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An Inquiry Into The Relationship Between Individuals Who Are Blind Or Visually Impaired And Suicide

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AN INQUIRY INTO THE RELATIONSHIP BETWEEN INDIVIDUALS WHO ARE BLIND OR VISUALLY IMPAIRED AND SUICIDE

by

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DISSERTATION

Submitted to the Graduate School

of Wayne State University,

Detroit, Michigan

in partial fulfillment of the requirements

for the degree of

DOCTOR OF PHILOSOPHY

2021

MAJOR: EDUCATION (Special Education)

Approved By:

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Co-Advisor / Date

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Co-Advisor / Date

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DEDICATION

This work is in honor of my parents, grandparents, and ancestors, who instilled in me a respect for

learning as the path to knowledge, so as to discern truth.

-

This work is in tribute to the people I have learned from:

Those who taught and mentored me, even if by unmindful example.

My students.

The participants in this study.

"If I should not be learning now, when should I be?"

Lacydes, 241 B.C.

ACKNOWLEDGEMENTS

I express my profound gratitude to my dissertation committee co-chairs Dr. Thomas Edwards and Dr. Jasmine Ulmer. Your support, encouragement, and belief in me have been instrumental to me in reaching this somewhat anomalous lifetime goal.

To the committee members Dr. Susan Gabel, Dr. Carla Harting, and Dr. Michael Kral: Your participation and encouragement have been exemplary, and I am most grateful for your pointing the way to me on this journey.

Dr. Stephanie Kastely, LPC, was a remarkable asset to the study with her deftness in the interview sessions. Making your acquaintance and your agreeing to participate in the study was a providential sign this story was going to be given its voice.

There are two additional individuals meriting my gratitude. Mr. Paul Johnson, now Assistant Dean, and Ms. Deborah Gibson, Academic Services. In a journey strewn with obstacles, there was never any question that you were there to put your shoulder to the barriers on the path and doing so with exemplary self-possession.

This is the highest compliment I can extend to each of you:

I have learned from you.

Thank you.

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Chapter One - Background

The purpose of this study is to determine the relationship between individuals who are blind or visually impaired and suicide. This study is important because it may prevent suicides and save lives.

To ascertain the relationship between individuals who are blind or visually impaired and suicide focuses on three bodies of knowledge: the study of blindness and visual impairments, the field of suicidology, and the subject of human cognition. There is considerable literature available in each of the areas, but very little is known about what happens when the three elements encounter one other. This study will investigate those three domains and the outcomes when they meld.

While suicide is allegedly not limited to humans (Ramsden, 2010; Stoff & Mann, 2006), it is regarded as an adverse human behavior. Suicide maintains blatant custody of its disproportionate share of superlatives, and it is unlikely to be unseated from that grisly distinction anytime soon.

Suicide is arguably one of the most singular of human behaviors: it stands out, it is different. Suicide is an action that is without issue; for the suicide everything comes to an absolute end. It is the ultimate social disconnect and the endmost rejection of life. Suicide is the antithesis of the most fundamental and shared tenet about living, self-preservation. With that one action a suicide irrevocably secedes from this universally shared experience of Life by murdering themself.

The devastating aftermath upon those a suicide leaves behind is indicative of how contrary suicide is to our shared assumptions about life. Non-suicides are not equipped with the same cognitive process as a suicide and the pertinent logic threads are not equipped with matching connectors. The suicide thought process is so alien to us that we futilely stretch to come up with a reason. The suicide decision must clearly be a case of faulty thinking, or a disruption of logic

due to insanity, overwhelming trauma, despair, impulsiveness, or perhaps drug or alcohol abuse? We understand, perhaps reluctantly, someone dying from disease, old age, or an automobile accident. While there may have been poor decisions involved, we do not choose to catch a disease or be in an automobile accident. But in the case of suicide a choice was made; why did the suicide not see that? We do not understand. While suicide follows a logic, it is not a rational logic. The suicide is following a script that we do not have, a program that somehow makes sense to them, but not to us. Suicide is the action that does not allow for continuation and evolvement. We typically learn from our mistakes but in suicide that becomes moot as one's entire experiential database is permanently erased.

Mise en Scène

During the 1970s in Lansing, Michigan, after my return from the Peace Corps and while finishing my undergraduate studies, during different episodes I was both an instructor in automotive technology and individualized vocational training at Michigan School for the Blind (MSB), a kindergarten through twelfth grade residential school serving blind or visually impaired individuals from the entire state. That experience launched my career in special education. I made many acquaintances amongst the students and teachers who became friends, and some remain so to this day. In 2013 I was honored to be graciously invited to attend a casual get together of MSB alumni from the 1970s that was held one weekend at the private residence of an alumna, just outside Lansing. During the gathering, there was a phone call informing of the suicide of one of their classmates. I was able to witness the effect of that phone call on the individuals assembled. It was one of profound loss.

During my teaching career there have been exposures, albeit infrequent, to suicide. One student attempted suicide by handgun and survived but the attempt had severed the optical nerves

in both eyes. Another adolescent student, after several years, was still dealing with the aftereffects of his father's suicide. A third instance was a murder-suicide in which the student was the murdered victim.

In 2017, as I was preparing for my qualifying exams, I came across a study from Finland that explored the suicide rate for individuals who are blind or visually impaired. The study indicated that data concerning suicide rates of individuals who were blind or visually impaired was exceedingly rare, but not for the Finns. Later, while seeking a topic for my dissertation, the Finland study connected with my memory of the phone call at the reunion years earlier. My decision as to a dissertation topic was made. The two elements having floated around in my reality bubble finally found a fertile field.

One of my life's philosophies is investing my energies in the education and well-being of the underserved. While broken things may not always be fixed, I find things can always be made better. Investigating the suicide risk factors for individuals who are blind or visually impaired was too important to go unaddressed and provided me with ample motivation to pursue the topic.

While determining the suicide rate for individuals who are blind or visually impaired may prove difficult if not impossible to determine, it should be possible to determine the nature of the relationship between those individuals and suicide by collecting and examining data elements generated by a surveillance system that focuses on suicide. Included in the surveillance system are suicide risk and suicide protective factors. This study uses Grounded Theory to address the issue of suicide in relation to individuals who are blind or visually impaired by collecting suicide surveillance data from that population.

When the topic of my dissertation should come up during a casual social interaction, it is common to find an individual who had a relative or friend who has suicided. It seems suicide and its effects are never far.

Chapter Two - Review of the Literature

Suicide

Making sense apropos to the 'why' of suicide is analogous to reading a letter that was never mailed. A suicide presents us with a message of considerable gravity, but we are unable to open the envelope and learn the implications. We face an enigma.

Maris (1981) succinctly captures the source of the suicide paradox when he states, "the major life problem we face is life itself" (p. xviii). Maris alleges that there are certain problems (the quandary) in life for which suicide emerges as a logical solution (its resolution), and life's problems and suicide each have considerable complexity in common. Maris states that suicide has been a constant throughout history and that a "certain minimum prevalence of suicide is probably unavoidable" (p. xviii). "The possibility of happiness, or even of a relatively tolerable, stable life, is frequently remote. But an accumulated life history of trauma, insult, and just plain bad luck leading to chronic melancholy or genuine hopelessness is something else" (p. 206).

Usage of the term 'suicidology' (as cited in O'Connor, 2016) was an indicator of academic attention being directed to the study of suicide ushering in new perspectives such as the rationality of suicide.

The concept of rational suicide introduces suicide as a human right and legitimizing the assistance of a physician. Is rational suicide now viewed as being yet another human behavior demanding acceptance, tolerance, and understanding as for racial equality, gender equality, sex worker rights, and LGBTQ rights? And if suicide is accepted as rational, then it follows that suicide should also be considered as justifiable. Humans have a penchant to attribute a behavior that we do not understand or that is contrary to our existing social mores as obvious insanity, a perversion, the result of faulty logic, an unexplainable anomaly, or a mystery. While suicide seems

poised to be understood and accepted, it is not there yet. Rational suicide will be viewed as an oxymoron until such time it is able to shuck the ignorance and stigma that surround it.

Suicide is not a rare human behavior. In 2014, 1.4% of deaths in the world are estimated to be suicides (WHO, 2014). That figure is probably a low estimate; we shall see that accurate suicide reporting is problematic and affects the accuracy of the data.

Shneidman, Farberow, and Litman (1961) advance the notion that "self-destruction reflects the relationship of the individual to his community and his civilization" (p. 16), echoing Maris (1981) when he states that perhaps a level of suicides is endemic and symptomatic of a culture. Brand (as cited in Ramsden, & Wilson, 2010), a pioneer in the study of suicide, raised this issue in 1879, asking, "is suicide a sign of civilization?" (p. 21). More recently, in the hegemony of globalization, less-contemporary cultures are losing whatever layer of protection they may have had from the ills of market economies, and one could expect an increase in suicide.

Whatever the link between civilization and suicide, Firestone (1997) points to the link between toxic relationships and suicide. He contends that primitive cultures have an edge in survival, because "the nuclear family in our culture has evolved into a destructive institution" (p.83). He contends that "normative child rearing practices in our society have pathogenic properties and effects" (p.189). Those behaviors may contribute to the formation of what Maris (1981) refers to as a suicide career.

Perhaps contemporary society has overtaken our evolutionary programming and is outpacing our ability to evolve and adapt. Is our ability to survive deteriorating? Are we equipped to not only keep up with change, but to also accommodate the incessantly accelerating technological headway being made as we approach warp speed?

Curphey (1961) would concur that humans collectively manifest a myriad of behaviors in anything they do, and in relation to suicide that would include a multitude of intentions and motivations but what might be the motivation to bring an existence to a definitive end?

Defining Terminology Used in Discussions about Suicide

While terms related to suicide have evolved in their meanings, the vernacular used in connection with suicide is rife with stereotypes, clichés, as well as usage and interpretation issues.

At the beginning of the nineteenth century, most countries had laws that provided for punishment, including jail sentences, for persons who attempted suicide. Such laws greatly interfered with suicide attempters from seeking help or to allow for positive interventions. In the last fifty years the situation has changed significantly; most countries have decriminalized suicide (WHO, 2014). However, the previous association of suicide with criminality persists and is perpetuated in the continued use of the term *commit* suicide, as in one commits a felony. To distance suicide from the notion of criminality and to move towards a model so those needing help are less inhibited to seek it, current practice is to avoid using the term commit and to use suicide as both a verb and a noun, as appropriate.

