Instilling Hope: Showing Individuals with New Disabilities Between the ages of 18 and 24 that Suicide is Not the Answer

Christine Ann Whiting
University of Arkansas, Fayetteville

Follow this and additional works at: http://scholarworks.uark.edu/etd

Part of the Counseling Psychology Commons, Psychiatric and Mental Health Commons, Vocational Education Commons, and the Vocational Rehabilitation Counseling Commons

Recommended Citation
Whiting, Christine Ann, "Instilling Hope: Showing Individuals with New Disabilities Between the ages of 18 and 24 that Suicide is Not the Answer" (2016). Theses and Dissertations. 1607.
http://scholarworks.uark.edu/etd/1607

This Dissertation is brought to you for free and open access by ScholarWorks@UARK. It has been accepted for inclusion in Theses and Dissertations by an authorized administrator of ScholarWorks@UARK. For more information, please contact scholar@uark.edu, ccmiddle@uark.edu.
Instilling Hope:
Showing Individuals with New Disabilities
Between the Ages of 18 and 24 that Suicide is Not the Answer

A dissertation submitted in partial fulfillment
of the requirements for the degree of
Doctor of Philosophy in Rehabilitation

by

Christine A. Whiting
Saint Vincent College
Bachelor of Arts in Psychology, 2001
Langston University
Master of Science in Rehabilitation Counseling, 2013

May 2016
University of Arkansas

This dissertation is approved for recommendation to the Graduate Council.
Abstract

The purpose of this dissertation is to explore what can be done to mitigate the onset of a disability for young adults aged 18-24 in order to prevent suicidal thoughts or actions. Research suggests that many factors play into suicidal ideation for this young population, including lost hope, lack of coping mechanisms, lack of financial security and bullying. The goal of this research is to determine what rehabilitation professionals can do differently that will hopefully eradicate suicide for this group.
Acknowledgments

Special thanks are extended to the staff of the University of Arkansas Graduate School for all of their help with this dissertation. It would be impossible to make it through the semester without their help, especially my committee.

Special thanks are extended to Dr. Mary Ramey for her outstanding commitment to her students and all of her genuine love and support.

Gratitude is also given to Dr. John Sassin for all of his support and encouragement throughout the entire PhD and dissertation process.

Appreciation is extended to Dr. Stephanie Lusk for her unwavering support of a single mom with far too much determination.

Thank you to Emeka Nnaka who helped me to uncover my purpose and research agenda.

Finally, so many thanks go out to Dr. Brent Williams. I would not be where I am today without your support and dedication.
Dedication

This doctoral dissertation is dedicated to the most amazing and supportive mother ever, Shirley Hiborik, and the best daughter in the world, Carina Whiting. I truly could have never accomplished this without your love, support and endless patience. I love you!

I would also like to thank my many, many friends who have loved and supported me tirelessly throughout this endeavor. I am so fortunate to have so many who love me!
Table of Contents

Chapter One .................................................................................................................................... 1
   Introduction.................................................................................................................................. 1
   Background of the Study ........................................................................................................ 1
   Statement of the Problem ...................................................................................................... 5
   Research Question .................................................................................................................... 6
   Theoretical Framework ........................................................................................................... 7
   Conceptual Design .................................................................................................................. 8
   Theoretical Sensitivity ............................................................................................................ 9
      Personal experience ............................................................................................................. 9
      Professional experience ...................................................................................................... 10
      Knowledge of the literature ............................................................................................... 10
      Analytic rigor ..................................................................................................................... 11
   Parameters of the Study ........................................................................................................ 11
   Limitations ............................................................................................................................. 11
   Definition of Terms ................................................................................................................ 11
   Summary ............................................................................................................................... 12

Chapter Two: Literature Review .................................................................................................. 13
   Search Strategy ...................................................................................................................... 13
   Introduction ............................................................................................................................ 13
   Attempted Interventions ........................................................................................................ 14
   Physician-Assisted Suicide .................................................................................................... 18
   Coping Strategies .................................................................................................................. 22
Chapter Three: Methodology ........................................................................................................ 36

Introduction .................................................................................................................................. 36

Focus of the Study ..................................................................................................................... 37

Research Design and Timeline ................................................................................................. 38

Researcher as an Instrument ..................................................................................................... 39

Site and Sample Selection ......................................................................................................... 39

Participants .................................................................................................................................. 39

Depth vs. Breadth ...................................................................................................................... 40

Data Collection .......................................................................................................................... 40

Interviews .................................................................................................................................... 41

Observations ............................................................................................................................... 42

Document Collection ............................................................................................................... 42

Researcher’s Role Management ............................................................................................... 43

Managing and Recording Data ................................................................................................. 43

Analysis of Data ........................................................................................................................ 44

Interpretive Analysis .................................................................................................................. 45

Trustworthiness .......................................................................................................................... 46

Prolonged engagement ............................................................................................................. 46

Persistent engagement .............................................................................................................. 46

Member checking ..................................................................................................................... 47
Table of Figures

Figure 1.1. Conceptual design....................................................................................................... 9

Figure 3.1. Timeline. .................................................................................................................... 38

Figure 3.2. Hatch's criteria for data analysis. .............................................................................. 45

Figure 3.3. Hatch's steps in interpretive analysis. ...................................................................... 46

Figure 4.1. Axial and sample of open codes from family members........................................ 56

Figure 4.2. Axial and sample of open codes from rehabilitation professionals. .................. 63

Figure 4.3. Axial and sample of open codes from individuals in this population................. 68

Figure 5.1. Researcher context to reader context. ................................................................. 78

Figure 5.2. Conceptual diagram—selective code: support..................................................... 79

Figure 5.3. Conceptual diagram—selective code: purpose................................................... 82

Figure 5.4. Conceptual diagram—selective code: being seen as a person rather than a disability................................................................. 84
Table of Tables

Table 2.1. Attempted Interventions ................................................................. 16
Table 2.2. Physician-Assisted Suicide ............................................................ 19
Table 2.3. Coping Mechanisms ............................................................... 23
Table 2.4. The Bullying Epidemic ............................................................... 29
Table 2.5. Security .................................................................................... 32
Table 4.1. Audit Trail Notations (Interviews and Observations) .................. 53
Table 4.2. Audit Trail Notations (Documents) ............................................ 54
Table 4.3. Descriptive Matrix: Axial Codes of Family Members ............... 57
Table 4.4. Descriptive Matrix: Axial Codes of Rehabilitation Professionals . 64
Table 4.5. Descriptive Matrix: Axial Codes of Individuals in this Population 69
Chapter One

Introduction

This study explores what can be done to mitigate the onset of a disability for young adults aged 18-24 in order to prevent suicidal thoughts or actions. Research suggests that many factors play into suicidal ideation for this young population, including lost hope, lack of coping mechanisms, lack of financial security and bullying. The goal of this research is to determine what rehabilitation professionals can do differently to prevent suicide, and why it is a crucial problem requiring further examination.

Background of the Study

People with disabilities are at a higher risk for suicide than their counterparts who do not have disabilities. This is especially true of young individuals living with some type of disability. According to the Massachusetts Young Health Survey (2007), 13% of middle school youth with disabilities reported attempting suicide at least once in the past year compared to 3% of those without disabilities. Similarly, among high school youth, adolescents with disabilities were more likely to report feeling so sad or depressed daily for at least two weeks during the previous year that they discontinued their usual activities, as compared to those without disabilities. In that group, 40% of those with disabilities reported these feelings compared to 13% of those without disabilities. In addition, 13% of high school youth with disabilities reported attempting suicide at least once in the past 12 months compared to 2% of those without disabilities (Massachusetts Young Health Survey, 2007).

Each year, nearly one million people die from suicide in the United States alone. In fact, military veterans who have experienced a disablity condition committed suicide at the rate of 18.7 to 20.8 per 100,000, when compared to other Americans not having a disabling condition at
the rate of 8.9 per 100,000. That is more than two times the overall national rate among disabled veterans. This number does not even include individuals with disabilities who are not in the military (Foster, 2014).

Given the negative social messages and connotations about disability that are being heard nearly every day, it should come as no surprise that individuals sometimes contemplate suicide after acquiring a disability. In fact, many of the aspects that are considered important in evaluating the potential for suicide Lack of financial stability, social inclusion, and freedom of mobility consistently pose challenges for people with disabilities. Taking this into consideration, it is remarkable that although 18.7% of all non-institutionalized civilians in America have a disability, they are virtually invisible when it comes to the discussion of suicide prevention. Researchers have fallen short when trying to find statistics on suicide as it relates to disability in the civilian community and this is not a new phenomenon. In an article published nearly 20 years ago, Gilson, Tusler and Gill (1997) noted that it was ironic that “so little suicide research has been conducted” (p. 12) on behalf of people with disabilities since so many medical and legal decisions are made concerning disability and the management of intentions to die. They were, of course, referring to physician-assisted suicide. This is a twist that makes all of the difference in the physician-assisted suicide debate. This mixed message suggests that the opinions of people with disabilities only matter on the issue of suicide when others, such as doctors and judges, are making the decisions for them. Furthermore, this message reinforces the notion that disability is a legitimate reason to wish for death, a belief that completely undermines the entire disability rights movement.

The development of mental health issues, including depression, subsequent to a disabling incident is not something that must occur. According to the Christopher Reeve Foundation
(2014), those who became disabled following a violent, sudden incident, such as a motor vehicle accident, are two to three times more likely to become depressed. Many people with sudden onset disabilities are treated for depression and do not progress to the point of suicidal ideation; others, however, are not as fortunate.

Many experiencing the onset of a new disability also experience depression because of their loss of hope due to possibly being unable to fulfill a life dream or goal. Hope, which may be the key to all suicide prevention, is important to everyone, not just a particular population. The idea of keeping hope possible is best accomplished through accepting reality, establishing control, restructuring hope, and purposive positive thinking (Bally et al., 2014). Without the ability or direction to keep hope alive, suicidal ideation is common.

Unbearable pain is another reason to contemplate suicide. In fact, pain that is difficult to live with has spurred a debate about whether people with disabilities should be permitted to end their lives with the assistance of a physician. An outspoken, politically active group of those with disabilities, including several prominent leaders of the disability rights movement, has specified that they are vehemently opposed to the acknowledgment of a right to physician-assisted suicide for individuals with newly acquired disabilities (Batavia, 1997). However, like any other politically, ethnically, and religiously diverse community, including that of physicians, the community of people with disabilities is far from united on this issue. Furthermore, many individuals in the disability rights movement believe that even if physician-assisted suicide was legalized for individuals with disabilities, it should still be forbidden because it hurts people with disabilities as a class (Scoccia, 2010). On the other side of the argument, many people with disabilities understand how the healthcare system in America actually works, fully comprehending the reality of undertreated pain and unnecessary suffering, the disempowerment
and dehumanization that generate support for physician-assisted suicide (Assisted Suicide and Disability, 2006).

Despite various intervention techniques such as individual and group therapy already in place, coping strategies that may actually lead to a decrease in the attempted and completed suicide rates remain somewhat elusive. Much of the literature pertains to the utilization of coping strategies as a way of adjusting to life with a newly acquired disability. Many will use humor to lighten the situation, and allow others to feel more comfortable around them. Others will choose isolation, accepting that they are no longer an active part of the world around them. Still others rely on the love, acceptance, and support of family and friends to manage what could potentially be a difficult, or seemingly impossible, life transition.

In a study by Jurišić and Marušič (2009), 58% of the participants were pensioned because of a newly acquired physical disability, indicating that those individuals did not return to work or to the social structure therein following the incident that caused the disability. This isolation from a workplace may impair social integration and subsequent psychological well-being. Government actions concerning the employability of these disabled persons may reduce marginalization of this population. Agencies, such as rehabilitation services, could potentially play a tremendous role in the prevention of suicide by embracing the changes in government policy. However, not having or risking financial security, such as that provided by a pension or Social Security, could also contribute to depression and subsequent suicidal ideation.

Another consideration is the bullying epidemic that has struck America, severely affecting the youth of this country. Although the phenomenon of bullying is discussed at length among the education system and among adolescents, people with disabilities are completely left out of the conversation, even though they are possibly the most vulnerable. If literature suggests
that individuals with a disability are more likely to attempt or complete suicide, what hope do they have if they are also being bullied?

Bullying of children with disabilities is significant but little research exists to document it. Only ten published studies in the United States have been conducted on the relationship between bullying and disabilities. All of these studies found that children with disabilities were two to three times more likely to be bullied than their peers without a disability. One study showed that 60 percent of students with disabilities reported being bullied regularly compared with 25 percent of all students (National Bullying Prevention Center, 2013).

Acting on this research could potentially lower a currently disproportionate suicide rate and save the lives of many young adults. This study could benefit rehabilitation professionals, friends, family members and support systems, as well as the individuals who are experiencing the disability. By discovering the underlying reason that these young people are not receiving the support they desperately need, the entire field of rehabilitation for this population could be improved dramatically.

**Statement of the Problem**

Suicide is an enormous problem faced by the rehabilitation community. Previous research suggests that the suicide rate and attempted suicide rate for individuals aged 18 to 24 who have experienced a permanently disabling incident to be disturbingly high. These particular individuals, who have acquired a disability from accidents such as a paralyzing car accident, a diving accident incurring a spinal injury or a traumatic brain injury, seem to have a loss of hope in a brighter tomorrow.

Much research explores why individuals commit suicide. Some of the most common themes that remain consistent across cultures include loss of an intimate relationship, death or
loss of a spouse, loss of face or defeat in battle, a need to escape or general hopelessness (Sahin, Sahin, & Tümer, 1994). This being said, very little attention has been paid to the disability population, despite the overwhelming statistics. Furthermore, given the best practices in the field of rehabilitation, the majority of these individuals are exposed to the very latest in evidence-based practice. According to Razzano and Cook (2005), authors of “Evidence-Based Practices in Supported Employment,” these evidence-based practices include: (1) competitive or supported employment services; (2) situational assessment; (3) rapid placement; (4) ongoing vocational supports; (5) clients’ individual preferences; and (6) economic disincentives, none of which include counseling or assistance with adjustment to life with the disability. So the question remains, what is missing? What is the magic ingredient that can save the lives and the futures of these young adults?

Very little research exists as to what can be done differently to prevent suicide within this population. Qualitative research is ideal for filling this gap because it allows for individualized attention to what is missing from the rehabilitation process. This research will be pertinent to individuals in this population, rehabilitation professionals, and perhaps most importantly, the family members of these loved ones that long to see hope in those eyes once again. Ideally, this research will determine the key component needed in the field of rehabilitation to prevent suicide in this population and instill hope for a better tomorrow. It will change what is commonly accepted as the best practices for this population, and save lives and heartache for all involved.

**Research Question**

People with disabilities are at a higher risk for suicide than their non-disabled counterparts. This is especially true with young individuals living with a disability. Suicide is an enormous problem faced by the rehabilitation community. Previous research suggests that the
suicide rate and attempted suicide rate for individuals aged 18 to 24 who have experienced a permanently disabling incident to be high. Despite various intervention techniques, why is the attempted and completed suicide rate in people aged 18-24 who have experienced a disabling condition still so high?

**Theoretical Framework**

Theoretical frameworks are a crucial part of the research process, establishing clear boundaries for the researcher as well as providing functional processes and integrity for the study. Theoretical frameworks are important to any exploratory study in which one does not know what is happening and is trying to learn more. No matter how little a researcher thinks they know about a topic or how unbiased they believe themselves to be, it is virtually impossible for a human being not to have preconceived notions, even if they are general in nature.

This study has used the qualitative method of phenomenology in order to investigate the nature of the lived experiences of the participants (Van Manen, 1990). Phenomenological inquiry is the technique of choice when one is seeking an understanding of how participants understand a phenomenon and how they experience it (Sites, 2008).

The purpose of the phenomenological approach is to illuminate the specific phenomena through how it is perceived by the participants in a situation. In the human sphere, this normally translates into gathering deep and meaningful information through inductive, qualitative methods such as interviews, discussions and participant observations. Phenomenology is concerned with the study of experience from the perspective of the individual. Epistemologically, phenomenological approaches are based on a paradigm of personal knowledge and subjectivity, and emphasize the importance of personal perspective and interpretation. As such, they are highly effective for understanding subjective experience, gaining insight into personal
motivations and actions, and slicing through the clutter of general assumptions and conventional wisdom.

