I couldn't take my own life, but I could do everything in my power to speed up the death.

Another co-researcher, Chris, reported that when he felt suicidal he considered stopping his HIV medication. He wondered if, by neglecting his physical health, he could bring about his death.

> I could just stop taking my HIV medication because I know sooner or later, if I'm off it long enough, something's going to happen. So that's another thought too, that crosses my mind—why don't I stop taking the meds?

While these methods may seem passive, it is also true that, given the seriousness of their health condition, it could also be effective.

Other methods that were revealed in the interviews varied. One indicated that he planned to hang himself; another stated that he would run into traffic and try to get hit; a third indicated that she now wonders whether by dating violent individuals she was trying to kill herself. Finally, one stated that he considered using a gun. However, he did not have access to one.

In talking about hanging, Adam implied that it was the speed of this method that was part of the attraction for him. He said: "And after your three minutes to end all the

pain, it's all good. It's a small thing." Chris saw ingesting tranquilizers as a peaceful way to die. He stated he expected to die in his sleep: "I'd fall asleep and that would be it."

Eric described using two very different methods, and also described feeling very differently about them. He stated that he tried to run into traffic to see if he would get hit by a car. He indicated that part of why he chose this method was the excitement. He said:

> I would run across really, really busy streets to see if I could cut across, try to get hit. And cars would just about hit me, but there sure was a rush. Cars would go right by me and I'd go: "Whoa! That was close." Then I'd run. I got a rush out of it, in a way.

While the excitement of this method was an attraction, he described his expectations about death by overdose quite differently. Instead of excitement, he reported that it was the lack of feeling that made overdosing attractive to him: "All I would do is go to sleep and not feel nothing."

Finally, Fran talked about her choice of cutting her legs. She indicated that her intention was to end her life. She described her attempt quite clearly.

> I subsequently cut my legs where my varicose veins are, trying to bleed that black blood so that I could die. I did it in a bathtub at home, there was nobody around, and I did it because I was in a lot of emotional pain.

What was important to Fran was getting rid of "the black blood." Her intention was to die. She also talked about why she chose to cut her legs. She stated that she chose this "because I figured if it didn't work, then nobody would be able to see the scars." It is clear from this that even in the midst of her suicide attempt, she was considering the consequences should she survive.

*Multiple attempts*

All co-researchers indicated that they had been suicidal more than once. Brenda described the fewest attempts (two), while Adam indicated that he had been suicidal more than five times. While he did not indicate his total number of attempts, he said: “I was certified five times in the period of two years, to save my life, ’cause really, I wouldn’t be here other than that.” Similarly, Chris stated that he had several periods of suicidality.

> Well, the first time I tried it I was eighteen, seventeen. I took about 80 Xanax; I was drinking heavily big-time. So I slept for two days, I woke up, and thought it was the next day. It didn’t work. That was back in ‘91–’92, something like that. And then I’ve been up in the crisis unit at the [name of hospital] hospital three or four times.

This indicates at least four significant periods of suicidal thinking or attempts—serious enough to be admitted to hospital.

Daniel described four distinct suicide attempts, enumerating and describing each one. He also stated that he believes some of his past actions were unconscious suicide attempts. This was a theme that others expanded on as well.

Fran described two distinct attempts—first by ingesting pills and secondly by cutting her legs. However, she also stated that when she looks back, there are a number of other instances where she wonders if her motivation was, in part, suicide. She implied that she has difficulty separating activities like drug use and dating violent individuals from suicide. If these were suicide attempts, then the number of her attempts would be much higher.

Eric also described his drug use in a similar fashion. He described consciously using more and more heroin that could end his life. He described doing this several times. He also described running frequently into traffic.

Several of the co-researchers indicated that their suicidal thinking occurred over a long period of time, even decades. Fran stated that she recalls attempting suicide when she was fifteen years old, and continued to consider suicide in her late twenties. Chris stated that he first attempted suicide when he was around seventeen and that only in the past few years he has not considered suicide. Similarly, Daniel stated that his first attempt was when he was twenty-one and his last attempt was in his early forties.

*Past thoughts and feelings about suicide*

In some interviews, the co-researchers were able to describe their thoughts at the time of attempting suicide. Escape from the pain of reality at the time was a major factor in past thoughts of suicide. The co-researchers used different words to describe this. Daniel described the escape: “For me, suicide isn’t about leaving this world; it is just about leaving the piece of the world that I exist in right at this moment, and it isn’t a happy world that I live in.” For Daniel, it was a way out of the world he was in.

Chris described wanting to get away, but not being sure what he wanted to escape from. He said, “I just wanted … just wanted … had to get away from something, ‘cause everything feels like it’s crashing down.” This implies that there may have been a sense of urgency as well. Chris also indicated that there was an element of frustration when he got these thoughts in the past, “And when I get confused … not confused but, I don’t know, frustrated or nothing’s going right … it [suicidal thoughts] pops into my head.”

Eric linked suicidal thoughts with feelings of self-hatred. He said: “I used to hate my life; that’s how you get the thoughts.” Eric also stated that his suicidal thoughts continue to confuse him to some extent. He continues to question why he had thoughts of suicide as he asks himself: “Why do those thoughts come to me? I don’t know.… What the reason would be, why I would do suicide, and I thought about that, and there is no reason.”

*Present thoughts and feelings about suicide.*

While none of the co-researchers stated that they are currently suicidal, several indicated that thoughts of suicide continue. Chris stated that he continues to have suicidal thoughts, but they are less intense.

> I think of it, but not as deep as I normally would, and stuff like that. It crosses my mind, and maybe for a split second I would want to do something, and then it goes. But it’s still there, in the back of my mind. But I haven’t had a bad episode of it for awhile now. For the last year, it hasn’t been too bad; it’s been pretty good. But it has crossed my mind.… It comes and goes, like I could say that every now and then it crosses my mind; not as bad.

The thoughts have not disappeared, but Chris indicated that they are less intense and he has noticed a marked improvement over the last year.

Eric stated that the only thoughts about suicide he currently has are about the consequences of suicide. The majority of these appear to be social consequences.

> I’ve thought about … not really doing it but … does that make sense? What would happen if I did it? What would my family and friends think about me?

> That's the only thing I think about; what would the consequences be of doing that.

From this comment, it appears that suicide seems to be present in his thoughts, but the way he thinks about them has changed (Further discussion on this is present in the section, *Change in Thinking*).

Daniel stated that his current thoughts of suicide are about the harm he has done to himself already. He stated that he sees having HIV as a suicide attempt that succeeded. When asked if he continues to consider suicide, he stated: "I don't really know if I consider it so much as I've come to terms with the fact that I've done it already: when I was infected." It appears that thoughts of suicide continue to be present, but are altered.

*Future thoughts and feelings about suicide*

Two of the co-researchers indicated that they wonder if suicidal thoughts will reoccur in the future. Fran was concerned that suicidal thoughts and feelings would reappear. She mentioned that she was concerned about the side effects of her HIV medication, and stated: "Hopefully, they won't push me to suicide again." It is evident that she can conceive of a situation in which she considers suicide. "My brother has HIV, but if I lost him, that might put me into a tailspin of suicide if I lose my brother."

Eric also considered what it would take for suicidal thoughts and feelings to return, but he did not identify the same circumstances that Fran did. He stated: "I've thought about it. What the reason would be…. The only reason would be if it could hurt people, and most people who would be really hurt would be my family. I don't want to hurt them." Instead of thinking of situations that would cause the suicidal thought to return, he indicated he would only reconsider it if his death would have a different effect.

*Euthanasia*

The theme of euthanasia arose in this study. Two co-researchers—Adam and Daniel—indicated that this was a current or past interest. Adam stated that he considers ending his life when he becomes seriously ill due to his HIV. When asked if he continues to consider suicide, he stated that he does not. He also stated that he carries a climbing rope around with him. When I asked about this, he stated:

> I have a quality of life issue because of the illness. There is a time at which I am going to, in the interest of my health, take my own life. I don't consider this a suicide. I consider this a mercy. My doctor agrees with me. I don't think that he would publicly take the stage and, you know, agree in front of an auditorium full of people. But, I think when we are alone, when we are talking about my life and how it is going to end and how badly it will probably end.… This a reasonable future decision to make.

It is clear that Adam considers this to be different from suicide. Daniel also explored the idea of euthanasia. He described euthanasia as something he contemplated in the past. He described this as something that was helpful to him.

> I learned a little bit about euthanasia and the proper process because at one point it was a goal of mine. So I did research and I think that helped. Maybe just … know that should I ever get to that point where I need to, or feel that that's it, done. Every attempt, everything, all my options are out, I can do it. Knowing is a good thing. I'm comforted in the fact that I'm not going to botch it again; I'm not going to come back and feel ashamed or embarrassed. That's good. The other part

is knowing that, it's the LAST option gives me that WHOLE range of … who knows what options there are? I have so many options.

*Stressors*

The co-researchers described many things that were unhelpful or detrimental to them. I organized these into categories that had a similar focus. Thirteen different categories emerged:

1. Isolation and loneliness
2. Drug use
3. Emotional pain
4. Childhood experiences
5. Negative thinking
6. Family
7. Relationship problems
8. Death of support persons
9. Peers
10. Homelessness
11. HIV diagnosis
12. Legal issues
13. Mental health concerns

*Isolation and loneliness*

The feeling of loneliness or being isolated from others was the second most common theme in this study. All co-researchers indicated that this had been a significant part of their experience when they were considering suicide. Some, like Fran, indicated

that they were separated from a particular individual or group of people. Others described isolating themselves from everyone or feeling generally disconnected.

Fran stated that she has ongoing feelings of abandonment and loneliness. She described these feelings as being particularly intense just prior to attempting suicide.

> I couldn't go home to foster care because they had told me that once I was gone, I was gone and I was rejected from there, and it was my upbringing so I had a lot of feelings of loneliness, abandonment, and ah.… Loneliness, abandonment issues, and put[ting] my son into care, and that was like suicide for me because I missed him so much … and it was being alone, being a single parent and um just.…

Fran stated that she was isolated and lonely due to past events, being a single parent, and losing her son to foster care.

Eric described feeling lonely in the past around his friends. He stated that: "Didn't really have friends, they were just drug friends, just people to get high with. I had the money, I had friends. They had the money, they had me as a friend, you know, just like a cycle." He also said he currently experiences a kind of self-imposed isolation: "Now, I come here, I've been … I'm trying to figure out how many friends I've got here … maybe two…. I think it's greedy or selfish of me to make friends."

Daniel frequently described feelings of loneliness. He attributed some of his loneliness to the deaths of his friends.

> I can't say that friends wouldn't have been the answer, because they were a big part of the answer, and their death hurt me a whole fucking lot…. Since they've been gone, I have not trusted anyone with those bonds…. To the point where, a year ago, I was beginning to think that I'll never be able to replace them.

Chris described a long history of feeling alone without anyone to talk to. He stated that as a child he felt isolated.

> I never had anyone to go to about it, like I said. So I had to try to take care of it myself, which when you're growing up is kind of hard. You know … my Pa was violent big-time—you know—and stuff like that. I was sexually abused a few times when I was a kid—kind of sort of—so that kind of screws you up a bit. And I never, ever told anyone about it. I just dealt with it myself … I don't know.

Chris also described intense periods of isolation when he cut himself off from everyone.

> I went back to the room and drank a bit more and stuff like that. I stayed in my room that time for two-and-a-half months. I didn't go anywhere. I didn't shower; I didn't change hardly or nothing like that.

Brenda stated that she sees her own loneliness reflected in the people she sees living on the street. She stated: "I wish I could help them out because I know their loneliness."

*Drug use*

Drug use was one of the mostly commonly cited stressors in this study. All six co-researchers mentioned it, and it was referenced 40 times. Only isolation and loneliness were referenced more often. Drug use appears to have been both a distal and a proximal factor in suicide among the co-researchers.

Drug use appears to have been a significant factor in the lives of the co-researchers while they were thinking of suicide. For some, this appeared to have been part of the daily experience: "Drugs, drugs, drugs, that's all it was. That's all I lived for back then was drugs" (Eric). They also indicated that it affected their daily living. "I had

very poor living habits; I was playing with all kinds of drugs. And had no consequences" (Adam). From these statements, we can see that frequent, even daily, use of drugs was a feature of their lives at the time.

Others attributed many of the problems in their lives at the time to their use of drugs. Adam indicated that he feels drugs were responsible for the death of his common-law partner. He stated: "It took a lot from me. It took six years of my youth, six formative years…. Heroin did that for me, and then fifteen years later it took the love of my life." He also revealed that he feels his own drug use that night was responsible for her death: "If I wouldn't get high with [partner's name] the night she died. You know, if I hadn't been high, she might have been alive."

Fran indicated that her addiction to alcohol caused her to engage in prostitution. She said: "I have worked the streets for alcohol." According to Fran, her use of drugs and alcohol caused greater issues in her life from which she wished to escape.

Daniel indicated that his drug use created a distance between him and others. He stated: "I still have a sister out there that loves me. I know she does. I love her and it hurts because I'm an addict and I understand that the distance is that." Eric indicated that the only people in his life at the time were people he used drugs with: "Didn't really have friends; they were just drug friends, just people to get high with. I had the money, I had friends. They had the money, they had me as a friend, you know, just like a cycle."

Other co-researchers stated they used drugs as an unsuccessful attempt to cope or treat physical concerns. Adam tried crack to cope, but it was not helpful. Chris drank excessively to help him sleep. Brenda used drugs to avoid her problems. She said: "I

didn't care about nothing but doing whatever to get problems out of my way, but it didn't seem that way. I had to deal with it."

Drug use also appears to have been a proximal factor in a number of the suicide attempts. Fran stated that it was when she was coming off drugs that she attempted suicide. In exploring her most recent suicide attempts, she stated: "It may have been associated with the aftermath of doing cocaine, smoking cocaine that I got suicidal psychosis." Chris reported that when he drank, he became reckless and this sometimes resulted in suicidal acts. According to Chris, "It was like rolling a dice; I didn't know what I was doing."

Drugs, according to the co-researchers in this study, played an important role in the suicide attempts. It was part of their daily lives; it caused greater issues in their lives; it contributed to their isolation; and it may have been a factor in why they chose to attempt suicide, either because it lowered inhibitions or because it affected their thinking.

