

PSYCHACHE AND SELF-HARMING BEHAVIOUR AMONG MEN WHO ARE
HOMELESS:

A TEST OF SHNEIDMAN'S MODEL

By

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ABSTRACT

Suicidal ideation among the homeless is 10 times greater than in the general population. Therefore, research helping mental health professionals better predict and potentially prevent suicide within the homeless population is an important societal focus. Various cognitive theories of depression and hopelessness have been proposed to explain suicidality, however, to date, none of these are able to fully explain the phenomenon. More recently, Shneidman has suggested a theory of psychache (i.e., unbearable psychological pain) to explain suicidality. Although this theory has been supported by investigations with university students, there has not been much research exploring psychache with populations at high risk for suicide. The current study attempts to assess Shneidman's theory with a high risk population, namely the homeless. Ninety-seven men were recruited at homeless shelters and drop-in centres. Participants completed questionnaires assessing criterion measures of suicidality and psychological predictors of depression, hopelessness, life meaning, and psychache. Analyses revealed that psychache was the only variable with statistical predictive ability over and above the other three psychological variables in predicting suicide ideation, motivation, preparation, and attempt history. This finding indicates that psychache is a better predictor of suicidality than depression, hopelessness, and life meaning and supports Shneidman's model of psychache as the most proximal cause of suicide. Results also indicate the potential use of a scale assessing psychache in mental health settings to predict those who are, and are not, at risk for suicide.

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CHAPTER 1

INTRODUCTION

Suicide is a critical issue within society today. The latest Canadian survey indicates that in 2005 there were 3,743 deaths by suicide (11.6 deaths per 100,000; Statistics Canada, 2009). Researchers have found that in the United States there are approximately 84 deaths by suicide each day (Kessler, Borges, & Walters, 1999). Although suicidal ideation occurs in roughly three percent of the U.S. population annually (Kessler, Berglund, Gorges, Nock, & Wang, 2005), suicidal ideation among people who are homeless is reported to be between 4 to 10 times greater than in the general population (Fitzpatrick, Irwin, Lagory, & Ritchey, 2007; Schutt, Meschede, & Rierdan, 1994). Death by suicide among people who are homeless is also reported to be between 2 to 8 times higher than that of the national average of the United States (Hwang, 2000; Wong, 2000). Therefore, it is apparent that suicide among individuals who are homeless constitutes a major mental health issue.

The 2001 Canadian census indicates that there were 14,150 people living in shelters across Canada. However, this statistic greatly underestimates the true number of homeless because it does not include individuals sleeping on the street and the statistic would likely be significantly higher if the count was done during the winter months when more homeless individuals frequent shelters. In spite of this issue, these data do indicate that there is a significant problem with homelessness in Canada and it does not appear that the problem is improving. In fact, the number of people who are homeless in North America is continuing to increase. One study conducted in British Columbia found that, between the years of 2002 and 2005, the homeless population nearly doubled from 1121

individuals in 2002 to 2174 individuals in 2005 (Sikstrom, 2006). Therefore, due to the higher prevalence of suicide among people who are homeless and the increasing homeless population, research in the area of suicidality among the homeless is pertinent.

Table 1

Definitions of Terms Related to Suicide

Term	Definition
Suicidality	General term related to all manifestations that indicate one's tendency to suicide, including thoughts and actions.
Suicide Ideation	Term related to having thoughts about suicide. These thoughts can vary in severity and may or may not involve thinking about an actual plan to commit suicide.
Suicide Intent	An individual's intensity or strength of their wish to die during a suicide attempt.
Suicide Motivation	Passive component of suicidal ideation, including one's attitude towards living or dying, and the frequency and duration of thoughts of suicide.
Suicide Preparation	A more active component of suicidal ideation, involving carrying out steps to a suicide attempt such as making a plan or formulating a suicide note.

Understanding Suicidality Among People who are Homeless

There are various reasons why suicide may be so prevalent among people who are homeless. First, those who are homeless are at risk for victimization, health issues stemming from exposure to the elements, and numerous psychological implications (Kermode, Crofts, Miller, Speed, & Streeton, 1998). Further, people who are homeless may feel forced into activities that are potentially dangerous (e.g., prostitution, theft, etc.) in order to survive. The events provoking homelessness (e.g., losing one's home, routines, and social roles) may in themselves produce symptoms of psychological trauma for some people. Among those who are not psychologically traumatized by becoming homeless, the ongoing condition of homelessness (e.g., living in shelters, lacking safety, predictability, and control) may undermine a person's coping skills and precipitate symptoms of psychological trauma (Goodman, Saxe, & Harvey, 1991). Thus, considering the trauma and deprivation homeless individuals face, suicide becomes an understandable option for many.

To my knowledge, to date, there is minimal information that exists on suicide ideation and its etiology among people who are homeless. However, such information is important in order to understand the distress among individuals who are homeless and its potential consequences. A better understanding in this area would aid in determining the necessary resources to reduce the problem (Schutt et al., 1994). By identifying and understanding the variables that predispose an individual toward suicide, society is better equipped to prevent suicides in the future.

Risk Factors Related to Suicide

Depression

Depression has long been explored as a risk factor for suicide. Arguably, the most well known theory of depression, Beck's cognitive theory of depression, suggests that it is the negative cognitions about the self, the world, and the future (the cognitive triad) which can explain depressive symptoms (Rush & Beck, 1978). This theory relates to suicide when an individual's negative cognitions, especially about the future, become unbearable and he/she may begin to consider suicide in order to escape the symptoms of depression. The relationship between depression and suicide has been studied across a variety of contexts.

Silver, Bohnert, Beck, and Marcus (1971) examined a sample of patients admitted to a hospital after having attempted suicide. Individuals were given the Beck Depression Inventory (BDI; Beck & Steer, 1987). It was found that 80% of individuals scored in the clinically depressed range ($M = 25.0$, $SD = 12.5$ on BDI-I). Further, their mean depression scores were significantly higher than the mean of a large sample of nonsuicidal psychiatric patients. Suicidal ideation was also explored. The results showed a participant's desire to die, as assessed by the Suicidal Intent Scale (Beck, Schuyler, & Herman, 1974 as cited in Misson, Mathieu, Jollant, Yon, Guillaume, Parmentier et al., 2009), was significantly related to the degree of depression. Although the sample size was relatively small ($N = 45$), the findings do indicate a relationship between depression and suicidality.

Goldney, Wilson, DalGrande, Fisher, and McFarlane (2000) conducted a study examining the impact of depression and traumatic events on suicidal ideation. Approximately 3300 individuals were randomly selected from the general population and contacted (75% response rate). Participants completed surveys assessing mental health

(general health questionnaire (GHQ) and the short-form health survey (SF-12)), quality of life, and suicidal ideation. The overall rate of suicidal ideation among the sample was 5.4%. Multivariate analyses assessing the association between depression (as measured by the SF-12 and the GHQ) and suicidal ideation (as measured by the GHQ) demonstrated a 46.9% risk of suicidality attributable to depression. In other words, 46.9% of the variance in suicidal ideation was attributed to clinical depression. These results demonstrate an important relationship between clinical depression and suicidality. This research is limited by the fact that suicidal ideation was assessed by only four questions on the General Health Questionnaire (Goldberg & Hillier, 1979). Although these four questions had not been validated previously, the face validity of them is high as their content was very similar to that on other measures of suicidality (Beck & Steer, 1993). Thus, despite the methods being imperfect, the results from such a large sample are of great use in establishing a relationship between depression and suicidality.

Support for the relationship between depression and suicide among a high risk population is provided by the research of Biggam and Power (1999). They found that incarcerated individuals under suicide watch had significantly higher ratings of depression than those incarcerated individuals not identified as having suicidal ideations. Incarcerated individuals were also explored by Palmer and Connelly (2005). They compared depression and suicidal ideation/attempt history among incarcerated offenders and found that, when compared to a matched sample, those who had attempted suicide and who presently reported suicidal ideation had higher scores on the Beck Depression Inventory than those who did not report an attempt history or present suicidal ideation.

Taken together, the aforementioned research suggests that some aspects of the depressive experience may be associated with a higher vulnerability to suicide. However, depression does not account for all of the variance in suicide and thus, there must be another variable which contributes to suicidality.

Hopelessness

Although depression appears to be an important predictor of suicidality, hopelessness, or the future component of Beck's cognitive theory of depression, has also been explored. Abramson, Metalsky, and Alloy (1989) contend that it is specifically the future element of Beck's model that relates to suicide. They created the Hopelessness Theory of Depression which suggests that it is a subtype of depression known as hopelessness depression which is responsible for suicide. They postulate that it is this addition of the hopelessness component to depression which relates to suicidality. The Hopelessness Theory of Depression specifies a combination of factors which together culminate in hopelessness depression. These factors are (1) the expectation that a desirable outcome will not occur and/or that a negative outcome will occur; and (2) the belief that there is nothing that can be done to change the outcome (helplessness towards making a change). Within the theory's more global explanation of hopelessness (negative expectations and an inability to make a change in any given situation), there are the inferences people draw about the event and its outcome which modulate whether individuals develop hopelessness depression when confronted by a negative life event. The inferences include (1) inferences regarding 'why' the event occurred, (2) inferences about the consequences of the event, and (3) inferences about the self given the event. Those suffering with hopelessness depression share many of the same symptoms of

depression. These symptoms include (a) retarded initiation of voluntary responses, (b) lack of energy, (c) apathy (“why bother if there is nothing that can be done to change the future?”), (d) sad affect, and (e) serious suicide attempts and suicidal ideation.

Support for the theory that hopelessness is required in addition to depression is provided by a number of researchers who have found that although depression and hopelessness are correlated with suicide intent, when the effect of hopelessness is controlled, depression is no longer predictive of suicidal ideation (Dieserud, Roysamb, Ekeberg, & Kraft, 2001). This finding indicates that the hopeless element of depression, or the negative cognitions about the future as it is described in Beck’s model, is the component largely responsible for suicide.

Further support for the mediation of the depression-suicide relationship is provided by Dyer and Kreitman (1984). They found that among post suicide attempt individuals, both hopelessness and depression scores correlated significantly with suicide intent. The researchers then held the depression scores constant (removing the effect of depression on the dependent variable of suicidal intent) and found that the relationship between hopelessness and suicidal intent remained significant. However, when hopelessness was held constant (removing the effect of hopelessness), the relationship between depression and suicide intent was no longer significant. This research suggests that the relationship between depression and suicidal intent appears to be mediated by hopelessness. However, the relationship between hopelessness and suicidal ideation is not mediated by depression.