Phenomenological research overlaps with other essentially qualitative approaches, including ethnography, hermeneutics and symbolic interactionism. Essentially, pure phenomenological research seeks to describe rather than explain, and to start from a perspective free from hypotheses or preconceptions (Husserl, 1970). Many humanistic researchers refute the possibility of starting without preconceptions or bias, and emphasize the importance of making clear how interpretations and meanings have been placed on findings, as well as making the researcher visible in the ‘frame’ of the research as an interested and subjective actor rather than a detached and impartial observer (Plummer, 1983; Stanley & Wise, 1993).

Phenomenological methods are particularly effective at illuminating experiences and perceptions of individuals from their own perspectives. Therefore, they challenge structural or normative assumptions. Adding an interpretive dimension to phenomenological research allows it to inform, support or challenge policies and action.

**Conceptual Design**

Nearly all research studies in social and behavioral sciences, regardless of discipline, require a rationale for conducting research. This rationale is often called a conceptual design. A conceptual design demonstrates how one theorizes or makes sense of the relationships among the factors that have been identified as important to the problem. In essence, it attempts to assimilate key pieces of information in a logical manner, thereby conceptualizing a problem that can be tested.
The conceptual design for this research incorporates the results of interviews and document collection culminating in a theory for suicide prevention for the rehabilitation community.

Figure 1.1. Conceptual design.

Theoretical Sensitivity

**Personal experience.** Being a suicide survivor as a young adult newly diagnosed with Post-Traumatic Stress Disorder (PTSD), I definitely see the benefit of saving others from this horrific level of despair. Although different from the onset of a physical disability, the sudden symptomology of PTSD can be equally debilitating. Regardless of the emotional or physical nature of the disability, the despair and isolation can be crippling, leaving that individual to feel as if they have no other choice than to end their life. At least, this is how I felt, when it happened to me.
Because I lived these experiences, I intimately understand the concepts and theories associated with this research. Being a young adult with a disability and a suicide survivor helps me to understand my participants on a deeper level, than had I not had these experiences.

**Professional experience.** As a clinical director at a state vocational rehabilitation service provider, I meet with individuals from this population on at least a weekly basis. Frequently, a client such as this will appear depressed, or possibly even suicidal. In fact, it can be challenging to instill hope in these individuals who have convinced themselves that the life that they once cherished is over.

Suicide among people with disabilities is a tremendous problem in the field of rehabilitation. Research suggests it, but I know it because I work with people in this population every day. I want to not only save the lives of the clients that I care about, but the people everywhere who have lost hope.

**Knowledge of the literature.** Devivo, Black, Richards, and Stover (1991) reported 50 suicides among a group of 9,135 spinal cord injury individuals. While this statistic might not sound powerful, this number is five times more than expected based on the participants’ age, sex and race. Most suicides occurred within one to five years after the injury, indicating that the crisis event itself played a contributing role to the suicide, perhaps because of the lack of time to adjust to the new life situation. While this sounds bleak, hope may indeed be possible. In a study conducted by Jaspers (1998), it was revealed that a combination of pharmacological, psychological and psychosocial treatments may improve patients’ quality of life. This hypothesis also suggested that preemptive intervention may be the key to suicide prevention among this population.
**Analytic rigor.** Analytic rigor, or procedural rigor, as renamed by Kline (2008), is “the means by which we show integrity and competence; it is about ethics and politics, regardless of paradigm” (p. 211). This particular study will adopt the grounded theory of qualitative research. By following the procedure of grounded theory, the participants in the study will develop the theory from the ground up using shared ideas, values, and theories.

**Parameters of the Study**

This study includes interviews, observations, the maintenance of a researcher’s journal and document collection. The research participants were questioned and observed using a semi-structured interview guide, focusing on knowledge, attitude, social influences and perception of disability and suicide (Sharma, Clark, & Sharp, 2014). The interviewees consisted of individuals aged 18 to 24 who have experienced a disabling condition, rehabilitation professionals, suicide hotline volunteers and family members. These participants were selected from Sassin and Associates and The Center in Tulsa, Oklahoma.

**Limitations**

This study is not generalizable to the general public; rather, it focuses exclusively on assisting individuals with a newly acquired disability in hopes of preventing suicide. An additional limitation is that while the use of phenomenological, qualitative research helps in the understanding of a problem from an individual perspective, it lacks the breadth of a quantitative study.

**Definition of Terms**

These terms are derived from common knowledge regarding suicide.

- **Suicide** is death caused by self-directed injurious behavior with any intent to die as a result of the behavior.
• **Suicide attempt** is a non-fatal, self-directed and potentially injurious behavior with any intent to die as a result of the behavior. A suicide attempt may or may not result in injury.

• **Suicidal ideation** involves thinking about, considering or planning for suicide.

**Summary**

In summation, the need for understanding how to prevent suicidal ideation for people with disabilities is absolutely necessary. Suicide is one of the three leading causes of death among people between the ages of 15-34 years, and an estimated one million people globally die by suicide (World Health Organization, 1999). Recent data indicate that suicide occurred more than twice as often as homicides, totaling 34,598 and 18,361, respectively, and suicide is the eleventh leading cause of death for all ages in the United States (Xu, Kochanek, Murphy, & Tejada-Vera, 2010). What is it about psychological treatment that is not decreasing the frequency of suicide, especially among those in the disability community? The goal of this study is to answer that question.

Chapter two explores the literature relevant to this study. Chapter three introduces the methodology used; chapter four presents the data and chapter five shares the results, recommendations, and conclusions.
Chapter Two: Literature Review

Search Strategy

Several strategies were employed to research the literature relevant to this dissertation. Online databases included EbscoHost, ProQuest, and Google Scholar. These databases were chosen because they are social science-based and have been established as a means of research for this discipline. Several books and documentaries were also included among the research.

Keywords used include suicide, disability, rehabilitation, hope, coping, loss, and many other words synonymous with these terms. Keywords were cross-referenced among all databases. In addition, the work of many authors who are subject matter experts on this topic was sought for the purpose of this literature review.

The organization of this chapter is divided into several areas that impact a person’s determination to take his or her own life. The sections include: Attempted Interventions, Coping Strategies, The Bullying Epidemic, and Security. This section will conclude with a summary of all literature presented.

Introduction

There are several reasons to theorize that newly acquired disabilities serve as a risk factor for suicidal ideation. First, physical disability represents a source of chronic stress that involves lasting difficulties in managing everyday instrumental and social activities (Turner & Noh, 1988). Secondly, more recent research has suggested strong relationships between physical disability, psychiatric and substance disorders, emotional distress, social inadequacy and alienation (Rokach, Lechelier-Kimel, & Safarov, 2006; Turner, Lloyd, & Taylor, 2006). To the extent that a person with a physical disability views him or herself as a relentless burden to others, especially close family and friends, they may see suicide as a solution to this perceived
issue (Joiner, 2005). Therefore, whether physical disabilities possibly increase the risk for suicidal ideation, or even attempted or completed suicide, and whether any such effects are directly or indirectly caused by psychiatric disorders are unanswered questions that are of vital importance for effective prevention. A resolution of these questions requires a determination of the risk significance of physical disability independent of variations in other forms of stress exposure, and history of psychiatric and substance disorders (Russell, Turner, & Joiner, 2009).

Alton (2014) observed that depression tends to be under-recognized in patients with multiple sclerosis (MS). Suicide rates are elevated in those individuals and are thought to be influenced by the disability itself and subsequent depression. Litov (2003) reported similar findings for individuals who have acquired fibromyalgia, while a third study cited the link between Post-Traumatic Stress Disorder (PTSD) and suicide completion (Villarreal, 2012). Finally, a fourth study indicated a strong relationship between Traumatic Brain Injury (TBI) and suicide (Lafferty, 2014).

As previously mentioned, Devivo et al. (1991) reported 50 suicides among a population of 9,135 individuals who had suffered spinal cord injuries. This statistic is much greater than expected in terms of age, sex, and race, with most of the suicides occurring within a one to five year post-injury window. Other studies have suggested that suicide rates in people with spinal cord injury are five to ten times higher when compared to their uninjured peers. Keeping these statistics in mind, we must ask ourselves if something can be done to increase hope and prevent such horrific endings.

**Attempted Interventions**

The purpose of this section is to illustrate the attempts made by the rehabilitation community to address the issue of suicide among people with disabilities. The entries in Table...
2.1 provide information regarding what interventions have thus far proven successful as well as elaborating on what could possibly be done better.
Table 2.1

*Attempted Interventions*

<table>
<thead>
<tr>
<th>Author</th>
<th>Research Type</th>
<th>Methods</th>
<th>Conclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jurišić and Marušič (2009)</td>
<td>Article</td>
<td>Correlational Study</td>
<td>Results support the need to explore suicide risk in regards to patients with permanent physical disability.</td>
</tr>
<tr>
<td>Blanchard and Hickling (1997)</td>
<td>Book</td>
<td>Survey</td>
<td>Motor vehicle accidents are the leading cause for Post-Traumatic Stress Disorder.</td>
</tr>
<tr>
<td>Rodriguez (2014)</td>
<td>Article</td>
<td>Review</td>
<td>Cognitive restructuring can lead to a reduced suicide risk.</td>
</tr>
<tr>
<td>Jaspers (1998)</td>
<td>Article</td>
<td>Literature Review &amp; Case Report</td>
<td>The treatment for individuals with Post-Traumatic Stress Disorder should be aimed at coping with trauma and not at chronic pain management.</td>
</tr>
</tbody>
</table>
According to Jurišić and Marušič (2009), the implications for the prevention of suicidal behavior in patients with permanent physical disability, particularly following a motor vehicle accident, are vast. First, one may consider screening for a family history of suicidal behavior. A family history of depression or other suicidal tendencies could potentially alert a practitioner or caregiver to the possibility of the same condition for the individual presented with a disability. For example, if a parent or sibling of the child who recently became disabled or a young adult is currently being treated for depression or anxiety, it may be prudent for the practitioners working with this individual to pay even closer attention to suicidal warning signs.

In a study conducted by Blanchard and Hickling (1997), good outcomes were reported for the use of cognitive behavioral therapy for patients with Post-Traumatic Stress Disorder symptoms following a disabling motor vehicle accident. This study indicated that if a practitioner provided coping mechanisms through practices such as cognitive restructuring and thought stopping, their client was less likely to display suicidal ideation following a disabling automobile collision. According to Rodriguez (2014), cognitive restructuring, also called cognitive reframing, is a behavioral technique associated with cognitive therapy. It teaches an individual to replace fundamental, faulty thinking with rational, realistic and more positive thinking. A great deal of research has suggested that it is the single most effective therapeutic tool to treat anxiety or depression. Thought stopping is a technique employed to combat or eliminate negative and self-defeating thinking that involves becoming aware of one’s own ruminations and employing the self-control to stop one’s mind from descending into despair, sadness, depression, or even suicidal ideation.

In a study conducted by Jaspers (1998), research revealed that a combination of pharmacological, psychological, and psychosocial treatments may improve patients’ quality of
life. Jaspers also suggested that preemptive intervention might be the key to suicide prevention among this population. Once again, being aware of the warning signs and also the threats for this particular population could be crucial to suicide prevention.

**Physician-Assisted Suicide**

The purpose of this section is to illustrate the effect that the legalization of physician-assisted suicide has had on the rehabilitation community, particularly in regards to the issue of suicide among people with disabilities. The literature presented in Table 2.2 below provides information regarding physician-assisted suicide and subsequent fallout among individuals with disabilities.
<table>
<thead>
<tr>
<th>Author</th>
<th>Method</th>
<th>Research</th>
<th>Conclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Batavia (1997)</td>
<td>Journal Article</td>
<td>Literature Review</td>
<td>The opponents of a right to suicide argued that the right cannot be limited to individuals with a terminal illness.</td>
</tr>
<tr>
<td>Scoccia (2010)</td>
<td>Article</td>
<td>Literature Review &amp; Case Study</td>
<td>The Oregon Death with Dignity statute is consistent with the view that physically disabled people have a satisfactory quality of life when they have an appropriate support network.</td>
</tr>
<tr>
<td>Assisted Suicide and Disability (2006)</td>
<td>Letter</td>
<td>Letter to the Editor</td>
<td>Many scholars are reluctantly changing their decisions to not support physician-assisted suicide in the disability community.</td>
</tr>
<tr>
<td>Werth and Cobia (1995)</td>
<td>Article</td>
<td>Qualitative Study</td>
<td>Data suggested three parts to rational suicide – hopelessness, free choice and an informed, decision-making process.</td>
</tr>
<tr>
<td>Maris (1982)</td>
<td>Article</td>
<td>Literature Review</td>
<td>Suicide is seen as simply an element of the human condition, and therefore an understandable part of life.</td>
</tr>
<tr>
<td>Koenig (1993)</td>
<td>Article</td>
<td>Survey</td>
<td>Data demonstrated that most Americans favor decriminalization of physician-assisted suicide.</td>
</tr>
<tr>
<td>Angell (1982)</td>
<td>Article</td>
<td>Literature Review &amp; Summary</td>
<td>Author suggested that the conversation with hopelessly ill patients must be more comprehensive and include discussion on physician-assisted suicide.</td>
</tr>
<tr>
<td>Wanzer (1989)</td>
<td>Article</td>
<td>Literature Review</td>
<td>Author suggested that euthanasia and physician-assisted suicide are plausible options for the seriously ill.</td>
</tr>
</tbody>
</table>
### Table 2.2 (Cont.)

*Physician-Assisted Suicide*

<table>
<thead>
<tr>
<th>Author</th>
<th>Method</th>
<th>Research</th>
<th>Conclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conwell and Caine (1991)</td>
<td>Article</td>
<td>Literature Review &amp; Case Study</td>
<td>Author suggested that suicide is a rational choice among people with serious illness or disability.</td>
</tr>
<tr>
<td>Chochinov (1995)</td>
<td>Article</td>
<td>Correlational Study</td>
<td>Data suggested that the majority of individuals initially surveyed preferred death, but in later interviews, those wishes diminished.</td>
</tr>
<tr>
<td>Silverman (2001)</td>
<td>Dissertation</td>
<td>Correlational Study</td>
<td>Research suggested that the most important consideration in physician-assisted suicide is the quality of life a person is experiencing.</td>
</tr>
</tbody>
</table>
As stated by Batavia (1997), a verbal, politically active group of people with disabilities, including several prominent leaders of the disability-rights movement, has specified openly that they are vehemently opposed to the recognition of a right to physician-assisted suicide for individuals with newly acquired disabilities. However, like any politically, ethnically, and religiously diverse community, including that of physicians, the community of individuals with disabilities is far from united on this issue. Furthermore, many individuals in the disability rights movement believe that even if physician assisted suicide was legalized for individuals with disabilities, it should still be forbidden because it hurts people with disabilities as a class (Scoccia, 2010). On the other side of the argument, many persons with disabilities understand how the healthcare system in America actually works, fully comprehending the undertreated pain and unnecessary suffering, the disempowerment and dehumanization that spur support for physician-assisted suicide (Assisted Suicide and Disability, 2006).

About 20 years ago, a set of empirically based criteria, for what was later deemed “rational suicide,” was created in an attempt to assist health professionals in assessing the rationality of a suicidal person (Werth & Cobia, 1995). The circumstances to be met include: the person has an unrelenting hopeless condition including, but not limited to, terminal illnesses, severe physical or psychological pain, physically or mentally debilitating or deteriorating medical conditions, or quality of life no longer acceptable to the person in question. Also, it must be confirmed that person is not pressured by others to choose suicide, and has engaged in “a sound decision-making process” (Werth & Cobia, 1995).

Professionals who oppose physician-assisted suicide have suggested a number of arguments for their position that “rational suicide” is not possible (Maris, 1982; Richman, 1988). The argument of the existence of excruciating suffering or pain is not thought of as a suitable
reason for allowing people to die, because pain can usually be reduced or possibly eliminated (Koenig, 1993). One of the major forces behind this argument is people’s perception that doctors make an insufficient effort toward helping relieve patients’ pain, thus increasing the public’s fear that unnecessary suffering will occur during the dying process (Angell, 1982). However, as the dispute over whether to legalize physician-assisted suicide has become public, the need for better palliative or hospice care has been recognized, and more professionals agree that chronic pain can and should be treated aggressively with pain-relieving substances, even when the treatment may result in a shortened lifespan (Wanzer, 1989).