*Emotional pain*

Emotional pain was cited by all co-researchers. All described emotional distress that was overwhelming and from which they wished to escape. They used a variety of different words to describe the pain. Some of the terms used include:

- Depression
- No purpose
- Rejected
- Horrid
- Loneliness
- Despair

- Hurt
- Mistrust
- A perpetuating feeling of shame
- I felt that I was a problem
- Desperate
- Insecure
- Hopelessness
- Anger
- No purpose

All these words indicate deep emotional pain and suffering. There were 37 references to emotional pain in the interviews, which makes it one of the most cited themes in this study. All co-researchers described experiencing profound periods of distress prior to their suicide attempts. Chris described these feelings as being surprising and overwhelming. He stated: “It comes in waves like, sometimes, you know, I can’t see it coming.”

The desire to end or escape this pain was often identified by the co-researchers as the primary motivation for wanting to end their lives.

> It’s hard. It’s not a good space to occupy: the feelings, the thinking, the loneliness, despair. It’s a heavy burden that can’t be carried alone…. I’ve accepted the fact that my life at one point was so horrid in my head that I sought escape prematurely and without proper evaluation. (Daniel)

> I didn’t do it to totally commit suicide, but tame the pain (Fran)

In addition to emotional pain, two of the co-researchers described feeling like they did not deserve to live, or feeling like a burden.

> I think a lot of times when I was suicidal it was because I felt that I was a problem; that the world would be better without me; that somehow I was the mistake, I was … whatever … that the world would somehow be better. (Daniel)
>
> I wasn't worth living. (Brenda)

*Childhood experiences*

The co-researchers in this study described painful childhood and adolescent periods. Five of the co-researchers discussed this in their interviews. Only one (Brenda) did not mention childhood pain. She did not mention her childhood at all. There were 30 references to childhood in the stories of the co-researchers; only four were not negative, and three of these were ambiguous.

Four of the co-researchers described being victims of child abuse. Adam described extreme physical abuse in his past.

> If I could truly show you my life, you would wonder how I got to be sitting here today. I remember being six and being choked out into convulsions by my step-father. He's crazy. The fact that I'm here is crazy. I should have been one of those statistics, one of those kids that got wiped out.

Adam experienced abuse and also feared for his life. He stated that he feels this greatly contributed to his suicidal period. He stated that, because of his childhood, he never learned a lesson that most people learn early in life. He stated: "I guess I had no understanding of the value of life, which is, I guess, you learn that as a child during your happy years [laugh] … except I skipped them, so I never got that."

Unfortunately, Adam is not alone in describing his past as being abusive. Chris described his father as being extremely violent, and disclosed that he was sexually abused.

> My Pa was violent big-time—you know—and stuff like that. I was sexually abused a few times when I was a kid—kind of sort of—so that kind of screws you up a bit. And I never, ever told anyone about it. I just dealt with it myself … I don't know.

It also appears that Chris was extremely isolated and did not receive any support in his childhood. He stated that this affected his schooling. He never wrote his Grade 12 exams because he was in too much emotional pain. He described his mother as being bipolar and that things at home were so bad he did anything to escape. He reports: "I was going to jail just to get away"—jail was preferable to life at home.

Fran also disclosed that she was sexually abused as a child. She stated that this began very early in her life.

> I had sex when I was three years old and, you know, to put up boundaries to stop these people from taking advantage of me could have a basis in why I became suicidal, too; because I knew what sex was as a three-year-old so I was already a working individual and had already lived a lifetime of … ah, sexual innuendo.

Fran reported ongoing effects from this abuse. She said she believes this abuse is connected to the suicidal feelings she had and that continues to affect her. She believes the abuse affected her memory. She reported: "I remember trauma more than I remember normal things." What is somewhat confusing is that later in the interview, Fran described her childhood as being "sheltered."

Fran also described her history in the foster care system as being extremely negative, with ongoing abuse and feelings of rejection. Fran reported leaving home at fifteen out of desperation: “I knew when I was fifteen that I was either going to run away or commit suicide, so I ran away and then tried suicide.” Eric also stated that he was involved with the foster care system. He stated that being separated from his siblings was the most difficult factor for him.

Daniel also disclosed that he was abused as a child and lived in a foster home. He described his family as being an extremely negative influence in his life, even today.

> Family? Absolutely not! A big zero and a minus sign on it, because if anybody could drive me further to suicide, it would be my family. They are NO support. It was a really negative influencing place (It is unclear whether Daniel is referring to his family of origin or his foster family).

Despite this negative description of his family, Daniel also credited the faith he learned from his foster family with helping him accept help later in life: “I think that maybe my foster family had instilled just enough of their faith in me that I was willing to take it.” This was the only positive statement made regarding childhood in any of the co-researcher interviews.

Childhood experiences were perceived as being important to most of the co-researchers. These early experiences were profoundly negative, and continue to influence their thinking and lives presently.

*Negative thinking*

All co-researchers described experiencing negative thoughts or negative thought patterns when they were suicidal. Adam described feeling like “I’m not worthy of value.”

Brenda described having similar thoughts. She stated: “I didn’t really care; I just kept on going out there and doing what I was doing until it ate my body up and I was disgusted about my weight and everything.” Fran echoes this, stating that she experienced “loss of self-respect, no self esteem … and, you know, that worked against me on my suicidal ideation.” Chris described several thought patterns with which he has struggled.

> I get brief episodes of depression, and I isolate myself big-time, and I can take a little thing and make it a big thing with my mind. I get down on myself or whatever.
>
> I went right down, and then, you know, you get psychotic, kind of sort of, like you know, and what not. Then you know, I just blew a fuse or whatever, and I didn’t care. When I get to a point like that, I say fuck it. You know, don’t matter, thoughts like that. My mind just races in a thousand different directions. I think of everything. I can remember when I was two years old, three years old. Like I bring all that in the back of my mind, and chase, and my mind goes.

Daniel focused on the content of his past thoughts: “Thinking that I was very self-centered and selfish, and always focused on the negative of life and not on the positive.”

*Family*

Family was a theme that occurred frequently. In approximately one-third of the statements made by the co-researchers, family was referred to as something that was unhelpful or even harmful when considering suicide. Fran indicated that being separated from her son was a stressor for her. “That was one reason why I tried cutting my legs, being separated from my little son.” Chris stated that he was never close to his family.

> I don't talk to my family; I don't call them up. Every now and then—maybe once every nine years—I might call them up and say hello. That's about it. I don't talk to them much. My mother died a couple years ago. My father died before that. My family's not close, you know?

Chris also described not getting along with his brother.

Brenda indicated that family concerns were present when she attempted suicide. However, it appears that for her, it was more about avoiding future concerns as opposed to a past or current event.

> Jill: Describe what was going on in your life when you were thinking about suicide.
>
> Brenda: I was thinking about it, just 'cause I've got three kids from three different fathers, and I have [had] one miscarriage from another guy. I was embarrassed to tell them when they grow up about their dad. Finding boyfriends in bars and that, just being too easy and not looking at what my real life is going to be like when my kids get older, and not caring about anything.

Daniel also indicated that he is hurt by his family, and that this is painful for him.

> I still have a sister out there that loves me. I know she does. I love her and it hurts because I'm an addict and I understand that the distance is that. THAT and not the HIV, but the rest of my family, which unfortunately she has to … because they're more blood to her than me; foster, right? She has to keep up appearances, and it's shallow and I hate to say … it hurts.… It affects me. I want to say, "I understand. I'm okay with it." I understand but am I okay with it? I'm hurt by it. I'm hurt by

> it. I can tell her that until I'm blue in the face and she'll nod her head, "Yes, I understand." That doesn't help.

Daniel is very clear that his relationship with his sister is difficult. It causes him pain and is not helpful.

*Relationship problems*

Relationship problems also emerged as a theme in the interviews with the co-researchers. Adam stated that he is currently in conflict with his girlfriend regarding her pregnancy. He stated: "If [girlfriend's name] thinks that what she is doing to this baby is tolerable, or acceptable, or in any way, shape or form, she is sorely mistaken. You know?"

Brenda reported that her past relationships were one of the main stressors when she attempted suicide: "I was thinking about it [suicide], just 'cause I've got three kids from three different fathers, and I have [had] one miscarriage from another guy."

Daniel described being abusive in past relationships. He reported: "I was verbally, physically, and mentally abusive to common-laws to the point where choking was involved." Fran stated that she was also in violent relationships.

> I ended up in an abusive relationship, and that could have very well been a form of suicide; being with a very violent individual, a career criminal…. I would pick these violent individuals—there was actually two that come to mind—that assaulted me on more than one occasion.

She also described being sexually assaulted while at the hospital. She reported: "There were two men who took sexual advantage of me in my dilapidated state, and I couldn't

tell at the time if it was right or wrong, but it was still promiscuity and that didn't help me."

Eric described a current struggle with relationships. He avoids them because he is living with HIV.

> I don't have a relationship with a woman now because I think it would be selfish on my part to have one. I want one, but I won't have one 'cause, like, I don't want to die before her or something like that, 'cause she'd be sad.

*Death of support persons*

One of the stressors referenced by the co-researchers was the death of supportive people in their lives. There were 14 references to this as a negative element, and four of the six co-researchers highlighted this as a concern. Some mentioned multiple losses, while others indicated that the distress was related to a specific loss of a significant person in their life.

Adam stated that a pivotal moment in his life was the death of his common-law partner. He stated that while her death gave him an appreciation for the value of life that has subsequently helped him survive, her death also caused a great deal of emotional pain. He stated that after her death, he felt torn between those two emotions.

> I was there when they passed at 27; my thoughts and views on suicide and the value of human life changed. Although I got diagnosed with HIV at the time, I couldn't even contemplate suicide because someone had just taught me [what] the value of human life was. Being a little, perhaps, mentally ill or mentally unstable … that put me in a really difficult position because … I've got half my mind

> really wants to off myself, and the other half going: “How can you even think that” [laugh]. It was kind of … like being torn in half.

Adam’s distress led to something positive because it changed his beliefs. However, that did not diminish the pain that accompanied this loss.

Adam experienced more than grief after this loss. He was present when she died, and described dreams and memories that can be considered traumatic.

> I can still see her face when I turned her over. Have you ever looked at death? At recent death? Have you? I’d wake up for about a year and a half with … her face was on my mind. Not her happy, lovely, spiritual face that I loved for five years, but [a] black and bloated face of someone who had choked to death in her own vomit, and had laid in it face down for a couple of days before I came out of my coma. It’s just horrific. I mean that is not the way that I want to remember somebody that I love.…

According to Adam, not only was he grieving this loss, but images of her death continued to haunt him. Adam describes this as being horrific and, certainly, as being a negative element in his life.

Brenda also indicated that grief was a considerable element in the emotional pain that resulted in a suicide attempt: “I just lost my late dad. That’s what made me try the suicide too, and I lost a late sister. I thought, ‘That’s it,’ because I was close with my dad and I still miss him.” For Brenda, the loss of her father triggered her suicide attempt.

Daniel appears to have been dramatically affected by loss. He attributed suicidal feelings to the death of others seven times in his interview. He spoke primarily about the

death of his best friend and how the sudden death triggered his most recent suicidal period.

> My best friend of almost twelve years—my best friend, I mean my, absolutely, my best friend … he died. It was unexpected, just out of the blue. He was not HIV positive; there was no reason for him to die…. He died and my life shattered. I didn't realize how hurt a person could be … I guess if you are married and lose your spouse … you've got that idea.

The fact that the death was unexpected and it opposed Daniel's understanding of the world adds to the significance of this loss.

The number of losses Daniel experienced also influenced him. In four separate instances, he referred to multiple losses of friends or peers (in the interview, Daniel used the word "peer" to indicate people he knew who were also living with HIV).

> Somewhere along the line … maybe a few more resentments and hurts, and deaths, happened, and I was suicidal again. When I come back to my world: to the living from (a treatment centre) and death, I found out a lot of my peers were dead. So after all the deaths, my third attempt would have been about ten years ago.

It may be that what made the losses significant was the number of deaths rather than the people who died.

Eric also referred to the loss of friends. After describing a friend who had been a major support to him, he stated: "He's dead now. All my friends are dead; all my close friends are dead." Multiple losses appear to be a significant factor in Eric's past as well.

*Peers*

References to peers indicated that this theme, like references to family, were both a positive and a negative factor in the lives of the co-researchers. Four of the co-researchers indicated that friends or peers were unhelpful or were a destructive element in their lives. When asked what wasn't helpful when he was suicidal, Adam stated:

> People who pretend to empathize, to gain a little bit of … what is the word … influence in your life. Because they have gone through something similar, but really they're looking to help themselves and not you at all, you know; if you feel really bad, they can feel really good because they don't feel THAT bad. It's so sad, but you see it a lot out there, you know; so, those things didn't help.

Brenda stated that her friends were a negative influence on her life: "I hung around those people who are going to be trouble and they get me into trouble and all that…. And what wasn't helpful was being out there and seeing those people I used to be with." Daniel also described peers as being unhelpful. He stated: "I found out a lot of my peers were dead, and the ones that were around I wasn't too sure about." Fran described peers as being a negative element in her life. She stated: "These people took advantage of me, and you know, that worked against me on my suicidal ideation."

*Homelessness*

Four of the co-researchers indicated that homelessness was something with which they struggled. It was mentioned by the co-researchers either as something that they were struggling with when they were suicidal, or as something that made coping with the suicidal feelings more difficult.

Chris clearly described the effect that being homeless has on his mental health. He stated that having a place to live is essential to his continued survival.

> I can't live on the streets anymore; I can't make it. I just can't, not like before. I won't last; if I'm living on the streets, I won't last…. No! I won't do that. I'd go downhill fast. I know I would. I wouldn't last. I'd say: "To hell with it." I know I would, eventually I would.

Adam described being homeless as his "number one problem" and something with which he still struggles. He stated that he finds it more difficult to cope when he is homeless: "You need to take time for yourself. That's easier with a place than without. It's a little difficult when you're homeless."

Daniel stated that during the last period of suicidal thinking, he left his home and became homeless – referring to a two-year period when he lived outdoors and ripped people off. He also stated that a turning point was when he said to himself: "I want a home. I want a home that is affordable and appropriate," and began working towards that goal.

Eric also stated that he was homeless when he was thinking about suicide. When asked what was going on in his life when he was thinking about suicide, the first thing he stated was: "Back then, I was on the streets… and doing a lot of drugs, and I was a complete drug addict."

*HIV diagnosis*

The co-researchers indicated that the time of HIV diagnosis was a particularly difficult period, and five indicated that after learning they were living with HIV, they became suicidal. Adam was the exception to this. He stated that he was diagnosed shortly

after the death of his partner, and this influenced his reaction to the news. He stated: "Although I got diagnosed with HIV at the time, I couldn't even contemplate suicide because someone had just taught me the value of [what] human life was."