Beck, Brown, Berchick, Stewart, and Steer (1990) and Beck, Steer, Kovacs, and Garrison (1985) have also explored the importance of depression and hopelessness and

found that hopelessness, as measured by the Beck Hopelessness Scale (BHS), has predictive utility for the assessment of suicide risk above and beyond that provided by measures of depression severity. They found that the mean Beck Hopelessness Scale scores are significantly higher among patients who subsequently committed suicide than among patients who did not (Beck et al., 1985). In fact, when Beck et al. (1985) followed-up on 200 individuals admitted to hospital due to suicidal ideation, 91% of individuals with a Beck Hopelessness Scale score of 9 or greater eventually committed suicide. Thus, a score of 9 or greater on the BHS has been considered an indicator of potential future suicidal behaviours.

Further support for the importance of hopelessness in predicting suicide risk is provided by the research of Kuo, Gallo, and Eaton (2004). They performed a longitudinal study (13 years) with a community sample of 3000 participants in order to determine if hopelessness was a long-term predictor of suicidal behaviour. They found that hopelessness was a predictor of completed suicide, self-reported attempted suicide, and suicide ideation. In fact, individuals who reported hopelessness at the beginning of the study were 11 times more likely to have completed suicide over the 13-year follow up period. The relationship between suicidality and hopelessness was stronger and more enduring than the relationship between depression and/or substance use disorders and suicidality.

Finally, Minkoff, Bergman, Beck, and Beck (1973) also demonstrated support for the role of hopelessness as a more proximal variable to suicide prediction than depression. More specifically, they found that among a group of psychiatric inpatients, hopelessness correlated more strongly with seriousness of suicide intent than did depression. Further,

the intent scores in the groups with high hopelessness were much higher than in those with low hopelessness scores (with level of depression being held constant). Although it appears there is a relationship between suicide and hopelessness, Minkoff et al. found that the correlation between the measures of hopelessness and intent accounted for only 22% of the variance in the scores. Thus, although the results support the hypothesis that hopelessness is more strongly linked to suicide than is depression, there must also be another variable influencing suicidality.

Meaning in Life

Life meaning generally refers to a global way of assessing or understanding one's life and the belief that life is meaningful. Life meaning is the attempt to create and/or discover meaning and/or discover a sense of purpose in one's life (Feldman & Snyder, 2005). Life meaning is difficult to concretely define as it is personal. The experiences that one individual values as giving their life meaning may be very different from what another individual values as important. Battista and Almond (1973) suggest that people who demonstrate a sense of life meaning have a consciously defined structure providing them with the framework from which to view their life. These individuals perceive their actions and behaviours as fulfilling these goals which creates feelings of worth, significance, and importance. DeVogler and Ebersole (1980) suggest eight sources from which individuals derive meaning in life including 1) Interpersonal relationships (relationships with family, friends, and/or partners), 2) Service (aiding and/or taking care of others), 3) Growth (working towards goals important to the individual), 4) Belief (being guided in life by religious, political, or social beliefs), 5) Existential-Hedonistic (everyday pleasures), 6) Obtaining (acquiring possessions and/or garnering respect), 7)

Expression (self-expression through the arts, athletics etc.), 8) Understanding (working to gain knowledge about something of interest to the individual).

Research has found a coherent sense of life meaning is associated with lower levels of negative emotions, psychopathology, substance abuse, and suicidal ideation (Feldman & Snyder, 2005; O'Connor & Chamberlain, 1996). In fact, researchers have found a strong inverse relationship between life meaning/purpose in life and suicidal ideation/history of previous suicide attempts (Lester & Badro, 1992; Edwards & Holden, 2003). Lester and Badro found that across a sample of undergraduate students, lower life purpose predicted previous suicide ideation, previous suicide attempts, and current suicidal ideation. This finding is substantiated by Edwards and Holden (2003) who found significant negative correlations between purpose in life and both suicidal ideation and self-reported likelihood of future suicidal behaviour. Taken together, it seems that the higher an individual's life meaning, the lower their level of suicidal ideations and/or number of previous suicide attempts.

Over the years, researchers have explored numerous possible predictors of suicidality including depression, hopelessness, and life meaning with some success however, none of these constructs alone, or combined, are able to fully account for, or predict, suicidality. More recently Shneidman (1993) has proposed a promising predictor of suicide which may provide a deeper understanding of suicidal behaviour and thus, may have a greater implication in the prediction of suicide risk.

Psychache

Although a variety of other factors have been theorized to relate to suicide, Shneidman (1993) asserts that psychache is an overarching variable that is a more

important predictor of suicide than is either depression or hopelessness. Psychache is a concept which was developed by Shneidman (1993) to be predictive of suicide. He defined psychache as the “hurt, anguish, soreness, aching, psychological pain in the psyche, the mind. It is intrinsically psychological – the pain of excessively felt shame, or guilt, or humiliation, or loneliness, or fear, or angst, or dread of growing old or of dying badly...” (p. 145, 1993). Shneidman contends that psychache is entirely responsible for suicide and, therefore, according to Shneidman, if there is no psychache, there is no suicide. He suggests that the utility of depression and hopelessness in explaining suicide is only relevant in terms of their relationships to psychological pain.

Shneidman’s (2005) Cubic Model of Depression conceptualizes suicide to occur with a synergy of three psychological factors which are: (1) psychological pain; (2) press (mostly external, occasionally internal pressures, stresses, or demands that impinge upon, move, touch, or psychologically affect an individual); and (3) perturbation (agitation). Each of these three factors exists on an axis of the model and can be rated from 1 to 5. Shneidman contends that suicide occurs when each of these factors (pain, press, and perturbation) are at their highest (rating of 5-5-5). Shneidman (1993) suggests that suicide occurs when an individual can no longer cope with these psychological factors and thus, suicide is seen as a way, and often perceived as the only way, of stopping the intolerable aching of the psyche. In that sense, suicide is purposeful. It is perceived as the only way to stop insufferable aching (Shneidman, 1999b). Shneidman does not understand suicide as a symptom of mental illness but instead as a behavioural outcome when an individual can no longer cope with their pain. Shneidman is silent on the issue of euthanasia

Shneidman (1999a) discussed that all suicidal individuals are in a state of perturbation (being upset or mentally distressed). He suggests that psychache is the introspective recognition of, or the psychological pain associated with perturbation. Psychache and internal perturbations have both been explored in terms of their relationship to suicidality. In the literature, psychache and internal perturbation have been equated (Davie, 2005; Holden & McLeod, 2000) as they will be throughout this thesis.

In 1993, Shneidman further theorized about how psychache relates to suicide by outlining 7 components which taken together culminate in suicide: (1) life stress, rejection, failure, and/or social or psychological insults; (2) genetic and social factors; (3) life stressors and insults are perceived as negative and are believed to cause pain; (4) the pain (psychache) is seen as unbearable and intolerable; (5) there is a belief that the only way to end the pain is through the cessation of consciousness; (6) the individual has a lowered threshold for coping with psychache; (7) the act of suicide takes place.

Psychache is suggested to be caused by blocked or unfulfilled psychological needs perceived by the individual as important (Shneidman, 1993). In order to reduce the incidence of suicide, the unfulfilled needs, which are causing the psychache, must be addressed and reduced or eliminated completely. According to Shneidman, a reduction in psychache will generally decrease or eradicate the lethality (imminent possibility of suicide) within the individual (Shneidman, 1999).

Shneidman (1999a, 2005) suggests five types of psychological needs which tend to cause psychache and are thus, implicated in suicide. First, unattainable love, acceptance, and belonging which relate to a need for acceptance and affiliation. Second, a lack of control, predictability, and certainty which relate to a need for achievement,

organization, and independence. Third, assaulted self-image and avoidance of shame, embarrassment, and dishonour which relate to a need for affiliation and preventing embarrassment. Fourth, broken relationships causing heartache and distress which relate to frustrated needs for nurturing and understanding. Finally, extreme anger, aggression, and hostility which relate to frustrated needs for aggression, supremacy, and superiority. The aforementioned needs are linked to suicide only in their ability to cause psychache. These needs are not all required in order for suicide to occur and the specific needs which are causing the psychache will be dependent on what the individual finds important.

Shneidman's (1993) theory of psychache has been supported by the work of a number of academics. DeLisle and Holden (2009) explored depression, hopelessness, and psychache among a large sample of university undergraduates through the use of the Beck Hopelessness Scale, the Beck Depression Inventory, and the Psychache Scale (Holden, Mehta, Cunningham, & McLeod, 2001). They found that psychache accounts for more of the variance in depression and hopelessness than these two variables account for in psychache. Further, they demonstrated that those individuals with the highest levels of psychache are perceived to be at the highest risk for suicide as measured by proxies such as previous suicide attempts and current suicide ideation

Shneidman's theory has been further substantiated by the research of Holden et al. (2001). They found that, across the spectrum of suicidal behaviours (i.e., ideation, attempts, believed likelihood of future attempts, and self-injurious behaviour), hopelessness had moderate correlations with the index of self-destructive behaviour. However, hopelessness was no longer a significant predictor of suicidal actions when psychological pain was included in regression analyses. This finding suggests that there is

a mediating variable between hopelessness and suicide, namely, psychache. Based on their findings, Holden et al. suggested a tentative path to suicide. The path begins with depression, and is followed by hopelessness, then psychache, and ultimately ending in suicidal behaviour (when the motivation to reduce the psychache is present).

Research has shown that the effects of psychache hold across populations as well. Holden, Kerr, Mendonca, and Velamoor (1998) explored self-reported reasons for attempting suicide. They collected data on hopelessness, reasons for attempting suicide, and self-reported suicide intent among 251 patients attending a psychiatric hospital for suicide ideation or a suicide attempt. Principal components analysis with the responses from a reasons for attempting suicide questionnaire found that the reasons for attempting suicide made up two components: internal perturbation-based reasons and extrapunitive/manipulative reasons. Further analysis revealed that only the internal perturbation based factor correlated significantly with the criterion measures (e.g., wish to die, suicidal desire, suicide preparation, overall suicide risk). Comparison of the correlations between both the hopelessness scale and the criterion variables and the internal perturbations scale and the criterion variables demonstrated that the hopelessness scale did not outperform the internal perturbations scale in predicting the criterion variables. Next, through multiple regression, each criterion measure was regressed on the extrapunitive/manipulative scale, the internal perturbations scale, and the hopelessness scale. Again, the extrapunitive/manipulative scale did not have a significant weight in a regression equation. On the other hand, the internal perturbations measure made a significant contribution independent of the other predictors, including the hopelessness scale. The hopelessness scale was neither a consistently significant, unique predictor nor

the consistently strongest, unique contributor in the regression equations. This study shows that internal perturbation-based reasons for attempting or considering suicide are likely important predictors of suicidality.

Combined, the aforementioned research suggests that psychache is the component most consistently and clearly indicative of proneness toward self-destruction. Further, psychache appears to be a more proximal predictor of suicide and acts as a mediator of other, more distal, risk factors.

