# SELF-REPORTED COPING STRATEGIES OF PARASUICIDAL INDIVIDUALS



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# Self-Reported Coping Strategies of Parasuicidal Individuals

By

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TABLE OF CONTENTS

Appendices

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# CHAPTER 1

# INTRODUCTION

## Rationale for the Internship

Graduate students pursuing a Master's Degree in Educational Psychology at Memorial University of Newfoundland have the option of completing either a thesis or an internship in order to meet the requirements for the degree. The internship consists of a thirteen-week placement in an approved professional setting. During the internship interns are expected to engage in a wide range of professional activities and they are also required to conduct a research study appropriate to the setting.

The intern chose the internship for the following reasons:

1. To obtain counselling experience in an alternate professional setting from the school system and provide exposure to a diverse adult population.
2. To gain practical experience in counselling and to apply theoretical concepts learned during the formal part of the program under the direct supervision of professionals.
3. To have the opportunity of direct supervision in both group and individual counselling, providing time to assess and improve counselling skills.
4. To obtain more knowledge through exposure to a variety of theoretical approaches and techniques in counselling.
5. To learn how to avail community resources and draw on support systems beyond the school and clinical boundaries.

6. To have the opportunity to conduct a research project focusing on a clinical area of interest.

## The Setting

The Psychology Department of the Waterford Hospital, the only major psychiatric referral centre for the province of Newfoundland, was the site for the internship placement. After contacting the Hospital, an interview was arranged between the intern and two of the hospital's psychology staff, Dr. Hassen Khalili, Acting Director and Dr. Assen Alladin, Senior Clinical Psychologist, to discuss the intern's reasons for pursuing an internship at this setting. As a result of the interview, the Hospital agreed to place the intern for a thirteen-week period from April 13, 1992 to July 10, 1992. Dr. Anita Russell, of the Faculty of Education (Educational Psychology Program area), was the faculty supervisor. Dr. Assen Alladin, Senior Psychologist at the Psychology Department, was the on-site supervisor.

The Psychology Department of the Waterford Hospital was chosen as the site for the internship for the following reasons:

1. The quality of learning opportunities and experiences such as Group Counselling, Educational Sessions and Workshops, available at the Hospital.
2. The opportunity to participate in case conferencing with other trained professionals.
3. The availability of a full-time placement for the duration of the internship.

4. The relevancy to and usefulness of the clinical experience to the intern's future career goals.
5. The quality of professional supervision provided by the Hospital and the availability of a qualified field supervisor on site.
6. The opportunity to conduct individual and group counselling with an adult psychiatric population.
7. A warm community oriented atmosphere in which to broaden the intern's knowledge of mental health treatment and services.

The Psychology Department of the Waterford Hospital currently employs eight full-time psychologists and one psychological assistant. The psychologists are available to provide counselling on a wide range of personal, social, emotional and psychological concerns. Counselling is available on both an inpatient and outpatient basis at the Hospital. A clinic has also been established on Duckworth Street, as an extension of the Waterford Hospital's Psychological Services. It provides counselling to people in the community on an outpatient basis.

Psychologists from the Waterford Hospital spend 3 to 4 hours at the Duckworth clinic per week providing counselling services to members of the community. Counselling has become more community oriented due to the establishment of this clinic.

Professional faculty employed at the Waterford Hospital's Psychology Department are:

| | |
|---|---|
| Dr. Hassen Khalili | Ph.D. (Director) |
| Dr. Assen Alladin | Ph.D. (Senior Psychologist) |
| Dr. Bill Kane | M.Sc. (Senior Psychologist) |
| Ms. Heather Dalziel | M.Sc. |
| Ms. Karen Swinton | M.Sc. |
| Mr. Malcolm Simpson | M.Sc. |
| Mr. John O'Connell | M.Ed.Psy. |
| Mr. Tom Horan | M.Psy. |
| Ms. Nina Sandevol | B.Sc. |

## Mission Statement

The mission of the Waterford Hospital is to provide a comprehensive range of high quality mental health services to a total population of approximately 550,000 people. The Waterford Hospital is a long standing mental health hospital, in St. John's, Newfoundland. Since its opening in 1855, it has provided a wide range of high quality psychiatric and support services on an in-patient, ambulatory and community service basis. The hospital provides a wide range of programs and services in acute psychiatry, long-term care psychiatry, psychogeriatrics, forensic psychiatry, adult mental retardation ambulatory care and community care. Staffing consists of a multi-disciplinary team of health professionals, including Dr. Assen Alladin (Ph.D.), a senior clinical psychologist, with extensive experience in the treatment of emotional disorders with cognitive therapy. Dr. Alladin was the on-site supervisor for this internship. In addition, there are several physicians, psychiatrists, psychologists, psychiatric nurses, special education teachers, social workers and occupational therapists, who make up the team delivering a variety of interrelated

services. These people consult regularly on cases and participate in weekly case reviews. The hospital has, in the past, trained students from medicine, nursing, psychology, social work, and education.

Goals

The goals of the Waterford Hospital, according to the administrative manual (Waterford Hospital Administrative Manual, 1991), are as follows:

1. To provide comprehensive programs of care to persons with mental health problems, and to provide for such persons an atmosphere conducive to carrying out indicated therapeutic programs.
2. To provide mental health services and facilities to meet identified community and provincial needs, an integrated plan which recognizes the services provided by programs in general hospitals, in other health care centres, and by other health and social agencies.
3. To participate in all aspects of the continuum of care related to the field of mental health, through promotion, prevention, intervention, diagnosis, treatment, rehabilitation and provision of special services for the handicapped.
4. To provide an organization with competent and dedicated professional, medical and support staff, which is conducive to the provision of quality health care.

5. To participate in teaching programs, designed to assist in the provision of manpower for the mental health field.
6. To support continuing education and encourage all staff to take an active part in programs of education, both internal and external to the Hospital.
7. To participate in and encourage mental health research in co-operation with other health, social and educational facilities and agencies.
8. To co-operate with other health, social, and educational facilities and organizations in the rationalization, co-ordination and planning of mental health services.
9. To participate in the development and upgrading of standards related to mental health services. (p. 2)

Philosophy

The overall philosophy of the hospital is a belief in the inherent worth of each individual. Specifically, the hospital's philosophy believes in:

1. the rights and dignity of all persons, regardless of race, religious creed, sex, marital status, physical or mental disability, political opinion, colour or ethnic, national or social origin;
2. the right to holistic health care for all persons who encounter or who are at risk of mental health problems;

3. the right of all persons to be involved in their own health care, and in decisions affecting investigation and treatment.
4. the rights of individuals to seek education and explore life's goals and have the best health services; to be loved and cared for in times of need; and to try again. (Waterford Hospital Administrative Manual, 1991, p. 1)

## Goals for the Internship

The primary objective for the internship was to gain further practical experience in counselling which would enhance the professional growth and development of the intern. In keeping with this purpose, the intern aimed to expand her knowledge and develop her skills through the goals and activities stated as follows:

1. To carry a minimum caseload of three clients for individual counselling, and become familiar with the concerns of an out-patient and residential psychiatric population with respect to personal, social and emotional domains.

   This was accomplished through (a) engaging in individual counselling with five clients, (b) reading journal articles pertaining to the concerns and psychological symptoms of such a population (see Appendix A for annotated bibliography), (c) disseminating relaxation tapes and cognitive therapy readings to clients.

2. To co-lead an open unstructured group, consisting of long-term psychiatric outpatients, diagnosed with schizophrenia and depression.

   This was accomplished by: (a) 1 hour weekly meetings for twelve weeks with an experienced leader, John O'Connell, and the outpatients; (b) discussion with supervisors and co-workers approaches to group counselling; and (c) case conferences with psychologists and nurses regarding the group.

3. To gain practical experience in counselling, improve the intern's ability to perform effective counselling and to further develop her knowledge of counselling theories and techniques.

   This was accomplished by (a) audiotaping sessions with clients, who consented to taping, (b) critically reviewing these tapes and recording observations, experiences, concerns and personal reactions to the sessions in a logbook, (c) weekly supervision with the intern's field supervisor to discuss counselling sessions, (d) meeting with the faculty supervisor periodically throughout the internship to discuss the intern's progress, (e) attending allocation meetings weekly to discuss new cases, as well as ongoing cases, with co-workers and the on-site supervisor, (f) attending and participating in workshops and educational sessions of interest and importance to counselling such as: (i) a Suicide Intervention Workshop,

(ii) The Association of Newfoundland Psychologists Workshops, and (iii) Hypnosis, Antipsychotic Drugs and Countertransference (educational sessions), (g) reading literature relevant to the clinical experience, i.e., theories of counselling, and (h) observing other psychologists during counselling.

4. To contact and familiarize the intern with at least four city agencies which offer counselling services to individuals.

This was accomplished by (a) taking an active part in the day-to-day activities of the Waterford Hospital, (b) contacting other agencies such as Iris Kirby House, Channal, Alcohol and Drug Dependency Commission, and Duckworth Clinic, and discussing the services they offer the community.

5. To participate in case conferencing with other trained psychologists.

This goal was accomplished by participating in monthly staff meetings, weekly allocation meetings, as well as consulting with psychologists one on one about particular cases.

6. To consult with professionals from different fields such as nursing, social work, and medicine to broaden the intern's knowledge and enhance the intern's skills and ability to operate as a member of a multi-disciplinary team.

This goal was accomplished by attending rounds on the Forensic Unit. During rounds each professional was consulted on his/her area of expertise in order to formulate a more comprehensive and clearer picture of clients, their characteristics, strengths and weaknesses, and fitness to stand trial.

7. To further develop knowledge of counselling theories and techniques.

This goal was achieved through (a) comprehensive reading in the area of counselling theories and techniques (see Appendix A) and (b) exposure to various theoretical approaches of trained professionals at the Hospital by means of case conferencing and discussions.

8. To conduct psychological assessments, including standardized personality and intellectual tests.

This was accomplished by (a) self administering the Minnesota Multiphasic Personality Inventory, (b) administering and interpreting tests and inventories to clients which included the Minnesota Multiphasic Personality Inventory (MMPI-2), Million Clinical Multiarial Inventory (MCMI), Eyseck Personality Questionnaire (EPQ), State Trait Anger Expression Inventory (STAEI), State Trait Anxiety Inventory (STAI), Weschler Adult Intelligence Scale-Revised (WAIS-R) and the Adaptive Behavior Checklist.

9. To attend a 2-day workshop of the Association of Newfoundland Psychologists (ANP) at the Health Sciences Complex in St. John's.

   The two sessions attended were titled "Sexual Abuse" and "Schizophrenia in the Family."

10. To focus on suicidal and parasuicidal behavior as a major component of the internship experience. This was accomplished through attending and actively participating in a suicide workshop, reading and reviewing literature related to the theory, intervention and research.

    This culminated in conducting a research project aimed at (a) interviewing individuals who have attempted suicide to obtain their perceptions of how they cope, and determine their overall satisfaction with the help they received; (b) analyzing and interpreting the data received to assess the relationship of client reports on coping to existing theories and research. (For a more detailed description of the study, see Section II of Report.)

## CHAPTER 2

## THE INTERNSHIP: A DESCRIPTION OF ACTIVITIES

This chapter describes the actual activities undertaken by the intern during the internship period of April 13, 1992, to July 10, 1992. The intern maintained a daily log of activities during the internship placement. A summary of these activities, complete with time allocations for each, is found in Table 1.

**Table 1**
**Hours Allocated to Internship Activities**

| Activity | No. of Hours |
|---|---|
| Orientation Activity | 26 |
| Individual Counselling | 36 |
| Assessment/Report Writing | 50 |
| Supervision | 20 |
| Case Conferencing/Assessment Consultation/Rounds | 140 |
| Research/Reading Workshops | 50 |
| Group Counselling | 22 |
| Maintaining Log and Case Files | 45 |
| Visiting Agencies | 20 |
| Total Number of Hours | 409 |

In reporting on the clinical experience and the research component, the standard and formal third person format was chosen. However, there are two exceptions where the first person was used in order to include personal reflections of the clinical experience and of the process of interviewing the participants for the research component of this report.

## Orientation Activities

The first week of the internship placement was mainly devoted to orientation activities in an effort to become familiar with the atmosphere and procedures of the Waterford Hospital. This included general routines and specific procedures such as emergency codes.

The intern scheduled individual consultations with the psychologists on staff to become personally acquainted with them. During these initial meetings the intern and psychologists exchanged information about themselves and discussed counselling orientations and work responsibilities.

During the orientation week the intern viewed videotapes on confidentiality, electro convulsive therapy (ECT) and fire safety regulations, and set up a weekly schedule for activities, for example, supervision meetings, allocation meetings, rounds, research and reading, individual counselling, group counselling and assessments. The schedule was maintained throughout the internship, with little alteration.

## Individual Counselling

During the internship placement the intern was available to both inpatients and outpatients for individual counselling regarding personal, social and emotional concerns. The intern's caseload consisted of five female clients.

The two major areas of individual counselling were brief therapy for the purpose of anxiety and stress reduction, and

long-term therapy issues. Four clients were seen for short-term or brief therapy. These clients consisted of individuals with a variety of symptoms such as generalized anxiety, stress due to financial problems, prior sexual abuse, mild depression, flying phobia, and alcohol abuse. Treatment provided by the intern included relaxation training, anxiety management, problem solving techniques, systematic desensitization, gradual exposure in vivo, and cognitive therapy.

One female client, an ongoing patient of Dr. Alladin, was seen for long-term therapy issues. She had been hospitalized for depression and suicide and was having difficulty coping with the loss of a loved one. Weekly meetings of treatment provided by the intern included grief counselling, cognitive therapy, and crisis intervention. Upon completion of the internship, she continued therapy with Dr. Alladin.

All relevant counselling information was recorded in the clients' files in order to allow for the continued counselling of clients or re-allocation with another psychologist, if necessary.

## Assessment

The intern conducted seven full scale assessments during the internship period: three personality assessments for the purpose of determining fitness to stand trial; an intelligence assessment for placement purposes; and three screening interview procedures of new inpatients on the Forensic Unit. The intern

administered and interpreted the results of the Minnesota Multiphasic Personality Inventory-Two (MMPI-2) to four of the seven clients. In addition, the intern administered and interpreted each of the following assessment inventories: Million Clinical Multiarial Inventory (MCMI), Eyseck Personality Questionnaire (EPQ), State Trait Anger Expression Inventory (STAEI), State Trait Anxiety Inventory (STAI), Weschler Adult Intelligence Scale-Revised (WAIS-R) and the Adaptive Behavior Checklist.

In preparation for the administration and interpretation of these standardized and interview-like tests, the intern read relevant material such as instruction manuals and books on the interpretation of the MMPI-2 and its clinical scales. Consultations were held with field supervisor, Dr. Alladin and staff psychologist, Malcolm Simpson. The Minnesota Multiphasic Personality Inventory-Two was also self-administered and interpreted in order to familiarize the intern with the test items and content.

## Supervision

One-hour meetings were held weekly with the field supervisor, Dr. Assen Alladin, for supervision. During this time discussion focused on details of the counselling sessions, various theoretical orientations, and specific goals for the clients. These meetings were beneficial in allowing the intern

to reflect on her personal style of counselling and receive some feedback, enabling her to improve her skills.

During the first half of the internship the intern met with both her field supervisor and faculty supervisor to finalize her research proposal, and review how the internship was progressing. The intern and her field supervisor and faculty supervisor conducted a summary meeting to review the intern's case files and discuss her strengths and weaknesses. The goal of this meeting was to summarize and organize what was accomplished and learned during the internship. Dr. Aladdin also completed an Internship Evaluation (see Appendix B). These summary meetings were very beneficial in that they assisted the intern with personal reflection of the internship.

## Case Conferencing/Assessment Consultation/Rounds

The intern participated in weekly one-hour allocation meetings and monthly staff meetings, during which current or ongoing cases were often discussed along with new cases and business. During this time other psychologists would offer feedback and suggestions aimed at developing greater insight and generating new alternatives. This experience enabled the intern to broaden her knowledge regarding the theoretical orientations and how theory influences the counselling process.

The intern presented cases of her own on two occasions. The opportunity to obtain different viewpoints and receive

recommendations and feedback, in an attempt to achieve more effective counselling, was exciting.

Assessment consultation and case conferencing was also held on a one on one basis with several psychologists: Dr. Assen Alladin, Dr. Hassen Khalili, Heather Dalziel, Malcolm Simpson, John O'Connell, and Nina Sandevol.

During the beginning part of the internship a great deal of the intern's time was spent in rounds on the Forensic Unit. Bi-weekly multi-disciplinary team meetings, which included a psychiatrist, psychologist, social worker, nurse, and usually an intern or two, were held to review cases and make recommendations.

The intern was consulted several times while she was on the forensic unit. Dr. Ladha, a forensic psychiatrist, questioned her about a cognitive and personality assessment. Forensic nurses also consulted with her regarding the management of a patient with inappropriate sexual behaviours, and a social worker asked her opinion of a patient's cognitive ability and fitness to stand trial.

Time spent on the Forensic Unit was very beneficial in that it exposed the intern to the alleged offender or abuser rather than the victim. This assisted the intern in seeing the situation from a different point of view and in providing treatment from a different perspective. The intern became familiar with techniques and approaches in counselling alleged

sexual offenders, for example, penile plethysmography and phallometry.

## Research/Reading

The intern was allocated approximately eight hours per week in which to pursue research and reading. The focus was on topics related to the research component and topics of clinical interest, such as sexual abuse, schizophrenia, depression, suicide, anxiety management training, relaxation training, assertiveness training, sleep disorders and counselling research. The Waterford Hospital Library, along with the Queen Elizabeth II Library, proved to be excellent resources. An annotated bibliography of books and materials read during the internship is presented in Appendix A.

## Workshops

The intern was involved in the presentation of a workshop, attended two workshops, and several educational sessions. She was actively involved in the planning, preparation and presentation of a workshop entitled Suicide Intervention with Dr. A. Aladdin, Mr. J. Dosley and Mr. T. O'Connell. Specifically, the intern was involved in several role plays and in organizing group activities for the participants. This workshop, presented on June 2 and 3, 1992 at the Waterford Hospital, focused on cognitive therapy. Several handouts on cognitive therapy and suicide were given to participants. Dr.

Alladin lectured on the origins of cognitive therapy, irrational cognitions, and the ABCDE model of breaking down irrational cognitions (see Appendix C for handouts). This workshop was very beneficial in that it provided the intern with experience in organizing and presenting a workshop to professionals in the field.

The intern also attended the Association of Newfoundland Psychologists (ANP) Spring Conference which was held at the Health Sciences Complex on May 22. Two sessions were attended, "Treatment of Sexually Abused Children" and "Schizophrenia in the Family." All sessions were presented by professionals working in the field of psychology and counselling. Attending this conference was very beneficial in that it enabled familiarization with various theoretical orientations and provided the opportunity to meet other Newfoundland professionals involved in research.

The third workshop the intern attended was a School Counsellor's Workshop in Clarenville on June 12 (sponsored by the school board the intern will be employed with next year). This one-day workshop involved nine guidance counsellors and two educational psychologists. There was a presentation on the effects of divorce in the family, as well as a discussion regarding presentation topics for the following year.

The educational sessions attended by the intern were usually held on Fridays and conducted by a professional employed by Waterford Hospital. The intern attended five educational

sessions: three were on hypnosis conducted by Dr. Alladin, one on countertransference by Malcolm Simpson, and another on antipsychotic drugs conducted by Dr. Karagianis.

## Group Counselling

During the internship the intern co-led a group with John O'Connell (psychological assistant). The group was a voluntary unstructured client-directed group consisting of twenty male long-term psychiatric outpatients diagnosed with schizophrenia and depression. The group began in January, 1992 and the intern joined on April 28, 1992.

The group was unstructured and client-directed, with an open agenda. Participants chose the topics of discussion and determined the direction of the sessions. Everything discussed during the group meeting was to remain confidential and the only rule was that one person was to speak at a time. The improvement of outpatient's problem solving skills was the goal. This was accomplished through education, increasing self-esteem, emotional support and the ventilation of feelings. Issues discussed within the group included resistance, anger, love, participation, sports, work, socialization, relationships, drugs, sex and mental illnesses. The intern feels this group was very beneficial in learning about how individuals live with a mental illness and how to conduct an unstructured group. Group leader role involves the facilitation of discussions and modelling good communication and conflict resolution skills.

## Maintaining Log and Case Files

The intern maintained a written daily log of activities complete with the amount of time devoted to each activity. The log consisted of reactions to sessions, group meetings, observations, reflections and questions. Maintaining the log was particularly helpful in compiling the summary of activities undertaken during the internship placement for the completion of the internship report. It also assisted in the reflection of experiences during the 13-week internship and enabled the intern to develop greater insight into the process undertaken when doing research and into the dynamics of a hospital working environment.

In keeping with the outpatient and inpatient regulations of the Waterford Hospital, the intern completed a patient information sheet on each client and a report outlining the presenting problem, the counsellor's view of the problem(s) and the recommended treatment for the client. The intern also maintained case file notes on each individual counselling session. A summary list of client names, concerns or diagnosis and treatment was compiled and submitted to the field supervisor at the close of the placement.

## Visiting Agencies

During the internship, the intern contacted and visited four outside referral agencies, the Duckworth Clinic, Iris Kirby House, Alcohol and Drug Dependency Commission and Channal.

Duckworth Clinic is a counselling service centre which is an extension of the Waterford Hospital. Psychologists and psychiatrists from the Waterford Hospital spend one morning or afternoon per week at the Clinic providing counselling services to the community. Counselling services are provided in the area of addictions, abuse and marital therapy.

Iris Kirby House is a shelter and transition house for battered women and their children, originally opened in 1981 under the auspices of the Newfoundland Status of Women Council. Iris Kirby House provides shelter for six weeks. During this time they have a safe place in which to evaluate their situation and plan for the future. They receive supportive counselling during this time.

The Iris Kirby House provides a variety of services, including: a crisis line, children's services (particularly in the area of counselling and recreation), a thrift shoppe, education and employment counselling, and public education and prevention. The staff people at Kirby House also spend time on public awareness through publishing pamphlets, posters and making presentations to other professionals, including police officers, lawyers, and psychologists.

Channal is a self-help support network affiliated with the Mental Health Association serving the needs of the Province's mental health consumers. It serves the following functions: to provide a voice in the community to advocate the needs of its members, to offer support while increasing members' independence

of the mental health system, to serve as a means of communication and forum for the exchange of ideas, and to educate the public about mental illness and mental health problems. The main goals of Channal are to prevent isolation, work towards improving the mental health care system and to provide personal help and support to its members. These goals are accomplished through self-help groups meeting weekly. Time spent at these agency sites provided the intern with valuable insight into their services and provided a possible contact for consultation or referrals in the future.

## Personal Reflections and Recommendations

In selecting the internship route over the thesis route my primary motivation was to gain clinical experience. In my view the Waterford Hospital provided me with diverse populations for clinical work, both on an inpatient and outpatient basis. Initially I wondered how I would feel working in this type of institution, but early on I felt very comfortable in this setting. The internship was also a valuable experience in providing me with the opportunity to meet and work with a number of professionals in a variety of situations.

My main observation was that all the patients were very similar in their basic needs and concerns. Further, these needs and concerns are those which all of us face, for example, love and belonging.

During the internship I was involved in conducting formal psychological assessments and in providing counselling. I became aware that I have a preference for the counselling role. I found the counselling provided me with a greater understanding of human nature and more personal satisfaction.

Similarly, co-leading and participating in an unstructured group was a rewarding experience. I was able to observe and participate in the group dynamics and serve as a mediator at times. For example, one concern that became important in the group was that I was a female in an all male group. We processed this concern within the group and ultimately my role as a female in the group was a facilitative factor for members in the group.

During the internship I found it very difficult to divide my time between clinical work and completing my research project. I needed to be very organized and focused with my time. As a result, I was not able to reflect upon my experiences during the internship to the extent that I would have liked. It was helpful to me to keep a journal of my daily experiences and thoughts, and I would highly recommend this to other interns.