Brenda stated that being diagnosed with HIV was definitely a factor in her suicidal feelings.

> Ah, when I found out I had HIV, I felt bad. I felt that's my end, my life, and my family didn't want … I didn't want … I was in too much shock to tell my family and friends. So I thought … I did it once, I did. I took a razor and tried to slit my wrists.

After receiving her diagnosis, Brenda attempted suicide.

Chris also described his HIV diagnosis as preceding a period of serious depression. He described his reaction.

> Well, when I found out I had HIV … I went back to the room and drank a bit more and stuff like that. I stayed in my room that time for two-and-a-half months.
>
> I didn't go anywhere. I didn't shower; I didn't change hardly or nothing like that.

Chris indicated that this period of depression and suicidal intentions resulted in an admission to a hospital crisis unit.

Fran and Eric both indicated that the time of their HIV diagnosis was also a time when they considered or attempted suicide. Fran stated: "Another time [I attempted suicide] was with the HIV, was finding out about it." Eric echoes this statement. He reflected on that period and reported: "When I first found out I was HIV positive, that was in '95, and I guess I was on a suicidal mission in a way."

Daniel stated that despite a myriad of difficulties in his life, knowing he has HIV is the most difficult thing for him. He described the reason he struggles with it so much.

> Had it not been for the HIV part of it, I would be well on my way to being a lot happier … I believe … I truly believe that I could have overcome a lot of things. My addiction, my frustration in relationships…. But all of those barriers, throw HIV into it and I can't break through because no matter how clean I get, no matter how well-spoken I am, I'm still HIV positive, which is a negative and people will reject us. The people that I need in the community for support and everything else reject me.

For Daniel, it is both the reaction of others and his own feelings about HIV that are difficult.

*Legal issues*

Three co-researchers indicated that legal issues had been a stressor for them. Adam stated that he spent six years in prison when he was a young adult, and he believes this had a lasting effect on him.

> That's probably why I am who I am today. All messed up and can't find a house, you know?… Eighteen to twenty-four—isn't that when you make your lifelong blunders and friendships? You know, like how to find places and jobs and do all that crap? Well, that wasn't for me. I was, you know, locked away [laugh] in a penitentiary for six years.…

Chris disclosed that he also spent considerable time in prison. He stated that this began in his teens and continued throughout his life. In the past, he found jail to be

helpful (something that will be further explored in the section on coping), but this changed. He described his current legal issues.

> I've been in and out of court; I've had some court cases come up here. I was just in court a couple of weeks ago, and I thought I was going to jail, but they gave me probation: 18 months. So I cleared that up. I just want to stay away from it now; I don't want to go back anymore. I'm getting too old for it.

Daniel also indicated that he had legal issues in his past. He described being arrested for violence in a relationship.

> I was verbally, physically, and mentally abusive to common-laws to the point where choking was involved, and I was charged; and when I was in front of the courts I said: "Lock me up and throw away the key."

He also described other legal issues. Daniel stated: "I was incarcerated … another bankruptcy," and "I'd robbed a bank."

*Mental health concerns*

Four co-researchers indicated that they have been diagnosed with mental health issues. Adam has been diagnosed with depression. Chris and Daniel referred to bipolar disorder (or manic depression): "My mother was manic depressive too, or something like that. So I think I got that from her, or I don't know, inherited it or whatever" (Chris); and, "I got my bipolar in check" (Daniel). Fran described being given multiple diagnoses.

> I've been diagnosed as bipolar, schizophrenic, borderline, front lobe atrophy, and depression, so that's what I seek the treatment for. So it's not any one thing. It's rather complicated.

*External Resources*

One of the interview questions asked of the co-researchers was who was helpful when they were considering suicide. I named this parent node "External Resources," and found that seven child nodes emerged from the interviews.

1. Professional support
2. Family
3. Agencies
4. Friends or peers
5. Legal intervention
6. Emergency treatment
7. Not wanting to hurt others

*Professional support*

The most commonly referenced external resource was professional support. All six co-researchers mentioned it, and this was the only child node in the "External Resources" node that all six co-researchers mentioned. It was referenced 44 times in the interviews. The most commonly referenced profession was psychologists/counsellors (16 times), followed by psychiatrists (12 times). Doctors and nurses were mentioned as being supports five times, as were staff members at community organizations (such as shelters, non-profit agencies, etc.). Also mentioned were a support group and a judge.

Adam stated that a particular support worker at an agency dedicated to serving people with HIV was most helpful to him.

> [She] was a big factor in it. I mean, she was there for me during business hours and after business hours, because I was a mess, you know.… She helped me survive the guilt of being a survivor…. But I don't know; I think without [her] I probably would have swung from a tree.

Adam credits this individual with being an essential support for him. During the interview, he also indicated that he is receiving or has received support from a counsellor, a psychiatrist, and a doctor.

> Brenda also referred to a variety of professionals as being supportive.
>
> I was at the [name of health centre], and the nurses for HIV there, too, I used to go there, and [name of ASO]. I just tried to go places where I know the staff were pretty nice and there is no drinking or anything around that area.

Like Adam, she referred to more than one kind of professional.

Chris stated that two professionals, his psychiatrist and his psychologist, are the only people to whom he talks. He described how he started seeing his psychologist regularly.

> Well, I seen [psychologist's name], my psychologist. The nurses came and seen me and stuff like that. They knew I was there, and that was kind of nice, kind of neat. They said: "Look Chris, [psychologist's name] came right over and I don't know how she … but I guess. Yeah, that was nice. It was nice to be thought of. That was nice. So I went back.

He described this as being helpful. He reports: "Now I don't think about it [suicide] as often as I used to 'cause I'm talking to [psychologist's name] and [psychologist's name] and I see [doctor's name] on a regular basis."

Daniel spoke of several professionals as being supportive. In particular, a judge was instrumental in his life.

> I guess I had a good judge. I had a judge that said: "There is something deeper. There is something much deeper here that is destroying a good man. You need to

> look at that." He did the best thing that could have been done. He put me in a psychiatric institution as opposed to a jail, so I could be rehabilitated as opposed to punished…. You know, that is probably the one thing that has kept me alive to this day, is the fact that I was given a break early.

Daniel also indicated that he has a psychologist, a psychiatrist, and staff at a community organization, and that this has been helpful.

Eric stated it was a support group that was most helpful to him: "I started going to support groups at the beginning and I … If it wasn't for support groups, I don't know … I don't think … I don't know.… Just those support groups helped me a lot." He identified a nurse as the professional who was most helpful to him: "She was a nurse back at the health centre when I started up this organization, so we got along really good."

Fran also indicated that professionals have been an important support for her. When asked what was most helpful to her, she stated:

> I see a psychiatrist every two weeks. I take antidepressant medication; I take antipsychotic medication, um, vitamins, minerals. I'd say just a lot of support from the professional community, and it has caused me to carry on where I'm not in as much pain.

*Family*

Family was referred to as a positive factor in five of the interviews, and was mentioned 35 times. Adam referred to his children as being important. He said his children helped him to hope: "My kids. During my suicidal period, my kids…. My hope is in my daughter. And it was well-placed apparently, because she's going hard."

When asked what helped her survive, Brenda said her family was essential. She stated: “Memories. I wanted to see how my kids were going to grow up. I’ve got a granddaughter now too. I’ve got more of a bond with my mom than I ever did.”

While Daniel said his family was not supportive, he credited his foster family for helping him to accept assistance later in life. He said: “I think that maybe my foster family had instilled just enough of their faith in me that I was willing to take it [support].” Eric also indicated that his family was very important to him.

Jill: Looking back, what do you think helped you to survive that period?

Eric: Family. I think it’s family. It was family. They were always there for me. ‘Cause there’s a lot of people I know who are HIV positive and never had family members there to help them out, never had anyone there to help them out. My family was always there, always. I’m very lucky to have family like I do. I get along with them so great right now. That’s why I moved back to Edmonton.

Jill: What was it about your family that helped you survive?

Eric: The love for each other. The love for each other, I guess.

Fran described three members of her family as being important to her. When asked who had been helpful in her life, she replied: “Well, [boyfriend’s name], he loves me unconditionally. He knew my HIV status right off the bat. And I guess my brother [brother’s name], and my brother-in-law [brother-in-law’s name]—these are very, very important positive people in my life.”

*Agencies*

Some of the co-researchers indicated that an agency or an organization rather than an individual was a helpful resource. Adam described connections to various agencies as something that helps him to cope now.

> I have people that I call when I'm in deep trouble, and, um, I have access to some community resources, like some offices that I haven't … some tools that I didn't have back then. I mean, they were available back then, but I didn't have them. I either didn't fit the criteria, or I had no idea they were out there.

Brenda named several agencies that were helpful to her. She mentioned a detoxification centre, a drug treatment centre, two ASOs, and a community health centre. She described how one of these is helpful to her: "This [name of agency] … it really helps me out. I like seeing people's faces, even though some go and some come."

Chris stated that it is often only because of his connection to a community organization that he leaves his room.

> That's why I try to go to [name of agency] every day. Just to get out a little bit … you know … I have a reason to go there just for something to do. So I will go, 'cause if I don't, I won't go anywhere…. That's why I try to make my appointment, and go to [name of agency]. That's what's keeping me going. It is, 'cause if I didn't have that, I'd probably be down and out. I would. I'd be sitting in my room.

Chris credited this agency as being extremely helpful.

Daniel stated that it was his connection to, and involvement with, an agency that gave him hope. He stated: “This agency has given me some hope. It has given me the opportunity to tap in to some hope.”

When asked who he turned to for help when he was feeling suicidal, Eric also mentioned an agency.

> That would probably be … I can’t remember … [name of agency]. When I found I was HIV positive, that is when they started up a new program for native people down there; just finding out they’re HIV positive…. We started this drop-in centre. It had, like, a little kitchen in there. It was really cool.

Many co-researchers described agencies and organizations as being important to them.

*Friends or peers*

I used the “Peers” node to describe all of the people the co-researchers labelled as helpful, but who did not fall into the other categories. This term came out of the interviews, and included friends, a sponsor, AA meetings, a landlord, and members of a support group. There were 11 references that fell into this node grouping.

Adam stated that peers helped him to value himself: “I learned that sometimes, for me to find value in something that is mine, I have to find value in theirs first.”

Brenda described a number of peers as being helpful. She stated: “I got a sponsor. I go to meetings every day…. Meetings were helpful, and getting a sponsor was helpful.” She also made a vague reference to her landlord being helpful: “I told my old landlord to drive me to the [name of detoxification centre].”

Eric described a friend that was an extremely important person in his life. He stated that part of this was due to the fact that they were both HIV positive.

> We found out we were both positive and then we became better friends, because we had the same common bond, this bond, because we knew about each other. Nobody else did, but we knew about each other, so we kept that between us.

*Legal intervention*

Two individuals (Daniel and Chris) identified that they found interactions with legal professionals as being beneficial. Daniel stated that it was only after being arrested that he received psychological care. According to Daniel, this was mandated by the judge he appeared before. He stated: “That judge only spent five minutes, and [in] that five minutes probably did more in my life than … he contributed the right thing at that right time. That was huge.”

Chris revealed that prison had been a valuable resource for a long time. He disclosed that he used prison as a way to get out of his home when he was a youth: “I was going to jail just to get away. I would do something like theft. I’d do six months, eight months, twelve months, fifteen months for whatever. I’d just go in and out.” He said prison continues to be a resource for him. When asked what it was about jail that was helpful, he replied.

> I knew what’s expected of me, in a sense. Not too much can go wrong. I did lots of drugs in jail too, and … not hard drugs, but hash and weed and, you know, I used quite a bit. I don’t know … it’s kind of neat. I didn’t have to bother with anybody; I just did what I had to do and I got by. I never wrote a letter or got a visitor or anything like that.

*Emergency treatment*

Four co-researchers indicated they had received emergency treatment at some point. Some indicated that they went to an emergency room following a suicide attempt, while others stated that they spent time in a hospital because of their suicidal intent.

Adam described an involuntary admission to the hospital: “I was certified five times in the period of two years, to save my life, ’cause really, I wouldn’t be here other than that.” Daniel described a similar experience: “I was locked up at the [name of hospital] on suicide watch.”

Chris described spending time at a hospital voluntarily to prevent him from attempting suicide.

> I put myself in the crisis unit because I knew I was going hard, you know, and I said: “Well, Chris,” and then I had a flash of reality—a little bit—and I put myself in there, just for protection against myself. And I stayed there three days or whatever.”

Fran described going to an emergency room after ingesting medication: “I got a ride to the emergency room, and I drank some charcoal drink and subsequently vomited up all the halcyon [a benzodiazepine, belonging to the group of medicines called central nervous system (CNS) depressants, which are medicines that slow down the nervous system] I had taken.”

*Not wanting to hurt others*

Four co-researchers indicated that two things that helped them survive were the understanding that their death would hurt others and their desire to spare others this pain.

Adam indicated that he worried about a child finding his body. He affirmed that his motivation was protecting others. He said: “I don’t want to traumatize anybody with my death.”

Brenda also stated that she worried about hurting others: “I was killing myself, and I felt really hurt that I was putting my kids and my family through danger, and people that love me, and myself.” She stated that this realization helped her continue making positive changes in her life.

Daniel described considering the feelings of others if he died by suicide: “The person that actually takes on the feelings of guilt, shame, and what not are not the people you intended to inflict it on.” Eric echoes this concern: “Most people who would be really hurt would be my family. I don’t want to hurt them…. What would my family and friends think about me?”

*Coping*

One focus of this study was to identify what the co-researchers found helpful. The elements that they identified were grouped into one large node entitled “Coping.” Thirteen different subthemes emerged from the interviews. They are presented in order of the number of references:

1. Change of thinking
2. Change of situation
3. Internal resources
4. Talking
5. Faith and spirituality
6. Resolving past issues

7. Search for meaning
8. Helping others
9. Medication
10. Less impulsive
11. HIV disclosure
12. Future oriented
13. Progress over time

There were a total of 152 references to these subthemes.

*Change of thinking*

All co-researchers indicated that one of the most significant changes between the time when they were considering suicide and the present was a change in their thinking or their attitude. There were 57 references to this, making it the most referenced theme in the entire study.

Adam described a belief in the value of life as an important element that helped him to cope, even when he experienced difficult situations.

> My thoughts and views on suicide and the value of human life changed. Although I got diagnosed with HIV at the time, I couldn't even contemplate suicide because someone had just taught me [what] the value of human life was.

Despite being diagnosed with HIV, Adam stated that it was his thoughts and views that helped him to survive.