Distinctiveness of the Constructs

Some might question whether depression, hopelessness, and psychache are distinct constructs or all part of a more overarching construct. Research has however, shown that in fact all three of these variables, although related, are distinct. Troister and Holden (2010) performed a confirmatory factor analysis attempting to determine if these three constructs are distinct. The researchers took a large sample of university students and explored the contribution and distinctiveness of these three factors in predicting suicidality. Through the use of maximum likelihood confirmatory factor analysis it was found that the results supported a 3-construct model with the three distinct constructs consisting of depression, hopelessness, and psychache. This finding is also supported by the research of DeLisle and Holden (2009) who also found that depression, hopelessness, and psychache, although correlated, are distinct constructs with predictive power for understanding suicidality.

Application to People who are Homeless

People who are homeless are a particularly vulnerable population who have been shown to demonstrate many of the suggested antecedents to later suicide including

depression, hopelessness, low life-meaning, and affective states similar to psychache. Therefore, because these factors have been shown to be predictive of suicidality, individuals who are homeless are an important population to explore.

Numerous researchers have shown that depressive symptomatology is prevalent among people who are homeless. Estimates are that as many as 80% of individuals who are homeless suffer with severe enough symptoms of depression (self reported) to meet criteria for depression (score of 16 or more on the Center for Epidemiological Studies Depression Scale (CES-D); LaGory, Ritchey, & Mullis, 1990; Ritchey, LaGory, Fitzpatrick, & Mullis, 1990). Thus, I predict that many people who are homeless will have high levels of depression, and that their depression will be correlated with suicidal ideation and past suicide attempts.

Hopelessness among people who are homeless has also been explored. Rew, Taylor-Seehafer, Thomas, and Yockey (2001) administered the Beck Hopelessness Scale (Beck, Weissman, Lester, & Trexler, 1974), Social Connectedness Scale (Blum, Harris, Resnick, & Rosenwinkel, 1989 as cited in Rew et al.), and the Death Related Attitude Schedule (Lewinsohn, Langhinrichsen-Rohling, Langford, Rohde, Seeley, & Chapman, 1995) to a variety of individuals who were currently homeless. They found that hopelessness was positively correlated with life-threatening behaviours and negatively correlated with social connectedness. This finding is substantiated by Kidd (2004) who performed a qualitative study with homeless individuals and reported that numerous individuals living on the street reported feeling hopeless. Based on this prior research, I am predicting that people who are homeless will have high levels of hopelessness and that this hopelessness will be positively correlated with suicide.

A lack of life meaning has been shown to be prevalent among individuals who are homeless. In one study of youth without housing, researchers found that the adolescents reported significantly lower overall subjective quality of life and personal meaning when compared to a non-homeless control group (Bearsley & Cummins, 1999). As previously mentioned, life meaning is the attempt to create and/or discover meaning and/or a sense of purpose in one's life (Feldman & Snyder, 2005). Living on the street would likely challenge a person's ability to find life meaning. The experiences found by DeVogler and Ebersole (1980) to create life meaning such as personal development, life work, and social activities are generally absent among people who are homeless. For example, social relationships which were noted as the most consistently reported experience that gives individuals life meaning (Baum, 1988; Baum, & Stewart, 1990; DeVogler, & Ebersole, 1981), is one of the biggest problems for homeless individuals. Social support among those who are homeless has been found to be significantly impaired (Bassuk, Mickelson, Bissell, & Perloff, 2002; LaGory et al., 1990; Shinn, Knickman, & Weitzman, 1991). Therefore, taken together, I predict that life meaning will be low among people who are homeless and will be negatively correlated with suicidality. In other words, lower life meaning scores will be correlated with more previous suicide attempts and higher current suicidal ideation.

Given the circumstances surrounding homelessness (e.g., a lack of control, isolation, victimization, etc.), I suspect that people who are homeless are at risk for significant psychological pain or psychache. This hypothesis is supported by the findings of Schutt et al. (1994), who found that individuals who are homeless have significantly higher levels of psychological distress than the general population. It is further

corroborated by the numerous studies exploring the consequences of homelessness (Goodman et al., 1991; McCarty, Argeriou, Huebner, & Lubran, 1991; Schutt et al.), and specifically by the work of Kidd (2004). Kidd performed a qualitative study of individuals who are homeless where he discovered a theme which appears to be very close to the concept of psychache. The theme which Kidd found to be most centrally and pervasively mentioned in the numerous interviews he conducted with people who are homeless was summarized as a sense of feeling/being trapped. Feeling trapped was broken down by Kidd into being unable to reduce negative feelings and being unable to flee an unbearable situation. From numerous interviews, Kidd surmised that, on the street, individuals were in a “position that is physically and emotionally painful and distressing, so much so that they felt that there was no way out except death” (p. 38).

Further, Shneidman (1999a) suggested 5 types of psychological needs which, if not met, may lead to psychache. As stated previously, these include a need for acceptance, a need for control and achievement, a need to feel affiliation and appear honourable, a need for nurturing and understanding, and a need for supremacy and superiority. Research suggests that people who are homeless often feel socially outcast, alone, and inferior. Many have reported feeling as if they are viewed as subhuman and are treated as such by many people while on the street. Many people who are homeless feel they have lost their dignity a view which is understandable given that it is generally accepted that digging through dumpsters is anything but honourable (Patterson & Tweed, 2009). Given these unfulfilled needs, which Shneidman suggests may precipitate psychache, and given previous research which has found an elevation in constructs

seemingly similar to psychache, it is expected that psychache will be prevalent among individuals who are homeless.

Current objective

Shneidman's theory of psychache suggests that psychache is the most important antecedent to suicide (1993). Numerous research projects have found support for this suggestion. However, the majority of research has focused on university samples (DeLisle & Holden, 2009; Flamenbaum, & Holden, 2007). Although some research has taken place with a forensic population (Holden & Kroner, 2003) and a psychiatric population (Pomill, Lester, Leenaars, Tatarelli, & Girardi, 2008), the majority has focused exclusively on student samples. Thus, the main purpose of the current research is to evaluate the generalizability of Shneidman's model to a previously ignored population, individuals who are homeless. Because people who are homeless are faced with so many difficult situations, I hypothesize that psychache will be prevalent among people who are homeless. Based on the literature reviewed, I further hypothesize that psychache will be a better predictor of suicidal ideation than the variables of life meaning, depression, and hopelessness.

The findings of the current research should be useful in providing researchers and mental health practitioners with information that will help identify those individuals at risk for suicide. Further, it may eventually aid in the development of effective preventive programs. Within a high risk population, such as people who are homeless, it is important to understand the antecedents to suicide in hopes of better preventing suicide in the future.

CHAPTER 2

Method

Participants

Ninety-seven adult men were recruited at homeless shelters in Toronto, Ontario and Vancouver, British Columbia with approximately equal amounts in each location. The shelters were similar in terms of the services and programs offered to clients. All shelters were advertised as temporary accommodation. The qualities of accommodations were consistent across shelters. Participants ranged in age from 19 to 77 years ($M = 46.58$, $SD = 11.97$). Forty-three percent of participants were recruited in Toronto, Ontario with the remaining participants recruited in Vancouver, British Columbia.

Forty-six percent of individuals reported their ethnicity as Euro-Canadian and 31% circled 'other' and specified that they were Canadian. Eight percent of participants were First Nations persons. The remaining participants comprised other ethnicities. In terms of schooling, 55.7% had completed high school, 13.4% had taken some college/trade credit, 9.3% had taken some university credit, 3.1% had completed up to grade 6, 2.1% had completed up to grade 7, 5.2% up to grade 8, 5.2% up to grade 9, 20.6% to grade 10, and 8.2% up to grade 11. The representativeness of the current population is supported by comparing the obtained demographics to those of the general homeless population (Statistics Canada, 2001; Toronto Shelter Support, & Housing Administration, 2009).

Participants were asked when they had become homeless for the first time. Twenty four percent of individuals became homeless between the ages of 7-18, 13% became homeless between the ages of 19-30, 16% between the ages of 31-40, 22%

between the ages of 41-50, 13% between 51-60, 5% between 61-70, and finally, 1% between 71-80. In terms of length of current homeless episode 26.8% reported being homeless for less than 2 months, 26.8% reported 2-6 months, 6.2% reported 7-11 months, 11.3% reported 1-1 year 11 months, 15.5% reported 2-5 years, and 13.4% reported being homeless for more than 5 years.

All participants were asked to cite all perceived reasons for their current homeless state. The reasons cited as antecedents to homelessness were vast. The most commonly cited reason for homelessness was drugs and alcohol use with 38.1% of participants endorsing this reason. Other reasons include economics (21.6%), illness (19.6%), family/relationship problems (17.5%), lack of affordable housing (17.5%), job loss (16.5%), mental health difficulties (16.5%), unsafe housing (9.3%), eviction (8.2%), marital problems (5.2%), new to the city (3.0%), immigration problems (2.0%), gambling (1.0%), and other (3.0%).

Twenty-three individuals (24% of the sample) indicated that they had attempted suicide at some point in their life. This was much higher than a study of university students where the rate of attempted suicide was 3.6% (Flamenbaum, 2009) and a forensic sample where the attempted suicide rate was 17.0% (Holden & Kroner, 2003) but is consistent with research which has found that attempted suicide among people who are homeless is 2 to 8 times greater than the general population (Hwang, 2000; Wong, 2000). Of the 23 individuals who had made a previous suicide attempt, 9 individuals were from Toronto, Ontario and 14 individuals were from Vancouver, British Columbia.

Of those who had made a suicide attempt, 43% attempted suicide with an overdose of pills and 22% attempted by cutting themselves. The remaining participants

attempted suicide by other means such as carbon monoxide poisoning, exposure, hanging, etc. Thirty-five percent of those who had attempted suicide had only tried to commit suicide once. Thirty-five percent of individuals had tried 2-3 times, 17% tried 4-6 times, 4% tried 7-10 times, and 8% tried more than 10 times. Suicide attempters reported a mean of 101.00 months since their most recent suicide attempt ($SD = 111.27$, range = 1.00 to 360.00), and a high to extremely high level of suicide intent at the time of the last attempt ($M = 4.36$, $SD = 0.73$) on a five-point rating scale. Interviews with three individuals were terminated early because they were unable to understand the questions due to problems with mental health (e.g., hallucinations) and/or substance use.

Materials

Beck Depression Inventory (BDI)

The Beck Depression Inventory (BDI; Beck & Steer, 1987) is a 21-item scale used to measure depression. Participants rate each item on a 4-point scale from 0 to 3 with higher scores indicating greater depression. Participants are asked to respond to questions such as “I do not feel like a failure” and “I can’t sleep as well as usual” based on their experiences from the past week. Research has found high internal consistency and validity with both psychiatric and nonpsychiatric samples (Beck et al., 1988).

