

COUNSELOR PERSPECTIVES ON SUICIDE AND SUICIDAL IDEATION:  
A QUALITATIVE STUDY

By

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COUNSELOR PERSPECTIVES ON SUICIDE AND SUICIDAL IDEATION:  
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Suicide has long been a significant concern for the counseling profession. Suicidal clients are likely to present a myriad of ethically challenging issues ranging from suicide prevention through considerations of suicide as a rational therapeutic option. This qualitative study approaches these challenges to the counseling profession by investigating the relationship between a counselor's personal beliefs about suicide and his or her attitudes toward clients expressing suicidal ideations.

Grounded Theory was the research method used to conduct this study. Data were collected through individual interviews, coded for thematic patterns, and analyzed by the process of constant comparison. All participants were professional counselors.

From the data, two basic and conflicting beliefs emerged, seemingly rooted in convictions about suicide. Participants were divided into two discrete camps contingent on the belief that either (a) suicide might be appropriate for some people, or (b) suicide is never appropriate for anyone. Numerous counselor attitudes toward clients expressing

suicidal ideations surfaced, each appearing contingent on this basic belief dichotomy. A data-analysis model is presented, detailing possible connections among these mutually exclusive beliefs, and such attitudes as a counselor's perceived role toward a suicidal client, willingness to involuntarily hospitalize a potentially suicidal client, perceived responsibility for client suicide, level of emotional response associated with client suicide, identification with a religion or religious belief system, age and professional experience, and personal suicide history.

Perhaps the most intriguing finding was that no counselor reported ever having treated a client for whom he or she deemed suicide to be an appropriate alternative. Discovering this to be the case for participants believing that suicide might be appropriate for some people, this attitude was labeled *suicide as an option (but not for my client)*. Cognitive dissonance theory was used to explore this and all other combinations of attitudes and beliefs, to help understand the relationship between a counselor's personal beliefs about suicide, and his or her attitudes toward clients expressing suicidal ideations. Finally, implications for counselor training, clinical practice, and future research were considered.

## CHAPTER 1 INTRODUCTION

A vast body of literature addresses suicide as an important issue for the counseling profession. During the course of their careers, most counselors will encounter at least one consumer with suicidal ideations (Carney & Hazler, 1998; McAdams & Foster, 2000; Rogers, 2001). These counselors potentially confront a myriad of ethically challenging suicide-related issues ranging from suicide prevention (Davidson, Wagner, & Range, 1995) through considerations of suicide as a rational option in therapy (Werth & Holdwick, 2000). Many counselors lack the knowledge and information required for the competent assessment of a potentially suicidal client (Carney & Hazler, 1998); and even those possessing this knowledge often find themselves in profound ethical conflict regarding treatment options (Lester & Leenaars, 1996; Corey, Cory & Callanan, 1998; Laux, 2002).

This conflict appears to represent a considerable diversity of counselor attitudes toward suicide. Some counselors advocate suicide prevention in all cases (Richman, 1992) while others sometimes view suicide as a viable option (Rogers, Guiulette, Abbey-Hines, Carney & Werth, 2001). Even counselors in the same professional organization hold differing attitudes toward suicide, as evidenced by member reactions to an *amicus curiae* [friend of the court] brief filed by the American Counseling Association (ACA) (Werth & Gordon, 2002) in favor of Oregon's Death With Dignity Act (1997). These and other examples of counselor attitudinal diversity toward suicide are discussed later.

Developing a better understanding of beliefs underlying the diversity of counselor attitudes toward suicide is at the core of much of the counseling literature on this topic (Neimeyer & Neimeyer, 1984; Moritz, Van Nes & Brouwer, 1989; Lester & Leenaars, 1996). Part of the motivation behind this professional interest may be the high level of importance associated with counselor beliefs and attitudes in the context of counselor competence. Knowledge of counselors' beliefs and attitudes is said to augment counselor competence in a variety of ways, from enhancing counselor education (Westefeld, Range, Rogers, Maples, Bromley & Alcorn, 2000), to ethical decision-making (Laux, 2002). Specific research exists pertaining either to counselors' individual personal beliefs about suicide, or to their attitudes toward clients expressing suicidal ideation. Yet little research indicates what, if any, relationship exists between a counselor's personal beliefs about suicide and his or her attitudes toward clients expressing suicidal ideations. This study aimed to help fill this information gap by answering the following research question. What is the relationship between a counselor's personal beliefs about suicide and his or her attitudes toward clients expressing suicidal ideations?

### **Purpose of the Study**

#### **Importance of Suicide**

It has been argued that the greatest influence on culture is death and dying (Aries, 1974; Glaser & Strauss, 1965, 1967; Kubler-Ross, 1969, 1975). Suicide is now the eighth leading cause of death in the United States (Centers for Disease Control, 2002) and would likely be ranked even higher were it not for societal attitudes heavily biased against declaring suicide as the cause of death (Fulton & Metress, 1995). Death by suicide differs from most other forms of death (e.g., heart disease, cancer, accidents) in that suicide carries with it a powerful social stigma, a particular type of disgrace (Moller,

1990) not present with most other deaths (Lester, 1993; Ingram & Ellis, 1995). Moller, Lester, and Ingram and Ellis assert that the stigma associated with suicide reflects on the suicidal person as being a weak, cowardly, and immoral individual. The relatives of a suicidal person (especially the parents) often find themselves cast within a similar penumbra of stigma and blame (Lester, 1990). According to Lester (1990, 1997), survivors of suicide are often treated unsympathetically by society and sometimes blame themselves for the suicide of a loved one. Other studies show that counselors of clients who have committed suicide are also prone to self-blame and recrimination (Chemtob, Hamada, Bauer, Kinney & ToriGoe, 1988; Moritz et al., 1989; Menninger, 1991; Little, 1992; McAdams & Foster, 2000). Yet between 66 and 80% of those who do commit suicide tell someone, often their counselor, of their intent (Grollman, 1988; Brems, 2000). Studies show that most counselors will encounter at least one consumer with suicidal ideations (Carney & Hazler, 1998; McAdams & Foster, 2000; Rogers, 2001), and that there is a 20% chance that a client will be successful in a suicide attempt (Bongar, 1992).

Considering the significant effect of death on culture, the high prevalence of suicide as a particularly stigmatizing form of death in the United States, and the likelihood of counselors encountering potentially suicidal consumers, it is not surprising that a vast body of research attests to the importance of suicide to the counseling profession (Lester & Leenaars, 1996; Neimeyer, 2000; McAdams & Foster, 2000; Rogers et al., 2001; Laux, 2002). In their article, *The ethics of suicide and suicide prevention*, Lester and Leenaars (1996) debate and disagree on numerous ethical issues related to this topic. Neimeyer (2000) illustrates the importance of such ethical dilemmas to the

counseling profession with specific attention to counselor training. He points out that the current state of inadequate counselor training in the areas of suicide and suicide prevention “leaves trainees substantially unprepared for managing the complexity of actual suicidal crisis” (Neimeyer, 2000, p. 551). McAdams and Foster (2000) further underscore the severity of this problem. The study by Rogers, Guiulette, Abbey-Hines, Carney & Werth (2001) found that practicing counselors disagree with one another and sometimes with their own professional codes of ethics, about issues related to suicide and its prevention. Laux (2002) outlined the need for counselors to improve their understanding of suicide in such areas as theory, risk assessment, intervention, prevention, postvention, and training. As recently as April of 2003, the ACA Ethics Committee published an outline of procedures to help members interpret the ACA Code of Ethics concerning end-of-life issues (Hubert, 2003).

Much of the existing research pertaining to counseling and suicide seems to indicate an unclear connection, and perhaps inconsistent relationship, between counselors’ personal reactions to their own consumers expressing suicidal ideations, and counselors’ reactions to the more abstract concept of death by suicide. This is of particular significance because of the impact such inconsistencies may have on counselor behaviors in the client-counselor relationship. The following is a description of this uncertain connection, its influence in the client-counselor relationship, and a discussion of why such an influence is important to the counseling profession.

### **Reactions to Suicide**

Studies on the personal reactions of counselors to their own consumers expressing suicidal ideations find significant uniformity of reactions. A number of similar studies (Chemtob, Hamada, Bauer, Kinney & ToriGoe, 1988; Moritz, Van Nes & Brouwer,

1989; Menninger, 1991; Little, 1992; McAdams & Foster, 2000) found client suicide to be the therapist's most frequently named cause of anxiety. According to these studies, many therapists viewed the suicide of a client as a professional failure on their part. In addition to questioning their own professional competency, the most common emotional responses to such an event included feelings of guilt, anger, and sadness.

Counselor reactions to the more abstract concept of death by suicide are more fragmented. Two clear examples of this may be found in the current counselor debate over rational suicide (Richman, 1988; Albright & Hazler, 1992; Rogers et al., 2001), and counselors' reactions to the recent Supreme Court battle over Oregon's Death with Dignity Act (1997).

Briefly, rational suicide is a term used to describe the conditions under which suicide would be considered by both the counselor and consumer to be a rational choice (Rogers et al., 2001). Proponents believe that some cases exist in which suicide is a rational alternative. This greatly concerns others who argue against even the concept that suicide could ever be a rational act (Richman, 1992), or that it is the moral duty of all healthcare professionals to prevent suicide (Elitzur, 1995).

Oregon's Death with Dignity Act (1997) was contested before the United States Supreme Court in the 1996 case of *Quill v. Vacco*. Several *Amicus curiae* [friend of the court] briefs were filed both for and against implementation of the Act. Prominent professional counseling organizations joined both sides (Werth & Gordon, 2002). Further demonstrating the lack of consensus on this issue were clear signs of dissension among the ranks of the organizations themselves. The debate over the decision by the ACA to

join the brief in favor of the Death with Dignity Act continues today (Donaldson, Patton & Wood, 2002; Bennett, 2002).

### **The Importance of Counselor Beliefs and Attitudes**

This uncertainty in the relationship of beliefs and attitudes held by counselors about suicide as a general construct, and toward those individuals expressing thoughts of suicide is at the core of this research question. The relationship between a counselor's own personal beliefs, and his or her attitudes toward suicidal consumers is important to understand, because of the impact it may have on counselor behaviors in the client-counselor relationship.

The quality of the counseling relationship, sometimes called the *therapeutic relationship* or *working alliance*, is generally considered to be the most important factor contributing to consumer growth and well-being in the context of professional counseling (Goldstein, 1962; Gladding, 1996; Walborn, 1996). "The successful outcome of any counseling effort depends on a working alliance between counselor and client" (Gladding, 1996, p. 142). Goldstein (1962) states, "There can no longer be any doubt as to the primary status which must be accorded the therapeutic transaction" (p. 105). Walborn (1996) asserts that possibly all schools of therapy recognize the primacy of the therapeutic relationship.

The general link between personal beliefs and behavior has been firmly established. Virtually all personality theorists recognize that a connection between the two exists. Albert Ellis, founder of the theory of Rational-Emotive Therapy (RET) (Ellis & Grieger, 1977), later to become REBT with the addition of "Behavior" to the title, states:

We largely (though not exclusively) control our own destinies, and particularly our emotional destinies. And we do so by our basic values or beliefs – by the way that

we interpret or look at the events that occur in our lives and by the actions we choose to take about these occurrences (p. 5).

Similar views, regarding the link between personal beliefs and behavior, are found throughout the literature related to counseling and consumer suicide. For example, in their discussions of euthanasia, Albright & Hazler (1995) argue that beliefs and attitudes are cultural derivatives that eventually determine individual behavior. Werth & Holdwick (2000) consider the debate over rational suicide and, citing the work of Fenn & Ganzini (1999) and Ganzini et al. (1996), state, "Professionals who believe that a person should not be allowed to have aid-in-dying may try to use their role as an individual's therapist (or the evaluator of whether the person has impaired judgment) to try to prevent the client from hastening death" (p. 526).

Viewed from the perspective of cognitive dissonance theory, the attitude of the counselor toward the consumer may be seen as a bridge between belief and behavior. Both beliefs and attitudes are, in essence, cognitions. These two cognitive elements will either concur or conflict (Festinger, 1957). According to the theory of cognitive dissonance, this concurrence or the resolution of this conflict is the major determinant of a person's behavior.

Since there is a strong likelihood that counselors will encounter consumers expressing suicidal ideations, a counselor's own personal beliefs and attitudes toward such a consumer are, therefore, subject to concurrence or conflict as represented in cognitive dissonance theory. Two possible kinds of cognitive relationships may exist. These two cognitive elements will either concur or conflict. Either of these situations, concurrence or conflict among beliefs and attitudes, may or may not be cognitively problematic for the counselor.

One possible cognitive relationship would be that a counselor's beliefs and attitudes are in congruence. Using the language of cognitive dissonance theory, these two cognitions are considered to be *consonant*. Consonant cognitions psychologically presuppose one another (Festinger, 1957). According to cognitive dissonance theory, consonance is not an impetus for behavioral change. The counselor is likely to continue the current therapeutic course. For example, believing suicide to be immoral would reflect an attitude of consonance when using no-suicide agreements with suicidal clients. Since consonance is not an impetus for behavioral change, the counselor is likely to continue using no-suicide agreements with his or her clients. Ethical problems related to consumer autonomy are possible in such a situation. The counselor, being without motivation in this circumstance, is unlikely to seek out potential ethical dilemmas.

The other possible cognitive relationship would be that a counselor's beliefs and attitudes conflict with one another. Using the language of cognitive dissonance theory, the counselor is experiencing cognitive *dissonance* (Festinger, 1957). Cognitive dissonance occurs "whenever a person has two or more cognitions that are dissonant [having an obverse relationship] with regard to each other" (Wicklund & Brehm, 1976, p. 2). According to cognitive dissonance theory, dissonance *is* an impetus for behavioral change. The counselor is likely to alter the current therapeutic course. For example, believing suicide to be a matter of personal ethical autonomy might reflect an attitude of dissonance when feeling duty-bound to use no-suicide agreements with suicidal clients. Since dissonance is an impetus for behavioral change, the counselor might choose to discontinue using no-suicide agreements with his or her clients.

In either case, the relationship between a counselor's own personal beliefs and his or her attitude toward a client expressing suicidal ideations is important to understand, since this relationship influences the therapeutic alliance. According to the theory of cognitive dissonance, the tendencies of belief and attitude to either concur or conflict is the major determinant of a person's behavior. Since the person's (in this case the counselor's) behavior is of the utmost importance to the therapeutic relationship, the determinants of this behavior must also be of vital importance. In the case of a suicidal consumer, these vitally important behavioral determinants are the counselor's own personal beliefs about suicide and his or her attitudes toward a consumer expressing suicidal ideations. Even more specifically, the counselor's behavior in the therapeutic alliance is governed by the relationship that exists among these beliefs and attitudes. Uncovering the nature of this relationship is the goal of this research question.

### **Summary**

Death and dying are arguably two of the greatest influences on human culture. Suicide, a particularly stigmatized form of death and dying, is now the eighth leading cause of death in the United States. Between 66 and 80% of those who do commit suicide tell someone, often their counselor, of their intentions. Studies have shown that most counselors will encounter at least one consumer with suicidal ideations, and that there is a 20% chance that a client will be successful in a suicide attempt.

Considering the significant effect of death on culture, the high prevalence of suicide as a particularly stigmatizing form of death in the United States, and the likelihood of counselors to encounter potentially suicidal consumers, it is not surprising that a vast body of research attests to the importance of suicide to the counseling profession. However, debate and disagreement currently exist on numerous points of

ethics related to this topic. Literature suggests that a current state of inadequate counselor training in the areas of suicide and suicide prevention “leaves trainees substantially unprepared for managing the complexity of actual suicidal crisis” (Neimeyer, 2000, p. 551). Practicing counselors often disagree with one another and sometimes with their own professional codes of ethics about issues of suicide and its prevention (Albright, & Hazler, 1992; Bongar, 1992; Davidson, Wagner & Range, 1995; Battersby, 1997).

Much of the existing research pertaining to counseling and suicide indicates a complex and unclear relationship among counselors’ personal reactions to their own consumers expressing suicidal ideations, and counselors’ reactions to the more abstract concept of death by suicide. This is of particular relevance because of the impact of counselor beliefs and values on counselor behaviors in the client-counselor relationship. Nearly all schools of therapy agree on the primacy of the therapeutic relationship to a positive therapeutic outcome, and virtually all personality theorists recognize a link among personal beliefs and counselor behaviors that result in the development of a strong therapeutic alliance. The perspective of cognitive dissonance theory, when applied to the attitude of the counselor toward the consumer, may be seen as a bridge between belief and behavior.

Therefore, it is the intent of this study to help answer the question: What is the relationship among a counselor’s personal beliefs about suicide and his or her attitudes toward clients expressing suicidal ideations?

### **Definitions**

- **Attitude:** individuals’ affective perspective or disposition, reflecting their general expectancy of a situation, based on their underlying beliefs. Attitude is the component of communication that is an affective perspective based on cognitive beliefs (Long, 1996, p. 110). “An idea charged with emotion which predisposes a class of actions to a particular class of social situations” (Triandis, 1971, p. 2)

- **Belief:** “A mental state as in when one accepts a proposition as true (judges it to be true) and is prepared to act (mentally or physically) on this basis” (Aydede, 2003, p.1).
- **Physician-assisted suicide:** “The process by which “the physician provides a patient with the medical means and/or medical knowledge to commit suicide” (Glasson, 1994, p. 92).
- **Rational suicide:** “Following a sound decision-making process, a person has decided, without being coerced by others, to end his or her life because of unbearable suffering associated with terminal illness” (Werth & Holdwick, 2000, p. 513).
- **Suicide:** “Death from injury, poisoning, or suffocation where there is evidence (either explicit or implicit) that the injury was self-inflicted *and* that the decedent intended to kill himself/herself” (O’Carroll et al., 1996, pp. 246-247).
- **Suicidal ideation:** literally refers to thought, or ideas, about suicide. However, since such ideations are so inherently private, this study uses this term to describe “Any self-reported thoughts of engaging in suicide-related behavior” (O’Carroll et al., 1996, p. 247).
- **Suicide-related behavior:** Potentially self-injurious behavior for which there is explicit or implicit evidence *either* that (a) the person intended at some (nonzero) level to kill himself/herself, or (b) the person wished to use the *appearance* of intending to kill himself/herself in order to attain some other end (O’Carroll et al., 1996, p. 247).

## CHAPTER 2 REVIEW OF LITERATURE

This literature review concerns the following research question. What is the relationship between a counselor's personal beliefs about suicide and his or her attitudes toward clients expressing suicidal ideations? Comprising five sections, this review asserts the importance and shows the relevance of this study. "Section One: American Attitudes Related to Death and Dying" discusses American attitudes related to the experience of death and dying. "Section Two: American Attitudes Related to Suicide" narrows that focus to suicide and the attitudinal ramifications of that particular manner of dying. "Section Three: Counselor Attitudes Related to Suicide" concentrates on suicide as it relates to the counseling profession. "Section Four: Theory" is a theoretical discussion of the positive correlation among human beliefs and actions. Section Four also sets forth the theory underlying the interview process. "Section Five, Conclusions" is a statement of tentative conclusions asserting the research question's relevance to counseling research and practice based on the information presented in the previous sections.

### **American Attitudes Related to Death and Dying**

It has been argued that the greatest influence on culture is death and dying (Aries, 1974; Glaser & Strauss, 1965, 1967; Kubler-Ross, 1969, 1975). It is likely the one experience shared by every human being who has ever lived. The following is an examination of that experience and its influence on American culture.

It would be a mistake to assume the existence of a homogenous American attitude toward death and dying. American societal attitudes toward death are as mixed and varied

as its citizenry. Our own personal experiences of death are far from universal. While humans may share some commonalities of experience and attitude, Corr (1979) notes “this sharing takes place in different and often distinctive ways from society to society and from individual to individual” (p. 8). As discussed below, in such a heterogeneous society as the United States, any attempt at defining an “American” societal attitude toward death and dying is fraught with difficulty.

Subcultures exist for many reasons. Some are the result of immigrant Americans bringing with them the culture of their country of origin. Others are religiously defined. Still others are formed on the basis of age or gender. Since subcultures often have subcultures in themselves, there is frequent overlapping among groups (Rubin & Roessler, 2001). Not only is the United States culturally heterogeneous, it is also geographically heterogeneous, as attitudes about death and dying often vary by region (Lester, 1998). Finally, socio-economic status (SES) is often the influence that overshadows and either accents or diminishes the effects of other cultural influences (Rubin & Roessler, 2001). Each of these impediments to a unified definition of a single American societal attitude on death and dying is examined.

Attitudes about death vary by cultural background (Lester, 1994; Levy, Ashman & Dror, 1999; Mishara, 1996). Consider the differences between the dominant White American culture that generally considers death a topic to avoid (Glaser & Strauss, 1965), and Mexican-Americans of the southwest who hold the annual holiday *The Day of the Dead*. *The Day of the Dead* is a time for singing, dancing, and celebration, all the while dressed in skeleton costumes (Green, 1980; Moore, 1980). Different cultural

attitudes about death might contribute to the fact that Caucasians also account for over 90% of all American suicides (Centers for Disease Control, 2002).

“Hispanos(as) in northern New Mexico remember the death of a loved one by a type of written narrative referred to as a *recuerdo*, a remembrance” (Korte, 1995; p. 245). According to Korte, the *recuerdo* is “recounting a person’s life in an epic, lyrical, and heroic manner” (p. 146). Cultures that have a special day to celebrate the dead, or honor the dead in song and dance, appear to be demonstrating a different attitude toward death than cultures opting to avoid that same subject matter. The United States is home to dozens of dramatically different ethnic backgrounds.

Attitudes about death vary by religious belief (Levy et al., 1999; Rasmussen & Johnson, 1994; Walker, 2000). While ethnicity and religion are often conterminous, they are here treated as conceptually discrete.

Nearly every religious belief system shares two common themes, some notion of an afterlife, and a “code of conduct” to be followed in this life so as to attain a desired afterlife situation (Walker, 2000). As shown next, an individual’s concept of these two themes affects (and is affected by) his or her attitude toward death. Some of the most prevalent approaches to eschatology in the United States may be found in the philosophies of extinctionism, existentialism, Shamanism, the Hebrew *Torah*, the Judeo-Christian bible, the Islamic Qur’an, Eastern beliefs in reincarnation, and various secular alternatives to (and/or combinations of) the above.

Extinctionism and Existentialism postulate that death is most likely the end of a person’s being, since no evidence exists to the contrary (DeSpelder & Strickland, 1996; Schrader, 1967). This view is common to Freudian thought (Freud, 1957), Confucianism

(Toynbee, 1973), Marxism, and humanitarism (Walker, 2000). Existentialist thinkers include Kierkegaard, Sartre, Camus, Marcel (Schrader, 1967), and Becker (1973).

Shamanism, still practiced by many Native American tribes, may have been the world's first religion to have a concept of spiritual immortality after death (Walker, 2000). According to Walker, Shamanism is thought to be the basis of all modern religions adhering to belief in an afterlife. The Hebrew Torah, also the Old Testament of the Christian Bible, may be two of the first incarnations of Shamanism into modern religious thought.

The Torah, while including the idea of an afterlife, does not include the notion of personal immortality or the soul (Plaut, 1981). The Torah and Old Testament view of the afterlife is that of *Sheol*, "the ancient Hebrew conception of death as a place of peace and repose" (Walker, 2000). Around the time of Jesus, the Hebrew view of the afterlife was beginning to change, as evidenced by the differing views of the Sadducees and the Pharisees. The Sadducees represented the Sheol view of the afterlife. The Pharisees taught that the Hebrews would be resurrected from the grave to help God recreate the earth or "New Jerusalem" (Plaut, 1981). According to Plaut, both believed in the necessity of a behavioral code of conduct, but for different reasons. The Sadducees taught that the code was necessary for an orderly civilization. The Pharisees believed that only those who followed the code would be resurrected at the end of time. This was envisioned as a corporal resurrection, reuniting the body and soul.

The Christian Bible, or the New Testament, has its roots in the beliefs of the Pharisees; and developed the idea that dead people's souls could go to be with God in heaven until the time of the resurrection (Plaut, 1981). This belief is reflected in the

Islamic Qur'an (Walker, 2000; Esposito et al., 2002). For both Islam and Christianity, adherence to a proper code of conduct is a prerequisite for being with God and for resurrection. Also significant to the Islamic tradition are various forms of death (including suicide in the service of God) to be discussed later. Islam contends that "the moment of death is foreordained and suffering should not be avoided because it serves for expiation of sins" (Smith & Perlin, 1979, p. 655).

Atheistic extinctionists, the agnostic existentialists, the animism of Shamanism, and the monotheisms of the Hebrews, Christians, and Muslims differ from the polytheisms of Hinduism and Buddhism. The eschatology of both Hinduism and Buddhism includes the concept of reincarnation, the belief that a person lived and died before this life, and will continue to be reborn after his or her death (Long, 1975). Hinduism teaches that, "no human life can be filled with a sense of meaning and efficacious action unless it is lived in full acceptance of the fact of death" (Long, 1975, p. 65). As stated by Hopfe (1987), "The basic world view of Hinduism is that life is an endless cycle of birth, life, death and rebirth and the goal of religion is to cease living" (p. 104). Buddhism, currently the world's largest religion (Esposito et al., 2002) teaches that the characteristics of one's reincarnation are dependent on the quality of one's karma (Smith & Perlin, 1979; Esposito et al., 2002). According to Smith and Perlin, in the Buddhist view, suffering enhances karma.

Each belief system suggests significant attitudinal variability. The United States is home to dozens of similar dramatically different religious backgrounds (Esposito et al., 2002) and to a great number of persons who "combine these belief systems, effectively

fusing religious faith with empirical knowledge and humanitarian codes of conduct” (Walker, 2000).

Basic differences in attitudes about death are also found by gender (Canetto & Feldman, 1993; Canetto, 1992; Humphrey & Palmer, 1990; Moremen & Craddock, 1998). One measure of this difference is evidenced by findings that females are more likely than males to attempt suicide (Canetto & Lester, 1995; Range & Leach, 1998; Westefeld et al., 2000; Laux, 2002). While female attempts far outnumber those of males, men are far four times more likely to be successful (and account for 72% of all suicides) (Centers for Disease Control, 2001).

In 1991, Canetto notes a stronger relationship for women than for men between level of dependence and suicidal behavior. That is, those exhibiting a greater level of dependence are more likely to engage in suicidal behaviors. However, her studies do not find this dependence to be related to a “love object,” as is the case in traditional psychodynamic theory (Canetto, 1992; Canetto & Feldman, 1993). This dependence is usually associated with nonfatal suicide attempts and suicidal ideation (Canetto & Feldman, 1993). Beck et al. (1973) found women more likely than men to cite interpersonal problems as the cause of their suicide attempt or ideation. Stillion et al. (1989) and Canetto (1992) attribute these gender-related differences to socialization. Stillion et al. found that surviving a suicide attempt carried with it much harsher negative social criticism for men than it did for women. Canetto (1992) points to considerable variation even within the sexes, stating that “suicidal behavior may be mediated by the person’s sensitivity to gender conventions” (p. 13).

While men are more likely to kill themselves than are women, 72% of Dr. Kevorkian's assisted suicides were women (Canetto & Hollenshead, 1999). In their study of the Kevorkian cases, Canetto and Hollenshead cite such perceptions of gender differences as possible reasons for this blatant gender discrimination. These include (but are not limited to) "pragmatism about one's death, a diminished sense of entitlement, social and economic disadvantage, and cultural definitions of the full life" (p. 183).

Gender differences regarding social attitudes about death are also reflected in newspaper obituaries (Moremen & Craddock, 1998). "Despite women's inroads into paid labor, they continue to receive less recognition for their accomplishments after death" (Moremen & Craddock, 1998; p. 248). According to Moremen and Craddock, women's obituaries tend to be shorter, less likely to include a photograph, and are published nearly eight times less frequently than men's. Finally, a specific study of death anxiety by Rasmussen and Johnson (1994) found higher levels of death anxiety among female participants than among males.

Death-related attitudinal differences are also found by age (Davis-Berman, 1998; Levy et al., 1999). Various cultures often respond differently to the impending death of an elder as opposed to the same condition in a youth. For example, Euro-Americans are generally more accepting of the death of an elder, whereas Asian-Americans tend to acknowledge the deaths more equally (Wass, 1979; Weaver & Koenig, 1996). Levy et al. (1999) found that "societally-transmitted negative stereotypes of aging can weaken elderly people's will to live" (p. 409). They further state that such negative Euro-American stereotypes dominate both the young and old, affecting individual and family decisions on end-of-life care. In her study of aging in relation to fear of death

among college students, Davis-Berman (1998) found such fears to be a factor in why some students balk at taking courses on aging. Davis-Berman notes that even students who do take such courses often retain their negative stereotypes toward aging.

Attitudes on death vary by region (Moreman & Craddock, 1998; Reid & Reid, 1999). One example is how the inhabitants of different regions choose to memorialize the death of a loved one. In such states as Texas and Oklahoma, it is commonplace to find roadside death memorials erected by family members on the site of a fatal automobile accident (Reid & Reid, 1999). These *descansos* [resting places] had their origin as grave markers of the early Spanish Conquistadors. Later, they became signs of those who died while traveling (OPB, 2002). Reid and Reid note that this particular outward sign of internal beliefs and attitudes toward the death of a loved one is much less prevalent in states such as Maine and Vermont. In their study on obituaries, Moreman and Craddock (1998) discovered regional differences in how women are remembered after their deaths as opposed to men. They found significant anti-female bias to exist in New York, but it was expressed less intensely in Miami.

Additional evidence may be reflected by regional suicide rates. “Suicide rates are generally higher than the national average in the western states and lower in the eastern and midwestern states” (Centers for Disease Control, 2002). Should such behaviors be indicative of internal attitudes, it would appear that regional attitudinal differences do exist.

Finally, SES may be the most influential of all (Rubin & Roessler, 2001). Corr further notes that the United States, the world leader in medical technology, does not lead the world’s mortality or even infant mortality rates. Many other countries have lower

rates of both general and infant mortality. Achieving notably better rates are Australia, New Zealand, and the Scandinavian countries (Corr, 1979). Corr points out that large heterogeneous countries, such as the United States cannot compete with smaller homogeneous countries and considers this to be largely a function of SES. Native Americans, perhaps the nation's lowest ethnic SES group, have a significantly higher mortality rate than the rest of American society (Corr, 1979). Regardless of an individual's ethnic, religious, or regional background, regardless of a person's gender or age, the level of his or her access to the healthcare system is greatly determined by his or her SES (Rubin & Roessler, 2001). It is, therefore, reasonable to postulate that, in addition to the other variables addressed above, a person's SES is a dramatic influence on his or her attitudes on death and dying. This conclusion is a direct derivative of SES as a determinant of an individual's access to healthcare. As Rubin and Roessler point out, the greater a person's healthcare access, the more options he or she has for end-of-life care. End-of-life care options have considerable variability from dying alone in a hospital (with or without palliative care), to dying in the company of friends and loved ones (as pain-free as possible) in a hospice situation (Beauchamp & Veatch, 1996). It may be reasonable to conclude that an individual's expectation of his or her own kind of death, which is influenced by SES, might help shape that person's attitudes about death. A country with such vast SES differences as the United States is unlikely to produce a common national attitude toward death and dying. Therefore, a discussion about societal attitudes toward death in the United States must be predicated on the existence of such variability.

To make such a diverse topic somewhat more manageable, the remainder of this section concentrates on the dominant White American culture of European ancestry. This segment of society is chosen for the following reasons. White Euro-American attitudes are manifest in laws passed and court cases heard. This provides a basis for empirical observation of behavior related to attitude. Secondly, the major social and psychological theories on death and dying in America have been written by and about this group. It would be remiss to omit these theoretical perspectives in a discussion of death and dying in America. Thirdly, the majority of counselors are members of this group. Lastly, this group is human and, therefore, bound to die. Aside from being American, this is certainly a point of commonality between this social segment and all others.