Another term replaced in the literature refers to a suicide being either a *completed* or *incomplete* suicide. Completed suicide referred to a person who had intentionally killed himself/herself; the individual is dead at their own hand. An incomplete suicide referred to a suicide that was attempted but the individual did not kill himself/herself; the individual is still alive. That usage has been dropped to avoid the use of technically accurate but colloquially incongruous presumptions such as a completed suicide somehow being construed to be a 'successful' suicide, or an incomplete suicide being referred to as an 'unsuccessful suicide'. This

is in the same vein as a news release about John F. Kennedy in Dallas and hearing that the Oswald assassination attempt was 'successful'.

In 2011, a CDC panel from the National Center for Injury Prevention and Control felt that the term *completed suicide* was unacceptable and suggested the term *suicide*, and in the case of incomplete suicide advocated the use of the term *suicide attempt*. This study will reflect those recommendations.

Establishing the Suicide Field

An appropriate starting point for examining suicide is to both reveal the pieces that compose the suicide mosaic and, in the process, clear away preconceived notions.

Suicide Myths

When facts are lacking, we devise myths to make sense of the world. Suicide being a "socially taboo subject with stigma" (WHO, 2014, p. 65), the lack of knowledge surrounding suicide is considerable and suicide has accumulated appreciable fiction. Defusing these myths will inform us and allow us to perceive suicide in a manner consistent with the research. Some of the more prevalent suicide myths are:

Myth: Suicide is immoral.

Suicide has been deemed sinful, criminal, and/or immoral, and depending on the culture, or creed, is sometimes still considered to be so. Shneidman et al., (1961) have found that "attitudes towards suicide have evolved and the morality or immorality of suicide is relative and judgmental" (pp. 13-14), resulting in the current trend for the decriminalization of suicide. In some areas where suicide persists in being considered illegal, after a suicide attempt the police are summoned and instead of delivering the alleged suicide attempter to jail, they instead head to a hospital. At this point in human history, prosecution for suicide is incongruous and inappropriate. Religions too

are more inclined towards compassion for suicides and attempted suicides, but again these situations are not universal and stigma towards suicide remains.

Myth: Suicide can be controlled by legislation.

This notion depends on the belief that the criminalization of a human behavior serves as a deterrence. Shneidman et al., (1961) found that rather than serving as a deterrence "legislation may actually increase the intensity of an attempt, or survivors of unsuccessful attempts may avoid seeking help" (pp. 13-14). Legislation may thus foster a "if you know you are going to get punished if you are caught, make sure you are not caught" mentality so extra measures are taken to ensure a suicide, which decreases the opportunity for intervention. Another complication is that suicide legislation may not take into account the difference between cry-for-help suicide attempts and obstructed suicide attempts which as we shall see are quite different.

Myth: Suicide happens without any warning.

Perhaps this myth is fostered by the stereotype that individuals are 'driven to suicide' which evokes imagery of emotional, impulsive, and rash reactions that are unable to be anticipated nor contained. Suicide generally does not occur suddenly or without warning (Shneidman et al., 1961). While impulsive suicides do occur, they are in the minority: "the majority of suicides have been preceded by warning signs, whether verbal or behavioural" (WHO, 2014, p. 29).

Caruso (n.d.) reinforces that "there are almost always warning signs" (third section), but some warning signs may be subtle such as a change in sleep patterns, social withdrawal, substance abuse, or depression. These signs may not be apparent if they are spread out over multiple social circles, casual acquaintances, or untrained professionals. Nevertheless, "many people who are suicidal reach out for help" (sixteenth section), and a suicide attempt is often a cry for help.

Suicides that appear to be impulsive may be the result of a suicide trigger, an event that breaks the camel's back. There are usually other pre-existing elements of significant intensity, number, duration, and without hope of improvement that have been operational and that have already absorbed what resiliency of the individual that might remain. (See below: Myth - Suicide is a single disease.)

Myth: People who talk about suicide will not suicide.

Caruso (n.d.) writes that suicides "usually talk about it first" (first section). This agrees with the World Health Organization (2014) observation that "People who talk about suicide may be reaching out for help or support. A significant number of people contemplating suicide are experiencing anxiety, depression and hopelessness and may feel that there is no other option" (p. 15). People who are talking about suicide are thinking about suicide. When we include behavior as a form of communication, Shneidman et al. (1961) found that "75% of suicides had previously attempted and/or threatened suicide" (pp. 13-14). Any talk by an individual about suicide should be considered a red flag and acted upon.

Myth: The tendency to suicide is inherited.

While there is no mention in the literature of an inherited suicide gene, there have been findings of genetic factors associated with suicides in an intermediate role. For example, genes that impact serotonin levels have been associated with suicide attempts in patients with mood disorders, schizophrenia, and personality disorders (Fudalej et al., 2010; WHO, 2014).

Like other suicide myths, attributing a hereditary element to suicide is yet another attempt to make sense of what appears to be a senseless act. However, as for suicide being hereditary, Shneidman et al. (1961) found "there is no evidence that it is" (pp. 13-14). While the influence of

a previous suicide in a family remains to be one of the most potent suicide risk factors, so far, that has not been attributed to a genetic link.

It is remarked that the pronounced effect of a suicide upon those left behind cannot be overstated, traumatizing not just family and friends, but upon health care professionals and first responders as well. WHO (2014) found that suicide brought "grief, stress, guilt, shame, anger, anxiety and distress" (p. 43) upon those left behind, and often economic hardship particularly if life insurance is voided due to the suicide. Even one of those factors is a formidable challenge with which to contend and in combination they may be overwhelming.

Suicide is unique in that it irrevocably removes the main actor from any participation in resolving ensuing issues, leaving those who were abandoned to face the situation alone. One legacy that suicides do leave behind for those remaining is a significant suicide risk factor; a previous suicide in a family generates an acute suicide risk factor for the abandoned.

Myth: Suicide is the 'curse of the poor' or the 'disease of the rich'.

There is no basis to say that the daily struggle of the impoverished is too difficult a burden to be borne. At the other end of the economic scale, there is a similar inclination to presume that the accumulation of wealth is so devoid of spiritual sustenance that it affects the will to continue living, as portrayed in the poem Richard Cory. Both beliefs are fabrications. There is no factor nor factors that predict who will suicide and "the incidence of suicide is not defined by socio-economic status" (Shneidman et al., 1961, pp. 13-14).

This myth resonates with a particularly insidious stereotype found in literature and the arts; the notion that being or becoming blind or visually impaired is portrayed as being such a tragedy that it becomes "a socially acceptable reason to suicide" (Bolt, 2005, p. 120) and foments hysteria about blindness.

This myth is a particularly onerous and toxic stereotype that individuals who are blind or visually impaired might contend contains no more logic than to assert that being sighted is a socially acceptable reason to suicide.

The ability to predict who will suicide remains elusive and as advanced by Caruso (n.d.), "suicide can strike anyone" (fifth section) and neither being poor nor being rich is a predictor of suicide.

Myth: All suicides are insane; only people with mental disorders are suicidal.

This myth piggybacks on the fallacy that suicide is illogical and therefore suicide must be the result of a defective thinking process, implying a mental illness. But suicide is typically the result of a logical thought process which quashes the implication of mental illness. Put succinctly, "many people living with mental disorders are not affected by suicidal behaviour, and not all people who take their own lives have a mental disorder" (WHO, 2014, p. 53).

While mental illness may be a suicide risk factor, it is not a predictor of suicide. Shneidman et al. (1961) state "a majority of suicides may have intense feelings, may be in physical pain, may be tormented and ambivalent, but their reasoning, judgement, and logic are rational. They are not psychotic" (pp. 13-14). This is supported by Maris (1981) who states that it is a "powerful misconception" to view suicide as "temporary insanity" (p. 205). To the contrary, "many self-destructive individuals have made an accurate empirical assessment of their life chances" (p. 206). Caruso (n.d.) makes it clear, "anyone could attempt suicide" (seventh section). The universality of who may suicide is a persistent theme throughout the literature.

While there may be an increased risk of suicide for individuals with a mental disorder, the mental disorder itself does not typically engender suicide. Depression, substance abuse, and antisocial behaviors are relatively common; but most people suffering from them will not display

suicidal behavior. "The lifetime risk of suicide is estimated to be 4% in patients with mood disorders, 7% in people with alcohol dependence, 8% in people with bipolar disorder, and 5% in people with schizophrenia" (WHO, 2014, p. 40). The most common disorders associated with suicidal behavior are depression and alcohol abuse. Cannabis and nicotine dependence are also demonstrated risk factors. Whatever the disorder, the suicide risk varies with the type of disorder. The World Health Organization (2014) did find that alcohol and other substances were present in 25% to 50% of suicides and demonstrating an even greater presence if there is comorbidity with psychiatric disorders. Significant psychiatric comorbidity may be present both in suicides and people attempting suicide.

Myth: Suicide and depression are synonymous.

This myth highlights the singular nature of suicide risk factors. As found by Shneidman et al. (1961) "depression is the best single indication of potential suicide, but it is not always present" (pp. 13-14). The suicide risk factors found by the National Institute of Mental Health (NIMH) (2018) include "depression, other mental disorders, or substance abuse disorder" (Risk Factors section, first section, para. 1), but again suicide risk factors are neither predictors nor causes of suicide.

Myth: Suicide is a single disease.

The research leaves little room for misinterpretation about the complexity of suicide. The NIMH (2018) is unambiguous: "suicidal behavior is complex and there is no single cause" (Risk Factors section, para. 1).

Using identical vocabulary, the American Foundation for Suicide Prevention (AFSP, 2018) states "there is no single cause to suicide. It most often occurs when stressors exceed current coping abilities of someone suffering from a mental health condition" (About Suicide section,

para. 1). As an example, if financial resources were an issue, they could "lead to an increase in the risk of suicide through comorbidity with other risk factors such as depression, anxiety, violence and the harmful use of alcohol" (WHO, 2014, p. 43).

Hopelessness, which is usually found in the company of depression and affects expectations about the future, is another example of suicide as the result of complex factors. This hopelessness leads suicides to perceive that things will never improve (WHO, 2014). If hopelessness were to be followed by chronic pain and illness (such as cancer, diabetes, or HIV/AIDS), the perception that things cannot get better will be reinforced and this has been found to increase suicidal behavior two to three times that of the general population (WHO, 2014).

Furthermore, if suicide were a single disease, it would be expected to present with a single etiology, but "suicide is expressed in various forms and shapes" (Shneidman et al.,1961, pp. 13-14), reflecting its complexity.