In summary, the clinical work furthered my professional development and competence as a counsellor. The competencies I gained through the internship include:

1. Implementing a suicide education program.

2. Employing behavioral and cognitive techniques for use in relaxation and counselling.
3. Greater awareness and understanding of a variety of socio-emotional problems, and the precipitating factors to psychological distress.
4. Exposure and experimentation with a variety of treatment modalities under supervision.
5. Enhancement of skills related to relationship-building.
6. Experience and skill in using and interpreting standardized personality tests.

I have benefited from conducting a research project aimed at determining the coping strategies utilized by individuals who have attempted suicide. This has made me more aware of the importance of research in counselling and of the importance of attaining the client's point of view when conducting research in counselling.

The placement at the Psychology Department of the Waterford Hospital has enabled me to work with a psychiatric population, as well as a non-psychiatric population (most of the outpatients), with a variety of concerns under the supervision of other professionals. I believe that this experience has been a valuable learning experience. The focus of my counselling has progressed from being content to process oriented. I also believe that I have learned how to become a more effective agent of change, and that the experience gained through the internship has been an ideal way of preparing me for the counselling

profession. I strongly believe that all students in the Master of Educational Psychology Degree Programme should have an intensive practicum experience.

# PART II: RESEARCH COMPONENT

## CHAPTER 1

## INTRODUCTION

In order to fulfill the requirements of the internship option offered by the graduate program in Educational Psychology, the intern must complete a research project relevant to the internship setting. Much thought and contemplation went into the types of projects which would enhance the intern's knowledge of counselling and be appropriate to the setting. The intern decided on a qualitative study involving ten participants who had been clinically diagnosed as depressed and who had previously attempted suicide. This section describing the study includes an overview and rationale, research questions, literature review, methodology, analysis of the interview data, and results and discussion.

### Overview

The general purpose of this study was to collect information about coping strategies from a group of 10 individuals who had at least one major depressive episode and a suicide attempt within the past three years. All individuals with major depression who had attempted suicide were used for the study because there is a strong correlation between clinical depression and suicidal attempts. Further, to reduce contamination, a more defined and distinct sample was examined. There is a correlation between suicide attempts and depression

as well as other psychiatric or psychological disorders. However, the diagnosis of major depression (Diagnostic and 'atistical Manual of Mental Disorders, Revised, 1987; DSM-III-R, Axis 1) rules out other psychiatric or psychological disorders. However, in order to ensure the well-being of those interviewed, the participants were not clinically depressed and/ or having active suicidal ideation at the time of the study.

It is a retrospective study to gather information on how depressed individuals who have attempted suicide learned to cope with suicidal thoughts and feelings. The study specifically determined past and current self-reported strategies for coping and perceptions of functioning. Information was also gathered on what these individuals perceived as beneficial from significant others in their lives and from professionals within the helping community. That is, the goal of the current study was to gain a better understanding of the personological and situational factors related to coping following a suicide attempt, rather than to infer or debate causal factors related to depression as a disorder.

Suicide is viewed as a phenomenon of great and growing concern in Canada. For example, Ramsay, Tanney, Tierney and Lang (1991) report that 14 in every 100,000 people in Canada commit suicide and that for every one completed suicide, there are 100 attempts. However, little research has investigated the coping strategies of individuals who attempt suicide. Even fewer studies report follow-up data on suicide attempters. A

search of the literature revealed that few studies attempt to uncover the individual's perceptions.

## Rationale

Suicide now ranks among the top ten leading causes of death in North America, and is currently the second leading cause of death for Canadians between the ages of 15 and 30 (Health and Welfare Canada, 1989; Hughes, 1988). However, very little research has been carried out despite the seriousness of this problem (Health and Welfare Canada, 1989).

Recent Canadian statistics report a high suicide rate. In 1983, there were 15.1 suicide deaths for every 100,000 people, clearly ranking in the upper 50 percent of the countries listed and well above the median of 10 per hundred thousand. A comparison study of the pattern of Canadian and U.S. suicide rates over the period of 1968-1983 has shown that Canada overtook and then consistently exceeded that of its southern neighbour. The average suicide rate from 1982-1988 in Canada has been 14 per 100,000 compared to 12 per 100,000 in the United States. Due to the inherent problems with reporting, suicide and attempted suicide data has not been systematically collected in Canada. However, self-injury studies in London, Ontario (1969, 1971) and Calgary, Alberta (1982), have indicated that the incidence of attempted suicide ranges from 730 to 1433 per hundred thousand (Linehan, Chiles, Egan, Devine, & Laffaw, 1986; Linehan & Laffaw, 1982; Ramsay, Tanney, Tierney & Lang, 1991).

The frequency of individuals who have attempted suicide has outnumbered completed suicides 100 to 1, with females being more likely to attempt, and males more likely to complete (Petti & Larson, 1987; Ramsay, Tanney, Tierney & Lang, 1991). There is a significant relationship between psychiatric or psychological disorders, particularly depression, and suicidal behavior (Linehan & Laffaw, 1982). For example, according to the Alberta data on completed suicides in 1980, 72% had a history of depression (Ramsay, Tanney, Tierney & Lang, 1991).

The ratio of attempted suicide to completed suicide as well as the percentage of all deaths accounted for by suicide have also been estimated in Canada. Both sexes were shown to be at the highest risk for attempted suicide between the ages of 15 and 44, with the female rate being three times that of males. Attempted suicide was most prevalent for males between the ages of 20 and 34 and for females between the ages of 19 and 24, while completed suicide was found to be most prevalent in males over 34 years of age and in females 35-64 years of age, with the male completed suicide rate being considerably higher. In addition, suicide was found to account for approximately one in seven deaths from all causes for both sexes under age 35 (Health and Welfare Canada, 1989; Ramsay, Tanney, Tierney & Lang, 1991).

The suicide rate in Newfoundland has been climbing steadily. In 1985 there was a total of 23 suicides, in 1988 there were 44 suicides and in 1990 there were 75 suicides (unconfirmed rates for 1990 released by the provincial

pathologist in the annual report, Hutton, 1990; Health and Welfare Canada, 1989).

According to Pattison and Kahan (1983), suicide attempters and suicide completers are clinically distinct yet overlapping patterns. Suicide attempters have been labelled parasuicidal individuals and the most common form of parasuicide is self-poisoning. Once someone has attempted suicide there is an 80% chance or more that he/she will attempt again and succeed (Goldney, 1980; and Prescott & Highly, 1985). Thus, it is crucial for professionals to study the area of coping strategies to learn the ways individuals who have attempted suicide cope and the strategies they have found helpful.

Research has recently focused on examining the cognitive processes in suicidal individuals. Weishaar and Beck (1990) state:

> Cognitive pertains to how individuals perceive, interpret and explain their environments. The process by which humans select stimuli to interpret, assign meanings to those stimuli, and respond affectively and behaviorally to them is often variable and strongly influenced by prior learning and mental set. (p. 469)

According to Fiske and Taylor (1984), a schema is a "cognitive structure that contains knowledge about the attributes of a concept and the relationships among those attributes. All types of schemata guide perception, memory, and

inference in similar ways, toward schema relevant information and often towards schema consistent information" (p. 149).

Based on personal experience and the literature (Burns, 1991), some people develop idiosyncratic, dysfunctional, or negative self-schemas. These negative self-schemas can lead to errors in perception and inferences which lead to faulty conclusions or inflexible thinking, limited response repertoires, deficits in conceptualizing, the consequences of which can lead to actions such as suicidal behavior or attempts (Weishaar & Beck, 1990; Burns, 1991).

Since individuals operate from these self-cognitions, it would be useful to study depressed individuals' perceptions of how they are coping, and what they perceive as their best coping strategy. The impetus for examining the role of cognitive processing in suicide has evolved from research on the cognitive aspects of depression and suicide (Beck, 1967; Beck, Rush, Shaw & Emery, 1979; Beck, 1987). Beck and his colleagues (1979, 1990) found that cognitive aspects of depression in adults, such as hopelessness and pessimism about the future, were more closely related to suicide than affective aspects of depression. This sense of hopelessness leads the depressed suicidal individual into believing that suicide is the only feasible strategy for dealing with the seemingly insolvable problems.

Hughes (1988) also found that depression is strongly linked to suicidal behavior in adolescents, particularly in females. Hughes reports that Bettes and Walker examined the frequency of

suicidal thoughts, acts and symptoms of 23 adolescents with major behavioral problems. Depression was found to be the most common symptom among adolescents manifesting suicidal thoughts and acts while anger was the most common symptom among nonsuicidal adolescents. According to Ramsay, Tanney, Tierney & Lang (1991), people in depressive states with the accompanying effects on thoughts, feelings, activities, and physical health are recognized as persons at risk for suicidal behavior.

Cognitive theorists believe that cognitions may identify the suicidal individual. The cognitive theory of psychological stress and coping is transactional in that the person and environment are viewed as being in a dynamic mutually reciprocal relationship. Thus, stress is defined as a relationship between the person and the environment, that is appraised by the person as taxing or exceeding his/her resources and as endangering well being. Cognitive appraisal and coping are identified as critical mediators of stressful person-environment relationships and their immediate and long-term outcomes (Lazarus & Folkman, 1984; Folkman, Lazarus, Gwen & Delongis, 1986).

Researchers have recently found differences in the cognitive processes between suicide attempters and non-attempters. For example, Bartfai, Winborg, Nordstron and Asberg (1990) found a decreased ability in individuals who have attempted suicide to generate new ideas or solutions to problems.

In contrast, Orbach, Bar-Joseph and Dior (1990) reported that suicide attempters did offer more active problem solving than did suicide ideators who have thoughts of suicide but make no attempt. However, both studies allude to the fact that it seems that special attention should be given to the problem solving skills of attempters or their ability to generate new ideas. It may be that suicide attempts are active problem solvers but the range of solutions they choose from are limited. Orbach and his associates (1990) recommend that treatment interventions should focus on broadening their range of solutions in problem solving. This approach is best served by the cognitive theory of suicide, which provides a framework for helping parasuicidal individuals learn how to cope.

In summary, there is a strong need to study the coping strategies used by individuals who have attempted suicide for several reasons. First, there is the need to impart valuable information about the coping strategies to professionals about this growing population. Second, there is a need to investigate the coping strategies utilized by individuals who have attempted suicide in order to understand their cognitive style. And third, current therapeutic techniques used with individuals who have attempted suicide can be refined by making them more consistent with clients' perceptions for implementation in a variety of settings such as psychiatric hospitals and schools.

## Research Questions

This study addressed the following general research questions:

1. How do individuals who have attempted suicide describe themselves, the suicide attempt, their thoughts, feelings and coping strategies currently versus in the past?
2. What are the self-reported coping strategies of individuals who have attempted suicide? What differences and similarities exist in these strategies?
3. How do the reported coping strategies coincide with the strategies stated in the literature as most effective?
4. How do the individuals report coping with their thoughts and feelings prior to the suicide attempt? That is, how did the individuals perceive themselves as coping in the past? How do they perceive themselves as coping now? How do they perceive themselves as coping in the future?
5. How do the types of prevention and intervention suggested by the individuals coincide with the existing intervention and prevention strategies?
6. What forms of social support did individuals who have attempted suicide receive from their family, friends and spouse or partner?
7. What suggestions do these individuals provide for ways in which professionals can develop better rapport with individuals who have attempted suicide?

8. What type of help did these individuals receive and were they satisfied with this help?
9. How can psychologists effect positive changes in the coping strategies of individuals who have attempted suicide?
10. What hypotheses for further research are illuminated by this study?

# CHAPTER 2

# LITERATURE REVIEW

## Introduction

Turning to the literature, it is important to elaborate on a number of issues relevant to examining self-perceptions and coping strategies of individuals who have attempted suicide and been diagnosed as clinically depressed. A search of the literature revealed almost no research which specifically addressed variables of interest in the present study. The present review represents a selection of issues and variables most germane to the present study. These include: definitional issues, characteristics of parasuicidal individuals, parasuicide as a gender issue, depression, life stressors, cognitive appraisals and attributions, personal resources, coping strategies and problem solving, and interventions.

## Definitional Issues

Throughout the years, attempted suicide has been labelled pseudocide, parasuicide, acute poisoning, deliberate self-injury, self-injury and most recently, propetria (Goldney, 1980). However, for the purposes of this study, the term parasuicide is used because it was encountered the most in reviewing the literature.

Parasuicidal Individuals refers to individuals who often contemplate, threaten or make suicidal attempts, in an attempt to communicate pain and in order to reach out for help. Suicide

Ideators refers to individuals who often contemplate, think or talk about suicide, communicating suicide intention but do not attempt it. Completers refers to individuals who commit suicide.

## Characteristics of Parasuicidal Individuals

There are several distinguishing characteristics of the parasuicidal individual. McLeavey, Daly, Murray, O'Riorden and Taylor (1987) report on Pattison and Kahan's (1983) work which states that suicide and parasuicide are distinct yet overlapping behavior patterns.

According to cognitive theorists, parasuicidal individuals are individuals for whom suicidal behavior is often a coping strategy in response to depression, to terminate perceived physical and psychological suffering. They are signalling a cry for help and demonstrating their depression more openly trying to force a solution to their problem (Beck et al., 1979; Glaser, 1981; Beck, 1987; Beck et al., 1990). Research findings (Prescott & Highly, 1985) suggest that the most common form of parasuicide is self-poisoning.

Parasuicidal individuals are 32% more likely to have prior substance abuse than non-attempters (Garfunkel, Froese & Hood, 1982). The frequency of parasuicides was found to outnumber suicide completers 50 to 1. Women and the young were found to be more likely to attempt suicide, whereas males and the elderly were more likely to complete suicide. There are 3.6 male

suicide completions for each female completion (Health and Welfare Canada, 1989).

According to Linehan, Chiles, Egan, Devine and Laffaw (1986), parasuicidal individuals admitted to an inpatient psychiatric unit immediately following a suicide attempt reported having more serious interpersonal problems than did suicide ideators and nonsuicidal psychiatric patients. In addition, compared to patients without a parasuicide history, they reported less active problem solving strategies such as talking to a friend and greater passive problem-solving strategies such as isolating oneself. The authors state that assertion deficits may characterize the psychiatric population in general, and suicidal behavior within psychiatric patients may be related to lower active problem-solving (Linehan et al., 1986).

Linehan and Laffaw (1982) conducted a survey and found that suicidal behavior was related to sex and income in the general population. Both women and poor individuals were found to be more likely to exhibit suicidal behavior or parasuicide. They found little, if any, difference between the reported incidence of suicide ideation and parasuicide between an outpatient psychiatric sample and a general population sample. Suicide is not only a psychiatric phenomena.

McLeavey et al. (1987) studied three groups: group one consisted of 40 self-poisoning patients (this was a parasuicide group with a mixed diagnosis of depression, according to the

DSM-III); group two consisted of 40 psychiatric patients; and group three consisted of 20 nonpatient controls. The three groups were compared on measures of interpersonal problem solving skills, Means End Problem Solving, the Optional Thinking Test, the Awareness of Consequences Test, Self Rating Problem Solving (SRPS) Scale, Rotter Internal-External Scale, Mill Hill Vocabulary Scale, Hopelessness Scale, and locus of control. No significant differences were found in locus of control between the self-poisoning patients and the nonpatient group nor was there any difference between hopelessness in the self-poisoning participants and the psychiatric or control participants. However, differences were found on all measures of problem solving between the self-poisoning group and the nonpatient controls. On measures which emphasize interpersonal content, self-poisoners and the psychiatric patient group performed more poorly than the non-patient controls. McLeavey et al. (1987) concluded that self-poisoning individuals were less flexible in social cognition and lacked the ability to consider the consequences of an action before it is carried out. However, they also concluded that locus of control did not differentiate self-poisoning patients from non-patient controls and that it is not an important factor in self-poisoning. They suggest that training in interpersonal problem-solving would be beneficial.

Linehan, Camper, Chiles, Strosahl and Shearin (1987) examined the relationship between interpersonal problem solving and parasuicide among three groups of psychiatric patients, who

had the following diagnoses: (1) Group 1 - current parasuicide; (2) Group 2 - serious suicide ideation; and (3) Group 3 - non-suicide related complaints. One hundred and twenty-three psychiatric patients, along with a control group consisting of 16 orthopedic surgery patients were given a revised version of the Means End Problem Solving Procedure, the Rathus Assertiveness Schedule, and a suicide expectancy measure. Differences were found between the psychiatric patients and the control group related to assertiveness, self-expectations and problem solving. Psychiatric patients scored lower than the medical control group on the assertiveness schedule but the differences were not found to be a function of suicidal behavior status. That is, psychiatric patients, irrespective of whether they were identified as suicidal, viewed suicide as a solution to problems more than the control group did. Parasuicides did not report less assertive behavior than other psychiatric patients. However, there were differences found in the problem solving skills of parasuicides and suicide ideators. Less active and greater passive problem solving discriminated first time parasuicides from suicide ideators and nonsuicidal patients. The indication was that suicidal behavior within psychiatric patients may be related to lower active problem solving. Thus, teaching parasuicides active problem-solving might be useful in preventing further parasuicides.

Since the late 1970's, parasuicidal individuals have been reported to have cognitive rigidity or a rigid style of

perceiving and reacting to the environment (Patsiokas, Clum & Lucomb, 1979), making it difficult for the suicidal individual to formulate alternative approaches to problems. However, in a one year follow up study, Perrah and Wichman (1987) administered tests of rigidity to individuals who had attempted suicide but were well past the crisis period and found that they were less cognitively rigid than attempters of previous studies on the Rokeach Map Test and the Alternate Uses Test. Their conclusion was that the rigidity observed in persons tested shortly after a suicide attempt may be a correlate of the high level of stress that accompanies crises. That is, that cognitive rigidity may indeed be situational specific as opposed to a defining personality trait.

Bartfai, Wimborg, Nordstrom and Asberg (1990), using a sample of nine male psychiatric patients, found a decreased ability in parasuicidal individuals to generate new ideas or solutions. Two control groups were used, one consisting of patients with chronic idiopathic pain and one consisting of healthy volunteers. Tests of intelligence (Synonym Reasoning and Kohs' Block Test), cognition (Perceptual Maze Test and the Wisconsin Card Sorting Test) and flexibility (Uses of Objects Test and the Stroop Test) were used. No significant differences were found in problem solving or flexibility in suicide attempters, contradicting the results of the previous studies (McLeavey et al., 1987; Linehan et al., 1987). While these contradictory findings may be a result of the different

instrumentation, they call for more careful investigation of this area of study.

Orbach, Bar-Joseph and Dior (1990), studied the qualitative aspects of problem solving among three groups: suicide attempters, suicide ideators and nonsuicidal patients. The measures included a suicidal intent scale, the Zung Depression Scale, and a problem solving task involving three dilemmas. Problem solving was analyzed along eight qualitative categories, as well as statistically. Differences were found in problem solving processes of suicidal individuals (attempters and ideators) and nonsuicidal individuals. The general coping style of attempters and ideators was a style of avoidance. Their solutions also showed less versatility, less relevance, less reference to the future, and more negative affect. Differences were also found in the energetic, motivational dimension. The suicide ideators and attempters tended to depend on others for their solutions. Affectively, the suicidal participants displayed a more pessimistic, giving up attitude in their solutions. Again, suicide attempters and nonsuicidal individuals compared to suicide ideators produced more active and energetic solutions. Parasuicidal individuals also offered more active problem-solving than did suicide ideators or individuals who contemplate or think about suicide but do not attempt it. Thus, special attention and interventions should look at changing the nature of the activity from destructive to constructive.

Research findings regarding the characteristics of parasuicides suggest that parasuicides see suicidal behavior as a coping strategy (Beck et al., 1979; Beck et al., 1990), are more likely to be women (Health & Welfare Canada, 1989), have distinct cognitive characteristics such as cognitive rigidity, more serious interpersonal problems (Arffa, 1983; Weishaar & Beck, 1990), have assertion deficits and lower active problem solving (Linehan et al., 1986). However, contradictory studies indicate that cognitive characteristics such as cognitive rigidity may be situational specific (Perrah & Wichman, 1987) and that suicide attempters do offer more active problem solving than suicide ideators but their range of solutions is limited (Orbach et al., 1990). Therefore, the teaching of active self-enhancing problem-solving skills (McLeavey et al., 1987; Linehan et al., 1986, 1987; Orbach et al., 1990; Bartfai et al., 1990) might be useful in preventing further parasuicides. In addition, the combination of interpersonal problem-solving and assertiveness training might be even more effective (Nezu & Perri, 1989; Lerner & Clum, 1990; Linehan, Camper, Chiles, 1987).

## Parasuicide as a Gender Issue

Feminist theories and research have provided a new perspective in viewing psychiatric symptoms, especially depression. Greenspan (1983) states: "Every woman - housewife or career woman, working class or middle class - knows what it

is like to be depressed" (p. 161). Women are reported to have higher rates of mental illness, especially depression, than men (Cove, 1987). Depression is the most common characteristically feminine symptom, and it is more common in married women than in single women (Greenspan, 1983). The symptoms of depression, feelings of hopelessness, helplessness, worthlessness, futility and suppressed rage are the affective components of the social condition of female powerlessness in a male society. Feeling helpless is in some sense a rational adaptation to the social status of being powerless. Thus, depression is often considered a normal, acceptable feminine behavior, or a way of getting cared for by men such as husbands, bosses or lovers, who have power over women (Greenspan, 1983; Cove, 1987).

According to Greenspan (1983), it is the inability to get angry that most characterizes depression for women. Women are depressed because they either do not feel able or cannot get angry. They are socialized to be sweet, loving, calm, quiet and nurturing to fill the role of daddy's little girl and the perfect wife and mother. However, without an authentic sense of one's capacity to feel and express anger, there is nothing to get a genuine sense of power going. Women are also afraid of power because everything in a woman's social experience teaches her that power is masculine. Women tend to associate power not with feeling good but with social isolation and/or abuse. Thus, the dilemma arises, feeling good means feeling powerful but

feeling powerful is not womanly, which is a threat to one's identity (Greenspan, 1983; Cove, 1987).

Women are three times as frequently depressed as men and for every male that attempts suicide, there are three females (Health & Welfare Canada, 1989). This indicates distinct gender differences in the area of depression and parasuicide.

Research on women and parasuicide has been documented for years. Wilson (1979) offered an explanation of sex differences based on W. Breed's (1972) five components of a basic suicide syndrome:

1. Failure, particularly in the realm of interpersonal relations.
2. Commitment to cultural goals and gender roles.
3. Rigidity or lack of ability to refocus.
4. Shame or guilt.
5. Isolation.

Wilson concluded that if sex differences were noted the model would be adequate because the same factors affect the sexes differently and the content and structure of male and female roles are different. For example, failure for males is obvious, it takes the form of occupational and unemployment failures. The female role, on the other hand, is lacking in standards for both success and failure. For example, how does a woman know if she's been nurturant enough? or feminine enough? Female commitment to role, role rigidity, shame and isolation are also different, because they are more diffuse and therefore confusing

and frustrating women. Attempted suicide seems to be related to stress induced culturally idealized role expectations without a realistic means of meeting them. Feelings of inability to cope precipitate depression, and when women attempt suicide they may be calling on others to help them (Wilson, 1979).

The composite suicide attempter is a young lower socio-economic female who has recently experienced interpersonal problems such as marital conflict, divorce or separation. They tend to rely on others for help, be passive in times of stress and might well attempt suicide as a sign of anger against those perceived to be the cause of stress (Herman, 1977; Wilson, 1979).

Hammen (1991) also found that women with unipolar depression, by their behaviors, for example, focusing conversation on their unhappiness, generate stressful interpersonal conditions that often contribute to the cycle of symptoms and stress that create chronic or intermittent depression.

Bourque, Kraus and Cosand (1983) investigated long term trends in suicides among females using data from coroner reports in Sacramento County, California. Of the 3,741 cases, 25.4% were female. The suicide data on the coroner reports suggest that there are three types of female suicides, and each type varies with the age of the woman. The three typologies suggested to describe suicides of women ages 25 to 64 were ill health, psychiatric disability, and status disintegration.