Brenda described her current philosophy. She stated:

> If you really want something in your life, you've got to fight for it, no matter what. When you feel lost, I try and understand and go through that path. To be honest and truthful with yourself.

Brenda focused on being truthful with herself and being persistent.

Chris also reported a difference in how he thought about things when he was suicidal and how he thinks now. He stated that he has a different attitude now.

> I kind of know it isn't as bad as it could be. I try to keep—you know—a positive attitude, to a point…. Don't give up. Bad as it may seem, it isn't all that bad. It can be worked out or … let people help you with it.

Chris described a change in perception.

Daniel described coping by focusing on himself.

> I was really, truly, was actively looking at … I can't change others, I can only change myself. What are my needs? What are my wishes? Why do I do the things I do? I stopped laying guilt on myself, or pulling all this: "Oh it's me. I'm the problem. If I were gone everybody would so much better off." Screw that. I wouldn't be better off.

Daniel described changing his focus to what he is able to control—himself.

Eric also described a change in his thinking. He stated that he now experiences less worry.

> My attitude towards life just changed. I see things more … don't worry about things like I used to. Now I don't worry. I just don't: "Okay, that's not going to happen." If it's going to happen, it's going to happen. I don't worry about it now,

> ’cause why should I? It’s just going to stress me out. I don’t worry about things no more.

Fran described thinking of life now as a gift: “I understand more than ever now that life is a gift.”

*Change of situation*

In addition to changed perceptions, attitudes, and views, all co-researchers indicated that they changed their situation. This included changing where they lived, entering into some kind of program, or changing friends.

Adam indicated that managing his physical pain was important. He described visiting his doctor after months of chronic pain.

> I was in serious pain [laugh]. I went to see my doctor a couple of months after, and he said: “Okay, are you ready for pain killers yet? Have you suffered enough, ’cause we can help.” So I let him, at that point.

Brenda described making significant changes in all aspects of her life. She also described concentrating more on her drug treatment program.

> I dropped my old friends; I quit hanging out in bars. It took a long time—it took a hard time to do that—but I did it. I stayed in my program, not going out on weekends and stuff like that. I just, you know, make myself feel stronger so that I could get out there, and starting saying “no” to people, and that.

Chris explained that after his first suicide attempt, he left home. He described this home as being extremely abusive.

> I took a transfer out of town. I went to [name of city]. I said I never went back. I haven't been back. I didn't go back home for maybe about twelve years. I went back for a week, and I haven't been back since.

Removing himself from a difficult situation appears to have been helpful for Chris. Fran also stated that leaving home was helpful. She reports: "I ran away." Daniel stated that one of the things that helped him was focusing on improving his living situation.

> I want[ed] a home that is affordable and appropriate. [Name of group home] gave me the idea of what appropriate housing was, as opposed to affordable housing, and we started working on a plan, and I got into where I'm at now.

Eric stated that one of the things he did to cope was to be closer to his family. He stated: "That's why I moved back to Edmonton." These co-researchers made significant changes to their situation and described this as being an important part of coping.

*Internal resources*

The "Internal Resources" node includes a wide variety of different activities. The common element is that they are things the co-researchers did independently. The activities include reading, exercise, time alone, keeping busy, music, writing, avoiding stress, and putting up boundaries with others.

Adam emphasized the importance of exercise. He stated that he initially started exercising to help his back. He discovered that it was helpful in other ways as well. He stated:

> The side benefit to exercise is that it keeps your mind healthy, too. It gets me out in the sunshine doing push-ups and shit. I feel good about that.

He also described the importance of spending time alone.

> I learned that people can drain you of your energy, and you need to take time for yourself…. For me now, that involves just walking off to a park that nobody goes to, and sitting there by myself for a couple of hours.

Brenda stated that keeping busy was helpful. She described several things that helped her cope.

> I go to the library. I go to the Y and work out. I do a lot of things to keep me busy, to not think about doing anything wrong.

For Brenda, these things helped because they distracted her. In the interview, Chris also described many things that he does to help himself cope.

> I'll read a book or something like that.… I'll go to the guitar store and play guitar for a little bit. Or sometimes I'll go to [name of hospital] and I'll fool around on the piano, that kind of helps. I like music and I don't mind reading…. I used to write poetry and stuff like that. I haven't written for a while, though, but I like playing guitar and stuff like that.

Daniel reported that learning about psychology has been one of the most helpful things he has done.

> To be able to work through it [my feelings] and find: here is the root. You can pull a dandelion and it will grow back: get the root. For me that has been … I dug for roots and that has been psychology.

Both Fran and Eric described putting up boundaries with others. Fran stated that she "put up boundaries to stop these people from taking advantage [of her]."

*Talking*

All six co-researchers indicated that talking was helpful in coping. Adam stated that one of the things he found helpful was becoming a public speaker and talking about HIV.

> I was in schools three, four times a week talking to CALM [Career and Life Management] classes, or whatever they were, about HIV and my experience, and the loss that I had recently experienced, and how that had given me a zest and a joy of life, and, uh, talking about it helped, you know.

Brenda stated that talking to staff at various organizations was beneficial.

> My place where I'm staying makes me feel strong, and [name of agency], because there is a lot of support here and people to help you and talk to…. It helps me with my feelings and that, so I don't think about suicide and all that.

Chris also emphasized the importance of talking. Talking to his psychologist and psychiatrist helped him change his perception.

> Now I don't think about it [suicide] as often as I used to 'cause I'm talking to [name of psychiatrist] and [name of psychologist] and I see [name of doctor] on a regular basis. Talking with them and starting to get the little things out, I'm starting to see it isn't all THAT bad. I've got it not too bad—to a point.

For Daniel, talking helped him cope when things got overwhelming. He described talking as a means of easing pain.

> Sometimes you've just got to set it down, take some time, and look around, talk to somebody. Help. Let go. It's not all my burden. As much as the pain is mine, it can be shared. It's not that heavy. Many hands make light work, or whatever.

For Eric, rather than speaking to a professional, daily conversation and company was helpful.

> My nephew is staying with me now, and that made a big difference, a BIG difference, him moving in with me. ‘Cause now I have someone to talk to. I used to always be at home by myself and watch TV, be a couch potato. Now I’ve got somebody to talk to.

Fran revealed that talking about her feelings was the first step in healing and coping.

> [Talking] has caused me to carry on where I’m not in as much pain ‘cause I’m used to it, I can talk about it, and that is the first step to healing, is being able share with somebody without falling to pieces.

*Faith and spirituality*

Five co-researchers indicated that faith and spirituality have been important and helpful to them. While many of the references were closely related to those in the “Search for Meaning” node, the “Faith and Spirituality” node includes spiritual practices such as prayer and references to God, higher powers, church, healing circles, religion, and afterlife.

Adam referred to God several times in his interview, and indicated that prayer is something he draws upon during difficult times. He stated: “All you can do is pray that you never have it happen again.” Brenda described her faith as being the biggest difference between her life now and her life when she was suicidal: “I never really did believe in God and all that, but he is. Now I do believe in him ‘cause I take Bible study every day, and you pray and everything.”

This statement indicates that faith is an important resource for her. Daniel indicated that his spiritual beliefs stopped him during a suicide attempt: “I guess there is part of me that is somewhat spiritual, so I couldn’t take my own life…. Even going into it I said, ‘I can’t go through with it, it’s against my religion, and I’m not religious.’”

Eric indicated that some of his motivation for his current choices is spiritual because he considers what will happen in the afterlife.

> Maybe it’s because I’m trying to understand the other side of life. Is there one? Am I doing all this stuff for no reason, or is there a reason? Is there going to be another side, or is there not going to be another side? Am I being a good guy for no reason, or should I be a bad guy? I don’t want to be a bad guy. Being a good guy is a good way because—I don’t know—maybe there is, and being a good guy will help out. A bad guy’ll go down.

Fran stated that healing circles and connecting with her traditional spirituality gave her acceptance. She said that what changed the way she sees things was: “an introduction to the Native culture, where I can be accepted regardless of … of … my suicidal attempts, and going to healing circles where I could sit and talk about my experiences.”

The co-researchers all cited beliefs, spiritual practices, and being part of a faith community as being helpful.

*Resolving past issues*

In addition to changing their current situation, five of the co-researchers indicated that resolving past issues or problems was useful. Many of the issues were referred to vaguely, but the issues that were highlighted were addictions, grief, communication, resentments, and past abuse.

Brenda stated that in the past, she avoided her problems and now is actively working on resolving past issues: “I didn’t care about nothing but doing whatever to get problems out of my way, but it didn’t seem that way. I had to deal with it. So that is what I’m doing now.”

Daniel stated that in the past, he resented women because of his childhood abuse. He reported: “I have learned valuable skills in how to communicate and deal with others, be it male or female. I have learned about tolerance and acceptance.”

Fran stated that she needed to resolve some of her grief around the loss of her son. When asked what was helpful, she stated.

> Getting older; putting some distance between me and my little son when he was three, four years old. He’s twenty-two now, so it’s kind of like long gone, past, over, done, finished; I can carry on.

*Search for meaning*

Four of the co-researchers indicated that wanting to find meaning or believing there was meaning in their life motivated them to carry on. When asked what helped him to survive, Adam stated that it was “curiosity to find out what is next.” After surviving a suicide attempt, Chris recalls his reaction: “I thought, whoa, I guess I’m here for a reason.” Daniel stated that what helped him survive is searching for answers and feeling that he is alive for a reason.

> If I just kill myself, a lot of questions are unanswered…. Whatever I’m paying over and over and over again is my debt to my higher power. I’m here for a reason. If I wasn’t supposed to be here, I wouldn’t be here. That I am here, there is a reason.

For these co-researchers, meaning was an important element in coping.

*Helping others*

There were 14 references to helping others. Some co-researchers indicated that they had taken on formal helping roles such as HIV educators or peer counsellors, while others described more informal helping such as giving away food or helping a family member.

Adam stated that after the death of his partner, he became an HIV educator: "I was in schools three, four times a week talking to CALM classes, or whatever they were, about HIV." Daniel stated that in order to cope, he focused on helping others: "So I switched gears, in a way, and became very active here [name of agency] and at other agencies, and started to really … give." Eric described helping people in many different ways. He reported acting as a peer counsellor, warning people he knew about HIV, helping his family with odd jobs, and doing volunteer work. He described a recent charitable action.

> The other day, I made a big roast and I had too much meat left over and I wasn't going to be able to eat it, so I cut it all up in sandwich size and went out on the streets and gave it away to people on the streets. "Here—hungry?" Give that away to them, that made me feel good. Back then, I would be the one asking for a sandwich; now I'm the one that's giving [it] away.

Focusing on others and helping them appears to have been valuable.

*Medication*

There were 12 references to medication in the interviews. Seven of these were related to HIV medications or treatment. Three references were to antidepressant or

antipsychotic medication, and two references were for sleeping medication. The co-researchers indicated that HIV medications helped them get or stay healthy, but some also expressed negative feelings about them.

Brenda indicated that she sees her medication as helpful, but dislikes taking her new medication.

> I just started the new pills. I don't really like taking them. I used to be down to two pills or three pills a day, but now I'm up to 12 or 14 pills a day because my blood is getting bad, but the only way to get that to go down is my meds.

Chris indicated that sleeping medication is essential for his well-being.

> That's why I have to take medication, but even when I … I toss and turn and all that. I'm restless, it isn't a sound sleep. It isn't. I know it isn't, and I'm tired but if I go home and lay down, I can't sleep. Like I said, I'm lucky if I get 2–3 hours. It's been a LONG time since I've had a good sleep.

Daniel described his HIV medication as helping him regain health, saying: "They got me healthy again. They got me back on my meds." He also stated that medication for his bipolar disorder has been helpful, although he did not start this medication until after his third suicide attempt. He reported: "It wasn't until after the third attempt at suicide that I ever saw a psychiatrist for pills." Fran also described medication as being important for her well-being. For her, antidepressants and antipsychotic medication has been helpful. Medication appears to be a component of health and well-being for many of the co-researchers.

*Less impulsive*

Four co-researchers indicated that one of the differences in their lives now is that they are less impulsive. They used an assortment of different terms to describe this, including taking time, being on the watch for thoughts, thinking twice, picturing the end result, and being patient with life.

Chris described how he currently works things out. He stated that he approaches things differently now.

> ‘Cause I don’t react on them right away, then I isolate myself and—you know—I’ll stay five, six days and kind of work it out in my head—kind of sort of—you know? Sometimes it takes longer…. I don’t react as fast. I kind of sit back and, okay, you know, I don’t get tunnel vision. I kind of think twice, where before I’d just … right off the hop. Yeah, I wouldn’t think twice and I wouldn’t care about the consequences. Now I’m thinking about consequences, too.

According to Chris, it is not so much that his thoughts have changed, but more that he does not react on his thoughts immediately.

Eric also described taking more time. He stated: “I just be patient with my life, I guess. That’s the word, patient with my life, and I just enjoy life.” Fran indicated that she also tries to be more cautious. She reported: “I learned a lot and I know a lot about myself but … I try not to be as careless or as freewheeling.”

*HIV disclosure*

Three of the co-researchers described telling people about their HIV status as being beneficial.

Brenda stated that she found it easier to cope with her diagnosis when she started talking to people in her life about it: “So I started telling people about my sickness and anybody around me. My family, they’re supportive now.”

Eric described talking about his HIV as being beneficial as well. He described telling people about his diagnosis to help them. He explained: “I would tell people like, ‘Hey, I’m HIV positive and I’ve been using with you; I think you should go get tested, get yourself checked out too.’” He also spoke of a special bond that he has with a friend because they are both living with HIV.

> Then we found out we were both positive and then we became better friends, because we had the same common bond, this bond, because we knew about each other. Nobody else did, but we knew about each other, so we kept that between us.

Fran also described feeling particularly close to her brother who is also HIV+. When she spoke to her brother-in-law about how she became HIV+, it was a positive experience.

> My brother-in-law said: “How did you get HIV?” and I told him: “I shared a needle with this ex-boyfriend of mine.” And he’s not vindictive, and he always tells me he loves me and he knows that about me. So, that’s okay, I can live with that; that’s a really good feeling.

For these three co-researchers, disclosing their HIV status and talking about it was important for their well-being.

*Future-oriented*

Some of the statements made in the interviews suggested that the co-researchers were focused on the future. They discussed goals and plans as well as commenting on the importance of focusing on the future.

Adam talked about seeing what his children do in the future. He stated: “There is good things to look forward to there, but we’ll have to see. There is hope in that for me.” Brenda stated that one of the things she finds helpful is going to places where “I can concentrate and look towards my future.” She also stated that her future seems bright, saying: “I’ve got everything to look forward to.” Chris indicated that he was considering a new housing program.