Suicide has been characterized as the result of the 'straw that broke the camel's back', again belying single factor causation. This adage is a creditable characterization of the suicide process. Stereotypically, the suicide process denotes the existence of multiple adverse elements, of significant intensity, over time, without any expectation of relief, coupled with the absence of protective supports. With endurance stretched to the breaking point and hope being lost, suicide emerges as the all-embracing solution. Within that context a precipitating incident (or incidents) may occur and is referred to as a suicide 'trigger', which may lead the casual observer to erroneously assume the presence of impulsivity. Perhaps a more illustrative image is that of 'a match in the powder barrel', the gist being that there exist multiple factors ready to explode needing only the tiniest spark.

Myth: Someone who is suicidal is determined to die.

Research indicates that suicidal individuals are often ambivalent about living or dying. Caruso (n.d.) states that "most people who are suicidal do not want to die; they just want to stop their pain" (fourth section). Access to emotional support at a critical moment can prevent suicide and this is an indicator that the desire to self-terminate is not absolute. An example of ambivalence cited in the literature (WHO, 2014) was an individual who ingested pesticides dying a few days later. In the interim they expressed the desire to continue living, but the poisoning was irreversible.

Other scenarios reinforce the idea that an individual who has decided to suicide may be the result of their latching on to a particular conclusion of a thinking process. Suicide becomes the only solution to the exclusion of other possibilities. Some suicides who have reached this point have been described as entering a trance-like state, but this state is not immutable. Emotional support at the right time may derail the suicide process. Given that social isolation has been found to be a risk factor, a potential suicide could have arrived at their decision without the input of another human being who might have pointed out other alternatives. Similarly, the suicide may be expressing either a verbal or non-verbal plea for someone to "save me from myself, tell me my decision is wrong".

Myth: Once someone is suicidal, he or she will always remain suicidal.

WHO (2014) determined that "heightened suicide risk is often short-term and situation-specific. While suicidal thoughts may return, they are not permanent" (p.47). Referring to Briggs (2014) and his experience, survivors indicated that they knew they made an error the second they jumped. Nevertheless, we are cautioned by Caruso (n.d.) that "most people are suicidal for a limited period of time. However, suicidal feelings can recur." (Tenth section).

Myth: Improvement after a suicide crisis means the suicide risk is over.

There is the notion that a suicide attempt is a one-time isolated incident, linked to the stereotype of individuals being impulsively driven to suicide. This mindset surmises that once the event has run its course, the drive to suicide is likewise expected to dissipate and a reoccurrence would not be expected. Not so, according to Shneidman et al. (1961) as they found "almost 50% of people who were past a suicide crisis, suicided within 90 days" (pp. 13-14). Caruso (n.d.) found that "people who attempt suicide and survive will oftentimes make additional attempts" (Sixth section). On the surface, additional attempts may appear to support the appearance of an individual being driven to suicide, but the time lapse between attempts may be lengthy which conflicts with the idea of suicide being the spur of the moment. Repeated attempts may also be an indicator of tenacity based on logic and conviction.

Myth: Talking about suicide is a bad idea and can be interpreted as encouragement.

Previous practice when dealing with individuals who were thought to be suicidal was to avoid any mention of suicide. This was based on the belief that mentioning suicide to an individual thought to be suicidal would risk putting the idea into their head if the idea was not already there.

According to Caruso (n.d.) that assumption is in disfavor and the current practice of talking about suicide will "allow them to diffuse some of the tension that is causing their suicidal feelings" (twelfth section). Caruso (n.d.) is reinforced by findings from WHO (2014): "given the widespread stigma around suicide, most people who are contemplating suicide do not know who to speak to. Rather than encouraging suicidal behaviour, talking openly can give an individual another option" (p. 65).

It is also believed that the social interaction itself, talking about suicide with an individual, is sufficient to provide needed positive support to that individual.

The above collection of suicide myths addresses the more common misconceptions, and simultaneously serves as a convenient framework to introduce current beliefs and practices pertaining to suicide.

Terminology Utilized in this Study

As used in this study the term *suicide* will indicate "the act of deliberately killing oneself" (Who, 2014, p.12) and will be used as either a noun or as a verb. Example: Suicide is still a back-burner issue for many of the world's governments. And: She suicided in a remote location.

Suicidal behavior refers to a range of behaviors that includes suicide ideation, planning for suicide, attempting suicide, and suicide completion (sic) (WHO, 2014).

Within the attempted suicide category, the literature delineates two subcategories.

In the first subcategory of an attempted suicide, had things gone as intended, the effort to suicide would have resulted in a fatality. Perhaps the vehicle in the closed garage ran out of gas and the individual came to, or someone stumbled onto the scene, opened the garage door, turned off the engine, and revived the individual. Investigation would reveal the presence of a distinct degree of intentionality. Despite the presence of sufficient intent, something interfered or obstructed the suicide. This suicide was interrupted or as defined in this study, obstructed. This would typically elicit prevention and intervention responses.

In a second subcategory, a non-suicidal self-directed violence incident is a cry for help (Briggs, 2014; Crosby, Ortega, & Melanson, 2011; Tsirigotis, Gruszczynski, & Tsirigotis, 2011; WHO, 2014). While all suicide efforts are a cry for help, in some incidents the level of intentionality and the expectation of discovery, as measured on a risk/rescue rating scale, are considered as being more of a call for help or call for attention than a manifestation of a desire to die. A fabricated scenario would be telephoning a friend and informing them about an intentional

overdosing with the expectation of rescue by that friend. As a form of self-harm, this suicidal behavior is better treated within a mental health context (WHO, 2014).

It is noted that not all attempted suicides necessitate medical treatment, which eliminates the collection of suicide data and interferes with determining degree of intent. The failure to seek medical treatment for a suicide attempt obviates the generation of any data, as attempts are much more likely to be underreported than suicides (WHO, 2014).

While obstructed suicide attempts are distinct from cry-for-help suicide attempts, all suicide attempts are a cry for help. Furthermore, many suicides may present with multiple attempts. Are multiple attempts the result of being repeatedly obstructed or are they indicative of persistent attention seeking? Multiple attempts have also revealed themselves to be documentation of an individual's ever increasing lethality learning curve.

The reader is reminded that obstructed suicides and cry-for-help suicide attempts each reflect a distinct body of literature with inevitable overlap.

In suicide, the degree of intent may be inferred from the lethality of the method utilized. The degree of lethality is typically higher in obstructed suicide attempts while cry-for-help suicide attempts typically demonstrate an increased expectation of rescue.

There is a distinct gender element surrounding suicide. "Men are more likely to die by suicide than women, but women are more likely to attempt suicide" (NIMH, 2018, Do gender and age affect risk? section, para. 1). Women also exhibit more nonfatal suicidal behaviors than men by a ratio of 2:1 (Firestone, 1997).

We have seen the importance of intent being a critical element in determining a death to be a suicide. Intent is a state of mind, is difficult to ascertain, and it is not accessible in a postmortem. There is no blood test for 'intent'. Furthermore "suicide intent can be difficult to

assess as it may be surrounded by ambivalence or even concealment" (WHO, 2014, p.12). We have already seen that suicide contains an element of ambivalence. Suicides may not necessarily want to die; they seek an end to their suffering. Stigma and shame foster concealment and impede suicidal individuals from seeking help.

The choice of a method used in suicide is linked to the accessibility of means, which is a major risk factor. Without means there cannot be a suicide but eliminating access to means is impossible. Still, any situation may be improved upon. That is the approach taken by the Golden Gate Bridge in Marin County, California, where the suicide help line telephone number is posted along the walkway on the bridge (Briggs, 2014). While the suicide help line may reduce suicides on that span, there nevertheless remains a profusion of other heights without postings, patrols, or guardrails. The availability and preference for a specific means of suicide often depends on geographical and cultural contexts (Who, 2014), but whatever the context, how feasible is it to limit access to medication, razor blades, ropes, heights, natural gas, poison, commuter trains, etc.? And since we are unable to predict who may suicide; how do we protect the person who locks up the medication? Given the reality of today's social media, inhibiting the dissemination of new methods has proven to be a continual challenge.

Since we are unable to eliminate the means to suicide, prevention and intervention remain as the primary measures to contain or counter suicide.

Suicide prevention incorporates measures that may be implemented at various points in the suicide process. The prevention of suicide includes examining the origins of suicide careers and seeking those elements that are propitious for suicide, reaching back to the formative phase of our reality bubbles. This examination should include not only accumulated experiences, but also examine how those experiences are processed such that they lead to a conclusion to suicide.

While suicide intervention is appropriate at any time, it is not always available when needed.

The income level of a country affects the kind or type of suicide means but that does not necessarily impede the availability of suicide means. The agricultural orientation typical of low- and medium-income countries provides increased access to pesticides, and pesticide poisoning is one of the more common methods in such countries; 30% of suicides are by ingestion of pesticide. In high income countries, 50% of suicides are by hanging (a method that would appear to be an alternative whatever the income level of the country, but this was not accounted for by the source) and in the United States, 46% of suicides are by firearms, the cost of which make them less accessible in low- and medium-income countries. A critical issue as concerns suicide is unsecured firearms and ammunition. Other methods of suicide such as jumping are situational; the rate of suicide by jumping increases as a country becomes more affluent and more tall buildings are constructed (WHO, 2014).

While women attempt suicide at thrice the rate of men, females survive those attempts with a far greater frequency than that of men (WHO, 2014). There is an ongoing discussion in the literature as to why this may be. One study indicated that women experience major depression at twice the rate of men and that accounts for the higher attempts at suicide (Tsirigotis et al., 2011). Given the increased number of suicide attempts by women in relation to men, and given that all attempts are a cry for help, does this imply that women are more likely to employ suicide attempts to seek help? It has also been speculated that women are not as familiar with firearms and knots and what we are seeing are not attempted suicides but obstructed suicides.

In suicides involving firearms in the United States, as for other methods, the rate of female suicide survivors remains higher than that of men. Stack and Wasserman (2009) showed men

tended to select the head as the main wound site in suicide by firearm, whereas women tended to select the body. Does this imply women lack knowledge about the comparative lethality of wound sites? Or is it perhaps women were unaware of the comparative lethality of handguns, which they preferred, versus the lethality of long guns, which men preferred? Maybe women preferred handguns since they are easier to handle than long guns? Stack and Wasserman (2009) indicated that manipulating a long gun for a head wound site demanded more dexterity, a skill less likely to be found in those not familiar with firearms. Those conjectures are inconclusive. An indication of the degree of intent is reflected by women who demonstrate a systematic progression of escalating lethality. Maris (1981) found that "females last [re: final] suicide attempts were much more likely to involve lethal methods than their first suicide attempts" (p. 269). This finding demonstrates that women appeared to be on a learning curve with their selection of methods, moving from means of lesser lethality such as poisoning, asphyxiation, and exsanguination to more lethal means such as hanging, jumping, and firearms.

