The Structure of Rational Suicidal Ideation as Experienced by Persons with AIDS: A Pilot Study

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ABSTRACT

TITLE: The Structure of Rational Suicidal Ideation as Experienced by Persons with AIDS: A Pilot Study

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In the United States, the growing public acceptance and the potential legalization of assisted suicide for terminally ill persons poses many challenges for the nursing profession. Perhaps the greatest challenge will be developing clinical criteria to determine whether or not terminally ill persons who want to end their lives are demonstrating either rational or irrational suicidal ideation. This phenomenologic-hermeneutic study utilized Parse's (1992) research method to develop preliminary practice criteria for rational suicidal ideation.

Data was gathered from intensive interviews with a purposive sample of four persons with AIDS (PWAs) who had experienced rational suicidal ideation. Interviews with participants were audio-tape recorded and transcribed verbatim. Data analysis was performed on verbatim transcripts using Parse's (1992) phenomenologic-hermeneutic method of extraction-synthesis that involved a "dwelling with" the data. Through extraction-synthesis, a structure of the experience of rational suicidal ideation for PWAs was

formulated. The structure of rational suicidal ideation was then used to develop and propose tentative practice criteria for determining the rationality of suicidal ideation verbalized by PWAs.

The structure provided a description of what it is that provokes and creates rational suicidal ideation for PWAs. The structure was then used to derive tentative clinical criteria for identifying rational suicidal ideation. The structure was also used to differentiate rational suicidal ideation from irrational suicidal ideation. Interestingly, physical pain, being a burden to others, and depression were not identified as components of rational suicidal ideation.

Criteria were developed from the structure and compared to those developed by Werth and Cobia (1995). Criteria from the current study were found to support most of the criteria developed by Werth and Cobia. Importantly, the current study strongly supports the notion that reliable, credible clinical criteria for rational suicide can be formulated using qualitative research methods. Another important discovery was that very similar criteria were described using different participant samples and research methods.

Limitations of the current study included the very small participant sample size. An additional limitation was the phenomenologic-hermeneutic method used which prevents generalization of the study results (Morse & Field, 1995). Additional limitations included time, monetary, and personnel restrictions. Due to the limitations of the study, it was recommended that the clinical criteria should not be used in

clinical practice. However, the current study was important in that it provided validation for existing clinical criteria for rational suicidal ideation (Werth & Cobia, 1995). The current research was also important because it revealed the actual experiences of rationally suicidal persons.

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CHAPTER I

The Structure of Rational Suicidal Ideation as Experienced by Persons with AIDS: A Pilot Study

In the past few years, professional nurses who work with terminally ill persons have been increasingly confronted with clients who voice suicidal ideation (Werth, 1992). For example, professional nurses who work with persons with Acquired Immunodeficiency Syndrome (AIDS) will almost certainly encounter a person with AIDS who verbalizes a decision to commit suicide as opposed to dying of AIDS (Jones & Dilley, 1993; Motto, 1994; Werth, 1995).

In the past, professional nurses in the United States (U.S.) have been ethically and/or legally bound to prevent the suicidal, terminally ill person from carrying to completion a suicide attempt (Beckerman, 1995). The practice of always preventing suicide stemmed from societal and professional beliefs that suicidal ideation was always a symptom of psychopathology (Lester & Leenaars, 1996; Werth, 1995). Thus, regardless of the contextual circumstances, U.S. society viewed all persons who expressed suicidal ideation as mentally ill and incapable of making independent decisions (Brown, Henteleff, Barakat, & Rowe, 1986). Within this frame of reference, suicidal ideation could not represent a rational decision between dying as the result of suicide and dying as the result of a terminal illness.

Recently however, social attitudes in the United States toward the prevention of suicide in the context of terminal

illness have begun to change (Lester & Leenaars, 1996). These changes acknowledge that a terminally ill person has the right to make a decision to commit suicide versus dying as the result of terminal illness (Beckerman, 1995; Werth, 1992). Furthermore, these changes reject the idea that, for terminally ill persons, suicidal ideation indicates mental illness. Instead, suicidal ideation for terminally ill persons can represent a rational approach to an imminent death (Werth & Liddle, 1994). Recent events and empiric research also reveal that attitudes toward assisted suicide are changing. Empiric research has demonstrated that the U.S. general public has developed a more favorable attitude toward suicide in the case of terminal illness (Beckerman, 1995; Werth, 1992). Some key events include voter passage of a law in Oregon legalizing physician-assisted suicide (Oregon Measure 16, 1994), and recent federal circuit court decisions striking-down laws that prohibit physician-assisted suicide.

The phenomenon of legalized assisted-suicide, which appears to be on the verge of becoming a reality, will change the manner in which professional nurses intervene with terminally ill persons who are also suicidal (Werth, 1995). Even now, some health professionals have demonstrated attitudes that endorse participation in assisted-suicide. For example, the National Association of Social Workers determined in 1993 that it is ethical for a practitioner to attend the suicide of a terminally ill person (Marks, 1994). Thus, it appears that no longer will the course of action be dictated by ethical or legal requirements to prevent all

terminally ill persons who voice suicidal ideation from committing suicide. Instead, the clinician will be faced with the difficult task of determining whether or not the suicidal terminally ill person is capable of making a decision that meets the criteria for what has come to be known as *rational suicide*.

Rational suicide is defined in the literature as suicide that follows a reasoned thought process (Clark, 1994; Werth, 1995). The "reasoned thought process" is the critical element (Siegel, 1989). The reasoned thought process is defined by a series of clinical and research based criteria that describe suicidal ideation arising in response to a hopeless physical condition (e.g., terminal cancer) as opposed to suicidal ideation arising from mental illness (e.g., major depressive disorder). Thus, rational suicide is described as a reasonable response to an intolerable and ultimately fatal disease process which differentiates it from *irrational suicide* that arises from mental illness (Beckerman, 1995).

Empiric research into the phenomena of rational suicide and rational suicidal ideation is necessary for several important reasons. Cogent scientific investigation will aid both ethicists and policy makers in making the difficult decisions concerning rational suicide that may become necessary in the near future (Werth, 1995). Also, in a society in which assisted-suicide is legal, both a scientifically sound definition and a clinically sound practice framework are necessary to safeguard the physical and mental well-being of terminally ill persons who voice a

desire to commit suicide (Werth & Cobia, 1995). However, at this time, an empiric definition for rational suicide is lacking. Furthermore, there is neither a reliable nor a valid practice framework for assessing whether or not individuals can make reasoned decisions to end their lives (Beckerman, 1995; Werth, 1995).

Theoretical Perspective

Achieving an empirical definition for rational suicidal ideation as the basis for a practice framework requires a research approach that will yield an accurate and reliable description of rational suicidal ideation (Polkinghorne, 1983). Such an approach is Parse's (1992) theory of human becoming in which the researcher formulates this description by tapping into the actual lived experiences of individuals who have experienced rational suicidal ideation. Thus, the theoretical perspective and research method that will guide this study is the nursing theory of human becoming developed by Parse (1992).

Parse's research method is an existential-phenomenologic approach in the tradition of Heidegger and Merleau-Ponty (Cowling, 1989; Polkinghorne, 1983). The existential-phenomenologic approach views humans as cognitively creating reality by means of the primary organizing principles of structures. The structures of lived experience describe how persons cognitively experience the world rather than separating experiences into measurable, observable entities (Polkinghorne, 1983). For example, the objective approach would separate the grief experience into psychological,

physical, and social aspects. A phenomenologic approach, however, would not attempt to separate the grief experience into different dimensions. Instead, grief would be described from the perspective of the person who is experiencing grieving. From the perspective of actual personal experience, grieving would be viewed as a holistic process in which all dimensions of the experience would be intertwined and inseparable (Parse, 1992). For example, Cody (1991) described the grieving experience as a process of the entire person moving forward in the present while remembering the past.

Parse (1992) goes beyond the idea of cognitive reality to view persons as holistic beings that physically, cognitively, emotionally, and spiritually interact with the universe. This implies a dynamic process in which persons and the universe interact to create a fluid and changeable reality. Reality is then said to be cocreated because it involves dynamic interaction between persons and the universe.

Thus, structures within Parse's theory of human becoming are the processes of constructing personal meaning by choosing from a multitude of options within the realms of lived experience. The researcher translates the common themes (essences) of lived experience into scientific language. By translating descriptions of lived experience into scientific language, the researcher makes the personal meanings of lived experience understandable to other people (Carpenter, 1995). Defining how these meanings influence and describe lived experience for the broader population occurs when the researcher places them within the language and the

organization of Parse's theoretical principles (Cody, 1991; Mitchell, 1993).

In keeping with the the phenomenologic research method, lived experience within the context of this study is defined as the lived experiences of adult, English-speaking, U.S. citizens. The importance of clarifying this lies in the idea that lived experience is culturally, personally, and temporally bounded. This means that the phrase "lived experience" has varied meanings to people depending upon the culture in which they are embedded, the time the lived experience occurs, and past personal experience (Doutrich, 1993). Thus, it is necessary in this study to explicate for whom the term lived experience is applicable.

Purpose of the Research

Within the context of this study, the structure of rational suicidal ideation is believed to be cocreated within the lived experience of a terminal illness. Therefore, the primary purpose of this study is to generate a description of the structure of the experience of rational suicidal ideation for terminally ill persons. In this study, the structure of rational suicidal ideation will be the researcher's formalized notion of the phenomenon of rational suicidal ideation as experienced by terminally ill persons.

The development of a reliable and valid practice framework is necessary to safeguard the physical and mental well-being of terminally ill persons who voice a reasoned decision to commit suicide (Werth & Cobia, 1995). Therefore, another purpose of this study is to develop a preliminary practice

framework within which the professional nurse can determine the rationality of a terminally ill person's suicidal ideation. The practice framework will flow directly from Parse's (1992) theory and utilize her practice framework approach. It is also believed that this study will add to the knowledge base on rational suicide.

CHAPTER II

Review of the Literature

Rational suicidal ideation has been a controversial subject for U. S. society since it was first introduced as a concept by Emile Durkheim in the nineteenth century (Hagerty, 1984). Heated debates regarding the ethics of rational suicide and suicide prevention have continued to the present day (Beckerman, 1995; Clark, 1994; Werth, 1995). These debates were instrumental in identifying those areas in which empirical research could inform the discussion between proponents and opponents of rational suicide. A discussion of the history of rational suicide is helpful to explicate those areas in which empirical research can be informative.

Background of Rational Suicide in the U. S.

For the better part of the past 1500 years Judeo-Christian values have dominated Western and European attitudes toward both suicide in general and rational suicide in particular (Mayo, 1986). Suicidal ideation was largely viewed as a matter of personal and spiritual weakness, and the suicide act was considered a sin and a crime. Suicide was forbidden and severe penalties were exacted from both the persons who attempted suicide and the estates of persons who committed suicide. These sanctions included such acts as denial of religiously sanctified burial, dismemberment of the deceased corpse, and seizure of the estate of the deceased person (Siegel, 1986).

Beginning with the works of Sigmund Freud and, later, Harry Stack Sullivan, suicidal ideation began to be viewed as

a symptom of a medical or psychological problem (Lester & Leenaars, 1996). Likewise, social attitudes toward suicide also began to change in the same manner. By 1950, suicide had made the transition from an act considered a sin to that of a psychological or physical malady that could be prevented with medical or psychological intervention (Mayo, 1986). However, this frame of reference considered suicidal ideation as the result of mental pathology over which an individual had no personal control (Lester & Leenaars, 1996). Hence, suicide continued to be viewed as an act that should be prevented regardless of the contextual circumstances (Werth, 1992).

In the U. S., the merits of always preventing suicide were first cast into doubt by Menninger (1938) who found that the primary reason for both suicidal ideation and suicidal acts was the desire to escape severe psychological distress, physical pain, or both. By the 1980s, the idea that persons with terminal illnesses were using suicide to relieve unendurable suffering was put forward by such authors as Humphry (1987), Lester (1993), and Szasz (1986). Over the past ten years, there has also been a considerable increase in U. S. public support for suicide as a means of relieving the suffering of a painful terminal illness (Beckerman, 1995, Motto, 1994). Moreover, many researchers assert that the higher than average suicide rate found among U. S. citizens with terminal illnesses indicates that rational suicide has long been used to achieve an end to physical and mental suffering (Werth, 1995). According to Motto (1994), the issue is no longer about how to prevent suicide in persons who are

terminally ill, but how to determine if the suicidal person is making a rational decision.

Consequently, the debate concerning rational suicidal ideation has become focused on two areas: a) whether or not rational suicidal ideation exists as a real phenomenon and b) whether or not it is clinically, ethically, and legally feasible to differentiate between rational suicidal ideation and irrational suicidal ideation.

Rational Suicide as an Identifiable Phenomenon

The majority of professional literature this author reviewed focused on the ethical considerations involved in the treatment of a terminally ill person who voiced suicidal ideation (e.g., Beckerman, 1995; Clark, 1994; Marzuk, 1994; Siegel, 1986; Werth, 1995). Within this body of literature, there was considerable disagreement over whether or not health professionals should allow terminally ill persons to commit suicide. However, almost all of the authors agreed that rational suicide existed as a real phenomenon. Thus, within the conceptual literature, rational suicide was considered a legitimate phenomenon.