Death may well be the one experience that all humans have in common. Not every person who has been born will grow old, but all people will surely die. Yet many seem to find death difficult to accept (Datson & Marwit, 1997; Neimeyer & Neimeyer, 1984). Perhaps this is because the reality of dying seems so dissonant with the continuity of daily life (Vickio, 2000). Whatever the reason, dialogue about death is not an easy subject for many Americans (Glaser & Strauss, 1965; Kubler-Ross, 1975). Witness the attitudinal cacophony surrounding the issues of abortion [legalized in all states in 1973 (Planned Parenthood, 2002)], the death penalty [legal in 38 states (MSNBC, 2002)], and physician-assisted suicide [legalized in Oregon only (Oregon Death with Dignity Act, 1997)].

While some people have learned to embrace death, as exemplified in the literary work *Tuesdays with Morrie* (Albom, 1997), one seemingly overriding American response to death is avoidance (Glaser & Strauss, 1965). The medical model of healthcare views

the death of a patient as failure (Simpson, 1979). Simpson postulates this view may be linked to the psychology of physicians themselves. Perhaps individuals choosing the profession do so partly due to a higher than average fear of death. “The intensity with which the physician experiences the fear of personal death has been associated with a variety of factors, including the choice of specialization, the ability to successfully repress their death anxiety, and demographic factors” (Hamama-Raz et al., 2000, p. 140). For example, Glaser and Strauss (1965) found surgeons to be generally better able than psychiatrists at dealing with their own death anxiety. Possibly indicative of these tendencies is the statistical finding that the suicide rate among physicians is twice that of the general American population. For psychiatrists, the occurrence of suicide is four times the national average (Grollman, 1988). The very words *dead* and *death* have been supplanted by the use of such tropes as *deceased*, *no longer with us*, or *passed away*. For many Americans death has become a forbidden, even shameful, subject (Aries, 1974).

Aries (1974) notes this was not always the case. Since the beginning of colonization, Americans had died in their homes surrounded by their children, family, and friends (Aries, 1974). Death was a socially accepted fact of life. All this changed in the mid 20<sup>th</sup> Century when Americans began to die in hospitals (Glaser & Strauss, 1965; Aries, 1974).

This change can largely be attributed to technological advances in medicine (Beuchamp & Veatch, 1996). Prior to this time, death was a simpler matter. When a person’s heart and respiration stopped, everyone agreed that he or she was dead. In America today, there is no such consensus. Each state decides for itself the condition(s) that constitute death. For some it remains the cardio-pulmonary definition of old, a

position supported by many Orthodox Jewish Americans, Japanese-Americans, and Native Americans (Beuchamp & Veatch, 1996). Other states take into consideration a condition identified as 'brain death' (Veatch, 1979; Fulton & Metress, 1995). Yet, as Fulton and Metress report, an exact definition of 'brain death' remains controversial and the subject of considerable debate.

Perhaps the most poignant death-related result of medical technology is the manner of death. People used to die relatively quickly (Aries, 1974). Technology has not only set people to debating the definition of death, but has caused them to die much more slowly, painfully, and expensively. The advent of the hospice movement, discussed later in more detail, is helping to change this end of life experience (Davidson, 1979).

As Americans began to die in hospitals, their children were among the first to be excluded from this experience (Aries, 1974). Gradually, all involved began to shield even the dying individual from the knowledge of his or her impending death. Family, friends, and healthcare professionals joined the dying patient in what Glaser & Strauss (1965) named, "The ritual drama of mutual pretense" (p.64). This drama is played out when all involved, including the patient, know that death is imminent yet pretend to lack such knowledge. The frequency with which this ritual is enacted illustrates the extent of American death avoidance behavior. The British anthropologist Gorer (1967) wrote in his essay *The Pornography of Death*, "We have come to view the subject as inherently abhorrent, one which can never be mentioned openly or discussed directly. Like all disgusting subjects, death can only be introduced into polite conversation obliquely or euphemistically"(p. 32).

As mentioned earlier, children, previously included at the bedside of a dying family member, have become increasingly shielded from the event of death (Aries, 1974; Kubler-Ross, 1975). The shielding of children from the death experience is perhaps the most damaging since it is considered by many to negatively affect their personality development (Stillion & Wass, 1979). In Erik Erikson's theory of human development (1950), infancy, early childhood, and adolescence are associated with the development of trust or mistrust, autonomy or shame and doubt, and initiative or guilt respectively. At each of these childhood developmental stages protecting the child from the experience of death is likely to engender psychological distress later in life (Kubler-Ross, 1975; Stillion & Wass, 1979). These children soon become society's next generation of adults.

According to this perspective, their negative attitudes on death and dying were shaped by the exclusion of the death experience. The essence of this situation is elegantly stated by Jocelyn Evans (1971) in her book, *Living with a man who is dying*. "We have created systems which protect us in the aggregate from facing up to the very things that as individuals we most need to know" (p. 83).

Yet, at the same time, there exists what Aries (1974) termed a "Cult of the Dead" (p. 74). Shrouded in patriotism and nationalism, Americans honor certain types of death with grand and massive memorials such as Arlington Cemetery and the Tomb of the Unknown Soldier. Glaser & Strauss (1965) state that Americans appear more comfortable with these particular socially accepted forms of death than with death in the abstract. "We engage in very little abstract or philosophical discussion of death. Americans are characteristically unwilling to talk openly about the *process* of dying itself" (Glaser & Strauss, 1965; p. 3).



All these stages are defense or coping mechanisms for dying. Kubler-Ross insists the one condition that persists throughout all the stages is hope. Without hope, transition from one stage to another would not be possible.

When Elizabeth Kubler-Ross began her death studies in the mid 1960s, there was very little literature available on the subject (Kubler-Ross, 1975). This is no longer the case. Today there are major professional journals dedicated to the study of death and dying including *Death Studies* (formerly *Death Education*), *Omega: Journal of Death and Dying*, and *Suicide and Life-Threatening Behavior*.

American attitudes have changed dramatically since 1975 and in no small part due to the efforts of Elizabeth Kubler-Ross (Fulton & Metress, 1995; Beauchamp & Veatch, 1996). In 1973 the United States Supreme Court ruled that a woman's right to an abortion is protected under the 14<sup>th</sup> Amendment in the Constitution that protects the concept of personal liberty (Roe v. Wade, 1973). In 1980 Derek Humphry formed the Hemlock Society after assisting his wife to commit suicide. The Hemlock Society has its main office in Eugene, Oregon and is dedicated to the right of an individual to end his or her own life (Humphry, 1991). In 1986 the Supreme Judicial Court of Massachusetts ruled that Paul Brophy could become the first permanently unconscious patient kept alive by a feeding tube to be allowed to legally die by the removal of said tubes. Four years later the Supreme Court denied Nancy Cruzan same option. The court did, however, not only hear the case, but also set the precedent for physicians to respect a Living Will, which Ms. Cruzan did not have (Cruzan v. Director, Missouri Department of Health, 1990).

Since 1990 the news media has brought numerous death-related issues to the attention of the American public. Throughout the 1990s, physician Jack Kevorkian

continually made headlines with his Mercitron or “suicide machine” (Fulton & Metress, 1995). Derek Humphry published his book, *Final Exit* about the mission of the Hemlock Society (Humphry, 1991). It became an immediate New York Times best seller. In 1997, as mentioned earlier, the state of Oregon passed its own Death with Dignity Act.

Perhaps most indicative of a nation-wide attitudinal shift is the hospice movement, which has also been largely credited to the efforts of Elizabeth Kubler-Ross (Fulton & Metress, 1995; Beauchamp & Veatch, 1996). Davidson (1979) explains the origin of the word as follows.

*Hospice* is a medieval term that refers to the wayside inns for pilgrims and other travelers, particularly at those places of the greatest vulnerability and hardship. The *hospice movement* represents the development of a variety of programs designed to better assist terminally ill patients for whom aggressive medical treatment is no longer deemed appropriate in travel through life (p.158).

Hospice care began, and largely remains, a grass-roots movement that arose in response to the conditions surrounding death and dying documented in the 1960s and 1970s by Aries (1974), Glaser & Strauss (1965, 1967) and Kubler-Ross (1969, 1975). While the hospice movement does not advocate suicide, assisted or otherwise, it does support a dying individual’s right to refuse further medical treatment beyond palliative care (Sendor & O’Connor, 1997).

Another movement, which does advocate for an individual’s right to die by means of suicide and assisted suicide, is Death with Dignity (Quill, 1991; Albright & Hazler, 1992). It’s members use the term *voluntary euthanasia*. Euthanasia, from the Greek, literally means “the good death” as opposed to *dysthanasia* or “the bad death” (Fulton & Metress, 1995). A bad death is considered to be long, painful and without dignity. The good death refers to dying without pain and with dignity.

At the fringe of this movement are dozens of nonphysician-assisted suicide activist groups. These groups, from around the world and from in the United States, are part of what Ogden (2000) terms, the *Deathing Counterculture*. While certainly not representative, the Deathing Counterculture in the United States is comprised predominantly by White Euro-Americans. Their goal is to provide all Americans the technological ability to end their own lives (Ogden, 2000).

### **American Attitudes Related to Suicide**

In 1999, there were 29,199 reported cases of suicides in the United States, which translates to about 12 suicides per 100,000 Americans (Centers for Disease Control, 2002). The number of suicides that year was 1.7 times higher than the number of homicides. The Centers for Disease Control (2002) ranks suicide as the ninth leading cause of death overall and third for people between the ages of 15 and 24. While these numbers may seem high, Blumenthal (1988) (as cited in Fulton & Metress, 1995) suggests the actual number of suicides is likely two to three times higher. While the reasons for this disparity in numbers range from lack of death certificate uniformity to insufficient information as to the cause of death, Fulton and Metress (1995) note *stigma* as a significant factor contributing to the official underreporting of suicide.

The term *stigma* is perhaps most closely related to the term *disgrace* (Moller, 1990). A person with a stigma is perceived as somehow negatively outside the norm of society. He or she is unusual, and in possession of qualities considered by the general public as undesirable. Moller writes, "Every society sets forth a range of qualities and behaviors which it prescribes as being desirable and an additional complex of attributes and behaviors which it proscribes as undesirable" (p. 67). Attached to those proscribed negative qualities is the notion of *stigma*.

Death and dying has certainly been awarded the social stigma of undesirability. The stigma associated with suicide is reflected as being, weak, cowardly, and immoral (Lester, 1993; Ingram & Ellis, 1995). Interestingly, American society has generally come to accept certain kinds of suicide, or rather, suicide by certain kinds of people. The suicide of the very old, the very sick, and the very disabled, has tended to meet with general societal approval (Beauchamp & Veatch, 1996; Canetto & Lester, 1995; Ellis & Hirsch, 2000). Survivors of suicide victims from these groups are similarly judged as being less “responsible” for the suicide than are survivors of young and healthy suicide victims (Range & Martin, 1990). This suggests the question, *why*. Why these groups and not others such as the young and healthy?

The answer may be found in the similarities among these three groups and an understanding of the stigma attached to disability. In a very real way, the elderly and the very ill may be perceived as being disabled. They are disabled by their age, their illness, or a combination of the two. Social attitudes are often sympathetic, sometimes even encouraging, of an individual with a severe disability who wishes to end his or her own life (Rubin & Roessler, 2001). This may be the result of the general social attitude that all persons with disabilities would choose to be rid of their disability if that choice were possible (Hahn, 1991). Martin and Range (1990) note, “preexisting prejudices and paranoias can affect social reactions to suicide” (p. 189).

Disability, in a society that caters to the youth culture of vigor and vitality (Corr, 1979), is stigmatized as representative of polar opposite qualities. The stigma of disability may accurately be viewed in the light of the stigma of death and dying, and the stigma of suicide. The beginning of this section discussed stigma as described by Moller (1990).

The following are two lines from that description, but in the place of the word “stigma” is the word “disability.” The reader is invited to mentally substitute, for “disability,” the words “very old” or “very ill.” A person with a disability is perceived as somehow negatively outside the norm of society (Rubin & Roessler, 2001). He or she is unusual, and in possession of qualities considered by the general public as undesirable. Some members of society might regard the suicide of such individuals as helping rid undesirable elements from the general public.

Physician Jack Kevorkian assisted 100 persons to die and, although tried several times, was never convicted for assisted suicide (PBS, 2000). The disability advocacy group “Not Dead Yet” lists, on its web site (Not Dead Yet, 2002), all those deaths assisted by Dr. Kevorkian. The group makes the case that these individuals were largely not immediately terminal and were allowed to die based solely on their disability. According to a study by Canetto and Hollenshead (1999) on those assisted by Dr. Kevorkian between 1990 and 1997, the foremost reason stated by the patients and their families for the suicide assistance was having a disability.

Dr. Kevorkian was convicted of murder in 1999 for administering a lethal injection to Thomas Youk, age 52. Mr. Youk had late-stage Amyotrophic Lateral Sclerosis and requested the injection (PBS, 2000).

In the case of *Quill v. Vacco* (1996), the Supreme Court heard arguments for and against the Oregon Death With Dignity Act (1997). As part of this hearing, the disability advocacy group Not Dead Yet entered an *amicus curiae* [friend of the court] brief (Not Dead Yet, 1996) in opposition to the Oregon law. Joining Not Dead Yet in the brief were several other disability rights groups also in opposition to physician-assisted suicide.

These groups included, the American Disabled for Attendant Physician-assisted Suicide, the American Disabled for Attendant Programs Today, the Association of Programs for Rural Independent Living, the Disability Rights Education and Defense Fund, Justice For All, the National Council on Disability, the National Council on Independent Living, the National Spinal Cord Injury Association, the World Association of Persons with Disabilities, and the World Institute on Disability (Not Dead Yet, 2001). Indicative of mixed attitudes among the health professions, the American Psychological Association (APA) signed on to an *amicus curiae* brief presented by the American Medical Association in opposition to the Oregon law (Werth & Gordon, 2002), while the American Counseling Association (ACA), the Association for Gay, Lesbian, and Bisexual Issues in Counseling; and an ad hoc Coalition of Mental Health Professionals Supporting Individual Self-Determination in Decisions to Hasten Death all signed on to another *amicus curiae* brief sponsored by the Washington State Psychological Association (WSPA) in support of the Oregon law (Werth & Holdwick, 2000; Werth & Gordon, 2002). The debate over the ACA decision to join the WSPA brief continued with individual letters in *Counseling Today* (Donaldson, Patton & Wood, 2002; Bennett, 2002).

### **Counselor Attitudes Related to Suicide**

American counselors are predominantly of European ancestry (Rubin & Roessler, 2001) and individual counselors are subject to generally the same social influences as the rest of the population. A counselor's attitude is, therefore, greatly influenced by the American culture of which he or she is a member.

Client, counselor, and third-party attitudes toward life and death are culturally driven, thereby making the recognition of cultural differences critical to understanding the vastly different decisions that can be made. These cultural value

judgments help determine one's thoughts, beliefs, and, eventually, actions (Albright & Hazler, 1995, p. 179).

As previously stated, suicide is now the ninth leading cause of death in the United States, the third leading cause for people between the ages of 15 and 24 (Centers for Disease Control, 2002), and would likely be ranked even higher were it not for social attitudes heavily biased against declaring suicide as the cause of death (Fulton & Metress, 1995). Westefeld et al. (2000) estimates that approximately one American in every 60 has encountered the death of a loved one via suicide. The magnitude of suicide in America creates an important counseling concern, the importance of which is evident in the counseling research literature. Studies, such as those by Carney and Hazler (1998), McAdams and Foster (2000), and Rogers (2001) indicate that a majority of counselors will experience at least one consumer with suicidal ideations. Of that group there is a twenty percent chance that a counselor will have a consumer successfully commit suicide (Bongar, 1992). This is because between 66 and 80% of individuals, who actually do commit suicide, tell at least one other person of their intentions. One of the people in whom they confide is often their counselor (Grollman, 1988; Brems, 2000).

The literature addressing counselor attitudes toward clients expressing suicidal ideations appears simultaneously to be both cohesive and fragmented. Studies on counselor's personal experiences with suicidal clients tend to show counselor attitudes to be quite similar. More abstract, cognitively oriented, studies that consider moral, ethical, and logistical aspects of suicidal clients in general, depict counselor attitudes as more disparate. The following is an examination of each, beginning with the more cohesive of counselor attitudes.

### **Similar Counselor Attitudes and Personal Experience**

Chemtob et al. (1988), Moritz et al. (1989), Menninger (1991), Little (1992), and McAdams and Foster (2000) conducted studies in which therapists most frequently named client suicide as a cause of anxiety. These authors discovered that many therapists viewed the suicide of a client as a professional failure. Feelings of guilt, anger, and sadness were documented as a counselor's most common emotional responses to the suicide of a consumer. Ensuing malpractice liability and legal repercussions often augment such feelings of self-recrimination (Bongar, 1991). Counselors are not alone in the self-blaming process. Studying individuals who had survived the suicide of a family member or close friend, Lester (1991) observed a great deal of perceived responsibility on the part of noncounselors. He also notes that survivors are routinely blamed by others in society, and that the degree of blame to a large degree hinges on how responsible society perceived the survivor to be for the life of the suicide victim while he or she was living. For example, a parent may be blamed more for the suicide of a child than for the suicide of a friend.

Several researchers report the development of counselor attitudes toward suicidal clients appears distinctive in that these attitudes are not seen as entirely the result of past experiences. Rather, as described below, this is in part due to the way in which the suicide-ideator client presents a special set of circumstances for the relationship with his or her therapist.

Suicidal clients tend to rely heavily on a process of communication termed projective identification (Malin & Grotstein, 1966). This process involves a continuous attempt at manipulating the counselor into validating the client's own internal perceptions

(Sandler, 1988). This kind of communication tends to evoke powerful emotions on the part of the therapist (Maltzberger, 1985).

Richards (2000) examined that relationship in the context of transference and countertransference. She found the counselor to be at significant risk of developing unconscious responses to the client expressing suicidal ideations. The suicidal client often projects intense emotions via the previously described process of projective identification. The counselor through the process of countertransference then acts on this emotional transference. The Richards (2000) study yielded results consistent with earlier studies on counselor attitudes toward clients who either expressed suicidal ideations or who actually committed suicide. The following statements by counselor study participants are descriptive of its findings.

- “I just felt very angry that she didn’t give me a chance” (p. 331).
- “The way the [suicide] attempt was announced to me was sadistic” (p. 331).
- “Her mother said, ‘I thought you may like to know that (name) killed herself.’ And the implication was that I had failed her” (p. 331).
- “I felt at times completely useless, hopeless as a therapist and a human being, always doing and saying the wrong thing” (p. 332).
- “I experienced something of his depression and feelings of helplessness and hopelessness” (p. 334).
- “I was initially angry with him, then sad. In subsequent months I experienced a loss of confidence as a therapist” (p. 334).

### **Fragmented Counselor Attitudes and More Cognitive Considerations**

Counselor attitudes toward clients expressing suicidal ideations remain fragmented on the more cognitive level. This is not surprising when considered in light of the current counselor debate over rational suicide (Richman, 1988; Albright & Hazler, 1992; Rogers et al., 2001). Briefly, rational suicide is a term used to describe the conditions under

which it would be considered by both the counselor and consumer to be a rational choice.

Rogers et al. (2001) considers suicide to be rational when the following conditions are met.

- (1) The person considering suicide has an unremitting hopeless condition. Hopeless conditions include, but are not necessarily limited to, terminal illnesses, severe physical pain, and/or psychological pain, physically or mentally debilitating and/or deteriorating conditions, or quality of life no longer acceptable to the individual.
- (2) The person makes the decision as a free choice (i.e., is not pressured by others to choose suicide).
- (3) The person has engaged in a sound decision-making process. This process should include the following:
  - Consultation with a mental health professional who can make an assessment of psychological competence.
  - Nonimpulsive consideration of all of the alternatives.
  - Consideration of the congruence of the act with one's personal values.
  - Consultation with objective others (e.g., medical and religious professionals) and with significant others (p. 238).

Proponents believe that there exist some cases in which suicide is a rational alternative. Proponents include 81% of psychotherapists (Werth & Liddle, 1994) and 76% of counselors (Rogers et al., 2001) “indicating some level of acceptance of the concept of rational suicide in working with an individual in a professional context” (Rogers et al., 2001, p. 370). This greatly concerns many people, including the members of Not Dead Yet (2002), who fear that counselors, as members of American society, may be predisposed to view suicide as obviously rational for persons with disabilities. This fear may be justifiable based on an understanding of stigma in American society.

As early as 1988, Richman (1988) leveled his challenge to the concept of rational suicide in, *The Case Against Rational Suicide*. Richman (1992) restated his position

against the very notion of dichotomizing suicide into the rational and irrational. “To imply that there are no cognitive errors behind rational suicide – that it is always the free choice of an individual, that there need be no contact with a counselor, no exploration of the decision, and no bringing in of the family or other support systems – is neither rational nor irrational; it reflects ignorance” (Richman, 1992, p. 130).

Rogers and Britton (1994) described rational suicide as a *slippery slope* in their discussion of its application to persons with AIDS. Firstly, note that the suicide rate of AIDS patients is much higher than that of the general public. Secondly, that studies such as those by Werth (1992) and Domino, Gibson, Poling, and Westlake (1980) indicate that the general public seems increasingly approving of suicide as an option for individuals with AIDS. The concern of Rogers and Britton (1994) is over the possibility that suicide is being considered as a rational choice for an ever-widening scope of individuals and groups. The attitude in opposition to the idea of rational suicide is expressed in the words of Corr, (1979).

Many people who threaten to commit suicide are really crying out for help. In response, we often ignore their real needs and sometimes we actually encourage their self-destructive tendencies. That is, we sometimes employ our freedom to convey to suicidal persons our agreement that their lives are without worth, when what is really called for is an effort to aid them to identify and to promote the values inherent in their lives (p. 39).

This attitude, predating the current debate concerning rational suicide, an individual’s right to die, and voluntary euthanasia, remains relevant today.

## **Definitional Issues**

### **Suicide**

In light of the controversy surrounding suicide, rational suicide, euthanasia, physician-assisted suicide, an individual’s right to die, and views that suicide is actually a

cry for help, a closer examination of the definition of suicide would appear pertinent. As is the case with so many other features of suicide, there exists little definitional homogeneity. Webster (1986) defines suicide as, “The act of killing oneself intentionally” (p. 1424). However, such a prosaic description of such a complex behavior proves inadequate. Numerous attempts to improve on this definition have been made over the years by researchers in the domains of sociology, psychology, philosophy and suicidology.

Sociologist Emile Durkheim (1951) viewed suicide in terms of an individual’s degree of social interaction or social relatedness. He believed people who committed suicide to be socially isolated and unable to identify with other members of the social group to which he or she belonged.

The Existentialist philosopher Jean Baechler (1979) defines suicide in terms of an individual’s quest for a solution to his or her own existence. “Suicide denotes all behavior that seeks and finds the solution to an existential problem by making an attempt on the life of the subject” (p. 11).

Psychologist Edwin Shneidman (2001) defines suicide as a reaction to what he terms *psychache*.

I believe that suicide is essentially a drama in the mind, where the suicidal drama is almost always driven by psychological pain, the pain of the negative emotions – what I call *psychache*. Psychache is at the dark heart of suicide; no psychache, no suicide (Shneidman, 2001, p. 200).

Williams (1997), believes the feeling of *entrapment* to be a necessary condition of suicidal behavior. He describes the suicidal individual as someone who feels trapped by life’s circumstances, and yielding to suicide being the sole option.

Roy, Nielsen, Rylander, & Sarchiapone (2000) point to evidence indicative of suicide having a genetic component stating, “The importance of psychiatric, social, and biological factors, psychodynamics and physical illness as determinants of suicide is well established. However, increasing data suggest that genetic factors may also play a part in suicidal behavior” (p. 210). The descriptions of Shneidman, Williams and Roy et al. (2000) afford but a glimpse into the complexity of suicide. While not all researchers subscribe to the notions of psychache or entrapment, and relatively few have examined the genetic factors, there does appear to be consensus about the multidimensionality and multideterminality of the suicidal act.

In 1985, Shneidman published a book dedicated entirely to the task of defining suicide. What follows is the culmination of that endeavor, “Currently in the Western world, suicide is a conscious act of self-induced annihilation, best understood as a multidimensional malaise in a needful individual who defines an issue for which the suicide is perceived as the best solution” (p. 203). There are two points of this broad definition that are most universally accepted. First, that it acknowledges that any definition of suicide must be understood relative to the time at which it is used, and the society in which it is used. Second, it describes suicide as being both a conscious decision and a self-induced action. Stillion & McDowell (1996) point out that not all suicidal individuals exhibit “multidimensional malaise”, one example being a person with a terminal illness who may try quite vigorously to end his or her own life. Another example of a lack or malaise is active euthanasia. While active euthanasia is generally considered to be suicide, passive euthanasia is not.

The definition used for this study is as follows. “Death from injury, poisoning, or suffocation where there is evidence (either explicit or implicit) that the injury was self-inflicted *and* that the decedent intended to kill himself/herself” (O’Carroll Berman, Maris, Moscicki, Tanney & Silverman, 1996, pp. 246-247). This definition reflects a broad understanding of the phenomenon including the two most common conditions found in the literature, intention and outcome. A majority of authors agree that, “To be classed as a suicide, a person must intend to kill himself, and he must actually do so” (Farber, 1968, p. 5).

While both conditions are necessary, this definition still remains open to a variety of individual interpretations. This is the case because although outcome is obvious (the individual is dead), intention is more problematic. The suicide victim is unavailable to explain his or her intentions. “Outcomes are clearer than intentions: The subject survives or he dies. But we cannot infer intention from outcome; outcome is determined by a number of contingencies” (Farber, 1968). Not every person who dies while engaging in self-destructive behavior intended to die. Conversely, not every person who attempts to kill him or herself succeeds. However, it would be incorrect to infer that one could learn about the intentions of successful suicide victims from the testimony of suicide attempters. Data confirming these constitute two distinctly different groups of individuals (and the information gleaned from one cannot be presupposed of the other) is so prevalent that some authors now use the word *parasuicide*. Parasuicide is a term used to describe intentional, but nonfatal, self-injurious behavior (Linehan, 2000; Maris, Berman, & Silverman, 2000).

**Suicidal ideation**

“In all but the most impulsive suicides there is a period of suicidal ideation” (Stillion & McDowell 1996, p. 27). Suicidal ideation refers to ideas about suicide or suicidal thoughts (Farber, 1968; Battin, 1982; Webster, 1986; Stillion & McDowell, 1996; Rudd, 2000). “Suicide ideators are individuals who think about or form an intent to suicide of varying degrees of seriousness but do not make an explicit suicide attempt or complete suicide” (Maris, Berman & Silverman, 2000, p. 20).

According to Kolko (1990), these ideations range from vague thoughts of suicide to specific ideas about one’s own suicide. They may or may not involve personal notions of intent, and may or may not include an actual suicide plan. While it is suspected that all those who suicide had been suicide ideators, relatively few suicide ideators actually follow through and commit suicide (Linehan, 1982; Maris, Berman & Silverman, 2000). However, of those who do, between 66 and 80% tell someone of their suicidal ideas (Grollman, 1988; Brems, 2000). Often, in addition to being nearly ubiquitous, suicidal ideations become compulsive. Thoughts of suicide intrude with increasing frequency until the individual feels unable not to think about suicide (Stillion & McDowell, 1996).

This study uses the following definition of suicidal ideation as “any self-reported thoughts of engaging in suicide-related behavior” (O’Carroll et al., 1996, p. 247). This definition takes into account the principal characteristic of suicidal ideation being the process of engaging in suicide-related thoughts, but specifically covers only those thoughts about which the client tells the counselor. By doing so, this definition rules out hearsay evidence of suicidal thoughts, and disallows the counselor attributing assumed thoughts to the client.

## **Theoretical Grounding**

The first two sections of this literature review provided an appreciation for the issues of death, dying, and suicide. The third section illustrated the importance of these issues to counseling. This section provides a theoretical underpinning for three questions of *why*. Why is the relationship between a counselor's personal beliefs about suicide and his or her attitudes toward clients expressing suicidal ideations important to understand? Why is qualitative research an appropriate method with which to analyze the research question? Why is the interview an appropriate qualitative technique with which to study the research question?

### **Theoretical Grounding for the Research Question**

Why is the relationship between a counselor's personal beliefs about suicide and his or her attitudes toward clients expressing suicidal ideations important to understand?

The answer is behavior, or more specifically, the behavior of a counselor toward a client expressing suicidal ideations. The quality of the counseling relationship, sometimes called the therapeutic relationship or working alliance, is generally considered to be the most important contributing factor to consumer growth and well-being in the context of professional counseling (Goldstein, 1962; Gladding, 1996; Walborn, 1996). "The successful outcome of any counseling effort depends on a working alliance between counselor and client" (Gladding, 1996, p. 142). Goldstein (1962) states, "There can no longer be any doubt as to the primary status which must be accorded the therapeutic transaction" (p. 105). Walborn (1996) asserts that possibly all schools of therapy agree with the primacy of the therapeutic relationship.

This therapeutic relationship, or alliance, has two major components: trust and collaboration (Walborn, 1996). While the consumer certainly comprises half this

relationship, the behavior of the counselor may be the most influential factor contributing to the nature of the therapeutic alliance. Counselor education stresses the importance of counselor behavior (both verbal and nonverbal) as evidenced by such techniques as *mirroring, active listening, responding, expressing positive regard, using silence, and empathic statements*. The fact that a counselor is listening, feels positive regard, or empathizes with a client is meaningless in a therapeutic relationship unless the client is aware of these thoughts and feelings (Long, 1996). It would seem a reasonable deduction that counselor behavior is necessary for the establishment of trust or collaboration, and an indispensable component of the therapeutic alliance.

Therefore, understanding why a counselor acts as he or she does must be considered important. Most personality theorists suggest a positive correlation among human beliefs and actions. Many contend that a person's beliefs are a primary cause of his or her behavior. Albert Ellis, founder of the theory of Rational-Emotive Therapy (RET) (Ellis & Grieger, 1977), later to become REBT with the addition of "Behavior" to the title, states

We largely (though not exclusively) control our own destinies, and particularly our emotional destinies. And we do so by our basic values or beliefs – by the way that we interpret or look at the events that occur in our lives and by the actions we choose to take about these occurrences (p. 5).

Viktor Frankl (1965), founder of Logotherapy, asserts that these personal values and beliefs are of ultimate importance because it is in these that a person finds the meaning necessary for life, and it is for these that he or she will live or die. Both Frankl and Ellis espouse the view that beliefs cause behaviors. Similar views are apparent throughout the literature related to counseling and hastened forms of death. For example, Albright and Hazler (1995) state, "These beliefs [about death and dying] result in

actions” (p. 179). Werth and Holdwick (2000), considered by many to be leading researchers in the field of suicide research, state that “it is apparent that personal values can and do affect professional actions” (p. 526). An alternative view, that behaviors cause beliefs, is found in behaviorist theory (Skinner, 1938). Assuming a causal relationship, regardless of direction, between beliefs and behavior, it would be reasonable to expect the knowledge of a person’s beliefs might provide valuable insight into his or her behaviors.

### **Cognitive Consonance and Dissonance**

The research question examines two kinds of cognitions, counselors’ personal beliefs about suicide, and counselors’ attitudes toward clients expressing suicidal ideations. Therefore, two possible kinds of cognitive relationships may exist. These two cognitive elements will either concur or conflict. For example, a counselor might believe that suicide is morally wrong *and* his or her attitude toward clients expressing suicidal ideations may reflect this belief. Such a counselor might attempt to dissuade the client from committing suicide. On the other hand, a counselor might believe that suicide is morally wrong, *but* his or her attitude toward clients expressing suicidal ideations may not reflect this belief. Such a counselor may opt to set aside this particular personal belief in favor of the ethical principal of autonomy, thereby accommodating the client’s right to self-determination. A variation on this second possibility could be a counselor who believes that suicide is a personal choice, *but* his or her employer requires employees to counsel clients against taking their own lives. For each of these situations, the relationship between a counselor’s personal beliefs about suicide and his or her attitudes toward clients expressing suicidal ideations are examined in the context of cognitive dissonance theory (Festinger, 1957).