Beck Hopelessness Scale (BHS)

The Beck Hopelessness Scale (BHS; Beck et al., 1974) is a 20-item true/false questionnaire that assesses an individual’s negative expectations for the future. Example questions include “I look forward to the future with hope and enthusiasm” and “I may as well give up because I can’t make things better for myself” Research has demonstrated strong internal reliability and concurrent and construct validity across a variety of

populations (Beck et al., 1974; Glanz, Haas, & Sweeney, 1995; Holden & Fekken, 1988). Beck et al. (1990) found that, of those individuals who scored a 9 or above on the BHS, 94% went on to die by suicide. Thus, the BHS is a predictive measure of suicide and thus, is a sensitive indicator of suicide potential.

Psychache Scale

The Psychache Scale (Holden et al., 2001) is a 13-item self-report scale used to assess psychological pain as defined by Shneidman (1993). Participants are asked to respond on a 5-point likert-type scale. The scale includes items such as “I seem to ache inside” and “I hurt because I feel empty.” Holden et al. report strong reliability (alpha coefficient = .92) and validity (demonstrating a medium effect size (Cohen’s $d = .66$)) at distinguishing between previous suicide attempters and nonattempters), when compared to other measures of antecedents to suicide. They also found that this scale significantly distinguishes between suicide ideators and attempters. Good construct validity and internal consistency have also been reported by Mills, Green, and Reddon (2005).

Beck Scale for Suicide Ideation

The Beck Scale for Suicide Ideation (BSS; Beck & Steer, 1993) is a 19-item self report scale used to measure suicide ideation and intent. Items are scored 0, 1, or 2 with higher scores indicating greater suicidality. The questionnaire includes such items as “How strong is your wish to live” and “Do you have any desire to attempt to end your life.” Alpha reliability coefficients of the entire scale range from .84 to .93 in psychiatric samples (Beck, Brown, & Steer, 1997; Beck, Kovacs, & Weissman, 1979; Beck, Steer, & Ranieri, 1988). Research has shown high internal consistency and construct validity for this scale (Beck et al., 1979; Holden & Kroner, 2003). The BSS consists of two sections.

The first subscale known as the Motivation subscale explores individuals' feelings towards death including the extent and frequency of suicidal thoughts. The second subscale known as the Preparation subscale assesses a more active stage of suicidality (e.g., the actual planning of a suicide attempt). A study of suicide attempters found support for this two-factor model (Holden & DeLisle, 2005), with alpha reliability coefficients of .85 for the Motivation and .73 for the Preparation subscales.

Multidimensional Life Meaning Scale

The Multidimensional Life Meaning Scale (MLMS; Edwards, 2003) is a 64-item self-report measure of an individual's sense of life meaning. The overall scale has high internal consistency and the subscales have acceptable reliability (Edwards). The current study only used one subscale from within the larger assessment. Specifically, I used the seven items of the subscale titled Fulfillment/Excitement which has reliability in the average range with a Cronbach's alpha of .82 (Edwards). This subscale includes questions such as "My life is empty, filled only with despair" and "Nothing very outstanding ever seems to happen to me." This subscale is the scale thought by the writer to be the one most applicable to individuals who are homeless.

Copies of all questionnaires can be found in Appendix A.

Procedure

Prior to beginning the current research, ethics approval was obtained from the Queen's University research ethics board. Participants were recruited through the use of flyers (See Appendix B) posted within drop-in centres and homeless shelters. Attention was brought to these flyers by announcements which were made by the researcher. An explanation of the research was important because some individuals would be nervous

about participating without first knowing the details of the research. Participation in this study had no bearing on the individual's access to services at the shelter or community centre.

The study began by having participants perform a reading test (WRAT3) to ensure they would be able to read the consent form and questionnaires. Upon completion of the consent form (See Appendix C), a \$10 gift card was given. By providing the participant with the gift card up front, it helped prevent individuals from continuing on with the study, even if uncomfortable, in order to obtain the gift card. Three participants did not complete the questionnaire after receiving the gift card. One individual was simply not interested in completing the questionnaire and interviews with the other two individuals were discontinued early due to profound symptoms of psychosis.

Interviews began with a demographic questionnaire asking about participants' age and gender, whether they had ever attempted suicide, how long ago their most recent attempt was, how they attempted to commit suicide, how intent they were on killing themselves during their most recent attempt, and how many times they had attempted suicide in their lifetime. Individuals were also asked questions about their history of homelessness. Participants were then given the Multidimensional Life Meaning Scale, the BDI, BHS, BSS, and the Psychache Scale in this order. All questionnaires were self-completed.

CHAPTER 3

Results

Preliminary Analyses

Preliminary analyses consisted of screening the data for accuracy and missing values. Any observed out of range values were corrected by verifying the correct values with the participants' original questionnaires.

Descriptive Statistics for predictors and measures of suicidality

Means, standard deviations, observed ranges, and coefficient alpha reliabilities are shown in Table 2. All coefficient alpha reliabilities exceeded .80 indicating that these measures were adequately reliable for further analysis. The mean scale scores for the variables of psychache, hopelessness, depression, and attempt history were higher among the current sample than previous scores found in prior research across a variety of populations as discussed below.

The mean score on the BDI among the current sample was 14.64 ($SD = 10.34$). The mean depression score among only those in the current study who had a previous attempt history was 23.59 ($SD = 8.63$). Both of these scores are higher than those obtained from a sample of university students ($M = 7.83$, $SD = 6.88$; Delisle & Holden, 2009) or a forensic sample ($M = 12.46$, $SD = 8.56$; Holden & Kroner, 2003). To gain some understanding of the differences between the means of the current sample of individuals struggling with homelessness and other populations Cohen's d , a measure of effect size, was calculated. The effect size between the entire sample of people who are homeless and university students (Delisle & Holden, 2009) was 0.77 (approaching a large effect size). The effect size between the current sample and a forensic sample (Holden & Kroner, 2003) was 0.21 (small effect size). Although comparisons between the aforementioned studies and the current study may not be entirely appropriate because

they involve different samples with different recruitment procedures in different settings, the Cohen's d comparisons provide a rough estimate of effect size.

The mean hopelessness scores among the entire sample of individuals struggling with homelessness ($M = 7.12$, $SD = 5.84$) and among only those who had attempted suicide previously ($M = 11.20$, $SD = 5.80$) were higher than for university samples ($M = 2.9$, $SD = 3.0$; Holden et al., 2001; and $M = 3.88$, $SD = 0.69$; Delisle & Holden, 2009) and a forensic sample ($M = 3.88$, $SD = 4.24$; Holden & Kroner, 2003). Again, the mean hopelessness scores for the homeless sample was slightly closer to a university sample consisting of only attempters ($M = 4.9$, $SD = 4.2$; Holden et al., 2001).

Again, to better understand the differences in levels of hopelessness among different populations an estimate of the amount of difference between means was undertaken. The effect size between the current sample and university samples (Holden et al., 2001; Delisle & Holden, 2009) was 0.76 (approaching a large effect size) and 0.55 (medium effect size) respectively. The effect size between the current sample and the forensic sample (Holden & Kroner, 2003) was 0.55 (medium effect size). Finally, when comparing only those from the current sample who have a previous attempt history to those from a university sample who have a previous suicide attempt (Holden et al., 2001), the effect size is 1.09 (large effect size).

The mean psychache score across the current sample of individuals who were homeless ($M = 26.28$, $SD = 13.69$) and among those from the current sample who had a previous suicide attempt ($M = 39.34$, $SD = 13.64$) was substantially higher than the mean of a sample of university students ($M = 23.3$, $SD = 8.0$; Holden et al., 2001; $M = 21.9$, $SD = 9.47$; DeLisle & Holden, 2009) and a forensic sample ($M = 20.1$, $SD = 9.0$; Mills,

Green, & Reddon, 2005). The means from the current study are closer to those of a sample of university student suicide attempters ($M = 28.0$, $SD = 8.4$; Holden et al., 2001).

The effect size of levels of psychache between individuals from a university sample (Holden et al., 2001; Delisle & Holden, 2009) and the current sample of people who were homeless was 0.22 and 0.32 respectively (small effect sizes). The effect size of levels of psychache among only those who had attempted suicide in the current sample compared to only those who had attempted suicide from a university population was 0.83 (large effect size). The effect size between the entire sample of people who were homeless and a forensic sample was 0.45 (approaching a medium effect size).

The mean attempt history scores were also higher among the current sample ($M = 0.24$, $SD = 0.43$) than among both a university ($M = 0.13$, $SD = 0.65$; DeLisle & Holden, 2009) and a forensic sample ($M = 0.17$, $SD = 0.38$; Holden & Kroner, 2003). The effect size differences between the current sample and both a university sample and a forensic sample were 0.26 and 0.16 respectively.

Overall, the current sample of individuals who are homeless had higher mean scores on the variables of depression, hopelessness, psychache, and attempt history than has previously been found in other research. This indicates a population potentially at higher risk for suicidality.

Table 2

Means, Standard Deviation, and Reliabilities for All Measures (N = 97)

	Possible Range	Observed Range	<i>M</i>	<i>SD</i>	α
Beck Depression Inventory	0-63	0-36	14.64	10.34	.90
Multidimensional Life Meaning Scale	7-49	7-49	25.02	9.82	.83
Psychache Scale	13-65	13-59	26.28	13.69	.96
Beck Scale for Suicide Ideation	0-38	0-30	8.34	6.72	.89
Suicidal Motivation	0-18	0-17	2.70	3.36	.84
Suicidal Preparation	0-19	0-16	5.50	3.80	.83
Beck Hopelessness Scale	0-20	0-20	7.12	5.84	.93
Attempter Status	0-1	0-1	.24	.43	--

Note. Due to missing data some descriptive statistics are based on fewer than 97 participants. Number of lifetime attempts was not included in the current table because those data were collected in a categorical format.

Correlations Among All Measures of Suicidality

Correlations among all variables are shown in Table 3. Significant, correlations were obtained between depression (positive correlation), hopelessness (positive correlation), life meaning (negative correlation), and psychache (positive correlation). The results of the current study were compared to previous research which also found relatively high correlations between the variables of depression, hopelessness and psychache (DeLisle & Holden, 2009). The correlations between each of the variables with each other (depression, hopelessness, and psychache) were nearly identical to those found by DeLisle and Holden. Similarly the correlations between life-meaning and suicidal ideation were similar to those found by Edwards & Holden (2001).

Significant, positive correlations were also found between the three predictor variables and each suicide criterion variable, including suicidal ideation, suicidal motivation, suicidal preparation, attempter status and number of lifetime attempts. The correlations between psychache, depression, hopelessness and suicide intent, motivation, and preparation were also very close to the correlations found by DeLisle and Holden (2009) with a university sample.

The results of the correlational analyses show that the outcome variables of suicide ideation, suicide preparation, attempt history, and number of lifetime attempts, had higher correlation values with psychache than they did with depression, hopelessness, and life-meaning.