Another argument against physician-assisted suicide revolves around the diagnosis of medical illness. The accuracy of diagnosis for many diseases is often inaccurate, and predictions about the time remaining in a person’s life are unreliable or wrong altogether (Koenig, 1993). Additionally, research on completed and attempted suicide provides confirmation that the presence of psychiatric illnesses, such as depression, influences the incidence of suicidal ideation (Conwell & Caine, 1991). Because depression is considered treatable, it can be contended that when the depression subsides, so will the wish for death (Chochinov, 1995; Silverman, 2001).

Coping Strategies

The purpose of this section is to demonstrate the impact that learning appropriate coping mechanisms has on suicide prevention in regards to people with disabilities. The literature presented in Table 2.3 below provides information regarding different coping mechanisms and the potential effect that they have when an individual is contemplating suicide.
### Table 2.3

**Coping Mechanisms**

<table>
<thead>
<tr>
<th>Author</th>
<th>Method</th>
<th>Research</th>
<th>Conclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jurišić and Marušič (2009)</td>
<td>Article</td>
<td>Correlational Study</td>
<td>Results support the need to further examine the relationship between disability and suicide risk.</td>
</tr>
<tr>
<td>Lazarus (1966)</td>
<td>Book</td>
<td>Review</td>
<td>Author emphasizes the importance of cognitive processes when dealing with stress and coping.</td>
</tr>
<tr>
<td>Chan, Cardosa, Da Silva, and Chronister (2009)</td>
<td>Book</td>
<td>Review</td>
<td>Book emphasizes the important role that rehabilitation professionals play when helping an individual adjust to a disability.</td>
</tr>
<tr>
<td>Cohen (2004)</td>
<td>Article</td>
<td>Correlational</td>
<td>Data suggests that the social interaction may be the key to addressing maladjustment issues.</td>
</tr>
<tr>
<td>Dumont and Provost (1998)</td>
<td>Article</td>
<td>Discriminant Function Analysis</td>
<td>The data indicated that self-esteem, problem-solving, coping strategies, and antisocial and illegal activities with peers helped to determine whether young adults could effectively deal with stressors.</td>
</tr>
<tr>
<td>Cohen and Willis (1985)</td>
<td>Article</td>
<td>Literature Review</td>
<td>Author examines the positive association between social support and the reaction to adverse situations.</td>
</tr>
<tr>
<td>Bolognini (1992)</td>
<td>Article</td>
<td>Literature Review</td>
<td>Author examines the relationship between personality and age and pre-adolescent stress.</td>
</tr>
</tbody>
</table>
Table 2.3 (Cont.)

*Coping Mechanisms*

<table>
<thead>
<tr>
<th>Author</th>
<th>Method</th>
<th>Research</th>
<th>Conclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Berkman and Syme (1979)</td>
<td>Article</td>
<td>Correlational Study</td>
<td>The age-adjusted relative risks for those most isolated when compared to those with the most social contacts were 2.3 for men and 2.8 for women.</td>
</tr>
<tr>
<td>Tucker, Schwartz, Clark, and Friedman (1991)</td>
<td>Article</td>
<td>Correlational Study</td>
<td>Results indicated that for men, who divorce and subsequently remarry is a stronger predictor of mortality risk prior to age 70. Whereas for women, number of children is a stronger predictor of mortality risk after age 70.</td>
</tr>
<tr>
<td>Gremore et al. (2011)</td>
<td>Article</td>
<td>Multilevel Analyses</td>
<td>Daily spousal support appears to be an important contributor to the daily emotional and physical well-being of females with breast cancer.</td>
</tr>
</tbody>
</table>
A great deal of research has centered on the utilization of coping strategies or coping mechanisms as a means of adjusting to life with a newly acquired disability. Many individuals will use humor to lighten the situation and allow others to feel more comfortable around them. Others will choose isolation, feeling that they are no longer an active part of the world around them. Still others rely on the love and support of family and friends to cope with what could potentially be a difficult life transition.

Most of the participants (58%) in the study by Jurišić and Marušič (2009) were pensioned because of their physical disability, indicating that those individuals did not return to work or to the social structure following the incident that caused their disability. This isolation from a workplace may impair social integration and consequent psychological well-being. Agencies, such as rehabilitation services, could potentially play a tremendous role in suicide prevention. However, not having financial security, such as that provided by a pension or Social Security, could also contribute to depression and subsequent suicidal ideation.

As stated by Lazarus and Folkman, coping strategies are defined as the ability to employ cognitive and behavioral efforts in such a way that enables an individual to tolerate, escape or otherwise minimize the effects of stress (Lazarus, 1966; Lazarus & Folkman, 1984). Coping strategies are frequently centered on problem solving and aimed at doing something, anything, to change the stressful situation at hand. Coping strategies are centered on emotions, and focus on avoiding the unbearable stimulus, without addressing the need to modify the actual situation. According to Seiffage-Krenke (1995), in young adults and adolescents (aged from 10 to 24), the problem-solving model appears to be more effective. Some behaviors that should be included in this model are seeking information or advice, accepting social support, and making an effort to solve the problem. However, the avoidant model is less effective in this age range. This model,
characterized by withdrawing, embracing fatalistic attitudes, and avoidance, can lead to dysfunctional behavior in the life of an adolescent or young adult.

Perhaps one of the best strategies to helping individuals with chronic illnesses, disabilities with depression or subsequent suicidal ideation is to present them with coping strategies that they can use any time they deem necessary. According to Chan et al. (2009), coping is defined by its positive aspects, qualities, and abilities that are inherent to an individual as opposed to impairment or insufficiency in one’s mind or body. In other words, it is facing difficulties in a successful, calm or merely adequate manner, or making the most out of an adverse situation. Conceivably, one of the single best coping mechanisms is having a sense of acceptance or social support. According to Cohen (2004), the most commonly held view of social support is that it refers to the provision of psychological and material resources by another person intended to benefit an individual’s ability to cope with stress. In other words, social support is simply the fact that the individual suffering with a chronic illness or disability has someone that or she can truly rely on, talk to, trust and depend on. In many situations, the selection for a social support system is easy. Many that become disabled have spouses, other family, and even very close church families that naturally fit this role. However, it is not always so simple. Oftentimes, individuals have to search for support systems in the form of support groups, telephone buddies, or other outlet opportunities presented through various non-profit entities (Chan et al., 2009).

As noted by Dumont and Provost (1998), social support is a concept which includes both the support that is actually received (for example, affirmation or information) and the sources of the support (for example, family members, friends, support groups or even pets). Cohen and Willis (1985) identified two major models to explain how social support eases the effects of
stress. First, the principle effect model stipulates that social supports provide an individual with an overall positive effect, regardless of the stressors surrounding him or her. The second, known as the stress buffering effect, proposes that adequate social support can actually offset the effect that stress has on an individual’s health and well-being. According to Bolognini (1992), individuals who reported lower degrees of social support also reported higher levels of depression, anxieties and sleep disturbances; all of which can lead to deeper emotional problems.

This concept of social support is crucial to the avoidance of suicidal ideation, and is perhaps not sufficiently pursued in the field of rehabilitation beyond a simple, “Do you have someone you can talk to about this” or “Do you feel like you have a good social system” Perhaps by asking questions such as, “Who do you feel is the stress buffer in your life,” clinicians would better tailor treatment to the needs of the individual, particularly within the confines of coping and social support.

In a longitudinal study conducted over nine years, Berkman and Syme (1979) discovered that the mortality rate of individuals coping with chronic illnesses or disabilities was nearly twice as high as those who reported high levels of social interactions. Is it possible that these social interactions prolonged their lives, or at the very least prevented their suicide?

Another study by Tucker et al. (1991) found that men who were married had a significantly lower mortality risk when compared to those men that were separated, divorced, or even remarried. For women, however, the risk was lower when they had a greater number of children and belonged to more social organizations. This study was interesting in its comparison of the difference between the sexes. While the men relied heavily on the traditional covenant of marriage for social support, women opted to rely on their children and their friends. This drives home the point of taking into consideration factors such as gender and culture when encouraging
social support for a client. It is crucial to make an appropriate recommendation when doing so. For example, a woman with very few friends and family who tends to prefer privacy may benefit more with social support from a telephone “buddy” with a similar diagnosis than a large group of multi-gender and multicultural individuals.

Another benefit of social support in stressful situations is the advantage of having a buffer, or someone to intervene and assist with the complications surrounding an already difficult situation. In a study conducted by Gremore et al. (2011), stress buffering was found to lessen depression and improve the ability to cope effectively. By embracing this level of social support, both negative appraisals, such as “I will never survive this disaster” or “Now I am truly alone in this world” and stress levels were reduced considerably.

The Bullying Epidemic

The purpose of this section is to demonstrate the impact that the bullying epidemic has on the suicide rate in regards to young people with disabilities. The literature presented below in Table 2.4 provides information regarding bullying and how putting a stop to bullying could potentially save the lives of individuals who have a disability or chronic illness.
<table>
<thead>
<tr>
<th>Author</th>
<th>Method</th>
<th>Research</th>
<th>Conclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurwisah (2011)</td>
<td>Article</td>
<td>Editorial</td>
<td>Mitchell Wilson’s death was ruled a suicide caused by bullies teasing him about having muscular dystrophy.</td>
</tr>
<tr>
<td>Hallford (2009)</td>
<td>Dissertation</td>
<td>Comparative Methods Approach</td>
<td>No relationship exists between the number of reported bullying incidents and the enactment of a bullying law.</td>
</tr>
<tr>
<td>Maslow (1968)</td>
<td>Book</td>
<td>Literature Review</td>
<td>Explores Maslow’s hierarchy of human needs within the context of human psychology.</td>
</tr>
<tr>
<td>Hirsch (2011)</td>
<td>Film</td>
<td>Documentary</td>
<td>Followed children being bullied, one resulting in suicide.</td>
</tr>
<tr>
<td>Abilitypath.org (2011)</td>
<td>Website</td>
<td>Report and Parent Handbook</td>
<td>Provides tools for parents of special needs children to assist with dealing with bullying</td>
</tr>
<tr>
<td>Rose, Monda-Amaya, and Espelage (2011)</td>
<td>Article</td>
<td>Literature Review</td>
<td>Explores the prevalence of bullying within the special needs community</td>
</tr>
</tbody>
</table>
In a country in which the bullying of a nation’s adolescents has become epidemic, it is disheartening to realize that individuals who have experienced a life-changing disability are virtually left out of the conversation. All human beings have a rudimentary need to not only be safe, but to feel safe; a concept that includes the need for security, protection, permanency, and freedom from fear or persistent anxiety (Hallford, 2009). In the hierarchical structure of today’s society, safety needs must be realized before self-actualization may take place (Harper et al., 2003; Maslow, 1968). This is most important for those who have experienced a sudden-onset disability.

Research on bullying and subsequent intervention programs first surfaced in Norway after it was surmised that a rash of adolescent suicides was the result of victimization from bullying. Olweus (2003), a trailblazer in bullying research, regarded the phenomenon of bullying in the context of human rights and social justice. He contended that it is a fundamental human right for a person to feel safe in society and be spared the recurrent humiliation implicit in bullying.

In March 2012, a documentary titled “Bully” was released. Originally designed to explore the relationship between bullying and disability, the researchers instead stumbled upon something far more disconcerting. Two of the boys ended their lives with suicide, while the three girls followed throughout the film were tormented relentlessly (Hirsch, 2011). Bullying is a complex issue, especially when physical and emotional limitations are included in the conversation and there is a great deal of evidence that individuals with disabilities are bullied more than their nondisabled counterparts (Abilitypath.org, 2011; Rose et al., 2011).

In 2011, an eleven-year-old boy named Mitchell Wilson committed suicide by wrapping a plastic grocery bag around his face the night before he was to return to school following
summer vacation. Muscular dystrophy had left Wilson struggling to do simple things like walking around the block or climbing stairs at school or home. He also had to use a walker at school. Doctors had urged him to exercise regularly to stave off the disease's effects, something that was growing increasingly difficult for the boy (Mandel, 2011).

Wilson was mugged by a 12-year-old boy from his school. The assailant was after the iPhone that Wilson had borrowed from his father. The bully was arrested and removed from the school they both attended. When Mitchell attempted to seek help for his bullying nightmare, the torture instead intensified, culminating in his suicide (Nurwisah, 2011).

Practitioners must ask themselves what they can do to change such outcomes and how to get involved in the conversation regarding suicide prevention. If research indicates that young individuals who have experienced a life-altering disability are more likely to complete suicide, what hope do they have when they are also being bullied?

Security

The purpose of this section is to demonstrate the impact that security has on the suicide rate in regards to young people with disabilities. The literature presented in Table 2.5 below provides information regarding security and how the promotion of security, both personal and financial, can play an important role in suicide prevention.
Table 2.5

Security

<table>
<thead>
<tr>
<th>Author</th>
<th>Method</th>
<th>Research</th>
<th>Conclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mittendorfer-Rutz, Alexanderson, Westerlund, and Lange (2014)</td>
<td>Article</td>
<td>Regression</td>
<td>Risk of a suicide attempt increased up until the granting of a disability pension in young individuals, after which the risk decreased.</td>
</tr>
<tr>
<td>Marmot (1997)</td>
<td>Article</td>
<td>Correlational Study</td>
<td>Possible links between social position and physical and mental health include smoking and the psycho-social environment at work and outside of work</td>
</tr>
<tr>
<td>Evans (1994)</td>
<td>Book</td>
<td>Literature Review</td>
<td>Showed that a lower hierarchical position denotes a higher level in mortality</td>
</tr>
<tr>
<td>Heaney and Israel (1997)</td>
<td>Book</td>
<td>Literature Review</td>
<td>Examined the role that social networks and friendships play on suicide prevention</td>
</tr>
<tr>
<td>House, Landis, and Umberson (1988)</td>
<td>Article</td>
<td>Literature Review</td>
<td>Showed increased risk of death for persons with low quantity of social interactions</td>
</tr>
<tr>
<td>Baranowski, Perry, and Parcel (1997)</td>
<td>Article</td>
<td>Literature Review</td>
<td>Explored how an individual’s environment and behavior interact.</td>
</tr>
<tr>
<td>Guralnik, Land, Blazer, Fillenbaum, and Branch (1993)</td>
<td>Article</td>
<td>Probability Study</td>
<td>Level of education has a greater effect than race on life expectancy.</td>
</tr>
<tr>
<td>Kaplan, Pamuk, Lynch, Cohen, and Balfour (1996)</td>
<td>Article</td>
<td>Correlational Study</td>
<td>Economic policies that increase income inequality may also have a deleterious effect on population health.</td>
</tr>
</tbody>
</table>
Table 2.5 (Cont.)

*Security*

<table>
<thead>
<tr>
<th>Author</th>
<th>Method</th>
<th>Research</th>
<th>Conclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pappas, Queen, Hadden, and Fisher (1993)</td>
<td>Article</td>
<td>Correlational Study</td>
<td>People who are poor or poorly educated have a higher mortality rate than those with more income or better education.</td>
</tr>
<tr>
<td>Lutz (2000)</td>
<td>Dissertation</td>
<td>Constant Comparative Dimensional Analysis</td>
<td>Explored how people with disabilities experienced the influence of disability on the quality of their lives</td>
</tr>
</tbody>
</table>
According to Mittendorfer-Rutz et al. (2014), a disability pension such as Social Security or an employer program reduced the risk of suicide markedly when compared to suicide rates of those who lacked financial security. If a lack of financial security is a contributor to suicidal ideation, what other things may make an individual feel more secure?

In accordance with attempting to discover what provides someone with a disability security or an acceptable quality of life, researchers have acknowledged multiple factors that determine the overall well-being of that specific population. While some overlap exists, these determinants can essentially be clustered into three general categories:

1. Individual factors, such as socio-economic status (Marmot, 1997), heredity, and personal lifestyle and behavior patterns (Evans, 1994).
2. Environmental factors, such as social support, working conditions, community involvement (Evans, 1994; Heaney & Israel, 1997; House et al., 1988), housing situation, pollution, and sanitation (Baranowski et al., 1997; Marmot, 1997).
3. Societal factors, such as disparity in income and education, and political, cultural, and economic influences (Guralnik et al., 1993; Kaplan et al., 1996; Pappas et al., 1993).