Suicides of older women (64+) were preceded by illness, and they showed little evidence of need for psychiatric care. Suicides of younger women were preceded by familial loss and disruption or psychiatric problems, particularly depression. The data also suggest that women ages 25-64 were affected by changing definitions of women's roles and were vulnerable to conflicts between multiple roles, changing definitions of self and low levels of social integration.

Endler and Parker (1990) examined the relationship between depressive symptoms and coping styles in a college sample using the Multidimensional Coping Inventory (MCI). The relationships between depression and both state and trait anxiety were also examined using the Beck Depression Inventory (BDI), the Endler Multidimensional Anxiety Scales and the Endler Multidimensional Anxiety Scales. Differences were found in coping behavior, between sexes with females reporting more emotion oriented and avoidance oriented coping behaviors than males. However, both males and females who scored high on depressive symptoms were found to use more emotion oriented coping.

Brooks, Morgan and Scherer (1990) studied the effects of sex role orientation and type of stressful situation on coping behaviors reported by individuals. Sixty males and 116 females at a college provided the data. The measures used for this study included the Ways of Coping Questionnaire (WOCQ) and the Male Female Relation Questionnaire (MFRQ). Differences were found in coping behaviors depending on individuals' sex role

orientations. Individuals with a nontraditional sex role orientation had a greater repertoire of coping behaviors than traditional individuals, regardless of gender or type of stressful situations encountered. Traditional females had the most restricted range of coping resources, and nontraditional females used more social support, meaning they sought out other people, friends, and professionals to talk to or confide in. Traditional sex role compliance is associated with a restricted range of coping strategies across both work and personal situations, possibly placing individuals at a higher risk for developing psychological disorders.

Billings and Moss (1984) found that coping responses directed toward problem solving and affective regulation were associated with less severe dysfunction, while emotionally discharged responses were more frequently used by women and linked to greater dysfunction.

Recent research (Nolen-Hoeksema, 1991; Hammen, 1991) indicates that depressed women are exposed to more stress than other women, had significantly more interpersonal event stressors and tended to be more dependent on others for their self-worth than other women.

Individuals, particularly women, who are suicidal often report preferring the company of others who are depressed (Rosenblatt & Greenberg, 1991) and pushing people or social supports away by their symptoms, behaviors, and characteristics (Hammen, 1991).

In a presidential address to the American Association of Suicidology, Sanborn (1990) points out that gender socialization, whereby males are socialized to be the strong silent type and to keep their problems ins le accounts for some of the reasons for the higher rate of male suicide completers. Men tend to commit suicide because they keep everything inside, they experience danger in connection with closeness which builds up and eventually explodes in a violent form of suicide. Conversely, women experience danger in separation and due to their diffuse roles and dependence on others attempt suicide more than men. Sanborn (1990) states that:

> the problem of suicide cannot be understood from a solely sociological, psychological or gender based perspective. But we need to develop individual self-esteem early in life so that each child has an internalized value because of who he or she is, not what he or she does. (p. 154)

## Depression

In order to obtain a fuller understanding of depression and parasuicide, knowledge about how and to what extent depressed and nondepressed persons differ in the ways they appraise, cope with and emotionally respond to the events of daily living is required. There are many different theories of depression such as the biological theory, psychoanalytical theory, behavioral theory and the cognitive theory, which are not the focus of this

review. Rather, this review focuses on research which attempts to define the relationship of depression and a variety of other psychosocial factors to parasuicide.

Relationship to Parasuicide

There is little research on the relationship between depression, coping and suicide attempters, or on how individuals see themselves as coping with suicidal thoughts, which is the purpose of this study.

Scholz and Pfeffer (1987) conducted a study on the relationship between depression, coping behavior and suicide. The participants consisted of twenty patients who had attempted suicide at least twice and twenty patients who were diagnosed as suffering from reactive or neurotic depression. The instruments included the Self Rating Depression Scale (SDS), the Coping Questionnaire (CQ) and an Attributional Style Questionnaire (ASQ). The results indicated that individuals having attempted to commit suicide repeatedly are as depressed as patients suffering from reactive or neurotic depression. The extent of depression is clinically significant in both cases. However, the patients who had attempted suicide tended to believe that they could not have prevented the situation by their own efforts. They also showed less problem focused coping behaviors and more wishful thinking. They tended to approach a stressful situation in a less problem focused manner and greatly emphasized the threat potential. In addition, the attributional

behavior of suicide patients seems to be of greater importance than their coping behavior. Depressed individuals explain their failures independent of their good character traits or successful performances by an internal stable, global type of attribution. This indicates that the attributional style of suicidal patients is characterized by its negative quality rather than its positive qualities or quantities.

A follow-up study of patients who have attempted suicide was conducted by Brauns and Berzewski (1988). Forty-eight patients who had attempted suicide were re-examined (twenty-four patients who had attempted suicide eight years ago and twenty-four patients who attempted suicide three years earlier and had received treatment in a crisis intervention ward). Measures included a semi-structured interview and self-rating scales (Stress Coping Questionnaire and the Global Assessment Scale).

Psychosocial development during the study period was evaluated according to the number and quality of life events, coping behavior and self-concept, sociodemographic variables, the subjective evaluation of the treatment in the crisis intervention ward, and cooperation with the aftercare program.

Results of the study found that 75% of the former patients perceived the treatment on the crisis intervention ward as helpful. Over half of the patients were still on medication and nearly half considered themselves psychologically healthy. Following this study, one third of the patients did attempt suicide again. The number of extremely stressful events was

found to be significantly higher for the group of inpatients with a recent suicide attempt. It was also found that both groups of suicide attempters responded to stressful situations primarily with emotional dismay and despair, which was characterized by resignation, self-accusation and social withdrawal. The patients in the study group who attempted suicide eight years ago showed more frequent use of cognitive coping strategies in the form of positive self-instruction. This seemed to lead to a direct and more constructive or active control of the patients' behavior. These former patients also appeared to have found alternate interests to distract them from losses and denials in the area of personal relationships. Finally, those who had attempted suicide eight years ago, considered themselves more capable of dealing with everyday problems, were more satisfied with themselves, and showed more positive self-esteem than those in the more recent suicidal group.

## Feelings and Cognitions Associated With Depression

According to the literature a variety of feelings and cognitions are related to depression (Beck et al., 1979; Weishaar & Beck, 1990; Beck et al., 1991; MacKenzie-Mortensen, 1991).

Mackenzie-Mortensen (1991) found that all of the 10 individuals in her parasuicide group reported that they were angry with someone at the time of their suicide attempt, and

many of these individuals reported being unable to deal with their anger.

According to Endler and Parker (1990) and Folkman and Lazarus (1988), emotion oriented coping involving feelings such as anger or fear are positively correlated with the symptoms of depression and hopelessness. Worthlessness, sadness, loneliness and hopelessness are feelings commonly associated with depression (Beck et al., 1979; Weishaar & Beck, 1990; Beck et al., 1990).

Distorted or irrational thinking is considered to be central to the etiology of depression with affective, motivational and physical symptoms being the consequence of the cognitive distortions. The depressed individual is perceived as holding negative views of herself, the world and the future (Weishaar & Beck, 1990; Beck et al., 1990).

## Life Stressors

Life's problems or stressors can have a profound effect on both men, women and children in today's society. Dunkel-Schetter and Folkman and Lazarus (1987) refer to a stressful encounter or life stressor as a situation that was difficult, troubling, upsetting and took considerable effort to deal with. It could include a range of events such as a confrontation with a significant other, a problem at work, a medical problem, a separation from someone important, or loss through death. For example, the two variables that were most predictive of both

individual and group treatment outcomes, according to Teri and Lewinsohn (1986), were the initial severity level of depression and the number of stressful life events such as a divorce, death or interpersonal conflict. They combined to yield a correlation of .48.

A number of studies also point out the strains associated with social roles and daily living (Coyne, Aldwin & Lazarus, 1981). For example, the strains of marriage, child rearing, time pressure and job performance evaluations can be related to stress (Billings & Moos, 1984).

## Cognitive Appraisals and Attributions

The cognitive theory of psychological stress and coping is transactional in that the person and environment are viewed as being in a dynamic mutually reciprocal relationship (Folkman, Lazarus, Gruen, & Delongis, 1986). Thus, stress is defined as a relationship between the person and the environment, that is appraised by the person as taxing or exceeding his or her resources and an endangering well being. Cognitive appraisal and coping are identified as critical mediators of stressful person-environment relationships and their immediate and long-term outcomes (Lazarus & Folkman, 1984; Folkman et al., 1986).

Nezu, Kalmar, Raman and O'Lanyo (1986) studied the relationship between causal attributions, problem solving and depressive symptoms. A variety of measures such as the Beck Depression Inventory, the Attributional Style Questionnaire and

the Problem Solving Inventory were completed by 128 undergraduate students. A multiple regression analysis indicated that low or ineffective problem solving scores were significant predictors of depression. A correlational coefficient of .61 was found between depression and negative attributions. For example, people who were depressed tended to attribute their depression to personal inadequacies such as lower cognitive abilities.

Locus of Control

According to Rotter (1978), the belief that one can have some control over what happens to oneself is perhaps the most important of all problem solving attitudes. The locus of control construct (Rotter, 1966) can thus be an important factor in examining suicidal behaviors.

The locus of control construct assumes that people develop a general expectancy related to their ability to control their lives. For example, people who believe their own behavior and personality characteristics influence the events that occur in their lives have an expectancy of internal control, while people who believe that the events in their lives are the result of fate, luck, chance, powerful others or powers beyond their control have an expectancy of external control.

It is important to note that internals seem to be more capable of surviving their ordeals because they do not give in as easily to dysphoric feelings and do not give up their

attempts to succeed at various tasks when compared to those who hold external control expectations (Lefcourt, 1983).

Mackenzie-Mortensen (1991) studied the relationship of locus of control (using the Norwicki-Strickland Locus of Control Scale for Children) and problem-solving with a group of adolescents. There was a significant difference between individuals in the parasuicidal group versus those in the control group. Individuals in the parasuicide group had less internal control and felt that the best way to deal with problems was to avoid them.

Goldney, Winefield, Tiggerman, Winefield & Smith (1989) also found a significant relationship between locus of control scores and suicidal ideation in participants of a yearly follow-up survey in Australia. They discovered that individuals who reported a degree of suicide ideation scored in a more external manner, while those who reported no suicide ideation scored in a more internal manner.

Whether people believe that they can determine their own fate is important in the way in which they cope with stress and encounter challenges (Lefcourt, 1982). Schwartz and Johnson's (1985) study found that a lack of control, feelings of powerlessness, rejection and losses can lead people to believe that they are unable to control the events in their life, indicating that an internal locus of control is better for overall psychological adjustment, however, the relationship is more complex. For example, there may be situations in which an

individual with an internal locus of control may feel responsible and experience a great deal of anxiety when the situation is beyond their control, supporting Seligman's (1975) learned helplessness theory.

Learned Helplessness

Theories of depression have been built around the notion of controllability and the individual's cognitive appraisals of life's situations. According to Seligman's (1975) behavioral learned helplessness model, depression is manifested in individuals who perceive themselves as having little or no control over rewards and punishments in their environment. This lack of control is the result of their history, a history of failure, rejection and losses which can lead people to believe that they are unable to control the events in their life (Schwartz & Johnson, 1985). Seligman's theory has been revised (Abramson, Garber & Seligman, 1980) to include components of the attribution theory, which suggests that a depressive attribution style exists. This style postulates that a depressive individual will make an internal stable and global attribution for failure and an external, unstable attribution for success. These internal attributions for failure and depression results from a pessimistic attitude concerning the future and are hypothesized to result in a low self-esteem (Clarizio, 1985). However, depression can also result from environmental circumstances or the situation one finds oneself in. For

example, individuals may find themselves in an environment that actually is beyond their control, they may have suffered sexual abuse, psychological abuse or physical abuse and are powerless to change what happened. Thus, they experience depression even though it's not happening anymore.

Barnett and Gotib (1988) studied married couples in which one partner scored high and the other scored low on depressive symptoms such as hopelessness. Depressed and non-depressed individuals were compared on appraisal, coping, emotion and encounter outcomes. Results indicated that individuals high in depressive symptoms felt they had more at stake in stressful encounters. They used more confrontive coping, self-control and escape-avoidance responses. They also accepted more responsibility for events and responded with more disgust or anger and worry or fear. The overall pattern suggests that individuals high in depressive symptoms were more vulnerable and hostile than those who were low in depressive symptoms, which is consistent with Beck et al. (1979) model of depression. However, the correlational nature of this research must be pointed out. The findings do not indicate cause and effect.

A model of recovery process from depression compatible with the hopelessness theory of depressive onset is proposed by Needles and Abramson (1990). They report that depressives who showed an enhanced attributional style for positive events by making self, global and stable attributes for such events, and who experience more positive events showed dramatic reductions

in hopelessness. This was accompanied by a reduction of depressive symptoms. Thus, a more internal attributional style for positive life events seems to be a factor that enables depressives to recover when positive events occur in their lives. Conversely, attributing negative events to external, situational factors (as opposed to internal, stable factors) would also seem self-enhancing for depressed individuals.

Hopelessness

According to Beck et al. (1979), hopelessness or the feeling that things will never get better plays a critical role in suicide, particularly the sequence of events that leads a person to commit suicide. The person interprets or perceives his or her experiences in a negative way and anticipates dire outcomes to problems. Eventually she or he is drawn to the idea of suicide as a way out of insoluble problems.

Beck, Brown, Berchick, Stewart, and Steer (1990) studied 1,958 psychiatric outpatients examining the relationship between hopelessness and ultimate suicide. They administered the Beck Hopelessness Scale and the Beck Depression Inventory and found that hopelessness as measured by the Beck Hopelessness Scale was significantly related to eventual suicide. The high risk group were 11 times more likely to commit suicide than the rest of the outpatients, and 16 of the 17 individuals identified eventually committed suicide. Thus, hopelessness may be more strongly

related to suicidal intent than depression (Beck et al., 1990; Beck & Weishaar, 1990).

Studies by Linehan and Nielsen (1983) concluded that because self reports of hopelessness are potentially confounded with social desirability caution must be exercised with predictions of suicidal behavior or parasuicide. Strosah, Linehan and Chiles (1984) emphasized the utility of including social desirability assessment in the risk assessment and prediction of suicidal behavior, especially among psychiatric patients and when historical reports of suicidal behavior are involved. However, Strosah et al. (1984) also go on to point out that using only hopelessness, depression, and social desirability assessments in suicide risk prediction produces a dangerously high level of false negative cases in both the general and psychiatric population samples.

## Personal Resources

When discussing the issue of personal resources it is important to note both the internal and external resources of parasuicidal individuals.

Internal resources can be described as positive self-views such as perceiving oneself as back in control, insightful, independent and worthwhile. It can also be described as having positive self-esteem. Branden (1992) defines self-esteem as: "the experience that we are appropriate to life and to the requirements of life. More specifically, self-esteem is: (1)

Confidence in our ability to think and to cope with the basic challenges of life; (2) Confidence in our right to be happy, worthwhile, deserving, entitled to assert our needs and wants, and to enjoy the fruits of our efforts" (p. vii).

External resources or social support, on the other hand, can be defined as consisting of both people and things, for example, friends, family, financial resources and jobs.

Dunkel-Schetter, Folkman, and Lazarus (1987) define social support as advice, tangible assistance or aid, and emotional support provided by other people. They report that the ways people cope with stressful encounters are strongly related to the kinds of support they received (Billings & Moos, 1984; Lazarus, 1984). Also, individuals are more likely to improve from both individual and group treatment for depression if they perceive more support from family members and more social support from friends (Teri & Lewinsohn, 1986).

Billings and Moos (1984) found that the number and frequency of contacts with social supports is important but the strength and quality of support involved in these relationships was more strongly related to depressed patients functioning.

Folkman and Lazarus (1988) discuss research findings which found that the ways in which people cope with stressful encounters were strongly related to the support they received from significant others. Thus, stressful encounters and supports are viewed as a complex interacting process.

Folkman and Lazarus (1986) report that depressed individuals sought more social support than did nondepressed individuals. It appears that depressed individuals display distress and seek support from others in a manner that stimulates more depression. Others provide reassurance and support but then reject and avoid the depressed individual because the depressed person's behavior is aversive to them and this, in turn, increases the depressed individual's uncertainty and insecurity, and the cycle continues.

## Coping Strategies and Problem Solving

According to Wilson (1979):

> Suicide is the ultimate coping mechanism because it rids one of the need to cope further. It is the most blatant, yet most rare, form of self-destructive behavior. Intentional self-injury, on the other hand, is a means of dealing with others when the victim is relatively powerless. (p. 133)

The two major functions of coping are (1) dealing with a problem that is causing distress or problem focused coping, and (2) regulating emotion or emotion focused coping (Folkman et al., 1986). Problem focused forms of coping include more active aggressive interpersonal efforts such as anger to alter the situation, as well as finding out more information about the problem and cool, rational, deliberate efforts to problem solve. Emotion focused forms of coping include more passive efforts

such as distancing, daydreaming about the future, self-controlling (e.g., trying not to feel angry), seeking social support, and escape avoidance. Researchers have shown that individuals use both forms of coping in almost every type of stressful encounter and that both are recommended depending on the situational factors such as the context or issue (Endler & Parker, 1990; Folkman et al., 1986; Folkman and Lazarus, 1986).

Folkman et al. (1986) define coping as "the individual's cognitive and behavioral efforts to manage, reduce, minimize, master or tolerate the internal and external demands of the person-environment transaction, that is appraised as taxing or exceeding to the individual's resources" (p. 572). It consists of the thoughts and behaviors an individual is using to manage the demands of a specific environment transaction that has relevance to his or her well-being.

There is a widely held belief among cognitive researchers that the ways in which people cope with the demands of a stressful event make a difference in how they feel emotionally, especially with regard to depression (Beck et al., 1979; Beck, 1987; Folkman & Lazarus, 1988).

Burns (1990) states the following:

> Highly productive people are more likely to have a coping model of success. They assume that life will be frustrating and that there will be numerous rejections and failures on the road to success. When

> they encounter these obstacles, they simply assume that things are as they should be and persist. They rise to the occasion with renewed determination and commitment. (p. 172)

Fleishman (1984) conducted a study involving a random community sample of 2,299 adults who were interviewed on the issue of stress and coping in everyday life. A questionnaire format was used to measure the following characteristics related to coping: self-denial, mastery, self-esteem, nondisclosure, marital status, sex, education, age and income. The characteristics of self-denial and nondisclosure were found to have the greatest effects on coping. Self-denial predicts the use of selective ignoring and emotion focused coping by increasing passive acceptance. Thus, to some extent the use of selective ignoring may arise from a general tendency to engage in self-denial. In contrast, nondisclosure reduced the use of advice seeking. Findings of this study also suggest that problem focused coping is not a homogenous category and that coping may depend upon whether problems occur in an interpersonal or impersonal context and on whether one prefers to act independently or seek out aid from others.

Folkman and Lazarus (1988) studied coping as a mediator of emotion by evaluating the extent to which coping mediated emotions during stressful encounters in two Caucasian, community samples, ages 35 to 45 and 48 to 68. They assessed the ways in which participants who recently experienced a stressful

encounter coped with the demands of those encounters and the emotions they experienced during those encounters. A structured protocol was used to reconstruct a recently experienced stressful or emotional encounter and the Ways of Coping Questionnaire was used to evaluate eight coping behaviors. All eight forms of coping: confrontative coping, distancing, self-control, seeking social support, accepting responsibility, escape-avoidance, planful problem solving and positive reappraisal, were associated with changes in all four sets of emotions: worried/fearful, disgusted/angry, confident and pleased/happy. While some forms of coping were associated with increases in positive emotion, others were associated with increases in negative emotions. Planful problem solving was associated with an overall improved emotional state. There were significant differences in the effects of coping on emotion between the two age groups. Positive reappraisal was associated with a decrease in negative feeling and an increase in positive feelings in the younger group but with a worsened emotional state in the older group. Confrontative coping was associated with a worsened emotional state for the younger group but showed no association with the emotional state of the older group. In addition, seeking social support was associated with increased positive emotions in the older group but showed no association in the younger group.

Folkman et al. (1986) measured personality factors, primary appraisal, secondary appraisal, eight forms of problem and

emotion focused coping, somatic health status, and psychological symptoms in a sample of 150 community adults. Using a regression model, predictor variables of primary appraisal, secondary appraisal, and coping did not explain a significant amount of the variance in somatic health status but did explain a significant amount of the variance in psychological symptoms, such as depression. For example, low scores on measures of primary appraisal and coping were associated with more depressive symptoms.

Endler and Parker (1990) report depression was found to be uniquely related to parasuicide. Survival coping beliefs or skills such as "I will get through this" were negatively associated with self predicted suicidal behaviors. Females scored higher on both emotion focused and avoidance focused coping than males, and college students who scored high on depressive symptoms also used more emotion focused coping. Beck et al. (1979) theory points to hopelessness as a central factor in the psychopathology of suicide and stress the importance of survival coping beliefs for adolescents.

Nolen-Hoeksema (1991) proposes that in order for people to recover from a depressive episode or cope they must either be distracted from their ruminative thoughts long enough for their depressed mood to be relieved or develop the belief that they can change the situations they perceive as causing their depressed mood.

The most significant correlation between coping and psychological symptoms such as depression and hopelessness was problem focused forms of coping. That is, planful problem-solving was negatively correlated with symptoms, whereas confrontative coping and emotion oriented coping was positively correlated with the symptoms (Endler & Parker, 1990; Folkman and Lazarus, 1988; Folkman et al., 1986).

Coping responses are behaviors which are a function of an individual's response including: (1) his or her appraisal of the event (primary and secondary) and the coping strategy utilized (problem versus emotion focused); (2) the stressors encountered; (3) the context; and, (4) the historical factors such as previous stressors and ways of coping with stressful situations.

## Psychological Interventions

Most conventional intervention therapies of suicidal behaviour employ a crisis management approach, viewing each suicidal episode as an interruption of the normal course of therapy. The suicidal crisis is managed, with subsequent return to other therapeutic issues for the patient. However, this perspective ignores the possibility of fundamental and critical differences between suicidal and nonsuicidal patients, which should be targeted in therapy. Specifically, the suicidal patient's cognitive distortions and problem-solving deficits may

predispose the patient to another suicidal episode (Weishaar & Beck, 1990).

According to the literature (Clarizo, 1985; Hughes, 1988; Beck, 1987), numerous forms of treatment have been provided for parasuicidal individuals, including individual and group therapy, with the most successful being cognitive behavioral therapy (Weishaar & Beck, 1990; Burns, 1990).

Lerner and Clum (1990) studied the effectiveness of social problem-solving therapy for treating suicidal individuals, who were believed to have deficits in problem-solving skills and, more specifically, interpersonal problem-solving skills. The results of a three-month follow-up indicate that problem-solving therapy was more effective than supportive therapy for reducing depression, hopelessness and loneliness but not significantly better at reducing suicidal ideations.

Teri and Lewinsohn (1986) randomly assigned 66 individuals diagnosed as Major or Minor Depressive disorder into an individual or group social learning approach for the treatment of depression. The findings support using a group social learning approach for depression and provide guidelines for identifying people most likely to improve from this approach.

Nezu and Perri (1989) also studied depressed individuals and found problem-solving to be an effective cognitive behavioral treatment approach for depression. Nezu and Perri (1989) emphasize the importance of addressing multiple target areas in depression. They found that focusing on motivational

training, perceptual training, and skills training in treatment was more effective than skills training alone, at least within the context of problem-solving approaches to therapy.

Various cognitive-behavioral techniques have been used with depressed and parasuicidal individuals. According to Hughes (1988), they include social skills training, attributional retraining, cognitive restructuring training, self control training, and relaxation training.