Either of these situations, concurrence or conflict among beliefs and attitudes, may or may not be cognitively problematic for the counselor. Suppose the counselor believes suicide to be morally wrong and his or her attitude toward the client reflects this belief. In turn, the counselor argues against committing suicide based on that moral conviction. In the absence of any strong competing beliefs, using the language of cognitive dissonance theory, these two cognitions are considered to be *consonant*. Consonant cognitions psychologically presuppose one another (Festinger, 1957). According to cognitive dissonance theory, consonance is not an impetus for behavioral change. The counselor is likely to continue the current therapeutic course.

Now suppose that same counselor also believes in the ethical principal of autonomy. Autonomy, the right of self-determination, is one of the four ethical principles stated by Stadler (1986) to be of utmost importance for counselors. In this case, the counselor may experience difficulty with his or her attitude toward the client. The counselor might think that he or she is violating a valued ethical principal by imposing his or her own beliefs and ignoring those of the client. Using the language of cognitive dissonance theory, the counselor is experiencing cognitive *dissonance* (Festinger, 1957). Cognitive dissonance occurs “whenever a person has two or more cognitions that are dissonant [having an obverse relationship] with regard to each other” (Wicklund & Brehm, 1976, p. 2). In this case, the dissonance arises from two competing beliefs, the immorality of suicide, and the necessity of client autonomy.

According to cognitive dissonance theory, a dissonant cognitive relationship creates an unpleasant tension that motivates the individual to act in some manner so as to alleviate that tension (Festinger, 1957). Cognitive dissonance theory does not predict how

a person will act to diminish the tension, only that he or she will act to do so. In other words, cognitive dissonance is a stimulus to behavior. The ultimate importance of counselor behavior toward his or her client has been previously established. While cognitive dissonance theory does not predict how a person will act to diminish tension; it does suggest a variety of possibilities. These possibilities are germane to the research question since they may be a part of the relationship between a counselor's personal beliefs about suicide and his or her attitudes toward clients expressing suicidal ideations.

There are two methods by which cognitive tension may be reduced or alleviated. One is for the counselor to attempt to reduce the importance of, or eliminate entirely, the dissonant cognition. The other is for the counselor to find additional supporting consonant cognitions or work to increase the importance of the existing consonant cognition (Festinger, 1957). Discerning which cognition is dissonant and which is consonant is a highly subjective process based on the relative importance of these cognitions to the counselor, and each cognition's individual resistance to change (Wicklund & Brehm, 1976). This choice among competing cognitions is an implicit statement of personal values. "Choices are mirrors of values" (Salladay, 1986, p. 20).

Should the counselor decide that his or her own personal moral beliefs are of paramount importance, he or she could attempt to reduce the importance of client autonomy, or declare it to be of no value whatsoever. For a member of the counseling profession, this would be a complex endeavor. Counselors are bound by specific ethical mandates and the fostering of client autonomy is one of those mandates (Kentsmith, Salladay & Miya, 1986; Cory, Cory & Callanan, 1998). According to Kentsmith et al., "Autonomy includes the freedom to make an irrational, harmful, or even stupid decision"

(p. 9). Even the ethical principal of nonmaleficence, which is generally considered paramount, might not trump autonomy when understood in this light. Therefore, should the counselor decide that such reduction is not an option; he or she might seek out new information to bolster the morality argument. For example, the counselor might look for alternative ethical positions more supportive of an antisuicide moral position and more imperious than his or her professional ethics. One such absolutist ethic, popular in the United States, is the Christian ethic (Salladay, 1986). According to Salladay, the Christian ethic locates the standard for right and wrong in God rather than in individual circumstances. Such a standard is absolute, unchanging, and not subject to the relativistic ethics of a profession.

The degree to which a cognition is resistant to change is more complex than the relative importance of various competing cognitions. Cognitive resistance to change is predicated on two conditions; the level of ambiguity associated with the cognition and the degree of difficulty involved in changing the cognition (Festinger, 1957). For some counselors there might exist no moral ambiguity. The counselor not questioning his or her moral certitude would view any competing cognition as dissonant and in need of change. Other counselors might not view their personal morals as unquestionable but may find the degree of difficulty involved in changing their position overly demanding. Such a counselor may have recently made a behavioral commitment to his or her religious organization such as enrolling a child in a parochial school. Cognitions based on behavioral commitment are highly resistant to change (Festinger, 1957). In both situations, that of moral certitude and recent behavioral commitment, the counselor is much more likely to act against client autonomy than against his or her personal moral

beliefs. He or she is likely to seek out information in support of the moral belief and, at the same time, actively avoid contact with any information that might call that belief into question (Festinger, 1957).

Two final issues for consideration are *foreseeability* and *responsibility* (Wicklund & Brehm, 1976). Foreseeability refers to whether or not the counselor was able to anticipate the cognitive conflict before it occurred. The counselor acting in accordance with his or her moral beliefs, but foreseeing the ethical challenge of addressing autonomy issues, will likely experience less motivational tension than the counselor who did not foresee the cognitive conflict. This is considered to be the case for two reasons.

One reason is because “Commitment is a necessary condition for the arousal of dissonance” (Wicklund & Brehm, 1976). According to Wicklund and Brehm, an individual committing to a belief entailing foreseen cognitive conflict is likely to make such a commitment in one of two ways. He or she may, in anticipation of the future conflict, commit less fervently to that belief thereby reducing the level of motivational tension experienced when faced with the conflict. Another tack is for the individual to commit to the belief with that belief carrying the caveat of future cognitive conflict. Hence, when the belief is challenged, the challenge is part and parcel of the belief itself. This being the case, the cognitive conflict produces less motivational tension than if it had not been foreseen and incorporated into the belief.

A second reason why foreseeability might reduce motivational tension may be found in the relationship between expectations and motivation. Aronson (1960) theorized that the confirmation of a person’s expectations is a major factor for the motivation of behavior. According to this component of cognitive dissonance theory, a person

expecting future cognitive conflict will view such conflict as confirmation of his or her expectations. Conversely, the absence of future conflict would be viewed as disconfirmation and produce greater levels of motivational tension. Therefore, while the person who does not encounter the expected conflict avoids experiencing the unpleasant emotions associated with such conflict (e.g., disappointment, frustration, and embarrassment) he or she will instead experience dissonance in the form of motivational tension. Such a person can be expected to actively seek out cognitive conflict, even at the cost of the above-mentioned negative emotions, to minimize dissonance.

Responsibility refers to the degree to which the counselor perceives that he or she is acting freely. Consider the previous example of the counselor who believes that suicide is a personal choice, *but* his or her employer requires employees to counsel clients against taking their own lives. Such coercion, formerly called *forced compliance* (Festinger, 1957), is now termed *induced-compliance* (Harmon-Jones & Mills, 1999). The counselor who believes that his or her behavior is the result of induced-compliance will likely experience less motivational tension than if the behavior is seen as the result of free choice. However induced the compliance, the resulting cognitive dissonance may still affect the counselor's self-concept (Aronson, 1999). This is in part because of the personal regret generated by an individual's actions, which are not in accord with that individual's beliefs or personal *orientation* (Seta, McElroy & Seta, 2001). Regret is an emotion owing to the cognitive dissonance theory assertion of the human desire for cognitive consistency (Festinger, 1957). According to Aronson (1999), such an individual might come to view him or herself as a hypocrite thereby experiencing "dissonance in the absence of aversive consequences" (p. 119).

Another issue, related to self-concept and lending support for the need to better understand the role of cognitive dissonance when researching the relationship between a counselor's personal beliefs and attitudes, is counselor happiness. Happiness has been found to benefit not only the happy individual, but also those with whom that individual interacts (Myers, 1992). In the case of a counselor, this may be translated into benefits for clients and increased job satisfaction. According to Lyubomirsky (2001), personal happiness is more a matter of subjective cognition(s) than of "objective variables" such as personal wealth and possessions. In support of this conclusion, Myers (2000) points to the relative stability of personal happiness levels in the United States over the past fifty years in spite of a near tripling in income. Lyubomirsky further proposes happiness to be largely the result of "cognitive and motivational processes" (p. 240). Cognitive dissonance theory would seem a sound theoretical foundation on which to examine such cognitive and motivational processes. While it is obviously an oversimplification to conclude that a happy counselor is a good counselor, the literature on counselor "burnout" points to a counselor's personal level of unhappiness as having a profoundly negative affect on his or her counseling proficiency.

Burnout is a term encompassing a myriad of unpleasant job-related feelings. People experiencing burnout are "experiencing dissatisfaction with their jobs, boredom, physical and mental exhaustion, frustration, low self-esteem" (Combs & Avila, 1985, p. 192). Edelwich and Brodsky (1980) define the term "to refer to a progressive loss of idealism, energy, and purpose experienced by people in the helping professions as a result of the conditions of their work" (p. 14). A counselor suffering from burnout is a counselor impaired (Brems, 2000). Such impairment manifests itself in the counseling relationship

as “the interference in ability to practice therapy” and “results in a decline in therapeutic effectiveness” (Sherman & Thelen, 1998, p. 79).

Burnout is widespread among counselors (Combs & Avila, 1985; Cory, 1986) who are, as a group, especially susceptible (Edelwich & Brodsky, 1980; Vacc and Loesch, 1994; Brems, 2000). According to Brems (2000), there are two chief reasons for this being the case. The first is directly related to counselor personality traits. The “traits that have guided them into their chosen profession” are also “traits that tend to be highly correlated with burnout” (p. 263). Burnout-related personality traits include paternalism for the feelings and actions of others, perfectionism about personal competence, self-doubt, and above average sensitivity to the feelings and reactions of others (Glickauf-Hughes & Mehlman, 1995). The second reason for counselor susceptibility to burnout relates to the contingencies of the counseling work environment. Among these contingencies are client behaviors, unpleasant working conditions, emotional isolation, and the counseling relationship itself (Bayne, 1997). One specifically identified client behavior contributing to counselor burnout is suicide.

The suicide of a client “can leave a clinician shaken and self-doubting for quite some time” (Brems, 2000, p. 275). Self-doubt, as earlier mentioned, is one of the counselors’ burnout-related personality traits. Brems (2000) further notes that self-doubt often leads to emotional isolation, another burnout-related personality trait. Finally, client suicide can contribute to burnout by casting doubt on a counselor’s self-perceived competency. Many therapists view the suicide of a client as a professional failure on their part, resulting in questioning their own professional competency (Chemtob, Hamada, Bauer, Kinney & ToriGoe, 1988; Moritz, Van Nes & Brouwer, 1989; Menninger, 1991;

Little, 1992; McAdams & Foster, 2000). Perfectionism about personal competence is a third counselor burnout-related personality trait (Glickauf-Hughes & Mehlman, 1995). Client suicide could therefore be considered a major contributor to counselor burnout.

It is anticipated that issues, (such as counselor burn-out) and considerations relevant to cognitive consonance and dissonance will provide a theoretic framework for the interviews, the analyses, and the conclusions reflected in generation of the final research report. The question of the relationship between a counselor's personal beliefs about suicide and his or her attitudes toward clients expressing suicidal ideations is theoretically anchored in cognitive dissonance theory.

### **Ethical Decision-Making**

The following is a brief discussion of counseling ethics and the ethical decision-making process. The role of ethical decision-making is pertinent to the research question because it offers a systematized and thoroughly researched method for coping with the cognitive dissonance inherent in many ethical dilemmas. The ethical decision making process may be employed whenever the counselor experiences an ethical dilemma, a situation involving two or more competing ethical principles (Kentsmith et al., 1986). Kentsmith et al. (1986) assert that "reasoning and logic" should be used in the process "based on values, attitudes, personal beliefs, duties, and obligations" (p. 6). Logic is necessary, according to Kentsmith et al. (1986), to combat the emotional distortion of ethical decision-making.

A number of different models have been proposed to guide the ethical decision making process. For example, Kentsmith et al. (1996) suggest a six-step model to "Determine the facts. Analyze the ethical aspects. Outline options. Make a decision. Take action. Evaluate the decision" (pp. 7-8). One year earlier, Hill, Glaser, and Harden had

introduced a similar seven-step model that stressed collaboration with the client as an essential component of the counselor ethical decision-making process.

Another model is the Tarvydas's Integrative Decision-Making Model of Ethical Behavior (Cottone & Tarvydas, 2003). This model is particularly relevant to the research question of this study. Its contextual elements add "the realization that many additional forces may affect the counselor" (Cottone & Tarvydas, 2003, p. 93).

Stage III, of the Tarvydas Model, identifies these additional forces as *competing, nonmoral values, personal blind spots, or prejudices*. "Nonmoral values involve anything that the counselor may prize or desire that is not, in and of itself, a moral value, such as justice, valuing social harmony, spending time with friends or working on one's hobby, or having personal wealth" (Cottone & Tarvydas, 2003, p. 93). Tarvydas points out counselor cultural encapsulation as one possible source of personal blind spots, or prejudices. She stresses the need for counselors to understand themselves, to be aware of the ways in which their own backgrounds and values may influence their ethical decision-making process.

Regardless of the model being employed to *define the problem* or *analyze the ethical aspects*, the counselor must understand the six underlying ethical principles of the Tarvydas's Integrative Decision-Making Model of Ethical Behavior (Figure 2-2). (1) autonomy (self-determination), (2) nonmaleficence (doing no harm), (3) beneficence (doing good), (4) justice (fairness or equal treatment), (5) fidelity (honoring one's commitments), and (6) veracity (honesty) (Kitchener, 1984; Corey et al., 1998). These principles refer to the counselor's responsibilities to his or her client.

### Themes or Attitudes in the Integrative Model

- Maintain an attitude of reflection.
- Address balance between issues and parties to the ethical dilemma.
- Pay close attention to the context(s) of the situation.
- Utilize a process of collaboration with all rightful parties to the situation.

### Stage I. Interpreting the Situation through Awareness of Fact Finding

- Component 1 Enhance sensitivity and awareness
- Component 2 Determine the major stakeholders and their ethical claims in the situation
- Component 3 Engage in the fact-finding process

### Stage II. Formulating and Ethical Decision

- Component 1 Review the problem or dilemma
- Component 2 Determine what ethical codes, laws, ethical principles, and institutional policies and procedures exist that apply to the dilemma
- Component 3 Generate possible and probable courses of action
- Component 4 Consider potential positive and negative consequences of each course of action
- Component 5 Consult with supervisors and other knowledgeable professionals
- Component 6 Select the best ethical course of action.

### Stage III. Selecting an Action by Weighing Competing, Nonmoral Values, Personal Blind Spots, or Prejudices

- Component 1 Engage in reflective recognition and analysis of personal competing nonmoral values, personal blind spots, or prejudices
- Component 2 Consider contextual influences on values selection at the collegial, team, institutional, and societal levels
- Component 3 Select the preferred course of action

### Stage IV. Planning and Execution the Selected Course of Action

- Component 1 Figure out a reasonable sequence of concrete actions to be taken
- Component 2 Anticipate and work out personal and contextual barriers to effective execution of the plan of action, and effective counter-measures for them
- Component 3 Carry out, document, and evaluate the course of action as Planned

Figure 2-2. Integrative Decision-Making Model of Ethical Behavior. From Cottone, R. R., & Tarvydas, V. M. (2003). *Ethical and professional issues in counseling* (2<sup>nd</sup> Ed.). Columbus, Ohio: Merrill Prentice Hall.

An ethical dilemma is often the result of two or more competing ethical principles. It is the duty of every counselor to evaluate each principle involved in a dilemma to act in the best interest of the client (ACA, 2002, A.1.a; Corey et al., 1998). Corey et al. (1998) also recommend that the counselor spend the time, including continuing personal therapy, necessary to understand him or herself in relation to one's stand on each ethical principal. This is another example of the previously mentioned need, "counselor, know thyself." "Without a high level of self-awareness, counselors will most likely obstruct the progress of their clients" (Corey et al., 1998, p. 34). Laux (2002) suggests that counselor ethical training should speak specifically to the ethical decision-making processes connected with work involving clients expressing suicidal ideation. The suggestions made by each of the aforementioned authors that counselors should strive for self-awareness may be understood in terms of *foreseeability* in the conceptual context of cognitive dissonance theory.

Foreseeability, as stated earlier, refers to whether or not the counselor is able to anticipate a cognitive conflict before it occurs (Wicklund & Brehm, 1976). Counselor training pertaining to the possible ethical dilemmas involved with the treatment of a suicidal client might increase a counselor's ability to anticipate various future cognitive conflicts. According to cognitive dissonance theory, foreseen ethical challenges are cause for less motivational tension than those that are unforeseen. Similarly, a counselor's own continuing personal therapy might reasonably be expected to lessen possible future cognitive dissonance since, as stated by Corey et al. (1998), such counseling will assist the counselor to better understand his or her ethical viewpoints. Counselor self-knowledge (whether via training, personal therapy, or experience) could directly affect

the foreseeability of possible future ethical issues related to the treatment of consumers expressing suicidal ideations.

Many authors also consider it crucial that the counselor involve the client throughout the decision-making process (Hill, Glaser & Harden, 1995; Walden, 1997; Corey et al., 1998). Reasons for such involvement include, client empowerment (Walden, 1997), and the counselor's ethical duty to "encourage client growth and development in ways that foster the clients' interest and welfare" and to "avoid fostering dependent counseling relationships" (ACA, 2002, A.1.b.). Avoiding the fostering of dependence is in keeping with the ethical principle of autonomy. The code of professional ethics for rehabilitation counselors specifically cites the counselor's duty to respect client autonomy in section A.1.d. including cases where "involuntary commitment or initiation of guardianship are taken that diminish client autonomy" (CRCC, 2002, p. 1).

Professional ethics codes are the formally expressed responsibilities that counselors have to their clients, peers, and the public (Bersoff, 1999). These codes are used by counselors to guide their professional behavior and by Ethics Committees to investigate and resolve accusations of unethical behavior (AAMFT, 2001; APA, 1992; ACA, 2002; CRCC, 2002). According to the American Psychological Association (APA, 1992), the ethics code "is intended to provide both general principles and the decision rules to cover most situations encountered by psychologists" (p. 9). The Commission on Rehabilitation Counselor Certification (CRCC, 2002) states, "The basic objective of the Code [of Ethics] is to promote public welfare by specifying ethical behavior expected of rehabilitation counselors" (p. 4). The American Counseling Association states that its

ethics code, “establishes principles that define the ethical behavior of Association members” (ACA, 2002, p. 1).

While these codes are helpful, they often provide little specific direction (Bersoff, 1999) and, therefore, are not a substitute for the ethical decision-making process. “When psychologists [and counselors] cannot refer to a specific standard, they must rely more heavily on their own value systems and on their own interpretations of the “spirit” of the APA [and other professional ethics codes] standards” (Tymchuk, Drapkin, Major-Kingsley, Ackerman, Coffman & Baum, 1982, p. 94). Without firm grounding in the theory and practice of ethical decision making, reliance on one’s own values may prove problematic since, as Kitcherer (1984) observes, “In some cases, however, one’s ordinary moral sense may be misleading or inadequate” (p. 134). The earlier mentioned Tarvydas ethical decision-making model specifically warns of the problematic, misleading, or inadequate nature of one’s own values or moral sense. “It is important that counselors allow themselves to become aware of the strength and attractiveness of other values they hold” (Cottone & Tarvydas, 2003, p. 93).

### **Theoretical Grounding for the Research Method**

Why is qualitative research an appropriate method with which to analyze the research question? Miles and Huberman (1994) consider a qualitative approach as most conducive for achieving a holistic understanding and to possible serendipitous discovery. These two research qualities are especially important when the phenomena under consideration are not clearly understood or lack sufficient previous research analysis (Glaser & Strauss, 1967; Miles & Huberman, 1994). Both of these preconditions exist for this research question. Little is known about the relationship between a counselor’s

personal beliefs about suicide and his or her attitudes toward clients expressing suicidal ideations.

As mentioned previously, research on this topic is limited for both psychiatrists (Werth, 1992; Werth & Cobia, 1995; Werth & Holdwick, 2000) and counselors (Rogers et al., 2001) and has been largely quantitative. The qualitative aspects of those studies are limited to attitudes related to the concept of rational suicide, which is a narrow subset of a much broader and larger unexamined issue. The grounded research methodology for this study is designed to allow the data to speak, as much as possible, for itself. Therefore any preestablished position as to the viability of suicide is unnecessary and could even prove counterproductive.

As explained below, grounded theory is the term used to describe the inductive use of data to generate a substantive theory concerning the phenomena from which that produced. Glaser and Strauss (1967) explain that their inductive methodology is predicated on the absence of a priori assumptions necessary for hypothesis testing. A more complete accounting of triangulation methods for this study is in the next section on *credibility and trustworthiness*.

Three major theorists in the area of death and dying (Glaser & Strauss, 1965; Kubler-Ross, 1969) employed qualitative methods in their studies, gathering data through individual interviews using open-ended questions. Extrapolating from their own qualitative methods, Glaser and Straus (1967) went on to create *Grounded Theory*. Grounded theory is used in answering this research question.

Grounded Theory is a qualitative research methodology designed for the development of substantive theory. Its basis is “the systematic generation of theory from

data, that is itself systematically obtained from social research” (Glaser, 1978, p. 2).

Theory development is also appropriate when the phenomena under consideration are not clearly understood or lack sufficient previous research analysis (Glaser & Strauss, 1967).

Additionally, theory development is specifically recommended by Laux (2002), in his recent article entitled, *A primer on suicidology: Implications for counselors*. This study is intended to develop a substantive (as opposed to formal) theory. Grounded Theory, its tenets, and relevance to the research question are discussed in detail in chapter three.

### **Credibility and trustworthiness**

Qualitative research is sometimes criticized as being too subjective. “Subjectivity has long been considered something to keep out of one’s research, something to, at least, control against through a variety of methods to establish validity. It has had a negative connotation in the research world” (Glesne, 1998, p. 105). However, this notion is now being challenged (Olsen, 1994; Glesne, 1998; Denzin & Lincoln, 2000). These authors argue a case for what Peshkin (1985) calls “virtuous subjectivity.” Virtuous subjectivity is a concept recognizing that subjectivity is present in all research. This being the case, it is incumbent on the researcher to recognize said subjectivity. Subjectivity, recognized and properly monitored, can actually contribute to the trustworthiness of the research (Peshkin, 1985; Olsen, 1994; Glesne, 1998; Denzin & Lincoln, 2000).

Establishing trustworthiness is essential to the credibility of the qualitative research findings (Glesne, 1998). While quantitative experimental research relies on realist concepts for verification and validity, qualitative research consists largely of verbal description having data that does not fit the paradigm of realism. In the realist paradigm, research has the supposed ability “to represent social phenomena in some literal fashion: to document their features and explain their occurrence” (Hammersley & Atkinson,

1995). However, “A personal narrative is not meant to be read as an exact record of what happened nor is it a mirror of a world (out there)” (Riessman, 1993, p. 64). Instead, qualitative studies rely on the concept of *trustworthiness*. According to Riessman (1993) *trustworthiness* is not the same as *truth*. Whereas *truth* is a realist concept presupposing the existence of objective reality, *trustworthiness* is a social constructivist concept holding that reality is itself a subjective matter. “The issue, then, is not really about objectivity. The issue is about researcher credibility and trustworthiness, about fairness and balance” (Patton, 1990, p. 481). It is the responsibility of each person to judge whether or not he or she “trusts” the study’s findings.

### **Methods used to establish trustworthiness**

Essential to the validation of trustworthiness is an adequate demonstration, on the part of the researcher, of the study’s limitations (Glesne, 1998). Glesne believes that the better a reader understands the details of the research; the better he or she is able to judge the trustworthiness of that research. “Limitations are consistent with the always partial state of knowing in social research, and elucidating your limitations helps readers know how they should read and interpret your work” (Glesne, 1998). This study thoroughly describes every aspect of the research process paying close attention to study limitations.

A second method for the enhancement of trustworthiness, according to Lincoln & Guba (1985), is for the primary investigator(s) to make use of an outside auditor for the purposes of developing and apply codes, and to assist with the interpretation of field notes. This study used an outside auditor, who also assisted the principal investigator with a third method for strengthening the study’s trustworthiness: bias recognition. Bias recognition is necessary for the researcher to effectively scrutinize his or her own personal subjectivity (Peshkin, 1988; Olsen, 1994; Glesne, 1998; Denzin & Lincoln,

2000). As previously mentioned, subjectivity is not necessarily a research flaw, however, if left unchecked or unrecognized it can seriously jeopardize the trustworthiness of the study's data.

According to Riessman (1993), there are at least four additional methods to enhance the trustworthiness of research data: persuasiveness, correspondence, coherence, and pragmatic use. The first of these, persuasiveness, is closely related to the concept of plausibility. Are the research finding plausible? Is the researcher's interpretation of the data reasonable? And finally, is the reader of the research convinced of its plausibility and reasonability? The researcher alone, therefore, cannot achieve persuasiveness. "Persuasiveness ultimately rests on the rhetoric of writing – on literary practices – and reader response" (Riessman, 1993, pp. 65-66).

The second of Riessman's (1993) additional methods, correspondence, is not used in this study. Correspondence entails the researcher bringing the research findings back to its participants for the purpose of obtaining their input. This study intends no further contact with study participants beyond the interview.

Coherence, proposed by Hobbs (1985) is a criterion with three categories: global, local, and themal. According to Hobbs, the interpretation of study data gains plausibility when in the context of, and applicable to, these three categories of coherence. Global coherence pertains to the broad goals of the research, of which the researcher is writing. The overall goal of this study is to better understand the relationship between a counselor's personal beliefs about suicide and his or her attitudes toward clients expressing suicidal ideations. To enhance trustworthiness, the data of this study are interpreted in terms of this global goal.

Local coherence pertains to the “linguistic devices” employed in the research report itself, intended to promote reader understanding of the research and the subsequent interpretation of its data (Hobbs, 1985). Local coherence is obtained in this study through a research report detailing the use of comparative analysis. As mentioned previously, Glaser and Strauss (1967) suggest a method of comparative analysis for the discovery of the *conceptual categories* necessary in the paradigm of grounded theory. This written description will guide the reader through the ongoing process of comparative analysis, which takes place throughout the coding process wherein the conceptual categories emerge. The comparative analysis in the report assists the reader to understand just how the researcher interpreted the data.

Thematic coherence concerns content, in the case of this study, interview content. According to Hobbs (1985), trustworthiness is enhanced when the study data, the interview content, is shown to have a coherent theme. Such thematic coherence may be demonstrated by highlighting the recurrent themes in the interview text. Riessman (1993) warns that the interview is not the best format for use of the thematic coherence criterion. This is because the interviewer potentially holds such powerful sway over the direction of the interview and could, therefore, artificially control its thematic content. This study proposes to circumvent such an objection by using the earlier outlined technique of the *active interview* described by Holstein & Gubrium (1995).

The last of the Hobbs (1985) coherence criterion to enhance trustworthiness is pragmatic use. This criterion cannot be determined before or during the time in which the study is conducted. Pragmatic use refers to “the extent to which a particular study becomes the basis for others’ work. In contrast to other validation criteria, this one is

future oriented, collective, and assumes the socially constructed nature of science” (Riessman, 1993, p. 68). This study is intended specifically as a springboard for future research. It is a preliminary step in the direction to better understanding the relationship between a counselor’s personal beliefs about suicide and his or her attitudes toward clients expressing suicidal ideations.

### **Triangulation**

In addition to trustworthiness, another technique to strengthen qualitative research credibility is *triangulation*. Triangulation is a method by which the same phenomena are studied using a combination of methodologies (Patton, 1990). Denzin (1978) explains the logic underlying the concept of triangulation is that “no single method ever adequately solves the problem of rival causal factors” and because “each method reveals different aspects of empirical reality” (p. 28). Patton (1990) adds “Triangulation is a powerful solution to the problem of relying too much on any single data source or method, thereby undermining the validity and credibility of findings because of the weaknesses of any single method” (p. 193). Triangulation, therefore, is a strategy by which the researcher attempts to minimize the weaknesses inherent in any single approach by adding the support of the strengths inherent in various other approaches. The four basic types of triangulation are: *data triangulation*, *investigator triangulation*, *theory triangulation*, and *methodological triangulation* (Denzin, 1978).

Data triangulation refers to using more than one source of data in the same study and then drawing comparisons. Comparing the interview accounts of a variety of participants, each with different perspectives of the same phenomenon, is one way of triangulating research data. This study triangulates in this manner by purposefully selecting participants from a variety of counseling settings (e.g., rehabilitation counselors,

mental health counselors, marriage counselors, etc.). There is evidence that strongly suggests that counselors from differing settings are likely to have different perspectives on the suicide phenomenon. One example is that counselors from differing settings become members of different professional accrediting organizations.

Rehabilitation counselors usually receive certification from the Commission on Rehabilitation Counselor Certification (CRCC). Mental health counselors are often members of the American Counseling Association (ACA). Marriage counselors are most often members of the American Association for Marriage and Family Therapy (AAMFT). Evidence exists demonstrating that different professional counseling organizations have different perspectives on at least some aspects of suicide. Some of these differing perspectives were mentioned in Chapter 1 pertaining to physician-assisted suicide as established by counselors' reactions to the recent Supreme Court battle over Oregon's Death with Dignity Act (1997). During this contest, *amicus curiae* [friend of the court] briefs were filed both for and against implementation of the Act. Prominent professional counseling organizations joined both sides (Werth & Gordon, 2002).

Investigator triangulation refers to using different investigators or evaluators in the same study. This study intends to employ this method of triangulation by adding an outside auditor for the purposes of developing and applying codes, and to assist with the interpretation of field notes.

Theory triangulation refers to using competing theoretical models to interpret the data of a single study. Until the onset of data analysis, the appropriateness of this mode of triangulation remains unknown.

Methodological triangulation refers to using more than one method to study a single phenomena or group of phenomenon. This study does not use this triangulation technique. Rather, it relies on the integrity of a single evaluation method. The rationale underlying this choice is based on the arguments of Guba and Lincoln (1988). They note that qualitative research designs possess their own internal consistency and logic, and state that the use of one internally consistent and logical approach is preferable to the mixing of methodologies. The caution is specifically aimed against the mixing of qualitative and quantitative methodologies in the same study. The argument is that a researcher cannot be simultaneously inductive and deductive. In other words, it is not possible to carry out hypothesis testing while concurrently remaining open to emergent data (Guba & Lincoln, 1988). This study uses grounded theory. As mentioned previously, grounded theory is the term used to describe the inductive use of data to generate a theory concerning the phenomena from which that data were produced. Glaser and Strauss (1967) explain that their inductive methodology is predicated on the absence of a priori assumptions necessary for hypothesis testing.

Patton (1990) asserts, “Triangulation is ideal. It can also be very expensive. An evaluation’s limited budget, short time frame, and political constraints will affect the amount of triangulation that is practical” (p. 187).

### **Theoretical Grounding for the Interview Process**

Why is the interview an appropriate qualitative technique with which to study the research question? “Preconceived ideas are pernicious in any scientific work, but foreshadowed problems are the main endowment of a scientific thinker, and these problems are first revealed to the observer by his theoretical studies” (Malinowski, 1922, pp. 8-9).

This study rests on the social constructionist approach wherein all interviews are *active* (Holstein & Gubrium, 1995), in the sense that, “Respondents are not so much repositories of knowledge – treasuries of information awaiting excavation – as they are constructors of knowledge in collaboration with interviewers” (p. 4). From this point of view any data gathered by means of an interview is collaborative. Therefore, this study project makes no attempt to sterilize the interview process or to downplay its reflexive nature. Instead, this study not only acknowledges the interview’s active nature as a feature of the research, but also capitalizes on what Douglas (1985) refers to as the *creative interview*. Douglas urges the interviewer, “Always be poised to pounce on any phenomenon that shines with the promise of a new truth – discovery” (p. 69).

Accompanying the creative or active interviewing process is the question of reflexivity. How much of the interviewee’s response is the result of the interviewer’s behavior? Since the interviewer/researcher is intimately and reflexively involved in all aspects of the research from the inception of the research question through the writing of the report, this question might be considered more broadly.