> I’ve just applied for [name of housing program]. If I get in, I’m going to try it. I don’t know if I’ll like it. They come and see you every couple of weeks, once a week, or twice a week, and then I guess you go out in groups. I don’t know how I’ll react to that. I’ll try it.

Daniel talked about a project he is working on: “I’m writing a book right now.” Fran talked about waiting to get into a treatment program and the changes that will follow: “Right now I’m waiting to get in to drug and alcohol treatment, and I will be totally off the street.”

*Progress over time*

Four of the co-researchers indicated they have seen positive changes in their lives, and that this has been important. Adam said: “I’m working on it. I’m ahead of the curve, I think. Ahead of my curve, anyways.” When asked where she finds hope now, Brenda stated: “In my recovery, my program.” Daniel remarked on the number of things he has

already surmounted: “There seems to be barriers placed, a lot of which I’ve overcome.” Eric described meeting with someone who was just diagnosed with HIV and was considering suicide. He noted that this experience helped him realize how much progress he has made: “I went there and talked to him, and it made me think, ‘God, I was like that too.’”

The themes that emerged from the interviews were diverse and included the method used to attempt suicide, childhood experiences, current beliefs, and relationships.

# CHAPTER FIVE: THEOLOGICAL REFLECTION

When I began working on this research project, I expected to learn about hope. If suicide is connected to hopelessness—as research indicates it undoubtedly is—then would not overcoming this hopelessness involve finding hope? I am no longer so sure. While the people in this study found something that enabled them to continue living, I am not sure that what they found is hope. The word did not seem to resonate with them. One co-researcher clearly said: "Hope … I don't have a lot of hope; even today, I think. I don't think I ever had a lot of hope …" (Adam).

Instead of learning about hope, I learned something else.

I was reading the *Book of Job* when I began interviewing the co-researchers. I had a vague sense that it might be interesting to work with this text in some way. The more I spoke with the co-researchers during this project, the more the words of this text resonated for me. To put it bluntly, the more I spoke to the co-researchers, the more I understood the *Book of Job*.

The *Book of Job* has frequently been used as a model for understanding suffering in pastoral theology.

> In an effort to gain insight and understanding of the meaning of human suffering scholars have studied the *Book of Job* from a variety of viewpoints. As one reads the *Book of Job* it is easy to detect evidence of a man experiencing physical, spiritual, and psychological suffering. (Johnson, 2005, p. 391)

It is also possible that what we learn from those who experience deep psychological pain can change the way that we read Job. I suggest that the experiences of the co-researchers

in this study are parallel to Job's experiences and that we can use this study's themes as a lens for reading the *Book of Job*.

*Job and Suicide*

In the *Book of Job*, there is no indication that Job sought to end his life. There is no description of him attempting suicide nor does he state that he intends to end his life. However, there are frequent references to Job's desire to die or to have never lived. In fact, these are the first words that Job speaks to his friends. He cries: "Let the day perish on which I was born" (3:3) and: "Why did I not die at birth, come forth from the womb and expire? Why were there knees to receive me, or breasts for me to suck?" (3:11–12). This is the same kind of painful cry that the co-researchers in this study described to me. Referring to Shneidman, who calls this degree of psychological pain "psychache", Maris, Berman, and Silverman (2000) note:

> Suicides flee (fugue) tormented, painful lives. Most probably just want the pain to stop. Many have tried alternatives short of suicide (e.g., psychotropic medications, various psychotherapies, alcohol and drug abuse, sexual promiscuity, divorce, religious conversion, overinvestment in work and careers, leaving town, sick leave, and leaving jobs) but are not faced with the ultimate egression (i.e., flight from life itself). Sadly, cession of all experience from many suicidal individuals is seen as preferable to continued existence in this world. (p. 49)

In Job's cry, I hear this kind of intense psychological pain.

Susan Anderson, in her 2006 thesis entitled *The Image of God in Suicidal Persons*, found six common markers in the emotional pain of people who are suicidal.

The first marker is “overwhelming pain”. Job describes his pain as being unbearable: “O that my vexation were weighed, and all my calamity laid in the balances! For then it would be heavier than the sand of the sea” (6:2–3). For Job, the weight of his pain is more than he can bear. He also uses the words “unrelenting pain” (6:10) to describe his current experience.

Anderson’s second marker is “wanting the pain to stop”. Job clearly indicates he wants the pain to end, saying: “I would choose strangling and death rather than this body. I loathe my life; I would not live for ever” (7:15–16). He also reveals a longing for peace and ease that he cannot find: “I am not at ease, nor am I quiet; I have no rest; but trouble comes” (3:26). Job longs for the pain to stop, and can see no way for this to happen aside from death.

The third marker is “thoughts of suicide”. While these are not overt in Job, he does indicate that he sees death as a way to end his pain. He states that he wishes he had never been born or had died at birth because if that had occurred: “Now I would be lying down and quiet; I would be asleep; then I would be at rest” (3:13). Some scholars have even suggested that when Job’s wife suggests that he “Curse God, and die” (2:9), she is actually suggesting a way to end his pain through death: “It is an impious suggestion she makes, but it does not arise out of impiety; it is human and entirely for Job’s benefit, this ‘theological method of committing euthanasia’” (Magdelene, 2006, p. 210). This would support the idea that Job has considered ending his life.

The fourth marker is “feeling alone”. Job speaks at length of his loneliness. He has lost his children, been separated from his wife and community by his illness, and lost the support of his friends.

> My breath is repulsive to my wife; I am loathsome to my own family. Even young children despise me; when I rise, they talk against me. All my intimate friends abhor me, and those whom I loved have turned against me. (19:17–19)

Job expresses the deep loneliness that those who consider suicide describe.

The fifth marker is “ambivalence”. Job expresses this as well. While he expresses a deep longing for the peace he believes death will bring him, he also clings to life and reveals there is still something that keeps him alive. Job describes a desire to be deemed innocent before his death. He states: “I have indeed prepared my case; I know that I shall be vindicated. Who is there that will contend with me? For then I would be silent and die” (13:18–19). Job both longs for death and longs to argue his case and be seen as innocent. This suggests ambivalence towards death that is similar to that seen in the emotional pain of suicidal people.

The final marker found by Anderson is “feeling frustrated by unmet psychological needs”. This too is evident in Job. He expressed the need for support from others (6:14–17), justice (9:15), comfort (10:20), understanding (5:24), and hope (7:6). While Job does not die by suicide or attempt suicide, his experience of emotional pain is so similar that they can be considered equivalents. Job has the same pain as those who attempt suicide.

*Commonalities between Job and the Co-Researchers*

Job also experienced many of the stressors that emerged in this study. These stressors were:

1. Isolation and loneliness
2. Drug use

3. Emotional pain
4. Childhood experiences
5. Negative thinking
6. Family
7. Relationship problems
8. Death of support persons
9. Peers
10. Homelessness
11. HIV diagnosis
12. Legal issues
13. Mental health concerns

Job experienced 11 of these stressors. Only drug use and childhood experiences are absent from the account of Job's situation. Another theme—HIV diagnosis—is not in Job's story. However, I see a parallel between an HIV diagnosis and Job's unnamed but obviously very painful illness.

*Isolation and loneliness*

Like those in this study, Job experiences profound feelings of isolation and loneliness. He is physically separated from others and is depicted as being alone in a pit of ashes. He has been rejected by those who once respected him. He describes being an important member of the community, but that has changed. Job states: "And now they mock me in song; I am a byword to them. They abhor me, they keep aloof from me; they do not hesitate to spit at the sight of me."(30:9–10). He is not simply alone but is actively rejected.

Job also describes feeling isolated from God. He states that while in the past he spoke to God and was answered (12:4), now he feels that God will not listen: “If I summoned him and he answered me, I do not believe that he would listen to my voice” (9:16). He describes not being able to see God any longer. He states: “If I go forward, he is not there; or backward, I cannot perceive him; on the left he hides, and I cannot behold him; I turn to the right, but I cannot see him” (9:8–9).

This separation and isolation is painful for Job. In Chapter 29, when he describes longing for the past, the first thing he mentions is his relationship to God.

> O that I were as in the months of old, as in the days when God watched over me; when his lamp shone over my head, and by his light I walked through darkness; when I was in my prime, when the friendship of God was upon my tent; when the Almighty was still with me. (29:2–5)

This longing suggests a feeling of profound isolation and loneliness, much like those in this study who described similar intense feelings.

*Emotional pain*

The presence of emotional pain is palpable in the words of Job. There can be no doubt that he experiences intense emotional pain. Simply reading these passages can be painful. In fact, Job uses the words “unrelenting pain” (6:10) to describe his feelings. He also makes the following statements, which elicit a sense of deep emotional pain.

> So I am allotted months of emptiness, and nights of misery are apportioned to me. (7:3)

> I go about in sunless gloom. (30:28)

> I loathe my life; I will give free utterance to my complaint; I will speak in the bitterness of my soul. (10:1)

> My face is red with weeping, and deep darkness is on my eyelids. (16:16)

Clearly, Job has deep emotional pain in common with the participants in this study.

*Negative thinking*

Job demonstrates a tendency to focus on the negative. Given his losses and situation, this is understandable. It matches the experiences of the people I interviewed. Job not only speaks of his own suffering but also of the unfairness of the world in general. Job speaks at length about the lack of justice he sees around him. Presumably, he saw these things prior to his illness. However, thoughts of these injustices during his illness are dominant. Job also suggests that he is overwhelmed with thoughts and that this prevents him from sleeping—a sentiment that echoes the experiences of the co-researchers: "So I am allotted months of emptiness, and nights of misery are apportioned to me. When I lie down I say, 'When shall I rise?' But the night is long and I am full of tossing until dawn" (7:3–4). Therefore, in the area of negative thinking, there are marked similarities between Job and the co-researchers.

*Family and relationship problems*

In this study, family and relationship problems were revealed as a source of stress or pain. The co-researchers identified being separated from family or experiencing family as unhelpful as an important element. Job, too, is separated from his family. His children have died, and he is physically separated from his wife. He describes his current relationship with his family.

> He has put my family far from me, and my acquaintances are wholly estranged from me. My relatives and my close friends have failed me; the guests in my house have forgotten me; my serving-girls count me as a stranger; I have become an alien in their eyes. I call to my servant, but he gives me no answer; I must myself plead with him. My breath is repulsive to my wife; I am loathsome to my own family. (19:13–17)

He is alone. Not only have his children died but his family has failed him. Even the servants no longer seem to know him.

*Death of support persons*

Like those in this study, Job has lost someone important to him—his children. The co-researchers spoke of the deaths of spouses, parents, and friends, while Job experiences the death of his children. These losses clearly impact Job and are a significant factor in his distress.

*Peers*

The co-researchers described times when friends or peers were hurtful. Job also seems to experience this. Even after he is joined by three friends, he feels alone. They sit with him in silence for seven days and nights, but when Job begins to speak his friends provide judgment rather than comfort or support. Samuel Balentine (2003) argues that the book of Job is centered on the idea of friendship.

> In between the beginning and ending of the book, the twists and turns of Job's painful journey tracks through the dialogues with various "friends"—Eliphaz, Bildad, Zophar, Elihu … and God—who make their way to his ash heap with words meant to make a difference in his situation. Indeed, of the forty-two

> chapters that comprise the *Book of Job*, no less than thirty-eight of them, roughly ninety percent of the entire story, are forged in the crucible of a lingering, but never articulated question: Who will be Job's friend? (p. 381)

If this is one of the questions of this text, we can conclude that at the moment of Job's deep pain, he is also asking: "Who is my friend?" And perhaps as well: "Where are my friends?" As Job refers to these three as "miserable comforters" (16:2), it is evident that he feels alone despite having these individuals with him.

*Homelessness*

Job does not experience homelessness in the same way as the co-researchers—he had a home. We know this because in Chapter 42, Job is described as eating with his brothers and sisters in his house. However, for most of the events in this story, Job is described as sitting among the ashes on the ground. Job is not at his house, likely as the result of his skin disease. In Leviticus, rules concerning those with this type of illness are clear. It states:

> The person who has the leprous disease shall wear torn clothes and let the hair of his head be dishevelled; and he shall cover his upper lip and cry out: "Unclean, unclean." He shall remain unclean as long as he has the disease; he is unclean. He shall live alone; his dwelling shall be outside the camp. (13:45–47)

Like those in this study, Job experienced homelessness.

*HIV diagnosis*

The people involved in this project were not simply people who had considered suicide. They were also living with HIV. Job, too, is living with an illness.

> So Satan went out from the presence of the Lord, and inflicted loathsome sores on Job from the sole of his foot to the crown of his head. Job took a potsherd with which to scrape himself, and sat among the ashes. (2:7–8)

Job, like the co-researchers, is living with an illness that is incurable and stigmatized.

It may also be that Job's questioning is perceived as a disease. While he is questioning his understanding of God and of the world, as well as his friends, he is treated as one who is ill (Balentine, 2003).

> Now Job is a threat, his words are horrifying. Like a virus bug loosed in the world, Job is now targeted as a disease. For the health and well being of the world, his poison must be eradicated; at the very least, he must be isolated, quarantined, ostracized. (p. 383)

The similarities between the experiences of Job and the co-researchers living with HIV are marked. While not identical, they are equivalent. Job and the co-researchers experienced isolation, stigma, and suffering as a result of their incurable illnesses.

*Legal issues*

Legal issues were mentioned by the co-researchers. Similarly, Job sees himself as being in the midst of a legal battle. Job's legal concern is with God: "As the debate goes on, Job several times resorts to the imagery of a court of law, and within such a setting not only asserts his innocence but asserts God's injustice for treating him other than he deserves" (Janzen, 2009, p. 55). Job believes he has been unfairly condemned by God and that he has a legal case against God.

For Job this is both a legal issue and a justice issue. Unlike Job, the co-researchers did not express feelings of injustice when they discussed their legal issues. However,

themes of injustice often arose when they talked about their childhoods. The co-researchers, like Job, expressed a sense that they were victims of extreme injustice.

### *Mental health concerns*

While the understanding of what we would today refer to as a mental health concern was quite different when the *Book of Job* was written, modern psychologists have examined the text using current diagnostic criteria. One such examination diagnosed the character of Job with depression: “This paper shows that Chapter 30 of the *Book of Job* is a key-index of ideas which, if followed through the book, divulges a description of depression that meets current diagnostic standards” (Kapusta & Frank, 1977, p. 760). Diagnoses of depression were also described by the co-researchers—once again, a striking commonality between them and the character of Job.