However, the literature included very limited empirical research examining the phenomenon of rational suicidal ideation (Werth, 1992). Much of the available empirical research was limited to descriptive epidemiologic studies that detailed the incidence and prevalence of suicide among persons who were terminally ill (e.g., Fox, Stanek, Boyd, & Flannery, 1982; Marzuk, Tierney, Tardiff, Gross, Morgan, Hsu, & Mann, 1988). These studies found that the risk of suicide

was increased among terminally ill persons. However, these studies did not attempt to discover if the phenomenon of rational suicide had occurred among the terminally ill persons studied.

Brown et al. (1986) examined whether or not rational suicidal ideation existed among terminally ill persons who voiced suicidal ideation. They studied persons with terminal cancer and found that all of those persons who voiced suicidal ideation in relation to their diagnosis were also exhibiting symptoms of depression. However, Brown et al. noted that their results could not be generalized due to the problems in their method of determining what constituted depression. Many of the criteria they used to diagnose the presence of depression were commonly found in terminal illness (e.g., fatigue, anorexia, and poor concentration). Moreover, Beckerman (1995) emphasized that depressive symptoms were commonly found among persons who were terminally ill. The depression was seen as a result of persons experiencing an unexpected and unwanted fatal disease (Werth, 1995). Brown et al. concluded that the existence of the phenomenon of rational suicide was neither proved nor disproved by their study. The work by Brown et al. was important because it seriously examined the phenomenon of rational suicide. However, the results did little to elucidate the existence of rational suicide. No comparable follow-up study could be found in the published research literature.

Werth and Liddle (1994) conducted a study in which

counseling and clinical psychologists were surveyed to determine their attitudes toward rational suicide. The study design used detailed case descriptions of the life circumstances of fictionalized suicidal ideators. Eighty one percent of those surveyed stated that rational suicide existed as a real phenomenon. Additionally, a similar percentage stated that suicide by terminally ill persons was often an acceptable alternative to dying as a result of a fatal disease. Part of the importance of Werth's and Liddle's work was in the establishment of rational suicide as a legitimate concept that warranted further investigation.

Differentiation Between Rational and Irrational Suicidal Ideation

A further important finding of the research by Werth and Liddle (1994) was that the determination of the rationality of suicidal ideation could be made if the totality of the suicidal person's life experience was considered. That is, the rationality of suicidal ideation depended in large part on circumstances within the lives of individuals such as terminal illness, pain, and suffering. However, the work by Werth and Liddle provided few insights into how the rationality of suicidal ideation could be determined. Werth and Liddle implied that the next step in the research process should be the development of criteria for rational suicidal ideation.

Within the available literature, some criteria exist for determining what constitutes rational suicidal ideation. Almost all of the criteria appeared to have been intuitively

developed from clinical practice (Werth, 1995), and few have been subjected to or developed from empirical research (Marzuk, 1994; Siegel, 1986).

An exception was seen in Werth's and Cobia's (1995) qualitative study of doctorally prepared mental health professionals. The survey asked each of the participants to identify criteria they would use to determine the rationality of a person who voiced suicidal ideation. Their first criterion was the presence of a hopeless, unremitting condition (including but not limited to terminal illness). The second criterion was that the rational suicidal decision was made as a free choice. The third criterion, that the suicidal person engage in a sound decision-making process, was divided into 5 subcriteria: a) the suicidal person sought an assessment from a mental health professional; b) all alternatives were considered so that an impulsive decision could be avoided; c) the suicidal act was congruent with personal values; d) the suicidal person considered the impact the suicide would have on significant others; and e) consultation was made with objective, non-mental health professionals (e.g., physicians and clergy) and significant others.

Another criterion found in the literature was that the suicidal act must be a positive, active attempt to end one's life through intervention as opposed to the withdrawal or refusal of life-sustaining treatments (Beckerman, 1995; Marzuk, 1994; Werth, 1995). In other words, unless one acted directly to kill oneself, then one was not committing

suicide. Werth and Liddle (1994) found empirical support for this criterion in determining the rationality of suicidal ideation. This is essentially a definition of suicidal ideation that sets it apart from related concepts such as passive suicide and withdrawal of life-sustaining treatments. (see Table 1, p. 14, for a list of all available criteria for determining the rationality of suicidal ideation).

One of the missing elements in the study of rational suicidal ideation among terminally ill persons is data from the persons themselves. Werth and Liddle (1994) and Werth and Cobia (1995) gathered their data from mental health professionals.

Although Brown et al. (1986) gathered data from terminally ill persons, they limited their measurement to two variables: suicidal ideation and depression. Brown et al. did not explore the many potential variables that could have influenced their subjects. Beckerman (1995) noted that depression was only one of many variables experienced by terminally ill persons. Werth and Liddle (1994) found that consideration of the person's entire experience was needed to determine the rationality of a person's suicidal ideation. Therefore, the data gathered by Brown et al. was probably not of sufficient depth to determine the rationality of the subjects who voiced suicidal ideation.

Thus, the literature clearly supported the existence of rational suicidal ideation as a distinct phenomenon and presented criteria for determining the rationality of suicidal ideation. However, two important aspects of rational

Table 1.

Explicit Criteria for Determination of Rational Suicidal Ideation in the Available Literature.

Authors	Criteria for Rational suicidal ideation	Source of criteria
Siegel, K. (1986).	1. The person has a realistic assessment of the situation. 2. The person is neither mentally ill nor severely emotionally distressed. 3. Motivation for suicide would be understandable to the majority of uninvolved people in the community or social group	Literature review, intuition, and clinical practice.
Werth, J. L. (1995).	1. Includes all three above criteria as noted by Siegel (1986). 2. The decision to commit suicide is deliberated and restated over a period of time. 3. If practical, the decision to commit suicide involved significant others.	Literature review intuition, and clinical practice.
Werth, J. L. & Cobia, D. C. (1995).	1. The person has a hopeless, unremitting condition. 2. The decision to commit suicide is made as a free choice. 3. The person has engaged in and completed a sound decision-making process. (Includes 5 subcriteria). a) a mental health assessment has been conducted by a health professional. b) all alternatives (e.g., pain control) have been exhausted. c) suicide is congruent with personal values. d) the person has considered the impact of the suicide on others. e) consultation has been made with objective, non-mental health professionals (e.g., clergy).	Empirical research.

suicidal ideation were missing from the research literature. First was the definition of rational suicidal ideation defined by persons experiencing a terminal illness. Second was the lack of a valid practice framework within which to reliably determine the rationality of a person's suicidal ideation. Moreover, only three studies examining rational suicide could be found among the available empirical literature. This represents an inadequate research base for a subject as important as rational suicide.

Rational Suicide and AIDS

The concept of rational suicide is particularly important when considering persons with AIDS (PWAs). Studies that investigated the suicide rate among PWAs consistently found rates many times those seen either in the general population or in other terminal illnesses (e.g., Cote, Biggar, & Dannenberg, 1992; Kizer, Green, Perkins, Doebbert, & Hughes, 1988; Marzuk et al., 1988). More recent studies of PWAs, however, are indicating that the suicide rate among PWAs may be decreasing over time since the onset of the AIDS epidemic (Rabkin, Remien, Katoff, & Williams, 1993).

Beckett & Shenson (1993) summarized the available empirical research that attempted to delineate variables associated with terminal AIDS and suicide. They found that neither a single variable nor a combination of variables could be consistently associated with the risk of PWAs to commit suicide. Rabkin et al. (1993) also supported this conclusion in their research on PWAs. Beckerman (1995) interpreted this to mean that rational suicide probably had a

significant role in the suicides committed by PWAs.

This interpretation was reinforced by Jones and Dilley (1993) who examined the phenomenon of rational suicidal ideation among 39 PWAs. They found that 26 of the PWAs they interviewed had considered rational suicide as an alternative to dying via the terminal phase of AIDS. Jones and Dilley also discovered that 7 of the PWAs they interviewed also knew someone with AIDS who had committed suicide. This study established rational suicidal ideation as a valid phenomenon among PWAs.

As with the research that pertained to persons with terminal illnesses, the data gathered on PWAs who contemplated rational suicide has lacked sufficient depth to describe the phenomenon of rational suicide. Additionally, only one empirical study was found that researched rational suicidal ideation among PWAs (Jones & Dilley, 1993). Thus, it can be asserted that research is needed that describes the phenomenon of rational suicidal ideation from the perspective of PWAs because of both the lack of research on rational suicidal ideation in general and the extent to which rational suicidal ideation appears to be present among PWAs in particular.

Theory and Practice Frameworks for Rational Suicidal Ideation

This author found no evidence of an explicit theoretical or practice framework within which to describe or explore the phenomenon of rational suicidal ideation. Also, there was no empirical nursing literature that examined the phenomenon of rational suicidal ideation among PWAs. This indicates a

knowledge gap that this study proposes to address. This study seeks to answer the questions: a) What is the structure of rational suicidal ideation as experienced by PWAs? and b) Can this structure be used to develop a preliminary practice framework for determining the rationality of the suicidal ideation of a terminally ill person?

As was stated earlier, a sound practice framework for assessing rational suicidal ideation is needed to safeguard the mental and physical well-being of PWAs who voice a decision to commit suicide (Werth, 1992; Werth & Cobia, 1995). It is believed that this study will provide necessary information to begin formulating a sound practice framework.

CHAPTER III

Method

Nurse researchers emphasize the necessity of using research methods that are epistemologically and ontologically congruent with the nursing theories used to underpin research (Mitchell & Cody, 1992; Parse, 1987). Therefore, the research method chosen for this study flows directly from Parse's (1992) theory of human becoming and is designed to be used with her theoretical framework. Traditionally, Parse's research method was limited to studying phenomena that are universal to human experience (Parse, 1992; Pilkington, 1993). Recently, however, Parse's method and theory have been used to study more specific yet still important phenomena (Parse, 1997). The suitability of Parse's research method to study important, specific phenomena is another reason it was chosen to guide this study.

Parse's (1992) research method is a descriptive qualitative method derived from her theory of human becoming. It is a unique phenomenologic-hermeneutic method of inquiry that requires the researcher to truly seek understanding of lived human experience from a personal perspective (Parse, 1997). It does not attempt to predict or control human actions (Polifroni & Packard, 1992). Instead, it attempts to describe human experience as it is lived. Parse holds that humans are freely choosing beings who are capable of changing their realities through open interaction with he universe. This cocreated meaning then becomes the unique reality of each person's lived experience.

An understanding of the lived experience of PWAs who have experienced rational suicidal ideation is necessary in order to understand the nature of rational suicidal ideation. The descriptive nature of Parse's theory was particularly appropriate for this study given the absence of research exploring the phenomenon of rational suicidal ideation (Artinian, 1988; Knafl & Howard, 1984).

Participant Selection

Appropriate participants were selected through a network sampling technique (Patton, 1990) in which an expert in the care of PWAs assisted in the recruitment of participants that met the study selection criteria. A complete list of criteria used to select participants for this study are in Appendix A. Paramount among the criteria were that participants needed to be free of mental illness, to be able to describe their experiences in detail, and to have experienced rational suicidal ideation. A list of selection and exclusion criteria was provided to the expert in the care of PWAs who assisted in participant recruitment (see Appendix B). The person who assisted participant recruitment was given recruitment brochures (see Appendix C) to distribute to potential study participants. The recruitment brochures were then mailed to the principal investigator by persons interested in participating in the research study. The principal investigator then contacted the potential participants to verify their interest in participating in the research study. After verifying interest, the principal investigator then established interview times and places with participants.

Participant recruitment was limited to four persons who experienced rational suicidal ideation in relationship to having AIDS. Time and resource limitations restricted the participant number to four persons. However, data analysis revealed that redundancy of themes (Parse, 1981) occurred after the fourth participant was dialogically engaged. Redundancy of themes was determined through the use of constant comparative analysis to ensure that the study included a sufficient number of participants (Glaser & Strauss, 1967; Miles & Huberman, 1994). This method of delimiting data collection has been both widely applied and successfully used in qualitative inquiry (Morse & Field, 1995; Streubert & Carpenter, 1995).

Four participants was probably not a sufficient number to ensure the saturation of essences as described by Glaser & Strauss (1967). Still, Glaser (1978) noted that within qualitative human science inquiry, most of the core concepts of a particular phenomenon appear very early in data collection. Also, Parse (1997) specified within her research method that between 2 and 12 participants is sufficient to establish the core concepts of the phenomenon under investigation. Therefore, the current research probably included sufficient participants to arrive at the core concepts of rational suicidal ideation. However, the limited number of participants did not ensure that all important concepts were revealed. In consideration of the aforementioned arguments, it was decided to limit the scope of the current research to a pilot study.