The literature has indicated that there are numerous counsellor characteristics that affect client change within individual counselling (Corey & Corey, 1989; Linehan, 1988; Highlen & Hill, 1984) such as genuine care and concern on the part of the counsellor, active listening, respect, honesty, confidentiality, feedback, and the delegation of responsibility or control. These counsellor characteristics are particularly important when building a rapport or trusting relationship with the client and important to any type of therapeutic intervention.

## Summary

In summary, the literature indicates that suicidal behavior is a response to depression and a coping strategy to extinguish physical and psychological distress.

Parasuicides have a variety of distinguishing characteristics. Some studies have found parasuicides to have deficits in the area of problem solving or cognitive rigidity

(McLeavey et al., 1987; Linehan et al., 1987), while Bartfai et al. (1990) found no significant differences in the area of problem solving. Orbach et al. (1990) found that parasuicides offered more active problem solving but the alternatives are from a restricted range. Linehan et al. (1986) suggest that cognitive rigidity may be situational as opposed to a defining personality trait.

Parasuicide is also examined as a gender issue, occurring more in females who have recently suffered a loss of some kind, such as a divorce, death of a loved one, or a traumatic experience, whereby they feel powerless (Herman, 1977; Wilson, 1979; Cove, 1987). It is also considered a gender issue from the perspective of gender socialization and societal expectations and reinforcement of male and female behaviors (Greenspan, 1983).

Depression, specifically the associated cognitions and feelings were reviewed, along with its relationship to suicide (Scholz & Pfeffer, 1987). Feelings and cognitions associated with depression were reviewed (Weishaar & Beck, 1990; Beck et al., 1979; Burns, 1991; Endler & Parker, 1990; Mackenzie-Mortensen, 1991; Folkman & Lazarus; Beck et al., 1991).

Cognitive appraisals (Lazarus & Folkman, 1984; Fleishman, 1984; Folkman et al., 1986), attributions (Nezu et al., 1986), expectancy or locus of control (Rotter, 1966, 1978; Lefcourt, 1983) and feelings of hopelessness (Beck et al., 1990; Barnett & Gotib, 1988), were discussed in relation to depression.

Although the exact nature of these relationships is unknown, they appear to be part of the complex nature of depression and parasuicide.

Stressful encounters or life stressors (Dunkel-Schetter et al., 1987; Perlin & Johnson, 1977; Coyne et al., 1981; Billings & Moos, 1984) indicate that normal daily encounters, such as child rearing and marriage, can be stressful, as well as specific life events, such as a confrontation with a significant other or loss through death and considered precipitating factors to attempted suicide.

Personal resources, both internal and external, and their influence upon the individual were discussed throughout the literature review. Internal refers to one's self-esteem and positive self-views (Branden, 1992) and external refers to social supports (Folkman & Lazarus, 1986, 1987, 1988; Lazarus, 1984; Billings & Moos, 1984).

Coping and problem solving strategies such as seeking social support, planful problem solving, distancing and confrontative coping (Burns, 1991; Beck & Rush, 1979; Fleishman, 1984, 1989; Folkman & Lazarus, 1988; Folkman et al., 1986; Endler & Parker, 1990) are reviewed as well. The importance of a variety of situations appropriate self aware, active, problems focused strategies is highlighted.

Finally, the topic of possible psychological interventions is also addressed (Hughes, 1988; Russell & Rayter, 1989; Weishaar & Beck, 1990; Lerner & Clum, 1990; Nezu & Perri, 1989).

Psychological interventions include crisis management, social problem solving therapy and cognitive behavioral techniques. It is clear that present emphasis is on cognitive approaches, but again further empirical support is required in supporting this method as a general approach, as well as to illuminate the specific processes involved in the therapeutic process.

The importance and value of counsellor characteristics, such as respect, genuine concern, and feedback, to rapport building (Corey & Corey, 1989; Highlen & Hill, 1984; Linehan, 1988) is addressed under this section, as well.

Based on the review of the literature, it is evident that there are many unanswered questions concerning parasuicide. In particular, virtually no information exists which examines the self-perceptions of parasuicides which is the objective of this study.

# CHAPTER 3

# METHODOLOGY

## Nature of the Study

The Waterford Hospital is the provincial psychiatric treatment facility for Newfoundland and Labrador, with a unique history dating back to 1855. Today, the Waterford Hospital is a 380-bed facility with an outpatient service. The participants for this study were obtained from the outpatient service at the Waterford Hospital. Dr. Alladin contacted outpatients, who met the criteria for the study, by telephone and asked them if they would be interested in participating in the study.

A semi-structured interview focusing on coping strategies was designed and conducted with ten outpatients at the Waterford Hospital. It is a qualitative client-centered study which focuses on the perceptions of coping of individuals who have attempted suicide.

## Sample

For the purpose of this study, a small sample procedure was employed. Such an approach is considered appropriate for studies in which in-depth interviews, projective measures and other such time-consuming measures are employed (Borg & Gall, 1989). In this study, the investigator undertook to identify the self-reported coping strategies of individuals with a history of major depression associated with suicide attempt.

Interviews were conducted by the investigator with 10 individuals, both male and female, ages 20 to 60.

The nature and size of the sample was based on a number of considerations. There was an attempt to refine the sample by setting forth a set of criteria as described below. Included here was an identifiable clinical group of age of consent. Further, given the topics of study, it was considered important that they not be actively suicidal or depressed at the time of the interview. A sample size of 10 was deemed sufficient to represent this group for comparative purposes and for highlighting individual differences.

In selecting a sample for this study the investigator requested Dr. Assen Alladin, Senior Psychologist at the Waterford Hospital, to select outpatients who met the following criteria:

1. Have been clinically diagnosed at the Waterford Hospital as depressed within the past three years according to the DSM-III-R (Axis 1) protocol. The diagnostic criteria for major depressive symptoms are provided in Appendix D.
2. Are 20 years of age or older.
3. Voluntarily agree to participate in this study.
4. Have attempted suicide at least once within the past three years.
5. Have not been clinically depressed for three months, which means that the diagnostic criteria for major depressive symptoms were not present within the last three months.

Individuals who met these criteria are referred to as participant or participants. In order to obtain this sample, the intern approached two psychologists and one psychiatrist and they examined their medical records. The psychologists and psychiatrist were provided with the interview protocol prior to contacting the participants. A total of 17 clients who met the criteria, clinically depressed with a suicide attempt were identified and listed. This list was generated based on a review of case files and there was no particular ordering of the list. The first 10 who were contacted by Dr. Alladin (psychologist) agreed to participate in the study.

The participants included seven females and three males, between the ages of 20 and 60. Nine of the participants ranged in age between 20 and 40, while only one was in the higher age range being 60. These individuals had a history of major depression and had been clinically diagnosed by a psychologist or psychiatrist as depressed within the past three years according to the DSM III (Axis I) protocol. All participants who were selected to participate in this study had attempted suicide at least once within the past three years and were not clinically depressed for at least three months. Two of the participants were divorced, three were separated (two reported being separated for therapeutic reasons), and four were single. Four of the participants were currently on medication for their depression. Six of the 10 participants were currently employed full time: two were professionals in their fields, having

secondary training; three were working in service jobs without formal training; and one was engaged in semi-professional work. One was employed part-time in a service activity job with no formal training. Three were not employed, one was a post-secondary student and two were currently receiving social assistance.

## Procedures

The intern sent a letter of introduction describing the study to Dr. Assen Alladin, a senior psychologist, two weeks prior to the commencement of the interviewing (see Appendix E). Dr. Alladin made the initial contact with individuals who met the sampling criteria by telephone and provided the names of those who were willing to participate in this study. These names were submitted to the researcher. Finally, an informed consent procedure was followed with each individual who agreed to participate in the study and anonymity was assured. Prior to the interviewing it was established that any information regarding suicidal ideation obtained during the interview would be forwarded to the appropriate psychologist. However, on no occasion was it necessary to do so.

Dr. Alladin adhered to the following procedure for obtaining the sample collection:

1. Dr. Alladin will obtain a list of possible participants who meet the criteria from his present caseload and those discharged. These possible participants will be contacted

by Dr. Alladin by telephone. The names of individuals who are interested in participating will be given to Ms. Avery. Ms. Avery will provide them with consent forms, together with the interviewers' guidelines for informed consent (see Appendix E).

2. If the number of participants required for the study is not met by the above procedure, Dr. Alladin will request the help of his colleagues from the Psychology Department and the above procedure will be followed.
3. If the number of participants required for this sample is still not met, Dr. Alladin will seek assistance from the Chiefs of Services (Psychiatrists) and the same introductory and consent format will be used.

## Instrumentation

A semi-structured interview was developed to examine the coping strategies of the participants. The study is a qualitative approach, one which identifies the participants' perceptions of their coping strategies, in a manner which reflects personal and contextual characteristics, such as the individual's feelings, thoughts and coping types of strategies, the situational variables, as well as knowledge of services and perceptions of these services.

Yin (1984) refers to the qualitative method as the preferred mode of research when "how" or "why" questions are being posed, when the researcher has little control over events,

and when the focus is on a current day phenomenon within a real life context. The goal of the researcher with this type of research is to expand and generalize theories.

A semi-structured interview was designed based on a review of the literature and in consultation with Dr. Anita Russell and Dr. Assen Alladin. The development of this interview protocol was informed by the interviewing design advocated by Haan (1982) and Borg and Gall (1989). A sequence of open-ended questions were asked and depending on the individual's response, further questions were used to probe aspects of the individual's experience, to prompt fuller elaboration, and to encourage individuals to fully explore their understanding of their coping strategies.

Based on a review of the literature, the semi-structured interview appears to be the most appropriate instrument for use in this study because of its effectiveness in gathering subjective information, such as people's perceptions and attitudes (Borg & Gall, 1989).

The semi-structured interview has the advantage of being reasonably objective, while still permitting a more thorough understanding of the respondents' opinions and the reasons behind them than would be possible using a questionnaire. It provides a desirable combination of objectivity and depth and often permits gathering valuable data that could not be successfully obtained by any other approach (Borg & Gall, 1989).

The major objective of the study was to examine self-reported coping strategies. Specifically, the areas of focus were how individuals cope with suicidal thoughts and feelings; the events which trigger suicidal thoughts and feelings; and, to determine a time perspective of past, present, and future coping. A secondary objective was to determine perceptions of assistance received from friends, relatives, and helping professionals (see Appendix F for the Semi-Structured Interview Questions).

## Protection of Human Subjects

In order to ensure that all appropriate ethical protocols were followed, this proposal was submitted to the Ethics Committee at Memorial University and the Research Review Committee at the Waterford Hospital for approval (see Appendix G).

After Dr. Alladin made the initial contact, the researcher arranged a time to meet with the potential participants to begin the informed consent process. This informed consent process included reviewing the interviewer's guidelines for informed consent (Appendix E) and the semi-structured interview questions (Appendix F). If the participants wished to proceed with the interview, a signed consent form was obtained and the semi-structured interview conducted.

If the participant chose to participate at a later date, signing of the consent form was postponed until immediately

prior to participation. In these cases, the consent form was reviewed again with the participant at the time of the interview.

Consent forms and the audiotaped interview were stored in a locked filing cabinet at the Waterford Hospital and destroyed when the interviews were transcribed. The interviews were administered at the Waterford Hospital.

The potential negative effects of this study was the possibility that the interview may evoke negative reactions which the individual may then have difficulty resolving. It was determined prior to the interviews that if the participant became upset and wished to discontinue, the interview would be terminated. Further, if the interview triggered any suicidal thoughts or feelings, he or she was to be provided with counselling by psychologists at the Waterford Hospital. However, this did not occur during any of the interviews.

# CHAPTER 4

# ANALYSIS AND RESULTS

## Analysis Procedure

The data for this research was collected through a semi-structured interview. The interview questions were compiled by the researcher, Dr. Anita Russell and Dr. Assen Alladin (Appendix F). The questions were then approved by both the Ethics Committee at Memorial University and the Research Review Committee at the Waterford Hospital. All interviews were audio recorded and transcribed for purposes of analysis.

As this study is of a qualitative nature, the analysis will identify theories, commonalities, and similarities between individuals. The goal is to illuminate various common perceptions but also to retain the uniqueness of the data.

A variety of themes were identified such as personal control issues, the importance of personal resources, coping strategies and hopes for the future. Also, many participants reported similar self-descriptions, suicide attempts, feelings and life stressors.

The semi-structured interview was analyzed question by question identifying both commonalities and variations which are discussed below. Based on these findings the researcher returned to the literature to find support for themes which evolved from the interview data but were not previously identified. These themes include the high prevalence of sexual abuse in parasuicides and their views of life and death.

## Results

The overall response to the interview was very favourable. The participants were willing to share their experiences and personal stories with the researcher. One participant said, "Today I feel pretty good because I'm talking to you about it but I live with the fear of how I'll feel tomorrow." This participant's uncertainty was also reflected in her response when asked "What are your hopes for the future?" She expressed her frustration saying "I'm getting a little bit frustrated. I guess I'd go on and do the same as I've been doing taking it day by day, but it scares me." Upon termination of the interview each person thanked the researcher and commented on how they hoped they could help someone else by telling their story and talking about how they learned to cope with their suicidal thoughts.

This chapter will discuss the analysis of the interview data focusing on coping strategies and a number of personological and situational variables. It is recognized that the use of pseudonyms would have provided more personalized descriptions and allowed for greater ability to link the participant's personal experiences. However, in order to ensure the anonymity and hence confidentiality of the participants, this option was not chosen.

## Self-Descriptions

When asked "How would you describe yourself?", some of the participants found it a little challenging saying things like "That's a hard one," or "I don't know." However, they did describe themselves in both positive and negative ways. Positive self-descriptions included insightful, outgoing, respectful, sensitive, soft hearted, caring, easy to get along with, happy-go-lucky, honest, having good communication skills, good at handling stress and understanding. For example, participant number five said, "I'd describe myself as more insightful into things that happened in the past" and participant number three said, "I am very independent, sensitive to other people's needs, respectful of others and very outgoing." They also described themselves negatively in a variety of ways, such as: unhappy, ugly, lonely, seeing no future and finding it hard to cope with everyday life. For example, participant number two said, "Right now I am a very unhappy person. I find it very hard to cope with everyday lifc, little things, nothing means anything to me."

Throughout the remainder of the interview every participant described themselves both positively and negatively in the following ways: more in control and independent, optimistic, guilty, important, being controlled by others, having flat affect, and crying a lot.

## Suicide Attempts

Prescott and Highly (1985) and McLeavey et al. (1987) found that the most common form of parasuicide is self poisoning. Nine of the 10 participants involved in this study reported overdosing in an attempt to commit suicide, thus supporting research findings. Other forms of attempted suicide reported by this study's participants include: hanging, drinking, ingesting liquid paper, going to sleep in the snow, and self injuries such as knife wounds.

Two participants recalled and described their suicide attempts in explicit detail. Their descriptions included methods, places, sequence of events, feelings and the aftermath. For example, one participant described his suicide attempt as follows: "I was working, it was my day off and I went to buy a gun but they wouldn't sell it to me because you had to have a licence to buy it so I got my prescription of drugs and 100 Tylenol tablets and drove to an isolated area and took the works and sat there. It seemed like a long time before they started to work and when they did I felt like I was gonna throw up so I opened the door and fell out. There were some people nearby who came over and saw the pill bottles and got me an ambulance. I was on life support system and in a coma for three days."

Another participant described her suicide attempt as follows: "My husband was at work and besides that I called him and told him I was going out with some friends, which was a normal thing. So I covered all these bases, so I could carry

out what I had to do. I had all kinds of pills, about 500, and I took them. The bottom line was two or three hours later, my husband was at work and felt something wasn't right. He knew the stress I was under and was already afraid to leave me alone for a long period of time. So he called up my friend looking for me and they said they hadn't seen me. He called home and there was no answer so he came home and I was barely breathing. I was connected to a respirator and he was told I would be brain dead if I did come out of the coma."

One participant described in detail the careful planning that went into the suicide attempt. It was a well thought out deliberate action as are many suicide attempts. Participant number two also expressed carefully planning her suicide attempt, "The last attempt I made I fooled my whole family and doctors by telling them I was fine."

Only one of the 10 participants described the suicide attempt as impulsive rather than planned. He acted on the thought of suicide without thinking about or planning it carefully.

## Feelings

The participants described a variety of feelings related to depression at the time of the suicide attempt, strengthening the research findings of Beck et al. (1979), Beck et al. (1990) and McLeavey et al. (1987). They described themselves as lonely, hurt, confused, depressed, betrayed, sad and as suffering a lot

of mental anguish over episodes of sexual abuse, physical abuse and emotional abuse. It is important to note that no direct question was asked pertaining to abuse during the interview. However, participants spontaneously revealed detailed information pertaining to the abuse they experienced and how it related to their suicide attempt. Every participant in this study suffered some form of self-reported abuse, particularly sexual abuse. Sullivan, Everstine and Everstine (1989) discuss the relationship between sexual abuse and suicide, alerting therapists that during the initial crisis discovery phase of incest, every family member is at a considerable suicide risk.

Brieve and Runty (1986) report that suicide attempts were more common among former sexually abused victims (54.9%) than among non sexually abused clients (22.6%). These findings indicate that there is more self-destructiveness among former sexually abused victims.

The findings from the present study suggest, contrary to cognitive therapy and more in tune with the feminists' view, that it is the events, such as being sexually abused, that are important factors contributing to a suicide attempt and not faulty or irrational thinking. A variety of societal issues are implicated here. For example, addressing issues of powerlessness for groups such as children, adolescents and women. This, specifically, points to the need for interventions at a societal level for the perpetrators, the family members, and modifications to the women's role, rather than only at an

individual level for the victim. Seven of the eight participants who voluntarily reported sexual abuse were women.

Provided below are comments of individual participants with reference to the abuse they experienced:

> One participant said, "We're talking about physical abuse, emotional, sexual, mental, everything. There is nothing that can be added. Even at four years old I knew what it was like to be sexually abused and I had knife wounds, scars from physical abuse." Another said, "I felt like nobody believed me (talking about sexual abuse). It was almost like my whole world was falling apart and no one cared how I was feeling." A third said, "There was so much going through my head that the suicide thoughts just came." A fourth said, "I felt sad and hurt. I was taking the pills to make it all go away." A fifth said, "I felt good because it was gonna be all over. I felt like no one loved me and I wasn't worthwhile. There's nothing left to life, I've lived my life, it's over." A seventh said, "Most of my thoughts were about the abuse I encountered and my parents abandoning me. I felt a lot of hopelessness. I wouldn't feel loved, wanted, accepted or a sense of belonging." An eighth said, "I felt like I was never going to be any kind of success and the people closest to me would be better off without me." A ninth said, "I didn't think I

could cope with life and I didn't want to cope with life at that particular time. I figured everyone was against me and betraying me. I figured I had no purpose in life. I knew something was wrong but I didn't know what it was (referring to sexual abuse) and I couldn't feel close to anybody." Also associated were feelings of anger. "I'd feel angry and frustrated anxious and depressed. I'd get down on myself and start thinking I'm a loser and nobody cares. I've got to do something before something happens to me again. So then I'd take it in my own hands and do something before anyone else can." These angry and frustrated feelings seemed to precipitate an attempt at suicide, as a last desperate effort to gain control.

Feelings of anger were expressed more generally as well. "Sometimes I feel so angry because I can't control what is going on in my life." These feelings of anger were common at the time of the suicide attempt, as well as after the attempt.

Participants also described feelings of not being loved, respected or cared for. One participant said, "One of the biggest things I found was there was no love." Another said, "My family just don't show love and I think that's what I needed most last year when I was suicidal."

## Life Stressors

Participants in this study viewed a variety of different situations as stressful, supporting the literature (Petti & Larson, 1987). For example, reported stressful situations included: not being believed by others, anniversary dates, past traumatic experiences, and loneliness. When asked "What types of situations or events do you find most stressful?", the following responses were given: "When I tell people what's wrong with me and they don't believe me." "Certain times of the year and holidays which are anniversaries of something that happened to me." "Changes, any kind of change is stressful for me at first." "Dealing with things in my past and loneliness." "I miss a personal relationship." "Being alone at the end of a work day."

However, two participants did not report viewing any situation as stressful since their suicide attempt. One participant said, "Nothing stresses me out anymore, it's like you have no feelings. You're not in the world. You're looking at yourself from somewhere detached and it frightens you, but when I was younger everything upset me." While another said, "Every little thing upset me before my suicide attempt ... I don't know what upsets me now."

When hypothetically questioned about what kinds of situations could possibly trigger suicidal thoughts, the majority of participants said personal or family problems, which is consistent with recent research as described in the

literature review (Nezu & Perri, 1989; Lerner & Clum, 1990), claiming that most attempted suicides are resulting from personal problems. However, two participants said it would have to be a combination of personal and financial problems, thus supporting the importance of individual interpretations, regarding what is stressful and what is not.

## Personal Control Issue

Comments of participants pertaining to the issue of personal control strongly supports the literature (MacKenzie-Mortensen, 1991; Goldney et al., 1980), indicating that individuals who have attempted suicide perceived themselves as having no control at the time of the attempt.

One participant said, "Everyday it seemed like I was locked up in a place where I had no control over anything and I couldn't find a way out. A lot of times my opinion didn't mean a thing and I had no say and was considered an idiot in the household. Another participant said, "Then I seen it as he (the rapist) winning again because he had control over what I did.... It was beyond my control."

Seven of the 10 participants in this study also expressed a decreased ability to generate new ideas or solutions supporting the literature described earlier on decreased problem solving skills (Bartfai, Wimborg, Nordstorm & Asberg, 1990). One participant said, "That's another part of my problem, I can't think about things like that, I haven't got the ability to

do that." Another said: "At that time I couldn't do anything to change it. I wasn't strong enough." Two of the participants expressed negative internal attributions. They attributed their lack of control and/or inability to generate new ideas or solutions to personal inadequacies. They felt they were not strong enough or did not have the ability to do so. In other words, sense of personal efficacy was low or non-existent.

After the suicide attempt and treatment, participants reported greater independence, and more control. One participant said, "I'm taking responsibility for my own thoughts now." Another said, "Now I feel that I'm in control and I can do wnat I want before they were in control. I had no control at all and that was the only way out." A third said, "I have much, much more control now."

In summary, if a person feels that he/she is unable to control his/her environment, it has an effect on the options perceived as available. On the other hand, if he/she does not feel he/she has much control over a situation intentional self-injury may be a method of controlling interpersonal relations because it is a way powerless people can exercise power by demanding that others change the situation (Wilson, 1979).

## Personal Resources

When questioning the participants about their resources it is important to note both their internal and external resources, as referred to in the literature (Folkman & Lazarus, 1986, 1988;

Branden, 1992; Lazarus, 1984). At the time of their attempted suicide, nine of the 10 participants reported that social supports (other than one's spouse or partner) or personal resources were badly needed but difficult to find, coinciding with the literature review Folkman and Lazarus (1988). One participant said, "My friends weren't there for me when I became depressed they walked away, but when I was physically sick I had lots of friends. This hurts and you can become depressed over it."

Other participants avoided their friends or did not want them to know, supporting the literature described earlier (Hammen, 1991). This is typified by comments such as: "I kept them out. I only let my friends get so close; that was one of my coping mechanisms," or "No, they didn't really know because I pushed them away. I wouldn't tell them because I told other people and got negative feedback from them and I didn't want my friends to be cold, too. I wanted them to accept me for the way I was without knowing my past."

Four of the 10 participants felt their social supports were there for them after the attempt, supporting the literature described earlier (Billings & Moos, 1984; Dunkel-Schetten, Folkman & Lazarus, 1981). One participant said, "My friend was there to hold my hand, hug me and talk to me."

When asked "Did you see your relatives as supportive?" (relatives here refer to family members other than one's spouse or partner), seven of the 10 participants reported that they

were not supportive at all. One said, "No, I don't have anything to do with my relatives. Another stated, "No, a lot of my relatives didn't want to admit I was sick because if they admitted I was sick they'd look at themselves as being failures." The remaining three felt that their relatives were supportive and made the following statements:

One participant said,

> "My daughter and husband were there for me, they called a lot when I was upset to check up on me and could tell by my voice how I am and often took me out for a drive. But sometimes I'd get angry and want them to go."