As is apparent in Table 3, there are a few variables which appear to be highly correlated. The presence of high correlations between predictor variables can indicate problems with multicollinearity. Values of .8 or .9 are commonly used cutoffs which

indicate problems with collinearity (Mason & Perreault, 1991). Therefore, as the correlations in the current study are all less than .8, collinearity, although present, is not believed to invalidate the results of the current study.

Table 3

Intercorrelations Among All Measures of Suicidality (N = 97)

Measure	1	2	3	4	5	6	7	8	9
<i>Predictors</i>									
1. Depression	--								
2. Hopelessness	.66*	--							
3. Psychache	.78*	.65*	--						
4. Life Meaning(negative)	.75*	.73*	.65*	--					
<i>Criteria</i>									
5. Suicide Ideation	.58*	.47*	.63*	.54*	--				
6. Suicide Motivation	.57*	.53*	.60*	.57*	.90*	--			
7. Suicide Preparation	.49*	.33*	.53*	.43*	.93*	.70*	--		
8. Attempter Status	.48*	.40*	.54*	.44*	.66*	.52*	.69*	--	
9. Lifetime Attempts	.51*	.35*	.52*	.41*	.71*	.54*	.73*	.85*	--

Note. Due to missing data, which at no time exceeded more than 3 data points, some correlations are based on fewer than 97 participants.

* $p < .01$, two-tailed. Correlations of .10, .30, and .50 correspond to small, medium, and large effect sizes, respectively (Cohen, 1992).

Multiple Regression Analyses

Analyses began by evaluating whether the assumptions of multiple regression were met. The normality of the predictors and outcome variables was assessed by calculating indices of skewness and kurtosis and by visually inspecting histograms. A lack of normality was indicated if the ratio of skewness or kurtosis to its standard error was greater than three or less than negative three. All of the predictor variables, with the exception of life meaning, were substantially non-normal based on their histograms and had either problems with skewness or kurtosis.

Due to violations of normality, a nonparametric bootstrapping approach was used to analyse the data. The typical parametric tests require assumptions to be met (i.e., normal distribution) regarding the data. When these assumptions are not met, conclusions cannot be accurately drawn regarding tests of significance. Thus, the technique of bootstrapping is used in these cases because it does not rely on assumptions of either normality or homoscedasticity.

Bootstrapping assumes that the sample obtained (in this case, $N = 97$) is representative of the population. Bootstrapping bases analyses on a sampling distribution which is empirically derived from the given sample. From the sample (which is seen to represent the population), a sampling distribution is created by taking a large number of samples randomly (with replacement). For each sample (5000 resamples in this case) the statistic of interest is calculated. These samples then comprise a frequency distribution which is used as an estimate of the sampling distribution. The resulting distribution is then used to draw inferences about the population and to generate confidence intervals for

significance testing (Cirincione & Gurrieri, 1997; Hesterberg, Moore, Monaghan, Clipson, & Epstein, 2005).

To assess the unique contributions of the four predictor variables of depression, hopelessness, life meaning, and psychache on the five criterion variables of suicidal ideation, suicidal preparation, suicidal motivation, attempter status, and number of lifetime attempts all four predictor variables were simultaneously regressed on each one of the five criterion measures using bootstrapping. For each of the five analyses, psychache was the only significant predictor able to account for unique variance over and above that contributed by the other three predictors. The beta weights for psychache in statistically predicting each of the suicide criterion variables are as follows: suicidal intent, $\beta = .42, p < .05$; suicidal motivation, $\beta = .31, p < .05$; suicidal preparation, $\beta = .39, p < .05$; attempter status, $\beta = .38, p < .05$; and lifetime attempts, $\beta = .34, p < .05$. Results are summarized in Table 4.

Table 4

Regression Coefficients for Predicting Suicidality (N = 97)

	Suicidal Ideation		Suicidal Motivation		Suicidal Preparation		Attempter Status		Lifetime Attempts	
<i>R</i> ²	.43*		.42*		.31*		.30*		.30*	
Statistical Predictor	<i>b</i>	β	<i>b</i>	β	<i>b</i>	β	<i>b</i>	β	<i>b</i>	<i>B</i>
Intercept	-1.31		-2.13		.90		2.26		-.65	
Depression	.10	.15	.03	.09	.07	.19	.00	.10	.03	.26
Hopelessness	.05	.04	.06	.11	.11	.16	.00	.02	.02	.09
Life Meaning	.12	.18	.08	.23	.06	.15	.01	.12	.01	.05
Psychache	.21	.42*	.08	.31*	.11	.39*	.01	.38*	.03	.34*

* $p < .05$, two-tailed, assuming standard parametric assumptions. All indicated significant results were confirmed using non-parametric bootstrapping with 5000 resamples.

CHAPTER 4

Discussion

Suicide ideation occurs much more often than actual completed suicide and, as a precursor to death by suicide, determining which factors predict or discriminate between those who do and do not have suicidal ideation is an important component for understanding who will and will not commit suicide. Shneidman's theory of psychache suggests that psychache is the most important psychological antecedent and thus predictor of suicide-related manifestations (1993). The importance of psychache in the prediction of suicidality has been demonstrated by a number of researchers focusing on a variety of populations. Although some work has been done with more high risk groups from forensic and psychiatric populations (Holden & Kroner, 2003; Pompili et al., 2008), the majority of research has focused on more low risk university samples (DeLisle & Holden, 2009; Flamenbaum, & Holden, 2007). One high risk population for suicide which had not received much attention until now are individuals who are homeless. The base rate of suicide among people who are homeless has been found to be substantially greater than the general population (Fitzpatrick et al., 2007; Schutt et al., 1994) and thus, research which may contribute to a clearer understanding of suicidality among this high risk population is of use.

The main purpose of the current research was to evaluate whether Shneidman's (1993) model extends to people who are homeless. The hypothesis was that, given the circumstances surrounding homelessness, psychache would be high among individuals who are homeless. Further, we hypothesized that psychache will be a better predictor of suicidal ideation than the variables of depression, hopelessness, and life meaning.

Overall the hypothesis that psychache would be the variable more strongly related to suicidal ideation, motivation, preparation, and attempt history was supported. More specifically, based on Shneidman's model of suicidality, it was predicted that psychache would correlate significantly with the criterion variables of suicidal ideation, motivation, and preparation. This would indicate that there is a relationship between psychache and these criterion variables and that psychache has validity for indicating suicidality. This prediction was supported as psychache was found to be positively correlated with the criterion variables of suicidal ideation, motivation, preparation, and attempt history. In fact, as hypothesized, psychache had higher correlation values with the criterion variables than did the variables of depression, hopelessness, and life meaning indicating a stronger relationship between psychache and the criterion than between the other variables and the criterion variables.

Multiple regression analyses demonstrated that the constructs of life meaning, depression, hopelessness, and psychache as a group are able to predict suicidal ideation, motivation, preparation, and attempt history. However, as predicted based on Shneidman's (1993) model of suicidality, in regressing each of suicidal ideation, motivation, preparation, and attempt history on psychache, depression, hopelessness, and life meaning, the regression coefficient associated with psychache was statistically significant and the regression coefficients associated with depression, hopelessness, and life meaning were not statistically significant. These findings indicate that depression, hopelessness, and life meaning do not have incremental validity above that of psychache for indicating suicidality and that psychache does have incremental validity above and beyond depression, hopelessness, and life meaning for indicating suicidality. The finding

that psychache was the strongest statistical predictor of suicide ideation in a high-risk sample is consistent with other research examining groups of attempters and/or suicide ideators (Holden, 2001; Holden et al., 1998; Munchua, 2003).

Overall Shneidman's (1993) claim that psychache mediates the relationship between all risk factors, such as depression and hopelessness, was substantiated. When the criterion variables were regressed on the four predictor variables simultaneously, psychache was the only variable which accounted for a significant proportion of the variance. Depression, hopelessness, and life meaning did not account for any unique variance in the criterion variables. This indicates that psychache is the best statistical predictor among those psychological variables studied for indicating suicidal ideation, motivation, preparation, and attempt history.

Theoretical Implications

Depression has tended to be considered the best predictor of suicidality. Beck's cognitive theory of depression, suggests that it is the negative cognitions about the self, the world, and the future (the cognitive triad) which can explain depressive symptoms (Rush & Beck, 1978). With no perceived hope for the future and negative self evaluations, an individual considers suicide as a means of escape. This relationship has been empirically supported numerous times (Biggam & Power, 1999; Goldney et al., 2000; Silver et al., 1971) yet, in none of these studies did depression account for most of the variance in suicide ideation. In hope of better understanding suicidality, some researchers have looked at the effect of hopelessness.

Research by Dieserud et al. (2001) found that when the effect of hopelessness was controlled, depression was no longer predictive of suicidal ideation. Therefore, it is the

hopeless element of depression which is responsible for suicide. This finding makes sense in light of the theory of hopelessness depression created by Abramson et al. (1989). They suggest that hopelessness depression is a subtype of depression and it is the hopeless component which relates to suicide.

Meaning in life has also been found to relate to suicidality. Individuals who report life meaning and actively engage in trying to achieve goals report feelings of worth, significance, and importance (Battista & Almond, 1973). On the other hand, those who do not have a sense of life meaning report more negative emotions, psychopathology, substance abuse, and suicidal ideations (Feldman & Snyder, 2005; O'Connor & Chamberlain, 1996). Taken together, it seems that life meaning relates to an individuals overall well being and suicidal ideations.

Psychache has also been considered as a possible antecedent to suicidality. Shneidman's theory of psychache (1993) contends that psychache is entirely responsible for suicide. He suggests that the utility of depression and hopelessness in explaining suicide is only relevant in terms of their relationship to psychological pain. Shneidman (1993) asserts that psychache is an overarching variable that is a more important predictor of suicide than both depression and hopelessness.

Overall, consistent with the aforementioned research, the variables in this study (i.e., depression, hopelessness, life meaning, and psychache) as a whole emerged as predictors of suicide ideation, preparation, motivation and attempt status. However, the variable of psychache was the only variable found to explain unique variance over and above the variance explained by the variables of depression, hopelessness, and life meaning on all suicide criterion variables. Therefore, the findings of the current study

provide support for Shneidman's theory of psychache (1993) which suggests that psychache has more predictive power than the other three variables in explaining suicidality. This finding suggests that in line with Shneidman's theory, when compared to depression and hopelessness, psychache is the variable most responsible for suicide.

Practical implications

Given that suicide is a major issue in Canada (Statistics Canada, 2009) research to demystify the issue is imperative. There are numerous consequences of suicide, for the individual, the individual's family, and society at large (McMenamy, Jordan, & Mitchell, 2008; Pompili et al., 2008). Because suicide is especially prevalent among those who are homeless, they are an important population to investigate (Fitzpatrick et al., 2007; Schutt et al., 1994). In order to prevent suicide, we must better understand the predictors. Past research has established psychache as a correlate to suicide among the general population (Holden et al., 1998; Johns & Holden, 1997), but no study had explored psychache among individuals who are homeless. The results of the current research suggest that psychache is a better predictor of suicide ideation, motivation, and preparation than are the variables of depression, hopelessness, and life meaning. Thus, in a mental health setting if a support worker or clinician is assessing suicidality it would be valuable to assess levels of psychache as this was found to be the best predictor of suicidality.