Descriptions of Participants

The four participants in this study described themselves as gay men and were between the ages of 29 and 51. All but one of the participants described themselves as White. The fourth described himself as Hispanic/Native American. One of the persons described himself as disabled and was receiving government disability funds. Two participants stated they were employed either part-time or full-time. One person stated he was self-employed. Two persons were receiving housing assistance through private and governmental funds. All of the participants described their access to health care as sufficient to meet their health needs. Data regarding participant descriptions was gathered using a demographic data information form (see Appendix D).

Two persons were excluded from the data analysis because they revealed during the interview process that they had been diagnosed as having AIDS dementia complex (ADC) which was one of the exclusion criteria for the study. Although the data could not be used in the current research, the interviews were completed. The interviews were completed in part because the participants insisted on being interviewed. The interviews were also completed because the researcher recognized that the participants gave lucid, cogent accounts of their experiences of suicidal ideation despite their diagnoses of ADC. Additionally, the participants with ADC did not demonstrate undue emotional stress or suicidal ideation while describing their experiences. However, to provide rigor in the research, the data was transcribed and then archived

for possible future research consideration.

Participant Protection

Protecting the rights of participants was accomplished by developing guidelines for participant protection (see Appendix E) that included an informed consent form (see Appendix F). The participant protection guidelines and informed consent form were then presented to the Human Subjects Committee of the Institutional Review Board (IRB) of the academic center where this research occurred. The IRB approved both the protection guidelines and the informed consent form. An expert in the care of PWAs was also involved in the study and served as a resource for ensuring that participants met the selection criteria (particularly that the participants were neither mentally ill nor suicidal at the time of the interviews). Participants were then given a consent form to read. The researcher clarified all questions and consent forms were signed before beginning interviews. Interviews were tape recorded after obtaining permission from each participant.

Each participant was assured that all identifying information including the taped recordings would be destroyed at the end of the research process. Also, each participant was assured that all identifying information linking them to the verbatim transcripts would also be destroyed at the end of the research. Participants were informed that their identities would remain confidential. Participants were informed that the research results would be published in a professional journal, but that no identifying information

would be used and identities would remain confidential. Participants were informed that research results would be reported using detailed quotes taken from the participant interviews. Quotes would be attributed to participants using two randomly selected initials for each participant. The initials were in no way related to the actual names of the participants.

Data Collection

Although the term "interview" is convenient, the "interviews" that were conducted in this study actually took the form of "dialogical engagement" (Parse, 1981). Dialogical engagement is a dialogue between researcher and participant that requires the researcher to engage in a *being with* in *true presence* with the participant during an unstructured exploration of the lived experience that is the focus of the research (Parse, 1992). That is, the researcher must share with the participant an authentic desire to uncover the meaning of the phenomenon in the words of the participant. In doing so, the researcher assists the participant to focus on the phenomenon of interest. The researcher does this by asking questions and making comments that keep the participant focused on the personal meaning of the experience (Cody, 1991; Parse, 1997). The purpose of dialogical engagement for the current research was to uncover the meaning of rational suicidal ideation for the participants.

The researcher used several activities to assist him to to be open to the lived experience of AIDS shared by the study participants during dialogical engagement (Pilkington,

(Pilkington, 1993). The researcher first prepared for dialogical engagement by looking at images, reading stories, watching films, and listening to music that related to the lived experiences of PWAs. A person with AIDS who is a close friend of the researcher was instrumental in helping to chose those activities that represented experiences of living with AIDS. The researcher used these activities to immerse himself as much as possible in the lived experience of AIDS.

The researcher began each dialogical engagement with the same question of asking participants to describe their experiences of suicidal feelings related to having AIDS. The researcher did not structure questions or answers but asked questions that helped to clarify and reveal the lived experience of rational suicidal ideation related to having AIDS.

The other tasks of the researcher was to both ask questions and prompt participants to keep them focused on the personal meaning of their experiences. Within Parse's (1992) framework and method, lived experiences are unique to each person and are known through personal meaning. Thus, it was of paramount importance that the participants remained focused on the personal meaning of their experiences of rational suicidal ideation.

Dialogical engagement ceased when the participants revealed that there was nothing further to communicate about their lived experiences of rational suicidal ideation. That there was nothing further to be revealed through dialogical engagement was agreed upon by both the researcher and the

participant in keeping with the theoretic principles and the methodologic framework of the Parse (1997) theory of human becoming.

Data Analysis

Parse (1997) has developed five processes of qualitative data analysis that she describes as "extraction-synthesis". The five processes of extraction-synthesis were used in this study to arrive at the structure of rational suicidal ideation for persons with AIDS. Before the processes of extraction-synthesis could take place, the researcher first immersed himself in the data (Pilkington, 1993). Immersion was accomplished through reading data transcripts, listening to taped interviews, listening to music related to the experience of living with AIDS, and reading phenomenologic research into the meaning of living with AIDS. The five processes of extraction-synthesis then occurred as the researcher *dwelled with* the data (Parse, 1992). Dwelling with the data consisted of repeatedly reading typed transcripts while listening to taped interviews (Morse & Field, 1995; Pilkington, 1993). During these processes (immersion in the data and dwelling with the data), the researcher moved the descriptions of the participants' experiences successively up several levels of abstraction to the level of scientific language (Parse, 1992; 1997).

Extraction-Synthesis: Extracting Essences

The first process of extraction-synthesis involved extracting essences from the interview data in the language of the participant-researcher. Extracting essences involved

the identifying and pulling-out of core ideas from both taped recordings and written transcripts in the language of the participant-researcher.

Although Parse (1997) states that the extraction of essences should be in the language of the participants, it was more accurate to describe this process as extracting participant-researcher essences for the following two reasons. The first is that the dialogical engagement involved not one person but two (the participant and the researcher) who were both active in revealing the description of the lived experience of rational suicidal ideation. Thus, the statement of participant-researcher is more congruent with the epistemology of Parse's research method. The second reason that the term participant-researcher was used is that Parse's theory of human becoming (1992) specifies that human meaning is cocreated through open interaction with the universe. This implies that although dialogical engagement and data analysis revealed the lived experience of rational suicidal ideation, it was recognized that the researcher interacted with the data (both during dialogic engagement and data analysis) in ways that explicitly and tacitly changed the meaning in order to understand what is being revealed by the participant (Morse & Field, 1995). Thus, the use of participant-researcher essences is congruent with the ontologic perspective of the theory of human becoming (Mitchell & Cody, 1992; Parse, 1992).

Extraction-Synthesis: Synthesizing Essences

The second process of extraction-synthesis involved

restating the extracted essences (the language of the participant-researcher) in the language of the researcher. This process used outside sources (e.g., related research literature), personal knowledge of the researcher (e.g., research and scientific), and the data transcripts to restate the extracted essences in scientific language. The name for this stage of data analysis is called synthesizing essences (Parse, 1992; Pilkington, 1993).

Extraction-Synthesis: Making Propositions

In the formulation of propositions, a statement was made that logically melded the core ideas revealed through synthesizing essences. The proposition is stated in the form of a lived experience for each participant. The formulation of the propositions was an iterative process that required the researcher to continuously compare extracted essences, synthesized essences, and data transcripts in order to ensure that the propositions were faithful to and representative of the original data (Morse & Field, 1995; Parse, 1992; Pilkington, 1993). Each proposition then provided a description of each participant's lived experience of rational suicidal ideation related to having AIDS.

Extraction-Synthesis: Core Concepts

The fourth step in extraction-synthesis involved identifying and pulling-out core concepts from all of the propositions of the participants' lived experiences of rational suicidal ideation (Parse, 1992; 1997). This required an intense creative *dwelling with* and constant comparison of all of the propositions together. The researcher followed the

technique used by Pilkington (1993). This technique involved identifying those concepts common to all propositions. The common concepts were then extracted and used to represent the essential meanings of the propositions taken as a whole.

Extraction-Synthesis: Describing Structures

The fifth process of extraction-synthesis was the logical linking together of the core concepts to form the structure of the lived experience of rational suicidal ideation (Parse, 1997). The completion of the process of structural synthesis answered the first research question of "What is the structure of rational suicidal ideation for persons with AIDS?"

Credibility and Dependability of the Data

The traditional concepts of validity and reliability did not fit with the data collection technique used in this qualitative research design (Marshall & Rossman, 1995; Parse, 1992). Validity and reliability belong to a philosophy of science based on an objective, unidimensional reality which is not appropriate for phenomenologic inquiry (Streubert, 1995). In this research study, a phenomenologic-hermeneutic method of inquiry was used. Thus, within the framework of this research, reality was viewed as subjective and multidimensional (Carpenter, 1995; Morse & Field, 1995; Parse, 1992).

Lincoln & Guba (1985) developed the concepts of *credibility* and *dependability* both to enhance rigor within qualitative inquiry and to overcome the paradigmatic limitations of validity and reliability. According to

Marshall and Rossman (1995), credibility is associated with how accurately the phenomenon is identified and described; dependability is concerned with the interpretation of the results and whether those interpretations match those of the participants. Credibility and dependability assume a changing world in which the concepts of repeatability and replication are always problematic in qualitative human inquiry.

Credibility. The credibility of the data gathered in this research study was dependent upon eliciting reflections of lived experience from participants that was not unduly influenced by preconceived ideas of the researcher (Carpenter, 1995; Morse & Field, 1995; Oiler, 1981). This research study employed two of the available methods for assuring the credibility of the data. One of the methods was that an expert in the field of qualitative inquiry reviewed interview transcripts for examples of deep and broad descriptions of rational suicidal ideation (Rew, Bechetel, & Sapp, 1993). The second method was the process of bracketing (Carpenter, 1995). Bracketing occurred when the researcher first identified all personal knowledge and feelings related to the phenomenon of rational suicidal ideation. For example, the researcher bracketed (set aside) what he knew about the criteria for rational suicidal ideation developed by Werth and Cobia (1995). Another example of bracketing was when the researcher set aside personal ethical beliefs about rational suicidal ideation. The researcher believed firmly that all persons with terminal illness had the right to assisted suicide. This belief was set aside as much as possible in

order to avoid overly-influencing participants' responses during dialogical engagement.

Additional bracketing occurred during data collection when the researcher cognitively set aside all prior knowledge and preconceptions related to rational suicidal ideation. During data analysis, the researcher then compared what was previously known about rational suicidal ideation to the data that were collected. This process ensured that the researcher's preconceived ideas did not unduly influence data collection. At the same time, through bracketing, the researcher acknowledged the possible influence of the researcher's ideas on the final data analysis (Morse & Field, 1995).

Dependability. Two techniques shown to improve the dependability of qualitative data analysis were employed in this research study. The first technique involved a researcher with expertise in the area of qualitative data analysis who reviewed the interview results for evidence of consistency in data analysis (Morse & Field, 1995). The second technique involved a member check procedure which was described in great detail by Hoffart (1991). Briefly, the member check procedure was a process whereby the the accuracy of the propositions was verified by soliciting input from the participants in a second interview through the process of member checking (Hoffart, 1991). In the member check, the researcher first read the proposition to the participant. Second, the participant was invited by the researcher to provide corrections, validations, or invalidations of either

parts of the proposition or the entire proposition. All of the propositions were accepted by the participants as representative of their experiences with rational suicidal ideation. Thus, the use of the member check procedure provided evidence that the propositions accurately reflected the lived experiences of the participants (Doutrich, 1993).

CHAPTER IV

Research Results and Discussion

All of the extracted essences, synthesized essences, and the propositions from the data gathered from the four participants are listed in Table 3 (see Appendix G).

Core Concepts

Following the technique used by Pilkington (1993), four core concepts were extracted from dwelling with the propositions. Each of the four concepts was found by the researcher to be common to all of the propositions. These concepts together contained the essence of the lived experience of rational suicidal ideation for PWAs. The four core concepts were:

a) pronounced suffering amidst overwhelming loss of quality of life (QOL);

b) thoughts of suicide surfacing comfort and anguish;

c) moving toward and away from valued others; and

d) emerging spirituality illuminating the ebbing and flowing of living-dying.

Pronounced Suffering Amidst Overwhelming Loss of QOL

This extracted concept revealed that a critical part of rational suicidal ideation is that the participants experienced the loss of all that they viewed as important and necessary for having a minimally acceptable QOL. This loss was revealed by the participants to be not just a loss within a particular physical or social realm (e.g., physical functioning; inability to be with friends), but the loss was perceived to be a complete, global loss of QOL.

Another critical part of rational suicidal ideation revealed by this concept was that the loss of QOL leads to and arises from profound suffering. The participants discussed suffering that was more than physical, cognitive, social, or spiritual in nature. The suffering that was experienced was as global and overwhelming as the loss of QOL. Participants used phrases such as "being humiliated", "being in prison", and "forced to live in hell" to describe their intense, holistic suffering.

> P.J.: *I felt that I was in hell...I was being held prisoner in this life that tortured me...every little thing I had to deal with like taking a pill or getting something to eat was painful and took away all of my energy...even listening to noises across the street was an effort.*

> S.L.: *I was tired of being sick...I was just existing...I was in pain but it wasn't that big of a problem...but being in pain is not all there is to suffering...I couldn't even get out of bed and go to the bathroom by myself...It was humiliating.*

Although the participants revealed that they were suffering profoundly with an overwhelming loss of QOL, they revealed through dialogical engagement that they had lived meaningful QOL through much of their lived experiences of

having AIDS. They revealed that although their lives had changed dramatically when they were first diagnosed with AIDS they had found meaning and joy in their lives although they perceived themselves as having a fatal illness.