### **General issues of reflexivity**

Reflexivity has been said to be a part of all research (Hammersly & Atkinson, 1995). It is that part of research on which the influence of the researcher is exerted, sometimes referred to as *researcher effect*. “Researchers are part of the social world they study” (Hammersly & Atkinson, 1995, p. 16). Hence researcher effect burgeons from the researcher’s own socio-historical background, from which arises his or her personal system of values, beliefs, and over-all point of view. It is “the impact of the researcher’s position and perspective” on the research and its results (Finlay, 2002, p. 537).

Researcher effect begins in the preresearch stage and continues through the writing of the

research report. Prior to the study the researcher must have some relationship to the study subject matter that prompted the formulation of the research question. Throughout the research process, Finlay (2002) advises researchers to “examine their motivations, assumptions, and interests in the research as a precursor to identifying forces that might skew the research in particular directions” (p. 536).

Researchers, especially quantitative researchers, have long striven to minimize or eliminate these effects. Numerous qualitative researchers are of the opinion that the elimination of researcher effect is impossible, even dangerous, since its consequence may go unnoticed (Douglas, 1985; Hammersly & Atkinson, 1995; Plummer, 2001). The results of researcher effect, when erroneously considered eliminated or marginalized, are likely to be attributed to subject variables. The source of the problem, according to van Manen (1990), is human commonsense. All researchers approach their research replete with an entire set of presuppositions and assumptions regarding the topic to be studied. These, along with the knowledge acquired throughout the literature review process, “predispose us to interpret the nature of the phenomenon before we have even come to grips with the significance of the phenomenological question” (Manen, 1990, p. 46).

According to Riessman (1993), in an interview situation, the interviewee is telling a story. He or she must construct past events and actions into a personal narrative. Regardless of the role played by the interviewer, the information contained in such a narrative may be incomplete, historically incorrect and/or an intentional falsehood (Riessman, 1993; Stivers, 1993).

Additionally, since the respondent is not conducting the research, the interview narrative must be interpreted. The words of a participant do not “speak for themselves” or

“provide direct access to other times, places or cultures” (Riessman, 1993, p. 261), as alternative interpretations are always possible (Stivers, 1993). Readers of research reports will interpret these words a third time. Still, these interview narratives do represent *truths*, the truths of personal experience (Stivers, 1993).

The interview is an attempt to acquire data about the attitudes of counselors from their point of view. Aware of this medium’s reflexive nature, the interviewer made every effort at *bracketing* (Miles & Huberman, 1984; Holstein & Gubrium, 1995) personal preconceptions, putting them on hold for the duration of the interview. This bracketing is part of distinguishing the presuppositions and assumptions of the participant from those of the researcher. Finlay (2002) points out that this is especially important when the researcher and participant share similar professional backgrounds; in this case both are counselors. She states, “I had to guard against assuming that we shared the same language and saw the job in the same way; if I failed to do so, I might have missed the point that there were differences” (p. 537).

At the same time, “One of the most important elements of context is the audience to which the actions, in the accounts, were directed” (Hammersly & Atkinson, 1995, p. 218). The participant knew that the interview was intended for research purposes. He or she was made aware of the research topic. It is then reasonable to assume that the interview context was constructed for the interviewer with the idea that, though anonymous, it was still a public rather than private exchange. Considering the relative sophistication of the interviewee there may be a commingling of description and analysis.

## **Purpose and Relevance to Practice**

### **Purpose**

The goal of this study is to explore the relationship between counselors' own personal beliefs about suicide and counselors' attitudes toward clients expressing suicidal ideations. Since these two types of cognitions may be either congruent or discrepant, cognitive dissonance theory (Festinger, 1957) provides a useful theoretical context for the investigation of this relationship.

### **Relevance to Practice**

The possible benefits resulting from such knowledge are considerable not only to the counseling profession, but also to the consumers they serve. As previously noted, congruence of thoughts, actions, and feelings is considered necessary for the essential counselor trait of genuineness (Cormier & Cormier, 1991; Long, 1996). According to these authors, the development of this same type of congruence for the client is often a goal of the counseling relationship.

Enhanced understanding could benefit counselors themselves. An educational outcome, stressed by most counselor education programs, may be represented by the phrase "Counselor know thyself" (Meier & Davis, 1993). "You [the counselor] should be aware of your own feelings, attitudes, values, and motivations for working with others" (Doyle, 1998, p. 6). Many counseling theorists deem this necessity for counselor self-awareness to be crucial to counselor competence (Cormier, 1986; Doyle, 1998; Egan, 1990). "Therapists must be able to look at their clients with objectivity and not become entangled in their personal dynamics" (Phares, 1992, p. 320). "If they [counselors] are self-aware, they may more effectively and honestly compensate for their conflicted impulses" (Cottone & Tarvydas, 2003, p. 93). Since the majority of counselors have

experienced at least one client expressing suicidal ideations (Rogers et al., 2001), a counselor might be well advised to know him or herself intimately in this area. Individual counselors may choose to carry out self-examinations of a kind similar to that which they read in this study.

Other benefits for counselors could be in the area of counselor training. Counselor education programs are largely research based (Neimeyer, 2000). If it is reasonable to assume that many counselor attitudes toward suicide are influenced by their training, then understanding the attitudes of current practicing counselors may lend insight into the end results of such training. Just as individual counselors may benefit from the knowledge of their peers attitudes and actions, counselor educators might choose to amend or bolster their current programs. Authors such as Westefeld et al. (2000) recommend that suicidology should be considered a necessary and integral part of counselor education. They suggest the study of suicide begin as early as possible in the counselor's academic program and continue throughout his or her field placements. The need for counselor training in the area of suicide and intervention is further indicated and supported by the research of Bascue (1977), and Foster and McAdams (1999).

The area of counselor training most often neglected, when training on suicide is offered at all, is the effect of a suicidal client on the counselor. "In spite of the fact that dealing with suicidal clients is threatening to most therapists, very little training in coping with the suicidal death of a client is included in graduate programs for therapists" (Stillion & McDowell, 1996, p. 242). Stillion and McDowell (1996) note that counselors are faced with a myriad of emotional, ethical, and legal issues after the suicide or even attempted suicide of a client. They urge counselor education programs to prepare

therapists for the likelihood of experiencing a grief reaction, calling into question their own professional competence, and the possibility of legal liability.

The need for enhanced counselor training is underpinned by the cognitive dissonance theory concept of *foreseeability* (Wicklund & Brehm, 1976). As stated earlier, foreseeability refers to whether or not the counselor was able to anticipate the cognitive conflict before it occurred. A counselor who is able to anticipate the myriad of emotional, ethical, and legal issues is likely to experience less cognitive dissonance associated with these issues than is a counselor lacking such foreseeability.

Relevance to counselor supervision may also be indicated. Counselors experiencing the suicide death of a client may feel overly responsible and need supervision to clarify their own role in the occurrence. For this reason, debriefing and perhaps even personal therapy have been suggested for therapists after the suicide of a client (Lavin, Roy, Dunne-Maxim & Slaby, 1994).

It is an increasingly common practice for counselors to seek regular supervision (Bernard & Goodyear, 1998). Since, as previously mentioned, most counselors will experience at least one client expressing suicidal ideations it is likely that such an experience might become a topic of supervision. Counselor supervisors are obliged, as are all practicing counselors, to keep abreast of current research literature (Bernard & Goodyear, 1998). The results of this study might help them to better address such issues.

Enhanced understanding in this area could be of great use to Counselor Professional Ethics Review Boards, or Ethics Committees. As part of their duty to protect the public, these groups are responsible for examining alleged counselor misconduct and for administering corrective measures (Walzer & Miltimore, 1993; Cobia & Pipes, 2002).

While research has generated a great deal of information about the specific ethical dilemmas facing therapists today, “relatively little is known about the nature of the actual situations that practitioners find ethically, legally, or professionally problematic” (Haas, et al., 1986, p. 99). Greater knowledge of counselor beliefs and attitudes about suicide and suicidal ideation might be of assistance in both tasks. They might more readily comprehend an accused counselor’s stated motives when determining guilt or innocence. Greater insight into counselor thinking might also enrich the creative thinking necessary for the design of remedial action and preventive education.

The conclusions sections of many research articles often include a plea for continued research in the area under study. Researchers appear overwhelmingly cognizant of their own incremental role in developing a deeper understanding of their subject matter. Often illuminated are the study’s own weaknesses and/or limitations as suggested topics for continued research. This is also the case in the area of counselor attitudes toward suicide and suicidal ideation. Relevance of this issue for psychotherapists has been previously documented (Werth & Holdwick, 2000). In so doing, the case was made for expanding exploration of this issue to other health professionals including counselors. Since those recommendations, this researcher is aware of only one study with counselor participants, that of Rogers et al. (2001). The following are five practice-related issues considered by Werth and Holdwick (2000) to have shared relevance with counselors.

The first issue is that of population diversity. As is the case with psychotherapists, counselors are apt to work with clients of diverse populations. Werth and Holdwick (2000) note that demographic diversity appears to significantly affect how clients view

issues of suicide. For example, they found African Americans and Latinos far less likely to accept hastened forms of death than White European Americans. Westefeld et al. (2000) recently reported similar findings in their compilation of suicide literature from across several diverse disciplines. Counseling practitioners “must be aware of how cultural diversity may affect end-of-life decisions, especially those related to hastening death in some way” (Werth & Holdwick, 2000, p. 525-526). Laux (2002) reminds counselors that when considering cultural diversity “it is vital to recognize that within-group differences often exceed between-group differences” and warns that “group comparisons may lead to overgeneralizations at the individual level” (p. 381).

The second issue concerns value conflicts. Werth and Holdwick (2000) further support the importance for mental health workers’ [including counselors] awareness of the personal value conflicts possible in the treatment of clients expressing suicidal ideations. They warn “it is apparent that personal values can and do affect professional actions” (p. 526).

The third issue is that of the “ethical and legal issues and the standard of care” (Werth & Holdwick, 2000, p. 526). According to Werth and Holdwick a pervasive ethical and legal misconception surrounds the treatment of clients expressing the desire to end their own lives. This misconception is the popular belief in the therapist’s duty to try to prevent suicide. Werth and Holdwick note that such intervention has neither a legal nor professionally ethical mandate.

The fourth issue relevant to practice is that of assessments. Werth and Holdwick (2000) note that therapists called on to assess client decisions about suicide should be aware of the aforementioned issues of population diversity, value conflicts, and the

ethical and legal aspects of standards of care. They are particularly interested in practitioner knowledge of depression, terminal illness, suicidal ideation, and rational suicide and comment on the general failure of professional training programs to educate on the topic of suicide.

Werth and Holdwick's (2000) fifth issue considered as relevant to counseling practice is that of professional training. They state the imperative of education and continued education as follows. "Counseling psychologists are normally not trained (a) to consider the possibility that a person's decision to hasten death may be rational or (b) to work with terminally ill individuals who are considering hastened death" (p. 530).

While rational suicide is not the sole focus of this study, it may be the most closely associated research spotlighting counselor attitudes toward suicide and suicidal ideation to date. The Rogers et al. (2001), Werth (1992), Werth & Cobia (1995), and Werth & Holdwick (2000) studies of rational suicide focus on the previously delineated definition as an accepted concept and examine subjects' attitudes toward this concept. This study does not limit itself to any particular paradigm or line of inquiry. Certainly, some participants may be familiar with the rational suicide literature, but this study is interested in any and all counselor attitudes toward suicide and suicidal ideation.

Further supporting this issue's relevance for counselors is the previously discussed ACA support for the legalization of physician-assisted suicide expressed by signing on to the *amicus curiae* ("friend of the court") brief submitted to the Supreme Court by WSPA in the case of *Quill v. Vacco* (Werth & Gordon, 2001). Apparently, understandings of counselor attitudes and beliefs regarding suicide are inconsistent and far more complex than was initially imagined. Opposition to this position by so many disability advocate

groups lends the topic special relevance to counselors working in the rehabilitation fields. Considering (1) the position of the ACA, (2) the reaction by some of its' members and several disability advocate groups, (3) the absence of any knowledge base about counselor attitudes toward rational suicide, (4) the Supreme Court's decision to allow individual states to make laws regarding physician assisted suicide, and (5) the recommendation by previous rational suicide researchers that further research is necessary, the issue of relevance for this pilot investigation of counselor attitudes toward suicide and suicidal ideation appears well grounded.

Counseling is a discrete profession stipulating a specific educational study required to achieve a master's or doctorate degree (Gladding, 1996). Such training is deemed indispensable by most professional organizations responsible for counselor certification (APA, 1996; CRCC, 2001; ACA, 2002b). The logic underlying this training is meant to "assure the public that the counselor meets minimal educational and professional standards" (Gladding, 1996, p. 7). Therefore it is the public, the potential consumers of counseling services, who are the primary intended beneficiaries of counselor training. As previously described, this study may be expected to benefit counselor training thereby providing benefit to consumers of counseling services.

The supervision of counselors is intended as an intervention supported by empirically based theories grounded in scientific research (Bernard & Goodyear, 1998). According to Bernard and Goodyear, one of the three chief purposes of counselor supervision is to protect the consumers of these services. It is therefore reasonable to assert that the efficacy of this protection is largely dependent on the theories supporting the supervisory intervention, which are in turn grounded in research. This study is

intended to help generate a substantive theory related to suicide. As previously described, such theory may benefit counselor supervision thus providing benefit to consumers.

While it is ethically permissible to expect fair compensation and professional gratification for their efforts, a counselor's primary duty and responsibility is to the consumer of his or her services (ACA, 2002; CRCC, 2002). Consumers are the ultimate beneficiaries of counseling research that may impact counselor training, supervision, or the remedial actions taken by Counselor Ethics Review Boards.

## CHAPTER 3 MATERIALS AND METHODS

The following methodology was used to answer the research question: What is the relationship between a counselor's personal beliefs about suicide and his or her attitudes toward clients expressing suicidal ideations? What follows is a presentation of the research method, characteristics of the study participants, and procedures for obtaining participants, procedures for data collection and analysis, and a pilot study synopsis.

### **Research Method**

The paradigm of this study is qualitative. This approach was used, for three reasons, each based on the nature of the research question: What is the relationship between a counselor's personal beliefs about suicide and his or her attitudes toward clients expressing suicidal ideations?

The first reason for proposing the use of a qualitative method is the current level of understanding concerning the relationship between a counselor's personal beliefs about suicide and his or her attitudes toward clients expressing suicidal ideations. A thorough literature search suggests that, at present, little is known about the nature of this relationship. Qualitative analysis is appropriate when the phenomena under consideration are not clearly understood or lack sufficient previous research analysis (Glaser & Strauss, 1967; Miles & Huberman, 1994). In such a situation, Glaser and Strauss recommend qualitative research for the generation of theory, called the "grounded theory" method. They suggest a method of comparative analysis to discover the *conceptual categories* necessary for theory generation. "In discovering theory, one generates conceptual

categories or their properties from evidence; then the evidence from which the category emerged is used to illustrate the concept” (Glaser & Strauss, 1967, p. 23). The details of this method are outlined later in the discussion of *grounded theory*.

The second reason for proposing the use of a qualitative method is rooted in the current state of the research most closely related to the research question. As mentioned in Chapter One, the existing research examines attitudes related to the concept of rational suicide. The focus is on the counselor’s attitudes related to the concept of suicide as being a rational choice for certain individuals under specific circumstances (Rogers et al., 2001). This research to date is largely qualitative. For example, Rogers et al. (2001) randomly sampled 1,000 members of the American Mental Health Counselors Association using a mailed survey. They received 241 usable responses. The survey, adapted from that of Werth and Liddle (1994), included a case vignette “describing the context and condition of an individual who has made a decision to commit suicide” (Rogers et al., 2001, p. 367). Based on that vignette, participants answered three quantitative questions and three open-ended qualitative questions. Two researchers, working toward consensus, coded the qualitative data. Responses for which category coding consensus could not be attained were dropped from the study.

The third reason for using a qualitative method is historically grounded. Glaser and Strauss (1965, 1967), who developed the qualitative method of grounded theory, did so through their research on death and dying. Elizabeth Kubler-Ross (1969, 1975), another preeminent researcher in the area of death and dying, also employed qualitative methods in her studies. The methodologies used by these researchers are summarized in Chapter

Two: Literature Review. Proposing the use of a qualitative approach in this study is to follow a well-established tradition to research phenomena related to death and dying.

### **Grounded Theory**

The essence of qualitative research is an attempt to make sense of, and extract patterns from, personal stories (Glesne, 1999). The above-mentioned method of grounded theory of Glaser and Strauss (1967) was the qualitative method employed for this study. Grounded theory is the term used to describe the inductive use of data to generate a theory concerning the phenomena from which that data were produced. Grounded theory “provides us with relevant predictions, explanations, interpretations and applications” (Glaser & Strauss, 1967, p. 1) appropriate to empirical situations. Hence a theory derived in this manner is inseparably linked to, or grounded by, the data from which it is produced.

Grounded theory provides a framework in which the researcher may move methodically from data collection, through data analysis, to writing the research report and the subsequent generation of theory (Glaser, 1978). This inductive process stands in contrast with most quantitative research, which according to Glaser and Strauss (1967) generally includes an “explanation [of the study’s findings] taken from a logically deduced theory” (p. 4). Whereas deductive methods attempt to confirm facts or interpret data relative to preexisting theory, Glaser and Strauss explain that their inductive methodology operates with the absence of a priori assumptions. Various contemporary authors stress the need for theory development related to suicide and counseling. Westefeld, Range, Rogers, Maples, Bromley, and Alcorn (2000) assert that counselors presently function atheoretically in the areas of suicide prevention and suicidology.

According to Laux (2002), “There is a great need for the development of a priori theories that would lead to testable hypotheses” (p. 382).

According to Glaser (1978), a properly generated grounded theory possesses the characteristics of *fit*, *relevance*, and *modifiability*. *Fit* refers to the criterion that its categories must fit the data. Theoretical categories, or themes, must emerge from the data. They should not be preconceived, or precoded, from some preexisting theory before the data are collected. *Relevance* refers to the relationship between the data and the theory grounded in that data. A grounded theory has the ability “to explain what happened, predict what will happen and interpret what is happening in an area of substantive or formal inquiry (p. 4)” because the relevance of that theory is derived from the data from which it emerged. *Modifiability* indicates that a grounded theory is never considered to be a fact. It is never completely finished. A grounded theory is inseparable from the data. As the data changes and new data become available the theory must remain open to modification.

### **Data Collection**

As was the case for the death and dying research conducted by Glaser & Strauss, and Kubler-Ross, the interview is the method for gathering the data for this study. There exist criticisms of the interview as being a limited data source. This is because the participant-interviewee is capable of relating only his or her own perceptions from his or her own point of view (Patton, 1990). Patton notes that interview data are, therefore, subject to the distortions of subjective personal bias, emotions, and even the participant’s own lack of observational skills. “Interview data are also subject to recall error, reactivity of the interviewee to the interviewer, and self-serving responses” (Patton, 1990, p. 245). Aware of these potential difficulties, this study proposes using a particular form of

interview described as an *active interview* by Holstein & Gubrium (1995) or as a *creative interview* by Douglas (1985).

The active, or creative, interview is a collaborative process undertaken by the researcher-interviewer and the participant-interviewee. The reflexive nature of the interview is acknowledged and capitalized on. The interview data was, therefore, analyzed with the knowledge that it is not an exact representation of the participant's activities, beliefs and attitudes, but rather a co-constituted accounting. The dynamics of the interview relationship itself influences research results. According to Gergen and Gergen (1991) different researchers present themselves differently, respond to participants differently, and trigger different responses.

Reflexivity applies to that part of research on which the influence of the researcher is exerted, sometimes referred to as *researcher effect*. "Researchers are part of the social world they study" (Hammersly & Atkinson, 1995, p. 16). Hence researcher effect burgeons from the researcher's own socio-historical background, from which arises his or her personal system of values, beliefs, and overall point of view. It is "the impact of the researcher's position and perspective" on the research and its results (Finlay, 2002, p. 537). Researcher effect begins in the preresearch stage and continues through the writing of the research report. Prior to the study the researcher must have some relationship to the study subject matter that prompted the formulation of the research question. Throughout the research process, Finlay (2002) advises researchers to "examine their motivations, assumptions, and interests in the research as a precursor to identifying forces that might skew the research in particular directions" (p. 536).

This study adopts a social constructionist point of view and does not attempt to minimize or eliminate these effects. The logic underlying this approach is the understanding that reflexivity is a part of all research (Hammersly & Atkinson, 1995). Failure to acknowledge this, including researcher attempts to minimize or eliminate its effect, is likely to result in the effects of reflexivity being erroneously attributed to subject variables (Douglas, 1985; Hammersly & Atkinson, 1995; Plummer, 2001).

Therefore, for this study, the construction of the interview is conversational in nature directed by the interviewer in ways designed to stimulate discussion about the relationship between the interviewee's personal beliefs about suicide and his or her attitudes toward clients expressing suicidal ideations. To this end, the interviewer prepared several open-ended questions prior to the interview. These questions were designed to elicit two types of information. First, information invested in the participant's memories about incidents involving client suicidal ideation and second, information regarding the participant's own beliefs about suicide. The questions possess the qualities of being both straightforward and respectful of the participant's beliefs and experiences. They are also adaptable to the changing conditions of the interview process, meaning that their exact wording was sometimes altered, some questions were not used, and other questions were added extemporaneously. The questions are listed below.

### **Sample questions**

- What does "committing suicide," mean to you?
- Please articulate your own personal views on committing suicide.
- Have you ever considered ending your own life?
- Do you have any advanced directives (e.g., Do Not Resuscitate) concerning your own death?

- Describe your own feelings relating to client suicide in your role as counselor.
- Take me through an experience of yours involving a client with suicidal ideations.
- Have you ever had a client successfully end his or her own life?
- If yes, can you describe how that experience affected you?

Supporting questions, drawn from the interviewer's experience as a counselor, are spontaneously dispersed throughout the interview. These are intended to encourage elaboration, build confidence (both in the participant's stories and the interview process itself), and show that the interviewer has understood what was being related. The remainder of the interviewer's contribution is non-verbal body language (such as mirroring the participant's posture) or simple reflections of the participant's communication. Such actions serve purposes akin to the supporting questions.

### **Participants**

The method for study participant selection is purposeful sampling. Purposeful sampling (Patton, 1990; Glesne, 1999) is appropriate as the purpose of the study is not wide generalizability to a larger population (Glesne, 1999). Each participant is selected for a purpose specific to a better understanding of the research question. "The logic and power of purposeful sampling lies in selecting *information-rich cases* for study in-depth. Information-rich cases are those from which one can learn a great deal about issues of central importance to the purpose of the research, thus the term *purposeful sampling*" (Patton, 1990, p. 169).

Of the various strategies for purposeful sampling, the method for this study is *maximum variation sampling* (Patton, 1990). According to Patton, the goal of maximum variation sampling is to allow for the description of themes arising from a wide variety of participants while employing a relatively small sample. This is accomplished by choosing

participants using such criteria as to maximize the variation within that sample. The rationale underlying maximum variation sampling is that “Any common patterns that emerge from great variation are of particular interest and value in capturing the core experiences and central, shared aspects or impacts” (Patton, 1990, p. 172). The following participant selection criteria are based on information culled from the literature review coupled with the requirements of the research question.

Each participant is a practicing counselor having experienced at least one client exhibiting suicidal ideation(s). The basic criterion is two fold. First, the research question requires that the investigation be limited to counselors. Second, the research question includes the components of counselor beliefs about suicide and counselor attitudes toward client(s) expressing suicidal ideation(s). This second component necessitates that the counselor participant actually possess such an attitude, not mere speculation as to what that attitude might be.

Geographically, recruitment took place within a one-hour drive radius of the University of Florida. This was an economically imposed study limitation. The research was not funded.

Study participants were recruited from a variety of counseling settings. The literature indicates possible attitudinal differences among counselors affiliated with varied professional organizations. For example, in the Supreme Court case of *Quill v. Vacco* (1996) involving physician-assisted suicide, *amicus curiae* briefs were presented both for and against the Oregon Death With Dignity Act (1997) by various organizations representing mental health practitioners. Additional attempts were made to recruit an equal number of males and females as the literature indicates possible attitudinal

differences between the sexes regarding death, dying, and suicide (Moremen & Craddock, 1998).

The number of participants was methodologically driven and included eight individuals. In accordance with grounded theory, “Beyond the decisions concerning initial collection of data, further collection cannot be planned in advance of the emerging theory (as is done so carefully in research designed for verification and description)” (Glaser & Strauss, 1967, p. 47). Glaser (1978) asserts that the emerging theory controls the data collection process. Therefore, the exact number of participants was not known before hand. With the collection of initial data came the development of cognitive themes such as belief structures, or ways in which individual participants view the suicide-related material discussed in the interviews. The process of interviewing new participants continued until it became evident that no new themes were forthcoming within the sample parameters. Glaser and Strauss (1967) refer to this condition as *theoretical saturation*. The final number of participants was established when the last new interviews produced only data repetitious of the previous interviews (Miles & Huberman, 1984).

This represents one of the major differences between qualitative and quantitative sampling methods. Quantitative research uses the logic of probability sampling. It derives its power from selecting a sample group of subjects from, and statistically representative of, a predetermined larger population. The goal is the ability to generalize from the sample to the population (Gravetter & Wallnau, 1999). Qualitative research uses the logic of purposeful sampling. It derives its power from the selection and in depth study of *information-rich cases*. “Information-rich cases are those from which one can learn a great deal about issues of central importance to the purpose of the research, thus the term

*purposeful* sampling” (Patton, 1990, p. 169). The technique of purposeful sampling operates in tandem with the sample size criterion of saturation. “In purposeful sampling the size of the sample is determined by informational considerations. If the purpose is to maximize information, the sampling is terminated when no new information is forthcoming from new sampled units; thus redundancy is the primary criterion” (Lincoln & Guba, 1985, p. 202).

### **Interview logistics**

The researcher interviewed each participant once. The interviews were audiotaped. The average duration of each interview was 45 minutes and took place at a site mutually agreed on by both interviewer and interviewee. The site was private to allow for confidentiality.

Preceding any participant contact, the Institutional Review Board (IRB) of the University of Florida approved the research. The IRB provided the researcher with approved Informed Consent forms, which were presented to each participant prior to the interview. The researcher thoroughly explained the content of the form to each participant and each participant signed an Informed Consent form (Appendix) before commencing with the interview. The forms are the only study record identifying the individuals by name and are stored in a locked file cabinet.

The audiotapes of each individual interview, also stored in a locked file cabinet, are identified numerically and sequentially in the order in which the interviews occurred. The name of the participant does not appear on the audiotape cassette. All attempts were made to avoid using the participant’s name during the taping of the interview. In the event his or her name was spoken while taping, that name does not appear in the tape’s transcription. A professional transcriber, familiar with the rules of research

confidentiality, transcribed the audiotapes verbatim. This study did strictly adhere to all professional and university guidelines to assure participant confidentiality.

No field notes were taken during the interviews. The researcher wrote field notes both before and after each interview. The preinterview notes were of an organizational nature. The postinterview notes were for the purpose of organizing the researcher's thoughts prior to the transcription of the audiotape and capturing immediate impressions and reflections of the researcher. Field notes were hand written, then later computer typed by the researcher for use with the NVivo program. Original hand-written notes are stored in a locked file cabinet.

### **Data Analysis**

The data for this study was analyzed by means of comparative analysis. Comparative analysis, in the context of grounded theory, is part of a system of discovery appropriate for use with a participant pool of any size (Glaser & Strauss, 1967). This study used a comparative analysis of the information presented by each study participant during his or her interview. Each individual interview produced a number of conceptual themes or categories. These themes or categories were analyzed, by means of comparison across interviews, for the purpose of generating a theory based entirely on that data. "In discovering theory, one generates conceptual categories on their properties from evidence; then the evidence from which the category emerged is used to illustrate the concept" (Glaser & Strauss, 1967, p. 23). Comparative analysis can then be used to detect commonalities and differences among participant themes. "Qualitative researchers seek to make sense of personal stories and the ways in which they intersect" (Glesne, 1999, p. 1). The underlying logic is to ascertain the generality of specific themes and concepts,

to establish boundaries for the newly generated theory. The specific method this study uses to accomplish this goal is termed *constant comparison*.

Constant comparison, according to Glaser and Strauss (1967), is a method consisting of four stages: “(1) comparing incidents applicable to each category, (2) integrating categories and their properties, (3) delimiting the theory, and (4) writing the theory” (p. 105). While each stage does lead to the next, previous stages remain operational and continue to function through the completion of the fourth stage. Beginning with the first interview, Glaser and Strauss (1967) explain, the data are coded “into as many categories of analysis as possible,” then subsequent interview data are added and constantly compared to the existing codes “as categories emerge or as data emerge that fit an existing category” (p. 105). This method of constantly comparing new data to old requires that categories and codes be continually integrated, updated, and revised (as dictated by the data) until the final research report is completed.

Constant comparison has become a staple of modern qualitative research analysis in area of death and dying studies (Leichtentritt & Rettig, 1999; Trainor & Ezer, 2000; Chochinov, Hack, McClement, Kristjanson & Harlos, 2002; Lyons, Orozovic, Davis & Newman, 2002). Numerous authors recommend its use with the grounded theory method (Strauss & Corbin, 1990; Bogdan & Biklen, 1998; Silverman, 2001; Camic, Rhodes & Yardley, 2003).

Dr. Mary Ellen Young, Ph.D. acted as the outside auditor for this study. In this capacity, she assisted the primary investigator with coding, constant comparison, and identification of researcher bias. Dr. Young is a seasoned qualitative researcher, well acquainted with the goals, methodology, and theoretical orientation of this study.

*QSR NVivo* computer assisted data analysis software was used for storing, cataloguing, searching, and coding the interview and fieldnote data. *QSR* (Qualitative Solutions and Research) has a 20-year history beginning with a program known as *NUD\*IST* (Non-numerical Unstructured Data Indexing, Searching, and Theorizing). *QSR NVivo* is specifically designed for qualitative data analysis “to integrate coding with qualitative linking, shaping and modeling” (QSR, 2003, p. 1). This is particularly appropriate for the research question concerning counselor’s beliefs and attitudes and for the interview research methodology, which includes much inquiry into the counselor’s personal experiences.

*QSR NVivo* allows for the flexibility required by qualitative research. “Qualitative research is a constant process of idea-generation and idea-development” (Richards, 2000, p. 30). The necessity to update and continually reinterpret the data of a qualitative inquiry is reiterated by many qualitative research authors (Glaser & Strauss, 1967; Miles & Huberman, 1984; Patton, 1990; Glesne, 1999).

### **Pilot Study**

A pilot study was conducted using the above research method and procedures for data collection and analysis. The study consisted of a single interview. The participant was a counselor having personal experiences with clients expressing suicidal ideations. The purpose was to explore the relationship between the counselor’s own personal beliefs about suicide and her attitudes toward clients expressing suicidal ideations. Analysis of the results included several themes, subthemes, and interviewer reactions both during and after the interview. Each was examined individually and contextually.

## **Interview**

The interview took place on a screened-in porch at the home of the participant. No one but the interviewer and participant were present and the interview was audiotaped for later transcription. Prior to the interview, the participant was made fully aware of the topic and its future uses. The length of the interview was preordained to be no more than one hour but would be allowed to conclude before that time if deemed appropriate by either the participant or interviewer.

The interviewer utilized the several open-ended questions listed above as the questions in the *Data Collection* section. The design of these questions was to elicit three types of information. First, was information about the participant's memories involving incidents involving suicidal ideation. Second, was information regarding the participant's own beliefs about suicide. Third, was information on the participant's view of her own cognitive processes that resulted in the way in which she responded to her client's expressions of suicidal ideations. To achieve this, the questions possessed the qualities of being both straightforward and respectful of the participant's beliefs and experiences. They were also designed to be adaptable to the changing conditions of the interview process.