A second participant said,

> "My father was supportive. I could always go to him and he would give me suggestions of what I could or should do in that situation. This made me feel better but I couldn't do anything to change it I wasn't strong enough." The latter part of the statement is a common internal negative stable attribute of suicide attempters as found in both the study and the literature. These types of attributions result in a lack of efficacy which then leads to inefficient and ineffective problem-solving strategies.

Four of the six participants who were married at the time of the attempt felt their spouse or partner was supportive. One

said, "He was supportive. He told me all the good things I was doing, how much I meant to him and encouraged me but this made me feel angry. It was like he was taking away what I was feeling and I had a right to feel that way." The importance of validating one's feelings is alluded to here. The spouse is trying to be supportive but at the same time is not addressing the participant's feelings. The participant wanted her feelings accepted and validated, no matter how bad they were, but this was not accomplished.

Another said, "Yes, very supportive but it was hard for him; there were times he couldn't understand where I was coming from. He was willing to help but it was limited. He'd offer to go somewhere and leave the choice to me. If I didn't want to do anything he'd say O.K., let's talk, what do you need right now? and if I needed to get help elsewhere he was supportive. This made me feel like I was getting back control and there were times in my life when I lost control. By giving me the freedom to make choices, it gave me the control and independence I so badly needed." The importance of choice and having control is again brought out in this statement. Choices are very important for maintaining an individual's autonomy or independence and especially important for individuals who are suicidal, supporting research described earlier (Weishaar & Beck, 1990; Burns, 1990).

When questioned about the ideal support from friends, relatives and partners, offering nonjudgemental understanding

was the consensus. For example, one participant said, "To be there and talk to me like a counsellor or psychologist could, to try and understand me without passing judgement." Another said, "Being there, listening to you and validating your feelings, not overreacting or underreacting ..., taking it seriously, being a little more observant and questioning any comments made about suicide, even if made jokingly." A third said, "To be there, give a listening ear, have an open mind and not be judgemental. To have some understanding of what I'm about and accept me." A fourth said, "To have believed me, accepted what happened and empathized with me." A fifth said, "To spend time with me trying to make me feel important, that I'm not alone and I'm worth saving. To show they cared ... and accept that I have a problem. The ideas of being observant, questioning, nonjudgemental, listening, accepting, believing, caring, empathizing, encouraging self-worth and validating one's feelings emerge as the ideal support one could provide for suicidal individuals.

Nine of the 10 participants felt that if they ever had suicidal thoughts again they would talk to someone. Talking to someone seems to be the key to extinguishing or at least controlling the suicidal thoughts. One participant said, "No one takes into consideration that all you need is a friend to listen, to be there and it would take away those thoughts. Regardless of what I said, I would have liked them (my relatives) to say, 'No, we're going up with you, we want to be

there for you', then I would have realized they really cared!" I always believed if I pushed people away they wouldn't get hurt the way I did and all people wanted to do was be there for me but I said, No, go to hell, I don't want you, but in actual fact I wanted them to say you're not gonna push me away, I'm gonna stay here and listen, but I never had anyone do that. My best friend, who I tried to push away and hit one day said, 'You can hit me all you want, you can beat me up but I'm not going anywhere', and that's what I needed from the start."

Seven participants participating in this study report perceiving themselves as having low self-esteem and define self-esteem as feeling unloved and helpless or hopeless regarding control over one's future, supporting the literature (Beck et al., 1979; Beck et al., 1990). For example, "I have a low self-esteem. I feel angry at myself. I feel you've come through enough, you know enough that you shouldn't be feeling like this and I think gee, maybe I'll never get better. If this is gonna be a lifelong process with you maybe you should end it. I feel like I'm losing my independence, losing my control." Another participant, "Back then I looked anorexic but no one ever said, 'Yes, you're ugly', but it was like my self-esteem had gotten really low." A third one said, "I felt like I wasn't worthwhile or loved."

## The Cycle

When questioned about the signals or cycle leading up to suicidal thoughts, nine of the 10 participants identified signals such as feeling tired, crying a lot, having religious thoughts, isolating themselves, difficulties with sleeping and eating and anniversary dates, supporting the literature (Beck, 1987; Petti & Larson, 1987).

One participant said, "I get tired and have a lot of religious thoughts." Another said, "I lose my appetite." A third said, "I don't want to be around others. I stare at nothing for hours, my mind races with unrelated thoughts, I become agitated and irritated and my sleep pattern changes." A fourth said, "I cry a lot and think about them (referring to suicidal thoughts)."

## Coping Strategies and Problem Solving

Coping information was obtained from a number of interview questions designed to define it, such as: "How would you describe yourself as coping now; by coping I mean dealing with things or handling situations?" Coping, then, refers to one's ability to do things and handle everyday life, and any of the problems or stressors that accompany daily existence. To these participants, coping is viewed as a major uphill battle, and it involves having some control over one's life. This is typified as follows by individual participants: "For a year now I've had to push, work and fight to be able to do things, otherwise I'm

depressed." "When I was feeling depressed and suicidal I had no insight into the things that might have caused it. Things that were going on at home mostly and the problems I was having myself, not being able to deal with them. All the pain I was going through I couldn't take it anymore." "It's not been easy but I've learned to put my past behind me and I've learned to cope."

The term "learning to cope" seems to refer to the participant taking control of the situation and doing something about it such as talking to a friend or counsellor, or doing something. Talking it out seems to be the key for nine of the 10 participants. One participant said, "I don't cope well because I don't talk about it and if I did I'd probably be less angry and frustrated than I am today," which supports Fleishman's (1984) findings that self-denial and nondisclosure had the greatest negative effects on coping.

I. Action Oriented

When questioned about their coping strategies for handling suicidal thoughts, participants reported that they do something, such as work, listen to music, pound a pillow, take a bath, or go for a walk, thus reinforcing the behavioral theoretical approach to working with parasuicidal individuals which links behaviors, thoughts and feelings to the principal of positive reinforcement (Clarizio, 1985). One participant said, "I bury myself in my school books or sports. My methods of coping are pretty good, I think; they are like slamming a volleyball

whereas before I'd smack the wall or hit someone or something which is not O.K." Other participants reported that, "Another way is I work a lot, put in more hours at work and release it that way." "A lot of times when I'm really depressed, I will do something simple like listen to soft music and that would relax me, it won't always control the suicidal thoughts but it will get me thinking about something pleasant. A lot of times I will just go and fill up the bathtub and relax." "It's very hard, I sometimes get down and want to die but I do something ... when I do a good day's work I forget everything, I get involved in what I'm doing." "Sunday nights for some reason are the most difficult time for me, so what I have to do is plan and go out, even though I'd rather stay home and curl up in the corner," supporting the distracting coping mechanism mentioned in the literature review (Nolen-Haeksema, 1991) and its effectiveness. One participant said, "Sometimes you want to kick a door down, kick a wall or smash something, then I get a pillow and pound on that."

Writing also seems to be a successful coping mechanism as described by the following participants: "I finally got to the point where I had to do something and writing was what really helped me. Writing is an excellent coping mechanism for me, writing poems and in a journal. There are times in my writing I will write about death and how beautiful death would be compared to life, but I don't think it stays in my thoughts because I'm expressing it on paper and it's O.K. on the paper,

it's not draining or risky." "I'd probably isolate myself and do a lot of writing. If I'm down and out I do a lot of poetry and I find that once I write and leave it alone, depending on the state I'm in I can come back and read it and laugh, and say to myself, I can't believe I wrote that." "There's another way I come out of it, I write a suicide note and that really makes me sad and I cry. I then realize what it would do to my family and I can't do that to them."

One participant commented on the effectiveness and value of contracting with a therapist, "That evening we contracted and that was the first concept of contracting I'd ever heard of. It was never done with me. I hate contracting because I have this big thing with promises and I had to promise to stay alive, but it's very useful and we were two hours trying to get a contract and that was the longest he'd ever had," supporting suggestions provided in the literature (Russell & Rayter, 1989).

II. Cognitive Strategies

Cognitive strategies of coping described by the participants in this study focus mainly on self-talk and problem solving, supporting the literature on the effectiveness of cognitive therapy with parasuicidal individuals (Beck et al., 1979, 1987; Beck et al., 1990; Weishaar & Beck, 1990). Problem solving can involve self-talk or talking to another individual about your problems or feelings. Comments made by participants include the following: "I talk to myself exploring alternatives to the situation, because it gets me back in control." "I do a

lot of self-analysis, self-talk but if the feelings get really strong I call my counsellor to talk." "I talk to myself and others to solve the problem." "I talk to myself and use the term, 'I'm going away' because that term has a meaning to me. "I talk a lot. I'm in three groups, OA, NA and NA and always get a second opinion before I make a decision."

## Views of Life and Death

The participants' view of life and death were not directly questioned. However, half of the participants spontaneously offered their views on death during the interview. Two of the participants seemed to perceive death as a peaceful, tranquil state where they will be with God. Other participants also described death as positive. "I was thinking it would be so nice not to have to cope with anything. I would be at peace, wouldn't be in torment anymore. It's actually a lovely feeling in a relaxed state of tranquillity and I thought I had it until she shook me." "I was feeling very happy because all my problems were finally gonna be over, it was a nice day and I was happy, I knew that no one would be able to stop me. I was feeling religious and I was thinking I was gonna be with God." Two participants simply viewed death as having to be better than the life they were living. "I was just thinking basically, that whatever came after death wouldn't be as bad as life." "I had come to a point in my life where I thought the hell I was going to was no worse than the hell I was living," supporting the life

and death attraction/repulsion as described by Orbach (1988). Five of the participants in this study did not make a reference to what their view of death was, they just saw it as their only way out of a stressful, painful situation.

Psychological nihilism refers to the erosion of meaningful existence which fosters cynicism, pessimism and fatalism (Mitchell, 1986). Many suicidal individuals feel that life is not worth living, it has no meaning or purpose for them. They are in an emotional state of boredom, and have an absence of enthusiasm. Mitchell (1986) uses the term psychogenic nihilism in describing adolescent psychological states which seems to be consistent with those of individuals who have attempted suicide.

Participant comments support the theory of psychological nihilism as a characteristic of suicidal individuals. "I wouldn't feel loved, wanted, accepted or a sense of belonging." "I would feel sorry for myself, not very worthwhile or loved." "My opinion didn't mean anything and I had no say." "I felt like I wasn't worthwhile or loved, I'm no longer needed, that's what I felt like. I have no purpose." These comments indicate that the participants felt unworthy, useless and unloved. Life was no longer meaningful for them. As humans, we need to get some kind of satisfaction out of life and the participants of this study did not perceive themselves as getting any satisfaction out of life, life was meaningless for them, supporting the existentialism viewpoint which focuses on the subjective experiencing and emphasizes individual meaning of

existence and purpose in life. Jean Paul Sarte, perhaps the best known literary existentialist, believed human existence has no meaning at all other than what the individual decides to make himself or herself. From this perspective, each person has the freedom and responsibility to choose what is important, his or her purpose in life, and hence define existence.

Orbach (1988) talks about exploring the attractiveness and repulsiveness of life and death and, as you can see, many of the participants in this study talked about how attractive death is to them. Life is so painful for them that death becomes very attractive. This kind of thinking makes the alternative of death more acceptable and serves as a coping mechanism against fear and pain.

However, the participants also showed their repulsion and ambivalence about death, when they were making their suicide attempt, as indicated by the following statements: "I woke up on my own and phoned on my own ... and seeing all the blood scared the hell out of me ...." "The third time I stabbed myself three times in the stomach and lay down. I decided then to go to the hospital. I got scared and drove to the hospital."

The participants seemed to be drawn to suicide because of the attractiveness of death, the peacefulness, relaxation and tranquillity, which they thought accompanied it. Also, they desperately wanted to get rid of the pains they were experiencing. However, there was also some repulsion towards

death and ambivalence about whether or not they really wanted to die.

## Hopes for the Future

Hopes referred to by the participants include getting a job, helping others and continuing to talk about their problems. When questioned about their hopes for the future, all participants expressed optimistic or positive hopes for the future. They all seemed to be feeling better about the future, while at the same time realizing that they will encounter problems and stressors but must cope with them to the best of their ability, supporting the literature (Burns, 1990; Folkman & Lazarus, 1988). One participant said, "I hope I'd find a job I liked and get an apartment." Another said, "I'm optimistic about the future but I know there's gonna be some problems, too." While still another said, "I see myself working in this area because I've been the lowest you can go and I want to help others." This participant also said how for once she realized life could be good. Another said, "I feel the sky is the limit as long as I keep talking about my problems."

However, three of the 10 participants expressed a little apprehension or fear about the future. They do not want to have suicidal thoughts any more and the thought of having them is scary. Two comments made were: "I hope I'd continue to improve the way I'm going now. Take it as it comes, day by day, but

it's scary and hard to fight." "I hope I never get these thoughts again and if I do I can talk about them."

They want to get over having suicidal thoughts or at least be able to cope with them when they do have them and lead the happy life they perceive everyone else to be leading.

## Interventions

When asked "How can counsellors build a rapport with suicidal individuals?", the participants involved in this study had some recommendations which support the literature (Corey & Corey, 1989). These include the following comments and views: (1) "They have to stick to their word, they are being watched by the suicidal person"; (2) "Not walk out when the times are tough"; (3) "Allowing you to be you, not masking your feelings for the counsellor"; (4) The availability of the counsellor; (5) Confidentiality; (6) "Provide reflections of where you are now in your counsellor's eyes"; (7) Honesty; (8) Sincerity; and (9) Genuineness.

One participant said, "They can listen, talk to them, make them feel comfortable and relaxed, give them time and don't judge them or tell them what to do." Again, the issue of control is referred to by the participants when discussing rapport building. The importance of allowing suicidal clients to maintain control over their situation seems to be necessary in order to build a positive rapport between client and counsellor and a prerequisite for client improvement. Linehan

(1988) feels that the best way to establish a positive working relationship is to offer behavioral change strategies that are efficient and effective in meeting the client's goals in therapy.

Another participant said, "Not getting into things too quickly, giving the person time to open up, and if a person comes into your office angry let them be angry. I think there are too many counsellors, psychologists and psychiatrists out there who are afraid to let people express their feelings. By validating what they are feeling in a safe and healthy environment it's showing the person I'm allowed to feel this way but I don't have to go out and beat something up or be destructive. I can feel whatever I'm feeling and express it in healthy ways." A different participant said, "Making me feel important ... giving me control over the counselling sessions. We stop when I want to ... not being separated by a desk and being on the same level."

Group therapy, along with individual therapy, was highly rated by the participants of this study. When asked "Do you think that suicidal individuals should be involved in therapy with other suicidal individuals in a group format? Why or why not?", participants responded in a manner supporting literature on the effectiveness of group therapy (Teri & Lewisohn, 1986). One participant said, "I want someone who you know can understand what I'm talking about. I will keep on talking and I feel safe around people who I know have gone through it. They

are not gonna judge me. I don't know where I'd be today if I didn't have people in my groups I could relate to." Another said, "Knowing how other individuals got through it, finding out their coping mechanisms and circumstances may help you. It's a bond that's there, just knowing that you're not the only individual that felt that way."

However, according to the participants, there are both advantages and disadvantages to group therapy. The advantages reported by the participants include the following:

1. Individuals can relate to each other.
2. It could help prevent people from attempting suicide.
3. It could be a form of support to suicidal individuals.
4. It reduces feelings of loneliness and isolation.
5. It provides options or alternative coping mechanisms to suicidal individuals.
6. It provides an avenue for talking out your problems.

The disadvantages reported by the participants include the following:

1. Suicidal individuals could get ideas for attempting suicide from others.
2. The group may trigger others to be suicidal by discussing a particular issue or experience, even if they weren't on that particular day.
3. It can be depressing or upsetting.

The participants also noted three recommendations when using group therapy with suicidal individuals: (1) The group

discussions must be completely confidential; (2) All group members must be at the same level of therapy and group therapy should occur later in therapy, after some individual one-on-one therapy; (3) Group therapy should also be conducted with the families of suicidal individuals to help them cope, coinciding with the concept underlying Alanon.

The results from the participants involved in this study support the use of cognitive therapeutic techniques such as self-talk, but they stated that cognitive therapy, they thought, is longer than other psychotherapies.

Individual one-on-one therapy was the preferred mode of treatment by all participants. However, eight of the 10 participants felt that group therapy was good in conjunction with individual therapy and later on in treatment.

Medication was not a preferred mode of treatment. In fact, it was negatively perceived in the eyes of nine of the 10 participants. Two participant comments were: "I'm wary of medications, it hasn't done for me what I've seen it do for some people." "The side effects of medications (anti-depressants) made me worse. They made me feel shaky, spaced out, I couldn't think clearly, and felt hungover in the morning." The overall consensus was that medications were good in the crisis period to keep the client alive but they did not have any long-term positive effects. The depression returned in time and the medication did not help. According to the participants, medications could lead to addictions as well. However, four of

the 10 participants were on medication during this period and felt that it was helping them, although it was not the preferred mode of treatment.

When questioned about the medical help they should have received, most participants said less drugs and more talking and even hospitalization or constant supervision. Two of the participants strongly believed they needed hospitalization, again referring back to the issue of control. These individuals perceived themselves as so out of control that they required someone to take over in this crisis situation. For example, comments made included the following: "There were times I should have been hospitalized and I wasn't, I was told to go home and sleep it off. I also received a lot of medications that I shouldn't have; I realize now what one was doing the other was counteracting. It wasn't safe to be on them. I was on 15 different drugs a day; that in itself could have caused suicide." "I think I should have been put somewhere where I could have been watched all the time."

When asked "What kind of counselling do you think you should have received?," nine of the 10 participants identified the kind of long term counselling they are getting now. They said, "(1) The kind I'm getting now, they recognize my needs and that it's gonna take a while for me to trust; (2) There were no expectations, except I was to stay alive to see the result; (3) Genuine concern and caring; (4) The availability of them when I needed them; (5) Not backing out on their work. They've been

there, stuck by me and presented me with options when I couldn't make them myself; and (6) Not taking control away from me."

However, another participant identified the kind of crisis counselling required immediately after the suicide attempt, "I needed someone to talk to, to see daily, to help me identify my feelings. I needed constant attention, constant counselling to sort out my feelings and confusion."

Participants involved in this study also made some very practical recommendations for counsellors when building rapport with suicidal individuals. These recommendations included the following:

1. Remember that everyone is different and may require different treatments, thus flexibility and open mindedness is very important.
2. Being nonjudgemental at all times.
3. Obtaining feedback from your client. For example, the counsellor could say, "I think we are here, where are you now?"
4. Setting goals and providing guidance in planning action oriented steps to get there.
5. Providing feedback to your client. Participant number one said, "It's important to know what the counsellor thinks because they have such low self-esteem and want to be liked or know the counsellor's opinion of them."
6. Asking the clients what kind of treatment they think they would like or benefit from, giving them some control.

7. Remember you are there to help the clients look out for themselves and not look out for them totally. Don't take the control and responsibility away from them; if you do they will feel inferior and go back to feeling suicidal.

   One participant said, "When I was seeing her, she used to say 'I think I'm gonna get your parents in to talk about that,' and I'd say 'no you're not,' and she'd say, 'Yes, I think I am,' and I used to feel so frustrated, I'd leave that building feeling like I was gonna jump off .... Instead of you telling them, let them tell you; if you don't agree, tell them and give them some alternatives, lots of choices. If you give them lots of choices it will help."

8. Don't automatically treat them with medications because it's playing right into their suicide option, or can lead to addictions. Drugs only bury the feelings by numbing the person, and should only be used as a last resort. Counsellors need to let the clients express their feelings, validate them and work through them.

9. Provide lots of time to allow the clients to open up. Don't rush them or they will alienate you.

10. Provide lots of support, encouragement and guidance. Be a caring friend, as well as a professional.

# CHAPTER 5

# SUMMARY AND RECOMMENDATIONS

## Discussion and Conclusions

One of the objectives of this study was to gather information on how depressed individuals who have attempted suicide learned to cope, because the coping skills employed seem to be the critical variable in examining stressful events among suicide attempters (Spirito, Overholser & Stork, 1989).

The interview protocols were analyzed in Chapter Four on a number of concepts and themes identified in the literature and others which emerged from the data. These focused on coping strategies and a variety of personological and situational variables.

This concluding chapter includes a section on the uniqueness of participants, the researcher's personal reflections, therapeutic recommendations, limitations of the study, and suggestions for future research.

## Summary of Results

In summary, it is important to note several points pertaining to the results of the data analysis, such as the internal attributions of participants, the self-esteem issue, the cycle leading up to a suicide attempt, the importance of talking, and the issue of values.

One participant spontaneously reported not being strong enough to do anything to change his situation. It seems that

this negative internal stable attribution is a common characteristic of parasuicidal individuals, contributing to their suicidal behavior and attempt. As noted earlier, these attributions reduce personal efficacy which reduces the ability to generate and implement alternate solutions.

The issue of personal control is a very important issue for these participants. They want to control their lives but felt unable to do so. At the time of the suicide attempt they report being out of control.

At first glance, this seems contradictory. That is, they say control is very important and should not be taken away from them by others, yet three of the participants said they needed to be hospitalized because they were so out of control and so needed someone to take control. However, a situational issue is evident here whereby a distinction is being made between the type of therapy required at the time of the suicide attempt or crisis versus the type of long term therapy required.

Choice, trust and sticking to one's word seemed to be two very important concepts that kept coming up. Participants felt that counsellors, friends or family members who stuck to their word, trusted or believed them, and provided them with a choice, letting them have some control over the situation, are what is needed for parasuicidal individuals.

According to the participants, it seems that their self-esteem and confidence is so low that if someone makes all the decisions for them, taking away their right to make choices, it

will reaffirm their self-defeating beliefs. These beliefs including being no good and unable to do anything, not even being able to make a decision or choice on their own. Thus, being supportive means guiding them by providing alternatives and suggestions for making decisions and choices. This will help them gain some independence and control over their lives.

All participants describe themselves in both positive and negative terms. In general, the kind of positive characteristics they described are human qualities generally related to effective interpersonal functioning, for example, caring, respectful, honest, and easy to get along with. A variety of feelings such as loneliness and depression were described related to a suicide attempt and episodes of abuse, particularly sexual abuse, which were spontaneously reported. Significant here is the support for looking outside the individual to societal and situational factors, as the feminist, sociological, and ecological theories suggest, rather than only within the individual. This perspective which involves externalizing the cause (attribution) would be self-enhancing.

There appears to be a definite pattern or cycle leading up to a suicide attempt, which, as counsellors, we should be aware of and look for in individuals whom we suspect may be suicidal. This pattern or cycle includes signals such as crying a lot, isolating oneself and difficulties with sleeping or eating. These are the symptoms characteristic of depressive disorders.

It is important to assist clients in identifying these symptoms as early as possible.

All participants seem to think that talking is the key. Talking to others allows problems to be analyzed from a more objective point of view. It also externalizes the problem enabling the person to separate himself or herself from the problems and go on with everyday life.

The issue of values is particularly important when deciding if a situation is stressful or not. The individuality of determining the stressfulness of a situation is highlighted. For example, some participants report that personal situations are most stressful, while others report that a combination of personal and financial problems are stressful.

Another point worthy of mention is that nine of the 10 participants report self-poisoning as the method used in their suicide attempt.

Personal resources such as social supports, especially friends and family, seem to be the most popular and effective resource. As a matter of fact, nine of the 10 participants felt they would talk to someone if they ever had suicidal thoughts again.

Another interesting observation is that contrary to our research on group therapy, these individuals believe that talking in group therapy may give others ideas on how to commit suicide, depending on how far along the others are in treatment.

Uniqueness was evident among the participants of this study. For example, most participants report having carefully planned their suicide attempt so they would not be discovered, but one said it was an impulsive act.

Most participants report coping mechanisms such as self talk, talking to others (a friend, counsellor or family member), writing poetry or a journal, and keeping active by doing something such as exercise or work. However, one reported writing suicide notes as a coping mechanism.