When considering each of these elements and how they interact with each other, security in all of these areas is a must for suicide prevention for individuals with disabilities (Lutz, 2000).

Summary

This literature review encompassed the major themes of this section: Attempted Interventions, Coping Strategies, The Bullying Epidemic, and Security. The information disseminated on attempted interventions shows that although other strategies have been tried in regards to suicide prevention, the rehabilitation profession is still missing the mark because the rate is still far too high. Coping Strategies introduced the reader to different tools that an
individual in this population can employ to help them to adjust to the disability. Once again, these strategies, while useful, are still not saving the number of lives necessary to be deemed the best practice for these people. The Bullying Epidemic section introduced an exacerbator in this already difficult adjustment. The abundance of bullying and cruelty among young people is an issue that has not yet been fully explored in regards to people with disabilities. Lastly, Security is another piece of the puzzle. Some research suggests that if an individual becomes disabled but has financial security, he or she will adjust better to life with the disability when compared to his or her non-financially secure counterparts.

Young people with disabilities are ending their lives because they cannot adjust to life with their disability. All interventions and approaches attempted by the rehabilitation profession have only achieved minimal success at best. Something has to be done differently to save these lives and provide hope for young people in this situation. And who can determine what is missing more than those people living in this experience?
Chapter Three: Methodology

This chapter provides the methodology of this project, and explains the way that data were collected using interviews, observations, document collection, the role of the researcher, managing and recording data, and trustworthiness. Research design, timeline, site and sample collection and participants are discussed, along with the concept of depth versus breadth which is crucial to the understanding of a qualitative study. Next, this section explores the concepts of prolonged engagement, time sampling, maintaining a researcher’s journal, member checking, and peer review. It then discusses the concepts of persistent engagement, triangulation, peer debriefing, member checks, and audit trail. This chapter concludes with evidentiary inadequacies and a summary.

Introduction

According to the Massachusetts Young Health Survey (2007), 13 % of middle school youth with disabilities reported attempting suicide at least once in the past year compared to 3% of those without disabilities. Similarly, among high school youth, adolescents with disabilities, compared to those without disabilities, were more likely to report feeling so sad or depressed daily for at least two weeks during the previous year that they discontinued their usual activities. Among high school youth, 40% of those with disabilities reported these feelings compared to 13% of those without disabilities. In addition, 13% of high school youth with disabilities reported attempting suicide at least once in the past 12 months compared to 2% of those without disabilities (Massachusetts Young Health Survey, 2007).

The focus of this research is to determine exactly why the incidence rate of completed and attempted suicide for people experiencing new disabilities aged 18-24 is high. While the reasons for suicides within this population are obvious, the solution to preventing it is not. Some
of those reasons may include: subsequent depression, loss of hope for a better future, or unbearable pain and suffering.

Depression subsequent to experiencing a disabling incident is not inevitable. According to the Christopher Reeve Foundation (2014), those who became disabled following a violent, sudden incident, such as a motor vehicle accident, are two to three times more likely to be depressed. Many people who experience sudden disabilities are treated for depression and do not progress to the point of suicidal ideation; others, however, are not as fortunate.

Many others who have experienced a new disability suffer depression because of the loss of hope they experience in relation to possibly never being able to fulfill a life dream or goal. Hope, which may be the key to all suicide prevention, is important to everyone, not just someone in this population. The idea of keeping hope alive is best accomplished through accepting reality, establishing control, restructuring hope, and purposive positive thinking (Bally et al., 2014). Without the ability or direction to keep hope alive, suicidal ideation is common.

Focus of the Study

People with disabilities are at a higher risk for suicide than their non-disabled counterparts. This is especially true with young individuals living with a newly-acquired or persistent disability. Suicide is an enormous problem faced by the rehabilitation community. Previous research has suggested that the suicide rate and attempted suicide rate for individuals aged 18 to 24 who have experienced a permanently disabling incident to be disturbingly high. These particular individuals, who have acquired a disability from accidents such as a car accident causing paralysis, a spinal injury in a diving accident or a traumatic brain injury, seem to have lost hope for a brighter tomorrow. Despite various intervention techniques, as discussed
previously, why are the attempted and completed suicide rates in people aged 18-24 who have experienced a disabling condition still so high?

**Research Design and Timeline**

![Timeline](image)

*Figure 3.1. Timeline.*

This study will include a semi-structured interview guide, focusing on knowledge, attitude, social influences and perception of disability and suicide. The participants interviewed will be questioned using standardized open-ended questions. The interviewees will consist of persons in this population, rehabilitation professionals, hotline volunteers and family members. The initial interviews will occur over a six week period. The completion of the research from first interview to results is estimated to take approximately three months.
Researcher as an Instrument

In conducting this study I drew upon my fifteen years of experience in the field of rehabilitation and mental health. This experience provided access to participants for the study from a wide sample of people that I have interacted with over the course of my professional career. It is through the agency that I am employed with as well as the Center, of which I have an established relationship that participants are known. The agency is a vocational rehabilitation placement agency that is contracted to provide vocational rehabilitation services to the state department of vocational rehabilitation. The Center provides a social outlet to many of the clients that we serve in a vocational capacity.

Site and Sample Selection

Participants are from the Tulsa, Oklahoma area. Conversations will also take place in rehabilitation facilities to determine the practices used to prepare their patients for life with their newly acquired disabilities. It will be determined not only if the practice that they utilize is evidence-based, but also if it is considered the standard for the field, meaning that the practice is truly in the best interest of the client. Furthermore, this is where I live and work; choosing participants from my own sphere of influence provides authenticity and credibility to this study. The participants will be chosen using purposeful selection, meaning that the members of the study are known to the researcher and selected from the local professional rehabilitation field and community (Sassin, 2011).

Participants

Participants in the study will be comprised of five individuals with newly acquired disabilities aged 18-24, five rehabilitation professionals, five suicide hotline volunteers and five family members. No identifying markers will be used. These participants will be from my
personal and professional sphere of influence, which provides much more meaning to this study for both the researcher, as well as the reader.

**Depth vs. Breadth**

Working with participants that I know and with whom I have a relationship will provide depth to the study. Being part of this infrastructure in which I have long-standing a professional status, the problem of trust brokering will be eliminated because the relationship already exists.

According to Turner, Bettis, and Burton (2002), the generalist approach to knowledge is called breadth, while the specialist approach to knowledge is considered depth. In other words, if an individual is doing a qualitative study, then one is going to do it in extreme depth to make sure that he or she has uncovered all the evidence that will help answer all of his or her research questions.

**Data Collection**

To address the controversy of quantitative research versus qualitative research, several authors have examined the use of qualitative research methodologies throughout various disciplines (Bonomo, 1985; Carson, Gilmore, Perry, & Gronhaug, 2001; Eisenhardt, 1989; Gummesson, 2000; Miles & Huberman, 1994; Parkhe, 1993; Perry, 1998; Yin, 1994), yet they did not specifically explore the fieldwork and data collection undertakings in exhaustive detail because of the broader perspective of their studies. Subsequently, information on a process of data collection and fieldwork that is rigorous and robust is not readily available; thus, the main criticism that qualitative research lacks rigor and structure has only been partially answered (Alam, 2005).

Qualitative research amasses enormous amounts of information on subjects that are often too complex to be quantified. However, qualitative research techniques can be used to explore
ideas, experiences or beliefs. The data used in such investigations are usually text that has been collected from interviews, questionnaires, observations, documents or artifacts. This particular study will collect data through the use of open-ended interviews.

**Interviews**

In-depth interviews are both more expensive and time consuming as data collection techniques relative to the quantitative methodologies (Tuten & Urban, 2001). However, the use of in-depth interviewing was considered an appropriate methodological vehicle given the goal of procuring richness in data through a comprehensive and forthright discussion with both the decision makers and consumers (O'Donnell & Cummins, 1999; Palmerino, 1999; Turner, 2010; Underwood, 2003).

This type of interview presentation uses a pre-established number of questions and special topics. They are commonly asked in the same systematic and consistent order for each participant. The strength of this method is that it allows the researcher to probe beyond the answers to the standardized questions. The structure helps build the information from the participant’s perception of the topic and expand the understanding of his or her view of the world. A semi-standard interview also helps to define and clarify specific language related to disability and suicide. Information is analyzed by contextual analysis to gain an appreciation of the participant’s perspective on suicidal ideation for people with disabilities (Berg, 2004; Patton, 2002).

Descriptive interviewing, when used properly, develops rapport and helps elicit more information (Spradley, 1979). The interviews being utilized for the purpose of this research study are standardized open-ended questions, which will be descriptive in nature. Those being
interviewed include rehabilitation professionals, people who have acquired a new disability aged 18-24, suicide hotline volunteers, and family members.

**Observations**

Despite the fact that Agar (1980) described the formal interview as the cornerstone of field study, he was also careful to note that direct observations and interviews mutually interact, painting a clearer and more vibrant picture for the researcher. Agar used the analogy of a funnel when referring to the relationship between interviewing and observation. Initially, investigations began with a wide perspective, so researchers obtained as much information as possible. Once the investigators narrowed their perspectives, more succinct questions were formulated (Blaser, 1990).

In this particular study, the information retrieved from the participants will be narrowed down to focus on the actual reason that young individuals in this population commit suicide and what could potentially be done differently. From that point, reoccurring themes will be explored to lead to one or two possible theories for the prevention of suicide for people with disabilities.

The participants who will be observed are those who actually work at rehabilitation facilities and who determine the course of treatment needed for this population to re-enter the world with the newly acquired disability.

**Document Collection**

Patton (1980) stated that all research should leave a proverbial paper trail so that an evaluator can follow it and learn from it. This can include all documentation from the study, including notes, memos, phone messages, letters, schedules and handouts (Pellerin, 1999).
In addition, document collection for the purpose of this study includes pamphlets from visited rehabilitation facilities, as well as the evidence utilized by the practitioners to prepare these young people to re-enter society.

**Researcher’s Role Management**

The researcher’s role will be that of a detached observer. According to The two dimensions of being a detached observer (2012), there are two dimensions to being a detached observer: the inner dimension and the outer dimension. The inner dimension of detached observation includes the skill or the technique to stand back or observe in a detached way one’s own thoughts, feelings, emotions, attitudes and behaviors. People, generally speaking, are creators and their thoughts, feelings, emotions and attitudes are their own, unique creation. A detached observer practices simply being the witness of whatever one is thinking and feeling.

The external dimension of detached observation is the technique of being a witness to or an observer of the scenes, of the world around him or her. As one stands back and watches the scenes of life being played on the world stage around him or her, without being actively involved, usually, one can see the ‘big picture’ more clearly. This makes it easier to clearly judge what is the most suitable contribution that one can make in a particular situation.

**Managing and Recording Data**

All interviews and subsequent conversations will be audio-recorded and transcribed verbatim. Confidentiality of all participants will be maintained by assigning numbers in lieu of a name or any other distinguishing characteristics. All files, transcriptions, tapes, media, notes and any other documents will be double-locked in storage.
Analysis of Data

The researcher’s ability to analyze and interpret the data is directly related to the methodology of the research. The goal is to understand the phenomenon of suicidal ideation from the stakeholders’ unique perspectives. The process is to make conscious the understanding of the stakeholder’s perspective; this is achieved by explicitly and consciously asking and answering questions about the data. This method enriches the understanding of the research questions (Kiefer, 2007). The process can be achieved by examining the patterns in the notes and asking how these facts fit into, or alter, or extend, the intuition of the research problem. The analysis is used to see if the stakeholders share similar patterns in their perception of suicidal ideation.

Data management is an important part of analysis; and by constantly asking questions and intuitively expanding and refining the information gathered from the answers, a “richer” understanding of the research question can be developed. The more data that is accumulated the more basic memory problems develop for the researcher, specifically with the minor details (Kiefer, 2007). Coding the data as it is analyzed organizes it and provides reference points to return to it from time to time to develop an audit trail.

Hatch (2002, p. 148) describes, “Data analysis is a systematic search for meaning” and it begins in the early stages of analysis. The fluidity of analysis during my interviews shaped the secondary level of questioning and was used to clarify meanings. Further analysis was used to categorize responses and to ensure that data is complete. Hatch identifies four criteria as outlined in Figure 3.2 below that will be used to ensure that data analysis is complete; they include the following questions:
1. Are all deviant cases and disconfirming data accounted for?
2. Can the analysis be explained and justified?
3. Can a complete story be told?
4. Can the analysis be organized into coherent written findings?

*Figure 3.2.* Hatch's criteria for data analysis (Hatch, 2002).

Knowledge is generated throughout the process. However, it is the participant’s interaction and knowledge generated from the interaction that makes this study come to life. All stakeholders having their own perception of disclosure bring new understanding of the phenomenon to their co-participants. This interaction was of primary interest and the reason for the heterogeneous design in the focus group. It was also why the participants had intimacy in the analysis of the research.

**Interpretive Analysis**

Interpretation is a defining element of all qualitative research (Hatch, 2002) and is a natural fit for the constructionist paradigm. In action research, the participants have ownership in the research and generating explanations for the data. Interpretation places the researcher in the “thick of things.” Denzin and Lincoln (1994, p. 504) expands this theme even farther stating that interpretation is a “productive process that sets forth multiple meanings of an event, object, experience, or text.” As the researcher co-constructs meaning of the research with stakeholders it will link the data with the stakeholder’s interpretation which in turn makes sense of the phenomena of disclosure. Denzin and Lincoln (1994) describes interpretation as the “artistic, creative side of qualitative work.”

Analysis of data using interpretive analysis is a process that helps frame the activity. The richness of the interaction and the possible outcome utilizes interpretive analysis as a catalyst for change and deeper understanding of how each participant views disclosure. Even though some
view qualitative research as “sexy” the process is very complex empirically and Hatch (2002) provides steps to guide the new researcher in this process.

Figure 3.3 describes these steps in the interpretive analysis as described by Hatch (2002).

1. Read the data for a sense of the whole.
2. Review the impression previously recorded in the research journal and bracketed in the otorpol and records these in memos.
3. Read the data; identify impressions, and record impressions in memos.
4. Study memos for salient interpretations.
5. Reread data, coding places where interpretations are supported or challenged.
6. Write a draft summary.
7. Review interpretations with participants.
8. Write a revised summary and identify excerpts that support interpretations.

Figure 3.3. Hatch's steps in interpretive analysis (Hatch, 2002).

Trustworthiness

According to Krefting (1991), researchers need alternative models appropriate to qualitative designs to ensure rigor without sacrificing the relevance of qualitative research. One must determine a general criteria for evaluation of research and then define each from both a quantitative and qualitative perspective. Some strategies to enhance trustworthiness include:

**Prolonged engagement.** According to Lincoln and Guba (1985), prolonged engagement refers to investing sufficient time for a desired purpose. This is best accomplished by embracing the culture being examined and building trust and rapport. Prolonged engagement activities with the participants in the study include time spent for in-depth interviewing as well as follow-up questions and conversation over a six-week period.

**Persistent engagement.** Persistent engagement is the process of research being continued until all anomalies are eliminated, and relevant data are selected through a logical
process of elimination. If the purpose of prolonged engagement is to render the researcher open to the numerous influences the mutual shapers and contextual factors that impose upon the phenomenon being studied, the purpose of persistent observation is to identify those features and elements in the situation that are most relevant to the problem or issue being pursued and focusing on them in detail. If prolonged engagement provides scope, then persistent observation provides depth (Lincoln & Guba, 1985).

**Member checking.** In order to establish authenticity, qualitative researchers often rely on member checks to protect credibility by giving the participants of the study the opportunity to correct mistakes, challenge interpretations and assess results (Reilly, 2013). Member checking will occur during the transcription process as well as the remainder of the writing process. This is done to ensure that the participants maintain the position that they have established as well as challenge any findings that may have surfaced. Doing so maintains credibility of this study. Thus, for the purposes of this study, participants will be contacted to review the transcription of any and all conversations to ensure accuracy and meanings. The participants will have the freedom to correct errors and reiterate what was meant by different statements.