Assessment

Shneidman (1999b) created the first scale to assess psychache called the Psychological Pain Assessment Scale (PPAS). It is a paper-and-pencil test (with pictures) used to assess the level of psychache experienced by individuals. Research has found that the PPAS has only a modest degree of validity and reliability (Leenaars & Lester, 2004).

Holden et al. (2001) also developed a measure to assess psychological pain as defined by Shneidman (1993). The scale is a 13-item self-report measure called the Psychache Scale. Research has found that this scale has good construct validity and internal consistency (Mills et al., 2005) with an alpha coefficient of .92 indicating a strong level of homogeneity (Holden, 2001). Support for construct validity was found in its strong to moderate relationship with other valid measures of depressed affect and psychiatric symptoms (Mills et al.) as well as in its significant and large correlation with a scale of suicide ideation and a significant medium correlation with a scale of suicide attempts (Holden, 2001) Research has found that the Psychache Scale is able to distinguish between suicide ideators and attempters (Holden et al. 2001). Thus, the use of this scale in a clinical setting may help distinguish between those potentially at risk for suicide.

Intervention

In line with Shneidman's theory of psychache (1993) the current research found that levels of psychache have a strong relationship to suicidality. Shneidman contends anything we can do to reduce psychache will potentially decrease levels of suicidality. Considering, based on the Cohen's *d* statistic of effect size, psychache is higher among those who are homeless than among both general population and forensic populations any intervention which will decrease levels of psychological pain/psychache among the homeless should, according to Shneidman, likely decrease suicidality.

In order to decrease psychache, Shneidman (2005) suggests focusing on the frustrated psychological need/s which is/are causing the psychache. Shneidman suggests therapy with a specific focus on reducing psychological pain (psychache) caused by

unfulfilled psychological needs (e.g., need for achievement, affiliation, autonomy etc.). He suggests that this can be done in two ways. First, by increasing the threshold of what an individual can cope with by redefining the pain from something that is *unbearable* to something seen as *bearable* and second, by trying to reduce and/or eliminate the psychological pain. Although Shneidman does not suggest specific techniques for changing levels of psychache certain Cognitive Behavioural Techniques (CBT) may be effective as they tend to target cognitive inflexibility and help an individual with restructuring their negative thought patterns.

A meta-analysis of CBT with suicidal clients has shown that CBT is effective in reducing suicidal behaviour (Tarrier, Taylor, & Gooding, 2008). Specifically, CBT tends to focus on improving cognitive flexibility and problem solving skills which may help an individual see alternatives to stopping the psychological pain and/or it may help them interpret the pain in another way. In other words, CBT may help an individual redefine their *unbearable* pain as *bearable*. CBT would also likely improve distress tolerance, emotion regulation, problem solving, anger management, and interpersonal skills through a variety of techniques. Cognitive restructuring could take place through the use of CBT techniques such as thought records. Socratic questioning would be helpful in challenging an individual's all or nothing thinking (suicide is the *only* way to stop the suffering) and suicide thought records would help an individual gain insight into their suicidality (e.g., what are their triggers). Although it would be extremely difficult to implement long term CBT treatments with a population as transient as the homeless, short term, low barrier, in house (within shelters or community centres), private or group therapy sessions may be helpful in restructuring maladaptive thinking patterns.

Limitations and Future Directions

Although the current research is promising, there are limitations. One limitation of the current study is that participants were identified and assessed based on their willingness to participate in the study. Participants that volunteer to talk about their experiences with self-harm are possibly different in some way than those who do not volunteer (e.g., more extraverted rather than introverted). This potentially limits the generalizability of the study. The information that is missed from these people may be important in determining the predictors of self-harm.

As with most questionnaires, demand characteristics may be another problem with the current study. Participants may not have been completely honest in describing their experience with self-harming behaviour. They may not have wanted to admit certain things to the researcher because the researcher was a virtual stranger. They also may lack insight into the factors related to self-harming behaviour.

Originally, the plan was to collect data from women and men who are homeless. However, after finishing data collection, only 9 out of 106 individuals were women thus, hindering our ability to generalize to women. This proportion of men and women makes sense in light of research which has shown that homelessness is much more likely to affect men than women (Baker, 1994). Men and women appear to have different patterns of homelessness. Specifically, men are more likely than women to have been homeless on a prior occasion, to remain homeless longer, and to have a higher overall prevalence of chronic homelessness (DiBlasio & Belcher, 1995; Wong, Pilavin, & Wright, 1998; Zlotnick, Roberston, & Lahiff, 1999). Therefore, although the sample of males and females is unequal, the distribution of men and women is representative of homelessness.

The problem is that with only 8% women, it is difficult to generalize the findings to all individuals who are homeless. Further, research has shown that men and women differ in their suicide related behaviours depending on gender (Edwards & Holden, 2003; Nock, Borges, Bromet, Alonso, Angermeyer, & Beautrais, 2008; Nock, Borges, Bromet, Cha, Kessler, & Lee, 2008). In fact, research has found that women are more likely to make a suicide attempt although men are more likely to actually commit suicide (Canetto & Sakinofsky, 1998; Moscicki, 2001). Thus, there is something different about men and women in regards to suicide. Therefore, in order to truly be able to generalize the results to all people who are homeless, women would need to be more represented. As the results were not really generalizable to women, the decision was made to exclude the data from women and concentrate only on men. Considering the aforementioned differences between men and women in terms of their experiences with homelessness, future research, which explores the experiences of suicidality and psychache among women, would be important.

Another area where further research would be essential is exploring the causes of psychache. Considering psychache was found to be a significant predictor of suicidality in the current study the next logical step is to explore the factors which are related to precipitating psychache. Psychache is proposed by Shneidman (1993) to be caused by unfulfilled psychological needs, therefore in the future, research which explores psychological needs among people who are homeless would be of interest. If we are better able to identify and treat these unfulfilled psychological needs in individuals who are suicidal, we will be better equipped to prevent suicide in the future. Research exploring these needs by comparing psychache and unfulfilled needs among the currently,

previously, and never before homeless would potentially be very informative. In order to better understand the relationship, it would be interesting to assess the three groups on activities proposed by Shneidman (1993) to reduce psychache. This would allow us to determine if there is a relationship among levels of psychache and the occurrence of those events. If so, perhaps interventions designed to create those events which can fulfill psychological needs would be useful.

Our small sample size is another limitation and potential direction for future research. A relatively small sample size limited our ability to explore factors which moderate the relationship between psychache and suicidality. With only 23 individuals in the current study endorsing prior suicidal action there is not enough power to determine if variables such as length of homelessness, years of completed schooling, social support etc. moderate the relationship between psychache and suicidality. Future research with a larger sample size, allowing for the exploration of these moderating factors, would be informative and important.

As the nature of suicide is such that once it is complete it is impossible to collect certain data, proxies for suicide are required. The use of proxies is another potential limitation. Traditionally suicidality is assessed by scores on measures of suicide attempts, suicide ideation, suicide motivation and suicide preparation. Therefore, there is the possibility that these criterion variables are not perfect proxies and the results do not generalize to individuals who have completed suicide. Support for the use of these variables as proxies comes from research which has shown that the presence of suicide ideation and a suicide plan significantly increase the risk of a suicide attempt and that risk of a suicide. Further, it has been found that prior suicidal behaviours are among the

strongest predictors of subsequent suicidal behaviors (Borges, Angst, Nock, Ruscio, Walters, & Kessler, 2006; Goldstein, Black, Nasrallah, & Winokur, 1991; Joiner, Conwell, Fitzpatrick, Witte, Schmidt, Berlim et al., 2005; Fawcett, Scheftner, Fogg, Clark, Young, Hedeker, et al., 1990). Although not perfect surrogates for suicide, the variables of suicidal attempts, ideation, motivation, and preparation are indicators of extreme psychological distress that, in and of themselves, warrant research attention.

Finally, the current study does not address all types of suicide. Specifically, this dissertation does not address euthanasia or altruistic suicide. Euthanasia is the act of ending the life of an individual suffering from a terminal illness or an incurable condition, as by lethal injection or the suspension of extraordinary medical treatment (Chochinov, Wilson, Enns, Mowchun, Lander, Levitt et al., 1995). Euthanasia occurs when an individual feels that physical pain is unbearable and believes death is the only way to stop the pain. Research has shown that, among individuals with both depression and a life-threatening illness, the vast majority describe the psychological pain as being worse than the physical pain (Osmond et al., 1984, as cited in Mee et al., 2006). Therefore, in that euthanasia is thought to occur when an individual's physical pain exceeds their threshold for tolerance and research has demonstrated that psychological pain is perceived as worse than physical pain, it would be interesting to explore the relationship between psychological pain, physical pain, and suicide/euthanasia.

Altruistic suicide on the other hand is suicide which takes place because the individual perceives that his/her death will have some positive impact on his/her society (Durkheim, 1951). Altruistic suicide has four key features: First it is characterized by excess social integration meaning the person is so closely tied to the rituals and cultural

beliefs of a group that he/she loses a sense of individuality. Second, altruistic suicide is supported by public opinion. Third, it benefits society materially or culturally. Finally, altruistic suicide tends to be pursued with a psychological state of enthusiasm rather than distress. This form of suicide has been linked with martyrdom, military heroism, and suicide bombings (Pedahzur, Perliger, & Weinberg, 2003). There are two places where altruistic suicide is likely to occur; in primitive societies or military. Shneidman (1993) is silent with respect to psychache in relation to euthanasia or altruistic suicide. These types of suicide seem to be viewed as fundamentally different from typical suicide perhaps because altruistic suicide is not thought to involve psychological disturbance (Slack, 2004) and euthanasia is thought to stem from unbearable physical pain (Chochinov et al.). There is a real lack of research surrounding distress and psychological pain among individuals who engage in these types of suicide and, thus, this would be an important area for future research.

CHAPTER 5

Conclusions

Overall the current research contributes to understanding the psychological predictors of suicide. The purpose of the current research was to test Shneidman's theory (1993) that psychache is the best predictor of suicidality with a high risk population, namely people who are homeless. Research has found individuals who are homeless to be much more likely to commit suicide when compared to the general population however, until now they have not been assessed. The current research suggests that among this high risk population, psychache is a stronger predictor of suicidality than depression, hopelessness, and life meaning. Overall, the current research has significant implications

for clinical practice. In order to prevent suicide among individuals who are homeless, it is important to understand the predictors. By discovering that psychache is the best predictor of suicidality among people who are homeless we are able to assess psychache among people who are homeless and potentially prevent suicide in the future. Future research should address the limitations present in the current study including research focusing on the experiences of women.