## *What This Means*

I noted many similarities between the people interviewed for this study and Job. They all described loss. Children, jobs, loved ones, and friends were lost. Health was lost. Respect from others was lost. Like Job, they were cast out in their loss and grief to (metaphorically) stand in ashes alone. If the experiences of the co-researchers and Job are parallel, then perhaps they can act as living texts that expand on and explain the *Book of Job*.

When I first began reading Job, I hoped the text would help me understand how the people I was working with had turned their lives around, changing the way they lived and how they felt about and viewed the world. I soon realized I was looking at this the wrong way. It was the people I interviewed that helped me to understand Job. They helped me to understand his suffering, his pain, and his loneliness. In their descriptions of

people who had been unhelpful, I began to truly get a sense of the pain that Job's friends caused. After speaking with them, I also read Job's restoration differently.

Using the lives and experiences of people as a way of entering into theological reflection is an established practice within pastoral theology. In this practice, lived experiences and text have a dialogue (Moore, 2001).

> [A] dialogue of question and answer is set up between the issues of the world and the Christian tradition, in which the questioning and the answering may travel either way. Theology arises from lived experience, which is brought into dialogue with the tradition in such a way that they mutually inform and shape one another. (p. 10)

The experiences that the co-researchers shared with me informed my understanding of chapters 38–42 of the *Book of Job*.

Both Job and the co-researchers were somehow able to move from a place of despair and hopelessness to a place of new life. To me, this is miraculous. Despite intense suffering, people are able to find a way to continue, and they do more than simply endure. They find a way to live a fulfilling life.

*Book of Job, Chapters 38–42*

Chapters 38 to 42 describe the transformation of Job, though it is hard to see how this transformation comes about. Whereas the previous thirty-five chapters consist of a debate between Job and his friends, the Lord now enters the conversation. Most of the next four chapters (126 verses out of 129) consist of the Lord asking rhetorical questions of Job, with Job speaking only briefly.

The questions the Lord asks demonstrate Job's lack of knowledge in comparison to the Lord. The Lord, through questioning, indicates knowledge and control over the earth and seas, the weather, and the animals both wild and mythical, whereas Job does not. In the midst of this, Job speaks only once, saying: "See, I am of small account; what shall I answer you? I lay my hand on my mouth. I have spoken once, and I will not answer; twice, but will proceed no further." (40:4–5). The Lord responds by continuing with another series of questions of a similar nature.

It is hard to know how these series of questions are helpful to Job. However, something about this is helpful. Something changes for Job in this exchange. The change or transformation is evident in Job's response following the Lord's oration. Job says:

> I know that you can do all things, and that no purpose of yours can be thwarted. "Who is this that hides counsel without knowledge?" Therefore I have uttered what I did not understand, things too wonderful for me, which I did not know. "Hear, and I will speak; I will question you, and you declare to me." I had heard of you by the hearing of the ear, but now my eye sees you; therefore I despise myself, and repent in dust and ashes. (42:2–6)

In this exchange with the Lord, Job hears "things too wonderful for me," and this leads him in a new direction. The Lord then criticizes the actions of Job's friends, and states that it is only by Job's prayer that they will not be "dealt with according to your folly" (42:8). Job prays for his friends, and his fortunes are restored.

*Lived Experience as a Guide*

The reason for this transformation in Job is not readily apparent. However, after reflecting on the experiences of the participants in this study—people who have had a

Job-like experience—I began to see some of these passages differently. Using the themes that emerged from this study, I searched for evidence of similar elements in the story of Job. In this way, the lived experiences of transformation among the co-researchers served as a guide to understanding what helped Job to make his transformation.

*External resources*

The co-researchers spoke about people who had been helpful to them and influenced their transformation, such as therapists, family, agency workers, friends or peers, legal workers, and medical professionals. Given the difference in time and culture, many of these would have been foreign to Job. However, knowing that people had a role in the rebirth of the co-researchers, I examined the people involved in Job's rebirth. At the time of Job's transformation, very few people are present. His friends—Eliphaz, Bildad, Zophar, and Elihu—are depicted as being unhelpful and are, in fact, silent when the change occurs in Job. God is also present. This is significant but God is of course different from the people that the co-researchers described. God is not a professional, an agency worker, or a legal authority. I will explore the impact of God's presence further in the section Faith and Spirituality in this chapter.

Following Job's rebirth, the presence of additional people is suggested. Once Job's fortunes are restored, people come to him.

> Then there came to him all his brothers and sisters and all who had known him before, and they ate bread with him in his house; they showed him sympathy and comforted him for all the evil that the Lord had brought upon him; and each of them gave him a piece of money and a gold ring. (42:11)

These people seem to be the ones that aid Job in his new life. They are described as being family: brothers and sisters. They provide two kinds of support. They listen and give sympathy, and they provide financial support. Similarly, the co-researchers indicated that family support was instrumental for them. Given this parallel, the actions of these brothers and sisters should not be underestimated. They may have been an essential element in Job's restoration to life.

*Change of thinking*

The co-researchers described a change in their thinking as being important. There is a suggestion that this occurs for Job as well. He states: "Therefore I have uttered what I did not understand, things too wonderful for me, which I did not know" (42:3). This suggests he now understands something that he did not know (or understand) previously.

Gerald Janzen (2009) believes that this change in thinking is connected to Job's understanding of divine justice. Janzen argues that Job believed that in order for him to be considered innocent of sin, God must therefore be guilty of injustice. Janzen suggests that this perspective changes due to the Lord's question: "Will you even put me in the wrong? Will you condemn me that you may be justified?" (40:8). Janzen (2009) suggests the following paraphrase of this question.

> Job, you don't have to put me in the wrong in order for you to be vindicated against the charges of your friends. But in order for you to appreciate this, you have to relinquish your understanding of the ultimate divine justice and see it rather in terms of the dynamic thrust towards life that you see manifest in the world around you. This understanding of my *mišpāt* does not rule out the

> possibility of undeserved suffering; but it places it within a context which will free you from the logic of your friends. (p. 97)

This encourages a new way of thinking about the world, suffering, and the Lord. If this is what Job heard, this change in thinking is a significant element in his transformation. Even before Job's suffering is ended, his transformation is evident. This suggests that something has changed internally, and supports the view that a change in his thinking transpires.

*Change of situation*

The co-researchers indicated that a change in situation was important in their transformation. If we use their parallel lived experience as a guide, then we would expect to find a change in Job's situation as well. It is true that Job's fortunes (and health) are restored and he returns home. However, as I previously stated, Job's transformation begins before this occurs.

So what has changed about Job's situation? His friends are silent. The Lord is speaking to him directly. He is no longer being accused of sin. In fact, the conversation is not about his suffering or situation at all. The conversation is about creation—about the wonders that the Lord influences and understands. The Lord is described as speaking to Job "out of a whirlwind" (38:1). This imagery is appropriate. Janzen (2009) suggests that the whirlwind indicates a change of seasons and the beginning of rain.

> What the "whirlwind," or sirocco, with its following rains, says to Job is that God is concerned, as Elihu has said with "his land"…. This weather that renews the earth also comes as a message to Job. (p. 103)

These changes—including the changing of the seasons—assist with Job's transformation.

*Talking*

The co-researchers emphasized the importance of talking in their transformations. This is difficult to see in chapters 38–42, as Job says so little. In fact, he speaks only 33 words. If we consider the text as a whole, Job speaks a great deal. He spends 35 chapters arguing with his friends and asserting his innocence. Perhaps, if asked, Job would describe this as being valuable. While the transformation does not occur until later, maybe the talking that Job has done allows him to transform later (Johnson, 2005).

> It seems that the greatest value derived from the approaches of Job's friends was that it served as catalysis for the purgation of his own frustrations. This, of course, is a psychotherapeutic method that provides people experiencing anger the opportunity to talk about their inward depression. (p. 398)

Job's speeches change through the book. He begins with an exclamation of his suffering and a longing for death. The last speech he makes focuses on his virtues and his desire to prove that he is virtuous (Johnson, 2005).

> As the debates continued and Job's friends became more frustrated and more severe in their criticism, Job became calmer and his bitterness and depression diminished. This is a paradoxical therapy technique that is frequently used with individuals who are angry and resistive to therapy. (p. 398)

While Job does not experience support or understanding from his friends, speaking to them and debating with them may have been valuable and allowed Job to be transformed by later experiences.

*Faith and spirituality*

Faith and spirituality were part of the co-researchers' transformations. This suggests that reflecting on Job's faith and spirituality may also be important. One of the first things we learn about Job is that he is a faithful man—one who takes his religious duties seriously. When his suffering begins, he struggles with his beliefs and with his relationship to God.

So what happens with Job's faith in chapters 38–42 that is transforming? It may be that his faith changes as a result of his change of thinking. It is also possible that he transforms because God speaks to him. Job states: "I had heard of you by the hearing of the ear, but now my eye sees you" (42:5). Perhaps having this intimate encounter with God is the basis of Job's rebirth. In the past, Job has simply heard God. Now Job has seen God as well (Ragaz, 1969).

> What is God's answer? It is powerful, at once crushing and uplifting and, as far as it goes, of eternal validity; it is God Himself. This means that God does not involve Himself with arguments for and against His dominion, but lets Himself be seen. His answer consists in His manifesting His greatness in powerful speech and creative deeds. This, rather than the arguments of God's defenders, causes Job to grow silent and beg God's forgiveness. He has been afforded no insight into the enigmas that have tormented him, but he has seen God Himself. (pp. 129–130)

We focus too much on what God says to Job and less on the act itself. It is hard to imagine speaking to God and remaining unchanged.

*Search for meaning*

A desire to find meaning and a curiosity about the future emerged in this study. The co-researchers stated that the search for meaning was an important part of their experience of renewal. This may also account for Job's renewal. Just before Job's moment of transformation, the Lord questions Job about the nature of the world and the creatures therein. Perhaps in this moment Job realizes all of the things he does not know, and this creates a desire to learn more. Perhaps Job changes because rather than focusing on what he does know—pain and suffering—he considers all of those things he does not know. Perhaps a spark of curiosity is revived in this moment, and this allows him to change. It is possible that questions were more helpful than answers would have been.

*Helping others*

In describing their experience of renewal, the co-researchers pointed to helping others as being pivotal. In Job's transformation, this theme is also present. After Job's internal experience has shifted but before his family and fortunes are returned, Job reaches out to help others. After speaking to Job, the Lord turns to his friends, expresses displeasure with them and their words and actions, and demands a sacrifice.

> Now therefore take seven bulls and seven rams, and go to my servant Job, and offer up for yourselves a burnt-offering; and my servant Job shall pray for you, for I will accept his prayer not to deal with you according to your folly. (42:8)

God puts Job immediately in the position to help his friends.

By enabling Job to become the one who helps rather than the one requiring aid, God may be furthering the transformation that has already begun. The ability to act as a helper may have been pivotal for Job as it was for the co-researchers. It certainly occurs

at a critical time, and is an opportunity that is embraced by Job despite the failure of his friends to be supportive during his time of need.

*Conclusion*

The story of Job is one of suffering and confusion. Even today, Job-like experiences are, unfortunately, all too common. The miracle is that neither Job nor the co-researchers stayed in the place of suffering. They were able to somehow transform their lives into something new. The lived experience of those who have been able to transform their own lives can act as a guide to understanding this difficult text. Their experiences highlight important elements that may otherwise be overlooked.

The story of Job also casts a new light on the experiences of those in this study. It helps us to see these lives as sacred experiences. By seeing the parallels between Job and the lives of the co-researchers, we are encouraged to see their lives as sacred stories, and to value them as such. Putting the experience of Job in conversation with the experience of the co-researchers persuades us to look for sacred moments in the lives of the persons around us, and to cherish those who are able to teach us about the kind of miracle Job experienced.

# CHAPTER 6: DISCUSSION

This chapter focuses on the implications of the results found in this study, their connection to established research, and potential areas for future research. This chapter is divided into the following major sections: Suicide, Stressors, External Resources, Coping, and Conclusions.

## *Suicide*

The information relating specifically to suicide in this study supports much of the previous research on suicide. The following sections explore points of commonality and difference between the experiences of suicide in this project and more general studies of suicide.

### *Method*

The methods of suicide described by the co-researchers are similar to those in the wider community. In 2003, 25% of deaths by suicide involved poisoning, 44% used hanging, 16% used firearms, and 15% used other methods (Centre for Suicide Prevention, 2003, p. 19). This only indicates the number of people who die by each method. For example, the number of attempted overdoses is much higher: “Among adolescents, drug overdoses may account for as much as 90% of parasuicidal behaviour treated in the hospital emergency room (Maris, Berman, & Silverman, 2000, p. 301). The choice of overdosing over other methods may be due to access or familiarity with medications or drugs. This may also be a factor in those who chose to use illegal drugs as a method.

*Multiple attempts*

All of the co-researchers in this study indicated that they had been suicidal more than once. Multiple attempts are difficult to study because they often are not recorded. However, those who have previously attempted suicide are at a higher risk of dying by suicide. The relative rate of death by suicide for those who have previously attempted suicide is 10–15% (Maris, Berman, & Silverman, 2000, p. 284).

*Thoughts and feelings about suicide*

Ongoing thoughts of suicide were also reported by the co-researchers. After many attempts, recurring thoughts of suicide could be expected: “Attempting suicide may become a conditioned reaction. The suicide attempter may learn to adapt to stress and life event by repeated self-destructive behaviours” (Maris, Berman, & Silverman, 2000, p. 285).

*Euthanasia*

Two individuals referred to euthanasia, and indicated that they considered it to be different from suicide. Adam stated that this is something he is considering in the future, and also described himself as not currently suicidal. It is worth noting that while he considers his future plan to end his life as being unrelated to suicide, he intends to use the same method—hanging.

Daniel indicated that by researching euthanasia, he was able to see options in his life beyond suicide. It also indicates a greater knowledge about lethality and the confidence that his next attempt to end his life would be successful. Something about this certainty encouraged him to see options. This supports the findings of previous research

that maintaining a sense of control was connected to a plan to hasten death in men living with HIV (Goggin et al., 2000).

> The most frequently cited reasons for making plans to end life were to maintain a sense of control, the desire to make one's own decisions, and to prevent suffering. The most common circumstances under which participants indicated they would consider ending their lives were loss of independence, intolerable pain, and no hope of improvement. (p. 134)

Euthanasia in HIV patients is associated with positive factors rather than with distress (Goggin et al., 2000).