The interviews identified a variety of the similarities and differences among the participants of the study. Although there were similar patterns and issues, each individual story had its own variations in emphasis, intensity and depth. Within the commonalities identified, there was the individual's personal story of struggle. This uniqueness and individuality was, in fact, a major theme identified by the participants. All of them wanted their uniqueness recognized as they struggled within themselves to define this individuality in their living. At some points within this struggle, they contemplated dying.

## Personal Reflections

In reflecting upon this study, I feel it was a very worthwhile study, yielding a great deal of valuable information about coping and the perceptions of individuals who have attempted suicide. I believe it has enhanced my understanding of counselling individuals with depression and suicidal

histories. It has also provided me with a valuable experience of interviewing individuals about the sensitive topic of attempted suicide.

According to Fivush (1991), personal stories or talking about the past is "an important social and self defining activity that begins early in development and continues throughout life" (p. 59). Talking serves as an evaluation or reflection on the past, thus contributing to our sense of ourselves, telling us how we feel about our past, what those experiences mean to us, and how they relate to our future.

Based on my reflections of the interviews conducted, I believe it is very important for people, and especially those experiencing difficulties, to tell their stories, to relate how their stories change over time, to describe the importance they attach to past events or problems, and articulate how they see themselves in the future. This externalization seems to be very important for recovery.

Prior to and during the first two interviews, I felt very anxious about conducting this type of interview. I did not know how the participants would respond to the personal questions I was asking and I was very concerned about their reactions. I worried about whether or not the questions would trigger suicidal thoughts again.

However, after completing the first two interviews I felt much more at ease with the whole interviewing procedure. I realized the participants' willingness to talk and was greatly

relieved by this. I also believe that talking was very therapeutic because it permitted each one to express his/her unique story.

Upon reflection on the interviews I recognized a key point to consider when counselling individuals who are depressed and have attempted suicide. I realized that they needed more time than is usually allotted in counselling, to open up to a counsellor and truly benefit from therapy.

## Therapeutic Recommendations

This researcher believes that the following therapeutic recommendations will greatly assist parasuicidal individuals in learning how to cope after a suicide attempt.

1. Therapy should focus on strengthening active self-enhancing strategies for coping with interpersonal problems. Teaching parasuicides active problem solving skills might be useful in preventing other parasuicides. Part of this would be assisting clients in identifying and detailing the cycle of suicidal thoughts and feelings in order that they might take steps to intervene earlier.
2. Another goal of the therapeutic relationship should be to strengthen the client's self-esteem and feelings of self-worth. One way in which this can be done is by providing specific behavioral feedback which gives a positive evaluation (Russell, 1984).

3. Hopelessness is an important clue that should alert counsellors to immediate or long-term suicide potential, and should be assessed. Assisting clients in developing and elaborating positive images of themselves in the future, followed by specific intermediate steps toward attaining these images will build a renewed sense of hope.
4. Clients must be provided with choices during therapy. They need to take some responsibility for their actions and obtain a sense of control over their lives. Thus, counsellors should provide alternatives or choices to clients when they cannot see these alternatives themselves, but the client must make the choice between alternatives.
5. The counsellor, friend, parent, or spouse must be able to communicate genuine care and concern for the parasuicidal individual. Given that this is so essential and that providing this support is in itself very taxing, family members and friends also need a supportive network. The utility of support groups should be further explored.
6. Individual one-on-one therapy is needed initially, and many cognitive and behavioral therapeutic techniques are quite effective at this time. However, later in treatment, group therapy can also be effective for certain individuals.
7. Having an eclectic theoretical orientation provides flexibility when working with clients. As counsellors we can share different therapeutic perspectives in tailoring treatment for depressed parasuicidal individuals. The

importance of incorporating feminist models of therapy is highlighted in this work. The contributing situational factors are important, not only the individual's predispositions and the individual cognitive/emotional responses to the situations.

## Limitations of the Study

Due to the ethical considerations and the low base rate of parasuicide, prospective studies and experimental designs in this area are nearly impossible (Linehan et al., 1987). Thus, the methods used to investigate this area are often susceptible to specific weaknesses. The following areas need to be considered when interpreting the results:

1. The data was collected after the crisis situation had occurred. Thus the accuracy of the data is dependent upon the ability of the individuals to recall the details associated with the crisis event and with their willingness to report this data. This is the central limitation of almost all research on this population. Factors such as cognitive dissonance (Weishaar & Beck, 1990) and social desirability (Linehan & Neilson, 1983; Strosahl et al., 1984) are also recognized as potential threats to the data.
2. The method of research utilized is vulnerable to subjective interpretations by the researcher, although objectivity was aimed at during the data collection and analysis. Thus,

there was detailed documentation of the data and analysis procedures.

3. The small size of the sample and sampling procedure make it difficult to generalize the results of the study to the population in question.
4. Due to the retrospective nature of the data and our inability to rule out the effects of unassessed situational characteristics, caution must be exercised in generalizing these findings.

## Suggestions for Future Research

Bagley and Ramsay (1985) outlined 20 research priorities and MacKenzie-Mortensen (1990) outlined 11 research priorities, which will not be reiterated here, but are greatly needed in the area of suicidology and would facilitate other research endeavours. The present results concur with a number of those priorities. In particular, the need for studies on the teaching of problem solving skills to parasuicides and research focusing on help seeking and support. Further, when conducting research it is important to collect adequate statistics on all forms of suicidal behavior because without that information it would be next to impossible to evaluate the outcome of any prevention activities.

An important contribution of the present study is that it employed a clearly defined homogeneous suicide population. Future work is needed to determine the usefulness of this

approach from both theoretical and practical perspectives. Recommendations for future research are as follows:

1. Research focusing on the comparison of different populations of suicidal individuals, perhaps with different psychiatric diagnoses should be carried out to help identify the role of specific cognitions in precipitating a suicide event.
2. A control group of nonsuicidal depressed individuals should be included in research studies to help identify cognitions common only to suicidal individuals.
3. The series of cognitions before, throughout and after an attempted suicide is an important topic of research, having important clinical implications.
4. Measurement should include a variety of techniques such as questionnaires, interviews, and rating scales.
5. Experimental studies should be launched into the effectiveness of a treatment program in interpersonal problem solving as an intervention strategy for individuals who have attempted suicide.
6. Coping and stress research should focus on identifying stable versus situational styles of appraising and coping. As a result, the links between appraisal, coping and outcomes should then become clearer.
7. Conditions that provide appropriate and effective support to suicidal individuals should be studied. These conditions should then be distinguished from those that are

characterized by a lack of support or the presence of negative reactions on the part of others. Further, conditions for providing support to family members and significant others should also be studied.

8. Further investigations regarding whether or not cognitive rigidity is a personality characteristic of parasuicides should be conducted. This would require a longitudinal study to examine the length of time cognitive rigidity is present following an attempted suicide. This would also require doing follow-up studies for a long period of time after the suicide attempt in order to monitor cognitive strategies.
9. The effectiveness of group therapy should also be further studied, as well as what point in time it should be utilized.
10. Future research should address the issue of the influence of the social context to individual outcomes. In psychology this area of research has been largely ignored, as problems have been viewed as residing almost exclusively within the individual.

**REFERENCES**

Abramson, L.Y., Garber, J., & Seligman, M.E.P. (1980). Learned helplessness in humans: An attribution analysis. In J. Garber and M.E.P. Seligman (Eds.), Human helplessness: Theory and application (pp. 3-34). New York: Academic Press.

Arffa, S. (1983). Cognition and suicide: A methodological review. Suicide and Life-Threatening Behavior, 13(2), 109-121.

Asarnow, J.R., Carlson, G.A., & Guthrie, D. (1987). Coping strategies, self perceptions, hopelessness and perceived family environments in depressed and suicidal children. Journal of Counseling and Clinical Psychology, 55(3), 361-366.

Asimos, C.T. (1979). Dynamic problem solving in a group for suicidal persons. International Journal of Group Psychotherapy, 24(3), 109-114.

Bagley, C., & Ramsey, R. (1985). Disrupted childhood and vulnerability to sexual assault: Long term sequels with implications for counselling. Paper presented at the Conference on Counselling the Sexual Abuse Survivor. Winnipeg, Canada.

Baker, A.L., & Wilson, P.H. (1985). Cognitive-behavior therapy for depression: The effects of booster sessions on relapse. Behavior Therapy, 16, 335-345.

Barnett, P.A., & Gotlib, I.H. (1988). Psychosocial functioning and depression: Distinguishing among antecedents, concomitants and consequences. Psychological Bulletin, 104, 97-126.

Bartfai, A., Winborg, A., Nordstrom, & Asberg. (1990). Suicidal behavior and cognitive flexibility: Design and verbal fluency after attempted suicide. Suicide and Life Threatening Behavior, 20(4), 254-267.

Beck, A.T. (1967). Depression: Clinical, experimental and theoretical aspects. New York: Harper & Row.

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

Beck, A.T. (1987). Cognitive models of depression. Journal of Cognitive Psychotherapy, 1, 5-37.

Beck, A.T., Brown, G., Berchick, R.J., Stewart, B.L., & Steer, R.A. (1990). Relationship between hopelessness and ultimate suicide: A replication with psychiatric outpatients. The American Journal of Psychiatry, 147(2), 190-195.

Bergin, A.E., & Lambert, M.J. (1986). The evaluation of therapeutic outcomes. In Garfield and Bergin (Eds.), Handbook of Psychotherapy and Behavior Change (pp. 139-180). New York: Wiley.

Billings, A.G., & Moos, R.H. (1984). Coping, stress and social resources among adults with unipolar depression. Journal of Personality and Social Psychology, 46(4), 877-891.

Borg, W.R., & Gall, M.D. (1989). Educational Research: An introduction (5th ed.). New York: Longman.

Bourque, L.B., Kraus, J.F., & Cosand, B.J. (1983). Attributes of suicide in females. Suicide and Life Threatening Behavior, 13(2), 123-137.

Branden, N. (1992). The power of self esteem. Florida: Health Communications.

Brauns, M.T., & Berzewski, H. (1988). Follow-up study of patients with attempted suicide. The International Journal of Social Psychiatry, 34(4), 285-291.

Breed, W. (1972). Five components of a basic suicide syndrome. Suicide and Life Threatening Behavior, 2(1), 3-18.

Briere, J., & Runtz, M. (1985). Symptomatology associated with prior sexual abuse in a non-clinical sample. Paper presented at an annual meeting of the American Psychological Association, Los Angeles, CA.

Brooks, P.R., Morgen, G.S., & Scherer, R.F. (1990). Sex role orientation and type of stressful situation: Effects on coping behaviors. Journal of Social Behavior and Personality, 5(6), 627-639.

Burns, D. (1990). The feeling good handbook. London: Penguin Books.

Clarizio, H.F. (1985). Cognitive behavioral treatment of childhood depression. Psychology in the School, 22, 308-322.

Cole, D.A. (1989). Psychopathology of adolescent suicide: Hopelessness, coping beliefs and depression. Journal of Abnormal Psychology, 98(3), 248-255.

Corey, M.S., & Corey, G. (1989). Becoming a helper. Pacific Grove, CA: Brooks/Cole.

Coyne, J.C., Aldwin, C., & Lazarus, R.S. (1981). Depression and coping in stressful episodes. Journal of Abnormal Psychology, 90, 439-447.

Diagnostic and Statistical Manual of Mental Disorders (3rd ed. - Revised) (DSM-III-R). (1987). Washington, DC: American Psychiatric Association.

Dunkel-Schetter, C., Folkman, S., & Lazarus, R. (1987). Correlates of social support receipt. Journal of Personality and Social Psychology, 53(1), 71-80.

Ellis, T.E., & Ratliff, K.C. (1986). Cognitive characteristics of suicidal and nonsuicidal psychiatric inpatients. Cognitive Therapy and Research, 10, 625-634.

Emery, G., Bedrosian, R., & Garber, J. (1983). Cognitive therapy with depressed children and adolescents. In D.P. Cantwell and G.A. Carlson (Eds.), Affective disorders in childhood and adolescence (pp. 445-447). New York: Spectrum.

Endler, N.S., & Parker, J.D.A. (1990). State and trait anxiety, depression and coping styles. Australian Journal of Psychology, 42(2), 207-220.

Fiske, S.T., & Taylor, S.E. (1984). Social cognition. London: Addison-Wesley.

Fivush, R. (1991). The social construction of personal narratives. Merrill-Palmer Quarterly, 37(1), 59-82.

Fleishman, J.A. (1984). Personality characteristics and coping patterns. Journal of Health and Social Behavior, 25, 229-244.

Folkman, S., & Lazarus, R.S. (1980). An analysis of coping in a middle-aged community sample. Journal of Health and Social Behavior, 21, 219-239.

Folkman, S., & Lazarus, R. (1986). Stress processes and depressive symptomatology. Journal of Abnormal Psychology, 95(2), 107-113.

Folkman, S., & Lazarus, R. (1988). Coping as a mediator of emotion. Journal of Personality and Social Psychology, 54(3), 466-475.

Folkman, S., Lazarus, R.S., Gwen, R.J., & DeLongis, A. (1986). Appraisal, coping, health status and psychological symptoms. Journal of Personality and Social Psychology, 50(3), 571-579.

Frank, E., Kupfer, D., Wagner, E., McEachran, A., & Carnes, C. (1991). Efficacy of interpersonal psychotherapy as a maintenance treatment of recurrent depression. Archives of General Psychiatry, 48, 1053-1058.

Gallagher-Thompson, D., Hanley-Peterson, P., & Thompson, L.W. (1990). Maintenance of gains versus relapse following brief psychotherapy for depression. Journal of Consulting and Clinical Psychology, 58(3), 371-374.

Garfunkel, B.D., Froese, A., & Hood, J. (1982). Suicide attempts in children and adolescents. American Journal of Psychiatry, 139, 1257-1261.

Gibson, R.T., & Mitchell, R.E. (1990). Introduction to counselling and guidance (3rd ed.). New York: MacMillian.

Glaser, K. (1981). Psychopathologic patterns in depressed adolescents. American Journal of Psychotherapy, 35, 368-382.

Goldacre, M., & Hawthoren, D. (1985). Repetition of self poisoning and subsequent death in adolescents who take overdoses. British Journal of Psychiatry, 146, 395-398.

Goldney, R.D. (1980). Attempted suicide: An ethological perspective. Suicide and Life-Threatening Behavior, 10(3), 131-140.

Goldney, R.D., Winefield, A.H., Tiggemann, M., Winefield, H.R., & Smith, S. (1989). Suicidal ideation in a young adult population. Acta. Psychiatr. Scand., 79, 481-489.

Greenspan, M. (1983). A new approach to women and therapy. New York: McGraw-Hill.

Guttman, H.A. (1983). Family therapy in the treatment of mood disturbance in adolescence. In H. Golomber and B.D. Garfunkel (Eds.), The adolescent and mood disturbance (pp. 263-272). New York: International Universities Press.

Hackel, J., & Asimos, C.T. (1980). Resistances encountered in starting a group therapy program for suicide attempters in varied administrative settings. Suicide and Life-Threatening Behavior, 10(2), 100-106.

Hammen, C. (1991). Generation of stress in the course of unipolar depression. Journal of Abnormal Psychology, 100(4), 555-561.

Hann, N. (1982). The assessment of coping, defence and stress. In Goldberger, L. and Breznitz, S. (Eds.), Handbook of stress theoretical and clinical aspects. New York: The Free Press.

Health and Welfare Canada. (1989). Suicide in Canada. Report of the National Task Force on Suicide in Canada. Ottawa, Ontario.

Herman, S.J. (1977). Women, divorce and suicide. Journal of Divorce, 1, 107-117.

Highlen, P.S., & Hill, C.E. (1984). Factors affecting client change in individual counselling: Current status and theoretical speculations. In Brown, S.D., & Lent, R.W. (Eds.), Handbook of counselling psychology (pp. 334-387). New York: John Wiley & Sons.

Hughes, J.N. (1988). Cognitive behavior therapy with children in schools. New York: Pergamon Press.

Hutton, D. (1990). Annual Report of Provincial Pathologist, St. John's, Newfoundland.

Imber, S.D., & Enarczuk, K.J. (1990). Brief crisis therapy groups. In Wells, R.A., & Giannetti, V.J. (Eds.), Handbook of the Brief Psychotherapies (pp. 565-581). New York: Plenum Press.

Imber, S.D., Pilkonis, P.A., Sotsky, S.M., Watkins, J.T., Shea, T.M., Elkin, I., Collins, J.F., Leber, W.R., & Glass, D.R. (1990). Mode specific effects among three treatments for depression. Journal of Consulting and Clinical Psychology, 58(3), 352-359.

Karaser, T.B. (1990). Toward a clinical model of psychotherapy for depression, II: An integrative and selective treatment approach. American Journal of Psychiatry, 147(3), 269-277.

Lambert, M.J., Hatch, D.R., Kingston, M.D., & Edwards, B.C. (1986). Zung, Beck and Hamilton's rating scales as

measures of treatment outcome: A meta analytic comparison. Journal of Consulting and Clinical Psychology, 54, 54-59.

Lazarus, R.S., & Folkman, S. (1984). Stress, appraisal and coping. New York: Springer.

Lefcourt, H.M. (1983). The locus of control as a moderator variable: Stress. In H.M. Lefcourt (Ed.), Research with the locus of control construct: Developments and social problems (Vol. 2, pp. 253-268). New York: Academic Press.

Lerner, M.S., & Clum, G.A. (1990). Treatment of suicide ideators: A problem solving approach. Behavior Therapy, 21, 403-411.

Lewinsohn, P.M. (1983). Clinical geropsychology. New directions in assessment and treatment. New York: Pergamon Press.

Linehan, M. (1988). Perspectives on the interpersonal relationship in behavior therapy. Journal of Integrative and Electic Psychotherapy, 7(3). Washington: Brunner/ Mazel.

Linehan, M., & Laffaw, J. (1982). Suicidal behaviors among clients at an outpatient psychology clinic versus the general population. Suicide and Life-Threatening Behavior, 12(4), 234-239.

Linehan, M., & Nielsen, S. (1983). Social desirability: Its relevance to the measurement of hopelessness and suicidal behavior. Journal of Consulting and Clinical Psychology, 51(1), 141-143.

Linehan, M., Camper, P., Chiles, J., Strosahl, K., & Shearin, E. (1987). Interpersonal, problem solving and parasuicide. Cognitive Therapy and Research, 11(1), 1-12.

Linehan, M., Chiles, J., Egan, K., Devine, R., & Laffaw, J. (1986). Presenting problems of parasuicides versus suicide ideators and nonsuicidal psychiatric patients. Journal of Consulting and Clinical Psychology, 54(6), 880-881.

Linehan, M., Goodstein, J., Nielsen, S., & Chiles, J. (1983). Reasons for staying alive when you are thinking of killing yourself: The reasons for living inventory. Journal of Consulting and Clinical Psychology, 51(2), 276-286.

McLeavey, B.C., Daly, R.J., Murray, C.M., O'Riordan, J., & Taylor, M. (1987). Interpersonal problem solving in self poisoning patients. Suicide and Life-Threatening Behavior, 17(1), 18-33.

Mackenzie-Mortensen, P. (1990). The development of a social information-processing model for examining adolescent parasuicide. Unpublished Doctoral Thesis, Department of Educational Psychology, Edmonton, Alberta.

Miller, I.W., Norman, W.H., Keitner, G.I., Bishop, S.B., & Dow, M.G. (1989). Cognitive behavioral treatment of depressed inpatients. Behavior Therapy, 20, 25-47.

Mitchell, J.J. (1986). The nature of adolescence. Calgary, AB: Detselig.

Morrison, J.T. (1987). Youth suicide: An intervention strategy. Social Work, 32(6), 536-537.

Needles, J.D., & Abramson, L.Y. (1990). Positive life events, attributional style, and hopefulness: Testing a model of recovery from depression. Journal of Abnormal Psychology, 99(2), 156-165.

Nezu, A.M., Kalmar, K., Roman, G., & O'Lanyo, A. (1986). Attributional correlates of depression: An interactional model including problem solving. Behavior Therapy, 17, 50-56.

Nezu, A.M., & Perri, M.G. (1989). Social problem solving therapy for unipolar depression: An initial dismantling investigation. Journal of Consulting and Clinical Psychology, 57(3), 408-413.

Nolen-Hoeksema, S. (1991). Responses to depression and their effects on the duration of depressive episodes. Journal of Abnormal Psychology, 100(4), 569-582.

Norem, J., & Cantor, N. (1990). Cognitive strategies, coping and perceptions of competence. In Sternberg, R., & Kolligian, J., Competence considered (pp. 190-204). New York: Yale University Press.

Orbach, I. (1988). Children who don't want to live. San Francisco, CA: Jossey-Bass Publishers.

Orbach, I., Bar-Joseph, K., & Dior, N. (1990). Styles of problem solving in suicidal individuals. Suicide and Life-Threatening Behavior, 20(1), 56-64.

Patsiokas, A., Clum, G., & Lucombe, R. (1979). Cognitive characteristics of suicide attempters. Journal of Consulting and Clinical Psychology, 47, 478-484.

Pattison, E.M., & Kahan, J. (1983). The deliberate self harm syndrome. American Journal of Psychiatry, 140, 867-872.

Pearlin, L.I., & Schooler, C. (1977). The structure of coping. Journal of Health and Social Behavior, 19, 2-21.

Perrah, M., & Wichman, H. (1987). Cognitive rigidity in suicide attempters. Suicide and Life-Threatening Behavior, 17(3), 251-255.

Petti, T.A., & Larson, C.N. (1987). Handbook of adolescent psychology. New York: Pergamon Press.

Prescott, L.T., & Highly, M.S. (1985). Drugs prescribed for self poisoners. British Medical Journal, 290, 1633-1636.

Ramsey, R.R., Tanney, B.L., Tierney, R.J., & Lang, W.A. (1988). A suicide prevention training program: Trainers' handbook (3rd ed.). Calgary, Alberta.

Rosenblatt, A., & Greenberg, J. (1991). Examining the world of the depressed: Do depressed people prefer others who are depressed. Journal of Personality and Social Psychology, 60(4), 620-629.

Rossman, P.G. (1982). Psychotherapeutic approaches with depressed, acting out adolescents. Interpretative tactics with their rationale. Adolescent Psychiatry, 10, 455-468.

Rotter, J.B. (1966). Generalized expectancies for internal versus external control of reinforcement. Psychological Monographs, 80, 1-28.

Rotter, J.B. (1978). Generalized expectancies for problem solving and psychotherapy. Cognitive Therapy and Research, 2, 1-10.

Russell, A., & Rayter, K. (1989). Suicide. Winnipeg, Manitoba: Peguis.

Russell, M.M. (1984). Skills in counselling women: The feminist approach. Springfield, IL: Charles C. Thomas.

Sanborn, C.J. (1990). Gender socialization and suicide: American Association of Suicidology Presidential Address. Suicide and Life-Threatening Behavior, 20(2), 148-156.

Sargeant, K., Bruce, M., Floria, T.I, & Weissman, M. (1990). Factors associated with 1-year outcome of major depression in the community. Archives of General Psychiatry, 47, 519-525.

Schaefer, C., Coyne, J.C., & Lazarus, R.S. (1981). The health related functions of social support. Journal of Behavioral Medicine, 4, 381-406.

Scholz, O.B., & Pfeffer, M. (1987). On the relationship between depression, coping behavior and suicide crisis, Crisis, 8(2), 138-150.

Schwatz, S., & Johnson, J. (1985). Psychopathology of childhood. New York: Pergamon.

Spirito, A., Overholser, J., & Stark, L. (1989). Common problem and coping strategies II: Findings with adolescent suicide attempter. Journal of Abnormal Child Psychology, 17(2), 213-221.

Strosahl, K.D., Linehan, M.M., & Chiles, J.A. (1984). Will the real social desirability please stand up? Hopelessness, depression, social desirability and the prediction of suicidal behavior. Journal of Consulting and Clinical Psychology, 52(3), 449-457.