M.T.: *When I was first diagnosed, I was devastated...but I knew that I would not just give-up... I found that I needed to make more realistic short-term goals, but I found joy in living day-to-day that I had not had before...But I also knew that I was going to die from AIDS and my life was going to be much shorter.*

P.J.: *I used to be able to run miles and miles. I went to college on a track scholarship...When I was first diagnosed I was depressed because I thought my life was over...but now I don't have to be an athlete to enjoy life...I learned that there are things in life that I could do that I could enjoy like going to the mall with friends or listening to music or cleaning the house.*

S.L.: *Before I had AIDS I had all sorts of plans...I went to some college...but now I don't ask that much...just to be able to do things for myself like go to the bathroom myself, dress myself, cook food, look for firewood...I know when I've had a good time when I take a drive with friends and I come home with a smile on my face.*

The experiences related by the participants are similar to those found by Nokes and Carver (1991) in their study exploring meaning for persons living with AIDS. Nokes and Carver found that persons diagnosed with AIDS were able to find meaning in living with AIDS through changing their expectations of the future and learning to live day-to-day. The participants in this study also revealed that through most of their experiences of living with AIDS, they perceived themselves as living a meaningful and fulfilling QOL.

Rabkin et al. (1993) reported that PWAs did not become suicidal as a response to being diagnosed with AIDS. Instead, PWAs became suicidal when they became very ill and needed to be hospitalized. Rabkin et al. also collected qualitative data from PWAs that revealed that their suicidal ideation corresponded to the loss of acceptable QOL that accompanied hospitalization. Furthermore, participants also reported that they felt their suicidal ideation was both justifiable and reasonable (Rabkin et al.). The findings by Rabkin et al. support the findings of the current research study that rational suicidal ideation arises from profound suffering amidst an overwhelming loss of QOL.

The profound suffering amidst overwhelming loss of QOL can be viewed in light of the first principle of Parse's (1987; 1992; 1997) theory of human becoming as "structuring meaning multidimensionally is cocreating reality through the languaging of valuing and imaging" (1997, p.33). Quality of life for each person derives from human-universe interaction (Parse, 1994). That is, QOL is determined neither by the

person nor by the universe, but through a dynamic interaction between the person and the universe. That is, QOL is cocreated by the human and the universe acting together. Thus, it must also be true within Parse's framework that a perceived loss of QOL also is cocreated. This perception was supported by the data from the participants who perceived their loss of QOL to be the result of both their own perceptions of what constituted meaningful QOL and the results of the progression of their AIDS or the result of an opportunistic infection.

The participants in this research were relating valuing by expressing their loss of QOL as both emanating from and contributing to their profound suffering. That is, living QOL was their value priority, and their loss of QOL (cocreated through participant-universe interaction) was experienced as profound suffering. Profound suffering then became the cocreated meaning of the situation for the participants.

Thoughts of Suicide Surfacing Comfort and Anguish

The participants related that thoughts of suicide were at once comforting and anguishing. Participants spoke of feeling that they would relieve suffering by ending their own lives, but they also revealed that there was considerable anxiety and dread when confronting the unknown of the dying experience. Participant's used phrases such as "standing at the edge of the abyss" and "it's the ultimate end". The anxiety and dread was emphasized by the pain and consternation evident in participants' voices when they spoke of events after death.

M.T.: *I would hate to just be there suffering and in pain...feeling that I am not in my own life, and if I can die, then it will relieve the suffering...but you know that none of us knows what's next...I don't mean I will be going to hell; I know that won't happen...but you are standing at the edge of the abyss.*

P.J.: *But when I die then I will be released from this hell that I am in...although I feel that I will not have AIDS...I also won't have my friends...you know I like the way I've been living even though I have AIDS.*

R.K.: *I like the idea of knowing that I will not have to suffer to the last like I saw happen to so many of my friends...but then I won't be around...it's the end, you know what I mean? It's still scary. I mean it's the ultimate end.*

The paradoxical surfacing of comfort and anguish with thoughts of suicide can be seen in light of Parse's second principle of her theory of human becoming "Cocreating rhythmical patterns of relating is living the paradoxical unity of revealing-concealing, enabling-limiting while connecting-separating" (1992, p. 37). Thoughts of suicide for the participants produced feelings of comfort when they perceived that dying would relieve suffering. However, the participants also revealed that thoughts of death with its

finality and infinite unknowns also provoked feelings of anguish. Feelings of comfort and feelings of anguish are two sides of a rhythm that coexist together and are not separable within the phenomenon of rational suicidal ideation.

Parse (1992) notes that enabling-limiting as a rhythmical pattern of relating involves both infinite latitudes and infinite restrictions. The participants revealed that this rhythm was also taking place when they were experiencing the comforting-anguishing rhythm of rational suicidal ideation. The participants revealed the concept of enabling-limiting by explicating the myriad of possibilities presented both by dying and by living.

> M.T.: *The number of things that can happen after I die is unfathomable...but I can't deny that continuing to live also could bring some new possibilities...or even a cure...and then my life would be so different.*

> S.L.: *Going on living could mean that I could be left on life support and that would be a nightmare way of living...but I'm very spiritual and dying could mean a whole lot of new things for me.*

The participants thus revealed that the experience of rational suicidal ideation is both multidimensional and paradoxical. The participants also explicated enabling-limiting in a more concrete manner. The data from the participants revealed that as the participants experienced

suicidal thoughts as comforting (moved toward dying), they limited their opportunities for such things as experiencing a cure from AIDS. Conversely, as the participants experienced suicidal thoughts as anguishing (moving toward living), they limited their opportunities for such things as relieving suffering. Thus, the participants supported the concept of enabling-limiting as posited by Parse's (1992) theory of human becoming.

Moving Toward and Away from Valued Others

The participants revealed that another core concept of the structure of rational suicidal ideation was the moving away from and moving toward valued others. The *valued others* that participants spoke of included, but were not limited to, close friends and family. Valued others also included trusted health care providers such as counselors and physicians. Moving together with valued others was revealed through descriptions of informing valued others of the intent to commit suicide as a means of circumventing the anticipated profound suffering of dying as an end result of their experience with AIDS.

> R.K.: *I felt that I would need to tell my friends and my family...they are close to me, and they shouldn't be just shocked to hear it. It's like withholding from them that you have AIDS, and they find out and they can't believe that you didn't tell them. It's not right.*

> S.L.: *At that time when I thought that I needed to move*

myself and tell my friends that I was moving to the phase of getting on with dying...I told them and it was no surprise. We had talked about it a lot before.

Participants also described desires to have valued others share in their dying experience. They revealed that the actual suicide act should be one where valued others would be comfortable enough with the act in order to share the dying experience with the dying person. Participants described the method of dying in detail, and specified that the means should allow the participant to pass away quietly and comfortably as opposed to a demonstratively painful death such as by hanging or gunshot.

S.L.: *I think that when you go through with suicide, it has to be something where your friends and family can be there with you and not be turned-off...like using a gun...who wants to see someone hang themselves? That kind of stuff isn't reasonable. That is the time when I want to have that little bottle of pills.*

R.K.: *You would have to do it in a way that isn't going to be shocking or painful...you have to have something...pills or something in your vein...that will let you die quietly.*

M.T.: *People in your life have been so important to you and they have done so much to help you...you need to*

drift away quietly with them there.

Participants spoke of needing a trusted health care provider (e.g., a physician) to be honest with them in determining whether there was any reasonable hope of regaining lost QOL and relieving the consequent profound suffering.

R.K.: *My doctor would have to be honest with me about it and tell me if I was going to get better...if I wasn't, he would need to be honest about it.*

S.L.: *I know the time when my body is reaching the point of no return...I need...my doctor to be honest and straightforward...I need that information, but I would know if he was lying just to talk me out of it...so, he can't lie to me because I would know it...you know how you know these things?*

Moving apart from valued others in the structure of rational suicidal ideation was revealed through participants' descriptions of affirming their independence in making the final decision to commit suicide. Although valued others were important to the participants in their decision to commit suicide, they adamantly stated that they both controlled the final decision themselves and did not need the permission of others. Also contained in the statements of the participants were images of moving away from valued others toward the

dying experience.

> P.J.: *You have to talk to other people because they've helped you...but they can't talk you out of it. I know they can't talk you out of it...I only need my own permission...if I am going to die anyway.*
>
> S.L.: *Talking with friends and family does not mean that I need their permission. After all, I will die anyway despite their permission.*

Participants moved toward valued others while at the same time separating themselves from valued others as they moved toward the dying experience. All at once, they sought information and support from valued others to know the time and means of their suicides while maintaining firm, personal control over the suicide experience. This apparent paradoxical movement occurs with all phenomena important to human experience (Parse, 1997). Within Parse's (1992) theory of human becoming, she describes "Connecting-separating is a rhythmical process of moving together and moving apart" (p. 38). The process of moving together and apart from valued others in the structure of rational suicidal ideation exemplifies Parse's concept. Parse (1992) describes it as both moving close to a phenomenon while moving away from the same phenomenon at the same time. The participants' descriptions supported this tenet of Parse's human becoming theory.

Emerging Spirituality Illuminating the Ebbing and Flowing of Living-Dying

Participants revealed that rational suicidal ideation included increased concerns with spiritual aspects of their dying experience. They spoke of wondering about the afterlife, the dying experience, and thoughts of a supreme being in the context of the experience of living with AIDS. These wonderings about spirituality were unique to each participant with each person expressing spirituality in different ways. For example, one participant described moving closer to God and that God was not going to punish him for rational suicidal ideation. Another participant described how his spiritual beliefs had expanded which allowed him to see suicide as a release from the profoundly debilitating effects of opportunistic infections. However, all of the participants revealed that their emerging spirituality shed light on the experience of living-dying.

P.J.: *I'm pretty spiritual. I think about a lot of what's after death...I don't believe in hell or anything like that...I know that when I die then I will be released from the hell of AIDS.*

S.L.: *Death will be a release. It was not something that I felt personally before I got AIDS. But I had [close people] die while I was there and I helped them to end it. Now that I've been there, I know the kind of release that [my friends] were looking forward to.*

Participants revealed the ebbing and flowing of the living-dying experience to be a process of moving closer to and away from the actual act of suicide. Moving away from suicide was accompanied by a resurgence of QOL with a remission in profound suffering. Moving toward suicide was attended by the sudden loss of QOL with a return of profound suffering. The participants revealed that the lived experience of rational suicidal ideation was a recurring of this pattern of moving toward and away from living-dying.

> R.K.: *It's at that point where I won't be able to do those things for myself...where I am getting dead to myself that I think of suicide...What can you do? It's only a disease...But I got better. I wanted to get better and I did. But I know that fighting AIDS is a matter of time before your not able to do those things that make life worth while.*

> S.L.: *It's all of the little things that make life worth while...if I can't do those things...I feel like I'm in prison...then I guess that is what I want to do is die. But I'm here now because I want to get through this thing.*

Nokes and Carver (1991) noted in their study on the lived experience of AIDS that spirituality emerged as a theme. Also, they noted that participants' themes included thoughts of mortality surfacing and subsiding. Within the

current research study participants described similar themes in their statements about experiencing rational suicidal ideation.It can be tentatively advanced then, that for the participants in this study the experience of rational suicidal ideation may also be integral to their lived experience of AIDS. Indeed, Nokes and Carver noted that some of their participants contemplated suicide, but the nature of participants' suicidal ideation was not explored to any depth.

Within the current research study, participants also revealed that they had experienced rational suicidal ideation more than once since being diagnosed with AIDS. That is, the experience of living with AIDS involved recurring cycles of losing and then regaining satisfactory QOL. However, rational suicidal ideation emerged stronger each time the cycle repeated itself as the experience of living with AIDS moved the participants closer to dying.

Paradoxically, participants revealed that once they regained their QOL, they perceived their QOL as the same as before the onset of an opportunistic infection or AIDS related complication. This is a significant finding in that AIDS is often regarded as a progressively worsening disease that results in eventual debilitation (Hardy, 1991; Rabkin et al., 1993). Participants revealed that although AIDS may be a progressive deterioration in physical and physiologic function, perceived QOL was based on their ability to engage in seemingly simple but fulfilling social, physical, and cognitive activities. Once the participants regained their

ability to engage in the aforementioned activities, rational suicidal ideation subsided.