> Where current plans to end one's life are a likely indicator of depression, the results of this study suggest that future plans are not. In the case of future plans, a proper assessment for depressive symptoms should be performed, but depression should not be assumed. Patients will likely benefit from a supportive environment where they can explore their thoughts about controlling the end of their lives, including a discussion of palliative measures that can reduce pain and suffering. (p. 134)

In this study, the co-researchers who had made plans for euthanasia to occur under specified conditions experienced that as helpful.

*Stressors*

The elements the co-researchers identified as being difficult or painful elements in their lives echo those found in other research. However, finding so many of these elements in each individual may be remarkable.

*Isolation and loneliness*

Research indicates that the more we are connected to others, the lower the risk of suicide. Isolation has long been associated with suicide and suicidal behaviour. Feelings of isolation and loneliness were often cited by the co-researchers, and are well supported by the literature on suicide. These feelings may indicate that these individual are more isolated, or may indicate that these individuals perceive themselves as being alone: "Empirical evidence was found linking perceived isolation and suicidal behaviour" (Beck et al., 1986, in Anderson, 2003, p. 25).

In addition to overt statements about feeling isolated, several experiences that resulted in greater isolation were also described. These included negative experiences with family members, which centered on separation from family members, feeling rejected by them, or feeling guilty. While family involvement is generally considered to be a protective factor against suicide, negative family interactions have been associated with suicide (Wagner, 1997).

> Death or separation or the threat of separation have been presented as promoting wishes to reunite (in the grave), guilt and a consequent wish to punish the self for causing the loss, revenge against the lost object, and feelings that one cannot live without the lost object. (p. 246)

Increased isolation may also be an underlying element in the "Death of Support Persons" theme that arose in the study.

*Drug use*

The co-researchers described their use of drugs and alcohol as a factor in becoming suicidal. This is well supported by previous research on suicide indicating that

alcohol and drug abuse can be both a proximal and distal risk of suicide. Those who use illegal drugs are considered to be at higher risk for suicide. It is common for individuals to use drugs or alcohol immediately prior to attempting suicide (Merrill, Milner, Owens, & Vale, 1992).

> The proportion of patients that had drunk alcohol prior to the attempt (males 54%, females 41%) concurs with the findings of other studies (males 44-67%, females 17–45%). Most patients were admitted to hospital in the evening and those that had been drinking had usually done so within an hour or so of self-poisoning. (p. 87)

Those who abuse drugs and alcohol are also more likely to commit suicide (Marzuk & Mann, 1988).

> Illicit drug abusers have high rates of completed suicide (Grinspoon, 1986). Abusers who suicide are typically between 20 and 40 years old, male, multiple drug abusers (including concurrent alcohol abuse—Roy and Linnoila [1986] found that typical alcoholic suicide had a mean age of 47 years and, on average, had been alcoholic for 25 years) and have comorbid diagnoses of depression, borderline personality disorder, of psychosis. (p. 301)

*Emotional pain and negative thinking*

The co-researchers described both the experience of emotional pain and the desire to escape this pain. The desire to end pain as a motive for attempting suicide is well established. In Susan Anderson's (2006) work on suicide, she found six markers of emotional pain in suicidal persons. Feelings of overwhelming pain and the desire to escape that pain were two of the six.

The co-researchers also described feeling like a burden. This has also been found to be connected with suicide (Van Orden, Merrill, & Joiner, 2005).

> Joiner and colleagues also investigated perceived burdensomeness, hopelessness, and generalized emotional pain as predictors of lethality of method in a sample of suicide notes of individuals who completed suicide. They found that perceived burdensomeness was the only variable that predicted lethality. (p. 187)

*Childhood experiences*

Those involved in this study described childhoods filled with physical and sexual abuse and separations from family members. They indicated that they believe these to be factors in why they became suicidal. Research supports the perception of the co-researchers that their early experiences played a role in later suicide attempts (Maris, Berman, & Silverman, 2000).

> Studies of family development have suggested that certain kinds of family pathology (e.g., early loss, early separation from one's mother for long periods, physical and emotional abuse by one's father [sometimes by a stepfather] or mother [including incest], young adult promiscuity, and frequent moving of one's residence) are all related to subsequent suicides as an adult. (p. 83)

*Relationship problems*

Several different relationship issues were described by the co-researchers. One indicated that he had been violent in past relationships. There has been research linking suicide—seen as violence towards oneself—and aggression towards others: "Clinical studies with psychiatric populations have generally confirmed the positive correlation

between suicide or suicidal behaviour and violence toward others" (Maris, Berman, & Silverman, 2000, p. 409).

Violence and sexual assault also arose in this study, confirming previous research: "Sexually abused patients reported significantly more previous suicide attempts than did those reporting no abuse, irrespective of frequency and duration of that abuse" (Shaunesey, Cohen, Plummer, & Berman, 1993, p.113-119).

*Homelessness*

Homelessness was a theme that arose in this study. The majority of the co-researchers stated that they were homeless when they were suicidal. One suggested that being homeless was difficult because it made using his other coping strategies more difficult. Another associated his homelessness with his drug use, and a third stated that it was part of his suicide attempt.

Research on the connection between homelessness and suicide is mixed, but a study by Motto (1980) of alcohol abusers found that one of the predictors of completed suicide was the type of residence. He found that those who lived in "small or medium hotels, large apartment house or no stable residence were more likely to complete suicide" (p. 233).

*HIV diagnosis*

In this study, increased suicidal thinking and behaviour surfaced immediately after the HIV diagnosis. The diagnosis was depicted as an extremely difficult time for all co-researchers. Research reflects an increase in suicidal thinking when a person first seeks a diagnosis. One third of people who sought HIV testing reported suicidal thinking. Among those who received a negative test result, the rate of suicidal thinking decreased

by 50 % (Perry, Jaconsberg, & Fishman, 1990). For those who tested positive, the prevalence of suicidal thinking remained high: “A 27.1% and 16.3% prevalence of suicidal thoughts was found one week and two months later, respectively” (Schneider et al., 1991). This elevated rate is still present six months after diagnosis (Jud & Mitch, 1996). This has implications for professionals working with the newly diagnosed—this is a time when screening for suicide and the provision of additional support appear to be essential.

*Legal issues*

Legal issues were described by the co-researchers, including time spent in prison. This also echoes research that has found those in prison to be at high risk of suicide (Cummings & Thompson, 2009).

> The rate of suicide in United States jails and prisons is considerably higher than the suicide rate in the general U.S. population. In fact, according to Hayes (2003), within most jails suicide is the leading cause of death. The rate of suicide in jails is 47 deaths per 100,000 inmates (Mumola, 2005), roughly four times higher than the rate reported for the general population. (p. 201)

This suggests that psychological care is important for those facing legal issues, and appears to be a time when support is needed to prevent suicide.

*Mental health concerns*

Mental health concerns were described by the co-researchers. While suicide is not the norm for those who have been diagnosed with a mental health issue, it is common to find a mental health issue among those who have committed suicide. Therefore, a mental

health issue is considered to be a risk factor for suicide. Karch, Dahlberg, and Patel (2010) investigated the association between suicide and mental illness.

> Overall, mental health problems were the most commonly noted circumstance for suicide decedents, with 41.5% described as experiencing a depressed mood at the time of their deaths. Nearly 45% were described as having a mental health problem, although only 33.8% were receiving treatment…. Among those with a current mental health problem, 74.9% had received a diagnosis of depression/dysthymia, 14.5% had been diagnosed with bipolar disorder, and 8.1% with an anxiety disorder. (p. 11)

Similarly, bipolar disorder and depression were the most commonly referenced mental health concerns by the co-researchers.

*External Resources*

One of the major themes that arose was that of external resources or support—individuals who helped the co-researchers. This is a theme that has generally emerged in research on suicide resilience (Rutter, Freedenthal, & Osman, 2008).

> The external protective domain reflects the individual's ability to seek out perceived external resources that are helpful when faced with personal difficulties or suicidal thoughts. This domain includes the ability or confidence to seek support from close relatives or friends when facing suicidal thoughts, especially to discuss suicidal ideation with such supports. (p. 143)

Research on suicide risk indicates that the greater the isolation, the greater the risk of suicide. Thus, we can probably assume that the greater the social connection, the greater the protection from suicide.

In this study, the co-researchers' perceptions of support were the basis rather than any empirical measure. However, this may be a more accurate measure, as some research has suggested that perceived support may be more predictive of mental health than actual support (McDowell & Serovich, 2007).

> Results of this study suggest that there are significant differences in the relationship of perceived and actual social support to mental health. Women, gay men and straight/bisexual men all experienced perceived social support versus actual social support as significantly more predictive of mental health. (pp. 1227–1228)

Reducing the sense of isolation is essential in helping individuals to become resilient to suicide and suicidal thinking. This has implications for the work of professionals who can focus on helping their clients build social relationships and become more aware of those that already exist.

*Professional support and agencies*

Professionals were the most commonly referenced supports in this study. Most studies have investigated more personal support such as friends and family. The frequency of professional support noted in this study stands out. This is somewhat unexpected, as research into the effectiveness of treatment, especially the treatment of high-risk individuals, is thin (Maris, Berman, & Silverman, 2000).

> Research on treatment effectiveness is both difficult and rare. Linehan (1998) decried the overall quality of this research finding only 20 published studies, using randomized clinical trials (RCTs). … Moreover, almost one-half of published RCT targeting suicidal behaviour (45%) excluded high-risk patients.

> This percentage increased to 88% when examining pharmacotherapy studies targeting depression. (p. 527)

A study of resilience in suicidal female adolescents also found references to professional support: “The majority of participants also recalled counsellors and psychologists who played a significant role in helping them overcome being suicidal” (Everall, Altrows, & Paulson, 2006, p. 465).

The co-researchers also described agencies as helpful resources. Agency support, like professional support, is an area that warrants further investigation because this study suggests that access to professionals and agencies is part of suicide prevention in people living with HIV. This also has implications for helping professionals who must not underestimate their importance in the well-being of those they serve.

*Friends or peers*

Not only were friends and peers described as helpful, but the co-researchers actively sought peers who would be positive and supportive. This involved seeking out agencies and attending support groups and AA meetings. This is similar to the findings by Everall, Altrows, and Paulson (2006) concerning adolescent activity.

> Participants actively sought out environments where they experience a sense of belonging, camaraderie, and acceptance that they did not experience elsewhere. For example, one participant who had felt rejected by her peers at school was able to find a sense of belonging in a church youth group. (p. 465)

Helping people living with HIV to develop expanded social networks is an important element in creating suicide resiliency.

*Family*

This study indicated that families provide support. All co-researchers who had children mentioned children in particular as being supportive. Children were described as important because of the co-researchers' desire to see them grow up. This was different from the way that other family members were described.

As mentioned previously, both marriage and children have long been considered to be protective factors. However, this has sometimes been attributed to decreased isolation. In this study, the co-researchers indicated that they were physically separated from their children, but the idea of losing a possible future relationship with children was a positive catalyst. Helping clients to focus on future relationships with children may be a part of successful therapeutic work.

*Legal intervention*

One co-researcher frequently referred to legal intervention as a helpful element. He stated that he would attempt to get arrested to go to jail because jail was a helpful place. He described using this tactic from adolescence well into his thirties. This is striking because of its contradiction of research that indicates the rate of suicide within prisons is much higher than among the general public (see the earlier section, Legal Issues). However, this co-researcher's actions reinforce the idea that individuals create and find solutions that work uniquely for them (de Shazer & Dolan, 2007).

Therapists can help individuals to find unique solutions. This is already part of solution-focused counselling. If a client is in the process of solving a problem, the therapist's primary role should be to encourage the client to do more of what is

> already working. SFBT [solution-focused brief therapy] therapists do not judge the quality of a client's solution, only whether a solution is effective. (p. 2)

*Emergency treatment*

Treatment in emergency rooms was described frequently in this study. This was seen as important in reversing the effects of a suicide attempt. More than one co-researcher used a hospital crisis unit. While these were seen as helpful in the short term, only one indicated that there was a long-term benefit. He stated that a visit from his psychologist while he was a patient inspired him to seek ongoing therapy.

Currently, outpatient treatment is the norm. This co-researcher's statement supports the value of short-term inpatient care in some instances. It also indicates that helping inpatients connect with ongoing professionals and having professionals visit clients in crisis units is beneficial.

*Not wanting to hurt others*

The co-researchers were motivated by the knowledge that others would be hurt by their deaths, and by the desire to protect others from pain. This may indicate that they feel more connected to others or may demonstrate a cognitive shift from seeing themselves as a burden to seeing death as negative for others in their lives.

*Coping*

The co-researchers described several individual changes or resources that were used to overcome suicidal thoughts, help manage stress, or resolve past issues. These actions or resources were identified as helpful, and were wide-ranging. They varied from internal to external foci and from attention on the past to anticipation of the future.

*Change of thinking*

The co-researchers noted a change of perspective. One change was seeing life as valuable and worth fighting for. There was also a sense of comparing the current situation to that of others, seeing themselves in a favourable light. They described being able to view problems as smaller or more manageable. The ability to let go of concerns rather than dwelling on them was also cited as a difference.

Changes in cognitive processes were also found in the Everall, Altrows, and Paulson (2006) study.

> Gaining greater perspective and focusing on the positive aspects of life was one of the most critical steps taken toward overcoming being suicidal. Participants "took a step back" and looked at what was "good" about themselves and their situations. (p. 466)

The results found here as well as other studies suggest that a focus of therapeutic work should be the thinking patterns of those experiencing distress. This may provide support for cognitive behavioural therapy (CBT) as a treatment modality or a focus for interventions by counsellors or psychologists.

*Change of situation*

The co-researchers emphasized the importance of changing practical elements of their lives such as moving, starting drug or alcohol treatment, or finding stable housing. These changes were significant and took time. The participants initiated these changes, indicating that they played an active role in making the changes. A previous study by Everall, Altrows, and Paulson (2006) supports this finding.

> For more than half of the participants, taking charge of their lives involved a significant change of environment, such as leaving a stressful situation at home or moving to a different city. These types of changes often represented a “fresh start” that enabled participants to gain a new perspective and leave the past behind. (p. 466)

While a focus on changing thoughts is important, addressing underlying issues and concerns is also imperative.

*Internal resources*

In addition to making large changes to thought processes and life situations, the co-researchers also described small actions that assisted in coping with stress. Physical exercise was cited as one such action. This matches research on the use of exercise to treat depression. “Reviews have reported that exercise as treatment for depression is more effective than no treatment and is as effective as traditional interventions, at least in the short term” (Daley, 2008, p. 145). Writing was another action seen as helpful, which was also found in the Everall, Altrows, and Paulson (2006) study. In addition, music has been found to be beneficial in the treatment of depression and anxiety (Choi, Lee, & Lim, 2008, p. 569). These coping methods should not be underestimated, and attention should be drawn to these actions when working with PLWHAs to prevent suicidal thinking and behaviour.