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Appendix A
Questionnaires

QUESTIONNAIRE BOOKLET:
SELF-HARMING BEHAVIOUR AMONG THE HOMELESS

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Today's Date : _____

Demographics

1. What is your age? _____
2. Please circle your gender: **Male** **Female**
3. What was your age when you were homeless for the first time (sleeping outdoors or in an emergency shelter because you lacked acceptable housing)? _____
4. How long have you been homeless this time?
2 weeks-1 month **2-6 months** **7-11 months** **1 year** **2-5 years** **> 5 years**
5. What is your reason for homelessness (circle all that apply)?
Lack of Affordable Housing **Economics** **Job Loss** **Family/Relationship**
problems **Unsafe housing** **Illness** **Marital Problems** **Drugs/Alcohol**
New to the City **Mental Health Difficulties** **Eviction** **Other** _____
6. How many times have you tried unsuccessfully to get off the street? _____
7. Country in which you were born? _____
8. What is your ethnicity (circle)? **Euro-Canadian** **Indo-Canadian** **First Nations** **Metis** **African American** **Chinese** **Other** _____
9. During the time you were homeless, did you regularly use illegal drugs other than marijuana? **NO** **YES**
10. What is the highest level of education you completed? _____
11. Have you ever attempted suicide (circle one)? **YES** **NO**
12. If YES, how long ago was your most recent attempt? _____
13. If YES, how did you attempt to kill yourself in this attempt? _____
14. If YES, how intent were you on killing yourself in this most recent attempt (circle)?
NOT VERY INTENT **SOMEWHAT INTENT** **MODERATELY INTENT** **QUITE INTENT** **EXTREMELY INTENT**

15. How many suicide attempts have you made in your entire lifetime (circle one)?

0

1

2-3

4-6

7-10

More than 10

Multidimensional Life Meaning Scale – Short Form

Please read each statement carefully and indicate to what extent each item characterizes your own life. You may respond by circling the appropriate number according to the following scale:

1	2	3	4	5	6	7	
Strongly Disagree			Neutral			Strongly Agree	
					SD	N	SA
1. I really feel good about my life.	1	2	3	4	5	6	7
2. Life to me seems always exciting.	1	2	3	4	5	6	7
3. If I could choose, I would prefer never to have been born	1	2	3	4	5	6	7
4. Living is deeply fulfilling.	1	2	3	4	5	6	7
5. My life is empty, filled only with despair.	1	2	3	4	5	6	7
6. Nothing very outstanding ever seems to happen to me.	1	2	3	4	5	6	7
7. I get so excited by what I'm doing that I find new stores of energy I didn't know that I had.	1	2	3	4	5	6	7

Beck Depression Inventory

This questionnaire consists of 21 groups of statements. After reading each group of statements carefully, circle the number (0, 1, 2, or 3) next to the one statement in each group which **best** describes the way you have been feeling the **past week, including today**. If several statements within a group seem to apply equally well, circle each one. **Be sure to read all the statements in each group before making your choice.**

1. 0 I do not feel sad.
1 I feel sad.
2 I am sad all the time and I can't snap out of it.
3 I am so sad or unhappy that I can't stand it.

2. 0 I am not particularly discouraged about the future.
1 I feel discouraged about the future.
2 I feel I have nothing to look forward to.
3 I feel that the future is hopeless and that things cannot improve.

3. 0 I do not feel like a failure.
1 I feel I have failed more than the average person.
2 As I look back on my life, all I can see is a lot of failures.
3 I feel I am a complete failure as a person.

4. 0 I get as much satisfaction out of things as I used to.
1 I don't enjoy things the way I used to.
2 I don't get real satisfaction out of anything anymore.
3 I am dissatisfied or bored with everything.

5. 0 I don't feel particularly guilty.
1 I feel guilty a good part of the time.
2 I feel quite guilty most of the time.
3 I feel guilty all of the time.

6. 0 I don't feel I am being punished.
1 I feel I may be punished.
2 I expect to be punished.
3 I feel I am being punished.

7. 0 I don't feel disappointed in myself.
1 I am disappointed in myself.
2 I am disgusted with myself.
3 I hate myself.

8. 0 I don't feel I am any worse than anybody else.
1 I am critical of myself for my weaknesses or mistakes.
2 I blame myself all the time for my faults.
3 I blame myself for everything bad that happens.

9. 0 I don't have any thoughts of killing myself.
1 I have thoughts of killing myself, but I would not carry them out.
2 I would like to kill myself.
3 I would kill myself if I had the chance.
10. 0 I don't cry any more than usual.
1 I cry more now than I used to.
2 I cry all the time now.
3 I used to be able to cry, but now I can't cry even though I want to.
11. 0 I am not more irritated now than I ever am.
1 I get annoyed or irritated more easily than I used to.
2 I feel irritated all the time now.
3 I don't get irritated at all by the things that used to irritate me.
12. 0 I have not lost interest in other people.
1 I am less interested in other people than I used to be.
2 I have lost most of my interest in other people.
3 I have lost all of my interest in other people.
13. 0 I make decisions about as well as I ever could.
1 I put off making decisions more than I used to.
2 I have greater difficulty in making decisions than before.
3 I can't make decisions at all anymore.
14. 0 I don't feel I look any worse than I used to.
1 I am worried that I am looking old or unattractive.
2 I feel that there are permanent changes in my appearance that make me look unattractive.
3 I believe that I look ugly.
15. 0 I can work about as well as before.
1 It takes an extra effort to get started at doing something.
2 I have to push myself very hard to do anything.
3 I can't do any work at all.
16. 0 I can sleep as well as usual.
1 I don't sleep as well as I used to.
2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
3 I wake up several hours earlier than I used to and cannot get back to sleep.
17. 0 I don't get more tired than usual.
1 I get tired more easily than I used to.
2 I get tired from doing almost anything.
3 I am too tired to do anything.
18. 0 My appetite is no worse than usual.
1 My appetite is not as good as it used to be.
2 My appetite is much worse now.
3 I have no appetite at all anymore.

19. 0 I haven't lost much weight, if any, lately.
1 I have lost more than 5 pounds.
2 I have lost more than 10 pounds.
3 I have lost more than 15 pounds.

I am purposely trying to lose weight by eating less. Yes _____ No _____

20. 0 I am no more worried about my health than usual.
1 I am worried about physical problems such as aches and pains; or upset stomach; or constipation.
2 I am very worried about physical problems and it's hard to think of much else.
3 I am so worried about my physical problems that I cannot think about anything else.
21. 0 I have not noticed any recent change in my interest in sex.
1 I am less interested in sex than I used to be.
2 I am much less interested in sex now.
3 I have lost interest in sex completely.

Beck Hopelessness Scale

Below you will find a series of statements that a person might use to describe himself/herself. Please read each statement and decide whether or not it describes you. Then circle your answer beside each statement. If you agree with a statement or decide it describes you, circle **T** for **TRUE**. If you disagree with a statement or decide it does not describe you, circle **F** for **FALSE**. Please try to answer every statement either true or false, even if you are not completely sure of your answer.

- | | |
|--|-------------------|
| 1. I look forward to the future with hope and enthusiasm. | T F |
| 2. I might as well give up because I can't make things better for myself. | T F |
| 3. When things are going badly, I am helped by knowing they can't stay that way forever. | T F |
| 4. I can't imagine what my life would be like in 10 years. | T F |
| 5. I have enough time to accomplish the things I most want to do. | T F |
| 6. In the future, I expect to succeed in what concerns me most. | T F |
| 7. My future seems dark to me. | T F |
| 8. I expect to get more of the good things in life than the average person. | T F |
| 9. I just don't get the breaks, and there's no reason to believe I will in the future. | T F |
| 10. My past experiences have prepared me well for my future. | T F |
| 11. All I can see ahead of me is unpleasantness rather than pleasantness. | T F |
| 12. I don't expect to get what I really want. | T F |
| 13. When I look ahead to the future, I expect I will be happier than I am now. | T F |
| 14. Things just won't work out the way I want them to. | T F |
| 15. I have great faith in the future. | T F |
| 16. I never get what I want so it's foolish to want anything. | T F |
| 17. It is very unlikely that I will get any real satisfaction in the future. | T F |
| 18. The future seems vague and uncertain to me. | T F |
| 19. I can look forward to more good times than bad times. | T F |

20. There's no use in really trying to get something I want because I probably won't get it.

T **F**

Beck Scale for Suicide Ideation

Please carefully read the following 19 statements and, for each, circle the most appropriate response for you.

1. How strong is your wish to live?
 - a) **Moderate to strong.**
 - b) **Weak.**
 - c) **None.**

2. Do you have any wish to die?
 - a) **None.**
 - b) **Some weak desire.**
 - c) **Moderate to strong desire.**

3. In considering your reasons for living and dying:
 - a) **the reasons for living outweigh the reasons for dying.**
 - b) **the reasons for living equal the reasons for dying.**
 - c) **the reasons for dying outweigh the reasons for living.**

4. Do you have any desire to attempt to end your life?
 - a) **None.**
 - b) **I have some weak desire.**
 - c) **I have at least moderate desire.**

5. If for any reason your life was endangered and you were in a position to intervene, would you:
 - a) **take the necessary action to save your life?**
 - b) **leave the final result of life and death to chance?**
 - c) **avoid any steps which could be taken to save your life?**

6. For what duration have you had thoughts of taking your own life?
 - a) **If at all, they have been at the most brief, passing thoughts.**
 - b) **They have persisted longer than the occasional passing thought.**
 - c) **They are continuously on my mind,**

7. How frequently have you thought of taking your own life?
 - a) **If at all, only on rare occasions.**
 - b) **Fairly frequently.**
 - c) **Quite often, almost all the time.**

8. How do you feel about any thoughts of ending your life you might have?
 - a) **I reject them.**
 - b) **I am unsure about them.**
 - c) **I accept them.**

9. Do you feel you can control any thoughts of ending your life you might have?
 - a) **I feel they are under my control.**
 - b) **I am unsure that I control them.**
 - c) **I have no sense of control over these wishes.**

10. Do you feel deterred from taking action to end your life by certain inhibiting factors (e.g., family, religious beliefs) within it?
- a) **I would not attempt to end my life because of deterrents.**
 - b) **I am moderately inhibited from ending my life by deterrents.**
 - c) **I am unconcerned about any deterrent.**
11. What reasons could you have for attempting to end your own life?
- a) **Only to get attention or revenge.**
 - b) **To get attention and to escape my problems.**
 - c) **To escape from my problems and solve them.**
12. Have you ever contemplated ending your own life to the extent of making a plan or choosing a method with which to do so?
- a) **No, I have not considered it.**
 - b) **Yes, but not to the extent of working out the details.**
 - c) **Yes, I have considered and worked out a plan to do so.**
13. What opportunity would you have to end your own life?
- a) **Very little, there is no available method or opportunity.**
 - b) **Some, but getting an opportunity and acquiring a means to do so would take some effort.**
 - c) **Considerable, an opportunity and means to do so are readily available.**
 - d) **Considerable, although opportunity and means are not currently available, they would be in the future.**
14. How capable could you feel in carrying out an attempt to end your life?
- a) **I would be too afraid, hesitant or incompetent.**
 - b) **I would be unsure of my courage and competence.**
 - c) **I would be quite sure of my courage and competence.**
15. Do you anticipate that you will ever make an actual attempt to end your life?
- a) **No.**
 - b) **I don't know; I am not quite sure.**
 - c) **Yes.**
16. Have you ever made any preparation for any attempt to end your life?
- a) **No, none whatsoever.**
 - b) **Some, but not complete preparation.**
 - c) **Yes, complete preparation for an attempt.**
17. Have you ever formulated a suicide note for yourself?
- a) **No.**
 - b) **I thought about one but only started composing or writing it.**
 - c) **Yes, I completed one.**

18. Have you ever taken any actions (e.g., insurance, will) in anticipation of attempting to end your own life?

- a) **None at all.**
- b) **Some, I have thought about such action and made preliminary arrangements.**
- c) **Considerable, I have made a definite plan or completed such arrangements.**

19. To what degree have you openly revealed any thoughts you might have of ending your life?

- a) **I have revealed any ideas openly.**
- b) **I have held back on revealing any thoughts of this nature.**
- c) **I have kept them to myself or taken measures to conceal their knowledge from others.**

The Psychache Scale

The following statements refer to your psychological pain, NOT your physical pain. By circling the appropriate number, please indicate how frequently each of the following occurs.