> P.J.: *I had to start using a cane and the pain made it so I could not even get out of my apartment...I thought about this being the end...I could not keep going...but I started to get better and I was able to go to the mall and meet with my friends, and then I was better again.*

> M.T.: *I was so sick that I just sat in my bedroom and laid on my bed and watched television...I never watched television...and I couldn't concentrate enough to write...but [my doctor] said I would get better...and I was able to start writing again...and I felt that I was back in my life.*

> S.L.: *I couldn't move around because of my hip...and I couldn't go out of the house...and I knew if this was the way it would be I was not going to live like that...but I got better on my own...and then I knew that I was better...I was able to go out with my friends and come back with a smile on my face.*

Rabkin et al. (1993) revealed in their study on suicidal ideation among PWAs that suicidal ideation appeared to arise with the occurrence of severe physical illness and consequent hospitalization. Qualitative interviews revealed that the suicidal ideation described by Rabkin et al. was related to

the loss of QOL for the PWAs. However, as PWAs experienced a recovery of their QOL, suicidal ideation subsided (Rabkin et al.). The current research study supports the data reported by Rabkin et al. Rational suicidal ideation for participants in the current study surfaced and subsided as QOL ebbed and flowed through the course of their experience with AIDS.

Within the lived experience of rational suicidal ideation, emerging spirituality sheds light on the pushing and pulling forces that move a person in profound suffering toward suicide. The rhythmic, recurring nature of the decline and the resurgence of QOL for PWAs creates an ebbing and flowing of living-dying. This rhythmic interaction creates the conflict between considering suicide as a means of relieving profound suffering and desiring to continue living with hope that QOL may return. Emerging spirituality then allows the participants to view this rhythm and move toward or retreat from living-dying in accordance with their cherished values and treasured beliefs.

Within the theory of human becoming, spirituality illuminating the ebbing and flowing of living-dying can be viewed as powering (Parse, 1992). Parse notes that powering is the energy that prompts people to move beyond their present experience to new experiences. Powering is also a rhythmic energy that represents the motivating and restraining forces within human experience. Parse posits that powering elucidates perspectives when conflict arises between motivating and restraining forces. Elucidation of perspectives then allows humans to move from their present

experience to new experiences. In the current study, *powering* was the force that allowed participants to move beyond living with profound suffering. The *moving beyond* profound suffering followed the variability in QOL described by the participants. As QOL deteriorated and appeared irretrievable, powering allowed participants to move toward rational suicidal ideation.

CHAPTER V

Discussion of Results

The results of the study revealed two important findings connected with the two purposes of the study. The first purpose was to describe the structure of rational suicidal ideation as experienced by persons with AIDS. The second purpose was to develop preliminary criteria from PWAs with which nurses could guide their clinical judgment when working with PWAs who voice suicidal ideation.

The Structure of Rational Suicidal Ideation

The research results provided four core concepts discussed above that were woven together to form a structure of rational suicidal ideation. The human becoming theory and research method of Parse (1992; 1987) guided both the data collection and data analysis. The structure of rational suicidal ideation as experienced by persons with AIDS is proposed to be:

> *Pronounced suffering amidst overwhelming loss of QOL prompts thoughts of suicide which surface comfort and anguish while moving toward and away from valued others which emerges spirituality that illuminates the ebbing and flowing of living-dying.*

A Translation of the Structure of Rational Suicidal Ideation

Parse's language presents a challenge for persons who are unfamiliar with her theory of human becoming (Polifroni & Packard, 1992). The researcher surmised that many persons reading this report will be perplexed by the simultaneous, complex language of Parse's theory of human becoming.

Therefore, the researcher endeavored to put the above structure in wording that may be more familiar persons not conversant with the Parse's language. The following is a "translation" of the aforementioned structure of rational suicidal ideation as experienced by PWAs.

The structure provided a description of what it is that creates and provokes rational suicidal ideation for PWAs. It was found that a complete, catastrophic loss of quality of life (prompted by a complication of AIDS such as an opportunistic infection) leads to a profound, global suffering. The suffering described involved spiritual, physical, emotional, psychological, and social anguish. Thoughts of suicide emerged from the suffering and provided both comfort and anguish as participants wanted to end their suffering by suicide but approached death with considerable trepidation. Participants reached out to valued others (e.g., family, friends, trusted health care providers) to discuss plans of suicide. At the same time, participants kept control of the act of suicide for themselves and affirmed their own self-determination. The experience of rational suicidal ideation also involved a renewed and insightful spirituality that allowed participants to know that suicide should only be used when they were past any hope of recovering an acceptable quality of life. Interestingly, physical pain, being a burden to others, and depression were not components of rational suicidal ideation.

Preliminary Practice Criteria for Rational Suicidal Ideation

The second purpose of the research was to use the

structure of rational suicidal ideation to develop clinical criteria for nurses working with PWAs who voiced suicidal ideation. In keeping with the epistemologic basis of Parse's (1992) theory of human becoming, research results were not used to reduce the experiences of participants to a clinical list of objective criteria. Instead, preliminary clinical criteria were developed from but remained within the core concepts of the structure of rational suicidal ideation. That is, criteria for rational suicidal ideation must be discussed in terms of the core concepts from which they were developed. Therefore, the core concepts form the organizing structure within which criteria for rational suicidal ideation will be discussed.

When clinical criteria for rational suicidal ideation were proposed, criteria were viewed within the limits of Parse's theory of human becoming. The criteria drawn from the proposed structure of rational suicidal ideation *cannot* be used to construct an objective check-list that is then used to score the "rationality" of a PWAs suicidal ideation. This would imply that a nurse can decide objectively and unilaterally (i.e., meeting certain clinical criteria) whether a person with AIDS is experiencing rational suicidal ideation. This implies a universal reality that is unidimensional and knowable in the same way to all persons (Mitchell & Cody, 1992; Morse & Field, 1995; Parse, 1992; Polkinghorne, 1983) and violates the theoretic basis of the research within which the current study was conducted.

Parse's theory avers that reality is multidimensional

and uniquely experienced. Parse further proposes that persons are experts of their own lives and fully responsible for the choices they make (Pilkington, 1993). Therefore, criteria (derived from research grounded in the theory of human becoming) need to be viewed as sign posts that signal important areas to be explored between nurses and PWAs who voice suicidal ideation. A nurse should not use criteria as a basis for unilateral action or inaction when working with a PWA experiencing suicidal ideation. Instead, criteria signal the need for the nurse and the PWA to work together to explore from where the suicidal ideation is originating. After a thorough exploration, the nurse and the PWA can determine the most appropriate course of action. It is within this framework that the following criteria for rational suicidal ideation were proposed.

Complete loss of QOL. When a PWA voices suicidal ideation, the nurse must become attuned to listening to how QOL is described. Nurses should be aware that QOL is uniquely experienced by the PWA and therefore only fully knowable to the PWA (Parse, 1992). The nurse needs to engage the PWA in a deep exploration when discussing QOL. The nurse should explore with the PWA the PWA's current QOL in light of the research evidence presented in this study.

Within the current research study, participants described an overwhelming loss of QOL in which they could not take care of their own basic needs (e.g., hygiene, nutrition, fluids), they could not participate in interactions with important others (e.g., unable to get out of the house or out

of bed), and they could not participate in enjoyable activities (e.g., creative endeavors, taking walks, going to a mall). Within the research, all of the participants described the loss of all of the aforementioned aspects of QOL, not just one or two. Therefore, the nurse should look for cues that a PWA has a completely compromised QOL.

Suicidal ideation varies with experienced QOL. Participants revealed that suicidal ideation increased and decreased in relationship to their QOL. As the participants' QOL improved, suicidal ideation subsided. Conversely, as the participants' QOL declined further, suicidal ideation reemerged.

The rhythmic ebbing and flowing of suicidal ideation in relationship to experienced QOL is important for at least three reasons. The first is that the nurse working with a PWA who voices suicidal ideation needs to examine descriptions of how the PWA's suicidal ideation changes with perceived changes in QOL. This would require the nurse to explore with the PWA how suicidal ideation ebbed and flowed in the past. For example, if the PWA communicates that suicidal ideation has always been present at the current intensity with a perceived adequate QOL, then irrational suicidal ideation is probably present considering the current research results.

A second reason that the rhythmic ebbing and flowing is important for delineating between suicidal ideation that is the result of being diagnosed with AIDS and suicidal ideation that is the result of an overwhelming loss of QOL. Participants in the current study denied that the actual

diagnosis of AIDS was reasonable cause to be suicidal. Participants revealed that suicidal ideation arising from being diagnosed with AIDS was irrational in nature. These data were supported by qualitative data from other researchers (Nokes & Carver, 1991; Rabkin et al., 1993). Participants in the current research study revealed that it was the profound suffering that accompanied the loss of QOL as a result of an AIDS complication that gave rise to what was described as rational suicidal ideation. Thus, if a PWA verbalizes suicidal ideation in response to the diagnosis of AIDS without evidence of a profound change in QOL, irrational suicidal ideation should be suspected.

The third reason that the rhythmic ebbing and flowing of living-dying is important is that a nurse who encounters a PWA voicing suicidal ideation needs to consider the structure of rational suicidal ideation as a whole. The concepts contained within the structure should not be used separately to examine the rationality of suicidal ideation voiced by a PWA. For example, the ebbing and flowing of living-dying must be examined in relationship to experienced QOL. Furthermore, determining the rationality of suicidal ideation would not be complete without examining the PWA's interpersonal relationships, feelings about the experience, and spirituality. Both the research results and the theoretical framework within which the research was designed require that the rationality of the suicidal ideation of a PWA be considered using the entire structure as a whole.

Profound suffering. Another critical component to

discuss is the aspect of profound suffering. The nurse should look for descriptions of profound suffering with respect to the research results. As with QOL, the research participants described suffering as all encompassing and integral to the loss of their QOL. The nurse working with a PWA who voices suicidal ideation needs to explore suffering in the same manner that QOL is explored. Descriptions of both how deeply felt and how encompassing is the suffering will assist the nurse in identifying the rationality of the PWA's suicidal ideation.

Participants described a holistic suffering that went beyond the concept of uncontrolled physical pain which is cited in the literature as a major reason many terminally ill persons commit suicide (Beckerman, 1995; Beckett & Shenson, 1993). Indeed, participants denied that physical pain was a major portion of their suffering and stated that they felt confident that their physical pain could be relieved. This result supports the notion that suicidal ideation arising from physical pain should be taken as a symptom of poorly controlled pain (Brown et al., 1986; Clark, 1992) and that the nurse should assist the PWA to seek better pain control. Also, this result suggests that suicidal ideation arising from uncontrolled pain may be a form of irrational suicidal ideation.

Thoughtful consideration of the consequences of suicide. When a PWA verbalizes suicidal ideation in relationship to their experience with AIDS, the nurse needs to discuss with the PWA feelings aroused by thoughts of suicide. The nurse

needs to pay close attention to how PWAs describe their feelings, and the nurse should view the feelings of PWAs in the context of the findings presented in this research study. The data from participants revealed that rational suicidal ideation was accompanied by the presence of both feelings of comfort and feelings of anguish.

The feelings of comfort appeared to arise from anticipating that death would relieve the profound suffering experienced by the participants. Anguish appeared to arise from thoughts of dying and the *not knowing* of what was to come after death. Also, the final separation of the PWA from self and the life world produced profound trepidation as revealed by the data.

The paradox of experiencing both comforting and anguishing feelings represents thoughtful consideration of all of the consequences of suicide (relief and anguish). The literature notes that a thoughtful consideration of the consequences of suicide is a criterion for determining that suicidal ideation is rational (Siegel, 1995; Werth, 1995; Werth & Cobia, 1995). It may be that the paradoxical presence of both comfort and anguish in the context of experiencing suicidal ideation for PWAs indicates rational suicidal ideation. Whereas, the presence of comfort or anguish by themselves indicates irrational suicidal ideation.

The data also revealed that the participants considered the impact of their suicide on important others. This further supported the notion that thoughtful consideration of the consequences of suicide is an important criterion for

rational suicidal ideation. Participants revealed that they felt it was important to reveal their plans for suicide to family and friends. Moreover, participants stated that the chosen method of suicide needed to be one that allowed important others to feel comfortable enough that they could remain with the participants throughout the dying process. Participants stated that the method of rational suicide needed to result in a quiet, comfortable death.

Overall, the thoughtful consideration of the consequences of suicide revealed that the participants were not acting or thinking in an impulsive manner. The literature reports that irrational suicide is often an impulsive act to relieve suffering brought about by a mental illness such as major depressive disorder (Beckerman, 1995; Clark, 1992; Siegel, 1989; Werth, 1995). Impulsivity implies that very little consideration is given to the consequences of suicide beyond the immediate relief of suffering brought about by mental anguish.

The nurse, in working with a PWA who voices suicidal ideation should examine whether or not the PWA has thoughtfully considered the consequences of suicide. The nurse should listen for descriptions from the PWA of having discussed the suicidal ideation with important others. If the PWA reveals that the suicidal ideation has not been discussed with others, then the PWA may be experiencing irrational suicidal ideation. The nurse should also listen for descriptions of the suicide plan. Suicide plans that describe violent means of death (e.g., gunshot or hanging) or means of

death where important others cannot be present (e.g., carbon monoxide poisoning) may again indicate that the PWA is experiencing irrational suicidal ideation. Conversely, if the PWA describes discussing a nonviolent suicide plan with important others and desiring that important others be present at the time of death, then (based on the current research data) the PWA is probably experiencing rational suicidal ideation.