An additional explanation advanced is that women's wound site choices may involve the "beautiful corpse thesis" (Schmeling in Stack & Wasserman, 2009, p. 18) reflecting a concern for casket presentation.

In trying to discern between cry-for-help suicide attempts and obstructed suicide attempts, instruments have been generated to determine the *risk: rescue ratio* which compares the degree of lethality of a method with the likelihood of the attempt being discovered.

Suicide attempts with a low level of intent raise the question of Factitious Disorder Imposed on Self, also known as Munchausen Syndrome, but further discussion is outside the purview of this study.

As previously indicated, all suicide attempts should be assumed to be fully intended suicides and must be treated with the utmost caution, concern, and appropriate action. "Suicidal thoughts or actions are a sign of extreme distress, not a harmless bid for attention, and should not be ignored" (NIMH, 2018, Suicide Prevention/ Risk Factors section, third para). This point is further bolstered by WHO (2104): "A prior suicide attempt is the single most important predictor of death by suicide in the general population" (p. 25).

While suicide attempts and suicides are linked, the inclusion of suicide attempts in this study would entail at least four different variations, each with their own body of literature:

- Behaviors that are considered self-harm,
- Call-for-help suicide attempts,
- Obstructed suicide attempts,
- Suicide.

While the potential remains to address the first three issues later, suicide is the focus of this study.

Forms of Suicide

As for other human behaviors, suicide has many variations:

- Altruistic Suicide: This is taking one's life for the benefit of others; there may not be enough food and suicide will reduce the number of mouths to feed. There are indications that this may have been a strategy during the Great Depression in the United States when a bread winner would suicide to allow for government relief for the family remaining.

- Anniversary Suicide: This refers to the "statistically significant increases in suicide events…around the anniversary of the loss…" typically of a loved one (Barker, E., O'Gorman, J.G., & De Leo, D., 2014, p. 305).

- Assisted Suicide: In instances where individuals have reached a decision to suicide but are physically unable to do so on their own, do not have the means, or lack expertise on how

to proceed, then those functions are provided by another. A recent example would be Dr. Kevorkian.

- Extended Suicide: Individuals perceive another individual as an extension of themselves and murdering the other person is perceived as their own suicide.

- Mass Suicide: This is when large groups of people suicide together. This is typified by the 1978 mass suicide of 909 people in what has been characterized as a cult in Jonestown, Guyana. (Others consider this to be a homicide-suicide referred to as the Jonestown Massacre.)

- Murder-Suicide: In these situations, an individual takes the life of another or others with the full intent of taking their own life at the conclusion of the murder(s).

- Rational Suicide: Most suicides are considered rational and involve a suicide process, which includes ideation and planning. This reasoned taking of one's own life is contrasted to spontaneous, impulsive, or spur of the moment suicide.

- Right to Die Suicide: This issue is slowly gaining in parts of Europe and the United States and is sometimes linked to assisted suicide, but it remains controversial. Firestone (1997) advocates for suicide only in cases of terminal illnesses and extraordinary pain and not for stress or emotional states which are often temporary.

- Suicide Attack: When an attacker carries out violence which they know will bring about their own death. This type of suicide includes suicide as an assurance to obtain martyrdom (9-11 World Trade Center attack), W.W.II Kamikaze attacks seeking honor, sacrifice, and martyrdom, and suicide bombers as a terrorist weapon, although in the last instance there has been evidence of coercion and or blackmail.

- Suicide by Cop: This form of suicide "occurs when people want to die but do not want to kill themselves. They put themselves in a position where a police officer is forced to shoot them" (Caruso, n.d.).

- Suicide Clusters (Robinson, Pirkis, & O'Connor, 2016): This suicide is a form of contagious imitation, also known as a *copycat suicide*, with various profiles such as point, mass, echo, or geographical clusters. Suicide clusters are sometimes referred to as the Werther Effect, named after a character in a 1774 novel by Goethe whose suicide in the novel provoked an 'epidemic' of real suicides. Clusters may result from inappropriate media reporting practices which sensationalize and glamourize suicide or they report explicit details about the suicide technique. This increases the risk of cluster suicides among vulnerable populations. "Exposure to models of suicide has been shown to increase the risk of suicidal behaviour in vulnerable individuals" (WHO, 2014, p. 32). Internet sites, social media, and traditional media have been implicated in both inciting and facilitating suicidal behavior contributing to cluster suicides. The Internet is now a leading source of information about suicide and contains readily accessible sites that are inappropriate in their portrayal and encouragement of suicide. Private individuals are also able to readily broadcast uncensored suicidal acts and information which can be easily accessed through media (Who, 2014, p. 32).

- Suicide Pacts: This involves two or more people who agree to suicide together, typically amongst elderly or romantically linked couples (Robinson et al., 2016).

Suicide Statistics

There are multiple issues making it very difficult to obtain accurate and comprehensive suicide data. Suicide data gathering varies greatly within and across countries. Cultural issues

such as shame, taboos, legalities with insurance, religious considerations, and the impact after a death is labeled a suicide upon those left behind affect both the reporting of deaths and the declaring a death a suicide. In countries that attach greater stigma to suicide there is an increased tendency to conceal a suicide by labeling the death an accident. In some situations, suicide is not distinguished from other forms of death; a death is a death. (This leads to conjecture as to the legitimacy of withholding insurance payments in suicides.)

Medical Examiners (MEs), also referred to as Coroners, have a short list to choose from in ruling on the cause of a death: natural, accidental, homicide, suicide, undetermined, and sometimes a sixth, under investigation. While MEs have considerable resources available from law enforcement to assist in homicide investigations, they do not have similar resources to assist in suicide investigations. MEs tend to be reluctant to reach a finding of suicide because motive or intent is much more difficult to ascertain. This has led to the formation of teams of professionals, typically comprised of social workers and psychologists, who conduct psychological autopsies to assist the coroner in determining whether a death is a suicide.

There are reports in the literature referring to deaths being certified as a suicide only if there was a suicide note.

The following data is presented with the caveat as to suicide data being frequently inaccurate.

Suicide rates vary by age within and across countries: in one country the suicide rate may be elevated for younger generations and taper off as the population ages, while in another country suicide rates may initially be low for the younger population and rise as the population ages. The diversity of suicide data from each of the world's countries limits the usefulness of consolidated data. Consequently, suicide data should be utilized with caution.

Suicide is a world phenomenon and reinforces suicide being a human behavior and not an isolated phenomenon. Of the 172-member countries in the United Nations, age-standardized rates of suicide over time have been relatively stable and range from 0.5 to 52.7 per 100,000 (WHO, 2014). The following points summarize the WHO world data:

- In 2012, the number of total world suicides was estimated to be 804,000 suicides, or 11.4 suicides for every 100,000 people. This is 1.4% of all deaths, making suicide the 15th leading cause of death.

- High-income countries had a slightly higher suicide rate (12.7%) than lower- and middle-income countries (11.2%).

- In 2012, the lowest suicide rate by region was 6.1% in the Americas, and the highest suicide rate was 17.7% in South-East Asia.

Worldwide suicide rates by age are lowest for both males and females who are under the age of 15 or over the age of 70. However, examining the 15 to 70 age range, the rates vary greatly. In one country rates may steadily climb throughout the 15 to 70 age range while in another country rates may start low, peak halfway through the range, and once again decline, or other variations depending on gender, age, region, and income (WHO, 2014). This worldwide data is representative of the difficulties associated with generalizing about suicide.

This study focuses on the United States and suicide reporting and the statistics that result are not immune to many of the issues as found in other countries. Suicide data for the United States according to the American Foundation for Suicide Prevention (2018) include:

- Each year, 44,965 Americans die by suicide.

- Suicide is the tenth leading cause of death.

- On average, there are 123 suicides per day.

- The age adjusted U.S. suicide rate is 13.42 suicides per 100,000 people.

- For every suicide, there are 25 attempted suicides (3075 per day).

- Suicides cost the U.S. $69 billion annually.

Descriptions of the Type of Individuals Who Suicide

  As concerns who suicides, it is "people of all genders, ages, and ethnicities" (NIMH, 2018. Do

gender and age affect risk? section, para. 1), which appears to encompass any living creature

with human DNA. Franklin (2018) indicates that no one knows who is going to suicide, that the

prediction of who might suicide barely outdistances random guessing. He echoes the previously

discussed paradox concerning human behavior, "…Nature is not simple and determinate.

…Nearly everything – from physics to biology to human behavior – is complex and

indeterminate" (The Need for Answers section, para. 5). Those descriptions are consistent with

the literature: anyone may suicide.

Inspecting the data from the American Foundation for Suicide Prevention for the United

States, 2018, Suicide Statistics section, para. 1):

- Men in the United States suicide 3.53 times more often than women.

- In 2016, 7 of every 10 suicides were white males.

- The highest rate of suicide is during middle age, especially for white males.

- The lowest age-adjusted suicide rate in the United States is New Jersey with 7.17 suicides
  for every 100,000 people.

- The highest age adjusted suicide rate in the United States is Montana with 26.01 suicides
  for every 100,000 people.

Firestone (1997) found that more whites suicide than blacks, and more Native Americans

who attended boarding school suicide than those who did not attend a boarding school. Shneidman

and Farberow (1961) found that suicide rates were affected by such factors as an individual's marital status, occupation, religion, and with whom one was living.

There are internal processes (human cognition) at play as to why suicide is an option for one person but not for another, but those processes remain difficult to determine and may be linked to the individual's suicide career and his or her reality bubble.

Suicide / attempted suicide profiles.

We note that cry-for-help suicide attempters form a group very distinct from that of suicides:

The profile of a person most likely to attempt suicide is a woman, and the person most likely to suicide is a man (NIMH, 2018, Suicide Prevention/Gender and age section, first para.). The data below is from Los Angeles, California (Shneidman & Farberow, 1961, pp. 45-46):

- Modal Suicide Attempter

Female, Caucasian, in 20's or 30's, married or single, housewife, native born, attempted by barbiturates, cited marital difficulties or depression, lived in an apartment or apartment house area.