*Talking*

Talking about one’s experience, thoughts, and feelings was considered by the co-researchers to be helpful. This may indicate that they had become less isolated, or that talking may have helped them confront difficult feelings and express these feelings to

others. These two elements emerged in a study of suicide resilience in adolescent girls (Everall, Altrows, & Paulson, 2006, p. 466). These ideas are not new, and are at the heart of the work of counsellors and psychologists.

*Faith and spirituality*

Faith and spirituality were depicted by the co-researchers as vital resources. Religiousness has long been considered to be a protective factor from suicide since early work in the study of suicide, and more recent studies continue to find support for this (Simonson, 2008).

> Present results indicate that college students who had considered suicide, especially those who were non-hopeless, were less religious than those who had never considered suicide. Durkheim's position that religion protects against suicide was indirectly confirmed; it was found that suicide ideation was greater among the less religious. (p. 956)

However, in this study, faith was described not simply as a belief system but also in terms of ongoing practices such as prayer and bible study. What it is about faith and religiousness that is helpful is not well understood, and may be an area for further research.

*Resolving past issues*

Participants in this study emphasized that focusing on and resolving issues from the past is critical. Since childhood abuse was named as a contributing factor in suicidal thinking by an overwhelming majority of the co-researchers, it makes sense that addressing this issue is part of the solution.

*Search for meaning*

The co-researchers were motivated by the desire to find meaning. They often referred to the desire to stay alive to find answers to questions, or to find the meaning for one's life. The search for meaning is not unique to this group of people (Frankl, 1959).

> [A] statistical study of 7,948 students at forty-eight colleges … asked what they considered "very important" to them now, 16% of the students checked "making a lot of money"; 78% said their first goal was "finding a purpose and meaning to my life." (p. 122)

According to Frankl, finding meaning is important to everyone. This study reveals that it can also act as protective factor against suicide. The use of existential counselling or readings may be appropriate for PLWHAs considering suicide.

*Helping others*

Helping others was also described as being useful. This may be connected to the previous section, Search for Meaning. For some, helping others was seen as meaningful and valuable to the world as well as to the individual. This echoes findings in other research (Everall, Altrows, & Paulson, 2006).

> For over half of the participants, a sense of purpose came from helping others or making a positive contribution to the community…. Knowing that people counted on them and would miss them if they were gone motivated them to turn their lives around. (p. 467)

This supports the practice of providing opportunities for people living with HIV to get involved in volunteer work. It is noteworthy that not all of the co-researchers'

contributions were connected to advocacy or supporting others living with HIV. Some of the activities were more general.

*Medication*

The co-researchers described medication (both antivirals used to treat HIV and medications for mental health conditions) as being helpful. The medications were attributed to keeping the co-researchers healthy and helping them cope with underlying conditions. Many expressed ambivalence about medication. They expressed distaste for them while still viewing them as important.

*Less impulsive*

One of the changes the co-researchers reported was learning to "sit back" and "think twice" rather than acting immediately on thoughts or feelings. This identification of restraint indicates a change from previous impulsive tendencies. Impulsivity has been linked to suicidal thinking in past research. One study (Neufeld & O'Rourke, 2009) found that impulsivity was a predictive factor in suicidal ideation.

> The findings of our study provide support for the assertion that impulsivity is significantly associated with suicide-related ideation among older adults, particularly those with an absence of meaning in life. Impulsivity appears to predict suicide-related ideation more broadly than hopelessness alone, with and without a broad presentation of depressive symptomatology. These findings have considerable implications for both suicide research and clinical practice as higher levels of impulsivity should be considered a risk factor. (p. 690)

For those who indicated a tendency to act impulsively, finding ways to counter this was important in moving forward. In addition to helping individuals reduce their distress, helping them to reduce their impulsivity may be equally important.

*HIV disclosure*

The co-researchers indicated that disclosing their HIV status was important for their well-being. However, they focused on describing events when their disclosure was met with acceptance and support. Encouraging disclosure should be done cautiously, as there continues to be a great deal of stigma surrounding HIV, and acceptance and support cannot be assumed. In a study of HIV and depression in aboriginal people in Canada, stigma following disclosure was a prevalent concern (Jackson et al., 2008).

> For many participants, the fear of being rejected by family and community was realized. While some had supportive family, friends, and communities, more frequently, participants told stories of being cut off from those they loved. Despair, depression and thoughts of suicide were common outcomes. (p. 21)

Clearly, while disclosing can be helpful, it can also be detrimental if not followed by acceptance.

*Future-orientation*

As indicated earlier, a focus on and resolving issues from the past were important. However, a focus on the future was also significant. This fits with some previously established research on hope. In his work on hope, John Dewey stressed the importance of goals (Fishman & McCarthy, 2005).

> For Dewey, when goals function properly, they are not so much about future accomplishments since the future is largely unknown. Rather, when goals

> function properly, it is because they do something important for us in the present. As we have said, for Dewey, they get us unstuck. They help us determine what we need to attend to in the present moments so that we can experience it more fully. (p. 681)

Dewey argues, and this study seems to support, that goals are important in helping us enjoy the present as well as to help create a future. Goal setting may be helpful in working with PLWHAs to promote hope.

*Progress over time*

The co-researchers made numerous significant changes in their thoughts and in their lives. Not only were all of these changes important, but the ability to see progress was also depicted as essential by members of this study. What helped the co-researchers to do this is unknown, and warrants further investigation.

If resilience is to be understood as an adaptive process involving the use of all available resources, both those external to us and those internal, then this study provides some insight into possible resources. By studying people who have experienced extraordinary difficult situations and yet overcome suicidal feelings, we gain important insight into the ways that we are able to cope with the difficult experiences in our own life.

*Conclusions*

This study helps us to understand the experiences of people living with HIV who are also considering suicide. By understanding their experiences, our empathy for those with HIV may be heightened, allowing us to work more effectively with them. This study highlighted some possible areas for future research. I believe that it is essential that

research in this area be cognisant of the potential vulnerability of the co-researchers and put measures in place to ensure their well-being.

This study provides indications about the kinds of interventions that will be helpful to those with whom we work as counsellors. Those who have survived suicidal thoughts and behaviours have special insights into helping others, and from their experiences, we may learn more effective ways to help people who are currently experiencing this type of pain.

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# APPENDIX 1: CONSENT FORM

Informed Consent to Participate in Research
**St. Stephen's College**

You are being asked to participate in a research study. This form provides you with information about the study. The Principal Investigator (the person in charge of this research) or his/her representative will provide you with a copy of this form to keep for your reference, and will also describe this study to you and answer all of your questions. Please read the information below and ask questions about anything you don't understand before deciding whether or not to take part. Your participation is entirely voluntary and you can refuse to participate without penalty or loss of benefits to which you are otherwise entitled.

**Title of Research Study: Suicide Resiliency in People with HIV/AIDS**

**What is the purpose of this study?** The purpose of my project is to learn about the experiences of people with HIV and AIDS who consider suicide. This includes learning what resources both internal and external that they used and what made them choose other options.

**What will be done if you take part in this research study?** Taking part in this study involves an interview in which you will be encouraged to describe you experience(s) of suicidal thinking and/or suicide attempts.

The interview will be recorded on a digital recorder. Files will be labeled and saved on the researchers personal computer and will be password protected. All interviews will be transcribed into text documents. Once this is completed all audio files will be deleted. The only people who will have access to the audio files are the researcher (Jill Delarue) and her supervisor (John Carr, PhD.)

Once transcriptions are completed you will be contacted, given a copy of the interview and asked to ensure that it is accurate. At this time you have the opportunity to add any further information that you feel is important for the researcher to know.

The researcher will then look for major themes among different interviews. The results of this research are intended for a thesis and publication in scholarly journals. Your name will be changed and every attempt made to keep your identity confidential.

Participation in this study is completely voluntary. At any point you can stop the interview and request that information collected be destroyed.

**The Project Duration is:** March 2010 – June 2010

**What are the possible discomforts and risks?**
Discussing your personal experiences may be emotionally painful for you. If, during the course of the interview, it becomes clear to the researcher that you are extremely upset then the researcher will be obligated to inform someone of your emotional state. This

could be a doctor, a counselor, or family member. You will be informed during the interview if the research feels this is necessary. In addition, you will be supplied with information on appropriate support services dealing with suicide and/or HIV.

**What are the possible benefits to you or to others?** This interview will give you the opportunity to talk about your experiences. We hope that the findings of this research will lead to a greater understanding of the experience of people with HIV in regards to suicide.

**Signatures:**

**As a representative of this study, I have explained the purpose, the procedures, the benefits, and the risks that are involved in this research study:**

_____

**Signature and printed name of person obtaining consent** **Date**

**You have been informed about this study's purpose, procedures, possible benefits and risks, and you have received a copy of this form. You have been given the opportunity to ask questions before you sign, and you have been told that you can ask other questions at any time. You voluntarily agree to participate in this study. By signing this form, you are not waiving any of your legal rights.**

_____

**Printed Name of Subject** **Date**

_____

**Signature of Subject** **Date**

_____

**Signature of Researcher** **Date**

# APPENDIX 2: INTERVIEW QUESTIONS

1. Tell me about your experience with suicide.
2. Describe what was going on in your life when you attempted suicide
3. Looking back, what do you think helped you survive during this period?
4. Looking back, what was good in your life at that time?
5. Where did you find hope during that time? Where do you find hope now?
6. What was helpful during that period?
7. Who did you turn to during that period?
8. Who was helpful?
9. What would you say is the biggest difference between the way you see things now and how you saw them then? What helped you reach this viewpoint?

# APPENDIX 3: LIST OF NODES AND EXAMPLES

1. **Coping**
    a. **Change of Situation**
    I dropped my old friends; I quit hanging out in bars. It took a long time - it took a hard time to do that - but I did it.

    b. **Change of thinking**
    I don't know, I just don't think that way. I don't have those thoughts no more.

    c. **Future Oriented**
    There is good things to look forward to there, but we'll have to see. There is hope in that for me.

    d. **Helping Others**
    So I switched gears, in a way, and became very active here (HIV Edmonton) and at other agencies, and started to really... give.

    e. **HIV Disclosure**
    So I started telling people about my sickness and anybody around me: my family, they're supportive now.

    f. **Internal Resources**
    I go to the library. I go to the Y and work out. I do a lot of things to keep me busy, to not think about doing anything wrong.

    g. **Less Impulsive**
    I don't react as fast. I kind of sit back and, OK, you know. I don't get tunnel vision. I kind of think twice, where before I'd just.... right off the hop. Yeah, I wouldn't think twice and I wouldn't care about the consequences. Now I'm thinking about consequences, too.

    h. **Medication**
    Like with my medication – I take a lot of meds – with my medication it doesn't make me cry because otherwise I'd be crying day in and day out.

    i. **Progress Over Time**
    Back then I would be the one asking for a sandwich, now I'm the one that's giving away. A big difference, a big difference in fifteen years.

    j. **Resolving Past Issues**
    I tried to adapt and resolve and work through and grow as a human being

    k. **Faith and Spirituality**
    I guess there is part of me that is somewhat spiritual, so I couldn't take my own life.

**l. Search for Meaning**
I thought, whoa, I guess I'm here for a reason.

**m. Talking**
I just needed someone to talk to, I think, to get those thoughts out of your mind.

2. External Resources

**a. Agencies**
The HIV offices, I've been going everyday and that supports me too to be stronger

**b. Not Wanting to Hurt Others**
Most people who would be really hurt would be my family. I don't want to hurt them.

**c. Emergency Treatment**
I got a ride to the emergency room, and I drank some charcoal drink and subsequently vomited up all the halcion I had taken.

**d. Family**
My hope is in my daughter. And it was well-placed apparently because she's going hard.

**e. Legal Intervention**
I was going to jail just to get away.

**f. Friends or Peers**
Then we found out we were both positive and then we became better friends, because we had the same common bond.

**g. Professional Support**
Talking to (my psychiatrist) in a sense, and seeing (my psychologist) and all that. Not too many people know what's going on in my life.

3. Stressors

**a. Childhood Experiences**
I remember being six and being choked out into convulsions by my step-father. He's crazy. The fact that I'm here is crazy. I should have been one of those statistics, one of those kids that got wiped out.

**b. Emotional Pain**
It's hard. It's not a good space to occupy: the feelings, the thinking, the loneliness, despair. It's a heavy burden that can't be carried alone.

**c. Death of Support People**
I just lost my late dad. That's what made me try the suicide.

**d. Drug Use**
Back then my mind was all drugged, blurred by drugs I guess you could say.

**e. Family**
If anybody could drive me further to suicide it would be my family. They are NO support. It was a really negative influencing place.

**f. HIV Diagnosis**
When I found out I had HIV I felt bad, I felt that's my end, my life.

**g. Homelessness**
Oh God. I've lived in the river valley for two years homeless. I'd given up. I didn't care. I didn't pay bills, ripped off people, because I didn't care.

**h. Isolation and Loneliness**
Loneliness, abandonment issues and put my son into care, and that was like suicide for me because I missed him so much.

**i. Legal Issues**
I was, you know, locked away (laugh) in a penitentiary for six years...

**j. Mental Health Concerns**
I've been diagnosed as bipolar, schizophrenic, borderline, front lobe atrophy, and depression.

**k. Negative Thinking**
I can take a little thing and make it a big thing with my mind. I get down on myself or whatever.

**l. Peers**
I hung around those people who are going to be trouble and they get me into trouble and all that.

**m. Relationship Problems**
After that experience I ended up in an abusive relationship.

4. Suicide

**a. Euthanasia**
I learnt a little bit about euthanasia and the proper process because at one point it was a goal of mine. So I did research and I think that helped.

**b. Feelings about Suicide**
For me suicide isn't about leaving this world, it is just about leaving the piece of the world that I exist in right at this moment.

**c. Long Suicide History**
Well, the first time I tried it I was eighteen, seventeen.

**d. Method**
I did it once, I did. I took a razor and tried to slit my wrists.

**e. Multiple Attempts**
I was certified five times in the period of two years, to save my life, 'cause really, I wouldn't be here other than that.

**f. Suicide Ideation**
It crosses my mind and maybe for a split second I would want to do something and then it goes. But it's still there, in the back of my mind.

**g. Survival**
Yeah, when I woke up, I didn't want to wake up. I had enough