Sullivan-Everstine, D., & Everstine, L. (1989). Sexual trauma in children and adolescents: Dynamics and treatment. New York: Brunner/Mazel.

Teri, L., & Lewinsohn, P.M. (1986). Individual and group treatment of unipolar depression: Comparison of treatment outcome and identification of predictors of successful treatment outcome. Behavior Therapy, 17, 215-228.

Walsh, M.R., & Cove, W.R. (1987). The psychology of women: Ongoing debates. New York: Yale University Press.

Waterford Hospital. (1991-1992). Administrative manual: Annual report. St. John's, NF.

Weishaar, M.E., & Beck, A.T. (1990). Cognitive approaches to understanding and treating suicidal behavior. In Blumenthal, S., & Kupfer, D. (Eds.), Suicide over the life cycle (pp. 469-499). Washington, DC: American Psychiatric Press.

Wellman, M.M., & Wellman, R.J. (1986). Sex differences in peer responsiveness to suicide ideators. Suicide and Life-Threatening Behavior, 161(3), 360-378.

Wilson, M. (1979). Suicidal behavior: Toward an explanation of differences in female and male rates. Suicide and Life Threatening Behavior, 11(3), 131-139.

Yin, K.Y. (1984). Case study research: Design and methods. Beverly Hills, CA: Sage.

# Appendix A

## Annotated Bibliography

## ANNOTATED BIBLIOGRAPHY

Abramouritz, I.A., & Coursey, R.D. (1989). Impact of an educational support group on family participants who take care of their schizophrenic relatives. Journal of Consulting and Clinical Psychology, 57(2), 232-236.

This study describes an educational support group offering family caretakers information about schizophrenia, training in problem solving skills for managing patient behavior and greater access to social and community resources. The results indicate that the caretakers in the educational support groups reported reduced anxiety and personal distress and more active coping behaviors.

Arffa, S. (1983). Cognition and suicide: A methodological review. Suicide and Lif Threatening Behavior, 13(2), 109-121.

This article reviews the literature associated with studies that measure various cognitive properties in suicidal patients. It employs the categories of suicidal logic, cognitive style, social cognition and cognitive control. The issues discussed also include sample characteristics, operational definitions of suicidal behaviors, the use of appropriate control groups and the nature of assessment.

Bartfai, A., Winborg, A., Nordstrom, & Asberg. (1990). Suicidal behavior and cognitive flexibility: Design and verbal

fluency after attempted suicide. Suicide and Life Threatening Behavior, 20(4), 254-267.

This article describes a study in which the aspects of problem solving were measured in male psychiatric patients hospitalized after attempted suicide. The controls were patients with chronic pain and healthy volunteers. It was found that suicidal individuals had lower scores on general intellectual tests and verbal and design fluency; no differences in problem solving or flexibility were found.

Beck, A.T., Brown, G., Berchick, R.J., Stewart, B.L., & Steer, R.A. (1990). Relationship between hopelessness and ultimate suicide: A replication with psychiatric outpatients. The American Journal of Psychiatry, 147(2), 190-195.

This article discusses how a study of outpatients found that hopelessness, as measured by the Beck Hopelessness Scale, was significantly related to eventual suicide. The group identified by the Scale was eleven times more likely to commit suicide than the other outpatients, thus indicating that the Beck Hopelessness Scale may be a good indicator of suicidal potential.

Billings, A.G., & Moos, R.H. (1984). Coping, stress and social resources among adults with unipolar depression. Journal of Personality and Social Psychology, 46(4), 877-891.

This article describes a study that used a stress and coping paradigm to guide the development of coping

responses and explore the roles of stress social resources and coping among men and women entering treatment for depression. An expanded form of the multiple domains of life stress was used. It was found that coping responses directed toward problem solving and affective regulation were associated with less severe dysfunction, while emotion responses, more frequently used by women, were linked to greater dysfunction.

Cox, E., Lothstein, R.M. (1989). Video self portraits: A novel approach to group psychotherapy with young adults. International Journal of Group Psychotherapy, 39(2), 237-251.

This article discusses a group therapy model that explores using video self portraits with severely disturbed psychiatric adolescents and young adults. Small groups of young adults made tapes on various aspects of their problems and presented them to a larger group for discussion. The authors hypothesized that this aided in self disclosure and the working through of some serious emotional conflicts.

Crandell, R., McCown, D.A., & Roble, T. (1988). The effects of assertiveness training on self actualization. Small Group Behavior, 19(1), 134-145.

This article provides evidence that the self actualization scale can be used to assess the consequences of assertiveness training. It was found that assertiveness

training resulted in (1) an acknowledgement of the sensitivity of the self actualized scale to clinical intervention and (2) a demonstrated increase in self actualization with this effect lasting for at least one year.

Crawford, M., & Maracek, J. (1989). Psychology reconstructs the female. Psychology of Women Quarterly, 13, 147-165.

Crawford and Maracek (1989) provide a critical appraisal of the diverse approaches to the study of women and gender. It begins by describing the prefeminist or "womanless" psychology, whereby women's experiences are thought to be too unimportant to study and goes on to analyze the four co-existing frameworks that have generated recent research. In the past 50 years, "womanless" psychology was reflected in the disproportionate use of males as experimental subjects, in the failure to examine gender differences when both sexes were used as subjects, in the assumption that conclusions drawn from the study of male behavior applied to women, and in the lack of attention to gender as a category of social reality.

The four frameworks discussed are:

1. Exceptional women, where research focuses on the correlates of high achievement for women and women's history.

2. Women as a problem or anomaly, where research emphasizes explanations for female deficiencies, such as their fear of success.
3. The psychology of gender, where the focus of research shifts from women to gender as a principle of social organization that structures relations between women and men.
4. Transformation, where research focuses on challenging the values, assumptions and normative practices.

Curran, D.K. (1987). Adolescent suicidal behavior. Washington: Hemisphere Publishing Corporation.

This book addresses the problem of adolescent attempted suicides in America today. The book discusses the scope of the problem, reasons for suicide attempts, attitudes towards attempters, the effect of modeling, assessment, treatment, and education. It highlights the importance of coping skills and peer counselling in the education and prevention of suicide attempters.

Davenport, Y.B., & Mathiasen, E. (1988). Couples psychotherapy group: Treatment of the married alcoholic group, International Journal of Group Psychotherapy, 2, 67-75.

This article advocates groups for alcoholic patients and their spouses which go beyond abstinence to improved functioning and growth in the family system. Group issues addressed include the genetic theory of alcoholism, loneliness and distancing, unwillingness to acknowledge

depression, repression of anger and rage, unresolved conflicts, failure to deal with early issues of loss, and changing roles and expectations. This case study serves as an indicator that this kind of treatment is clinically and cost effective.

Dobson, K.S. (1989). A meta-analysis of the efficacy of cognitive therapy for depression. Journal of Consulting and Clinical Psychology, 57(3), 414-419.

This article reviews the effectiveness of Beck's Cognitive Theory for depression in a meta analysis format. Results indicate greater improvement with cognitive therapy compared to a waiting list or no treatment group, pharmacotherapy, behavior therapy, and other psychotherapies. The degree of change seemed to be associated with the age of the client suggesting that older clients will be more receptive.

Endler, N.S., & Parker, J.D.A. (1990). State and trait anxiety, depression and coping styles. Australian Journal of Psychology, 42(2), 207-220.

This article discusses a study that examined the relationship between depressive symptoms and coping styles using the Multidimensional Coping Inventory (MCI) to assess coping styles. The results indicate gender differences in coping behavior with females reporting more emotion oriented and avoidance oriented coping behaviors than males. Males and females who scored high on depressive

symptoms were found to use more emotion oriented coping than those scoring low on depression. In addition, a strong relationship was found between state anxiety and depressive symptoms, suggesting that both constructs may be part of a general psychological distress response.

Essex, Klein John, & Smith, Benjamin. (1985). Intimacy and depression in older women. Psychiatry, 48, 159-178.

Essex and Smith (1985) studied the effects of the qualities of intimate relationships on depression in older women; 480 women over the age of 50 were given a questionnaire on two occasions about depression and the quality of their intimate relationships. Differences were found between depressed and non-depressed women in the relationship area. Depressed women felt:

1. The relationship was less friendly.
2. Their friendly feelings were not reciprocated by the significant other.
3. Their relationship was less consistent and predictable.
4. There was less time spent with the significant other in the last state. (Relationships in the last state were characterized by friendliness, interdependence and consistency.)

The more depressed women were, the more they felt they behaved and were treated in a less consistent and friendly way, thus indicating the importance of the qualities of

intimate relationships to the psychological well being of older women. Their perceptions of the major relationship is importantly related to their feelings of depression.

Hammen, C. (1991). Generation of stress in the course of unipolar depression. Journal of Abnormal Psychology, 100(4), 555-561.

This article describes a study exploring the effect of depression on stressful events. Interview assessments were used and it was found that women with unipolar depression were exposed to more stress, had more interpersonal event stress, and tended to be more dependent than women without depression. The implication was that depressive symptoms generate stressful conditions, which are mainly interpersonal, and have the potential for contributing to the cycle of symptoms and stress that create chronic or intermittent depression.

Karaser, T.B. (1990). Toward a clinical model of psychotherapy for depression, II: An integrative and selective treatment approach. American Journal of Psychiatry, 147(3), 269-277.

In this article the author explores the current status of psychotherapy for depression in a two part series. The psychodynamic, cognitive, and interpersonal approaches to the psychological treatment of depressive disorders are described and contrasted. They are described as different but complementary with regard to basic characteristics such as theoretical orientation goals and advantages and

limitations. This clinical comparison forms the foundation of an integrative model of treatment for depression.

Lerner, M.S., & Clum, G.A. (1990). Treatment of suicide ideators: A problem solving approach. Behavior Therapy, 21, 403-411.

This study is an example of systematic treatment research with suicidal individuals. It evaluates the effectiveness of social problem solving therapy compared to supportive therapy for treating older suicidal adolescents. The results indicate that problem solving therapy was more effective than supportive therapy for reducing depression, hopelessness and loneliness but not significantly better at reducing suicidal ideations.

Needles, J.D., & Abramson, L.Y. (1990). Positive life events, attributional style, and hopefulness: Testing a model of recovery from depression. Journal of Abnormal Psychology, 99(2), 156-165.

This article presents a model of a recovery process from depression that is compatible with the hopelessness theory of depressive onset. It was found that depressives who showed both an enhancing attributional style for positive events (made global stable attributions for such events) and experienced more positive events showed dramatic reductions in hopelessness and less depressive symptoms.

Nezu, A.M., & Perri, M.G. (1989). Social problem solving therapy for unipolar depression: An initial dismantling investigation. Journal of Consulting and Clinical Psychology, 57(3), 408-413.

This study tests the efficacy of social problem solving for unipolar depression, examining the contribution of training in the problem solving mode to the overall model. The findings suggest that problem solving is an effective cognitive behavioral treatment approach for depression, thus stressing the importance of including problem orientation training.

Nolen-Hoeksema, S. (1991). Responses to depression and their effects on the duration of depressive episodes. Journal of Abnormal Psychology, 100(4), 569-582.

This article discusses the belief that the ways people respond to their own symptoms of depression influence the duration of these symptoms. People who focus on their symptoms and the possible causes and consequences of their symptoms will show longer depressions than people who take actions to distract themselves from their symptoms. These response styles are further discussed, explaining the greater likelihood of depression in women than men, and suggestions are made to help depressed individuals stop engaging in ruminative responses.

Numeyer, R.A., & Feixas, G. (1990). The role of homework and skill acquisition in the outcome of group cognitive therapy for depression. Behavior Therapy, 21(3), 281-292.

This study evaluated the effect of homework and cognitive therapy when working with depressed individuals. Results indicate that the homework condition showed more substantial improvements in the symptomatic features of depression but this effect was not maintained at a six-month follow up. These results reinforce the value of homework during the active treatment phase of cognitive therapy of depression and the importance of skill acquisition in maintaining and prompting treatment gains when therapy has ended.

Perrah, M., & Wichman, H. (1987). Cognitive rigidity in suicide attempters. Suicide and Life-Threatening Behavior, 17(3), 251-255.

This study was designed to find out whether cognitive rigidity was a personality trait of suicide attempters or simply a transient characteristic limited to the crisis period. Tests such as the Rokeach Map Test and the Alternate Uses Test were administered for rigidity to persons who had attempted suicide but were well past the crisis period. These persons were less rigid than attempters in the crisis period from previous studies, implying that if there is a suicidal personality, rigidity is not a defining trait.

Rosenblatt, A., & Greenberg, J. (1991). Examining the world of the depressed: Do depressed people prefer others who are depressed. Journal of Personality and Social Psychology, 60(4), 620-629.

This article describes two tudies conducted to examine the interpersonal world of tne depressed person. The first study confirmed the hypothesis suggesting that depressed persons may prefer others who also tend toward depression. The second study found that depressed individuals felt better after talking to other depressed individuals.

Scott, M., & Stradling, S. (1990). Group cognitive therapy for depression produces clinically significant reliable change in community based settings. Behavioral Psychotherapy, 18(1), 1-19.

This article discusses two studies which show that cognitive therapy produces as much change when presented in a small group format as when presented in an individual format.

Strosahl, K.D., Linehan, M.M., & Chiles, J.A. (1984). Will the real social desirability please stand up? Hopelessness, depression, social desirability and the prediction of suicidal behavior. Journal of Consulting and Clinical Psychology, 52(3), 449-457.

This article describes a clinical study in which the usefulness of the social desirability assessment (Crowne

Marlow SD Scale) in the risk assessment and prediction of suicidal behavior is analyzed using a general population and psychiatric sample. It was found that prediction accuracy is increased by including a social desirability assessment, especially among psychiatric patients with a history of suicidal behavior.

Teri, L., & Lewinsohn, P.M. (1986). Individual and group treatment of unipolar depression: Comparison of treatment outcome and identification of predictors of successful treatment outcome. Behavior Therapy, 17, 215-228.

This article describes a study consisting of subjects diagnosed as major or minor depressive disorder who were randomly assigned to an individual or group social learning approach for the treatment of depression. There were no differences in depression outcome between the two treatments. However, the two variables identified as predictive of successful treatment outcome were the initial level of depression and the number of stressful life events. Findings do support using a group social learning approach to depression.

Weishaar, M.E., & Beck, A.T. (1990). Cognitive approaches to understanding and treating suicidal behavior. In S. Blumenthal and D. Kupfer (Eds.), Suicide over the life span (pp. 469-499). Washington, DC: American Psychiatric Press.

This chapter deals with cognitive approaches to suicidal behavior. It discusses the cognitive model of

psychopathology focusing on cognitive distortions and features, the cognitive model of depression and the cognitive triad. It explores research on the risk and prediction of suicide, describing assessment scales such as the suicide intent scale and the hopelessness scale. Models of suicidal behavior are briefly discussed, as well as the relationship of hopelessness to problem solving skills and cognitive therapy.

# Appendix B

## Evaluation

## *INTERNSHIP EVALUATION*

*July, 1992*

***Part I:***

***Name of Intern:*** Sandi Avery

***Place of Internship:*** Waterford Hospital

***Date of Internship:*** April 13 – July 10, 1992

***On-Site Internship Supervisor:*** Dr Assen Alladin

Nature of Internship Placement (brief description of clientele served by the intern, e.g., forensic, out-patient, agency referrals, etc., and services provided by the intern, e.g., individual assessment, group counselling, family therapy, etc.):

Clients: In- and outpatients adult psychiatry
Acute, long-term and rehabilitation cases
Forensic unit and Day Care

Services provided: assessments, treatments, consultation, liaison. Mainly individual cases but also ran a group as co-leader

**Part II:** Please comment on the following areas as they relate to the Intern's performance during the placement.

1. Adjustment to working environment and relationship with other staff members:

Adapted very well to the demanding environment and related very well to colleagues and staff from other departments.

2. General counselling skills (ability to relate effectively with clients, establish direction/focus, make progress toward therapeutic objectives):

Very mature approach to understanding clients' problems. Had clear direction re- treatment goals, however, flexible with treatment process.

3. Development of specific skill areas related to the internship (complete those which are applicable):

A. Assessment:

1. Cognitive assessments
2. Neuropsychological assessments
3. Personality assessments
4. Behavioural assessment
5. Assessment related to "fitness" for trial
6. Assessment of anger
7. Assessment of clinical symptomatology e.g. anxiety

B. Individual counselling:

1. Supportive psychotherapy
2. Cognitive therapy
3. Behaviour therapy
4. Hypnosis
5. Relaxation training
6. Grief counselling
7. Counselling with survivor of sexual abuse
8. Problem-solving strategies
9. Crisis intervention with suicidal patients

C. Group counselling:

1. Cognitive therapy focus
2. Self-esteem building
3. Pain Information/education
4. Facilitated ventilation of feelings
5. Facilitated group processes
6. Dealing with resistance in group therapy

D. Family therapy:

~~Advised~~
Not applicable

E. Consultation:

1. Forensic psychiatrists re- cognitive & personality assessments
2. Forensic Nurses re- management of inappropriate sexual behaviours
3. Outpatient department re- personality assessme
4. Social Workers re- "fitness" to stand trial
5. Psychologists re- cognitive/intellectual/education assessments

F. Teaching/lecturing/presenting:

1. Helped to organize and run a Two-day Workshop on Management of Suicide
2. Case presentation at allocation meetings

G. Coordination of services or other leadership roles:

1. Co-leader in group therapy sessions
2. Helped organize social events/activities for patients

H. Other:

Prepared protocol for research on Coping Skills in Suicidal Clients, which was very informative to members of staff in Waterford Hospital.

3. **Quality of report writing, recommendations, and follow-up with clients:**

Report writing: 1. Concise and good sense of integrating assessments with clinical information/observation.

2. Useful treatment recommendations and clear direction to other clinical staff re- intervention

3 Prepared clients properly before termination of therapy.

**Part III:** Summary Comments and Feedback

Given the stressful situation (and under the pressure of getting her research protocol right), Sandi adapted very well to the Department, clients and other staff. She had been a very hardworker and well-liked by the staff in the hospital.

August 12/1992

# Appendix C

## Handouts From Suicide Workshop

## THEORIES OF SUICIDE

1. Psychoanalytical Theory
2. Psychosocial Theory
3. Behavioural Theory
4. Humanistic Theory
5. Sociological Theory
6. — Biological Theory
7. Cognitive Theory

## PSYCHOANALYTIC THEORY OF SUICIDE

Freud viewed each human being a closed energy system (libido).

Dynamic balance between two forces: Eros and Thanatos.

Interplay between eros and thanatos represents a lifelong struggle.

When "healthy" eros dominant in personality.

When depressed or hopeless, thanatos dominant.

Therefore suicidal behaviour is under the influence of thanatos.

Others believe suicide is an unconscious manifestation of anger turned inward.

Suicide also a conflict between ego and superego (re - idealized self).

## PSYCHOSOCIAL THEORY OF SUICIDE

Erickson's psychosocial theory of development provides a framework both for understanding and for working with suicidal persons. Erikson believed that there are special developmental periods when specific psychosocial lessons are learned, dependent on the environmental conditions (positive, unhealthy, nurturing, etc.).

### Erickson's Stages of Psychosocial Development

| Stage | Most sensitive ages | Task | |
|---|---|---|---|
| | | Positive pole | Negative pole |
| Sensory stage | 0-2 | Trust | Mistrust |
| Muscular development stage | 2-4 | Autonomy | Shame, doubt |
| Locomotor stage | 4-6 | Initiative | Guilt |
| Latency stage | 6-12 | Industry | Inferiority |
| Puberty stage | 12-18 | Identity | Role diffusion |
| Young adult stage | 15-20 | Intimacy | Isolation |
| Adulthood stage | 30-65 | Generativity | Stagnation |
| Maturity | 65+ | Ego integrity | Despair, disgust |

## BEHAVIOURAL THEORY OF SUICIDE

Suicidal behaviour acquired through imitation and modeling.

Learned helplessness can lead to suicidal behaviour.

## HUMANISTIC THEORY OF SUICIDE

Provided basic needs are met, humans are essentially growth-orientated creatures, whose nature is directed toward realizing their potential (if external conditions permit).

Inability to discover meaning in life can lead to feelings of uselessness, hopelessness, depression and suicidal feeling.

## SOCIOLOGICAL THEORY OF SUICIDE

Durkheim hypothesized that suicide can occur as a result of the kind of "fit" that an individual experiences in society.

He postulated 4 different types of suicide:

- egoistic suicide
  (bond detaches from society)

- altruistic suicide
  (overintegration to society)

- anomic suicide
  (alienation from society)

- fatalistic suicide
  (oppressed by society)

## BIOLOGICAL THEORY OF SUICIDE

- Deficiency of serotonin level implicated in depression and suicide, particularly impulsive suicide.

- Genetic predisposition to suicide.