- Modal Suicide Completer (sic)

Male, Caucasian, in his 40's or older, married, skilled or unskilled worker, native born, completed (sic) by gunshot wound, hanging, or carbon monoxide poisoning, cited ill health, depression, or marital difficulties, lived in an apartment or apartment house area.

Significant Perspectives Related to Suicide

The following two citations are significant because they are indicative of where a search for understanding why people suicide inevitably winds up. Those citations are being lassoed and broke to harness as a team to draw in a hulking segue for this study.

In suicide, "no single factor is sufficient to explain why a person died by suicide: suicidal behaviour is a complex phenomenon that is influenced by several interacting factors − personal, social, psychological, cultural, biological and environmental" (WHO, 2014, p.11). This WHO insight is taken to the next level by Maris (1981): "Self-destruction is a joint product of that what we have called loosely 'the human condition' and the collapse over time of social supports and ego defenses" (p.171).

How much broader in scope can one get? We find ourselves addressing "interacting factors" that encompass all of life, as well as "the human condition" for goodness' sake. Can we imagine a space any farther from the quantitative, not that we are aspiring to go there?

While I do not know how WHO (2014) and Maris (1981) arrived at that point, I am able to explain the sequence of events that led me to that same space.

Suicide is a human behavior and human behavior stems from multiple factors such as dementia, hypnosis, and tumors. Included in that list is our cognitive processing.

Aberrant behavior resulting from aberrant factors is not unexpected. If we consider suicide to be aberrant, then aberrant factors would likely be assigned as the cause of suicide. What is unexpected is when suicide is manifested in the absence of aberrant factors and is assigned as being the outcome of a cognitive process. When WHO (2014), and Maris (1981), and I examine suicide, one is drawn to find the answer to 'what were they thinking'? How did the suicide arrive at opting out of life as a rational solution?

The difficulty in determining why people suicide is intrinsic to suicide being a human behavior. That question inevitably leads to how our cognitive processing is formed? We apparently are not all born with the same cognitive processing otherwise all of us would suicide

or none of us would suicide. We apparently do share the same process for creating our individual cognitive processing, and that is what we will now be examining.

Human behaviors, usually but not always, derive from the accumulation of a unique mix of experiences and the subsequent formation of their proprietary cognitive processing.

While there are reasons why humans behave the way they do, sometimes those reasons are not apparent. WHO (2014) and Maris (1981) justifiably allude to (or hide behind?) the infinite mix of variables contained in the list of interacting factors or the Human Condition. It is reminiscent of the adult saw, "because, just because".

That list of the interacting factors and elements of the human condition rather well contains the variables when defining a suicide career or the creation of a reality bubble.

Maris (1981) reminds us that death is universal. We may presume that we will live through the next minute, live through today, and that we will be here tomorrow and the day after then, but there is absolutely no basis or assurance whatsoever for our presumption, but we nevertheless operate on the basis that we will endure. Without the assumption of a future, efforts taken toward a future become pointless. Living requires a 'long view' of the future and a dose of altruism. Our assumption of 'not dying' and seeing an extended life span as a given inevitably leads to a de facto, status quo state of denial as concerns mortality and death. Our belief in a future is grounded upon the need to live as if death was not the omnipresent possibility that it is. We are continually gambling, betting we have a next minute. Suicides do not do that. They make an appointment.

Maris' (1981) reminder that death is universal is intriguing. It is as if he is implying that, "We are all going to die anyway. Does it really matter how (or why) we get there?"

Based on a considerable number of studies of which WHO (2014) and Maris (1981) are representative, suicide is not a goal. Suicide is a means. It is the means to bring relief from a

situation, to end intolerable suffering. This is characterized as the individual having reached the point of 'I just can't take it anymore' being fused with hopelessness as to the possibility of the situation getting any better. The individual arrives at the conclusion that suicide is the only vehicle able to bring that end about.

The literature uses the terms logical and rational interchangeably, and not without a degree of justification, and those terms will be repeated in this study as they are encountered in the literature.

Drilling deeper, the definitions for logic and rational share many concepts. With logic, there emerges a nuance of rules, proofs, validity, and argument. Rational immediately introduces the concept of reason: able to think clearly and sensibly. Those nuances will be adopted in this study when not constrained by citations. A pertinent example is while suicide may be determined to be logical, for most people it is not rational. The thought process to suicide may be based on sound demonstrable principles but it is in contradiction to the generally shared belief that life is worth living.

The literature indicates that there is almost always a way other than suicide to bring relief from a given situation and that relief may take on different forms. For depression, which is one of the most prevalent risk factors, relief may be in the form of medication or therapy. For risk factors based on financial issues, relief may be in the form of declaring bankruptcy. Sometimes the suicide is in a state of pain or hopelessness (hopelessness is also a risk factor), is unable to think coherently, and is 'blinded' or has tunnel vision as concerns non-lethal solutions.

It was previously discussed that suicide is the means to a goal, the goal to end something, usually suffering. But what if the mechanism involved with suicide is not the result of a search for a solution or an end to suffering?

What if some people, in a given situation, engage in a particular thinking process? This thinking process is described as a logic strand that arrives at the immutable conclusion that suicide trumps all other considerations. This logic loop portrays suicide as the ultimate solution to everything, which, from an exclusively logical perspective, it is. The only drawback to this conclusion of course is that with suicide one stops living. But rationality is not a consideration in a purely logical train of thought; it is the logic that is paramount. This is suggestive of Asperger's Syndrome and the supremacy of logic as a modus operandi.

The literature indicates that once the decision to suicide is reached, which may be weeks or months before an attempt is made (which refutes notions of impulsivity and reinforces notions of logic), the individual may enter a trance like state.

While suicide is a logical act, suicides are not necessarily committed to suicide and may be open to intervention. This presents us with an image of someone who, after having arrived at a particular solution and failing to generate any alternatives, is open (and perhaps even hopeful?) that there may be another logic path leading to a different conclusion that they may have overlooked. There is also a finding that the second an individual initiates a suicide, the thin veneer of a logical-organizational thinking process is revealed and overcome by the rational-emotional nature that is characteristic of humans, and the attempter realizes they are making a mistake. Rather than examining the multitude of risk factors whose role in suicide is relative, attention might better be directed towards the thinking process and how it is formed that leads one to a suicide conclusion.

Suicidal Intent

Suicidal intent was previously addressed in a general manner. Here we examine intent more closely.

"Most persons who engage in suicidal behaviour are ambivalent about wanting to die at the time of the act, and some suicidal acts are impulsive responses to acute psychosocial stressors" (WHO, 2014, p.23). That ambivalence may indicate the conflict between logic and rationality which impacts the level of resolve demonstrated by a suicidal individual. Given the permanency of suicide, ambivalence would appear to be sufficient cause (either logical or rational) to suspend making an irrevocable decision.

Sgt. Briggs (2014) of the California Highway Patrol spent most of his twenty-three years on patrol in the southern extremity of Marin County, which includes the Golden Gate Bridge. Briggs indicates there have been over 1,600 suicides since 1937, making the bridge one of the world's most utilized suicide locations, calling it a "suicide magnet." (There are other such magnets on the globe.) He indicated that 1% to 2% of the jumpers manage to live through the 75 mile per hour impact that shatters bone and drives the shards through vital organs, then it means avoiding drowning and surviving the struggle in the water. (Surviving suicide does not mean one is unscathed.)

What Briggs wanted to impart was that the one to two percent who have survived jumping off the bridge and are still able to talk about it, most of those folks have said that the second that they let go of the rail, they knew they had made a mistake and that they wanted to live. (Briggs, 2014, TED @ 12:51 minutes)

Is this the point where logic interfaces with rationality; the realization that logic is a flawed basis for suicide and results in the making of a horrible mistake? Brigg's (2014) account is a rare opportunity to peek into those letters that are never sent.

Risk Factors

Elements connected to suicide are commonly referred to as *suicide risk factors*. Initially, those elements were referred to as *stressors*. That usage is still seen and will be utilized by this study. The connection between risk factors and suicide is not always apparent. Studies consistently indicate that risk factors are neither indicators nor predictors of suicide; risk factors are relegated to playing a more indirect role. "Risk factors are those characteristics associated with suicide - they might not be direct causes" (CDC, 2018. Suicide: Risk and Protective Factors section, para.1). As defined by WHO (2014), risk factors "relate to the likelihood of a person developing suicidal behaviours" (p. 40). When we address human behavior, thinking processes and motivations are not always apparent.

While risk factors are associated with suicide, it is only via the intermediary link of suicidal behaviors. Recall that suicidal behaviors encompass a large field which includes self-harm, and that suicidal behavior does not necessarily result in suicide. "Suicidal behavior is complex and there is no single cause" (NIMH, 2018. Risk Factors, fourth section, para.1). The list of risk factors is lengthy, broad, and abounds with clarifications and qualifications.

Describing the relationship between risk factors and suicide is reminiscent of describing participation in a long-term relationship while remaining non-committal. There may be many shared experiences, memories, emotions and all the trappings of a committed relationship, but no rings tying the two together have been exchanged yet.

In my initial ignorance I thought that I would get a list of suicide 'factors', whatever it was that made people kill themselves, and see how many were applicable to my target population. I could not have been more wrong. It quickly became evident that trying to capture the complexity of suicide is every bit as challenging as trying to define what life is.

A comprehensive review and discussion of the literature concerning risk factors is outside the scope of the present study and what follows is intended to instill in the reader a working conceptualization of risk factors.

A consistent theme in the literature is that risk factors do not have the same effect on everyone; what may be a risk factor for one individual may not be a risk factor for another. Sources discussing risk factors often include a qualifying statement: for a given suicide risk factor or a set of suicide risk factors, one individual may suicide, and another will not. The implications of this concept are highly significant.

The significance of a risk factor is not the risk factor itself per se. Many risk factors are relatively benign. But the effect the risk factor exerts on a particular individual, specifically the impact of a stressor upon an individual's thinking process, is most significant if not key. What may be a stressor for me is not necessarily a stressor for you. It is the thinking process of the individual that is the operant.

There are some suicide elements that are often present in suicide. Depression and a previous suicide in the family are two examples of stressors that stand out from other suicide risks, if only by their prevalence, in the case of depression, or their toxic potency, in the case of a previous suicide.

It is not that these or other stressors impact an individual's thinking process leading to the decision to suicide, but in some ways, it appears as if they prepare the thinking process to be amenable to the consideration of suicide. The argument has not necessarily been made, but the soil has been tilled and fertilized to receive the argument. It is as if the individual finds themselves in a different situation, and they rationalize that now they should think differently too.