Supporting questions were also dispersed throughout the interview. While some were preplanned, most were spontaneous and drawn from the interviewer's experience as a counselor. These questions served the purposes of encouraging elaboration, building confidence (both in the participant's stories and the interview process itself), and demonstrating that the interviewer understood what was being related. The remainder of the interviewer's contributions was largely non-verbal or simple reflections of the participant's speech. These actions served purposes akin to the supporting questions.

**Field Notes**

While no field notes were taken during the interview, several pages were produced both before and after. The pre-interview notes served an organizational function. The post-interview notes were for the purpose of organizing thoughts prior to the transcription.

**Transcription and Software**

A professional transcriber transcribed the audiotape, used to record the interview. The verbatim transcript was 13 pages in length, single-spaced, and with number 10 New Courier font. The tape itself was easy to hear and understand. The form of the transcription was designed to accommodate the N5 software program used to analyze the interview.

**Themes**

Two main themes emerged during the interview. Associated with each of these were several sub-themes. Each sub-theme carried a number of ancillary themes, all of which were identified, categorized, and analyzed using the N5 program and grounded in the data of the actual words of the interview.

**Relevance to Research Proposal**

The pilot study served the purpose of discerning the plausibility of technique and the appropriateness of applying grounded theory to this research question. Discerning the plausibility of technique included logistical concerns and the researcher's ability to carry out an interview appropriate to both the research question and the methodology of grounded theory. The pilot study revealed that the technique of conducting a one-on-one interview at a location chosen by the participant, and using a combination of both preconceived and extemporaneous questions, was indeed effective. The interview

proceeded smoothly producing a plethora of information, which proved useful in later data analysis. The audiotape was easily understood and transcribed. This professional transcriber also transcribed the tapes of the current study.

The process of data analysis employed for the pilot study established the appropriateness of applying grounded theory to this research question. Several themes and sub-themes were generated, grounded in the participant's actual words, and relevant to both the participant's beliefs about suicide and attitudes toward clients expressing suicidal intentions. An example of this was the theme *Consumer Type*.

The participant had experience with two types of consumers, adolescent "Anywhere from 17, probably the youngest I have ever had that threatened [suicide] was eight," and geriatric "I dealt with it also in the nursing home that I worked in with older patients who were very ill." During the interview it became apparent that the participant regarded these groups quite differently. "Interviewer: When you are counseling and you have a client who has suicidal ideations, how do you deal or how have you dealt with the client?" "Participant: It depends on the age." Behaviors and attitudes related by the participant about counseling stratagems and opinions varied greatly between the two. They came to be the major sub-themes associated with the major theme of *Consumer Type*.

### **Summary**

The preceding methodology was used to answer the research question: What is the relationship between a counselor's personal beliefs about suicide and his or her attitudes toward clients expressing suicidal ideations? The importance of this research question stems from the knowledge that suicide is the ninth leading cause of death in the United States. Between 66 and 80% of those who do commit suicide tell someone, often their

counselors, of their intentions. Studies have found that nearly all counselors will encounter at least one client expressing suicidal ideations during their careers.

While attitudes toward their own specific experiences with suicidal clients have been found to be relatively consistent among counselors (Chemtob et al., 1988; Moritz et al., 1989; Menninger, 1991; Little, 1992; McAdams & Foster, 2000), counselors' reactions to the more abstract concept of death by suicide are more fragmented. Two clear examples of this may be found in the current counselor debate over rational suicide (Richman, 1988; Albright & Hazler, 1992; Rogers et al., 2001), and counselors' reactions to the recent Supreme Court battle over Oregon's Death with Dignity Act (1997). This uncertain connection is the source of the question for investigation. This research question attempts to discover, in part, why and how counselor attitudes toward their own suicidal clients appears in some cases to differ so dramatically from counselor beliefs about suicide when not applied to a specific personal circumstance or client, while for others it is relatively constant.

The qualitative method of grounded theory was used in this study for three reasons, each based on the nature of the research question. First, qualitative analysis is appropriate when the phenomena under consideration are not clearly understood or lack sufficient previous research analysis. At present, little is known about the nature of the relationship between a counselor's personal beliefs about suicide and his or her attitudes toward clients expressing suicidal ideations. In such a situation, grounded theory methodology is recommend. Second, the most recent research on this subject has been qualitative. Third, the use of a qualitative method for the study of death and dying is historically grounded by the work of preeminent researchers Glaser and Strauss, and Elizabeth Kubler-Ross.

Study participants are counselors having experience with at least one client expressing suicidal ideations. Participants were acquired by means of purposeful sampling. All relevant University of Florida IRB regulations were followed precisely. Data were collected by means of one-on-one interviews conducted by the researcher. Interview questions were both preconceived and extemporaneous. The N5 computer program was used to analyze the data. The researcher under the guidance of the dissertation committee coded data. In accordance with the principles of grounded theory, there was no use of preconceived codes; rather, the codes, themes, and categories, were allowed to emerge from the data.

#### **Researcher Bias Statement**

In a study of counselor beliefs and attitudes related to suicide, those same beliefs and attitudes of the researcher become relevant because of their potential influence on the study, in the form of researcher bias. While attempts were made to control for this bias, such as the use of an outside auditor and researcher awareness, it may be useful in the interpretation of this study's results to disclose researcher bias.

The researcher is a Caucasian male, 47 years of age, with a background in counseling and working for people with disabilities. He has worked with clients who have taken their own lives, and many others expressing suicidal ideations. This bias statement is written so as to correspond with the data analysis model of this study.

The researcher believes that suicide might be appropriate for some people. Of the clients he knows who have committed suicide, he believes that while their suicides might have been appropriate, he did not advocate for that choice. In each case, it was his professional opinion that other avenues were still available for exploration. Since the client disagreed, and those avenues remained unexplored, the ultimate appropriateness of

the suicide relative to those untried options remains unknown. For clients expressing suicidal ideations, options other than suicide were chosen and considered appropriate by both client and counselor.

The researcher perceives the role of the counselor is to help alleviate hopelessness, with the rationale of alleviating psychological pain. He does not believe that role to be suicide prevention. Involuntary hospitalization is viewed as a last resort. He believes a client may require such hospitalization in cases such as those involving severe situational depression. The rationale is to preserve life long enough to stabilize the client and continue therapy. Involuntary hospitalization is not seen as appropriate for any client to prevent suicide.

The perceived responsibility of the counselor for client suicide is considered by the researcher to be low, provided the counselor is acting competently and ethically. An individual is generally viewed as responsible for his or her own behavior. As a counselor, the researcher's emotional response associated with client suicide was lower, experiencing some sadness and regret.

The researcher was raised Catholic, but currently has no religious affiliation or identification with a particular religion or religious belief system. He does not believe in any deities or life-after-death scenario. There have been no personal suicide attempts. None of his family members or friends has committed suicide.

From the onset of this study, the researcher expected to find a strong link between a participant's religious beliefs and his or her beliefs about suicide. He expected to discover that such religious belief would affect the counselor's attitudes towards a client expressing suicidal ideations. The expectation was that the majority of participants would

likely have strong religious links, and that those with such ties would believe suicide to be morally wrong. In the mind of the researcher, such moral certainty would lead to the counselor belief that suicide should never be an option for anyone, and this would be the attitude of the counselor towards suicidal clients.

He shared this bias with the outside auditor. Dr. Young cautioned the researcher to be wary of this preconception, which she did not share. She suggested he proceed as planned, but allow the data to ground the theory and not allow previous assumptions to slant the analysis. Therefore the data analysis described in Chapter Four began with this prejudice, and with full awareness of its existence. As the analysis proceeded, the data did not support this researcher bias. The bias was discarded.

CHAPTER 4  
DATA ANALYSIS

**Answering the Question**

The data for analysis consists of eight one-on-one private interviews with eight individual counselors conducted by this study’s primary investigator. The demographic profile of the participant sample includes age, gender, religious orientation, counselor professional affiliation, and race (Table 4-1).

Table 4-1. Participant Demographic Profiles

Participant	Age	Sex	Race	Religious affiliation	Professional setting
1	Late 30s	Male	White	None	Vocational rehabilitation
2	Early 30s	Female	White	Lutheran	Rehabilitation
3	Late 40s	Male	White	None	Mental health
4	Early 50s	Female	White	Jewish	Mental health
5	Late 20s	Female	White	Catholic	Rehabilitation
6	Early 60s	Female	White	Founded Own	Hospice
7	Early 40s	Female	White	None	Private practice and hospice
8	Late 40s	Male	White	Unknown	Mental health

Participant ages ranged from early 20s to late 50s. Genders include three males and five females. Religious orientations included three participants reporting no religious affiliation (but having been raised Catholic), one participant with a strong

affiliation with the Lutheran religion, one participant with a strong Catholic identification, one participant with a cultural Jewish affiliation, and one participant who founded her own religion. Counselor professional affiliations included four rehabilitation counselors, one private practice marriage and family counselor with experience working with hospice clients, one hospice counselor, and two mental health counselors. All participants were Caucasian.

The first question was always to establish that the interviewee was, at a minimum, a master's level counselor having had at least one client who expressed suicidal ideations. These were the two participant inclusion criteria. Everyone interviewed either met or exceeded these criteria, most having had several such clients.

Next each participant was invited to tell of one such client. This telling never failed to bring emotional memories to the surface, imbuing the participant's tale with clear points of personal connection with his or her client. Participant Two: "I was pregnant at the time. I remember that with my first child. And he was one of my favorite clients. You're not supposed to have favorites but he was special." Participant Five: "He wanted another way. He wanted, I mean, he's such a great person, you know." Participant Eight: "And this [client] was a really kind of a neat woman, I liked this person a lot. And her whole presentation. I was very personally touched by her obviously. I was very engaged with her." Participants reported a stark recognition of the painful and often hopeless world that their client brought to the counseling session.

Participant Eight: And what struck me is that there was a phase there where she was actively between sessions she would pop emails to me that were just so

powerful. And her writings were very incredible, not only to express herself and bring tears to my eyes in her ability to express the level of her pain and her sense of hopelessness.

There were also obvious efforts on the part of the counselor to work with his or her client's pain and ferret out some hope in a seemingly desperate life.

Participant Five: People that are hopeless come in here all the time and I feel that it is my job and anybody else's job here to help that person find hope whether it be coming back to me or starting out small, you know, working to where this person sees the hopelessness and how we can assist them to see – to step outside of themselves and to see in this pain that they might be feeling, right now, to other times when they felt joy and other times when they felt good about life and how we can get them back to that point.

This story, which often became multiple stories, served as a portal for inquiry into the participant's personal beliefs and attitudes. Rather than imposing a series of preordained questions, subsequent questions were drawn from the themes, such as *hopelessness*, that emerged from the story to formulate the next question.

During the first interview, the foundation of each question was two fold. The initial questions were formulated before hand, by the researcher alone, in an attempt to answer the research question. As themes emerged during the discussion, some received follow-up questions while others did not. The themes chosen for elaboration were based on the research question. The goal was for the participant to provide information about his or her own personal belief system in relationship to suicide, death and dying, and attitudes toward his or her clients expressing suicidal ideations.

While subsequent interviews were conducted in a similar manner, they differed in that the questions evolved to be less preconceived by the interviewer, and increasingly rooted in the emergent themes of the previous interviews. This was possible because each interview was analyzed prior to conducting the next.

After transcription, the interview data were thematically analyzed line-by-line with the assistance of NVivo qualitative data analysis software. Emergent themes were then examined for their pertinence to the research question. In turn, the research question received constant scrutiny for its own relevance to the emergent themes. These themes became the basis for further inquiry.

As themes such as hopelessness emerged repeatedly in interview after interview, the qualitative technique of *constant comparison* (Chapter 3) was applied across interviews to discover any developing thematic patterns. Similarities and differences were noted in the manner in which each participant addressed each theme. For example, whether or not each participant did address each theme, and in what ways the statements of one participant varied from those of another. Also examined were demographic similarities and differences among participants relative to their expression of the various themes. For example, demographic data were compared among participants reporting similar or divergent beliefs or behaviors. Each of these comparisons was charted in table form. As new participants were interviewed, the tables were expanded to include their views (Tables 4-2 and 4-3).

Table 4-2. Hopelessness

Participant	Did every client having suicidal ideations express a sense of hopelessness?	Did the participant ever share in this sense of hopelessness with client?
1	Yes	No
2	Yes	Yes

Table 4-3. Did the participant ever share in this sense of hopelessness with client?

Demographic Data Participant:	Yes Participant 1	No Participant 2
Age	Mid 30s	Late 20s
Sex	Male	Female
Race	White	White
Religious Affiliation / Spiritual Beliefs	None/ Monotheistic	Lutheran/ Strongly identifies w/ religion

Similar tables do not appear after each theme. An overview table and detailed flow chart are presented later in this chapter.

### **Developing Thematic Patterns**

The following are individual analysis of each emergent theme. Each theme appears in the order in which it emerged. This ordering may not be indicative of any kind of priority on the part of the participants, since they were often responding to interviewer questions. In accordance with grounded theory, since the themes emerge from the data, they are also grounded in that data. Demonstrating this process of analysis is accomplished by the inclusion of select quotes from the interview data. These quotes are representative of the data from which the theme emerged and in which the theme is grounded.

The emergent themes of this study are divided into two basic categories: counselor beliefs and counselor emotions. Associated with counselor beliefs are themes rooted in cognition. These are themes that relate what a participant thinks about a particular situation or phenomenon. Associated with counselor emotions are

themes rooted in affect. These are themes that relate how a participant feels about a particular situation or phenomenon.

Counselor belief themes include the following. *Feelings of hopelessness*: all participants reported the belief that feelings of hopelessness were the core problem facing each of their suicidal clients. *Suicide as an option*, which refers to the manner in which each participant views suicide as being a possible legitimate client option. *A counselor's own personal suicide ideations*, refers to the degree to which participants have contemplated the possibility of their own suicide. The theme of *appropriate action* explores the variety of behaviors, on the part of the counselor toward the suicidal client, conceived by each participant as appropriate. *Human worth* refers to an underlying belief in the value of a person based solely on the condition of his or her humanity. *The ripple effect* considers the importance assigned by counselors to the manner in which an individual's decision to end his or her own life affects the people connected to that individual. The theme of *religious beliefs* delves into some of the possible implications surrounding each participant's religious beliefs or lack thereof.

Counselor emotion themes include the following. *Feelings of professional failure and self-doubt*: the feeling (on the part of the counselor) that the suicide of a client represents a failure of his or her counseling abilities, and the feelings of self-doubt that may accompany such failure. *Feelings of responsibility*, examines the degree to which a counselor may feel that he or she is personally responsible for the suicide of a client. *Feelings of responsibility and counselor age*, refers to the relationship of such feelings of responsibility to the age of the counselor. *Unfettered*

*feelings* are considered to be those participant-reported emotions that appear to exist independently of other participant beliefs or demographic traits. Such unfettered feelings include anger, fear, resentfulness, and sorrow.

### **Counselor Beliefs**

#### **Feelings of hopelessness**

In each and every interview, the participant emphasized the sometimes-overwhelming sense of hopelessness expressed by every client having suicidal ideations. Some interviewees also noted intense issues of client shame, guilt, and often depression. Yet, it was the client's resolute view that his or her life was never going to change that remained constant throughout all the interviews. Participant One: "I always try to assess feelings of hopelessness in conjunction with depression. The greater the feelings of hopelessness, the greater the likelihood that they [clients] would actually commit suicide." Participant Seven: "I thought she [the client expressing suicidal ideations] was very serious. And she was hopeless, you know. Which is what suicide is about, I think."

Since the focus of this study is the counselor, not the client, one of the questions after a discussion of client feelings of hopelessness refocused that feeling back onto the participant. "Do you ever feel or think, either feel or think, that perhaps, for some [clients], there is no hope? That perhaps they're right [about their feeling of hopelessness]?"

The counselors were much more diverse when it came to their own sense of hopelessness in the clients' lives. The following represents the extremes in this spectrum of answers.

Participant Seven: You know I don't think I think that. I think that they can't see any hope. I believe that that is their experience. And I guess that's my optimistic viewpoint on life that hope springs eternal. We just have to dig and find it sometimes.

Participant Five: At that point when he had expressed that [the client's particular set of problems] to me, I'll be honest with you, I was like, you know, how do I even help this person see hope?

Participant Five continued stating,

Even internally I was thinking it was this challenge for me to provide counseling to where he would be able to find hope in my, we talked about it, you know, but when he was explaining it to me I was going, and I knew the situation, I'm going, 'Gosh, you know, every time he tries to get ahead, he gets stamped back ten times. You know, every time he can't pay any bills. He can't go anywhere. He hasn't got money. He's in constant pain. He can't even pay for food. If he wants to get food he has to go to sell something.' You know, so in me it was difficult, you know, to really try and figure out how I can assist him in finding hope in life, finding short-term goals that we can concentrate on that he could be successful at to where he can see that there is the hope in life to keep moving. That's there's a reason why he is here. There's a reason why he's going through these times and, you know.

These various counselor responses seemed especially poignant because the earlier descriptions of their clients and client's situations appeared quite similar. It was not readily apparent that the client, the client's presenting situation, or specific suicidal ideation had lead to the counselor's apparent "sympathetic" versus "empathetic" response. Some counselors were apparently willing to consider that a situation might indeed be hopeless while others were not.

### **Suicide as an option**

Following up on the counselors' beliefs (or lack thereof) in the possibility that some situations may indeed be hopeless, the interviewer posed variations of this question. "Have you ever had a client who, you thought, maybe suicide might be an option in their case, a legitimate option? Can you think of a scenario where it might be a legitimate option for somebody?"

While only one participant was familiar with the term *rational suicide*, the others had clearly considered the concept. Perhaps predictably, those counselors who reported an ability to share in their clients' assessment of a hopeless situation also thought that the possibility of suicide being a rational choice under some conditions might exist.

Participant Four: I think life may be sometimes too painful to live, for some people to live. And I guess until you brought it up I never really thought about it being, I mean I truly believed in Kevorkian's opportunity of being able to chose death if you were dying of something rather than having such an impaired quality of life. I truly believe in that.

Interviewer: The physician-assisted suicide?

Participant Four: I do. I don't think people should be made to live. I don't think they should be forced to live if they don't want to.

Those interviewees sharing the attitude of hope springs eternal, expressed serious doubts about suicide ever being a rational choice.

Participant One: I believe that there are people who feel so hopeless about their lives that, to them, suicide is a legitimate option and they believe that. I personally don't think there's ever a situation that's that black that can't be worked out. But that's from my vantage point so I'm biased because of what I do.

Other participants reported being able to understand the client's desire to commit suicide, but still believed doing so was not a viable option.

Participant Five: I don't ever think that there is an okay time to choose to end your own life, personally. You know, I feel that it is definitely the people that chose to do this are really hopeless. I'm making a conscious effort to do something to take them out of the pain that they're feeling or whatever the situation is, and I would never say, 'Yeah, I think he should kill himself.' You know, he would get out of his pain. But I found myself struggling with, not struggling with, but I was understanding how he was getting to the point of wanting to go through with suicide.

While participants' views on the legitimacy of rational suicide varied, their views concerning their own behavior did not. No counselor reported believing it his or her role to suggest, or even discuss, rational suicide with a client.

Participant Four: I don't know if suicide is an alternative that I would explore with a client. Not that I don't believe in it, the option of it, but I don't know if I would explore, I don't know how to explore suicide as an option with a client.

Interviewer: So you haven't done that.

Participant Four: No.

Participant Eight had clearly thought through his reasoning for never having recommended suicide to a client:

Participant Eight: I can't actively ask that [ask the client whether he or she thinks suicide might be rational in this circumstance], even if you ask it, then you're asking to change the relationship and, wait a minute, what are we doing here? Let's get out of therapeutic relationship and become buddies or something. If you're going to do that ethically then, I'm not.

Participant Seven, the participant who had earlier expressed her belief that hope springs eternal, made this observation.

Participant Seven: You know, if somebody, I think if I had Lou Gehrig's disease, I'm not so sure I would be able to find any hope and I'm not so sure I'd want to go on living with that quality of life, so I'm not saying that there wouldn't be [a time when suicide might be a rational alternative].

Interviewer: You were saying that in your experience there hasn't been a time when there wasn't hope.

Participant Seven: Not for the clients that I was working with. In the broader concept, I'm not willing to paint a broader stroke and say, 'It [hope] always springs eternal.' No, I'm not willing to say that because I don't know that that's true. I think the folks that I've dealt with and the folks that have been able to get here and that I've had the privilege of working with. I can't say that I couldn't see hope for them.

Participant Seven seemed to be making a distinction between personal experience and theoretical experience. She was unwilling to judge all cases based solely on her own counseling experience.

This apparent disconnect between a counselor's belief that suicide may indeed be a legitimate option for some individuals, and that same counselor's report of never having had such a client in his or her own practice, is discussed at length in the next chapter.

### **Counselors' own personal suicide ideations**

Participants reported varied opinions concerning the option of suicide in relationship to their clients. The purpose of this next question was to assess how the counselors viewed the option of suicide for themselves. "Would suicide ever be an option for you?" While some participants responded more adamantly in the negative than did others, none reported having seriously considered killing themselves.

Participant Two: No. Never, ever, ever, ever. I personally believe that you are given life and to take your life is a sin. And our feeling is very religious and very spiritual at the same time and we are raising our kids that way and, absolutely not, ever, no way. There is nothing that is so terrible that you can't either pray about it or have faith that you won't be helped through that time.

Participant Five: I really have never said, 'I want to kill myself.' I never have done it. 'I don't want to live. I don't want to ever see anybody again. I don't want to breathe another breath of air.' I've never had that feeling. I'm sure I've had, you know, 'life sucks' and, you know, all these other feelings but not that, 'I just want to die.'

### **Appropriate action**

Participant One: It [suicidal ideation] has come up many times in my practice and the first thing that I always do is assess lethality to see how serious it actually is and what I am looking for is certain variables that could increase the likelihood that the person could actually seriously kill themselves and then, of course, the next step would be to take the appropriate actions.

The actions counselors deemed appropriate for themselves in response to client suicidal ideations were notably uniform. Regardless of the counselor's earlier position on the perceived hopelessness of a client's situation, or the legitimacy of rational suicide, no participant reported discussing suicide as a viable option with his or her client. To the contrary, interviewees all opted for nonvoluntary hospitalization over suicide.

The subthemes of *professional liability* and *institutional policies* emerged from participant responses in the discussion of appropriate actions. Some seemed quite comfortable with the goal of suicide prevention, and expressed a more paternalistic mindset with an eye toward beneficence. Participant Five specifically stated, "I don't ever think that there is an okay time to choose to end your own life." In reference to Florida law, Participant Two stated, "And he was pretty serious about it. So we had to have him Baker-acted [involuntarily hospitalized for 72 hours], of course." Participant Four also mentioned the law. "If someone is threatening to shoot themselves, they would get Baker-acted or arrested and hospitalized. That's the reality. That's how you get somebody into treatment, when they're admittedly at risk."

Others acknowledged that they would involuntarily hospitalize suicidal clients, but expressed a personal repugnance regarding the infringement of personal liberties, freedom, and client autonomy.

Participant Eight: I do not consider myself a suicide prevention therapist. That's not to say that I haven't on occasion had a moment taken responsibility for somebody or gotten involved with them and involuntarily hospitalized them but I'm not very eager about that, I'm not sure that I'm doing much good. In the long run it may be counterproductive. Certainly the literature doesn't support it [involuntary hospitalization].

Yet even in this case, the participant reported setting aside this value in favor of non-voluntary hospitalization over suicide.

Citing a lack of guidance in this area from both vague professional codes and nearly non-existent classroom training (this issue to be discussed later), some participants reported conflicted thoughts and emotions and an underlying fear of legal repercussions in the event of a completed suicide.

Participant One: We have, for liability reasons you know, all these hoops you have to jump through to make sure that you are assessing lethality.

Participant Eight: I think in many places that [suicide prevention] is the way they operate. I think it just seems counter to everything. It seems counterproductive.

Interviewer: That [suicide prevention] is counter to the research?

Participant Eight: Well, it's [suicide prevention] not counter to managed care. It's not counter to liability.

Regardless of a participant's comfort level, everyone reported a profound understanding for the seriousness of this act.

Participant One: In my experiences, pretty much anytime you take away anyone's autonomy to make their own decisions and you act contrary to what they want, there usually is some reaction and it usually comes in my – your direction – whoever's direction is doing that. So I usually prepare myself for that and, you know, I think about, you know, okay – I'm usually very methodical and careful about how I proceed in those situations.

All interviewee responses were very similar regarding what they thought was the best therapeutic strategy before turning to involuntary hospitalization. Without exception, participants stated perceiving their role to be one of facilitator for finding hope. Participant Seven states, "There is a certain responsibility that clients have also but I feel that I have a responsibility too and part of my job, I think, is to help them

discover some hope if I can.” In most instances the participant reported that hope was indeed found, a discovery that sometimes surprised even the counselor.

While all study participants reported their willingness to prevent client suicide by means of involuntary hospitalization, they reported differing rationales for doing so. Some participants appeared to see themselves as duty-bound to save the suicidal individual from death. Others seemed more focused on helping the client to improve his or her quality of life. The fact that the individual might decide not to commit suicide was reported as an almost ancillary benefit. In response to the question, “As their counselor, do you feel that it is your duty to keep clients from killing themselves?” Participant Four responded, “No. It’s my duty to help them find, to encourage them to find a sense of hope from this in their lives. Perhaps explore options for themselves in the future. Help them explore the positives of their lives.”

Yet, whatever the rationale, all interviewees reported participating in similar counseling behaviors when confronted by a client expressing suicidal ideations. Their attitudes were those of respect, empathy, and a commitment to help facilitate the discovery or development of hope in a life perceived by their client as utterly futile.

Participant Eight: I’m trying to connect with this person [the client] and be respectful of this world that they’re in and try to understand it and see if there’s any way I can help them figure out how to make it manageable or maintainable or reducing hopelessness.

### **Theme: Human worth**

All study participants universally held belief in human worth. The basic belief that a human being has value simply by virtue of being human emerged from the very first interview.

Participant One: Because I think the thing that bothers me [about suicide] is that the person, I think inherent in that decision is the belief that they don’t have

worth and that could be wrong. I may not be correct. I don't know people that believe that consciously, 'I'm not worth anything.' So I just don't think of it that way.

Interviewer: Would it be a fair statement then to say that you believe that all people have worth?

Participant One: I believe that there's a place for everyone and so, yes everybody has worth.

Various iterations of this belief would surface in subsequent interviews. For some participants, a client suicide represented a tragic waste of human potential, of human worth. Others concentrated more on what could be called the *ripple effect* surrounding suicide.

**Theme: The ripple effect**

“The ripple effect of suicide on human suffering has major implications for mental health counselors” (Carney & Hazler, 1998, p. 28). Between 1970 and 1990, the National Center for Health Statistics (1996) estimates that just over four million Americans have been affected in some way by the suicide of a loved one. The ripple effect is a term used by a number of participants to describe how the suicide of one individual affects numerous others with whom they are socially connected. The analogy being that of a pebble tossed into a still pond sending out ripples, which in turn affect everything (to various extents) in that pond.

Participant Five: I think that that's [suicidal ideating] a moment where that person is, of course, focusing on themselves, and how it would be a gratification for them at that moment. But I see the aftermath and how it affects not only that person, because they're not here anymore, but all the other people that this person is around and with.

Numerous interviewees acknowledged this ripple effect. Some appeared to weigh this phenomenon more heavily than did others when making therapeutic treatment decisions. Just how much consideration a participant afforded the ripple

effect ran along a continuum. Yet social context is always reported to take a back seat to the needs of the individual client. For example, Participant Five states, “But it wouldn’t be my intention to assist somebody in not, or to help somebody to not commit suicide just so that it didn’t affect other people.”

It seemed prudent to delve more deeply as to the roots of these differences. The researcher suspected that the personal histories of the individual participants would yield the answers. By way of making clear a possible researcher bias, the expectation was that counselors who reported the need to consider the ripple effect more heavily to have experienced a history of personal suffering resulting from the suicide. Conversely, the expectation was not to find such a history with those who did not consider the effect so highly. This study failed to uncover any such differences. While the counselors expressing the most impassioned need to consider the ripple effect did indeed have painful suicides in their histories, so too did others along the continuum including the counselor who expressed the most alternative perspective.

### **Theme: Religious beliefs**

The importance of religious or spiritual beliefs to many individuals was previously discussed in Chapter 2. In the same chapter, the literature also supported a strong link among religion, death and dying, and suicide. This study’s interviews investigate counselor beliefs regarding suicide and include the counselor’s report of his or her own religions or spiritual beliefs. Since these interviews were often the researcher’s first meeting with each individual, the decision was made to ease into the topic rather than simply ask outright. The intention was to avoid participant defensiveness to being questioned about their religious beliefs. Therefore the interviewer posed a question about the importance of religion to the client expressing

suicidal ideations. “Did she [the client] discuss, her spiritual beliefs or religious background?” “Did her Christianity, that background, come into play with her discussion of her own suicide?” The ensuing discussion invariably led to direct dialogue concerning the counselor’s own religious beliefs.

Before continuing, it may be helpful to expose another source of possible researcher bias. The experiences of the researcher in North Central Florida led to the beliefs that (a) the predominant religion is Southern Baptist, and (b) this religion plays a dominant role in the lives of believers. These prejudices led to the conclusion that (a) many participants could be Southern Baptists, and (b) the tenets of this religion could play a dominant role in the participant’s counseling relationships. Prior to conducting the interviews, the researcher acquired a modest understanding of this religion.

The data failed to support this bias, as the participants presented a veritable cornucopia of religious and spiritual views, and none were Southern Baptists. This variety of religious belief systems is reflected by participant responses to variations of the question, “Do you have any spiritual beliefs or religious beliefs that link in with suicide?”

Participant One: No. I was raised with that belief but I personally do not believe that. There’s no spiritual connection to thinking that it’s wrong. It’s kind of like tearing away at the fabric of society from my perspective.

Participant Two: We are very active in our church. I strongly believe in the Lutheran faith, absolutely.

Participant Three: I’m not involved in any organized religion anymore, you know, I grew up Catholic, so I can relate to all those beliefs.

Participant Four: My background is Jewish. I’m not a God-believer. I come from a cultural frame of reference.

Participant Five: I don't really have a religion. I don't think that my feelings about suicide are theologically based.

Participant Seven: The thing that I take from the Catholic faith was the social justice, awareness that was part of the Catholic Church that I grew up in and I believe in a just and merciful God and I can't go for the fire-and-brimstone.

Participant Eight: [no mention]

Faced with such a divergence of counselor religious affiliations and personal beliefs, combined with such a convergence of counselor reports about client hopelessness and counselor reactions to client suicidal ideations, another way to look at the data became necessary. Therefore, in addition to the two previously displayed tables examining the theme of *hopelessness*, a third table was devised to help sort out over-all similarities and differences in the counselor's reports (Table 4-3).

Table 4-4. Over-all similarities and differences

Uniform counselor reports	Divergent counselor reports
Having personally had no clients considered for suicide as an option.	Suicide as possible alternative for some people.
Hopelessness as root of suicide ideation. Perceived role of the counselor is to help alleviate hopelessness.	Individual participant rationale for perceived role of the counselor.
History of, and willingness to, hospitalize against client's will to prevent suicide.	Individual participant rationale for the willingness to hospitalize against client's will to prevent suicide.

**Counselor Emotions**

**Theme: Feelings of professional failure and self-doubt**

McAdams and Foster (2000), Little (1992), and others discovered feelings of professional failure and self-doubt to be common emotional reactions among counselors after the suicide of a client. This present study found that these particular emotional responses were reported predominately in the interviews of participants

who also reported having a strong identification with their traditional religious beliefs. Participant Seven states, “I felt like a failure. I felt bereaved. I mean I felt like there were two levels of grief going on. There was grief for the loss of his life and my own grief, feeling like I had failed him.” Feelings of self-doubt arose when the counselor was faced with another client expressing suicidal ideations just after having a previous client complete suicide.