**Peer review.** In research, peer review means simply that peers evaluate each other’s work. (Eschenbach, 2001; Newell, 1998). For the purpose of this study, peer review, or debriefing, was accomplished by exposing the research to a disinterested peer in a manner paralleling an analytic session and to the purpose of exploring aspects of the inquiry that might otherwise remain only implicit within the inquirer’s mind.

Peers, for the purpose of this study, will include other professors with doctorates in rehabilitation, as well as certified rehabilitation counselors. Like the researcher, they will
already have established relationships with the participants, which allows for better authenticity and depth of study. Several peers included will also have disabilities and/or be suicide survivors.

**Triangulation.** One of the strengths of qualitative research is that it enables the use of many different data sources through the process of triangulation of evidence. In essence, triangulation of evidence means collecting data from: multiple sources, multiple projects, multiple key informants, or multiple research methodologies (Jick, 1979; Patton, 1990; Yin, 1994). Triangulation is essentially a validity procedure where researchers search for convergence among multiple sources of information in a study (Cresswell & Miller, 2009).

Denzin (1978) identified several types of triangulation. One type involves the convergence of multiple data sources. Another type is methodological triangulation, which involves the convergence of data from multiple data collection sources. A third triangulation procedure is investigator triangulation, in which multiple researchers are involved in an investigation. Related to investigator triangulation is researcher-participant corroboration, which has also been referred to as cross-examination. Triangulation in this study will be obtained through interviews, researcher’s journal and document collection.

**Audit trail.** An audit trail will be left in such a fashion as to ensure that a reasonable person could use the same data from this study and make the same conclusion.

**Evidentiary inadequacies.** Evidentiary inadequacies occur when the researcher is unsuccessful in obtaining evidence across a range of different kinds of sources, such as direct observation, interviewing, or documents, to merit key assertions through triangulation. Evidentiary inadequacies can include: an inadequate amount of evidence, an inadequate variety in kinds of evidence, faulty interpretative status of the evidence, inadequate, disconfirming evidence and inadequate case analysis. In this study, evidentiary inadequacies will be addressed
by prolonged engagement, persistent engagement, triangulation, member checks and peer
debriefing. Furthermore, all data will be considered, even if it is not necessarily supportive to
the emerging hypothesis (Erickson, 1986).

Summary

This study utilized techniques specific to qualitative research. These techniques
included: data collection, interviews, and document collection. Throughout the research, special
attention was paid to engagement, both prolonged and persistent, and triangulation. Member
checks and peer review was also utilized to ensure accuracy. Chapter four will address the results
from this study.
Chapter Four: Data Presentation and Analysis

Introduction

The purpose of this study was to determine what can be done differently by rehabilitation professionals to decrease, or potentially eliminate, suicidal ideation in young adults who have experienced the onset of a sudden disability. The intent of this study was to identify best practices and contribute to the field of rehabilitation counseling. This chapter provides an analysis of the data collected and an interpretation of findings and discussion from the study. The chapter begins with an account of my interviews with the study participants; namely, individuals between the ages of 18-24 who have experienced a sudden disability, family members of young adults who have experienced a sudden disability, and rehabilitation professionals who have worked with people who have experienced a sudden disability. Following the report of the interviews, a presentation of the data from the three groups of participants is presented. Two tables listing the audit trail notations are also provided. A conceptually clustered matrix is also included within each section. Following the data presentation, a summary of the findings is presented.

Interviews were the primary source of data used for this study. Fifteen standardized open-ended interviews were conducted. Data was also obtained through document collection and observation. A research journal was also maintained. Documents were collected from various rehabilitation facilities. These documents were used to provide additional data and also complete triangulation for this study. Observations took place in various rehabilitation settings.

Audience

The primary audiences addressed include rehabilitation professionals, rehabilitation instructors, people with disabilities, and their significant others. My objective was to select a
study relevant to my own personal and professional experience. The objective of this qualitative study was to answer the research question and provide rehabilitation professionals research-based ideas for working with people with disabilities, particularly those experiencing suicidal ideations. Considering my present position as a clinical director at a rehabilitation counseling agency, this research can be used to influence prevention and intervention techniques for PWD that have expressed suicidal ideation made at my own agency. Therefore, the findings in this chapter are written and formatted in such a way to be beneficial to most rehabilitation professionals.

Transcribed Interviews

The interviews for this study were recorded and transcribed. Participants often spoke in informal language, therefore, the wording in the quoted passages is not wording that one would actually choose when writing a similar passage. Frequently, when being interviewed, a participant would speak in incomplete sentences. Many of the participants were relaxed and informal throughout the process. This informal setting should be considered when reading the transcribed interviews throughout the study.

The reader should also be aware that the use of brackets [ ] used to clarify the meaning of jargon often used among rehabilitation professionals. In addition, a parentheses ( ) is used to maintain the anonymity of participants and identifying landmarks or institutions.

Audit Trail Notations

Tables 4.1 and 4.2 consist of a list of audit trail notations, which are used in chapter four. The notations identify each of the participants, observations, and collected documents for this study. To ensure confidentiality, all participants were assigned a code comprised of letters and numbers. Chapter four also includes direct quotes from the participants. When using the direct
quotes, the identification code for the participant is applied followed by a slash and a number. The number identifies the original transcribed interview page from which the direct quote was selected. This procedure assisted in the organization of data and ensure that none of the participants’ identifies were acknowledged to anyone other than the researcher.
Table 4.1

*Audit Trail Notations (Interviews and Observations)*

<table>
<thead>
<tr>
<th>Notation</th>
<th>Participant</th>
</tr>
</thead>
<tbody>
<tr>
<td>FM1</td>
<td>Family Member</td>
</tr>
<tr>
<td>FM2</td>
<td>Family Member</td>
</tr>
<tr>
<td>FM3</td>
<td>Family Member</td>
</tr>
<tr>
<td>FM4</td>
<td>Family Member</td>
</tr>
<tr>
<td>FM5</td>
<td>Family Member</td>
</tr>
<tr>
<td>RP1</td>
<td>Rehabilitation Professional</td>
</tr>
<tr>
<td>RP2</td>
<td>Rehabilitation Professional</td>
</tr>
<tr>
<td>RP3</td>
<td>Rehabilitation Professional</td>
</tr>
<tr>
<td>RP4</td>
<td>Rehabilitation Professional</td>
</tr>
<tr>
<td>RP5</td>
<td>Rehabilitation Professional</td>
</tr>
<tr>
<td>PWD1</td>
<td>Person with Disability</td>
</tr>
<tr>
<td>PWD2</td>
<td>Person with Disability</td>
</tr>
<tr>
<td>PWD3</td>
<td>Person with Disability</td>
</tr>
<tr>
<td>PWD4</td>
<td>Person with Disability</td>
</tr>
<tr>
<td>PWD5</td>
<td>Person with Disability</td>
</tr>
<tr>
<td>OBS1</td>
<td>Observation-The Center</td>
</tr>
<tr>
<td>OBS2</td>
<td>Observation-Sassin &amp; Associates</td>
</tr>
</tbody>
</table>
Table 4.2

Audit Trail Notations (Documents)

<table>
<thead>
<tr>
<th>Notation</th>
<th>Document</th>
</tr>
</thead>
<tbody>
<tr>
<td>DOC1</td>
<td>The Rehabilitation Center Brochure</td>
</tr>
<tr>
<td>DOC2</td>
<td>Precise Services-The Rehab Center Brochure</td>
</tr>
<tr>
<td>DOC3</td>
<td>Community Rehab Center Brochure</td>
</tr>
</tbody>
</table>

Data Analysis

The data in this chapter were analyzed using a qualitative technique referred to as coding. This method is used to generate themes and descriptions from ordinary text (Cresswell & Miller, 2009). The coding process assisted the researcher in regards to analyzing and organizing the data. Data analysis was completed by hand. The coding of data was accomplished in three distinct stages: open coding, axial coding and selective coding (Strauss & Corbin, 1998). This process of coding included a line-by-line and word-by-word analysis of the interview data. This process was performed on every interview, every observation, and every document that was collected.

The purpose of the axial coding stage is to narrow the broad themes into more succinct and focused categories. This process is used to reconfigure data that was previously deconstructed in the axial coding phase of analysis. While some variation was detected in the axial codes from each group, data indicated major themes across all groups of participants. Selective codes were discovered from a thorough synthesis of the axial codes. These will be discussed further in chapter five.
Findings and Major Themes

The findings in this chapter are divided into three categories which are: Family members, rehabilitation professionals, and people with disabilities. The data is triangulated by interviews, observations, and document collection. The qualitative study focuses on what can be done differently in the field of rehabilitation to prevent suicide for young adults who have experienced the sudden onset of a disability. The three separate groups generated three separate categories of major themes. Many of the themes were similar or even the same.

Family Members

The major themes that emerged from the data collected and analyzed by the five family members interviewed included (a) having something to do, (b) support, (c) having an outlet to express one’s feelings. This section provides data from interviews, observations, and collected documents to meet triangulation, as well as support the major themes.

Through the process of open coding, axial codes began to emerge from the data provided by the family members. The axial codes were combined, analyzed and narrowed in order to develop the major themes. Figure 4.1 identifies a sample of the open codes and the three axial codes discovered in the data provided from the family members.
**Figure 4.1.** Axial and sample of open codes from family members.

**Descriptive Matrix**

Table 4.3 is a conceptually clustered descriptive matrix, which provides a visual display of the axial codes, or major themes, that have emerged from the data obtained from the family members in this study. Data in this matrix represents standardized, open-ended interviews. Each conceptually clustered matrix is followed by additional data obtained from observations and document collection which also support the major themes.
### Table 4.3

**Descriptive Matrix: Axial Codes of Family Members**

<table>
<thead>
<tr>
<th>Participant</th>
<th>Something to Do</th>
<th>Social Support</th>
<th>Having an Outlet to Express One’s Feelings</th>
</tr>
</thead>
<tbody>
<tr>
<td>FM1</td>
<td>We are hoping that her being involved with the band will help. We think if we can find something that she likes and can focus on then she will be happier.</td>
<td>We encourage her as much as possible. Applaud the small and big accomplishments.</td>
<td>I imagine that her sisters will be there for her to talk to.</td>
</tr>
<tr>
<td>FM2</td>
<td>Finding ways to help others can show hope to do more good and boost your spirits when you get down.</td>
<td>I think that the main thing that makes him feel more comfortable in adjusting to the way life is now is the support system he has from family, friends, and the rehab center.</td>
<td>It is very important to have somebody to talk to or relate to when you go through such a traumatic event that changes your life for a long period of time.</td>
</tr>
<tr>
<td>FM3</td>
<td>It is important to set reasonable goals and to take responsibility to make something out of her life,</td>
<td>The only support is my husband and I most of her and our supportive friends left long ago.</td>
<td>She is on an antidepressant medication and talks to people on Facebook.</td>
</tr>
<tr>
<td>FM4</td>
<td>She will never be what most people consider normal, but she will be able to accomplish the goals she has set for herself.</td>
<td>It’s being loved by her family and friends that give her the most strength and optimism.</td>
<td>Encouragement and positive results always help.</td>
</tr>
<tr>
<td>FM5</td>
<td>Trying small tasks outside her comfort zone and realizing small successes give her hope for more success.</td>
<td>Having stable jobs and relationships provides continued improvement in coping with anxieties.</td>
<td>Dealing takes time, talking to others who understand your loss.</td>
</tr>
</tbody>
</table>
**Something to Do**

Upon open coding the data and further reviewing and analyzing the axial codes, the first major theme that emerged was Purpose. All five family members placed a great deal of importance on the individual with a disability feeling like they had a purpose in life following the disabling incident. This would support earlier research that suggested that activities with peers helped to determine whether young adults could effectively deal with stressors related to the disability (Dumont & Provost, 1998). In other words, the family members indicated that having a purpose or at least something to do, helps these young adults to more effectively mitigate the stressors associated with adjustment to a life with a disability.

The data indicated that a relationship did exist between having a purpose and positive emotional outcomes for the person with the disability. One family member stated:

Finding ways to help others can show hope to do more good and also boost your spirits when you are down (FM2/2).

Similarly, another family member explained that she felt that her daughter would be happier in life if she had an activity in which she enjoyed participating.

We are hoping that her getting involved in band will help. We think if she can find something she likes that she can focus on her life will be much happier (FM 1/1).

Keeping busy helps a lot. The more time spent on a project or activity, the less time there is for the person to sit inside their own head and think about all the things that make them depressed. Keeping busy can also help them find new interests and passions to occupy their minds when there is, inevitably, nothing else to do (FM5/3).

Other family members speculated about the difference that having a purpose or goal might have in their daughters’ life.

She is on an anti-depressant med [medication], but I believe if she set reasonable goals, she may no longer feel depressed (FM 3/1).

Encouragement from family and friends [is crucial]. Trying small tasks outside her comfort zone and realizing small successes that give hope for more success (FM 5/1).
Finally one husband shared that he believed his wife’s disability would contribute to her purpose and subsequent success.

The day she has a showing at an art gallery. It would be her first truly big break into the art world. And undeniable proof of what all of us who love her already know. She is amazingly talented, in part because of her so-called “disability,” and deserving of respect and even admiration (FM5/2).

All five of the family members spoke about the need to have a purpose in life, or at least a reason to wake up in the morning. The priority of assisting a young adult to find a purpose in life will be addressed in chapter five.

**Social Support**

Another concept spoken of by all five family members was the importance of support, particularly social support. This finding supports earlier research that suggested that the key to being able to cope with the onset of a disability was the presence of a strong support system (Berkman & Syme, 1979; Cohen, 2004; Cohen & Willis, 1985; Gremore et al., 2011).

Four of the interviewed family members stated concern because of the lack of social support from anyone outside of the family unit.

She has me and my husband, her two sisters, my extended family and my husband’s extended family. My family is great, but his family tends to get frustrated with her easily and often. She tends to fight a lot with her sister, but I think that is just a normal sibling rivalry. Her peers treat her pretty much the same for now, but I think that they are beginning to notice that she is different and always going to be different moving forward. I am worried she will lose them, or worse that they will start being mean or cruel to her (FM2/1).

They [peers outside of the immediate family unit] don’t really understand her. I don’t fully understand all of her issues and triggers and what she is and isn’t capable of dealing with, so I very much doubt that anyone who hasn’t loved with her could. However, most people have the mentality of, “if it’s different, it must be wring,” so they don’t even try to understand (FM4/3).

She was not as social as her peers because of her peers, so she is often more isolated (FM5/1).
The only support system is her father and I. Most of her and our supportive friends left long ago. The only contact she seems to have socially is on Facebook (FM3/1).

All 4 of the individuals take medication for depression. Could this data indicate a link between depression and the lack of social support for individuals in this population? Even more so, the final family member of an individual in this population who does not take an anti-depressant reported a strong support system that just continues to grow.

I would describe his support system to be very strong. He knows and connects with a lot of people anywhere he goes; therefore, he has support everywhere. He is very much extroverted, so people just naturally gravitate to him. Family support is very heavy, not only in America, but back in Nigeria as well. His life that has been created in Oklahoma has been the largest support because of all the work he has put in Tulsa [building a community of family and friends]. His friends that have turned into family have been able to hold him down along with his father which has been very great. He has become a leader in Tulsa working with the church he attends and creating a brotherhood group with him and his friends to just develop the relationship amongst them to uplift and encourage one another (FM1/2).

Finally, one husband shared the importance of utilizing the support system that is in place for that individuals.

One of the problems seems to be that the whole rest of the world seems to be against them. That's a lot of weight and pressure to bear. A strong support system is absolutely necessary to help them bear that weight until they can get help in lessening it. Even then, that support system is needed to prevent them from piling the weight right back on. Sometimes, though, the problem isn't a lack of support system, it's that they don't utilize the support they have. This one is a little harder for me to understand. I have never been afraid of not belonging. However, I know that for my wife, the thought of having nowhere to belong brings her to tears. She has to fit in somewhere, or she feels incredibly lonely, and that loneliness causes great emotional distress and depression. I suppose it kinda goes back to the need for a support system. The whole world is a lot of weight to carry, and if you're all alone, you have no one to share the burden with. It's not a pleasant place to be. (FM5/3).

**Having an Outlet to Express One’s Feelings**

The third and final theme that emerged from the data from the interviews of family members is having an outlet to express one’s feelings. All three family members interviewed placed specific importance on having someone to vent to when the individual simply needed to
be heard. This finding supports research that suggests that the key to suicide prevention lies in having an outlet to express one’s frustrations and emotions (Chan et al., 2009; Cohen, 2004).