Once the mind is 'prepped', other elements enter in to exert an influence. As we have seen, our behavior is usually based on how we think. How we think is a product of our reality bubble created from our experiences. The concept of a suicide career, nested in its own reality bubble, is the product of a particular thinking process.

It is an individual's interpretation of a factor that renders a factor malignant. Instead of seeking why did someone suicide or what caused someone to suicide, a primary consideration may be what is the thinking process of an individual that led him/her to suicide?

Recalling Franklin (2018), we are unable to determine who is going to suicide and predicting suicide has proven to be barely better than guessing. It is more accurate to state that we have not yet been able to detect the suicide chain of logic.

It is not understood why for the same set of risk factors one individual may suicide while others are apparently unaffected (Robinson et al., 2016). Mondays, the day of the week for most suicides, and wintertime the season of the year for most suicides, presumably due to seasonal sunlight deprivation, are not a suicide risk to all the individuals sharing that day and season. Why? Do the unaffected somehow acquire immunity to the suicide chain of logic?

Suicide risk factors are, "…characteristics that are associated with suicide" (CDC, 2018. Risk Factors for Suicide, para. 1), and includes many elements, but the suicide risk factors most often present are:

- Depression, other mental disorders, or a substance abuse disorder
- Certain medical conditions that impact the quality of life
- Chronic pain
- Family violence, including physical or sexual abuse
- A family history of a mental disorder or substance abuse

- Being exposed to others' suicidal behavior, such as that of family members, peers, or celebrities

- A family history of suicide

- A prior suicide attempt

- Having guns or other firearms in the home

- Having recently been released from prison or jail

(NIMH, 2018. Risk Factors, Fourth section, para.1)

Schizophrenia also exhibits a high association with suicide.

Suicide Contexts

Suicide encompasses multiple motives and rationales, and these are manifested in various contexts. This list of suicide contexts is informative in assisting us to establish the field.

- Copycat Suicide / Cluster Suicide / Suicide Contagion: The CDC (1994) indicates that the occurrence of one or more suicides may induce others to suicide. These suicides may be provoked by the media and how the media portrays a given suicide as inappropriate reporting may aggravate this situation.

- Cultural: Sati is the traditional practice of a widow throwing herself on her husband's pyre and is a practice in Hindu, Sikh, and other cultures.

- Despair is related to hopelessness, and both are a key factor in suicides. Phoebe Prince, a Massachusetts (U.S.A.) high school student whose suicide was triggered by bullying, was allegedly in a state of despair. Her suicide in 2010 became a cause célèbre in the United States against bullying.

- Escape: Suicide is the ultimate escape, everything ends. This is a way to remove oneself from an intolerable situation; where the victim "prefers death to his suffering" (Felix as

cited in Farberow, & Shneidman, 1961. Foreword, n.p.). This motive offers an escape from suffering due to terminal disease or other medical condition (Litman & Faberow, 1961). The individual finds themselves in an unsustainable position without hope of amelioration.

- Heroism: This form of suicide "is characteristic of soldiers…was common among the North American Indians (sic), Polynesians…" (Maris, 1981, p. 239). Falling on a grenade to save comrades-in-arms is an example.

- Honor: Suicide to avoid falling into the hands of the enemy is an example of an honor suicide. Seppuku, also known as hari-kari, is to take one's life and preempt being taken prisoner or put to death by an enemy, denying the enemy the opportunity, and the honor, of so doing. There is the instance of Polish Captain Władysław Raginis who in the face of evident and monumental odds (a situation blatantly without hope of any outcome other than death) sending his men to the rear while he remained in position and fought to the death rather than surrender or retreat.

- Loss: Following any one of a variety of losses, suicide may ensue. Losses include the death of a loved one, loss of employment, or the ending of a significant relationship (Litman, & Faberow, 1961). This concept extends to the unexpected or sudden loss of familiar environments, such as inmates being released from prison with little warning.

- Military or Terrorist Tactic: These suicides are grounded in the larger context of societal conflicts. Two examples include what are referred to as suicide missions and 'suicide bombers' with explosive vests. Social pressure and coercion are sometimes a factor and raise the question of intent.

- Philosophical: This form of suicide is adopted in situations when one finds life meaningless or not worth living. While suicide may be an existential statement, it may be linked to depression.

- Protest: Suicide is dramatic and as such may be used to draw attention to an intolerable situation. Examples include self-immolation such as Buddhist monk protests during the Viet Nam war and Mohammed Bouazizi of Tunisia whose suicide launched the Arab Spring.

- Rational: In some Yuit cultures, ending one's life is perceived as an act of courage, respect, and wisdom when an individual's dependence upon a group increases and their material contribution decreases. (Maris, 1981)

- Religion: Examples include Joan of Arc who voluntarily suffered being burned at the stake as the penalty for refusing to renounce her religious principles. The mass suicide of the Sicarii rebels at the Siege of Masada, Muslim Acehnese performed suicide attacks against the Dutch as *istishhad* or martyrdom; each are instances of suicide linked to religion. While the intent in each instance was not to suicide, the decisions taken by these actors effectively led to certain death and of which they were aware.

- Socio-Economic: In suicides linked to socio-economic factors, there are often multiple and complex associations. Some of these connections are work ethics which are typically linked to religious beliefs, or identification of self-worth connected with employment roles such as status, power, earning potential, career progress, work related social integration, a sense of achievement, etc.

Suicide Profiles

A frequent research aim is the creation of profiles based on commonalities and differences derived from the data. Once a profile is established, an individual fitting a given profile is assumed to be predisposed to behave in a manner as do others with a similar profile.

Suicide profiles currently center around a set of suicide risk factors. An example of a suicide profile would be the increased suicide rate of United States military personnel who had returned from Gulf War service and who had acquired Post Traumatic Stress Disorder (PTSD). The operative assumption is that other returning Gulf War military personnel with PTSD may also be at an increased risk of suicide. This 'profiling' assumes that individuals with similar characteristics will behave in a similar manner. That assumption enables heightened vigilance and the implementation of suicide intervention and prevention measures.

Another example of a suicide profile is *cluster suicides,* defined as being "a group of suicides or suicide attempts, that occur closer together in time and space than would normally be expected" (as cited in Robinson et al., 2016, p. 758). These cluster suicide profiles call attention to certain groups which include teenagers in school settings, mental health in-patient units, the incarcerated, indigenous communities, and those in geographically remote and economically deprived settings (Robinson et al., 2016). The members of these groups fit a profile for cluster suicides. Being aware of increased risk allows for steps to be initiated to decrease the risk. In the instance of a teenage suicide in a school setting, data indicates that such a suicide is expected to generate additional suicides and steps could be taken to reduce the possibility of a spike in suicides such as making school counselors available both in school and on social media as soon as possible after the precipitating event.

Other suicide profiles include individuals who had previously attempted suicide: "Individuals who have made prior suicide attempts are at much higher risk of dying by suicide than individuals who have not made prior suicide attempts" (WHO, 2014, p. 25). An individual with a family history of suicide also fits a profile of being at higher risk (AFSP, 2018; CDC, 2018; NIMH, 2018). Mental illness presents us with a suicide profile. Over ninety percent of suicides have a mental illness when they suicide, with depression being the most prevalent (Caruso, n.d.; NIMH, 2018). Studies inform us that a mental illness condition may not always be recognized or diagnosed at the time of a suicide which leads to underreporting. There are risk factors that address residential data, such as people living in rented apartments having a higher incidence of suicide than those living in a house (Shneidman & Farberow, 1961). Having guilt about a previous experience may also put one at risk (Firestone, 1997). A high level of perturbation such as panic disorders, a personality disorder diagnosis, living alone, being unmarried, and being unemployed are also risk factors.

Risk factors alone are not sufficient to explain suicide. The suicide stage is populated with actors such as mental disorders, context, impulsivity, accessibility to means, resiliency, history of violence, child abuse, or discrimination (WHO, 2014).

Some risk factors such as alcoholism are considered indicators of what has been termed *chronic suicide* (as cited in Maris, 1981. p. 171) while other studies have added obesity, overworking, and smoking to that list.

WHO (2014) provides us with an additional perspective and includes these risk factors:

- Suicides are often comorbid and suicide risk may be undetected by a health system that is unaware of its role in intervention.
- Community issues such as war, dislocation, discrimination, and trauma or abuse.

▪ Societal attitudes toward suicide may act as barriers that inhibit individuals from seeking help.

▪ Social isolation, lack of support, conflict, and loss exert an influence as risk factors.

The Suicide Process

While spontaneous suicides do occur, most suicides usually follow a process. Oravecz and Moore (2006) broadly outline that process as "making the decision, making a plan, organizing it, and carrying it out" (p. 275). The process is sometimes separated into two components.

▪ Suicide ideation encompasses *thinking* about suicide but stops short at taking action to suicide.

▪ Suicide behavior is distinguished by *actions* to bring about a suicide such as seeking a location by visiting tall buildings, deciding when, learning about knots, etc.

As "there is no single explanation of why people die by suicide" (WHO, 2014. p.7), there is no single process every suicide follows. There are, however, common elements to the suicide process, which follow below.

Suicide initiation.

The suicide process may start days, months, or years prior to the suicide. Maris (1981) refers to suicide as a "career" to convey the concept that the initiation of the suicide process is not easily determined, if at all. He contends that suicides are constructed over time from multiple elements within each individual's life span, each element contributing its piece to the eventual suicide. This implies that suicide is a progressive process and that risk factors are diverse and specific to the individual. In those instances, determination of an exact time of the initiation of suicide ideation may be difficult to establish.

Suicide risk factors as part of the suicide process.

We previously examined various types of risk factors in considerable detail, but here we examine their role in the suicide process. One would assume that the presence of a risk factor would put a person more at risk of suicide, and one would be wrong. Maris (1981) considered risk factors to be *predictors*, but that perspective is no longer current; risk factors are currently viewed as elements *associated* with suicide. When two individuals face the same set of conditions (set of risk factors), one individual may suicide, and another may not (Van Heeringen & Bijttebier, 2016). Risk factors are not the determining element of a suicide.

Some authors indicate that as an aspect of human behavior, a certain level of suicide is to be expected. Recall Brand's (as cited in Ramsden & Wilson, 2010, p.24) assertion that suicide is an integral attribute of civilization. These observations imply that a part of every generation is expected to suicide. This provokes considerable speculation.