Connectedness with family and friends. Another concept of the structure of rational suicidal ideation revealed by the research participants was that they connected and separated with friends, family, and others (e.g., health care providers) in the process of their suicidal ideation. This is an especially important finding considering that the literature notes that many people with suicidal ideation tend to withdraw from close and supportive relationships (Werth, 1992; Werth, 1995). The participants revealed that they had discussed their suicidal ideation with others and had not withdrawn from friends, family, or others.

Self-determination. Although the participants shared their suicidal ideation experiences with important others, the participants also revealed that they did not give up their self determination in the process of suicidal ideation. Much to the contrary, the participants retained control over the final decision of suicide. Self-determination is recognized in the suicide literature as very important for determining the rationality of suicidal ideation (Siegel, 1989; Werth & Cobia, 1995). The participants in this study

supported that self-determination is an important factor in rational suicidal ideation.

For the nurse working with a PWA who voices suicidal ideation, it is proposed that the PWA's relationships with significant others must be explored to determine the presence of moving toward important others. Important others may also include health care providers. Additionally, self-determination can be supported by observing for expressions from PWAs that they are retaining for themselves the final action of suicide.

Spirituality and congruence with personal beliefs. Spirituality is not a concept that can easily be explored or assessed by a nurse working with a PWA who verbalizes suicidal ideation. However, the nurse should look for expressions of wanting to move beyond the experience of living with AIDS. Within the research, participants shared their ideas of spirituality in several ways. Two participants directly mentioned that they perceived a spiritual awakening that allowed them to feel more at ease with the idea of suicidal ideation as a means of relieving profound suffering. Another participant spoke of feeling the need to move beyond his earthly existence. Within the literature, the closest concept supporting spirituality as a criterion for rational suicidal ideation is the requirement that suicide must be congruent with personal beliefs (Werth & Cobia, 1995). Within the current research study, the participants revealed that rational suicidal ideation was congruent with their cherished personal values.

Absence of depression. Participants described knowing when they were depressed and when they were not depressed. Participants stated they knew when they were depressed because they felt life was not worthwhile but that they were able to engage in activities and relationships that comprised a satisfactory QOL. The participants stated that suicidal ideation at these times would be irrational. Conversely, participants described experiences of rational suicidal ideation in which they knew they were not depressed. During these experiences, participants stated that suicidal ideation was prompted by a loss of QOL that encompassed many if not all aspects of their lived experience (e.g., social aspects, physical aspects, psychological aspects, and spiritual aspects). They described suffering as an experience that was different from depression. Participants described suicidal ideation at these times as rational.

Thus, depression did not appear to be a component of rational suicidal ideation for participants. This finding is particularly important in that much of the literature claims that suicidal ideation is a symptom of depression even for persons who have terminal illnesses (Brown, 1986; Clark, 1992; Siegel, 1986; Werth, 1992). However, the data from the current study rejects the notion that suicidal ideation is always a symptom of depression. Indeed, participants of the current research study delineated between rational and irrational suicidal ideation based upon the presence or absence of depression. Participants were also able to describe in concrete terms how they knew they were or were

not depressed.

Cognitive complexity and rational suicidal ideation. Although not explicitly revealed by participants, the data revealed that the participants engaged in a very complex cognitive process when they experienced rational suicidal ideation. Participants took into account numerous complex variables in their consideration of suicidal ideation (e.g., consequences of suicide and experienced QOL). Participants also monitored their QOL closely and engaged in a complex decision-making process when determining if they could regain lost QOL. Additionally, the participants revealed that the rationality of suicidal ideation cannot be determined by just one or two of the aforementioned criteria. Instead, all of the criteria need to be present in order to deem suicidal ideation to be rational. Thus, the nurse working with a PWA who verbalizes suicidal ideation needs to look for evidence of a thoughtful, complex thinking process in which all of the various criteria for rational suicidal ideation have been described.

Comparison of Results with Related Research

No nursing research was found that examined rational suicidal ideation. Within the research literature, only one study was found that empirically examined criteria for rational suicidal ideation. Werth and Cobia (1995) described three criteria (with 5 subcriteria for the third criterion) for rational suicidal ideation in their qualitative study examining rational suicide (see Table 1, p. 15).

The structure of rational suicidal ideation derived from

the current research study supported many of the criteria proposed by Werth & Cobia (1995). The core concepts also clarified some criteria. The core concepts did not support at least on of the criteria proposed by Werth and Cobia. A table comparing Werth's and Cobia's criteria to the core concepts derived from the current research is included on page 65 (Table 2).

The concept of moving toward and away from important others supported the criterion that persons with rational suicidal ideation consider the impact of the suicide on significant others. The concept of emerging spirituality illuminating the ebbing and flowing of living-dying supported the criterion that rational suicide should be congruent with personal values. The concept of moving toward and away from valued others supported both the criterion of rational suicide as a free choice and the criterion of engaging in a sound decision-making process.

Results of the current research also clarified the criterion of a person having a hopeless and unremitting condition (Werth & Cobia, 1995). Participants revealed that being diagnosed with AIDS did not constitute a hopeless and unremitting condition. Although participants perceived AIDS as a grave and ultimately fatal illness, they stated that despite the diagnosis of AIDS they lived fulfilling and rewarding lives. Participants described instead that it was the complete loss of QOL related to an AIDS complication (e.g., an opportunistic infection) combined with no reasonable chance of recovery that constituted the hopeless

Table 2.

Werth's & Cobia's Criteria for Rational Suicidal Ideation and Supporting Core Concepts from the Structure of Rational Suicidal Ideation.

Werth & Cobia (1995) Criteria	Core Concepts Supporting the Criteria
1. The person has a hopeless, unremitting condition.	Pronounced suffering amidst an an overwhelming loss of QOL.
2. The decision to commit suicide is made as a free choice.	Moving toward and away from valued others.
3. The person has engaged in and completed a sound decision-making process. (Includes 5 subcriteria).	Surfacing of comfort and and anguish. Moving toward and away from valued others. Emerging spirituality illuminates the ebbing and flowing of living-dying.
a) a mental health assessment has been conducted by a health professional.	Moving toward and away from valued others.
b) all alternatives (e.g., pain control) have been exhausted.	Pronounced suffering amidst an an overwhelming loss of QOL.
c) suicide is congruent with personal values.	Emerging spirituality illuminates the ebbing and flowing of living-dying.
d) the person has considered the impact of the suicide on others.	Moving toward and away from valued others.
e) consultation has been made with objective, non-mental health professionals (e.g., clergy).	Not supported by the core concepts.

and unremitting condition. For participants, AIDS provided the context within which a complete loss of QOL was experienced. However, it was the complete loss of QOL that served as the basis for the hopeless and unremitting condition and thus the criterion for determining the rationality of suicidal ideation. That is, suicidal ideation cannot be rational for a PWA who can experience an adequate QOL.

Based on the current research data, in order for suicidal ideation to be rational, the presence of a diagnosis of AIDS needs to be accompanied by a QOL that is so desperately deteriorated that it evokes profound suffering. Furthermore, the PWA's disease condition needs to be such that prospects for recovery of QOL are exceedingly poor. Participants revealed that even a severely compromised QOL was tolerable for a time if recovery was viewed as reasonably possible.

The only criteria from the literature that was not supported by the data was that a non-medical professional (e.g., clergy or psychologist) should be consulted to assist in the determination of rational suicidal ideation (See Table 1, p. 14). Participants in the current research study revealed that a trusted health professional, friends, and family were included as *valued others*. Participants revealed that the aforementioned valued others were all of the persons that needed to be consulted. It is conceivable that non-medical professionals also are included as valued others by certain PWAs. However the current research data do not

support the need of PWAs to consult with outside professionals that are not already considered valued others.

Implications for Research and Practice

This research study represents a first step for examining the phenomenon of rational suicidal ideation as experienced by PWAs from a nursing perspective. The current research is important because it is the first nursing research study to examine the phenomenon of rational suicidal ideation from the perspective of persons actually experiencing the phenomenon. Also important was that the research data were used to propose tentative criteria for rational suicidal ideation. Additionally, the research data were used to examine the validity of criteria for rational suicidal ideation in the research literature. The results of the current research also generated new questions for future research into the phenomenon of rational suicidal ideation. Despite the importance of the current research, the study had important limitations that restricted the usability of its findings. Following is a discussion of the limitations, practice implications, and research implications of the research results.

Limitations of the Research

The most important limitation of the current study is that it involved a small number of participants. Although the number of participants resulted in the redundancy of themes as described by Parse (1987), the number of participants could not ensure the saturation of themes as described by

Glaser and Strauss (1967). Thus, it is possible that some themes important to rational suicidal ideation remained undiscovered in the current research. Moreover, the very serious nature of suicide obligates researchers to conduct further research before recommending that criteria for rational suicidal ideation be implemented into clinical practice. Therefore, the criteria for rational suicidal ideation developed from the current research study are not recommended for use within a clinical practice situation.

Another limitation of the current research is that all of the participants were men with AIDS. The results of the study are limited by the lack of data from women. This means that the research results do not provide a description of the lived experience of rational suicidal ideation for women with AIDS. Therefore, it would be impossible to determine if the structure of rational suicidal ideation developed within the current study also applies to women with AIDS.

The exclusive involvement of PWAs as participants also limits the usability of the research results. Although the study design specified PWAs as a theoretical population, other populations of gravely ill persons (e.g., persons with terminal cancer) have also been identified as experiencing rational suicidal ideation (Beckerman, 1995). Because the study did not include persons with other grave illnesses, the results cannot be applied to these groups for similar reasons that the results could not be applied to women with AIDS. That is, based on the current research results it would be impossible to determine if other persons with grave illnesses

experienced rational suicidal ideation in the same manner as PWAs.

The phenomenologic-hermeneutic design of the current research provides another limitation to the use of the research results. Phenomenologic-hermeneutic designs do not lend themselves to generalizing results (Morse & Field, 1995; Streubert, 1995) because the purpose of phenomenologic-hermeneutic designs is to provide detailed descriptions of participants' personal experiences of particular phenomena (Polkinghorne, 1983). This means that participants are selected for phenomenologic-hermeneutic research because of their intimate knowledge of and extensive experience with the phenomenon under investigation (Morse & Field, 1995). This is in contrast to more generalizable research designs in which participants are randomly selected to reflect the larger population. Thus, results from phenomenologic research are not usually generalizable.

Strengths of the Research

The phenomenologic research design that limits the research is one of the major strengths of the current research study. The results of the current research study tapped into the experiences of PWAs who perceived their suicidal ideation as rational. Additionally, the research design resulted in detailed descriptions of the phenomena of rational suicidal ideation from the perspective of persons who actually experienced the phenomenon. The participant descriptions were rich enough to provide the basis for tentative clinical criteria for determining the rationality

of suicidal ideation verbalized by a PWA.

Another strength of the research was that participant descriptions of the experience of rational suicidal ideation provided a means by which to examine the validity of criteria for rational suicidal ideation empirically developed by Werth and Cobia (1995). That is, the use of a different participant group (i.e., people who actually experienced rational suicidal ideation) and a different design (i.e., Parse's research method) resulted in criteria for rational suicidal ideation that were similar to those developed by Werth and Cobia. The use of different research methods to examine a phenomenon is called *triangulation*, and triangulation which results in similar findings between studies supports the validity of the findings (Polit & Hungler). Thus, although the results from the current research cannot be recommended for use in clinical practice, they supported the validity of existing criteria for rational suicide.

Practice Implications of the Research Results

The nursing literature contained no extant practice framework for working with PWAs that voiced rational suicidal ideation. Therefore, an effort was made to place the research results in a nursing practice context. The way this was done was to translate the concepts of the structure of rational suicide into clinical criteria that can be used by nurses to explore with PWAs the rationality of their verbalized suicidal ideation. However, both the limited number of participants and the data analysis from the current research study were not sufficient to develop a nursing practice

framework. In order to develop a nursing practice framework, research involving a larger number of participants is needed to provide a greater amount of confidence that the research results represent a broad, intersubjective phenomenon. Also, the data analysis will need to be moved to the level of *heuristic interpretation* in which the structure of rational suicidal ideation is woven into the theoretic principles of the theory of human becoming (Parse, 1992; Pilkington, 1993). The current study stopped the data analysis at the level of structural description. Future research should focus on gathering data from a larger number of participants and then taking the data analysis to the level of heuristic interpretation. Once the connections with Parse's theory are made, then a clinical practice framework can be developed.

Research Implications of the Research Results

Future research should be directed at testing the credibility of the structure of rational suicidal ideation formulated from the data collected in the current research study. One method of testing the credibility of the structure of rational suicidal ideation is through the use of a different qualitative method with a similar group of PWAs (Marshall & Rossman, 1995; Polit & Hungler, 1995). For example, would criteria developed using a grounded theory approach be similar to or different from the criteria developed using Parse's (1992) research method? Another method of testing the credibility of the core concepts is by subjecting the structure of rational suicidal ideation to varying levels of concept analysis (Morse, 1995; Morse &

Field, 1995).