RET WORK-SHEET

| DATE | A<br>ACTIVATING EVENT<br>Describe actual event, stream of thoughts, daydream, etc. leading to unpleasant feelings. | B<br>IRRATIONAL BELIEFS<br>Write automatic thoughts and images that came in your mind. Rate beliefs or images 0 – 100% | C<br>CONSEQUENCES<br>1. Emotion: specify sad, anxious or angry. Rate feelings 1 –100%<br>2. Physiological: Palpitations, pain, dizzy, sweat, etc.<br>3. Behavioural: Avoidance, in bed.<br>4. Cognitive: Reaching conclusions. |
|---|---|---|---|
| | | | |
| | D<br>DISPUTATION<br>Challenge the automatic thoughts and images. Rate belief in rational response/image 0–100% | E<br>EFFECT OF DISPUTATION<br>1. Emotion: Re-rate your emotion 1–100%<br>2. Physiological: Changes in bodily reactions (i.e. less shaking, less tense, etc.)<br>3. Behavioural: Action taken after disputation.<br>4. Cognitive: Reappraise your conclusion and initial decision. Future beliefs in similar situation. | |
| | | | |

## Completed RET Work-Sheet

| DATE | A<br>ACTIVATING EVENT<br>Describe actual event, stream of thoughts, daydream, etc. leading to unpleasant feelings. | B<br>IRRATIONAL BELIEFS<br>Write automatic thoughts and images that came in your mind. Rate beliefs or images 0 – 100% | C<br>CONSEQUENCES<br>1. Emotion: specify sad, anxious or angry. Rate feelings 1 –100%<br>2. Physiological: Palpitations, pain, dizzy, sweat, etc.<br>3. Behavioural: Avoidance, in bed.<br>4. Cognitive: Reaching conclusions. |
|---|---|---|---|
| 10.3.87 | A worked example:<br>Thinking of going to grandson's christening party | 1. I won't enjoy it (100)<br>2. I can't cope with it (90)<br>3. Everyone will hate me (90)<br>4. I will spoil it (100)<br>5. I can never be happy (100) | 1. Depressed (75), unhappy (100), miserable (90)<br>2. Weak, tired, head heavy<br>3. Don't want to go, prefer staying in bed<br>4. I will never be able to enjoy myself again |
| | D<br>DISPUTATION<br>Challenge the automatic thoughts and images. Rate belief in rational response/image 0–100% | E<br>EFFECT OF DISPUTATION<br>1. Emotion: Re-rate your emotion 1–100%<br>2. Physiological: Changes in bodily reactions (i.e. less shaking, less tense, etc.)<br>3. Behavioural: Action taken after disputation.<br>4. Cognitive: Reappraise your conclusion and initial decision. Future beliefs in similar situation. | |
| | 1. How do I know I won't enjoy it? The chances are I may like it being in company (60)<br>2. I may still feel depressed, but I can cope with it. Nothing bad will happen (80)<br>3. No one hates you when you feel down, it's just my wrong belief (80)<br>4. I may be quiet but not spoil it for all (90)<br>5. I've felt this way in the past, but has always recovered/come on top (100) | 1. Less depressed (20), not too unhappy (30), no longer feeling miserable (0)<br>2. Still feeling tired and weak but head feels light, and feels like making a move<br>3. Out of bed, ironing clothes for the party tomorrow, wish to be present at party<br>4. Even if I feel depressed, I can make myself happy by going out to social functions | |

CAB FORM FOR MONITORING IRRATIONAL BELIEFS/THOUGHTS/IMAGES/DAYDREAMS RELATED TO EVENTS/SITUATIONS

| DATE | C = EMOTIONS<br>1. Specify sad/anxious/angry, etc.<br>2. Rate degree of emotion 0 - 100 | A = FACTS OR EVENTS<br>Describe:-<br>1. Actual event that activated unpleasant emotion/reaction<br>2. Images, daydreams, recollection leading to unpleasant emotion | B = AUTOMATIC THOUGHTS ABOUT A<br>1. Write automatic thoughts that preceded emotions/reactions<br>2. Rate belief in automatic thoughts 0 - 100% |
|---|---|---|---|
| 10.3.87 | Depressed (75)<br>Unhappy (100)<br>Miserable (90) | Thinking of going to grandson's Christening party tomorrow | I won't enjoy it (100)<br>I can't cope with it (100)<br>Everyone will hate me (90)<br>I will spoil it for everyone(90)<br>I can never be happy again (100) |
| | | | |

## COGNITIVE PROFILE OF EMOTIONAL PROBLEMS

| DISORDER | SPECIFIC COGNITIVE CONTENT |
|---|---|
| **ANGER** | How can they do this to me?<br>He/she has no right to treat me this way.<br>He/she is so stupid.<br>How can a person behave this way?<br>I shouldn't have done it. |
| **FRUSTRATION** | Everything is so difficult, I can never get on with anything.<br>It's too hard, not worth trying.<br>It'll take too long.<br>I don't have time, too many things to do. |
| **ANXIETY (FEAR)** | Something bad will happen to me.<br>I'll lose control or lose my mind.<br>I'll faint, have a heart attack, etc.<br>Everyone will look at me, they will think I'm stupid, nervous, etc.<br>I can't talk, don't know what to say, I'll freeze. |
| **DEPRESSION** | I'm worthless, inadequate, deprived and defective.<br>No one cares, everyone is against me, life is too difficult, the world is unfair.<br>I can never be happy, I'll always be miserable.<br>I'll never be right.<br>There is no way out. |

| | |
|---|---|
| **LOW SELF-ESTEEM (WORTHLESSNESS)** | I'm no good.<br>I'm a failure.<br>I'm no one, I don't belong. |
| **GUILT (SELF-BLAME)** | I'm a bad person, I did the wrong thing.<br>I should have known better.<br>I should have done the right thing.<br>I am responsible for his/her sufferings. |
| **LOSS/SEPARATION** | I can't live without him/her.<br>I can never be happy without him/her.<br>It's over, life is not worth living.<br>I can't cope on my own.<br>I've lost everything. |
| **PHYSICAL/MENTAL ABUSE** | He made me this way.<br>He took my confidence, my personality away.<br>I never used to be like this, he is responsible for the way I feel.<br>I can never be right again.<br>My life, my happiness is ruined.<br>I can't do anything now. |
| **SEXUAL ABUSE** | I'm to be blamed, it's my fault.<br>I've no feeling, I'm dead.<br>I can't express feelings.<br>I should have stopped it.<br>I never did the right thing.<br>I can never trust anyone. |
| **RAPE** | It's my fault, I should have said no, struggled, etc.<br>I should have done the right thing.<br>I can't trust men.<br>Everyone thinks I'm a bad person. |

| | |
|---|---|
| **ABORTION** | I'm horrible, I took a life away.<br>I should have kept the baby.<br>I made the wrong decision.<br>I can never forgive myself.<br>Everyone looks at me, they know what a bad person I am. |
| **ACCIDENT** | It's my fault, I should have left a bit earlier/later, etc.<br>I could have prevented it.<br>I'm always doing the wrong thing. |
| **PERSONAL DISABILITIES** | I'm abnormal.<br>I'm horrible, ugly, everyone will hate me.<br>I can never do anything, I'm useless.<br>It's my fault.<br>I feel so bad for my family, children, etc. |
| **OPERATION** | I'm deformed.<br>Everyone hates me.<br>I'm not a man/woman anymore.<br>It's so hard for my husband/wife. |

## REFERENCES


**A GOOD INTRODUCTION**

Stillion JM, McDowell EE & May JH (1989). Suicide Across The Life Span: Premature Exits. Hemisphere Publishing Corporation, New York.

**A COMPREHENSIVE TEXTBOOK**

SJ Blumenthal and DJ Kupfer (1990). Suicide Over The Life Cycle: Risk Factors, Assessment, and Treatment of Suicidal patients. American Psychiatric Press, Inc., Washington, DC.

**EXCELLENT FOUNDATION OF COGNITIVE THEORY AND COGNITIVE THERAPY**

Beck AT (1976). Cognitive Therapy and the Emotional Disorders. New York, New American Library.

Beck AT, Rush AJ, Shaw B & Emery G (1979). Cognitive Therapy of Depression. New York, Guildford.

## DIFFERENCE BETWEEN SUICIDE COMPLETERS AND ATTEMPTERS

| | SUICIDE COMPLETERS | | SUICIDE ATTEMPTERS |
|---|---|---|---|
| 1. | Disturbed personality profiles | 1. | More disturbed personality profiles |
| 2. | More men | 2. | More women |
| 3. | Older | 3. | Under 24 years of age |
| 4. | Depression | 4. | Neurotic disorders |
| 5. | Alcoholism | 5. | Personality disorders |
| 6. | Make private and violent attempts, using lethal means | 6. | Commit public, impulsive, suicidal acts using less lethal means |

## COGNITIVE RIGIDITY

**DEFINITION**

Beliefs regarded as rigid rules, hence the tendency to disregard other viewpoints. "My children will be better off without me." "The world is unfair."

**INTERVENTION**

Therapist and patient work together to generate other interpretations, to withhold harsh judgement that would eliminate other viewpoints, and to examine logically and test alternatives behaviourally.

- employ collaborative empiricism: test the patient's assumptions logically and empirically. "You say your children will be better off if you kill yourself. Let's examine this."
- role play with role reversal to generate alternatives (patient takes role of therapist).
- look for evidence in support of alternative interpretations. "Getting better is the best way to help your family."
- visual imagery/cognitive rehearsal.

# HOPELESSNESS

**DEFINITION**

Perception of no hope, based on rigid conclusions that things cannot improve and difficulties cannot be resolved (minimizing/overestimating). "I'll never be right, there's no way out, except to kill myself."

**INTERVENTION**

Communicate to the patient that hopelessness is a consequence of negative expectations, not an accurate reflection of reality; other courses of action and alternative interpretations are possible; and they can work with the therapist to generate realistic alternatives.

- active role by therapist initially to generate solutions to problems

- help identify internal and external resources (evidence from past experience, community resources, etc.)

- introduce evidence to contradict patient's beliefs

P: "I can't stand this pain."
T: "Last year you had even greater pain when you were in labour."

P: "Nothing works. It's no use."
T: "Since we started therapy you have gone back to work."

# PROBLEM-SOLVING DEFICITS

## DEFINITION

Suicidal persons have a limited ability to find solutions to interpersonal problems. Less able to consider alternatives, produce new ideas, or think flexibly and persist in ineffective problem-solving strategies and perceive negative consequences of using alternative strategies.

## INTERVENTION

Apply problem-solving training, including:

1. Accepting problems as a normal part of life.

2. Inculcate the belief that one is capable of solving some problems.

3. Not maximize difficulties and minimize resources by believing "I can't handle anything. Life is unfair."

4. Define problem precisely by:
   - obtaining information in clear and specific terms
   - differentiating fact from inference
   - identifying what makes a situation a problem
   - setting realistic goals.

5. Generating alternatives by eliciting as many solutions from the patient. (Suicidal patients often give up when their standard solutions fail).

6. Decision making by evaluating alternatives with regard to their consequences for self and others, immediately and in the long run. (When suicide is viewed as a solution, many consequences of the act are ignored or minimized).

7. Implementing solutions by/through:
   - increasing tolerance for frustration
   - reducing anxiety and discomfort
   - cognitive/behaviour rehearsal for future problems
   - stress inoculation.

   (These techniques distract suicidal ideation)
   - minimizing cognitive distortions.

## VIEW OF SUICIDE AS DESIRABLE

**DEFINITION**

Tendency (cognitive deficit) to view suicide as a way out when usual way of dealing with problematic situations fails. Also had a low tolerance for uncertainty and prematurely abandon problem solving. Suicide is thus a kind of "opiate", a relief and escape from problems.

**INTERVENTION**

Challenge patient's assumptions that suicide will achieve a desired goal with causing further complications

- elicit reasons for dying and reasons for living.
- describe advantages and disadvantages of suicide relative to other solutions
- correct cognitive distortions about advantages of dying.

## THINKING ERRORS OR COGNITIVE DISTORTIONS

1. **ALL OR NOTHING THINKING**
Things are seen as black or white; there is no grey or middle ground. Things are good or bad, wonderful or awful, and if a performance falls short of perfect, it is a total failure. For example, if a meal does not turn out to be perfect, the depressed housewife may conclude: "I can't even cook, I'm no good, I'm a total failure."

2. **OVERGENERALIZATION**
A single negative event is seen as a never-ending pattern of defeat. If there is a misunderstanding or a disagreement with a person, regarded as important (for example, a husband), it is assumed by the wife that he does not understand or care about her, never has, and never will. Therefore the wife thinks she will always be isolated and misunderstood: "No one understands or cares about me."

3. **MENTAL FILTER OR SELECTIVE ABSTRACTION**
A single negative detail is picked out from an event or situation and the person dwells on it until everything is darkened, like a drop of ink that discolours the entire beaker of water. If a housewife makes a nice dinner, but adds a bit too much dressing on the salad, then she thinks only of the ruined salad until she sees the entire dinner party as a disaster.

4. **DISQUALIFYING THE POSITIVE**
Positive experiences are rejected by insisting they "don't count" for some reason or another. In this way, a negative belief is maintained, although it's not based on everyday experiences. For example, a person may not allow himself or herself to enjoy good feelings because the person believes bad feelings will follow if he or she allows himself or herself to feel good. Thus, the person even feels bad about feeling good.

5. **JUMPING TO CONCLUSIONS (ARBITRARY INFERENCES)**
Negative interpretations are made, although there are no definite facts to support the conclusions. A person jumps to conclusions either by <u>mind reading</u> or <u>fortune telling</u>.

   a. <u>Mind Reading</u>: Tendency to see things as negative and not bothering to check out the facts. For instance, if a friend at work does not say "Good morning," a person may conclude the friend dislikes him or her and gets upset about it and do not bother to check whether the friend himself or herself is upset or worried about something.

b. Fortune Teller Error: Anticipates that things will turn out badly and don't allow for the possibility that they may be neutral or positive. In other words, a negative prediction is treated as an established fact: "No need to take the exam, I'm sure I'll fail" or "I'll not enjoy the party, not much point in going".

6. **MAGNIFICATION AND/OR MINIMIZATION**
This is also called the "binocular trick". An extra big deal is made about personal errors and extra big deal is made about other people's success. At the same time, it is maintained that other people's errors don't really matter and that personal successes and good qualities are really small and don't count for much. In other words, the importance of things are exaggerated or inappropriately shrunk until they appear tiny. "I made a mistake, I'm a horrible person", "They say I have a good home, this doesn't count, anyone can do housework, I'm so unhappy and miserable".

7. **EMOTIONAL REASONING**
It is assumed that the negative feelings being felt result from the fact that things are negative. If a person feels bad, then it means the world situation is bad and the person doesn't bother to check if things are really bad. "I feel rejected, therefore it must be true that people dislike me".

8. **SHOULD STATEMENTS**
This refers to the tendency when one tries to push or improve oneself with should's and shouldn't's, musts, and oughts. For example, "I should do more"; "I should have known better"; "I must not fail"; "I ought to be a good father"; "I should have done the right thing". The emotional consequences of these statements are guilt, anger, and resentment. Should statements are often used when "I wish" or "I would like to" or "It would have been desirable" would have been more accurate.

9. **LABELING AND MISLABELING**
This is an extreme form of overgeneralization. Instead of describing an error or mistake, a negative label is attached to the self: "I said the wrong thing, I'm no good". When someone disagrees or disproves one's point of view, the person is negatively labeled: "He's horrible, he's odious", rather than "he disagrees with my opinion". Labeling and mislabeling involves describing an event or a person in emotionally loaded language. Such description severely restricts the focus of attention to few isolated details and makes inference to characteristics unrelated to a particular person or situation.

**10. PERSONALIZATION**

One sees oneself as the cause of some external unfortunate or unpleasant event for which, in fact, one is not actually responsible for. A woman, for example, who was emotionally and physically abused as a child blames herself for these "bad things" because she believes she is a bad person and "was born bad".

# Appendix D

## Diagnostic Criteria for Major Depressive Symptoms, Diagnostic and Statistical Manual of Mental Disorders, 3rd Edition, Revised, 1987 (DSMIII-R)

At least five of the following symptoms have been present during the same two-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood, or (2) loss of interest or pleasure. (Do not include symptoms that are clearly due to a physical condition, mood-incongruent delusions or hallucinations, incoherence, or marked loosening of associations.)

(1) depressed mood (or can be irritable mood in children and adolescents) most of the day, nearly every day, as indicated either by subjective account or observation by others.

(2) markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated either by subjective account or observation by others of apathy most of the time).

(3) significant weight loss or weight gain when not dieting (e.g., more than 5% of body weight in a month), or decrease or increase in appetite nearly every day (in children, consider failure to make expected weight gains).

(4) insomnia or hypersomnia nearly every day.

(5) psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).

(6) fatigue or loss of energy nearly every day.

(7) feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).

(8) diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).

(9) recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide. (DSM-III-R (Axis 1), 1987, pp. 222-223)

# Appendix E

Letter Of Introduction
Guidelines For Informed Consent
Consent Forms

(Letter of Introduction)

Memo June 11, 1992

To: Dr. Assen Alladin
Senior Psychologist

FROM: Sandi Avery, B.Sp.Ed.

RE: Semi Structured Interview

Introduction

The Waterford Hospital Research Review Committee has given me approval to conduct a semi-structured interview with 10 individuals who have attempted suicide. I have chosen to conduct descriptive research regarding their perceptions of coping as my research project which is a requirement for my Masters in Educational Psychology Degree.

The purpose of this study is to describe the perceptions of individuals who have attempted suicide regarding their coping strategies. This study may illuminate further research questions and may assist in the development of more effective treatment for suicidal individuals.

Definition of Coping Strategies

For the purposes of this study, coping strategies is defined as the ways in which parasuicidal individuals cope with suicidal thoughts. Coping strategies are characterized by three dimensions: self-coping strategies; help available and help unavailable or recommendations.

Sample Criteria

The semi-structured interview will be conducted with outpatients who meet the following sample criteria:

1. are at least 20 years old.

2. voluntarily agree to participate in the study.

3. were clinically diagnosed as depressed by the DSM-III-R (Axis I).

4. have been an outpatient for at least 6 months.

5. have not been clinically depressed for 3 months, which means that the diagnostic criteria for major depressive symptoms have not been present within the last 3 months.

Procedure

Beginning on June 26, 1992, I will contact you to obtain the names of outpatients who have met the sampling criteria and are willing to participate in this study.

Attached to this memo is a copy of the question format to be used in the semi-structured interview; and a request for participation.

Once the outpatients agree to participate in the study, I will arrange a personal meeting with them and conduct the interview. It is important to note that I will be conducting the semi-structured interview in an open questionnaire format.

Once the interview has been conducted with 10 outpatients, I will notify you immediately to inform you the study is completed. A copy of the results will be made available to you, once approved.

On June 24, 1992 I will contact you to arrange a time to meet briefly with you to further discuss this study and address my questions or concerns you may have.

I realize this study will mean additional work for you; however, I really believe that this study can provide a basis for future research questions and a basis for improving treatment for suicidal individuals.

Thank you in advance for your anticipated consideration.

Sandi L. Avery, B.Sp.Ed.

Interviewer's Guidelines for Informed Consent

1. Purpose of the Study:

I am interested in finding out about your understanding of the coping strategies which you use in dealing with suicidal thoughts and life's stressors or problems. This is part of my effort to better understand how individuals learn to successfully cope with their depression or suicidal attempts. If you have any questions or concerns regarding this interview or my role, please feel free to contact Dr. Assen Alladin, a Senior Psychologist with the Psychology Department, and my on-site supervisor, or Dr. Anita Russell, my University supervisor.

2. What you will be Asked to do:

I plan to conduct an interview focusing on coping strategies. If you agree to participate, I will interview you. During the interview, I will ask you a number of questions intended to help you to tell me your understanding of how you cope with life's problems and suicidal thoughts. I will also ask you some questions such as your age, sex, stressors or problems you have encountered and how you see yourself coping in these situations.

3. Amount of Time:

The interview will take about 30 minutes to 1 hour to complete, and may be conducted either at the Hospital or your home, depending on what you would prefer. The interview will be audiotaped. This tape will be erased when the study is completed.

4. Some Further Information:

Should you consider any question inappropriate or, for any reason, one which you would prefer not to answer, please tell me at any point in the interview. If you are uncomfortable you may stop the interview at any time, and your refusal will not be held against you and no one except me will be aware that you have made this decision. You will still be eligible to receive services from this hospital, and your decision not to participate will be

respected. You are under no obligation to participate in this study.

5. Possible Benefits of Study:

The results of this study may be useful in the development of more effective coping intervention strategies or techniques (psychologists and counsellors could use to assist people in coping with life's stressors). It may also lead to great insight or understanding on your part regarding how you do cope with life's stressors.

6. Confidentiality:

The information you share in this interview will be held in the strictest of confidence. The only exception would be any current reports of abuse or intent to harm oneself or another. Please be advised that I would have to report this information to Dr. Alladin, or your psychologist or psychiatrist for protective reasons. Professional services will then be made available to you. With this exception, all information is strictly confidential. Your name or any other identifying information will not appear in the report. The consent forms and all recording of the interview will be kept in a separate locked filing cabinet at the Waterford Hospital. All this information will be destroyed upon completion of the final report.

7. What Will be Done With the Information?:

Information received from each individual in the interview will be combined, interpreted and an overall perception of how individuals see themselves as coping with life's stressors will be collected in a final report. This report will be submitted to the Waterford Hospital's Research Review Committee and the Department of Educational Psychology at Memorial University.

Results of the study will be available to you. You can make your request known at the time of the interview or contact me through the Psychology Department at the Waterford Hospital at a later date.

Consent Form

I agree to participate in an interview to be conducted by Ms. Sandi Avery. I realize that I am under no obligation to participate and I may withdraw from the study at any time.

I understand that:

1. The interview will take about 1 hour to complete and will be conducted at the Waterford Hospital.

2. The purpose of the study is to get people's opinions of how they cope with suicidal thoughts and life's stressors or problems.

3. My name will not be associated with the study in any way.

4. Information regarding abuse or intent to harm myself or another must be disclosed to the Psychology Department.

5. The Waterford Hospital's Research Review Committee and the Faculty of Education Ethics Committee have consented to this study.

I understand what is involved in this interview on coping strategies. I realize that my participation is voluntary and that there is no guarantee that I will benefit from my involvement. I also acknowledge that a copy of this form and the interviewer's guidelines for informed consent has been offered to me.

_____ _____

Signature of Participant Date

I have fully explained the nature of this research study, invited questions and provided answers. I believe that the individual fully understands the voluntary nature of this semi structured interview.

_____ _____

Signature of Investigator Date

Consent Form for Audiotaping

I agree to the audiotaping of the interview conducted by Ms. Sandi Avery. I have been informed that this tape will be erased when the study is completed.

| | |
|---|---|
| Signature of Participant | Date |
| Signature of Investigator | Date |

# Appendix F

## Semi Structured Interview Questions

Semi Structured Interview Questions

The following are the anticipated questions to be asked during the interview:

1. How old are you?

2. Are you married?

3. I understand from Dr. Alladin that you have had some difficulties with depression and suicidal thoughts. Can you tell me about your suicidal attempt?
   Possible probes: How old were you? What did you do? What were you thinking at the time? How did you feel at the time? How many times did you attempt suicide?

4. Did you receive any form of counselling?
   Possible probes: What kind? How did it help you?

5. Did you receive any form of medical help?
   Possible probes: What kind? How did it help you? Are you on any medication right now? How does it help you?

6. Did you receive any form of group therapy?
   Possible probes: What kind? How did it help you?

7. Who would you contact if you felt suicidal?

8. If you happen to feel suicidal and cannot contact anyone, what would you do?
   Possible prompt: For example, some people would call emergency help lines while others would stay at home alone with the phone off the hook.

9. What kind of situations would normally trigger suicidal thoughts?
   Possible prompt: For example, some people report that personal or financial problems trigger suicidal thoughts.

10. What kinds of thoughts do you have at these times?
    Possible prompt: For example, some people report thinking that they cannot do anything right, and that things will never get better.

11. What do you usually do in these situations?
Possible prompt: For example, some people drink a lot while others cry.

12. When you have suicidal thoughts how do you feel?
Possible probe: What feelings are you aware of?
Possible prompt: For example, some people report not feeling very worthwhile or loved by others while others report feeling very angry.

13. When suicidal thoughts come into your mind what do you do?
Possible probe: Are there ways in which you try to control these thoughts?
Possible prompt: For example, some people talk to themselves in an attempt to solve the problem, while others exercise or treat themselves to something nice.

14. What do you do in these situations to prevent these thoughts from occurring?
Possible prompt: For example, some people try to find out more about the problem or think of alternatives to the problem; others tend to daydream or seek social support, while others tend to avoid the problem altogether by treating themselves to something nice.

15. How do you see ways of coping with suicidal thoughts in the past as different from the way you cope with suicidal thoughts now?
Possible probe: When did this change occur? How did it occur? How do you think your ways of coping with suicidal thoughts in the future will be different from the ways you cope with them now? What are your hopes for the future?

16. When you have suicidal thoughts do you evaluate the situation to see if it is relevant to your well-being?
Possible prompts: For example, some people look at whether or not they have anything to lose in the situation such as their self-esteem, while others look at whether or not anything can be done to improve the situation.

17. Can you describe a recent situation that you saw as a problem in which you think you coped well?
Possible probes: What did you do? What were you thinking or saying to yourself at the time? How did you feel?

18. What kind of support do you receive from your relatives, your friends, your spouse or partner?
Possible probes: What did they do? How did you feel? What did you do?

19. What kind of support do you think you should have gotten from your relatives, your friends, your spouse or partner?

20. What kind of counselling do you think you should have received?

21. What kind of medical help do you think you should have received?

22. Do you think suicidal individuals should be involved in therapy with other suicidal individuals in a group format? Why or why not?

23. How do you think professionals can build a rapport or trusting relationship with people who are depressed and suicidal?
Possible probe: What do you think they should do to show they really care?

24. What would you recommend to professionals when working with depressed individuals who have attempted suicide?
Possible probe: How should they treat these individuals?
Possible prompt: For example, should they use medication, counselling, or group therapy?

# Appendix G

## Approval Of Study From The Ethics Committee At Memorial University

**FACULTY OF EDUCATION**

**Memorial University of Newfoundland**

**Faculty Committee for Ethical Review of Research Involving Human Subjects**

**Certificate of Approval**

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Investigator: Ms. Sandi Avery

Investigator's Workplace: Graduate Student, Faculty of Education

Supervisor: Dr. Anita Russell/Dr. Glenn Sheppard

Title of Research: Self-Reported Coping Strategies of Parasuicidal Individuals

Approval Date: May 27, 1992

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The Ethics Review Committee has reviewed the protocol and procedures as described in this research proposal and we conclude that they conform to the University's guidelines for research involving human subjects.

Dr. George A. Hickman
Chairperson
Ethics Review Committee

Members: Dr. Ron Lehr
Dr. Walter Okshevsky
Dr. Dennis Sharpe
Dr. George A. Hickman
Dr. Patricia Canning