Is there a set of stealth risk factors not yet discovered that are so persuasive that their influence impacts the same percentage generation after generation? The idea of the existence of stealth risk factors and a recurring segment of the population being susceptible to them appears counterintuitive. Such a situation should have benefited, if that is the term, from natural selection and susceptible populations should have self-extinguished.

Ostensibly any susceptibility to risk factors is not genetically transmitted. This is supported by the existence of suicide protective factors that function as immunization agents. Indeed, studies have demonstrated that it is possible to inoculate people against suicide. These techniques include fostering strong personal relationships, healthy lifestyles, and physical well-being. (De Leo, Hickey, Meneghel, & Cantor, 1999; Firestone, 1997.) But there is an air of unproven causality surrounding suicide inoculation.

But if susceptibility to suicide is acquired, how is it acquired? Can it be reversed engineered?

We have contended that we humans acquire data and construct our thinking process, but maybe we do not, at least not entirely. Drawing a distinction between logical thinking and rational thinking, perhaps we sometimes acquire a predilection for logical thinking over rational thinking, such as is manifested in autism spectrum disorders. That preference for logical thinking, or an inability to resist the tyranny of logic appears somehow to be hard wired into those individuals. For most of the population, the dictatorship of logic is held in check by some mechanism and is only manifested when that mechanism is absent. This might explain how a thinking process may repeatedly find its way into the reality bubbles of certain segments of our population, generation after generation. A recent trend in autism research does point to there being a genetic role in ASD.

The contention of an unleashed logic-dominant thinking process may explain why some individuals adopt a suicide friendly cognitive process and might explain more than adding yet another factor to the growing list of risk factors that is possibly innocuous.

Other studies (NIMH, 2018; WHO, 2014) suggest risk factors do not so much contribute to a suicide as they may provide a rationale for suicide, in an end justifies the means configuration. This buttresses Maris' (1981) view that it is not the risk factors that exert a compelling influence on suicide so much as it is how an adverse situation is interpreted and processed. The thinking process transforms what would be an unremarkable event into a risk factor(s) for that individual. Perhaps the suicide of a family member has subliminally conditioned the individual's thinking to accommodate the idea of suicide. Maybe the individual's thinking may lack the necessary skills to surmount the life challenges being faced. Or there are just too many intense, persistent, and adverse events that overwhelm or erode the ability to think how to persevere and prevail.

Furthermore, there is always the possibility that the thinking process may be impaired by substances or physical defects and the cognitive processing ability is fatally flawed.

Some risk factors such as age or gender are concrete and easy to document. Others such as depression and hopelessness are less concrete and are entirely possible to be missed even by professionals and loved ones. Things such as the day of the week or skipping meals appear totally benign and are easily overlooked. They may be flying under the radar and not sound any warning bells but warning signs they are.

Another risk factor consideration is their cumulative effect. While the recent loss of a relationship is recognized as being emotionally significant, with our compartmentalized lives it is unlikely that others in our dispersed social pockets get together to compare notes and alert us to the gestalt of unemployment, financial stress, insomnia, chronic physical illness, being elderly, affected by a natural disaster, living in a rural community, or it being winter with its shortened daylight.

A sampling of populations that conform to a particular risk profile include being an adult in a foreign country, being a Native American, elderly, in prison, orphaned, a hospital patient, infected with HIV/AIDS, an adult-home resident, a veteran, a college student, a high school dropout, or a heroin addict. Some attributes, such as gender, we are born with and are inherent to our identity, other attributes we accrue during our life, such as dropping out of school.

Given the diversity of risk factors, the suicide career concept takes on increased substance. At what point may we discern the start of a suicide career? Maris (1981) compares a suicide career to a professional career. What point would one select as the beginning of the process that resulted in one's current position; being born into a household with two working parents, the schools one attended, significant mentors? The suicide career concept feeds speculation that a suicide-trigger

may likewise derive from a past event or trauma, a booby trap that was planted and has been malignantly evolving, awaiting a particular misstep, or encountering a particular catalyst.

Suicide ideation.

At some point an individual starts to think about making a suicide happen and sets conditions for the suicide (Van Heeringen & Bijttebier, 2016). Not unexpectedly there is a strong relationship between suicidal ideation and suicide, ideation often being a precursor to a suicide or a suicide attempt. Suicide ideation covers a range of behaviors that center around thinking about suicide and planning a suicide, but the criterion for ideation is that it stops short of taking any action to suicide.

Ideation manifests itself in multiple ways and is as individualized as the suicide. But "comparison of self-reported rates of suicidal ideation across groups is particularly problematic because suicidal ideation is often a fleeting, fluctuating experience that is not observable by others" (Who, 2014, p. 26).

Suicide triggers.

When an additional adversity arrives, it amplifies the felt effect of the already existing risk factors. The increase in intensity pushes the individual over a threshold which 'breaks the camel's back' and triggers a suicide. This includes diminishing physical health or a mental health condition that interferes with tolerating a situation. In either scenario the suicide threshold is lowered. A previously tolerated element is no longer able to be sustained. Everything that was previously tolerable becomes much harder to endure (Van Heeringen, & Bijttebier, 2016).

A "trigger mechanism is a catalyst that may provoke a suicide…" (as cited in Maris, 1981). Trigger mechanisms are "immediate, situational precursors" (p. 273) to suicide. While the catalyst may be in the form of a risk factor (or factors), triggers are not limited only to existing risk factors.

Indeed, it is these non-risk-factor triggers that mistakenly lead to attributing impulsivity to a suicide, making the suicide appear to be situational while it is the suicide trigger that is situational (WHO, 2014).

Suicidal intent.

The demarcation between *ideation* and *intent* is when an individual initiates an action to suicide it is no longer ideation. Williams et al., (2016) finds a particular cognitive process may be involved. He indicates that suicidal individuals apply or engage in a "doing mode of mind in response to emotional problems" (Williams et al., 2016, p. 460) which appears analogous to a problem solving or task orientated mind set. The decision to suicide having been made, logic would be called upon to determine the necessary actions to bring the suicide about. We are again presented with a particular cognitive process.

Joiner (2005) indicates that the suicide ideator starts to become desensitized to violence, slowly loses fear of pain, and starts gathering the required expertise. "Sometimes suicidal people feel better because they have decided to die by suicide and may feel a sense of relief that the pain will soon be over" (Caruso, n.d., Suicide Myth section, 13th on list). Maris (1981) found that once the decision is made, suicides fall into a state of detachment …a kind of monotonic stupor" (p. 205).

Suicidal Issues

There exist ancillary issues to suicide.

Protective factors.

As there are suicide risk factors, so too there are factors that protect one from suicide. These include:

- Strong personal relationships.

- Religious or spiritual beliefs.

- A healthy lifestyle and physical well-being.

- Mental well-being and appropriate coping skills.

(WHO, 2014).

For people who are highly resilient, the association between the risk of suicide and suicidal behavior is diminished (WHO, 2014).

Suicide prevention.

There is no cure for a suicide, a suicide is not able to be brought back to life. By default, "the only practical approach to suicide is prevention" (Felix, 1961, Foreword. n.p.).

The current practice of prevention centers on determining:

- Why particular people suicide,

- The presence of certain factors,

- The components of a suicide trigger,

- The implementation of protective factors.

Interventions such as Hot Lines, suicide risk assessments, and health care screenings demonstrate limited effectiveness. While WHO (2014) emphasizes the identification and elimination of suicide risk factors as a means of intervention, it considers suicide protective factors to be as equally effective as are interventions.

Prevention techniques are typically directed towards at-risk individuals who are already engaged in the suicide process. But again, suicide prevention is impeded because it is usually unknown why people suicide. Some suicides leave notes and give a reason ("I can't face another round of chemo."), but notes are usually unreliable and uninformative. Suicide notes typically address details ("Don't forget to pay the water bill.") or seek to comfort the loved ones left behind.

Suicide notes do not typically address the 'why' of the suicide and even the term 'suicide' is rarely present in suicide notes (as cited in Oravecz, & Moore, 2006).

As concerns the two variations of attempted suicide, complete confidence as to whether the attempt is a call-for-help or an obstructed attempt is difficult to determine, and even then, only offers limited insight.

Interviews fortuitously conducted prior to a suicide reveal part of the evolution of the suicide process. Statements used by the suicide evolve from 'I *don't know* anymore…' to 'I *can't* anymore' (Oravecz, & Moore, 2006, p. 274). "In the presence of a physician or health care professional, as an individual approached the end of the suicide process, indications are that they are not interested in life saving communications and deterrence is questionable" (Oravecz, & Moore, 2006, p. 276). It is at this point in the suicide process that the suicide mindset appears to congeal. Statements are often from the perspective of "I can't", and communications typically do not generate much useful information.

Regrettably, reliable suicide prediction remains elusive. To be able to predict suicide would have a major influence on prevention. None the less, there are advances in suicidology that are instrumental in prevention. These advances are summarized in a global overview by WHO (2014):

- The discovery of multicausality, comorbidity, and the roles they play in suicide. Identification of risk factors, protective factors, and cognitive processes linked to suicides. The need for social supports and coping skills. Realizing the significance of cultural and psychosocial elements as both risk factors and protective factors.

- In the area of policy: the formation of suicide prevention strategies at the national level, increasing suicide awareness, decreasing suicide stigma with efforts such as World Suicide

Prevention Day, and increasing suicide research and training, each having a positive impact on prevention.

- Prevention practices are centered on bringing awareness to primary health care practitioners, the utilization of self-help groups for the survivors of suicide attempts, the people left behind after a suicide, and the training of volunteers to assist those seeking help in a crisis.

Prevention efforts directed at suicide triggers are comparable to those made for suicide risks. Additional suicide prevention efforts include Help Lines, suicide risk assessments, suicide risk inventories, and physician suicide screenings.

Let us briefly shift our focus and surmise why people do not suicide. Perhaps non-suicides reject the premise that suicide is logical. But should a non-suicide arrive at the conclusion that suicide is logical, they appear to either dismiss it out of hand or they apparently do not feel compelled to obey lethal logic. Which leads to our next point.

Despite there almost always being other solutions, and "staying is always an option" (as cited in Schumacher, 2019), the suicide bypasses those conclusions, and focuses on suicide. Why? Suicide offers ultimate closure; everything comes to an end. Apparently, nothing equals the allure of that temptation.

If we accept that premise, then suicide is not so much the conclusion of a logical thinking process so much as suicide is a magnet drawing logic blinded individuals to it like Sirens in the Odyssey, confident that no other option can compete with what it promises. Such a promise is irresistible to those who are ruled by logic. But does the suicide comprehend that they are not just ending a problem, they are ending their own life?