Two of the identified limitations of the current research study was that all of the participants were PWAs and all of the participants were men. Future research could expand the investigation of rational suicidal ideation to other groups of people experiencing either grave disease or terminal illness (e.g., malignant cancer or multiple sclerosis). An example of a future research question might ask what is the structure of the lived experience of rational suicidal ideation for persons with terminal cancer? Additionally, further research might inquire as to whether the structure of rational suicidal ideation is experienced differently by diverse groups of PWAs. For example, is the structure of rational suicidal ideation for women with AIDS similar to the structure of rational suicidal ideation for men with AIDS? Answers to these additional research questions would assist in broadening the knowledge base for rational suicidal ideation. The knowledge derived from such research could then be used to expand, narrow, or refine clinical criteria for rational suicidal ideation.

Another important research area to be explored is in the area of irrational suicidal ideation. The current research study revealed the structure of *rational* suicidal ideation, but some of the results indicated that *irrational* suicidal ideation may also have a distinct, describable structure. Future research should explore the structure of irrational suicidal ideation as experienced by PWAs (or persons with other types of grave and terminal illnesses). Importantly,

descriptions of irrational suicidal ideation would provide *negative cases* of rational suicidal ideation that would assist in further defining and refining criteria for rational suicidal ideation (Morse, 1994).

Rational Suicidal Ideation versus Assisted Suicide

It is very important to note that the phenomenon of rational suicidal ideation is separate from the issue of assisted suicide. Rational suicidal ideation is a phenomenon that is supported by both recent empiric investigations and the conceptual literature (Beckerman, 1995; Werth & Cobia, 1995). That is, rational suicidal ideation has been revealed to be a legitimate phenomenon that can be described in terms of clinical criteria and human experiences (Werth & Cobia, 1995). Thus, a person voicing suicidal ideation (in the presence of a nurse or other health care professional) can then be determined to be experiencing either rational or irrational suicidal ideation.

Participation in the act of assisted suicide, however, is an ethical issue that is guided by personal beliefs, legal parameters, and by personal mores concerning suicide (Clark, 1992; Werth, 1992). Answers to ethical issues cannot be determined using empirical research (Polit & Hungler, 1995). That is, the right and wrong of assisted suicide is a matter of personal belief and can only be answered in the context of personal and social philosophies. The rightness or wrongness of assisted suicide is determined by the ethical beliefs of the persons involved. To put it bluntly, if a person is morally opposed to suicide under any circumstances then

participation in assisted suicide will always be deemed unethical no matter how criteria are developed for rational suicidal ideation.

Research into rational suicidal ideation is aimed at ensuring that those persons who feel assisted suicide to be ethical will make informed decisions (Werth & Cobia, 1995). That is, research into rational suicidal ideation may help to protect PWAs (and perhaps other gravely ill persons) who believe assisted suicide is ethical. The research concerning rational suicidal ideation would protect PWAs by providing health care professionals with a reliable, empirically based clinical framework for determining whether or not PWAs are actually experiencing rational suicidal ideation. In the likely event that assisted suicide becomes legal, empirically based clinical frameworks are more desirable than clinical frameworks based upon the personal beliefs of health care professionals.

A Brief Conclusion

The current research study supports the notion that a reliable clinical framework can be developed for guiding decisions about rational suicidal ideation. The research results also emphasized the need to examine the phenomenon of rational suicidal ideation from the perspective of persons who are faced with grave disease and terminal illness. The results of the current study should serve as an impetus for developing clinical frameworks through the conduct of empirical research.

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Appendix A

Selection and Exclusion Criteria for Participant Recruitment

Selection and Exclusion Criteria

Diagnosis of terminal illness. The first criterion is that the participants be diagnosed with a terminal illness. This criterion is derived from the conceptual and empirical literature in which the presence of a terminal illness was found to be a key, defining criterion of rational suicidal ideation (Beckerman, 1995; Siegel, 1986; Werth & Cobia, 1995; Werth & Liddle, 1994).

Experience with suicidal ideation. The second criterion is that the participants must have had the experience of suicidal ideation. Because phenomenologic inquiry focuses on lived experience, this criterion is essential. If one has not experienced a phenomenon, one cannot describe the experience.

No current suicidal ideation. The third criterion is that the participants are not suicidal at the time of the interviews. This criterion is important both from a participant protection aspect and from a research method perspective. From the protective aspect, concomitantly suicidal persons may be at increased risk for psychological trauma when prompted to discuss the events in their lives that led them to suicidal ideation. The selection of persons that are not actively suicidal will minimize the risk of unintentional psychological trauma. Therefore, acutely suicidal persons will be excluded. From a methodologic perspective, phenomenologic research requires a retrospective examination of lived experience. A person cannot communicate lived experience while currently living that experience. Lived experience is only identifiable after the specific

experience has passed; only then is one capable of reflecting on the experience in a meaningful way (Carpenter, 1995; Morse & Field, 1995; Oiler, 1981; Polkinghorne, 1983).

Ability to verbally describe lived experiences. The fourth criterion is that the participants must be able to verbally describe their personal experiences in detail. This criterion flows directly from the phenomenologic paradigm (Carpenter, 1995; Morse & Field, 1995; Parse, 1992; Polkinghorne, 1983).

National Institutes of Health diagnostic criteria for AIDS. Based upon the preceding criteria, PWAs are a theoretically significant population with regard to rational suicidal ideation. The available literature discussed previously indicates that PWAs form a population at significant risk for suicide, and that clinicians working with PWAs are likely to encounter a client who voices a reasoned decision to commit suicide (Beckerman, 1995; Motto, 1994; Werth, 1995). Thus, PWAs form a population that meets the requirements of theoretical sampling as described above (Glaser & Strauss, 1967; Polit & Hungler, 1995). Because of the aforementioned reasons and because of the probable role of rational suicide in PWAs who commit suicide, the participants selected for this study will be persons who meet the National Institutes of Health (NIH) diagnostic category for AIDS (Hardy, 1991).

Exclusion of persons with AIDS Dementia Complex. Persons with AIDS Dementia Complex (ADC) will be excluded from participation in this research study. Persons with ADC often demonstrate cognitive changes that include short term memory

loss and poor concentration (Newton, 1995; Selnes, Galai, Bacellar, Miller, Becker, Wesch, Van Gorp, & McArthur, 1995; Swanson, Cronin-Stubbs, Zeller, Kessler, & Bieliauskas, 1993). The process of phenomenologic research requires that participants be able to provide accurate, detailed descriptions of personal experience (Morse & Field, 1995; Carpenter, 1995). The aforementioned cognitive impairments will prevent persons with ADC from providing accurate, detailed accounts of their experiences with suicidal ideation.

The decision to exclude persons with ADC requires iterated criteria for exclusion. The determination of ADC is usually made with neuroimaging combined with neuropsychological testing which are both time consuming and expensive (McArthur, Hoover, Bacellar, Miller, Cohen, Becker, Graham, McArthur, Selnes, Jacobson, Visscher, Concha, & Saah, 1993; Newton, 1995; Swanson et al., 1993). For this research study, neuroimaging and neuropsychologic testing are unfeasible. Instead, criteria for exclusion were developed in consultation with an expert in the clinical treatment of AIDS. The following are criteria which can be used to reasonably ensure the exclusion of persons with ADC (M. Loveless, personal communication, November 11, 1996): a) the presence of a diagnosis of ADC; b) current treatment for moderate to severe anxiety; c) current or past treatment with psychotropic medications including neuroleptics, antidepressants, lithium, carbemazipine, or methylphenidate; d) presence of either a brain infection or a brain lesion;

e) a clinical history of major depressive disorder. Although these criteria are not specific for ADC, they are sensitive enough to reliably exclude persons with ADC (M. Loveless, personal communication, November 11, 1996).

Implementing the aforementioned exclusion criteria as opposed to using definitive testing presents the possibility that a person with ADC could be included in the sample of participants. If it is suspected during or after data collection that a participant has ADC, the data in question will be excluded from data analysis. The gathered data will then be archived for possible use in later research.

Age of participants. Participants eligible for inclusion into this study will be between 21 and 60 years of age. This age range was chosen for two reasons. The first reason relates to conceptual concerns. Among elderly persons (i.e., greater than 60 years of age) and teen-aged persons (i.e., between 11 and 21 years of age), suicide and suicidal ideation have more complex etiologies related to growth and development factors not seen in young and middle adulthood (Capuzzi, 1994; Schmid, Manjee, & Shah, 1994). These differences in etiology may pose problems for the credibility and trustworthiness of the data in this study. The second reason concerns participant protection. Elderly and teenaged persons are vulnerable populations, and it was determined that PWAs already compose a population that can be considered vulnerable due to the history of social and political discrimination that PWAs (as a group) have experienced (Werth, 1995). Thus, it is not appropriate to compound this

vulnerability by including persons in the elderly and teen-age ranges.

Appendix B

Clinical Provider Guidelines for Participant Recruitment

Clinical Provider Guidelines for Recruitment of Participants

Criteria for Participant Selection for Inclusion in the research study: "The structure of rational suicidal ideation as experienced by persons with AIDS."

The following is a list of selection criteria to assist you in identifying potential participants in this research study. Thank you for you assistance in this research endeavor.

Inclusion criteria:

1. The client must have a diagnosis of AIDS (as defined by the National Institutes of Health diagnostic criteria for AIDS).

2. The client must have had an experience of suicidal ideation after they were diagnosed with AIDS (as defined above).

3. The client must be capable of verbally describing the experience of suicidal ideation in great detail.

4. The client must be between the ages of 21 years and 60 years of age.

Exclusion criteria:

1. The client is either currently suicidal or states suicidal ideation.

2. The client has or is suspected of having a diagnosis of AIDS Dementia Complex (ADC). The client must be reasonably free of any suspected ADC. The following are exclusion criteria which, if any are present, the client cannot be considered for inclusion in this research study:

a) The presence of documentation of ADC in the client's medical record.
b) The client is being treated for moderate to severe anxiety.
c) The client is being or has been treated with the following medications:
   -neuroleptics
   -antidepressants
   -lithium
   -carbemazepine
   -methylphenidate
d) The presence of either a brain infection or a brain lesion
e) Any clinical history of Major Depressive Disorder

Appendix C

Participant Recruitment Brochure

Oregon Health Sciences University
School of Nursing
3181 SW Sam Jackson Park Road
Portland, OR 97201-3098

OHSU OREGON HEALTH SCIENCES UNIVERSITY

Oregon Health Sciences University includes the Schools of Dentistry; Medicine, and Nursing; Biomedical Information Communication Center; Center for Research on Occupational and Environmental Toxicology; Vollum Institute for Advanced Biomedical Research; University Hospital; Doernbecher Children's Hospital; University Clinics (medical and dental); and Child Development and Rehabilitation Center.

An equal opportunity, affirmative action institution

Terminal Illness and Assisted Suicide

A RESEARCH STUDY

By Darryl Stewart, RN, C, BSN
Graduate Nursing Student
Oregon Health Sciences University

OHSU

Where Healing, Teaching, and Discovery Come Together

Greetings:

My Name is Darryl Stewart. I am a Registered Nurse and a graduate student at Oregon Health Sciences University School of Nursing.

Since the Passage of the Oregon Physician-Assisted Suicide Law (Oregon Measure 16, 1994), the issue of assisted suicide has become very important for both health care providers and persons facing a terminal illness. More than ever, information is needed about this important subject.

I am currently recruiting volunteers to participate in a research study that will examine the issues and ideas surrounding assisted suicide.

Some of the possible benefits of shedding light on assisted suicide may include:

1) A better understanding of why people consider assisted suicide;
2) Information to help safeguard the rights and lives of persons considering assisted suicide.

If you wish to have more information about particpating in this study, fill-out the information card, detach, and mail in the postage-paid envelope provided.

All information provided will be kept confidential.

Terminal Illness and Assisted Suicide

A RESEARCH STUDY

First Name

Telephone

Thank You for your assistance in this research endeavor.

Appendix D

Demographic Information Form

DEMOGRAPHIC INFORMATION FORM

1. NAME (optional).

2. AGE.

3. GENDER

4. ETHNIC, CULTURAL, OR RACIAL IDENTITY

5. OCCUPATION

6. EDUCATIONAL BACKGROUND

7. SPIRITUAL OR RELIGIOUS IDENTITY

8. SOCIECONOMIC IFORMATION (optional).
   a. Income (annual).
   b. Housing situation.
   c. Health care needs (met and unmet).

Appendix E

Participant Protection Guidelines

Participant Protection Guidelines

Of paramount concern in this study is the protection of the physical, emotional, and mental well-being of the study participants. The reasons for the emphasis on protection are related to the nature of the phenomenon under investigation.

The phenomenon under study is rational suicidal ideation. This means that the persons who are participants in the study have experienced suicidal ideation at some time in the recent past and may be at an increased risk of suicide related to talking about their past suicidal ideation. A review of empirical and clinical literature indicates the opposite.