Two family members went so far as expressing that the presence of a confident was the key ingredient to rebuilding morale following the onset of a disability.

I believe that family and the people around you are the best way to handle and cope with any new situation. Having people to talk to and enjoying the life that you are blessed to have with family and friends will go a long way with keeping a high morale and spirit (FM1/3).

Professional counseling with expertise [in this population] and having friends at church [are important] (FM5/1).

She has me. I am not the best possible support to have arounds, as I think very differently from her, and I don’t always understand exactly what she needs or what she is trying to do. I have gotten better over the years; as she has worked with me to help me better understand. I am still not great, but we are working on it. She has her mother, whom she sometimes has to go to when my thick skull simply cannot fathom what she needs. She also has her best friend, who always supports her whenever she needs it, and in ways I am not always capable of doing, it does get pretty bad, sometimes even to the point that she disassociates and retreats into herself for a time. However, between the three of us, we are always able to help her back on her feet (FM4/3-4).

Another family member suggested that her daughter actually felt better physically and reported better outcomes when she had the opportunity to speak with anyone that has taken the time to bond with her daughter.

I believe that all therapists, both mental and physical, should really get to know their clients. When they [therapists] spend more time with my daughter she tends to behave differently and not act out so much (FM2/2).

Summary

As a result of these interviews, an anomaly was presented in regards to attitudes of the family members and subsequent anti-depressant usage by the family member with the disability. Of the three family members interviewed, two expressed negative views towards the disability and the future of their adult child. Both of these people with the disabilities also took anti-depressant medication to cope with reoccurring depressive issues. The third family member,
however, was extremely optimistic, going so far as to describe the disability as a “blessing” (FM1/2). Not only did this family member’s brother not take medication for anti-depressants, but he reported never feeling like he needed help with depression issues.

From the analysis of interviews with the family members of people who have experienced the sudden onset of a disability at a young age, family members believe that the most important tools for suicide prevention for their loved one include; having a purpose having a strong support system, and having an outlet when one needs to express frustrations or worries. It was apparent that all family members want to see their loved one succeed in life and be happy. Some were more optimistic than others, but all saw a need for these concepts in regards to successful rehabilitation and suicide prevention.

Observations from Sassin and Associates (OBS2) and the Center (OBS1) supported these findings as well. It was apparent that those people in these agencies that had the ability to utilize all three of these tools were faring better in regards to outcomes then those whom remained isolated. Documents procured from the Rehabilitation Center (DOC1), Precise Services (DOC2), and the Community Rehabilitation Center (DOC3) also report success with similar programs.

Rehabilitation Professionals

The major themes that emerged from the data collected and analyzed by the five rehabilitation professionals interviewed included (a) seeing a person first, instead of the disability, (b) support, (c) purpose. This section provides data from interviews, observations, and collected documents to meet triangulation, as well as support the major themes.

Through the process of open coding, axial codes began to emerge from the data provided by the rehabilitation professionals. The axial codes were combined, analyzed and narrowed in
order to develop the major themes. Figure 4.2 identifies a sample of the open codes and the three axial codes discovered in the data provided from the rehabilitation professionals.

Figure 4.2. Axial and sample of open codes from rehabilitation professionals.

**Descriptive Matrix**

Table 4.4 is a conceptually clustered descriptive matrix, which provides a visual display of the axial codes, or major themes, that have emerged from the data obtained from the individuals in this population in this study. Data in this matrix represents standardized, open-ended interviews. Each conceptually clustered matrix is followed by additional data obtained from observations and document collection which also support the major themes.
Table 4.4

*Descriptive Matrix: Axial Codes of Rehabilitation Professionals*

<table>
<thead>
<tr>
<th>Participant</th>
<th>Goals</th>
<th>Emotional Support</th>
<th>Being Seen as a Person Not a Disability</th>
</tr>
</thead>
<tbody>
<tr>
<td>RP1</td>
<td>On a positive and productive pathway that will lead to the goal.</td>
<td>The fact that someone cares about them. It is shown by what is said, but not only that, but what is done.</td>
<td>See themselves as a person first. Then as a person with a disability.</td>
</tr>
<tr>
<td>RP2</td>
<td>Having a job makes them happier people every day.</td>
<td>I believe that it [rehabilitation] is more effective with someone to talk to.</td>
<td>Really get to know your clients. Think of them as family or a close friend.</td>
</tr>
<tr>
<td>RP3</td>
<td>Keep your head up, look forward, don’t look back on your past.</td>
<td>Positive supports. Church family, one neighbor and an ex-marine that are good friends.</td>
<td>Do not treat your clients like kids.</td>
</tr>
<tr>
<td>RP4</td>
<td>Pray that God gives you the strength to continue with life and stay busy doing something.</td>
<td>Family and friends are a big inspiration. It means a lot just to know that someone has your back.</td>
<td>Don’t treat anyone differently. If anything support and encourage more.</td>
</tr>
<tr>
<td>RP5</td>
<td>Keep moving forward.</td>
<td>A support system is very effective, especially those including doctors, family and friends.</td>
<td>Friends do not think twice about making adjustments to accommodate the disability.</td>
</tr>
</tbody>
</table>
Goals

Upon open coding the data and further reviewing and analyzing the axial codes, the first major theme that emerged was Purpose. All five rehabilitation professionals placed a great deal of emphasis on feeling like they had a purpose in life following the disabling incident. This finding supports earlier research that suggested that activities with peers helped to determine whether young adults could effectively deal with stressors related to the disability (Dumont & Provost, 1998). In essence, these interviews indicated that having a purpose, or at least something to do, helps them to more effectively mitigate the stressors associated with adjustment to a life with a disability.

One of the interviewees placed a greater emphasis on keeping busy or finding ways to occupy spare time, in this way alleviating subsequent depression.

I prayed that God would give the strength to continue with life. It is also important to stay busy doing something (RP4/2).

Others emphasized the importance of an actual goal and having that goal to focus on to alleviate depression.

I believe that clients want independence so badly that they come for services so that they may omit their own inadequacies (RP1/1).

Having a job makes my clients happier people every day (RP2/1).

Keep your head up, look forward, and don’t look back on your past (RP3/1).

Take one day at a time. Take it easy and don’t rush (RP5/2).

Emotional Support

Another code determined by all of the rehabilitation professionals is the importance of support, more specifically emotional support. This finding supports earlier research that indicated that the key to being able to cope with the onset of a disability was the presence of a
strong support system (Berkman & Syme, 1979; Cohen, 2004; Cohen & Willis, 1985; Gremore et al., 2011).

All five of the rehabilitation professionals expressed similar views concerning the importance of social support in regards to the alleviation of depressive symptoms, as well as the rehabilitation process in general.

It is crucial to have friends who understand that this particular individual is limited in activities and make adjustments to include them (RP5/1).

I believe that it is very effective to always have someone to talk to (RP2/1).

Family and friends are a big inspiration. It means a lot just to know that someone has your back (RP4/2).

Whether its church family, neighbors, or friends, positive supports are the key (RP3/2).

The fact that someone cares about them and is shown by what they say, but not only that but what they do for that person (RP1/1).

**Being Seen as a Person Not a Disability**

The final point referenced by all 5 interviewed rehabilitation professionals is the desire to be seen as a human being rather than being judged by the disability. This finding negates the research previously conducted regarding whether or not individuals with disabilities should have the right to physician-assisted suicide. Much research implies that the general public favors the decriminalization of physician assisted suicide in this population, which suggests that the general public does not value a person with a disability as much as a temporarily able-bodied individual (Angell, 1982; Batavia, 1997; Conwell & Caine, 1991; Koenig, 1993; Maris, 1982; Silverman, 2001; Wanzer, 1989).

Offer classes for others to learn more about the disability. Education is the key (RP5/3).

Seeing themselves as a person first. Then as a person with a disability (RP1/1).

Really get to know your clients. Think of them as family or a close friend (RP2/1).

Do not treat anyone differently. If anything encourage and support (RP4/2).
Do not treat the clients like kids (RP3/2).

Summary

From the investigation of interviews with the rehabilitation professionals, the conviction surfaced that the most important tools for suicide prevention include; having a purpose, having a strong support system, and being treated as a person of value, regardless of abilities. All five rehabilitation professionals had very strong opinions about their profession and how the job should be accomplished.

Observations from Sassin and Associates (OBS2) and the Center (OBS1) also reinforced these findings. It was apparent that those people in these agencies that had the ability to utilize all three of these tools were faring better in regards to outcomes then those whom remained isolated. The people with disabilities who were choosing to utilize the services offered by both organizations were experiencing positive outcomes. In other words, they were the people choosing a vocational goal (purpose) and engaging in social situations (support). Documents obtained from the Rehabilitation Center (DOC1), Precise Services (DOC2), and the Community Rehabilitation Center (DOC3) also report success with similar programs, particularly in regards to vocational and social programs.

Individuals in this Population

The major themes that emerged from the data collected and analyzed by the three individuals in this population interviewed included (a) purpose, (b) support, (c) to be seen as a person not a disability. This section provides data from interviews, observations, and collected documents to meet triangulation, as well as support the major themes.

Through the process of open coding, axial codes began to emerge from the data provided by the family members. The axial codes were combined, analyzed and narrowed in order to
develop the major themes. Figure 4.3 identifies a sample of the open codes and the three axial
codes discovered in the data provided from the family members.

![Figure 4.3. Axial and sample of open codes from individuals in this population.](image)

**Descriptive Matrix**

Table 4.5 is a conceptually clustered descriptive matrix, which provides a visual display
of the axial codes, or major themes, that have emerged from the data obtained from the
individuals in this population in this study. Data in this matrix represents standardized, open-
ended interviews. Each conceptually clustered matrix is followed by additional data obtained
from observations and document collection which also support the major themes.
Table 4.5

*Descriptive Matrix: Axial Codes of Individuals in this Population*

<table>
<thead>
<tr>
<th>Participant</th>
<th>Moving On</th>
<th>Support</th>
<th>Being Seen as a Person Not a Disability</th>
</tr>
</thead>
<tbody>
<tr>
<td>PWD1</td>
<td>I have to do what is best for me because everything I do now affects my future.</td>
<td>I have a lot of support from family members and friends. In fact, the entire family has become closer now</td>
<td>I can still go everywhere with my friends and girlfriend.</td>
</tr>
<tr>
<td>PWD2</td>
<td>I imagine a life that is full because I am able to help other people.</td>
<td>I have immediate friends whom I consider family, starting with my close group of five guys, center friends I work out with, and people from my school.</td>
<td>Your disability does not define you, your disability is only a part of you.</td>
</tr>
<tr>
<td>PWD3</td>
<td>I feel more hopeful when I regain the ability to do something.</td>
<td>I have a jumble of people for support, friends, a bunch of family, friends at art, friends at gym and all kinds of places.</td>
<td>People see me in the chair unable to speak without assistance and unless they have been informed to reality, they treat me like I am two or have no brain.</td>
</tr>
<tr>
<td>PWD4</td>
<td>I look forward to having a fulfilling career and marriage someday.</td>
<td>I have an incredible family that supports me 100%. I also have a great medical team that give me hope and strength.</td>
<td>I would feel more comfortable with my diagnosis if people understood it. I am not always sure how people will perceive me.</td>
</tr>
<tr>
<td>PWD5</td>
<td>Recently I have been able to find places to go and feel connected; I look forward to more of that.</td>
<td>I’m lucky to have two great people to help me. I don’t think I would have made it this far without them.</td>
<td>My peers haven’t always understood. They have often treated me as a hindrance or like someone who is entertaining, but not fully there as far as a human connection. It is very alienating.</td>
</tr>
</tbody>
</table>
Moving On

Upon open coding the data and further reviewing and analyzing the axial codes, the first major theme that emerged was Moving On. All five people with disabilities placed a great deal of importance on feeling like they had a purpose in life following the disabling incident. This would support earlier research that suggested that activities with peers helped to determine whether young adults could effectively deal with stressors related to the disability (Dumont & Provost, 1998). In other words, these interviews indicated that having a purpose, or at least something to do, helps them to more effectively mitigate the stressors associated with adjustment to a life with a disability.

Several of the individuals interviewed expressed the importance of having a project, purpose or something to look forward to.

Keep working hard [to achieve your goals] (PWD1/1).

Keeping busy is important because if you don't keep busy you have time to think about your injuries/disabilities which tends to increase depression & therefore the odds of suicide go way up (PWD3/2).

Distraction is one of my main coping mechanisms. Without meaningful activity I fall prey to depression much more easily. I think feeling useful and productive is very important for any person not just someone with a disability (PWD4/2).

Keeping active has helped me a lot, but it hasn't always been something I have been able to do, or felt like I was able to do. Because of my disability, I have to pace myself carefully, so I can't always get out even if it will help me mentally. I also sometimes feel so depressed that nothing sounds interesting anymore. It has helped to keep something steady like a job, a weekly volunteer schedule, a class, or other recurring events because it helped me get out even when I didn't feel like it. And even if I didn't feel like going out, going out often helped. Being in one place doing nothing all the time gets me into a cycle of negativity and makes me get claustrophobic in my own head. I think the hardest thing is finding activities that I can do. I wish there was a resource for that (PWD3/3).

I imagine a life that is full because I am able to help other people (PWD2/1).

I look forward to more opportunities to be out in the community. I’m in a production at a community theater, and it has been really positive for the most part. Sometimes I’m unable to do the things, like hold a steady job, that get people out of the house every day.
But, recently, I’ve been able to find places to go and feel connected. I look forward to more of that (PWD5/1).

I look forward to having a fulfilling career and marriage someday (PWD4/1).

Another person expressed the actual psychological value of having a way to spend time.

I think one of the big things is just staying busy, so that I do not have time to sit and mope (PWD3/1).

Support

Another construct identified by all individuals is the importance of support, particularly social support. This finding supports earlier research that suggested that the key to being able to cope with the onset of a disability was the presence of a strong support system (Berkman & Syme, 1979; Cohen, 2004; Cohen & Willis, 1985; Gremore et al., 2011).

All five of these people placed importance on having key people in their lives for emotional and social support.

I have a jumble of people for support, friends, a bunch of family, friend at art, friends at gym, all kinds of places (PWD3/1).

I think it's very important to have a support system of people to trust and talk to. I feel very lucky to have a couple of people close to me that I can be very open with and know that they will listen and be encouraging. I know that not everyone has that opportunity, and honestly, I feel that there have been points in my life that without a strong support system would probably have led to a suicide attempt. I don't really know what people without that kind of support, which is unfortunately a luxury in our world, can do to find that kind of help. All I know is that I try to be available to friends who might be struggling and that I always try to encourage people who might be going through dark times. I think compassion is so important because there were times that I could have been helped so much by just a kind word when no one was there, and other times that it could have been much worse if I hadn't had people that I knew loved me (PWD5/3).

I have an incredible family that supports me 100%. I also have a great medical team that includes a psychiatrist and a psychologist that gives me hope and strength (PWD4/1).

A lot of support from family members and friends. A little more than before the accident because the family is all together now (PWD1/1).

My immediate support is my dad. He is also my caregiver. He helps me get dressed and helps with my bathing and care. Outside of that would be my immediate friends who I
consider family starting with my close group of five guys, center friends who I work out with, and people from school. My support group extends further than family to my colleagues. Is it effective? Absolutely. After my accident, I lost a lot of friends, that I thought were friends and that was hard, but ultimately I have been able to gain people that met me at the bottom and watched me climb. They have not missed a beat when it comes to helping me, even if it means they have to carry me or carry my chair. They don’t see me as burden (PWD2/1).

I believe that support in the form of a close-knit family, loving church/community family, and caring medical professionals is essential for the survival and success of any person with mental illness. I have been so blessed to have all three. Lacking support in any of these three areas makes a person vulnerable to stronger relapses and slower healing progress (PWD4/2).

Feeling like I belong has always been a huge struggle for me. Even now, I often question my purpose or why I think so differently from most people. It sometimes makes me feel useless or like I was put on this earth to wander and suffer. It's something I've never really figured out. I know that a lot of my depress stems from this, and usually keeping a focus on the people I do trust is what keeps me going. I am very blessed to know these people and again, don't know where I would be without them (PWD5/3).