Participant Two: I was afraid after that, working with some of my other clients to even go there when they would talk about, ‘I just want to die.’ I was afraid to even work with them. I was afraid to talk to them. I thought, and any time any of them even mentioned it, I said, ‘I’m calling the Crisis Unit. Are you suicidal?’ And we’d talk about it and I didn’t even want to go there with them. I was like, ‘Um, you’re going to the CSU.’ And that was my job to keep them out of the CSU but I was just very gun-shy I guess, I don’t know if that’s the right word.

Those participants reporting little or no personal identification with traditional religion, tended not to attribute the completed suicide of a client to their own professional competence, and expressed fewer feelings of self-doubt.

Participant Three: I think it’s natural to ask yourself, if you look back, if you look at behavior, if you look at statements that were made, some of them you could interpret at least, looking back, as clues. But, you know, you just can’t get lost in that. I think it’s natural to ask that question, to do that retrospective. Did I miss something? To say, well okay what can we learn from this, you know, and then there’s a place for that. But you don’t want to cross the line to taking responsibility for it [the client’s suicide].

### **Theme: Feelings of responsibility**

Feelings of self-doubt and professional incompetence appear to be connected with the counselor feeling that he or she is, in a major way, personally responsible for the survival of the client. Interviews suggest that as the level of a participant’s feelings of responsibility increase, so too do his or her feelings of professional failure

and self-doubt. Participant Five expresses how both strong feelings of responsibility for her clients are tied to feelings of professional competence.

Participant Five: But I know that when you're in that point where somebody's telling you that [suicidal ideations], you hold a very important role, you know, at that moment, with that person. And if you don't know how to handle it, it can be the difference between somebody living or not. And it's your fault that they chose to kill themselves. But you are given that moment, this person is crying out to you, even if it's in the simplest way they're putting it out there for you to give them some type of assistance in finding hope, so that's a big responsibility.

Conversely, interviews suggest that as the level of a participant's feelings of responsibility decrease, so too do his or her feelings of professional failure and self-doubt. Participant Eight illustrates this point as follows.

Participant Eight: Again I'm open to the possibility that people are responsible for themselves and that I can't really be responsible for them and so why call myself a suicide preventionist? Working with the system we have here, appreciating that we're dealing with hundreds of actively suicidal folks each year. Okay? Within this system. And working with a number that complete it each year. So the numbers are pretty good and that over the last 20 years there's only been a couple of times where I've thought, 'Man, I could have done better.' But that was irrelevant. And even in those cases where I thought we could do better, I never really had a sense that we could have made a difference, you know. Maybe, maybe, who knows? I've never really had any strong sense of that. Now, I don't know what that means but I'm struck by the concept of the feeling, I really screwed up. I should have done something. I don't know exactly what that looks like.

### **Themes: Feelings of responsibility and counselor age**

Some older participants, over 35 years of age, reported feeling a greater degree of responsibility for their clients earlier on in their careers than they felt presently. Such comments suggest that feelings of responsibility for a client may be related to either, or both, the counselor's age or experience.

Participant One: I think over time that my thoughts on that have, you know, changed considerably. Yes, I was a lot younger then and felt a lot more responsible for a lot more than I really, than I would now. (Age: Late 30s)

Participant Four: I guess I don't, you know, personalize it like I have to fix them [the clients]. I don't feel like it's my responsibility to fix them. I feel less responsible for fixing them. I'm able to step myself back from the situation a lot more than I did as a newer clinician. (Age: Early 50s)

Participant Eight: Well, truthfully I was thinking how the issues have changed so much for me over the years since the first client I ever had that was suicidal was when I was in fact a second year grad student. This was over 25 years ago. What's interesting is though I suspected it very much shaped me even at that point. I was 22 or something, 23. I think it took a lot of mystique or mystery out of it. And so I don't know that, I know that over the years when I had clients, and I'm not saying I don't get anxious or uncomfortable with it at different times, it was never the same because, as then with the first client ever had completed suicide. (Age: Late 40s)

As the result of comparing each participant's responses with their ages, the age of approximately 35 seemed to emerge as a kind of cut-off point. Those counselors above that age appeared to share the feeling that the greatest degree of responsibility rested with the client. Participants below the age of 35 shared the feeling that the counselor bore the greatest degree of responsibility. Closer scrutiny showed participant age to be indicative of counselor experience, since the study participants all began their counseling careers at the approximate age of twenty-five.

### **Unfettered feelings**

In this context, *unfettered feelings* refer to those counselor emotions seeming to exist regardless of a participant's other traits (e.g., religious beliefs, age, sex). These feelings include anger, fear, grief, love, sadness, and stress. While not every participant reported experiencing all of these *unfettered feelings*, each was reported frequently and typically with profound emotion detectable via the interviewee's voice or demeanor. The following are responses to variations of the question, "I'm interested in your feelings when you heard [about the client suicide]." Participant One, "I was really angry." Participant Two, "I was happy but I was scared, I was

very scared. I was mad. And then I was sad. And then I was really sad.” Participant Three, “Yes, it's free-floating [emotion]. I'm just resentful. This is not right. This is not fair.” Many of these perceptibly heartfelt statements served to reinforce previous cognitive assertions as to the participant’s respect for, and empathy with, the client.

Participant Eight: What can I do? And I do believe that the most powerful thing that I have to offer is I’m willing to be with them [clients] and try to understand that world they’re in and not withdraw from them, not shut down. I’m trying to connect with this person and be respectful of this world that they’re in and try to understand it and see if there’s any way I can help them figure out how to make it manageable or maintainable or reducing hopelessness.

These emotions lend insight into the motivations underlying the counselor’s attitudes. They do not appear to affect the attitudes themselves. Each participant reported very similar attitudes toward clients expressing suicidal ideations regardless of which *unfettered feelings* they also reported.

### **Steps in Developing a Data-Analysis Model**

Data analysis began immediately after the first interview. That interview was transcribed; the data copied into NVivo, and coded line by line for emergent themes. These themes were then utilized in the formulation of questions for the next interviews. This procedure continued throughout the study. The resulting themes are presented earlier in this chapter.

After the coding of each new interview, the themes from all the interviews were comparatively analyzed. The results of this constant comparison were continually evolving models of data analysis, the formulation of new interview questions, and the necessary recoding of previous interviews. Previous interviews were recoded to keep them up to date with newly emerging themes in later interviews that may have gone

unnoticed, and to keep researcher bias in check. Researcher bias tended to diminish as newly emergent themes challenged previously held biases.

Throughout the data collection and analysis process, Dr. Mary Ellen Young, Ph.D. acted as the study's primary outside auditor. In this capacity, Dr. Young assisted in the development and application of codes, the interpretation of data, and researcher bias recognition. Bias recognition is necessary for the researcher to effectively scrutinize his or her own personal subjectivity (Olsen, 1994; Glesne, 1998; Denzin & Lincoln, 2000).

As previously mentioned for the example of *hopelessness*, comparisons were charted in expanding table form. Soon after, a third table was devised to help sort out over-all similarities and differences in the counselor's reports. This last version follows as (Table 4-4). Although this table above provides a well-condensed summary of this study's findings, it remains cumbersome and does not adequately depict the manner in which the themes may be related. Therefore, a data analysis model was developed to provide a more elegant overview depicting the flow of thematic interrelationships. While alternative models are certainly possible, the final data analysis model of this study is shown in (Figure 4-1).

Table 4-5. Suicide as a Possible Alternative: Final Table of Possible Connections

Yes – Might be appropriate for some.	No – Never appropriate for anyone.
Rationale for Perceived role of counselor to help alleviate hopelessness is to: Alleviate psychological pain.	Rationale for Perceived role of counselor to help alleviate hopelessness is to: Find meaning in life. Find reasons to live. Prevent suicide.
Yes – Might be appropriate for some.	No – Never appropriate for anyone.
Rationale for willingness to hospitalize against client’s will to prevent suicide: Avoid institutional / legal sanction. Policy of Postponement	Rationale for willingness to hospitalize against client’s will to prevent suicide: Insure client safety.
Level of perceived responsibility for client suicide: Low – most, if not all, responsibility rests with the client, Shared – while the ultimate decision rests with the client, the counselor does share some degree of responsibility.	Level of perceived responsibility for client suicide: Shared – while the ultimate decision rests with the client, the counselor does share some degree of responsibility. High – should the client commit suicide, the counselor is highly responsible decision.
Level of counselor emotional response associated with client suicide: Low – experiences such feelings as sadness, anger, and regret.	Level of counselor emotional response associated with client suicide: High – in addition to such feelings as sadness, anger, and regret, counselor experiences feelings of professional failure, self-doubt about his or her ability to cope with suicidal clients in the future.
Degree of counselor identification with a particular religion / religious belief system: Low – little or no identification. Medium – some identification, but no strong identification. High – Reports being an active member of a specific religion.	Degree of counselor identification with a particular religion / religious belief system: High – Reports being an active member of a specific religion.
Counselor’s age (in this case also indicative of counseling experience): Above 35	Counselor’s age (in this case also indicative of counseling experience): Below 35
Counselor’s personal history of suicide: No personal suicide attempts. No serious suicidal ideation. Having had a personally close individual commit suicide.	Counselor’s personal history of suicide: No personal suicide attempts. No serious suicidal ideation. Having had a personally close individual commit suicide.



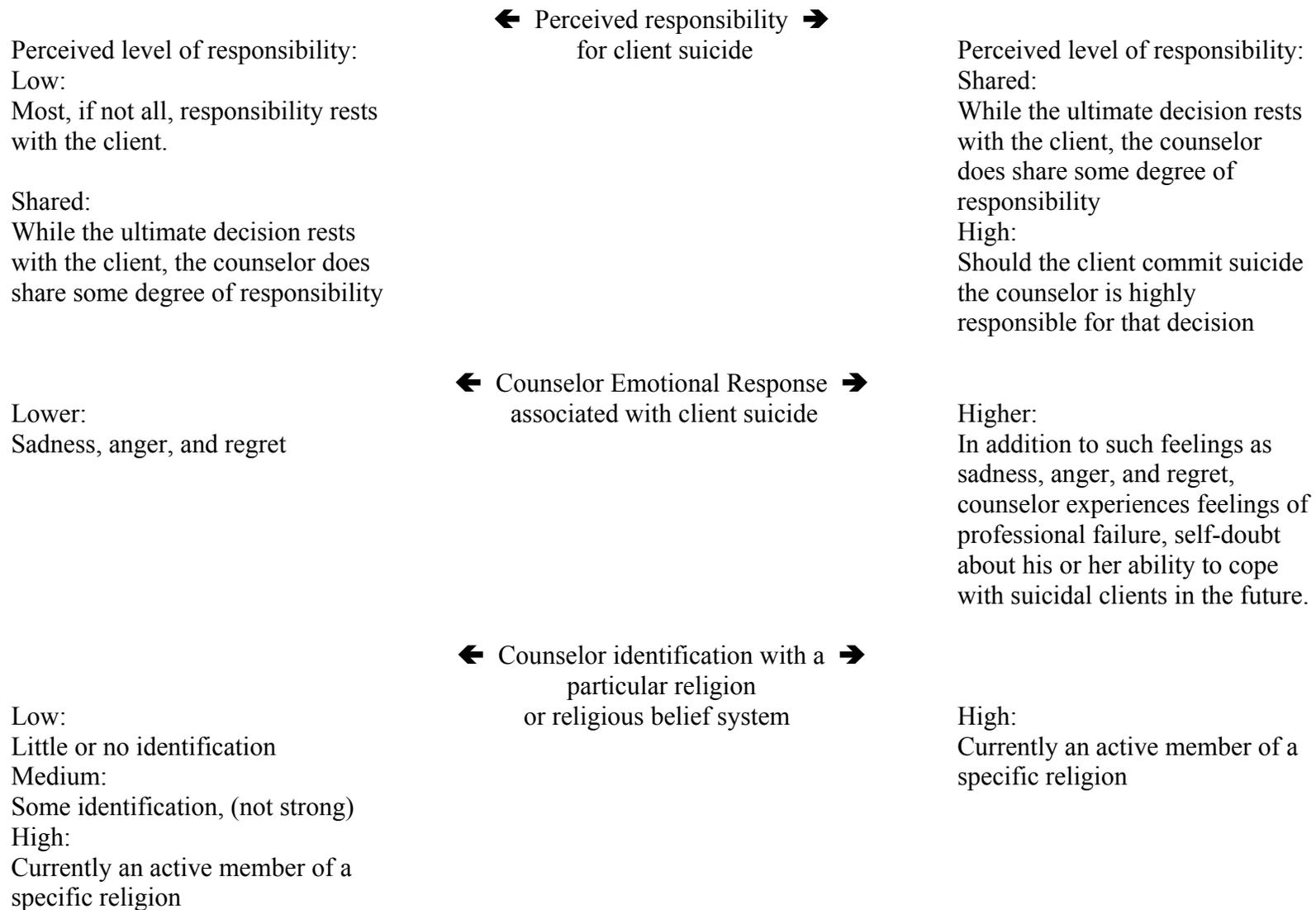


Figure 4-1. Continued

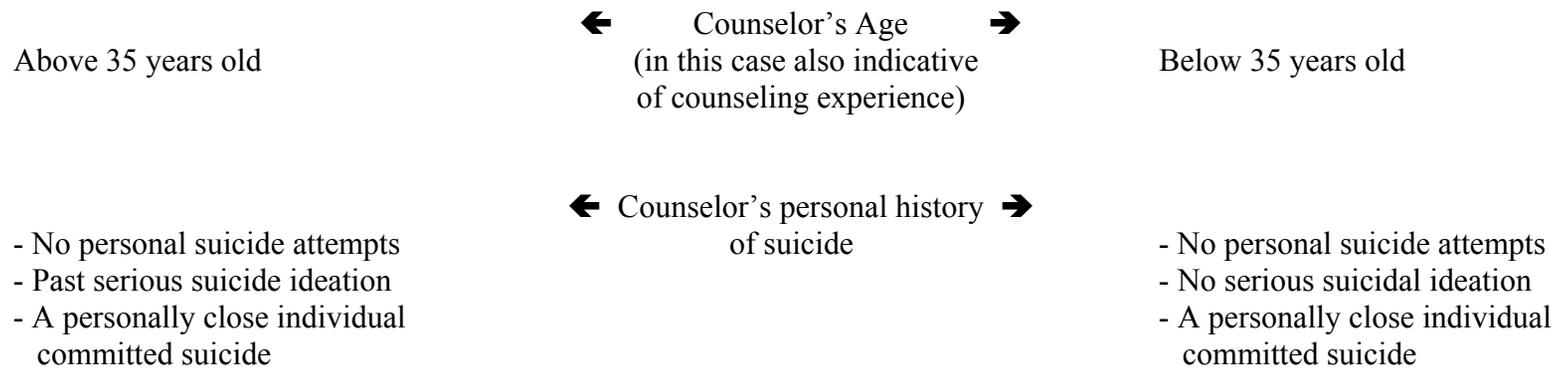


Figure 4-1. Continued

### Explanation of the Data-Analysis Model

The perception of suicide as a possible alternative for some individuals emerged as a major line of demarcation for the participants of this study. Certainly there are other important divergences of opinion, belief systems, reasoning, and affective responses to situations involving suicide and suicidal ideation. However, when analyzing the data, every other theme could readily be connected to the counselor's perception of suicide as a possible alternative for some individuals. Therefore, this theme appears at the top and center of the data analysis model flow chart.

As previously mentioned in this chapter, this information was elicited through variations of the following question: "Have you ever had a client who, you thought, maybe suicide might be an option in their case, a legitimate option? Can you think of a scenario where it might be legitimate option for somebody?" Participants did not report ambiguity about suicide being a possible alternative. Each of their answers to this query was either *yes* or *no* (represented in the model by downward diagonal arrows).

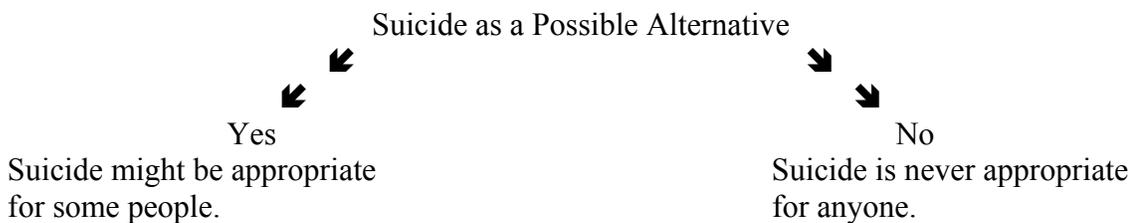


Figure 4-2. Data Analysis Model: Suicide As A Possible Alternative – Step 1

Participants did thoroughly explain the precise parameters of this belief. Those answering in the negative stood firm with a black and white view of the very possibility. For them suicide could never be a possibility for anyone. Those answering in the affirmative expressed the view of a wide swath of gray, filled by individual situations, possible scenarios, and unforeseen circumstances.



subthemes illustrating the manner in which participants either differ or concur) in relationship to each theme.

### Perceived role of counselor

In every case, the perceived role of the counselor is to help the client alleviate hopelessness. The difference among participants is their rationale for doing so.

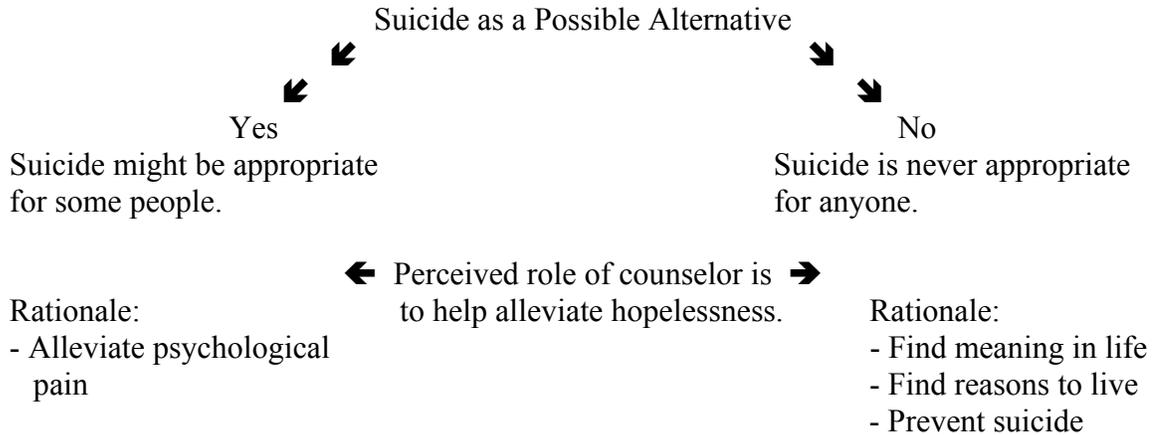


Figure 4-4. Perceived Role of Counselor

In the left or *Yes* column, the stated rationale for the counselor to help the client alleviate hopelessness is the goal of lessening the client's psychological pain. These participants state that the client has not come to their offices because of suicidal ideation. Rather, the client is there because he or she is suffering intense psychological pain. The suicidal ideation is viewed as a secondary response to that psychological pain. Participant Four states, "I'm thinking while suicide itself been the focus of discussion, it's been the sadness, the despair, the unhappiness related to what their life was like. So, I think suicide is the side effect of their emotionality at that time, of their feelings." The counselor therefore believes that suicidal ideations will diminish along with the primary problem of psychological pain. Since it is this primary issue that these counselors report should be addressed, they do not perceive themselves to be suicide prevention therapists.

In the right or *No* column, the stated rationale for the counselor to help the client alleviate hopelessness is primarily suicide prevention. To achieve this goal, these counselors report that they attempt to help their clients find meaning in life and reasons to live. Participant One: “Of course, it makes sense to come up with reasons to live.”

Participant Five: You know, so in me it was difficult to really try and figure out how I can assist him [client expressing suicidal ideations] in finding hope in life, finding short-term goals that we can concentrate on that he could be successful at to where he can see that there is the hope in life to keep moving. That’s there’s a reason why he is here. There’s a reason why he’s going through these times.

**Willingness to hospitalize against client’s will**

All participants expressed their willingness to involuntarily hospitalize a suicidal client for the purpose of preventing that person from taking his or her own life. Further, all participants state that they have actually done so in the past. Once again, the difference among participants is rationale.

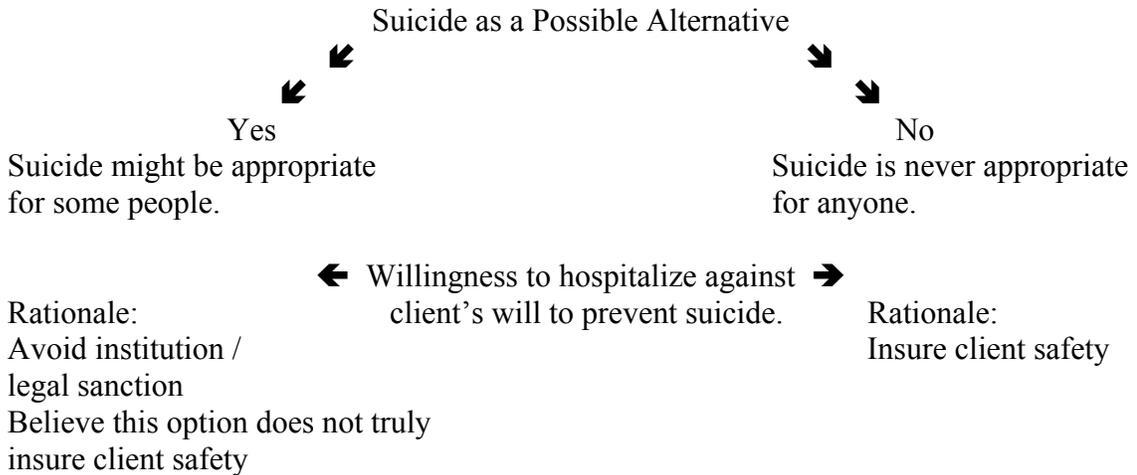


Figure 4-5. Willingness to Hospitalize

In the left or *Yes* column, the stated rationale for the counselor to involuntarily hospitalize a suicidal client is to avoid sanction by either the institution for which they work or the legal system. These counselors refer to the state of current literature, which does not support involuntary hospitalization as being an effective means of avoiding

suicide. One counselor stated that the literature actually pointed to such an action as ultimately counterproductive. Participant Eight: “I think in many places that [suicide prevention] is the way they operate. I think it just seems counter to everything. It seems counterproductive.” These participants report discomfort with their behavior, but see no current alternative.

In the right or *No* column, the stated rationale for the counselor to involuntarily hospitalize a suicidal client is to insure client safety. These counselors do not cite literature, but rather state their intense desire to preserve life.

Participant Five: I think it’s morally wrong, oh, yeah, as far as your human life and it’s your choice if you do want to live or die. We all have that choice. But I think it’s more of being a soul on this earth and giving that soul the opportunity to grow and renew and to see those other things in life that, you know, you’d want to live for.

These participants report discomfort over client autonomy issues, but see no current alternative.

### **Perceived responsibility**

Participants’ perceived levels of responsibility for the suicide of a client varied greatly. Three levels or degrees of perceived responsibility emerged from the data: low, shared, and high (Figure 4-6).

A *low* degree of perceived responsibility indicates that the participant reported most, if not all, the responsibility for the suicide rests with the client. These counselors report the belief that the role they play in their clients’ lives is influential enough to perhaps help a client alleviate a degree of hopelessness, but not influential enough to persuade a client to not commit suicide. Participants Seven and Eight articulated this view as follows. Participant Seven: “There is a certain responsibility that clients have also







founded a new religion, complete with a church, a congregation, and herself as a minister. Each counselor states that his or her religious beliefs, or lack thereof, played no important role in his or her professional views on suicide. However, those who reported having some level of religious identification stated that these beliefs did play an important role in their personal lives.

Participant Three: I would consider myself as a spiritual person in the sense that I think there's a bigger picture of some kind. I'm not sure I understand exactly how that works. Things that are spiritual like honesty and truth and love and all those things that seem to be part of all spiritual beliefs are important beliefs to me.

In the right or *No* column, participants all reported having a *high* level of religious identification. They identified themselves as devout Christians with close ties to a specific organized religion. Each counselor stated that their religious beliefs played an important role in their lives and professional views on suicide. Participant Two: “Well, I try to keep my personal beliefs to myself. And I feel sad for them [clients expressing suicidal ideations] that they haven't found the peace of something greater than themselves to be able to help them.”

### **Counselor's age / experience**

By the end of the final interview, it became apparent that the age of the counselor might be related to his or her beliefs as to whether or not suicide could ever be a possible alternative for some clients. For the participants in this study, age is also indicative of counseling experience. Each counselor-participant began his or her professional career at about 25 years of age. Thirty-five years of age emerged from the data as the approximate age, above which the counselor considered suicide a possible alternative for some clients, and below which the counselor did not. In the left or *Yes* column, participants were above 35 years of age. In the right or *No* column, participants were below 35 years of age.



### Counselor's personal suicide history

No participants reported ever having attempted suicide themselves, or ever having had serious suicidal ideations. Most participants reported having someone personally close to them who committed suicide. In this study, a counselor's own personal history of suicide does not appear to be associated with his or her personal beliefs about suicide being a possible alternative for some clients.

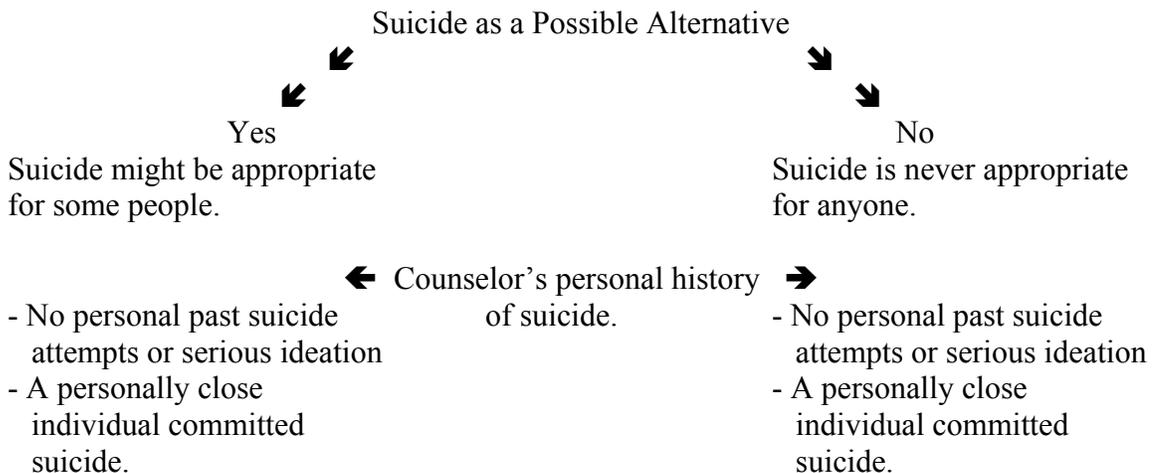


Figure 4-10. Counselor's Personal History of Suicide

In both the left or *Yes* column and the right or *No* column, participants reported (a) no personal suicide attempts, (b) no serious suicidal ideation, and (c) that a personally close individual had committed suicide.

### Ancillary Themes

Although no less important, the next themes appeared to bear no connection with the relationship between a counselor's personal beliefs about suicide and his or her attitudes toward clients expressing suicidal ideations. These themes, therefore, do not appear in the data analysis model. However, their consistent emergence in the interview data seems to signify a noteworthy connection to the subject of client suicide and suicidal ideation.

### **Disability and illness factors**

Many participants reported having clients with disabilities or illnesses who express suicidal ideations. Depression is the most commonly cited, however, there are also reports of head injury, and terminal illness. The literature suggests an individual's disability or illness is likely to factor significantly into the emotional reactions, attitude, and behavioral decisions of many people in American society. Social attitudes are often sympathetic, sometimes even encouraging, of an individual with a severe disability who wishes to end his or her own life (Rubin & Roessler, 2001). This was not the case for the participants of this study. None of these factors seemed to influence any participant's emotions or attitudes toward a client expressing suicidal ideations.

### **Suicide vs. other forms of death**

The impetus for the conception of this study was the behavior of various counselors after the suicide of a client. During the interviews, I wondered aloud about the difference in people's reactions to suicide versus death by some other cause. "How about the difference then between a death, such as this woman who drowned. Now, what do you suppose the difference would have been if this woman had committed suicide?" The following answer seemed particularly insightful.

Participant Three: I usually ask that question the other way around. 'Would you feel different if it hadn't been a suicide?' 'How would it be different?' 'Is there anything that you would think about differently or feel differently now knowing that it wasn't a suicide, it was a car accident, it was cancer.' And sometimes, you know, you get a few individuals where they realize it would make a difference. Sometimes they're actually shocked themselves. Just like, 'Hey what's different?' So, sometimes you get that process going and usually they struggle a little bit with that and often it comes back to things like strongly held beliefs. And sometimes there's some cognitive mental activity you know, 'I love this person. I liked them so much but now they did this thing that I think is wrong and, so what am I going to do about this now? I miss him a lot. I'm upset, but on the other hand my belief tells me that I need to kind of reject them for what they did.' I think that's helpful sometimes for people.

### **Issues of counselor training**

The literature states that one of the areas of counselor training most often neglected is suicide. “In spite of the fact that dealing with suicidal clients is threatening to most therapists, very little training in coping with the suicidal death of a client is included in graduate programs for therapists” (Stillion & McDowell, 1996, p. 242).

Participant belief that their master’s level counselor training inadequately addressed the issue of suicide was universally reported. The following are typical responses to variants of the question: “In your training, did you have any training on suicide?”

Participant Three: Let me think about that. If there was anything at all it was rather peripheral and insignificant. I can remember like something that was dedicated to the issue of suicide, suicide prevention, suicide intervention. I'm sure it comes up when you discuss your psychopathology and your major depression and some counseling theories stuff, but it doesn't stand out as something that people spend a lot of time on.

Participant Five: I don't think that we were given the appropriate training of what to do with somebody that says this [client expressing suicidal ideations]. I don't want to say it wasn't appropriate training but I don't feel that there was enough background or explanation or any type knowing what counseling theories, and things like that. I didn't walk out of there saying, okay I know what to do if somebody comes in and says I want to kill myself and I have the appropriate means to do so and I'm planning on doing it at this time. I wish that I had more training.

Participant Seven: Not specifically. That was one of the suggestions that I made. Actually I was one of the folks who talked with the CACREP folks. I said I'd like to see more specific issues that clinicians do deal with and will deal with, that they're going to see if they're working with clients. And suicide is one. Working with the gay and lesbian population is one. Grief. And so we talked about the advantages and disadvantages of having courses just dealing with suicide or just dealing with grief or just dealing with gay and lesbian. I think that would have been helpful.

### **Saturation**

In a qualitative study, the final number of interviews cannot be predetermined prior to the data collection process. “Beyond the decisions concerning initial collection of data, further collection cannot be planned in advance of the emerging theory (as is done so

carefully in research designed for verification and description)” (Glaser & Strauss, 1967, p. 47). Glaser (1978) asserts that the emerging theory controls the data collection process. It is always possible to add another interview. The question, therefore, becomes whether another interview would add substantively to the data. The process of interviewing new participants must continue until it becomes evident that no new themes are forthcoming. Glaser and Strauss (1967) refer to this condition as *theoretical saturation*. The final number of participants is established when the last new interviews produce only data repetitious of the previous interviews (Miles & Huberman, 1984). This is a subjective decision that every qualitative researcher must make; yet it is the goal of *purposeful* sampling. A detailed discussion of purposeful sampling appears in Chapter 3.

“In purposeful sampling the size of the sample is determined by informational considerations. If the purpose is to maximize information, the sampling is terminated when no new information is forthcoming from new sampled units; thus redundancy is the primary criterion” (Lincoln & Guba, 1985, p. 202). Based on the preceding criteria, and the understanding that it is not the role of qualitative research to generalize its findings to any larger population (Patton, 1990), interview number eight was determined to be the final interview of this study. This last interview seemed to represent the point of saturation for this study.