According to the National Alliance for the Mentally Ill (1996), talking about suicide and suicidal ideation does not increase suicide risk. In fact, the National Alliance for the Mentally Ill states that talking about suicide and suicidal ideation actually decreases the risk of suicide. This assertion is supported by Schmid et al. (1994) who found that failing to talk about suicidal ideation actually increased the risk of suicide attempts among study participants. Another study exploring suicidality among PWAs found that suicidal ideation occurred almost exclusively during events of serious illness (Rabkin et al., 1993). Additionally, two studies exploring suicidal ideation among PWAs did not report an increased risk of suicide from participation in the study (Jones & Dilley, 1993; Rabkin et al., 1993). Thus, it can be reasonably asserted that participation in this research will not increase suicidal potential among the participants.

Although participation in this study does not present a

suicide risk for the participants, the nature of the study design could expose the participants to emotional and psychological stress. Most qualitative research designs require extensive emotional and cognitive participation on the part of participants (Morse & Field, 1995). This usually arises from divulging personal information about unpleasant or unwanted experiences (Polit & Hungler, 1995). Within this study, the participants will be asked to describe their personal emotions and experiences around suicidal ideation. These emotions and experiences are typically very unpleasant (Rabkin et al., 1993). The task then is to minimize the emotional trauma that could result from participation in this study.

The primary investigator will minimize emotional stress for participants through the following actions. The first action will be to include emotional stress as a potential risk on the informed consent form to allow potential participants to assess their risk in collaboration with the investigator (see Appendix C). The second action will be to assess emotional stress before, during and after the research interview. The third action is to follow-up with the participants at one week and one month intervals to assess for subsequent emotional difficulties (member checks will be conducted at the same time). The fourth action will be to consult with a mental health faculty within the graduate school of nursing; the faculty will review data transcripts for messages that indicate potential emotional difficulties. The fifth action will be to provide the participants with:

a) telephone numbers for crisis centers and hotlines and b) telephone numbers of local health organizations that have psychiatric services. Each participant will be instructed to use these and other resources if feeling emotionally overwhelmed. In addition, each participant who has regular mental health counseling will be encouraged to continue their therapy.

In order to maintain rigor within the research design, each of the participants will be informed that the role of the researcher is that of an investigator and not that of a therapist. Participants will be provided with numbers and addresses of local psychological and psychiatric resources as noted above. Only in the unforeseen event that a participant becomes acutely mentally ill will the researcher intervene in a therapeutic manner as is required of a person with the Registered Nurse credential (American Nurses Association, 1985).

Confidentiality will be provided through the use of randomly assigned pseudonyms for data coding. In addition, transcripts of the data (and all copies or facsimiles) will be stored in a locked safe. Identifying information such as telephone numbers and addresses will be kept in a separate locked safe. Information contained within the transcripts will be shared only with those persons involved with data collection and analysis. The intent to share this information with the aforementioned persons will be provided in the informed consent.

Appendix F

Informed Consent Form

IRB#: 4262
Approval Date: 1/10/97

OREGON HEALTH SCIENCES UNIVERSITY
Consent Form

TITLE: **The Structure of Rational Suicidal Ideation as Experienced by Persons with AIDS.**

PRINCIPAL INVESTIGATOR: Darryl Stewart, RN, BSN.
Telephone: (503)-282-2063

CO-INVESTIGATORS: Leslie N. Ray, RN, PhD.
Telephone: (503)-494-3806
Carol Burckhardt, RN, PhD,
Telephone: (503)-494-3895

PURPOSE: The purpose of this research project is to increase health professionals' understanding of the experience of suicidal feelings of persons with life-threatening illnesses. You have been invited to participate in this research study because you have personal knowledge that is important to understanding the experience of suicidal feelings in persons with a life-threatening illness.

PROCEDURES: During this research project, you will be involved in interviews that will be conducted at least twice. Each interview will last approximately one hour. During these interviews, you will be asked to describe your personal experiences, feelings, and thoughts related to suicidal feelings. Interviews will be audio-tape recorded and written records will be copied from the tapes. The tape recordings, written records, and any copies will not be shared with anyone other than the investigators of this study. All tape recordings, written records, and copies will be kept in a locked safe. Only the principal investigator will have access to this safe. The final report will contain anonymous quotations, and it will be published in a professional journal (magazine). Upon request, the tape recordings and transcripts will be destroyed or returned after the study is completed.

RISKS AND DISCOMFORTS: Risks for participating in this research project are expected to be minimal. There are no physical risks for participation. However, strong emotions and feelings may occur when talking about your experience with suicidal ideation. These feelings can include from embarrassment, anger, and sadness. Assistance with referrals to psychological or psychiatric counseling will be provided by the investigators if requested by the participant.

BENEFITS: You may or may not personally benefit from participating in this study. However, by being a participant, you may contribute new information which may benefit persons with life-threatening illnesses in the future. Also, your participation may contribute to changes in the treatment of persons with life-threatening illnesses who have suicidal feelings.

ALTERNATIVES: You may choose **not** to participate in this study.

CONFIDENTIALITY: All information obtained from this study will be kept strictly confidential. Neither your name nor your identity will be used for publication or publicity purposes.

COSTS: There are no costs for participation in this study. There is no monetary or material compensation for participation. However, you have not waived your legal rights by signing this form.

LIABILITY: The Oregon Health Sciences University, as a public institution, is subject to the Oregon Tort Claims Act, and is self-insured for liability claims. If you suffer any injury from this research project, compensation would be available to you only if you establish that the injury occurred through the fault of the University, its officers, or its employees. If you have further questions, please call the Medical Services Director at (503) 494-8014.

PARTICIPATION: Your participation is voluntary, and you may refuse to participate or withdraw from participation in this study at any time without affecting my relationship with the Oregon Health Sciences University or the investigators. You also understand that you may refuse to answer specific questions during the interviews.

If, at any time, the investigator believes that you are becoming too emotionally stressed, the investigator reserves the right to end your participation in this study. You also agree that the investigator, at his discretion, may discontinue your participation in this study at any time.

Darryl Stewart [(503)-282-2063)] has offered to answer any other questions you may have about this study.

If you have any questions regarding your rights as a research subject, you may contact the Oregon Health Sciences University Institutional Review Board at (503)-494-7887.

Your signature below indicates that you have read the foregoing and agree to participate in this study.

You will receive a copy of this consent form.

_____ _____

Participant's signature Date

_____ _____

Investigator's signature Date

_____ _____

Witness' signature Date

Appendix G

Extraction-Synthesis Tables

Table 3
Extraction-Synthesis With Related Propositions
Participant: **M.T.**

Extracted Essences (Participant's-Researcher's Language)	*Synthesized Essences (Researcher's Language)*
Living day-to-day with AIDS, the participant focuses on attainable goals while hoping for a cure that will allow him to attain lifelong goals, while enjoying every aspect of being creative, doing everyday tasks for himself, and spending time with close friends and family.	Living with AIDS emerges living QOL through: a) creative expression, b) being with cherished others, and c) doing simple tasks independently.
Sudden, debilitating physical deterioration takes away all of his energy to: a) to do even simple every day tasks, b) to concentrate on writing which is his cherished form of creative expression, c) to have meaningful interactions with close friends, partner, and family. This causes him to begin envisioning an existence beyond his earthly presence.	Traumatic loss of QOL surfaces thoughts of suicide and profound spirituality.
He shares his thoughts of dying with close friends, family, trusted health provider, and partner, and he seeks guidance from them to determine the right time of dying. He insists on maintaining control over his death, but he wants others to share his dying experience.	Thoughts of mortality become more prominent leading to moving toward and away from cherished others.
His thoughts of suicide subside as physical wellness returns because he is able to: a) once again write, b) have meaningful relationships with others, c) do every day tasks of living. His thoughts of suicide increase as physical wellness decreases and he again cannot do the above. Throughout this, he hopes a cure is found for AIDS and he can live without AIDS.	Continuing to live health as a cherished value prompts moving toward and away from suicide as QOL ebbs and flows.
As he perceives death becoming imminent, he relies on memories of the deaths of others he has known, his dreams, his confidence in a higher power, and his knowledge of himself that suicide will alleviate the unnecessary suffering of dying as the end result of having AIDS. Suicide at this time will also make his death reflect those values that he has always cherished: a) independence, b) being healthy, c) controlling his own future.	Remembrance of always trying to live cherished values illuminates confident moving toward living/dying.

Proposition: The lived experience of rational suicidal ideation for this PWA is the emergence of thoughts of suicide from a traumatic loss of QOL which prompts moving toward and away from living and dying as suffering ebbs and flows. Thoughts of suicide simultaneously lead to moving toward and away from cherished others amidst the surfacing of profound spirituality that illuminates confident movement toward living-dying.

Table 3 (continued)
Extraction-Synthesis With Related Propositions
Participant: **S.L.**

Extracted Essences (Participant's-Researcher's Language)	*Synthesized Essences (Researcher's Language)*
Living one day at a time with AIDS leads this participant to enjoy all activities he can do for himself and share with friends and family. He also looks forward to the future while remembering the past without regrets.	Living with AIDS means that living QOL is expressed through valuing self and important others.
Suffering a severe illness, he is unable to do any activities for himself and he is unable to share important experiences with others. He feels that he has lost his quality of life and his health both of which he values highly in living his life. This leads to thoughts of choosing suicide as a means of continuing to live important personal values.	Shocking loss of QOL emerges living important values through thoughts of suicide.
As dying comes closer, he reaches out to important others, alive and dead, to affirm that dying will relieve his suffering. At the same time he accepts the understanding and compassionate beliefs of important others to determine the right dying moment.	Anguish of impending death is relieved through comforting being with others. This leads to confident and serene movement toward dying.
Both wanting to remain alive and realizing that dying is inevitable, he continues to hope for a cure for AIDS and is ready to move away from living-dying at any time. At the same time, if no cure is available, he wants to have control over his dying experience as an expression of living cherished personal values of a) living health, b) living quality of life, and c) independence.	Remembrances of living health and QOL as cherished values prompts movement toward and away from suicide.

Proposition: The lived experience of rational suicidal ideation for this PWA is the emergence of thoughts of suicide amidst a shocking loss of QOL which prompts moving toward and away from being with cherished others. Remembrances of living health through valuing self and important others prompts serene movement toward and away from living and dying.

Table 3 (continued)
Extraction-Synthesis With Related Propositions
Participant: **R. K.**

Extracted Essences (Participant's-Researcher's Language)	*Synthesized Essences (Researcher's Language)*
The participant realizes that death is imminent and inevitable because he is unable to participate in activities with important others, and he is unable to do the tasks of everyday life for himself. Thoughts of dying emerge and become prominent, but they are not overwhelming.	Loss of QOL surfaces comforting thoughts of suicide.
Remembering the deaths of important others from AIDS and anticipating his own dying experience from AIDS motivates him to plan a dignified death that reflects the importance he places on living QOL and health as cherished personal values.	Living health as a cherished value emerges confidence to move toward and away from the dying experience.
Picturing a dignified death, he reaches out to friends and family to share his feelings of fear and hope. While he he seeks guidance from his friends and family to know the right time to die, he insists on maintaining control over his dying experience. Simultaneously, he desires for friends and family to share his dying experience.	Prominent thoughts of mortality prompt being with cherished others and being alone with self.
He knows that he is strong and he always desires to be cured of AIDS, he continues to hope that he will regain his QOL. At the same time, he requires that he be able to choose his own time of dying to avoid unnecessary suffering and humiliation.	Desires to live treasured values of dignity and independence lead to a self-chosen, planned suicide.

Proposition: The lived experience of rational suicidal ideation for this PWA is the surfacing of thoughts of suicide amidst suffering loss of QOL. Prominent thoughts of mortality lead to moving together and apart from important others. Remembrances of living health and QOL as cherished values prompts confident movement toward and away from living and dying.

Table 3 (continued)
Extraction-Synthesis With Related Propositions
Participant: **P. J.**

Extracted Essences (Participant's-Researcher's Language)	*Synthesized Essences (Researcher's Language)*
The participant experiences a severe illness that eliminates his ability to care for himself or participate in enjoyable physical and social activities. This leads to feelings of being imprisoned in an unwanted life, and he seeks suicide as a means of escaping and relieving suffering.	A shocking loss of QOL surfaces comforting thoughts of suicide to relieve suffering.
As thoughts of mortality become more prominent, he reaches out to important others to share his anguish. He insists on maintaining control over his decision to die, but he also values the understanding and compassion of important others.	Prominent thoughts of mortality lead to comforting being with important others. Being with others relieves anguish and sustains valued independence.
Throughout, he maintains hope that he will be cured of AIDS and continue living. As he begins to perceive death as both inevitable and imminent, he views suicide as a triumph over AIDS. This leads to a spiritual awakening that allows him to confidently toward a existence beyond his earthly presence.	Prevailing feelings of mortality lead to spiritual awakening and new confidence to move toward and away from dying.

Proposition: The lived experience of rational suicidal ideation for this PWA is the surfacing of comforting thoughts of suicide amidst a shocking loss of QOL. Prominent thoughts of mortality lead to moving together and apart from important others which prompts remembrances of living independence and QOL as cherished values. Simultaneously, prominent thoughts of mortality lead to spiritual awakening that prompts confident moving toward and away from dying as QOL ebbs and flows.