One expressed what like felt like with and without a strong support system.

I have experienced some loss, mostly the loss of trust with people I considered friends. I always took it really hard because the worst thing to me is feeling alone. I dealt with it by writing, drawing, talking to my family—anything expressive. I cried a lot. I never told myself it wasn’t so bad, or that I was overreacting. I let it all out. Eventually I was able to move forward after taking all that grieving and using it to make decisions about how to do things differently. Unfortunately, I also sometimes turned to cutting myself. It felt like it reset all the negativity in my head long enough for me to think. Afterwards, I always felt guilty. I’ve developed some better skills, but it is still a temptation (PWD5/1).

My support system is mostly my husband and my best friend. I can’t always talk to my family any more about what I am dealing with because of religious differences, but I always have someone to talk to. That helps a lot. I also have a therapist that I use regularly. A lot of my processing in hard times is by venting, processing by taking time to draw or paint, and then talking about solutions and deeper meaning with people close to me. So far it has been really effective. I’m lucky to have two great people to help me. I don’t think I would have ever made it this far without them (PWD5/2).

This [having a strong support system] is important because head injuries increase one's self-consciousness enormously with all the disabilities & corresponding stares from others. Having a place where you belong gives you a break from it all & you can go back to being yourself and maybe half forgetting your issues for however long (PWD3/2)
Being Seen as a Person Not a Disability

The final point acknowledged by all 5 interviewed individuals is the need to be seen as a human being rather than being judged by the disability. This finding, closely aligned to these persons being viewed as human beings of value, negates the research previously conducted regarding whether or not individuals with disabilities should have the right to physician-assisted suicide. Much research suggests that the general public favors the decriminalization of physician-assisted suicide in this population, which suggests that the general public does not value a person with a disability as much as a temporarily able-bodied individual (Angell, 1982; Batavia, 1997; Conwell & Caine, 1991; Koenig, 1993; Maris, 1982; Silverman, 2001; Wanzer, 1989).

Your disability does not define you. I do not consider myself a spinal cord injury. I consider myself a man with a spinal cord injury. Something I always tell people is that your disability does not affect my ability to do anything. Yes, I know I cannot walk, but I can do other things. You have to focus on what you can do, not what you cannot do (PWD2/2).

It would really help if people would understand that I can’t always process things the same way they can. If people just understood that I go about things in a different way, and were willing to let me, it would be a lot better. I’ve gotten in trouble for drawing when I should be working, but really I am just needing to sketch to process what I was thinking about to move forward on the job. I also wish that people would understand that sometimes I get anxious or feel hurt and need to process that. I don’t think people want to understand. I think they just want to label me as “crazy” or “unstable” or “difficult” and move on (PWD5/1).

Being able to transcend one's diagnosis, if only for a short time, is vital. Living in the midst of disease every day is dehumanizing and unhealthy for anyone, mentally ill or otherwise. Having value and identity beyond a diagnosis reminds us that we are more than an anomaly or a burden (PWD4/2).

This [being seen as a person rather than the disability] is important because it can feel like you yourself are forgotten & just an injury. So therefore how could anyone miss something that's not really there? Making someone feel like an actual person could change their outcome (PWD3/2).

I sometimes feel like people will judge me for my diagnosis. It really took me a minute to get to get past the stigma of my OWN diagnosis, so it's very hard knowing others probably don't take it seriously. For me it's less about people treating me like a disability and more about people treating me like I should be able to snap my fingers and have no
problem at all It really takes away from the fact this is real. It affects me. It hurts me. And it hurts even more when people treat me like I can "get over it" (PWD5/3).

A lot of people just need to be able to see the future instead of just seeing that man that will not walk again (PWD1/1).

I would feel a lot more comfortable with my diagnosis if more people understood it. I don’t always feel comfortable sharing my diagnosis because I am not sure how others will perceive me (PWD4/1).

I would like to gain the ability to smack or spit on people who can see me in a chair and start treating or talking to me like a 2-year-old. Although I suppose being able to talk, and perhaps tell them off, would be more proper. People see me in the chair unable to speak without assistance and unless they have been informed me to reality, they treat me like I am 2 or have no brain. I have been looked down on plenty (PWD3/1).

Summary

From the analysis of interviews with the people in this population, the belief surfaced that the most important tools for suicide prevention include; having a purpose, having a strong support system, and being treated as a person of value, regardless of abilities. All five individuals interviewed had a mostly positive outlook in life, mostly thanks to having the support of family and friends that loved them for who they were regardless of the disability, as well as having goals and something to keep them busy.

Observations from Sassin and Associates (OBS2) and the Center (OBS1) also supported these findings. It was apparent that those people in these agencies that had the ability to utilize all three of these tools were faring better in regards to outcomes then those whom remained isolated. The people with disabilities who were choosing to utilize the services offered by both organizations were experiencing positive outcomes. In other words, they were the people choosing a vocational goal (purpose) and engaging in social situations (support). Documents obtained from the ReHabilitation Center (DOC1), Precise Services (DOC2), and the Community Rehabilitation Center (DOC3) also report success with similar programs, particularly in regards to vocational and social programs.
Summary of Chapter Four

To meet triangulation, I used interviews, observations and documents to collect data for this study. I open coded and analyzed the data to find axial codes, or major themes, which developed throughout my analysis. Standard, open-ended interviews were conducted with five family members, five rehabilitation professionals, and five individuals from this population. I observed two rehabilitation centers, and documents were collected throughout the study. All themes were confirmed by member checks by the participants of the study.

The axial codes were identified, displayed and additional data was presented to support the major themes. Three major themes developed from each group: family members, rehabilitation professionals, and individuals in this population. The axial codes, or major themes revealed were: (1) support, (2) purpose, (3) being seen as a person not the disability, and (4) having an outlet to express one’s feelings.

Selective codes, or major trends in the data, have been developed using these four axial codes. These selective codes, attached to literature from the field and verified by member checks, are utilized to demonstrate the process of grounded theory and answer my research question. In addition, recommendations to the discipline, as well as implications for future research, will be discussed in Chapter Five.
Chapter Five: Conclusions and Recommendations

Introduction

The purpose of this study was to ascertain what can be done in a differently in the field of rehabilitation to decrease, or potentially eliminate, suicidal ideation in young adults who have experienced the onset of a sudden disability. The intent of this study was to identify the best practices and contribute to the field of rehabilitation counseling. Structured open-ended interviews were completed with five family members of individuals in this population, five rehabilitation professionals, and five people in this population. I observed interactions at Sassin and Associates, as well as The Center. Documents to meet triangulation were collected at each stage of research.

Three primary groups of participants were a major part to this qualitative case study, including family members, rehabilitation professionals, and individuals in the actual population. Data were analyzed through open, axial, and selective coding. Data were organized and evaluated by hand to maintain intimacy with all data.

Chapter Five describes the grounded theory generated from this study, explains the findings and the relationship to the literature in the field, and answers the research question. In addition, recommendations to the field of rehabilitation and recommendation for further study are presented. Figures 5.1, 5.2, 5.3, and 5.4 display the selective codes and axial codes, or major themes, to support the findings, conclusions, and recommendations.

Grounded Theory

This qualitative study involved grounded theory. Strauss and Corbin (1998) state that grounded theory is “derived from data, systematically gathered and analyzed through the research process” (pg. 12). The grounded theory within this study materialized through an in-
depth analysis of data discovered through participant interviews, observation, and document collection. Data confirmed nine major themes, or axial codes, which influenced why people in this population are at high-risk for suicide. Four selective codes, or trends, emerged from the major themes, which explain the relationship of the grounded theory in this study to answer the research question. The three selective codes that developed from the data are: (1) support, (2) purpose, and (3) being treated as a person rather than a disability.

Subsequent to grounded theory, transferability between the researcher’s context of the study and the reader’s context of the study occurs. Instrumental utility, coherence, and insight assist the reader in making this determination. The reader asks several questions: Is this research applicable to me? How can I utilize the findings of this research? Can this study assist me in my professional career? In addition, the reader determines what, if any, facets of the study are actually valid. Instrumental utility will differ based on the reader’s context and personal experience. Coherence is also determined through asking several pertinent questions: Does this research make sense? Insight initiates the reader by asking what this study can tell me that I do not already know. This qualitative study may not be considered relevant to the entire field of rehabilitation, but hopefully will provide a framework to rehabilitation professionals who desire to learn more about suicide prevention for this at-risk population. The following illustration demonstrates the concept of transfer as it relates to the researcher’s context and the context of the reader:
Figure 5.1. Researcher context to reader context.

For transfer to occur between RC1 and RC2, emergent themes must be identified and summarized for the reader. In Chapter Four, the grounded theory began to emerge as a result of an analysis of the triangulation of data, including interviews, observations, and document collection. As a result of the step-by-step analysis of data, selective codes emerged which clarify and support the relationship of the grounded theory in this study to the research question.

**Discussion: Theory One**

The first selective code to emerge is support. Support was supported by three axial codes, mentioned by every participant interviewed for the purpose of this study. Figure 5.1 displays a conceptual design of the axial codes supporting the selective code of support.
Figure 5.2. Conceptual diagram—selective code: support.

Support

As indicated, Figure 5.1 clearly illustrates the importance of support in regards to psychosocial adjustment to disability as well as alleviating depression and suicidal ideation. Data indicated that all people, namely family members, rehabilitation professionals, and people in this population, stressed the importance of a strong support system for optimal mental health following the onset of sudden disability.

Horowitz, Reinhardt, Boerner, and Travis (2003) found that being unmarried, having poorer relationships with family members and having lower stability in friendships were at a significant risk for developing depression or suicidal ideation. From the data, all three groups of participants confirmed this finding by expressing the importance of a strong support network when coping with the onset of a disability, especially in the age range specified.
This is not the first time that social support has been mentioned in the literature regarding adjustment to disability. Social support is a vital component to consider in regards to depression and functional disability. Social support theory (Wills & Fegan, 2001) suggests that social support has both a direct and indirect impact on a variety of life dimensions, including health concerns such as morbidity and mortality. Indeed, individuals with disabilities whom report poor quality relationships are consistently associated with a greater number of depressive symptoms (Koenig, Hays, George, Blazer, & Larson, 1997; Oxman, Berkman, Kasl, Freedman, & Barrett, 1992; Reinhardt, Benn, Boerner, & Su, 2001) and greater functional impairment (Berkman, 1995; Steffens, Hays, & Krishnan, 1999; Travis, Lyness, King, & Cox, 2001). Therefore, investigating the affective qualities of people’s with disabilities relationships is a particularly productive area of social support research in understanding depression as well as overall adaptation to the onset of a sudden disability.

The concept of support, important enough to be mentioned by every participant in this study, but not necessarily new to the field of rehabilitation took on the task of addressing different needs for the different individuals in this population. The concept of support went from caregiver to church friends, to neighbors, to workout buddies. The concept was clear, the more love and acceptance an individual in this population maintained, the better the outcomes.

Several participants revealed that many people that they believed to be supportive friends and family abandoned them, but when given the option to reconnect with society, such as church, art class, or the gym, many found social support in other ways and in new people that seemed even more supportive in nature than the ones that were lost following the disabling incident. The significance of having someone that cares about you, in regards to suicide prevention, was an
overwhelming theory in this study. In short, the more people that care and support the individual, the better the outcome.

An anomaly was also found in regards to social support. In the interviews it was found that those individuals in this population, who reported a strong support system, also reported not needing medication for depression. Inversely, those who reported not having a strong support system all relied on medication for depression. This finding supports previous research that suggests that social isolation can make depression worse (Lewis, Bates, Posthuma, & Polderman, 2014).

**Discussion: Theory Two**

The second selective code to emerge is purpose. Purpose was supported by three axial codes, and again, mentioned by every participant interviewed for the purpose of this study. Figure 5.2 displays a conceptual design of the axial codes supporting the selective code of purpose.
Figure 5.3. Conceptual diagram—selective code: purpose.

**Purpose**

As indicated, Figure 5.2 demonstrates the importance of purpose in regards to psychosocial adjustment to disability as well as alleviating depression and suicidal ideation. Data indicated that all people, namely family members, rehabilitation professionals, and people in this population, stressed the importance of finding a life’s purpose for optimal mental health following the onset of sudden disability.

Literature suggests that accomplishing something meaningful every single day has been shown to be closely associated with perceived health, well-being, quality of life, self-mastery, and social interaction among people with disabilities (Bejerholm & Eklund, 2007; Eklund & Leufstadius, 2007). Spending more time in work or education and less on sleep, which is a common problem for people adjusting to the onset of a disability, has shown to be related to better health and functioning (Eklund & Leufstadius, 2007; Leufstadius, Erlandsson, & Eklund,
An ongoing and high level of occupational engagement in general has been found to be associated with wellness and better mental health (Bejerholm & Eklund, 2006, 2007). Moreover, having routines and a daily rhythm following the light-dark cycle has shown to be important to individuals with disabilities (Leufstadius, Erlandsson, Björkman, & Eklund, 2008) and to promote social interaction and mastery (Leufstadius et al., 2006). Thus, occupational patterns characterized by work-related occupations, ongoing occupational engagement without long periods of nothingness, and a daily rhythm that follows the light-dark cycle are related to well-being for people with disabilities. Also, quiet activities may be beneficial if they function as a break between activity peaks, but detrimental if they form the only or dominating option for filling time (Bejerholm & Eklund, 2006).

Data from this study supports the notion that when a person has a purpose, he or she have a life with meaning and hope. Some individuals, especially those that are people from the population, interviewed elaborated on the idea of a grand purpose, a calling from God, or a reason that the disabling incident occurred. Others, especially the rehabilitation professionals and family members, just saw the importance of keeping busy to avoid thoughts of depression, hopelessness or suicidal ideation. All study participants put great value on having a purpose, or simply something to do. The concepts of oversleeping or isolating were suggested as pathways to depression and subsequent suicidal tendencies.

**Discussion: Theory Three**

The third selective code to emerge is being seen as a person rather than a disability. This selective code was supported by two axial codes, and mentioned by many of the participants, particularly the rehabilitation professionals and the individuals in this community interviewed for
the purpose of this study. Figure 5.3 displays a conceptual design of the axial codes supporting the selective code of being seen as a person rather than a disability.

![Conceptual diagram](image)

*Figure 5.4. Conceptual diagram—selective code: being seen as a person rather than a disability.*

**Being Seen as a Person Rather Than a Disability**

As indicated, Figure 5.3 demonstrates the importance of being seen as a human being of value in regards to psychosocial adjustment to disability as well as alleviating depression and suicidal ideation. Data indicated that rehabilitation professionals, and people in this population, stressed the importance of being seen as a person rather than a label or diagnosis for optimal mental health following the onset of sudden disability.

Literature suggests that a strong link exists between being labeled with a disability and poor mental health outcomes. According to Tucker (2010), much interest lies specifically on the effect that words have on the quality of human life when those words are used to label
disabilities, or more importantly the people with those disabilities. Although individuals are not responsible for the behavior of others, each person is responsible for the impact that his or her words may have on their behavior—especially when they become aware of how the words that they choose may be experienced by people who hear them. Perhaps no more potentially dangerous words exist than those that choose to label another human being. Much of what is published in the field of rehabilitation deals with the ethical, if not moral, realities of malpractice in this profession that should be most concerned with basic human rights; this being said it is crucial to remember that disability rights are human rights.

Data from this study proposes that when an individual in this population is seen as “that guy in a wheelchair” or “that girl with a brain injury” they experience a devaluation of humanity that can lead to depression and subsequent suicidal thoughts. Interventions focusing on value, compassion, and education could be the key ingredients in mitigating the effects of depression and suicidal ideation for this community.

**Summary of Findings**

The purpose of this study was to investigate the phenomenology, or the lived experience, of suicidal ideation for people age 18-24 that experience a sudden disability. Data indicates that the influences which affect depression and subsequent suicidal tendencies are found in three primary trends: (1) Support, (2) Purpose, and (3) Being seen as a person rather than a disability. Each of these trends is supported by axial codes and open codes from triangulation of the data, including standardized open-ended interviews, observations and document collection. Together, the major themes build on each other to support the influences directly affecting suicidal ideation for this population.
Interpretation of the Data

Through open, axial and selective coding, a thorough analysis developed nine major themes, which enabled me to develop three selective codes, or major trends. The three selective codes, as displayed in Figures 5.1, 5.2 and 5.3, provided the answer to my research question.