## CHAPTER 5 DISCUSSION

### **Study Findings and the Previous Literature**

What is the relationship between a counselor's personal beliefs about suicide and his or her attitudes toward clients expressing suicidal ideations? This chapter discusses each of this study's findings as outlined in the data analysis model.

The findings of this study may be conceptually divided into two thematic categories. The first category consists of a theme not previously observed in the studies by other researchers. This theme, suicide as an option (but not for my client), represents a possible new discovery and is perhaps this study's most intriguing finding. The second category consists of the collective relevant relational themes observed in the previous work of other researchers. Examples of these themes include feelings of hopelessness (Richards, 2000), feelings of professional failure (McAdams & Foster, 2000), feelings of self-doubt (Brems, 2000), feelings of responsibility (Brems, 2000), and counselor training (Westefeld et al., 2000). Reference to, and further citations of, such previous studies may be found in Chapter Two.

The remainder of this chapter is divided into four sections. Section one is a general discussion of suicide as a possible alternative. This is the main theme on which the data analysis model is constructed. Section two is an in-depth discussion of the first theme, suicide as an option (but not for my client), discussed in the context of cognitive dissonance theory. Six possible scenarios of cognitive dissonance are examined. Section three discusses the collective relevant relational themes observed in the previous work of

other researchers, and is subdivided into two parts. The first discusses the relevance of findings consistent with the literature to the trustworthiness of this study's research data. The second examines the individual themes as they appear in the data analysis model. The final section four is a general summary with special attention paid to the implications for clinical practice, counselor education, and future research.

### **Suicide as a Possible Alternative**

The unambiguous division of study participants, based on suicide as a possible alternative, is the foundation on which the data analysis model for this study is constructed. Each participant clearly stated either the belief that suicide might possibly be a legitimate option for some clients, or the belief that suicide should never be an option for anyone. This fundamental dichotomy is represented in (Figure 5-1).

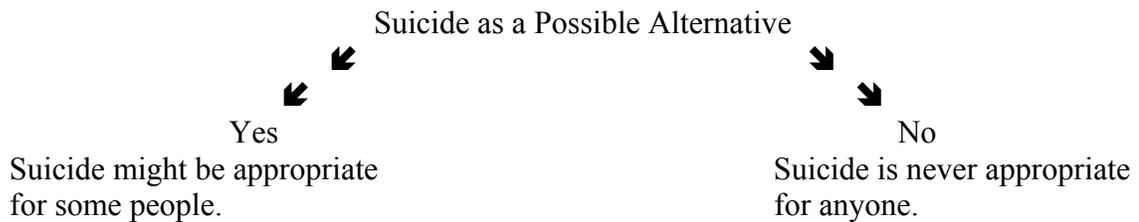


Figure 5-1. Suicide as a Possible Alternative

Participants Four and Five represent these two points of view. Participant Four: “I don’t think people should be made to live. I don’t think they should be forced to live if they don’t want to.” Participant Five: “I don’t ever think that there is an okay time to choose to end your own life.” These statements reflect a critical division in the counseling professions.

This division is evident in the debate surrounding the Supreme Court decision in favor of Oregon’s Death with Dignity Act (1997), in the case of *Quill v. Vacco*. This act allows for physician-assisted suicide in certain circumstances and under specific

conditions. During the Supreme Court's hearings, *amicus curiae* [friend of the court] briefs were filed both for and against implementation of the Act. Prominent professional counseling organizations joined both sides (Werth & Gordon, 2002).

Further evidencing this dichotomy of counselor beliefs is the ongoing discussion on rational suicide (Werth & Holdwick, 2000). As discussed in chapter two, rational suicide is a term used to describe the conditions under which suicide would be considered by both the counselor and consumer to be a rational choice (Rogers et al., 2001). Proponents believe that there exist some cases in which suicide is a rational alternative. This greatly concerns others, such as Richman (1992), who argue against the very concept of suicide ever being a rational act.

### **Suicide as an Option (But Not For My Client)**

A review of the literature reveals the emergence of what might be considered a kind of cognitive-affective disconnect among counselors in the arena of client suicide and suicidal ideation. Much of the existing research pertaining to counseling and suicide seems to indicate an unclear connection, and perhaps inconsistent relationship, between counselors' personal affective reactions to their own consumers expressing suicidal ideations, and counselors' cognitive reactions to the more abstract concept of death by suicide.

Studies on the emotional reactions of counselors to their own consumers expressing suicidal ideations including those of Chemtob, Hamada, Bauer, Kinney, and ToriGoe (1988), Moritz, Van Nes, and Brouwer (1989), Menninger (1991), Little (1992), and McAdams and Foster (2000) find a uniformity of response. Therapists most often name client suicide as their number one cause of anxiety. Large numbers view the suicide of a client as a professional failure. After a client suicide, it is far from unusual for a therapist

to question his or her own professional competency. Feelings of guilt, anger, and sadness are common emotional responses.

Studies concerned with the cognitive reactions of counselors to the general, more abstract, concept of death by suicide find much less uniformity of response. Richman (1988), Albright and Hazler (1992), and Rogers et al. (2001), found examples of this discord in the debate over rational suicide. Werth and Gordon (2002) write about the difference of opinions among therapists expressed in the 1997 Supreme Court battle over Oregon’s Death with Dignity Act.

However there appear to be no studies combining the two. No one seems to have drawn this cognitive-affective connection. This gap in the literature became apparent when this study discovered a phenomenon apparently not reflected by any previous studies. This is the apparent disconnect between (a) a counselor’s belief that suicide may indeed be a legitimate option for some individuals, and (b) that same counselor’s report of never having had such a client in his or her own practice. The following is an in-depth discussion and analysis of this discovery.

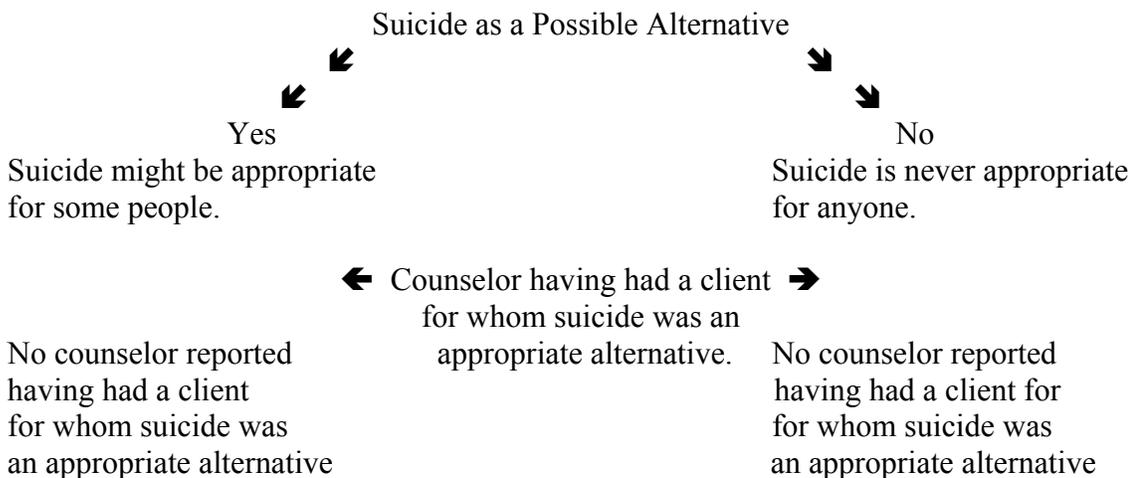


Figure 5-2. Counselor Having Such a Client

Representative of these two points of view are the following statements by Participant Two, and Participant Seven. Each interviewee was asked if suicide had ever been an appropriate alternative for any of his or her own clients. Participant Two, who believed that suicide could never be appropriate for anyone, answered simply, “No.” Participant Seven, who believed that suicide might possibly be an appropriate alternative for some individuals, answered, “Not for the clients that I was working with.”

A key reason for conducting a qualitative study (as opposed to one that is quantitative) is to learn something about a phenomenon under consideration that previously may have gone unnoticed or has been under examined. Miles and Huberman (1994) referred to this aspect of qualitative research as serendipitous discovery. This study’s examination of the relationship between a counselor’s personal beliefs about suicide and his or her attitudes toward clients expressing suicidal ideations, uncovered an apparent cognitive disconnect between a counselor’s belief that suicide may indeed be a legitimate option for some individuals and that same counselor’s report of never having had such a client in his or her own practice. This discovery may constitute a serendipitous discovery with interesting and potentially important implications. This study examines the significance of that disconnect from the perspective of cognitive dissonance theory.

### **Conditions of Cognitive Consonance and Dissonance**

#### **Condition of Cognitive Consonance**

As previously noted, a great deal of evidence exists to support the assertion that members of the counseling profession are divided over the question of whether or not suicide can ever be a legitimate client option. The results of this study reflect such a division. Counselors holding the belief that suicide is never a legitimate option also report never having had the experience of it being a legitimate option for any of their own

clients. This finding is not unexpected as the former belief is consistent with the latter empirical observation. In the language of cognitive dissonance theory, these two co-existing cognitions, that (a) suicide is never a legitimate option, and (b) suicide has never been a legitimate option for any of my clients, are considered to be *consonant*. Consonant cognitions psychologically presuppose one another (Festinger, 1957). A condition of consonance is not an impetus for behavioral change. For example, the counselor experiencing cognitive consonance is unlikely to seek out suicide research that challenges his or her own beliefs. A condition of consonance is emotionally comfortable. Cognitive consonance might therefore be considered a force for inertia. Should the counselor happen across such research, he or she is behaviorally reinforced to disregard it as flawed and invalid.

The danger in this situation is that consonance is not equivalent to correctness. The counselor experiencing a comfortable congruence of simultaneously held ideas would be unaware if either or both of these ideas were in error, and unlikely to discover the error. For example, this counselor likely assumes it to be true that he or she has had no clients for whom suicide is an appropriate alternative because it is true that suicide is never an appropriate alternative. However, the possibility exists that the one belief may be prejudicing the other. Having had no clients for whom suicide was an appropriate alternative may have given rise to the belief that suicide is never an appropriate alternative when, in fact, the possibility exists that any counselor's relatively limited exposure to the pool of all possible clients might simply have not included such clients.

Conversely, the held belief of suicide never being an appropriate alternative may have prejudiced the belief that the counselor has never had a client for whom suicide was

an appropriate alternative. In this case, the occasion when suicide might have been the appropriate alternative for a client is prejudicially overlooked.

### **Conditions of Cognitive Dissonance**

A possibly less expected discovery is that the counselors in this study holding the belief that suicide could be a legitimate option for some clients also reported never having had the experience of it being such an option for any of their own clients. This finding is less expected, as the former belief may be perceived as inconsistent with the latter empirical observation. In the language of cognitive dissonance theory, these two co-existing cognitions, that (a) suicide may a legitimate option for some clients, and (b) it has never been a legitimate option for any of my clients, cannot be considered consonant since they do not presuppose one another. However, lack of cognitive presupposition is not sufficient, by itself, to create the alternate condition of *dissonance*. For cognitive dissonance to occur the cognitions must have an obverse relationship (Wicklund & Brehm, 1976). This situation may be experienced as *dissonant* in a variety of situations. A condition of dissonance is an impetus for behavioral change. The degree of change is greatly dependant on the level of discomfort accompanying the cognitive dissonance. The next six scenarios depict a variety of situations in which dissonance might occur.

The order in which these scenarios are introduced is based on the degree of complexity of thought required to alleviate the discomfort of dissonance. For the sake of discussion, the assumption is made that in each of these situations the counselor holds no preconceived supplementary beliefs capable of justifying the inconsistency.

## **Six Possible Scenarios of Cognitive Dissonance**

### **Legal or professional sanctions**

Suicide-related lawsuits have long represented one of the most frequent legal actions brought against mental health professionals (Baerger, 2001). Some counselors may fear the possible legal or professional sanctions too much to act in such a manner that might incur these sanctions. These counselors may choose to endure the discomfort and anxiety associated with cognitive dissonance. While no participant in this study directly reported fearing sanctions, some made a point of acknowledging either their existence or that his or her professional behavior was not in keeping with his or her own beliefs about the effectiveness of counseling. According to Tjeltveit (2000), the demands placed on therapists by managed care sometimes contribute to the complexity of ethical decision-making. Additionally, managed care standards have resulted in a sizable increase in the number of clients involuntarily hospitalized as “high-risk suicidal persons” (Wysoker, 1999). Participant One stated, “We have, for liability reasons, all these hoops you have to jump through to make sure that you are assessing lethality.” Participant Eight stated, “I think it [suicide prevention] just seems counter to everything. It seems counterproductive. Well, it’s [suicide prevention] not counter to managed care, it’s not counter to liability.” However, according to cognitive dissonance theory the impetus to relieve these tensions will eventually stimulate the counselor to either employ rationalizations, or change careers. Possible rationalizations might include the following.

- Having invested so much money, time, and effort in becoming a counselor it would not make sense to quit over such a minor issue.
- With the exception of this one issue, this is a very enjoyable job.
- The priority of my having a family to support supercedes this particular issue.

- Everyone else is functioning under these rules.

Such thought processes may have the effect of producing a situation of *learned helplessness*. According to the American Psychiatric Glossary (1994), learned helplessness is the “general expectation that one cannot control important events, leading to lowered persistence, motivation, self-esteem, and initiative.” It is “a condition in which a person attempts to establish and maintain contact with another by adopting a helpless, powerless stance” (p. 1). In the language of cognitive dissonance theory, such a response is considered the result of *negative-incentive effect*, when the effect of diminishing cognitive dissonance results in a greater degree of emotional discomfort than did the original dissonance (Linder, Cooper & Jones, 1967). In such a situation, cognitive dissonance may be perceived as preferable to consonance.

Such a stance is made more understandable in light of much risk management literature. Key to the majority of suicide-related malpractice suits is the concept that, “The loss of a patient to suicide is the most feared outcome in mental health care, signaling a calamitous, irrevocable failure in treatment” (Bongar, Berman, Maris, Silverman, Harris & Packman, 1998). Accusations of therapeutic negligence abound in malpractice actions involving suicide (Packman & Harris, 1998).

### **Competing ethical principals**

A counselor may attempt to transform a condition of cognitive dissonance into consonance by appealing to the primacy of the ethical principal of beneficence when making ethical decisions regarding his or her own suicidal clients. By doing so, the counselor may reason that even involuntary hospitalization was an appropriate alternative because, in those specific cases, beneficence was the most appropriate ethical principal.

Such an appeal is easily fortified by a cursory examination of the counseling literature. The APA has codified the therapist's duty to suicide prevention in Principle five, Confidentiality of the *Ethical Principles of Psychologists* (APA, 1992). Additionally, the stated overall goal of the American Association of Suicidology (AAS) is, "To understand and prevent suicide" (AAS, 2003, p. 2). Rosenbluth, Kleinman and Lowy (1995) write, "For the acutely suicidal patient, beneficence must be given primacy, as it should for the chronically suicidal patient who is unable to control self-destructive impulses" (p. 919). In such cases, the extent of beneficence reaches beyond simply preserving life. The underlying rationale, for the involuntary hospitalization of a suicidal client, is considered by researchers such as Heyd and Bloch (1981) as a postponement of treatment. While no participant in this study explicitly stated this rationale, the thinking is that the client must be kept alive in order that treatment of the underlying problems may be continued at a later date.

Arguably however, such an unyielding adherence to beneficence might actually prove harmful, when applied to all suicidal patients without regard to individual circumstances. For example, the foundation for the policy of postponement mentioned above is that the desire to kill oneself is evidence of some underlying disorder. This disorder is considered so severe as to have rendered the suicidal individual incapable of making choices in his or her own best interest. The therapist backs up this assumption with the most basic belief that people functioning normally wish to go on living (Heyd & Bloch, 1981). Yet it is this final assumption that is at the very heart of the beneficence dilemma. It assumes not only the existence of a universal concept of life, but that the therapist understands this universal concept. Yet numerous authors, such as Albright and

Hazler (1992), assert that no such universal concept exists. In fact, different clients, different religions, and different cultures hold very different moral, and personal views of death and dying.

A second example of how adherence to counselor beneficence over client autonomy may prove harmful to the client is the fostering of dependence. Suicide prevention shifts decision-making responsibility from the client to the counselor. The counselor may unwittingly be encouraging client dependence in the most basic of all decisions, whether or not to go on living. "Thus the patient's long-term welfare may in fact be compromised by a rigid adherence to short-term protective beneficence" (Rosenbluth, Kleinman & Lowy, 1995, p. 920). In this way, counselor beneficence may, in reality, be little more than rescuing. According to Long (1996), "Rescuing interferes with the development of self-responsibility" (p. 138). Long (1996) warns counselors to examine closely their motivations for rescuing behavior, since it often satisfies the needs of the counselor, not the client.

The danger in this scenario is twofold. First, once consonance is achieved, the individual likely ceases to seek out further information (Cooper, 1999). Since only a cursory examination of the literature is required to alleviate dissonance, the ensuing condition of consonance may well preclude the more in-depth search necessary to uncover the mistake. Second, it is the emotional discomfort of dissonance that spurs the person to seek consonance. The counselor's rescuing behavior is itself a source of comfortable emotions. When one couples the ending of emotional discomfort achieved by the validation that a cursory review of the literature can provide, with the comfortable emotions brought on by the rescuing behavior, it becomes much easier to understand why

the supposedly beneficent suicide prevention has long been the counseling standard operating procedure.

### **Limited client numbers**

A third way in which a counselor might help reconcile the discord between his or her own beliefs that suicide may be appropriated for some individuals, and the conflicting belief that it is not appropriate for any person he or she has ever counseled, might employ the following reasoning. Any individual counselor is exposed to a relatively limited number of clients out of the pool of all possible clients. It is therefore reasonable to postulate that he or she may have simply not encountered a client for whom suicide might be a legitimate option. The fact that the counselor has not treated such a client is in no way indicative that such a client does not exist. Since logically, the absence of proof is not the same as the proof of absence, this knowledge could transform the previously dissonant relationship into a condition of cognitive consonance. Should such reasoning prove adequate to alleviate the discomfort caused by cognitive dissonance, the counselor is likely to assimilate this belief as the true answer. At this point, the impetus for change has ended and the counselor may cease to seek out alternative explanations.

The danger with this scenario is that, once again, consonance is not equivalent to correctness. There remains the possibility that suicide is not an appropriate alternative for anyone. Should this possibility be true, and there is no client for whom suicide is an appropriate alternative, then the counselor's belief that suicide may be appropriate for some clients must be false. Knowing the possibility of this alternative explanation would likely present another situation of cognitive dissonance. The counselor would again have the inducement to question his or her beliefs. However, such a counselor is unlikely to become aware of this dissonant relationship. This is because the original dissonance was

resolved without recognition of the possibility that no such client exists. Once a state of consonance has been achieved, the counselor has no incentive to reexamine the possibilities.

### **Special conditions of hospice**

Participants Six and Seven discussed their experiences working with hospice clients. Both expressed the belief that suicide could possibly be an appropriate alternative for some clients. The conditions that hospice affords its clients form the basis for this fourth possible dissonance scenario.

Both participants asserted their belief that, in the face of perceived hopelessness, some clients opt for suicide as a means of control. Such clients saw suicide as their only means of taking control and putting an end to the unbearable pain (physical or psychological) of their situation. Such a view of the motivation behind suicide is shared by some of the major researchers in this field. Williams (1997), describes suicide as the only means, perceived by the individual, to escape the feeling of being trapped by his or her life's circumstances. Shneidman (2001) describes suicide in terms of the individual's reaction to *psychache*, or intense psychological pain, for which death is seen as the sole remedy.

Considering the client's ultimate goal to be in control, the ability to relieve the pain of hopelessness, the counselors in this scenario postulate that hospice provides the client with a degree of control sufficient to render the decision to end one's own life unnecessary. The decision to commit suicide supplies the suicidal individual three measures for controlling the pain of hopelessness. It delivers control over where, how, and when the individual will end his or her hopeless situation. Participants Six and Seven expressed their beliefs that hospice supplies two of those measures. Along with the

additional support of a caring and professional team, hospice delivers control over where and how the client will end his or her hopeless situation. They believe this sufficient for the client to relinquish control over when. Participant Seven framed this belief as follows.

You know, when I think about hospice, if you engage in the hospice experience fully, as a patient you're engaging, then you're taking a full active role in your death. So how is that different than [suicide]? But this way you also determine how. And with hospice you determine, 'this is how I would like to die and so I'm going to work toward this end, dying in this manner.' And you don't know the exact moment. You don't have that, as you do with suicide, but you're still working on the control.

This supplemental cognition may transform the dissonance into consonance thereby relieving the anxiety. For these counselors, the conditions of hospice are sufficient to satisfy the discrepancy between the two concurrently held beliefs that (a) suicide is a legitimate alternative for some people, and (b) I have never treated a client for which suicide was a legitimate option because (c) I work with hospice clients. As was the case in the previous scenario, these counselors are now unlikely to seek out alternative explanations, or question further their currently held assumptions. They therefore remain open to the danger that the assessments of the situation may be in error.

These counselors were able to move from cognitive dissonance to consonance based on the assessment regarding the degree to which the control that hospice affords is sufficiently acceptable [to the client] in reducing the patient's pain and suffering. This assessment is widely held in the hospice community of professionals and researchers (Caplan, 1997). Yet there is mounting evidence that this view may not be entirely justified. Death statistics do appear to support claims that suicide among hospice clients is indeed rare (Sendor & O'Connor, 1997). As the debates over physician-assisted suicide and rational suicide expand, *when* a suicidally hopeless person dies appears to be of increasing significance. The importance of timing intensifies, for the suicidal individual

when considering factors such as the loss of physical, cognitive, and even financial abilities (Fenn, & Ganzini, 1999). Caplan (1997) warns that the legalization of physician-assisted suicide may well mean the end of hospice itself.

Therefore, the danger in this scenario remains. Since the discomfort of cognitive dissonance may have been alleviated without deliberation about these factors it is improbable that such deliberation will take place in the future. Competing explanations will likely not be examined to further challenge currently held assumptions. Counselors, such as Participant Six and Participant Seven, therefore remain vulnerable to the hazards associated with a mistaken appraisal of circumstances.

### **Personal experience**

Some counselors may take the more philosophical position that their own personal experiences should not be the basis for all their beliefs. These counselors may weigh the opinions, experiences, and research of others more heavily in their belief formation processes. They may be aware that the discussions mentioned earlier, over rational suicide and physician-assisted suicide, represent only the most visible positions of the suicide controversy. Counselors who choose to delve more deeply into this issue affecting so many of their potential clients, friends and families, may find reason to question simplistic answers and beliefs. They may therefore be willing to dismiss their own lack of personal experience. The following are some brief examples demonstrative of such opinions, experiences, and research. Each is described at length in Chapter 2.

Geographic demographics strongly influence the characteristics of a counselor's client pool. The location of a counselor's practice may limit that counselor's client experiences by many factors including race, culture, age, and socioeconomic status (SES). These factors have been shown to have strong effects on how an individual

perceives suicide, death, and dying. While most people may share some commonalities of experience and attitude, Corr (1979) notes “this sharing takes place in different and often distinctive ways from society to society and from individual to individual” (p.8).

Whether a client is male or female has been shown to have an effect on how that individual may view suicide and death (Moremen & Craddock, 1998). In addition to demographics, the counselor may know that the gender make-up of his or her clientele can influence personal experiences with suicide. Females are more likely than males to attempt suicide (Westefeld et al., 2000; Laux, 2002), but men are far four times more likely to be successful and account for 72% of all suicides (Centers for Disease Control, 2001).

The counselor may take into consideration the levels of relative health and disability of his or her clientele. American society (and, possibly therefore by extension, the counselor) has generally come to accept suicide by certain kinds of people. These include the very old, the very sick, and the very disabled (Ellis & Hirsch, 2000).

Any or all of the above examples may be sufficient to give a counselor pause when considering whether his or her experiences with clients are representative of clients as a whole. Should this knowledge prove sufficient for the counselor to move from a position of cognitive dissonance to one of consonance, the search for alternative explanations ends with the reasoning that (a) suicide is a legitimate alternative for some people, and (b) I have never treated a client for which suicide was a legitimate option but (c) the opinions, experiences, and research of others shows the likelihood that such clients do exist, and it is my own personal and professional situation that has precluded my treating such clients up to this point.

Yet the danger of consonance not equaling correctness still remains. The possibilities do exist that the opinions, experiences, and research of all these other people is faulty, or perhaps the counselor misunderstood their implications, or still more contradictory opinions, experiences, and research needs to be found. The possibility still exists that the reason the counselor has experienced no clients for whom suicide was an appropriate alternative might be because no such clients exist.

### **Role of the counselor**

A leading researcher in the field of suicidology, Shneidman (1994), has written extensively about the danger of counselors treating suicide as a legitimate option for their clients. It is his belief that suicide is unnecessary and need never happen (Shneidman, 1994). Participant Eight related strongly with this reasoning as to why he did not, as a counselor, treat suicide as a legitimate client option.

I thought, 'That's right. He was right!' Shneidman was right. I need to be respectful of my role and not get trapped into crossing that boundary. Empathy is not sympathy. Although I can be empathetic, I can't be sympathetic. If they are going to kill themselves then that will be their decision, but that is not to be my role because I really am there to see if I can make their life bearable.

This counselor is making a distinction between what he considers to be the counselor's role, and the appropriateness of suicide for some individuals. "I'm certainly not questioning the right for people to kill themselves or the possibility that it could be the right thing for somebody." For Participant Eight, these are not mutually exclusive propositions.

I do believe that my role, in terms of working in this system, it's not that we question the right of the individual to kill themselves but we do feel the responsibility that if involved with somebody, that is not our role. And we can separate out the two.

Shneidman is not alone in his opinions on client suicide. Richman (1988), and Rogers (2001) have also underscored the dangers of legitimizing suicide as a client option. For the sake of this scenario, it is assumed that such views may have been enough for Participant Eight to move from a condition of cognitive dissonance to one of cognitive consonance. It is further assumed that this participant's assertion of it not being the counselor's role to treat suicide as a legitimate option for clients precludes any discussion with the client about suicide as a possible legitimate option.

The reasoning by which this transition may have been achieved is as follows: (a) suicide is a legitimate alternative for some people, and (b) I have never treated a client for whom suicide was a legitimate option but (c) I have not done so because I am a counselor, and treating suicide as a legitimate option for clients "is not the role of a counselor." My role as a counselor is to "see if I can make their life bearable."

The possibility exists in this scenario, as in all those previous, that the counselor may be wrong about any belief. Perhaps (a) suicide is never a legitimate option for anyone. This mistake would not be dangerous in this scenario, because this counselor would treat no client as if suicide were an appropriate alternative.

Perhaps (b) I have treated a client for whom suicide was an appropriate alternative. This mistake may have been because the counselor misread the client's problems, or because of the counselor's belief that treating suicide as a legitimate client option "is not the role of a counselor." Either situation is potentially detrimental for the client because the appropriate alternative was never considered.

Perhaps (c) I have not done so, even though I am a counselor, and treating all client options as legitimate (including suicide) is the role of a counselor. This possibility could

be the most hazardous mistake of this scenario because of the ethical implications. If indeed it is the responsibility of counselors to treat all client options as legitimate, and suicide is a possible option, how is it then justifiable to refuse to help clients consider suicide? By refusing to consider this one specific option, is not the counselor abdicating his or her responsibility?

There is evidence in the literature to support that the role of a counselor does encompass the duty to treat client options as legitimate, at least until such time as they can be revealed to be unreasonable (Long, 1996). Generally considered to be the most important contributing factor to client growth and well being, in the context of professional counseling, is the quality of the counseling relationship (Goldstein, 1962; Gladding, 1996; Walborn, 1996). One important attribute of this relationship is that the counselor maintains an attitude of nonjudgmental acceptance toward the client. Such an attitude presupposes that the client possesses both the “right to make his or her own decisions” and ability “to choose wisely” (Brammer, Abrego, & Shostrom, 1993, p. 93).

For a counselor to prejudicially refuse to even consider a particular possibility might be interpreted by the client, as sending the message that the counselor views that option as being unwise, or unworthy of the counselor’s further deliberation. In this context, the counselor’s refusal to consider the option of suicide with the client might also be perceived by the client as disrespectful, paternalistic, or arrogant. It is difficult to see how such a perception might augment the counseling relationship.

Simply exploring an option does not mean that option is the best alternative for the client. According to Bruch (1981), the specific goal of counseling is to “accomplish something beneficial to the complaining person” (p. 86). Yet, failure to explore an option

in no way rules that option out. Certainly the client is (or has) considered suicide as a possible solution. A counselor's refusal to explore the option of suicide would seem to rule out only the possibility of that alternative being examined in the safety of the counseling relationship. Gladding (1996) states that one of a counselor's roles is to "help clients change distorted or unrealistic objectives by offering them the opportunity to explore thoughts and desires in a safe, accepting, and nonjudgmental environment" (p. 144).

There is also evidence in the literature to support the position that suicide is an exception to this general approach. In the context of a discussion concerning a counselor's ethical duty to maintain client confidentiality, Welfel (2002) concludes that the duty to warn and protect sometimes trumps confidentiality. She cites client suicidal ideation as one such circumstance when this should be considered. "When a client is at immediate risk of suicide, the primary obligation of the counselor is to protect the client from the self-destructive impulse" (Welfel, 2002, p. 86).

Discussing the role of client suicide within the mental health treatment community, Bonner (1990) deemed suicide to be one of this community's "ultimate tragedies." Range and Martin (1990) note the negative psychological effects of suicide on society, in general, and the bereaved families, in particular. They consider the counselor's obligations to others who may be affected by client actions. Richards (2000) warns counselors to beware the dangers of countertransference when working with suicidal clients. He discusses the possibility that, in some cases, countertransference may be the actual source of a counselor viewing suicide as a reasonable client option. Richman (1988) makes the case that while he respects client choice; he disagrees with the

arguments in support of rational suicide. Richman (1988) employs some of the reasoning used to support rational suicide as his rationale for continued therapy.

### **False disclosure**

This last scenario describes a situation of pseudo-dissonance involving the phenomena of false disclosure. The term *response bias* is applied to purposefully inaccurate participant reports (Fox & Tracy, 1986). In this study, there was no overt cause to suspect any participant of deliberately falsifying his or her responses. Still, according to Bardwell and Dimsdale (2001), response bias frequently occurs in research involving self-report with questions concerning sensitive personal attitudes and “should be considered when assessing psychosocial variables by self-report” (p. 34).

In this scenario, a participant might choose to answer falsely for any number of reasons. Uncertainty about the parameters of confidentiality could motivate an individual to provide “safe” answers. Such a participant might have treated suicide as a legitimate therapeutic client option, but state that this never occurred based on fears pertaining to confidentiality. Such fears might include that the researcher would feel ethically bound to report such behavior on the part of the counselor, someone else viewing the research data might feel this way, someone in the hallway outside the interview room might over-hear their conversation. Underlying each of these fears is *social desirability*, the desire not to be viewed negatively, or the desire to be viewed more positively, by others. Social desirability is defined as, “The tendency to give socially desirable responses in self-description” (Edwards, 1957, p. 35).

*Social desirability*, is expressed as response bias by “the tendency to give answers that make the respondent look good” (Paulhus, 1991, p. 17), avoid social disparagement, or seek approval, and is a common response bias motivator (Herbert, Ma, Clemow,

Ockene, Sapheria, Merriam, & Ockene, 1997). In the case of client suicide, it is possible that the phenomena appearing as cognitive dissonance might actually be cognitive consonance disguised by social desirability. For example, the situation in which the participant reports holding the belief that (a) suicide may be a legitimate alternative for some people, and also states that he or she (b) has never treated a client for whom suicide was a legitimate option, appears to be a situation of cognitive dissonance. However, the actuality might be a situation in which the participant believes (a) suicide may be a legitimate alternative for some people, and (b) has treated suicide as a legitimate alternative for at least one client. This hidden situation of cognitive consonance would then be a response bias motivated by social desirability.