1 = Never; 2 = Sometimes; 3 = Often; 4 = Very Often; 5 = Always

	Never	Sometimes	Often	Very Often	Always
1. I feel psychological pain.	1	2	3	4	5
2. I seem to ache inside.	1	2	3	4	5
3. My psychological pain seems worse than any physical pain.	1	2	3	4	5
4. My pain makes me want to scream.	1	2	3	4	5
5. My pain makes my life seem dark.	1	2	3	4	5
6. I can't understand why I suffer.	1	2	3	4	5
7. Psychologically, I feel terrible.	1	2	3	4	5
8. I hurt because I feel empty.	1	2	3	4	5
9. My soul aches.	1	2	3	4	5

Please continue this inventory using the following scale:

1 = Strongly Disagree; 2 = Disagree; 3 = Unsure; 4 = Agree; 5 = Strongly Agree

	Strongly Disagree	Disagree	Unsure	Agree	Strongly Agree
10. I can't take my pain any more.	1	2	3	4	5
11. Because of my pain, my situation is impossible.	1	2	3	4	5
12. My pain is making me fall apart.	1	2	3	4	5
13. My psychological pain affects everything I do.	1	2	3	4	5

Thank you for answering all these questions.

Is there anything else you'd like to say, or is there anything else we should have asked, but didn't?

Appendix B
Recruitment Form



Are you currently homeless?

If yes, we need your help.

- Participants will be asked to fill out a number of questionnaires asking about their experiences with self-harming behaviour.
- Interviews will last about 30-45 minutes.
- Questionnaire responses will be kept confidential.
- Participants will receive a \$10 gift certificate to a grocery or department store.

**Interested in participating? please come see me
in room _____ on _____, 2009 at ___pm**

Appendix C
Letters of Information/ Consent Form/Debriefing Form
Letter of Information – Toronto, O.N.
**Psychache and Self-Harming Behaviour Among the Homeless:
A Test of Shneidman's Model**

Who

- The research is being carried out by Allisha Patterson, a Masters student, working with Dr. Ronald Holden, a psychology professor at Queen's University in Kingston, Ontario.

Purpose

- Understand how feelings of psychological pain relate to thoughts of suicide. The more information we have the better able we are to predict suicide risk and hopefully aid in future suicide prevention.

What will you do?

- Fill out questionnaires asking about predictors of suicide and previous suicidal thoughts. These questionnaires ask about topics which may be personal or stressful.
- Your involvement in the study is voluntary and you may stop participating at any time.
- If there is a question that makes you feel uncomfortable you do not have to answer.
- You can keep the \$10 gift card even if you don't answer a question or want to stop participating early.
- We estimate that it will take about 45 minutes to complete these questionnaires.
- There are no known physical, psychological, economic, or social risks associated with completing the questionnaires; this research has been approved by the Queen's University General Research Ethics Board.

Requirements

- At least 18 years of age.
- Homeless for at least 2 weeks.
- Successfully complete a test of reading ability.

Privacy

- Your responses will be kept confidential.
- The only time that privacy may be disrupted is if you tell me that you are currently feeling suicidal. In this case I am required to assess the situation further and ensure you receive immediate help at the hospital.
- Nobody, except for myself and my supervisor, will be able to identify you from your questionnaire.
- Data will be stored in a file cabinet in a locked room until the questionnaires are no longer needed.
- Questionnaires and consent forms will be separated so your name will not be associated with any answers.
- To help us ensure your privacy, please do not put your name on any of the research study answer sheets.
- Any presentation of the findings will be of general findings and will never breach individual privacy.
- Should you be interested, you are entitled to a copy of the findings.

What to do if you feel distressed

- If any of the questions make you feel distressed, I am trained to assess the situation further and will immediately consult with Dr. Ronald Holden.
- Further, I can provide you with a list of resources (i.e., Distress Center Ontario, 416-537-7373; Community Mental Health Crisis Response Program, 416-498-0043; Gerstein Crisis Centre, 416-929-5200; Toronto - Distress Centre, 416 408-4357).
- If you do contact my supervisor and indicate that you are at immediate risk, we will attempt to act to ensure your safety.

Contact Information

- If you have any complaints, concerns, or questions about this research, please contact Dr. Ronald Holden, (613-533-2879, or holdenr@queensu.ca), the Head of the Department of Psychology (613-533-2492), or Dr. Joan Stevenson, Chair of the General Research Ethics Board (613-533-6081) at Queen's University.

**Letter of Information – Vancouver, B.C.
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- The only time that privacy may be disrupted is if you tell me that you are currently feeling suicidal. In this case I am required to assess the situation further and ensure you receive immediate help at the hospital.
- Nobody, except for myself and my supervisor, will be able to identify you from your questionnaire.
- Data will be stored in a file cabinet in a locked room until the questionnaires are no longer needed.
- Your questionnaires will be separate from your consent form so your name will not be directly associated with any answers.
- To help us ensure your privacy, please do not put your name on any of the research study answer sheets.
- Any presentation of the findings will be of general findings and will never breach individual privacy.
- Should you be interested, you are entitled to a copy of the findings.

What to do if you feel distressed

- If any of the questions make you feel distressed, I am trained to assess the situation further and will immediately consult with Dr. Ronald Holden.

- Further, I can provide you with a list of resources (i.e., The Crisis Centre, 1-800-SUICIDE (784-2433); Vancouver Coastal Health, Psychiatry, 604-875-4023; VGH, Outpatient Psychiatry Program, 604-875-4794). If you do contact my supervisor and indicate that you are at immediate risk, we will attempt to act to ensure your safety.

Contact Information

- If you have any complaints, concerns, or questions about this research, please feel free to contact Dr. Ronald R. Holden, (613-533-2879, or holdenr@queensu.ca), the Head of the Department of Psychology (613-533-2492), or Dr. Joan Stevenson, the Chair of the General Research Ethics Board (613-533-6081) at Queen's University.

Consent Form
Psychache and Self-Harming Behaviour Among the Homeless:
A Test of Shneidman's Model

Please answer the following:	True	False
I may stop participating at any time.	<input type="checkbox"/>	<input type="checkbox"/>
I have to answer all questions.	<input type="checkbox"/>	<input type="checkbox"/>
Everybody at Queen's University has access to my answers.	<input type="checkbox"/>	<input type="checkbox"/>
If I say I am feeling suicidal the researcher will be required to act to ensure my safety.	<input type="checkbox"/>	<input type="checkbox"/>

I, _____(Name - please print clearly) have volunteered to participate in the study titled, Psychache and Self-Harming Behaviour Among the Homeless: A test of Shneidman's Model.

1. I have read the Letter of Information and have had any questions answered to my satisfaction.
2. I understand that I will be asked to fill out questionnaires pertaining to my own self-harm history and suicidal ideation, as well as related scales, so that potential predictors may be better understood.
3. I understand that my participation in this study is voluntary and I may stop participating at any time.
4. I understand that every effort will be made to maintain the privacy of the data now and in the future. The data will be stored in a file cabinet in a locked room, and only Allisha and Dr. Holden will have access to this data. To ensure security, participants' names will be kept separately from answers to the questionnaires. If the data is presented it will be of general findings and will never breach individual confidentiality.
5. I am aware that if I have any questions, concerns, or complaints, I may contact Dr. Ronald R. Holden, (613-533-2879, or holdenr@queensu.ca), the Head of the Department of Psychology (613-533-2492), or Dr. Joan Stevenson, the Chair of the General Research Ethics Board (613-533-6081) at Queen's University.

I have read the above statements and freely consent to participate in this research:

Signature: _____ Date: _____

Debriefing Form: Toronto, O.N.

Self-Harming Behaviour Among the Homeless

Suicidality and self-harm are growing concerns in our society. By performing this research, we hope to find out more about the factors involved in suicidality and self-harm, especially with regards to thoughts, feelings and motivations. We are particularly interested in focusing on intense psychological pain and feelings of hopelessness and their link to suicidal ideation and self-harming behaviour. If we are able to discover a relationship we can better prevent suicide in the future.

We appreciate you taking the time and effort to share your experiences with us for this study. If remembering these experiences has caused you to feel distressed and you would like to speak to someone about how you are feeling, or you would like more information on suicide and self-harm, you are strongly encouraged to contact your local health practitioner (e.g. your physician). Alternatively, please contact any of the following resources available to you in Toronto:

Distress Centre Ontario.....416-537-7373

Community Mental Health Crisis Response Program.....416-498-0043

Gerstein Crisis Centre416-929-5200

Toronto - Distress Centre.....416-408-4357

Individual results cannot be provided to you because we have no way of identifying the questionnaires. However, if you are interested in a general summary of the findings, please contact Dr. Ronald R. Holden at holdenr@queensu.ca or 613-533-2879 for more information.

If you have any questions, complaints, or concerns about this research or the manner in which it was conducted, please contact Dr. Ronald R. Holden (613-533-2879, or holdenr@queensu.ca). You may also contact the Head of the Department of Psychology (613-533-2492), or Dr. Joan Stevenson, the Chair of the General Research Ethics Board (613-533-6081) at Queen's University.

Thank you very much for participating

Debriefing Form: Vancouver, B.C.

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Vancouver Coastal Health, Psychiatry.....604-875-4023
VGH, Outpatient Psychiatry Program.....604-875-4794

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Thank you very much for participating