Research Question

People with disabilities are at a higher risk for suicide than their non-disabled counterparts. This is especially true with young individuals living with a disability. Suicide is an enormous problem faced by the rehabilitation community. Previous research suggests that the suicide rate and attempted suicide rate for individuals aged 18 to 24 who have experienced a permanently disabling incident to be high. Despite various intervention techniques, why is the attempted and completed suicide rate in people aged 18-24 who have experienced a disabling condition still so high?

The influences affecting suicidal ideation for this population include: (1) Support, (2) Purpose, and (3) Being seen as a person rather than a disability. Support includes having the social support of friends and other meaningful relationships. It also encompasses emotional support and having someone to talk to about anything. Finally, the participants also acknowledged the danger of isolating from society and truly becoming alone.

All 15 participants placed emphasis on having a purpose in live following the onset of a disability. Many also noted that keeping busy kept the mind free from being caught up in depressive thoughts and memories. Regardless, feeling like one has something to truly live for was a keep component in maintain good mental health and avoiding suicidal thoughts.

Lastly, and perhaps most important to the individuals in this population and the rehabilitation professionals interviewed, is being seen as a person rather than a label or a
disability. Individuals in this population feared being trapped as “that person in a wheelchair” and wanted to be seen for who they were rather than the accommodations they needed for everyday life.

**Recommendations to the Field**

**Introduction.** The purpose of this study was to determine the influences that affect the phenomenology of suicidal ideation for young people that acquire a new and sudden disability. Rehabilitation professionals, rehabilitation students, family members and individuals in this population comprise the primary audience for this dissertation. This research is relevant to five groups of potential readers: policy-makers, family members, and rehabilitation professionals and students, and family members.

This section includes recommendations that should be implemented to help save the lives of the young people who experience a new and sudden disability. For rehabilitation professionals, this research has the foundation to serve as catalyst for change in the rehabilitation field.

**Recommendations to policy makers.** Policy-makers at the federal, state and local levels should continue providing rigorous goals and expectation for their rehabilitation agencies and communities. Many people with disabilities, often from disadvantaged backgrounds, often without a public voice, rely on policy-makers to approve policy ensuring effective leadership, quality professionals, and more positive outcomes for all people with disabilities. I also recommend that all policy-makers provide more opportunities for financially-limited individuals with disabilities to receive quality supports and services, ensuring that they are viewed as people of value, regardless of the accommodation present to function in everyday life.
Recommendations to family members. Based on this study, suicide for this population is avoidable. However, I recommend that family members get involved in the rehabilitation community and demand higher standards of care for their loved ones, especially in the form of supports and programs. Family members need to also ensure their loved ones that they are loved, valued and seen as the people that they are, rather than the disability.

Recommendation to rehabilitation professionals and rehabilitation students. I recommend that rehabilitation professionals and future rehabilitation professionals do the same thing that the rehabilitation professionals in this study committed to—being willing to change the way rehabilitation services and supports are provided in the best interest of the client. This could be as simple as monitoring the nomenclature used. Use words that empower and fill the clients with value and confidence. Look up from the computer screen, make eye contact and smile. Treat all clients the way that you would want to be treated if you were to experience a sudden disability.

Recommendations for Further Research

Introduction. Considering the limitations of this study, I was unable to address all the struggles faced by young adults facing the onset of a sudden disability. Therefore, I recommend further research in the following areas:

1. In order to expand this study, consideration should be given to children and teens that experience the onset of a sudden disability. The study should focus on the phenomenology of suicidal ideation in children and teens to see if transferability exists. Suicide has become much more common in children than it was in years past. In the United States, for children under age 15, about one or two out of every 100,000 children will commit suicide. For those 15-19, approximately 11 out of 100,000 will commit
suicide. Suicide is the fourth leading cause of death for children ages 10-14 and the third leading cause of death for teenagers 15-19. If a child has depression, he or she is seven times more likely to try suicide than his or her non-depressed peer. About 22% of depressed children will attempt suicide (Gluck, 2013).

2. I recommend a follow up study on the rehabilitation professionals in this study to see if the small changes in how they began to treat their clients had an impact on mental health outcomes. These “small changes” could include: (1) smiling more frequently, (2) making more eye contact, (3) looking away from the computer, and (4) treating clients as people rather than a disability.

3. I recommend a study recruiting participants of different minority groups. This study would allow the formulation of best practices for minority groups; furthermore, it would explore the phenomenon of suicide among various cultures. Despite the fact that the white population commits suicide nearly twice as much as minority groups, statistics may change when disability is incorporated into the equation (Burns, n.d.).

4. I recommend a study of state and federal funds. A particular study could be focused on supports and programs that are funded for the rehabilitation program, and whether they are monies well spent, or better spent on newer, more innovative interventions. Some programs, such as Arkansas PROMISE, are already offering new supports to see if outcomes are better with the young adult population.

Conclusion

Two years ago, I sat at a lunch meeting with colleagues from state and private rehabilitation agencies, sadly discussing the passing of a client whom had taken his life. Much to my shock, my colleagues began expressing that they also would chose to end their lives if they
were to experience a sudden disability in the prime of their life. This revelation both saddened
and horrified me, and I desperately wanted to change their minds.

This qualitative phenomenological inquiry focused on these agencies, particularly the
professionals, clients and family members of the clients of these agencies. Through interviews,
observations, and document collection and data from 15 participants, three primary influences
emerged, including: (1) Support, (2) Purpose, and (3) Being seen as a person rather than a
disability. These three trends were supported by nine major themes.

The focus in this study is suicidal ideation. Having support and purpose was
demonstrated as invaluable to all participants. Being seen as a valuable member of society was
focused exclusively on by the individuals in this population as well as the rehabilitation
professionals. I learned from this study best practice in rehabilitation, ways to show support to
those who need it, paths to a purpose, and remembering to always see others as people of value,
despite limitations. I was also rewarded by witnessing firsthand the change of heart in my
colleagues, as they watched their clients transform from a case number to a friend.

Truly, all lives are valuable, and everyone matters. Regardless of ability, or color, or
religion, all people have the power to make a difference and change their sphere of influence. I
congratulate all of my participants and friends who have found their purpose and are living
happy and fulfilling lives. Furthermore, I applaud my students and colleagues who have realized
the value in one another, and will continue to pass the torch of this knowledge to others, like the
ripples in a pond.
References


Appendix A

Informed Consent Form

University of Arkansas

Department of Rehabilitation Studies & Research

Informed Consent for Participants

Study Name: Instilling Hope: Showing Individuals with New Disabilities between the ages of 18 and 24 That Suicide is Not the Answer

Principal Investigator: Christine Ann Whiting

Faculty Supervisor: Dr. Brent Williams

PLEASE READ THIS DOCUMENT CAREFULLY. YOUR SIGNATURE IS REQUIRED FOR PARTICIPATION. YOU MUST BE AT LEAST 18 YEARS OF AGE TO GIVE YOUR CONSENT TO PARTICIPATE IN RESEARCH. IF YOU DESIRE A COPY OF THIS CONSENT FORM, YOU MAY REQUEST ONE AND WE WILL PROVIDE IT.

The policy of the Department of Rehabilitation is that all research participation in the Department is voluntary, and you have the right to withdraw at any time, without prejudice, should you object to the nature of the research. You are entitled to ask questions and to receive an explanation after your participation.

Description of the Study:

This is a qualitative study in which participants will be interviewed about their feelings towards how to eradicate suicide among people with disabilities. Those interviewed will include
people with disabilities, rehabilitation professionals and family and friends of people with disabilities.

Nature of Participation:

Each participant will be interviewed one time, but will also possibly be contacted for clarification and follow up.

Purpose of the Study:

The purpose of this study is to determine what can be done differently in the field of rehabilitation to prevent suicide in young adults who experience a disabling condition.

Possible Risks:

a) Participants may find the subject matter unpleasant, upsetting, or otherwise objectionable. For instance, most people do not like to think about a loved one considering suicide.

b) Participants will be asked to provide personal and confidential information.

Possible Benefits:

a) When your participation is complete, you will be given an opportunity to learn about this research, which may be useful to you in your course or in understanding yourself and others.

b) You will have an opportunity to contribute to psychological science by participating in this research.
Confidentiality:

You will be assigned a code number which will protect your identity. All data will be kept in secured files, in accord with the standards of the University, Federal regulations, and the American Psychological Association. All identifying information will be removed from questionnaires as soon as your participation is complete. No one will be able to know which your questionnaire responses are. Finally, remember that it is no individual person's responses that interest us; we are studying the usefulness of the tests in question for people in general.

Opportunities to Question:

Any technical questions about this research may be directed to:

Principal Investigator: Chrissy Whiting

Any questions regarding your rights as a research participant or research-related injuries may be directed to UARK's Office of Research, Ethics, and Compliance.

Opportunities to Withdraw at Will:

If you decide now or at any point to withdraw this consent or stop participating, you are free to do so at no penalty to yourself. You are free to skip specific questions and continue participating at no penalty.

Opportunities to be Informed of Results:

In all likelihood, the results will be fully available around October 1, 2015. Preliminary results will be available earlier. If you wish to be told the results of this research, please contact:

Principal Investigator: Chrissy Whiting
She will either meet with you or direct you to where you can read a copy of the results. In addition, there is a chance that the results from this study will be published in a scientific journal, which would be available in many libraries. In such an article, participants would be identified in general terms as undergraduate students at a large state university.

Your signature below indicates that you voluntarily agree to participate in this study.

Dated this ______________ day of (month) ______________, 20 __

_________________________________ __________________________
Signature of Participant Signature of Person Obtaining Consent.
Appendix B

IRB Protocol

Informed Consent Form

University of Arkansas
Department of Rehabilitation Studies & Research

Informed Consent for Participants

Study Name: Instilling Hope: Showing Individuals with New Disabilities between the ages of 18 and 24 That Suicide is Not the Answer

Principal Investigator: Christine Ann Whiting

Faculty Supervisor: Dr. Brent Williams

PLEASE READ THIS DOCUMENT CAREFULLY. YOUR SIGNATURE IS REQUIRED FOR PARTICIPATION. YOU MUST BE AT LEAST 18 YEARS OF AGE TO GIVE YOUR CONSENT TO PARTICIPATE IN RESEARCH. IF YOU DESIRE A COPY OF THIS CONSENT FORM, YOU MAY REQUEST ONE AND WE WILL PROVIDE IT.

The policy of the Department of Rehabilitation is that all research participation in the Department is voluntary, and you have the right to withdraw at any time, without prejudice, should you object to the nature of the research. You are entitled to ask questions and to receive an explanation after your participation.

Description of the Study:

This is a qualitative study in which participants will be interviewed about their feelings towards how to eradicate suicide among people with disabilities. Those interviewed will include
people with disabilities, rehabilitation professionals and family and friends of people with disabilities.

Nature of Participation:

Each participant will be interviewed one time, but will also possibly be contacted for clarification and follow up. These interviews will be recorded and transcribed verbatim and will last approximately one hour. All follow up will be in the form of emails and/or phone calls. All recordings will be destroyed following the completion of this study. The recordings will be transcribed with a code, and any name references removed or replaced with pseudonyms. The code linking the participant’s name with their responses will be destroyed at the end of the study.

Purpose of the Study:

The purpose of this study is to determine what can be done differently in the field of rehabilitation to prevent suicide in young adults who experience a disabiling condition.

Possible Risks:

a) Participants may find the subject matter unpleasant, upsetting, or otherwise objectionable. For instance, most people do not like to think about a loved one considering suicide. A resource list will be provided if follow-up counseling is needed.

b) Participants will be asked to provide personal and confidential information.
Possible Benefits:

a) When your participation is complete, you will be given an opportunity to learn about this research, which may be useful to you in your course or in understanding yourself and others.

b) You will have an opportunity to contribute to psychological science by participating in this research.

Confidentiality:

You will be assigned a code number which will protect your identity. All data will be kept in secured files, in accord with the standards of the University, Federal regulations, and the American Psychological Association. All identifying information will be destroyed upon completion of this study.

Opportunities to Question:

Any technical questions about this research may be directed to:

Principal Investigator:

Christine Whiting

Faculty Advisor:

Dr. Brent Williams btwilli@uark.edu 479-575-4758

GRAD154

University of Arkansas

Fayetteville, AR 72701
Internal Review Board (IRB):

Iroshi (Ro) Windwalker, CIP       irb@uark.edu         479.575.2208
IRB/RSC Coordinator
Research Compliance
109 MLKG Building
Fayetteville, AR 72701

Any questions regarding your rights as a research participant or research-related injuries may be directed to UARK's Office of Research, Ethics, and Compliance.

Opportunities to Withdraw at Will:

If you decide now or at any point to withdraw this consent or stop participating, you are free to do so at no penalty to yourself. You are free to skip specific questions and continue participating at no penalty.

Opportunities to be Informed of Results:

In all likelihood, the results will be fully available around January 1, 2015. Preliminary results may be available earlier. If you wish to be told the results of this research, please contact:
Principal Investigator: Christine Whiting

She will either meet with you or direct you to where you can read a copy of the results. In addition, there is a chance that the results from this study will be published in a scientific journal, which would be available in many libraries. In such an article, participants would be identified in general terms with no identifying characteristics.

Your signature below indicates that you voluntarily agree to participate in this study.
Mental Health Resource List

Associated Centers for Therapy 918-492-2554
Family & Children’s Services 918-587-9471
Indian Health Care Resource Center 918-382-1241
Mental Health Association 918-585-1213
Parent Child Center 918-599-7999
Tulsa Center for Behavioral Health 918-293-2100
Tulsa Vet Center 918-628-2760
Youth Services of Tulsa 918-582-0061

This information is provided solely for your convenience. The University of Arkansas provides no endorsement or guarantee of the services provided by these facilities.
Appendix C

Interview Questions

1. When you imagine what the rest of your (his or her) life looks like going forward, what do you imagine?

2. What do you think would help you (him or her) feel more comfortable adjusting to the way life is now, as opposed to the way it was before the accident?

3. What do you think would make you (him or her) feel more hopeful or optimistic towards the future?

4. Describe one thing that you are looking forward to (for him or her).

5. Have you ever experienced loss in your life before the accident and how did you deal with it?

6. Describe your (his or her) current support system. Is it effective in helping to deal with the current situation?

7. How have you (he or she) been treated differently by your (his or her) peers since the accident?

8. Have you (he or she) experienced bullying or teasing?

9. Do you think medication would help in regards to coping with the new situation?

10. What could be done differently be rehabilitation professionals to make this transition easier on you (him or her)?

11. How would you advise a person in your (his or her) situation to find hope going forward?

12. How would you convince an individual in this situation to not commit suicide?
MEMORANDUM

TO: Christine Whiting
Brent T. Williams

FROM: Ro Windwalker
IRB Coordinator

RE: New Protocol Approval

IRB Protocol #: 15-09-124
Protocol Title: Instilling Hope: Showing Individuals with New Disabilities between the Ages of 18 and 24 that Suicide is not the Answer
Review Type: ☐ EXEMPT ☑ EXPEDITED ☐ FULL IRB
Approved Project Period: Start Date: 10/28/2015 Expiration Date: 10/27/2016

Your protocol has been approved by the IRB. Protocols are approved for a maximum period of one year. If you wish to continue the project past the approved project period (see above), you must submit a request, using the form Continuing Review for IRB Approved Projects, prior to the expiration date. This form is available from the IRB Coordinator or on the Research Compliance website (https://apred.uark.edu/units/rcp/index.php). As a courtesy, you will be sent a reminder two months in advance of that date. However, failure to receive a reminder does not negate your obligation to make the request in sufficient time for review and approval. Federal regulations prohibit retroactive approval of continuation. Failure to receive approval to continue the project prior to the expiration date will result in Termination of the protocol approval. The IRB Coordinator can give you guidance on submission times.

This protocol has been approved for 15 participants. If you wish to make any modifications in the approved protocol, including enrolling more than this number, you must seek approval prior to implementing those changes. All modifications should be requested in writing (email is acceptable) and must provide sufficient detail to assess the impact of the change.

If you have questions or need any assistance from the IRB, please contact me at 109 MLKG Building, 5-2208, or irb@uark.edu.