This form of bias is controlled by statistical means in quantitative research (Ellington, Sackett & Hough, 1999). However, qualitative studies do not employ such methods. Instead of relying on the researcher, qualitative research places its emphasis on the participants and the circumstances of the investigation (Guba & Lincoln, 1981). This constitutes a type of external validity reliant on replicability, and internal consistency (LeCompte & Goetz, 1982). To safeguard validity, objectivity, and credibility, this study took great care to detail every aspect of the research making its general methods and procedures easily replicable by other researchers and understandable by its readers. There is a comprehensive audit trail recording exactly how this study followed these methods and procedures. Lastly, the preceding seven scenarios depict and consider competing hypotheses, allowing readers to assess objectivity for themselves.

Additionally, these scenarios serve as possible explanations for the findings of this study. Such explanations are a critical component in the grounded theory-building

process. Various contemporary authors stress the need for theory development related to suicide and counseling. Westefeld, Range, Rogers, Maples, Bromley, and Alcorn (2000) assert that counselors presently function atheoretically in the areas of suicide prevention and suicidology. According to Laux (2002), "There is a great need for the development of a priori theories that would lead to testable hypotheses" (p. 382).

### **Study Themes and the Previous Literature**

This section is an examination of those themes that both (a) emerged from this study's data, and (b) may also be observed in the previous work of other suicide researchers. The relevance of this study's findings is in their contribution to the field of suicide research. Findings consistent with past research serve to strengthen the trustworthiness of the research data. One method of enhancing the trustworthiness of research data is *persuasiveness*. Persuasiveness is closely related to the concept of plausibility (Riessman, 1993). Are the research finding plausible? One might reasonably question the plausibility of a study's findings should those findings be wholly at odds with those of comparable previous studies, especially if those previous studies are themselves considered plausible.

Therefore, a degree of data consistency in this study with comparable previous reputable studies lends a measure of plausibility to the data found by this study. Since plausibility adds to persuasiveness, and persuasiveness enhances trustworthiness, then study findings consistent with previous studies cited in the literature serves to strengthen the trustworthiness of the research data.

Individual themes consistent with the literature are presented in the order in which they appear in the data analysis model.

## **Themes**

### **Perceived role of counselor**

Every participant consistently reported a belief that client suicidal ideations are constructed on the foundation of hopelessness. Participants stated that regardless of individual circumstances, suicidal clients believed their situation to be irreversible. Litman (1996) expresses the belief that most suicidal clients, “see suicide as a solution to their problems of living, but they would rather live if they could find a better answer” (p. 1). Hopelessness also was found to be at the core of suicidal ideations by (Williams, 1997; Richards, 2000; Shneidman, 2001).

In response to this sense of hopelessness on the part of the client, all participants reported perceiving their role as counselors to be that of a helper in alleviating this hopelessness.

As detailed in Chapter 4, the differences among participants were their rationales supporting this role. The basis for these rationale variations appears to be the participant’s belief about suicide as a possible client alternative.

For those participants who believed that suicide is never an appropriate alternative for anyone, the rationale for the counselor’s role being that of helping to alleviate hopelessness is suicide prevention. Some such participants’ stated goal was to help their clients find meaning in life. For others the goal was helping their clients find reasons to live. Regardless of the specifically stated objective, the underlying rationale was to prevent the client from committing suicide. From a cognitive dissonance theory perspective, this rationale would bring no emotional discomfort and would, therefore, result in a condition of cognitive consonance.

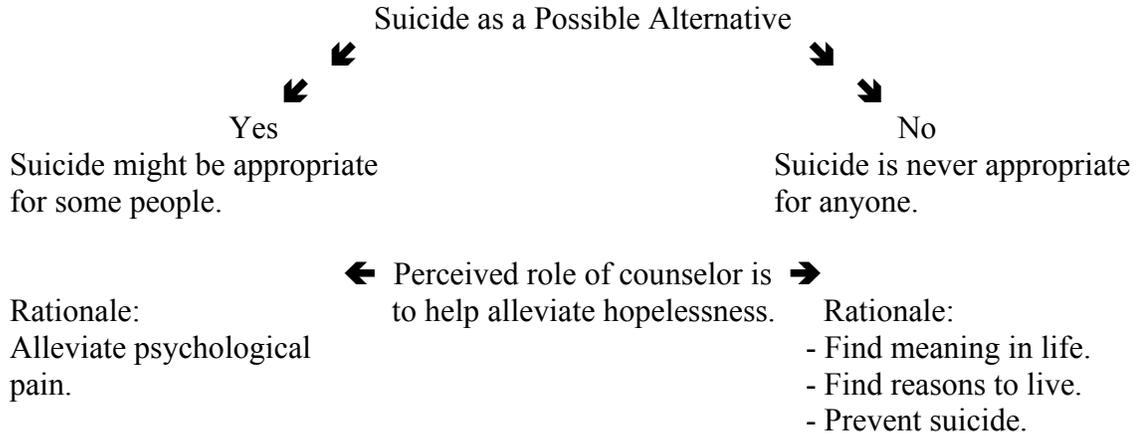


Figure 5-3. Perceived Role of Counselor

The participant is likely to reason that (a) suicide is never appropriate for anyone, and (b) the role of a counselor is to help alleviate client hopelessness, because (c) the lessening of such hopelessness might also aid in suicide prevention. Cognitive consonance is maintained since the rationale (c) for the counselor's role (b) is not inconsistent with the counselor's belief (a). The goal of preventing suicide is entirely consistent with the belief that suicide is never an appropriate alternative.

For those participants who believed that suicide might be an appropriate alternative for some clients, the rationale for the counselor's role being that of helping to alleviate hopelessness is to alleviate the client's psychological pain. From the perspective of cognitive dissonance theory, since this rationale is not cause for emotional discomfort, the result in a condition of cognitive consonance.

The participant may reason that (a) suicide might be appropriate for some clients, and (b) the role of a counselor is to help alleviate client hopelessness, because (c) the lessening of such hopelessness might also aid in the alleviation of the client's psychological pain. Cognitive consonance is maintained since the rationale (c) for the counselor's role (b) is not inconsistent with the counselor's belief (a). The goal of helping

assuage psychological pain is not inconsistent with the belief that suicide might be an appropriate alternative. Seeking to alleviate psychological pain is not the same as striving to prevent suicide, although successful easing of such pain may indeed result in the client no longer wishing to end his or her own life.

**Willingness to hospitalize against a client’s will to prevent suicide**

Involuntary client hospitalization for the purpose of suicide prevention appears to be the rule rather than the exception in the counseling profession (Lester & Leenaars, 1996). Although autonomy has steadily increased in importance among ethical principles, client suicide remains an area in which client safety continues to trump client autonomy (Pellegrino & Thomasma, 1988). Welfel (2002) emphatically states, “The legal and ethical responsibility to protect the client from harm is unequivocal” (p. 86).

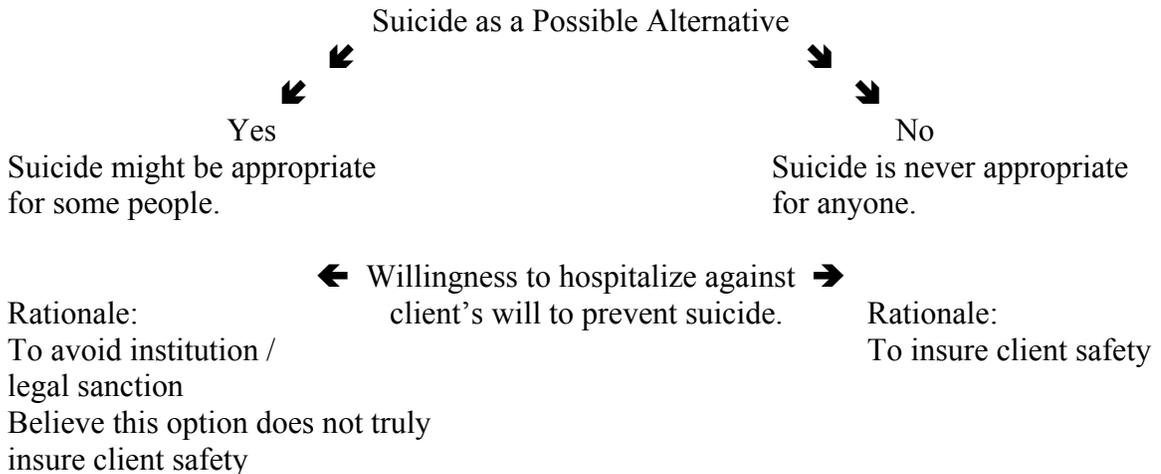


Figure 5-4. Willingness to Hospitalize

Every participant reported the willingness to involuntarily hospitalize a client who is in imminent danger of taking his or her own life. Again, the difference among participants was their rationale for this willingness.

For those participants who believed that suicide is never appropriate for anyone, the rationale for their own willingness to involuntarily hospitalize a client to prevent suicide

is to insure client safety. These participants believed that this option truly insures client safety, and expressed their willingness with conviction. Since this rationale contributed to the counselor's emotional comfort, the result was a condition of cognitive consonance.

For those participants who believed that suicide might be an appropriate alternative for some clients, the rationale for their own participation in the involuntarily hospitalization of a client was two fold. Part of their reasoning appeared to be to avoid institutional or legal sanction, and part was clinging to the hope that continued therapy might still follow the hospitalization. These participants believed that this option does not necessarily insure client safety, and expressed their willingness to hospitalize with reluctance. This rationale contributed to a degree of emotional discomfort on the part of the participant, leading to a condition of cognitive dissonance. Participants seemed to acknowledge that their actions were based on selfish concerns rather than on the ethical principal of beneficence. They appeared to believe that involuntary hospitalization sacrificed client autonomy in favor of legal considerations for the counselor, institution, and Health Maintenance Organization (HMO).

Contributing to this dissonance is the literature that does not support the assumption that involuntary hospitalization actually helps the client avoid suicide in the long term, and may actually contribute to client emotional distress and could hinder the development of independence in some clients (Rosenbluth, Kleinman, & Lowy, 1995). The problem, these authors contend, is that many institutions, HMO's, and laws make no distinction between acutely and chronically suicidal clients in their policies on involuntary hospitalization. Yet such a distinction is critical. While both types of clients may be viewed to be in immediate danger at the moment the counselor opts for their

hospitalization, the decision to usurp the person's autonomy should take into account this important difference. According to the policy of postponement (Heyd & Bloch, 1981), the involuntary hospitalization of an acutely suicidal client is appropriate, in some cases, to keep the client alive so that the therapist might later treat the underlying source of his or her suicidal ideations. However, the unilateral application of this policy might be inappropriate since "some chronically suicidal patients may be capable of resisting these impulses, and in such situation, respecting patients' autonomy facilitates clinical work and prevents the therapist from being drawn into a role that encourages regression" (Rosenbluth, Kleinman, & Lowy, 1995, p. 919). Moreover, hospitalization does not guarantee client safety. On average, one patient each day commits suicide while hospitalized (Litman, 1996). The thinking in this situation might be as follows.

The counselor (a) believes that suicide might be an appropriate alternative for some clients, and (b) was willing to hospitalize against a client's will to prevent suicide, but (c) holds that the rationale for involuntarily hospitalization was to avoid his or her own institutional or legal sanction, rather than to benefit the client. Such a counselor might choose to ameliorate this dissonance by appealing to the principle of the greater good, a central tenet of the moral theory of Utilitarianism as described by John Stewart Mill. According to Mill (1863) it is ethically acceptable to make individual sacrifices if those sacrifices are made in the service to the greater good. In this case, the counselor might reason that the (a) occasional sacrifice of client autonomy to (b) avoid his or her own institutional or legal sanction, is acting in the interest of the greater good principle because (c) he or she is able to continue counseling thereby helping other clients, and supporting his or her own family.



counseling and training of counselors warns against the counselor becoming overly responsible for his or her client, advocating for a proper balance between client and counselor responsibility. "Taking appropriate responsibility for helping the client to focus and grow, through purposeful selected responses of empathy and/or expression, without taking responsibility *for* the client by rescuing or blaming, reflects appropriate responsibility-taking" (Long, 1996 p. 114).

Participants perceiving themselves as highly responsible for the life of a suicidal client will find little, if any, counseling literature to support this perception. However, there is much support in the general society. Parents of a child suicide often feel responsible and often received blame from society (Lester, 1991). Lester (1991) concludes that perceptions of responsibility for suicide are strongly linked with perceptions of degree of control over that individual while he or she was living. Parents may feel more responsibility for the suicide of their child because they had a high degree of control over that child while it was living. It may follow, that counselors feeling a higher degree of control over the lives of their clients could perceive themselves to be more responsible for a client suicide than might a counselor feeling a lower degree of control.

There appears to be no cognitive dissonance associated with either of these scenarios. There is no obvious cognitive conflict between the belief that (a) suicide might be an appropriate alternative for some clients, and (b) the perception of either a low or shared level of responsibility for the suicide of a client. Neither does the belief that (a) suicide is never appropriate for anyone, seem to contradict (b) the perception of either a shared or high level of responsibility for client suicide. In either situation, a state of



emotional discomfort seem congruent with participants' beliefs. A counselor believing (a) suicide to be inappropriate for anyone might expect to feel (b) more intensely unpleasant emotions after the suicide of a client since (c) he or she believes that suicide could not possibly have been an appropriate course of action for that client. A counselor believing (a) suicide be appropriate for some people might expect to feel (b) less intensely unpleasant emotions after the suicide of a client since (c) he or she believes that suicide might possibly have been an appropriate course of action for that client. In the language of cognitive dissonance theory, either case results with a condition of cognitive consonance, and is unlikely to be a source for behavioral change.

### **Counselor religious identification**

Slightly less than 90% of Americans identify themselves with a particular religion, and practically all religions incorporate a suicide taboo (Esposito, Fasching & Lewis, 2002). Participants of this study all identified some religion, but to varying degrees. While there appears to be no definitive relationship between religiosity and death anxiety (Rasmussen & Johnson, 1994), no studies examining the relationship between religiosity and suicide were found. This study did investigate this relationship.

A condition of cognitive consonance appears to exist for all participants among their beliefs about suicide, and their levels of religious identification. Participants who believed that (a) suicide is never appropriate for anyone also reported (b) identifying highly with a particular religion, which (c) contains a strong taboo against suicide. Since each of these cognitions presupposes the others, there is no cognitive dissonance and therefore no stimulus for change.





It would appear then that experience was far more likely than age to have been the attribute related to a counselor's beliefs about suicide. Should this be the case, it might be reasonable to consider that a less experienced counselor might be more inclined to view suicide as an inappropriate alternative than would a counselor with greater experience. While it is quite possible that this particular study finding is more the result of a small sample size than of an actual phenomenon, no data were found indicating that counselors with a great deal of experience hold the belief that suicide is never an appropriate alternative for anyone.

### **Counselor's personal suicide history**

The development of counselor attitudes toward suicidal clients may be more the result of client communication than of the counselor's own personal experiences with suicide. According to Malin and Grotstein (1966), suicidal clients introduce a subtle, yet intense, set of circumstances into the therapeutic relationship.

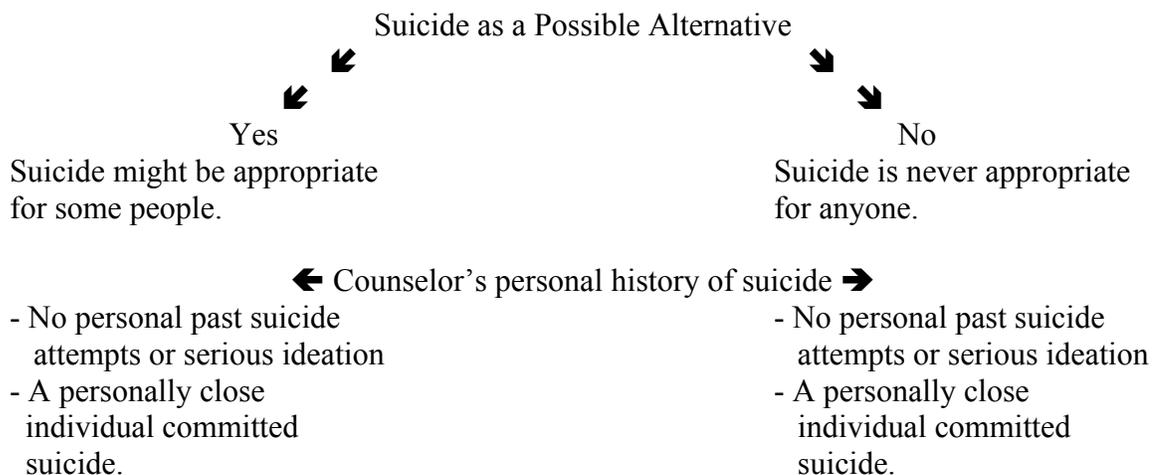


Figure 5-9. Counselors Personal History

These clients employ the communication process of projective identification (Malin & Grotstein, 1966), in which they are continuously attempting to manipulate the counselor. The goal of projective identification is to convince the counselor, often

surreptitiously, that the client's own internal perceptions are valid (Sandler, 1988). Such communication tends to evoke powerful emotions on the part of the therapist (Maltsberger, 1985). Richards (2000) found the counselor to be at significant risk of developing unconscious responses to the client expressing suicidal ideations.

This study did not uncover evidence of projective identification. It did seem to confirm the conclusion of previous research in that the development of counselor attitudes toward suicidal clients appears distinctive in that these attitudes are not seen as entirely the result of past experiences. The participants in this study reported similar histories of experiences with suicide and suicidal individuals, irrespective of the participant's beliefs about the appropriateness of suicide.

### **Implications for Training, Clinical Practice, and Future Research**

This section examines some of the implications of this study's findings in the areas of counselor training, clinical practice, and future research.

#### **Counselor Training**

Previous research has consistently reported a greater need for counselor training in the area of client suicide and suicidal ideation, than is currently afforded student counselors (Carney & Hazler, 1998; McAdams & Foster, 2000). Neimeyer (2000) states that the current state of inadequate counselor training in the areas of suicide and suicide prevention "leaves trainees substantially unprepared for managing the complexity of actual suicidal crisis" (p. 551). According to Carney and Werth (2001), insufficient training may be a contributing factor to the present-day situation, in which counselors disagree with one another and sometimes with their own professional codes of ethics, about many client-related suicide issues.

The dire need for improving counselor training was reiterated by all but one participant in this study. In the case of that one participant, the topic of counselor training was not raised. Participants uniformly expressed the belief that more suicide training is necessary.

The knowledge that counselors believe their own suicide training to have been incomplete, and that they believe that they could have benefited from better training, might carry implications for the counseling profession when designing counselor education programs in the future. Counselor educators might be advised to reconsider the type and amount of suicide training offered in their master's programs.

Considered from the standpoint of cognitive dissonance theory, student counselors would likely be better served by being made aware that (a) a dichotomy of belief exists about the possible appropriateness of client suicide, (b) there will be others in their profession who will not agree with them no matter which position they take, (c) heated controversy currently exists over rational suicide, hospice, right to die laws, duty to protect ethics, and (d) they may possibly be held liable for client suicide or attempted suicide by clients, suicide survivors, or other affected parties. Counselor training pertaining to these and other possible legal and ethical dilemmas involved with the treatment of a suicidal client might increase a counselor's ability to anticipate various future cognitive conflicts.

The benefits of anticipating future cognitive conflicts may be understood in terms of *foreseeability* in the conceptual context of cognitive dissonance theory. Foreseeability, described in detail in chapter two, pertains to whether or not the counselor is able to anticipate a cognitive conflict before it occurs (Wicklund & Brehm, 1976). More

appropriate counselor training could provide the new counselor with a greater degree of foreseeability. Counselors might be better equipped to anticipate issues associated with client suicide before encountering them in actual practice. According to cognitive dissonance theory, foreseen ethical challenges are cause for less motivational tension than those that are unforeseen. Therefore, a counselor with a greater degree of suicide training than is currently provided would be likely to experience a lesser degree of emotional discomfort associated with cognitive dissonance, than would a counselor educated under the present system.

Another argument in favor of increased counselor suicide training is that lack of training is likely to produce stress, and stress is responsible for diminished decision-making ability. According to Friedland and Keinan (1982), a person lacking knowledge about (or exposure to) future conditions is likely to experience a greater degree of stress when exposed to those conditions than would a person who is more aware and prepared for those conditions. It has been previously established that client suicide and suicide ideation is perceived by counselors as a major source of stress. Lack of suicide training is likely to add to that stress. Stress has an inherently negative effect on decision-making. “The competence of human judgment is decreased by stress” (Hammond, 2000, p. 6). Therefore, stress reduction associated with client suicide might be seen as a sensible goal of counselor education.

### **Clinical Practice**

This study might prove particularly helpful in the area of counselor supervision, and to the phenomenon of client suicide-related counselor burnout. Considering the high frequency with which counselors provide therapy to suicidal clients (Juhnke, 1994), coupled with the severe and lasting effects of suicide on therapists (Foster & McAdams,

1999), counselor supervisors are all but guaranteed to encounter situations with supervisees involving client suicide. This study may assist such supervisors in their understanding of the psychological pain and ethical dilemmas faced by these supervisees. It might also facilitate supervisors' decisions about the kinds of advice and assistance they may choose for both counselors dealing with clients having suicidal ideations, and those coping with the actual suicide of a client.

Using the example of a counselor seeking ethical guidance with providing therapy to a client with suicidal ideations, a supervisor might draw on the information in this study when suggesting an ethical model of decision-making. This study provides evidence supporting the use of decision-making models that encourage a multifaceted examination of the dilemma, such as the Integrative Decision-Making Model of Ethical Behavior (Cottone & Tarvydas, 2003) in such situations. This model advocates that the decision-maker analyze his or her own personal "competing nonmoral values, personal blind spots or prejudices" and "consider contextual influences on values selection at the collegial, team, institutional, and societal levels (Cottone & Tarvydas, 2003, p. 89)." Such an approach to ethical dilemmas involving client suicide, or suicidal ideations, would appear appropriate when considering that much of this study's focus is on individual counselor beliefs and attitudes, with particular attention paid to the cognitive dissonance insinuated by the contextual influences of fellow professionals, work environment, HMO's, and society.

Closely related to the subject of counselor supervision is the issue of counselor burnout. Burnout is an expression used in reference to numerous unpleasant job-related emotions, including self-doubt, low self-esteem, and the questioning of one's

professional competence (Combs & Avila, 1985). It is also a condition that is widespread among counselors (Cory, 1986). Providing therapy for suicidal clients is also widespread among counselors (Juhnke, 1994). So too, are the accompanying feelings of self-doubt, low self-esteem, and the questioning of one's professional competence (Stillion & McDowell, 1996). Counselors and supervisors might make use of this study to identify and anticipate these parallels between the emotions associated with burnout and those linked to counseling suicidal clients.

One possible outcome of better understanding these affective similarities would be to develop suicide-related professional development activities. Another might be to incorporate this knowledge into preexisting professional development efforts that are designed to aid counselors in the avoidance of, and the recovery from, burnout. According to Vacc and Loesch (1994), counselor participation in such activities is essential since they benefit not only the individual counselor, but also the counseling profession, and ultimately the clients they serve. Including participation with professional organizations, and continuing education, these activities are "the means by which professional counselors keep current, improve, and remain professionally motivated" (Vacc & Loesch, 1994, p. 78).

### **Future Research**

This study may possibly be the first to investigate the relationship between a counselor's personal beliefs about suicide and his or her attitudes toward clients expressing suicidal ideations. The study found no apparent relationship. Regardless of a counselor's personal beliefs about suicide, his or her attitude toward clients expressing suicidal ideations was characterized by respect, empathy, and efforts to ameliorate client

hopelessness. None of the participants reported considering suicide for any of their clients, nor discussing suicide with any of their clients, as an appropriate course of action.

Future researchers may wish to test the trustworthiness of this finding by continuing this line of inquiry with other participants. It might be useful to expand the pool of participants to include counselors who practice in areas not represented in this study, and in various geographic locations. This qualitative study's findings may not be generalized to any population or persons beyond the study's participants. Future researchers may wish to test these findings quantitatively for purposes of assessing generalizability. Some ways in which this might be accomplished are as follows.

#### **A multicultural approach**

This study was culturally and ethnically limited. For three reasons, Caucasians were the only ethnic group studied. Firstly, they represent the dominant culture in the United States. White Euro-American attitudes are manifest in laws passed and court cases heard. Secondly, the major social and psychological theories on death and dying in America have been written by and about this group. These reasons underlying the decision to study members of the dominant culture are detailed in chapter two. Thirdly, the introduction of two or three non-Caucasian participants could have seriously confused the results. This study was not prepared to screen for ethnicity.

Future researchers might wish to study various other ethnic groups. It could be helpful to discover the extent to which ethnicity and acculturation affects the data. Participants from other ethnic backgrounds could be studied both qualitatively and quantitatively.

Race and ethnicity are but two aspects of a multicultural approach. Future researchers might focus on other aspects such as religion, geography, or nationality. None

of these were used as inclusion criteria in this study. All of the participants had either had either Christian or Jewish religious affiliations, lived in northern Florida, and were citizens of the United States. It could be helpful to discover the extent to which other inclusion criteria might affect the data.

APPENDIX  
INFORMED CONSENT FORM

***Informed Consent to Participate in Research***



You are being asked to take part in a research study. This form provides you with information about the study. The Principal Investigator (the person in charge of this research) or a representative of the Principal Investigator will also describe our study to you and answer all of your questions. Before you decide whether or not to take part, read the information below and ask questions about anything you do not understand. Your participation is entirely voluntary.

**1. Name of Participant ("Study Subject")**

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**2. Title of Research Study**

Counselor Perspectives on Suicide and Suicidal Ideation.

**3. Principal Investigator and Telephone Number(s)**

Stephen Lussier ..... (352) 273-6745

**4. Source of Funding or Other Material Support**

University of Florida

**5. What is the purpose of this research study?**

To explore the relationship between counselor attitudes toward clients expressing suicidal ideations and counselor beliefs about suicide.

**6. What will be done if you take part in this research study?**

Should you choose to be a part of our study, you will be interviewed by the principal investigator. The interview will be about your own experiences, as a counselor, with clients who have talked about their own suicide plan and/or suicide attempt. The interviewer is interested in your thoughts, feelings, and actions. The interviewer is also interested in your own personal beliefs about suicide. This interview is expected to take about one hour and will be audiotaped. Your name will not be mentioned on the tape, written on the tape, or on any documents.

**7. What are the possible discomforts and risks?**

There is the possibility of feeling some stress or anxiety speaking about such counseling sessions, especially if the client was successful in taking his or her own life.

Throughout the study, the researchers will let you know if there is any new information that might affect your decision to remain in the study.

If you wish to discuss the information above or any discomforts you may experience, you may ask questions now or call the Principal Investigator or contact person listed on the front page of this form.

**8a. What are the possible benefits to you?**

Often one's ideas become clearer when spoken aloud. The interview is an opportunity to speak about your own thoughts, feelings, beliefs and behaviors regarding the subject of suicide and suicidal thinking.

This research may lead to a better understanding of the relationship between counselor attitudes toward clients expressing suicidal thinking and counselor beliefs about suicide. As a counselor, you might benefit from such knowledge.

**8b. What are the possible benefits to others?**

Should this research lead to a better understanding of the relationship between counselor attitudes toward clients expressing suicidal thinking and counselor beliefs about suicide, such enhanced understanding could benefit both the counseling profession and its consumers.

**9. If you choose to take part in this research study, will it cost you anything?**

No.

**10. Will you receive compensation for taking part in this research study?**

No.

**11. What if you are injured because of the study?**

If you experience an injury that is directly caused by our study, only professional consultative care that you receive at the University of Florida Health Science Center will be provided without charge. However, hospital expenses will have to be paid by you or your insurance provider. No other compensation is offered.

**12. What other options or treatments are available if you do not want to be in our study?**

The option to taking part in our study is doing nothing. If you do not want to take part in our study, tell the Principal Investigator or his/her assistant and do not sign this Informed Consent Form.

**13a. Can you withdraw from this research study?**

You are free to withdraw your consent and to stop participating in this research study at any time. If you do withdraw your consent, there will be no penalty, and you will not lose any benefits you are entitled to.

If you decide to withdraw your consent to participate in this research study for any reason, you should contact Stephen Lussier at (352) 273-6745.

If you have any questions regarding your rights as a research subject, you may phone the Institutional Review Board (IRB) office at (352) 846-1494.

**13b. If you withdraw, can information about you still be used and/or collected?**

No.

**13c. Can the Principal Investigator withdraw you from this research study?**

You may be withdrawn from the study without your consent for the following reasons:

- If you are unable to complete the interview for any reason.

**14. How will your privacy and the confidentiality of your research records be protected?**

Authorized persons from the University of Florida, the hospital or clinic (if any) involved in this research, and the Institutional Review Board have the legal right to review your research records and will protect the confidentiality of them to the extent permitted by law. Otherwise, your research records will not be released without your consent unless required by law or a court order.

If the results of this research are published or presented at scientific meetings, your identity will not be disclosed.

**15. How will the researcher(s) benefit from your being in our study?**

In general, presenting research results helps the career of a scientist. Therefore, the Principal Investigator may benefit if the results of our study are presented at scientific meetings or in scientific journals. Our study is part of the Principal Investigator's doctoral dissertation.

**16. Signatures**

As a representative of our study, I have explained to the participant the purpose, the procedures, the possible benefits, and the risks of this research study; the alternatives to being in the study; and how privacy will be protected:

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 Signature of Person Obtaining Consent

---

 Date

You have been informed about our study's purpose, procedures, possible benefits, and risks; the alternatives to being in the study; and how your privacy will be protected. You have received a copy of this Form. You have been given the opportunity to ask questions before you sign, and you have been told that you can ask other questions at any time.

You voluntarily agree to participate in our study. By signing this form, you are not waiving any of your legal rights.

---

 Signature of Person Consenting

---

 Date
**17. Consent to be Audiotaped and to Different Uses of the Audiotape(s)**

With your permission, you will be audiotaped during this research. Your name or personal information will not be recorded on the audiotape, and confidentiality will be strictly maintained. The audiotape will be transcribed by a professional medical transcriber familiar with the ethics of confidentiality.

The Principal Investigator of our study, Stephen Lussier, or his successor, will keep the audiotape(s) in a locked cabinet.

Please sign the following statement that indicates under what conditions Mr. Lussier has your permission to use the audiotape.

I give my permission to be audiotaped solely for this research project under the conditions described.

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 Signature

---

 Date

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## BIOGRAPHICAL SKETCH

Stephen Lussier received his Bachelor of Arts degree in English literature from the University of Connecticut in 1978. Two years before completing of that degree, he began work at Mansfield Training School as a Direct Care Worker for people with mental retardation. Stephen continued with this employer until 1990, during which time he rose to the position of Residential Program Supervisor. In this capacity, he managed a residential program for 500 consumers, in a facility with 42 cottages.

In 1990, Stephen moved to San Diego, California, where he completed a program in massage therapy at the Health Sciences Institute. After achieving certification, he worked as a self-employed massage therapist, until returning to Connecticut.

In 1995, Stephen received his master's in rehabilitation psychology, again from the University of Connecticut. On completion of this degree, he began working as a Residential Counselor for individuals with mental health disabilities, at Sunshine Projects Inc. (Hartford, Connecticut). Sunshine was a supported community-living project, using the Fairweather Lodge model. Consumers lived and worked in the community with primary support from the counselors of Sunshine Projects Inc.

In 1999, Stephen received a second master's degree in counseling from the University of New Mexico. In partial fulfillment of the requirements for this degree, he interned at a private psychiatric hospital in Albuquerque, working with consumers having mental health diagnoses. After this degree, Stephen continued on to pursue his doctorate at the University of Florida. Maintaining his interests in counseling and persons with

disabilities, Stephen specialized in the area of human social and behavioral integration, concentrating on the specific topic of suicide counseling. He graduated in 2004 with a doctorate in rehabilitation science.