This area requires further examination of the role of suicide careers, reality bubbles, logic, rationality, and the incidence of suicide specifically for individuals on the Autism Spectrum.

Evaluation and assessment of suicide propensities.

Attempts to be able to predict who may suicide is the continuing quest of suicidology. While "supportive health systems and societies can help prevent suicide" (WHO, 2014. p. 32) and instruments have been developed and made available to address suicide behaviors and propensities, the ability to predict suicide remains elusive.

Litman and Farberow (1961) refer to the Evaluation and Assessment of Self-Destructive Potential. Firestone (1997) lists psychological tests used to assess self-destructive potential, but he indicates that they are not very effective:

- Beck Depression Inventory,1978.

- Beck Suicide Inventory, 1991.

- Beck Hopelessness Scale, 1978.

- Reasons for Living Inventory by Linehan, 1983.

- Suicide Probability Scale by Cull and Gill, 1988.

- Firestone Assessment of Self-Destructive Thoughts, 1996.

- Suicide Ideation Questionnaire by Reynolds, 1985.

Oravecz and Moore (2004) indicate that several other assessments exist such as the Scale for Suicide Ideation (as cited in Oravecz and Moore, 2004) and the previously mentioned Reasons for Living Inventory (as cited in Oravecz and Moore, 2004). Linehan and others indicate that the assessments are not "readily accepted" (as cited in Oravecz and Moore, 2004, p. 3) because screening for suicide is not perceived as the main consideration of physicians while other professionals prefer interviews in a clinical setting. Another study found that when physicians do

inquire as to any suicidal tendencies it is done in a rudimentary manner with little to no follow up questioning. The inquiry is performed more in a manner so as to be able to check off a box that the question had been asked. The inquiry itself is typically blunt: "Do you want to kill yourself?" (Silverman in O'Connor &Pirkis, 2016.)

As concerns assessing the influence of risk factors, Firestone (1997) indicates such assessment is not very effective as many individuals who may qualify to be in a high-risk group are not in reality a high risk. Firestone (1997) does however point to clinical symptoms that may be present:

- Making verbal threats,

- Having created a lethal suicide plan,

- Having access to the means to commit suicide,

- Having poor physical health,

- A history of previous suicide attempts,

- Experiencing a diminished mental status,

- Suffering from recent negative life events,

- An absence of social support.

Suicide interventions.

Three levels of intervention have been identified by WHO (2014).

- Universal intervention, which is aimed at an entire society.

- Selective intervention, which targets profiled groups that may be at risk.

- Indicated intervention, which is directed at individuals with demonstrated suicidal potential or who have previously attempted suicide.

Focusing on indicated intervention: "prior to committing suicide, people usually indicate to one or more persons, in more or less overt ways, their intention to die" (Firestone, 1997, p. 23). Shneidman et al. (1961) indicate that the "great majority" (p. 7) of suicides are detectable. They indicate that threatening suicide, attempting suicide, or specific behavior changes such as depression and substance abuse are included in detectable factors. Moreover, "the majority of suicides have been preceded by warning signs, whether verbal or behavioural" (WHO, 2014. p. 29).

Oravecz and Moore (2004) indicate that "interactions between potentially or apparently suicidal individuals and health professionals may be crucial suicide prevention and crisis intervention opportunities" (p. 9) because many people believe health professionals provide both physical and mental relief. Despite these increased opportunities, the ship often sails right on past the dock. Maris (1981) found that "40-50 percent of suicide completers (*sic*) received medical treatment in the year preceding their deaths" (p. 204), and up to two-thirds of suicides have seen a family physician in the month before their death (as cited in Oravecz, & Moore, 2006) and half of those suicides are under-detected by the practitioner. This situation has been characterized as "one of the most prevalent and preventable clinical errors in behavioral health" (Beaudin, Vigil, & Weber, 2004, p. 269). It is not just professionals who are sometimes lacking in detecting suicide behavior; symptoms often go unrecognized by family and other supports as well (Silverman in O'Connor, & Pirkis, 2016).

Suicide Helplines in the United States are a resource for individuals in crisis. Typically, helplines offer support over the phone. Helplines may be available to the general population, or they may target a particular group. In the latter case, they typically offer peer support. Helplines

have demonstrated the ability to reduce suicide risk during the phone call and for subsequent weeks, but lack of evaluative data makes their effectiveness unproven (WHO, 2014).

Issues reporting suicides.

While suicide is not illegal in the United States, it is illegal in twenty-five countries and in ten additional countries practicing Sharia law. Attempted suicides may be subject to punishment. This impacts suicide data collection with "under reporting and misclassification" (WHO, 2014, p.19) impeding suicidology and the formulation of generalizations about suicide (WHO, 2014). "Penalties stipulated in the laws range from a small fine or short period of imprisonment to life imprisonment. However, many of the countries with laws stipulating punishments do not actually prosecute people who attempt suicide" (WHO, 2014, p. 51).

Accurate reporting is hampered because only 60 countries of the 172 WHO Member States have "good-quality vital registration data that can be used to estimate suicide rates" (WHO, 2014, p. 19), and those 60 are typically high-income countries leaving low- and middle-income countries under-represented.

The issue of reporting suicides is complex. As we have seen, coroners are not comfortable arriving at a determination of suicide (Curphey, 1961). While the cause of death in a suicide may be concrete, for example a poisoning or a gunshot wound, intention and motivation are much less able to be verified. Curphey (1961) reports that medical examiners appreciate the additional perspectives from suicide teams in helping the ME to make a determination.

Two examples will illustrate some of the difficulties when classifying and reporting suicides.

WHO (2014) refers to a situation in which an individual with suicidal intent ingested a pesticide, but during the days it took for the pesticide to take effect, she changed her mind. The

outcome, however, had been determined at the time of the ingestion. Would this death be described as an unintended suicide or…?

In another situation, an individual joked around at parties he gave in his home playing Russian roulette, always using the same revolver. Before pulling the trigger, he would carefully position the cylinder so that the sole cartridge would rotate away from being in the position to be fired when the trigger was pulled. While at a party in another home, he was given a different pistol with which to demonstrate his party trick. This revolver used a cylinder that rotated in the opposite direction than the revolver he used at home, with the expected result. Might this be classified as an accidental suicide?

While these two cases are unusual, suicide as an attribute of human behavior includes many variations that are not always easily determined. Farberow and Shneidman (1961) agree that suicides are underreported due to "the pervasive social pressures against the certification of a death as a suicide in most parts of the world" (p. 3).

Hospital suicides are an issue as they "may systematically record suicide attempts as 'accidents' because of stigma, lack of insurance coverage for suicidal behaviour, or concern about potential legal complications" (WHO, 2014, p. 26). Declaring a death occurring within a hospital to be a suicide raises liability issues which hospitals would just as soon avoid. Curphey (1961) indicates multiple reasons for the importance of an accurate determination of a cause of death such as the generation of data. But again, the determination is not as straight forward an action as may be thought.

Determining a death to be a suicide has serious ramifications, besides the stigma and shame foisted on those the suicide abandons. An official determination of suicide impacts the healing process of the family. There is likely to be an extended period of recovery time and suicide is

particularly onerous in small communities with close woven social structures. Curphey (1961) found that those left behind are subject to guilt and depression and are often in need of help. In addition, a finding of suicide inflicts an economic blow that impacts the well-being of the family since most insurance policies are invalid in instances of suicide. This imposes an economic hardship on the abandoned of which Coroners are all too aware.

Gender affects cause of death findings. "Women's suicides are more apt than those of men to be misclassified as non-suicides since women use nonviolent methods more than men do" (Stack, & Wasserman, 2009, p. 2). Presumably an overdose may be more nebulous than rope marks in the determination of death, thus "nonviolent suicides are more apt to be disguised as accidents, or undetermined deaths" (p.2).

Currently there is not an international structure for criteria to determine suicide *attempts*, but both the International Association for Suicide Prevention and the International Association for Suicide Research are addressing the issue. While the need for criteria is important in many areas, it is especially important in relation to prevention measures.

Suicidology.

There are several elements that impede reducing suicide, starting with suicide being a "low public health priority" (WHO, 2014, p. 16). Silverman (in O'Connor & Pirkis, 2016) indicates that the tremendous variation in all aspects of suicide has complicated the situation: "Advances in suicidology are hindered by a lack of a standardized nomenclature and classification system" (p. 39). Silverman (in O'Connor &Pirkis, 2016) also noted that same lack of standardization impeded the reporting of suicide. To advance suicidology, "A guiding conceptual framework must be created in a culturally specific manner" (WHO, 2014, p.11).

Control of suicide.

Efforts at suicide prevention require multiple elements of society to increase both suicide awareness and coordinated action to reduce suicides. These efforts should include reducing the stigma and taboos that surround suicide as well as limiting access to means (WHO, 2014) as efforts in those areas have been demonstrated to be effective.

Suicide Summary

The considerable suicide literature reflects the diversity and complexity inherent in any human behavior. Our behaviors are the result of the sum of our experiences and our processing of those experiences, starting at least in utero and continuing up to now, with me writing and you reading these words. Who we are encompasses the experiences we lived through, the experiences we lack, how we process the data generated, and how we arrive at our conclusions. Since no two individuals share identical life experiences, we have each accumulated a different data set that shaped our cognitive processes that are unique to each of us. The complexity of human behavior results from each of us having our unique processing system.

This diversity and complexity of humans poses significant challenges in studying their behavior. But suicide has shown that it is different from other human behaviors. Suicide is the human behavior that has a definitive end; it is perhaps the one human experience that is not a learning experience. Suicide is the ultimate rejection or denial of the one experience that joins us all: living. The negative effects of suicide on those remaining behind are difficult to overstate.

The literature indicates that the typical suicide is not crazy, that their decision and carrying out that decision is typically done with logic. It is difficult to accept someone deciding that it is not worthwhile to continue living. Closure for a suicide is usually lacking because the individual who might provide the answers is no longer there.

The literature indicates that there is "almost always" a solution for suicide. The effects of suicide on those who remain, which is the severest form of abandonment, would be ample justification as to why not suicide. In our culture, most suicides are ultimately a selfish act. But who are we to judge at what point existence is found to be intolerable and perhaps it is we who are being irrational?

A suicide thinks differently. It is as if nothing quite provides what suicide appears to offer. Suicides become locked into a logic sequence with a fatal conclusion. One is given the impression that in some cases a suicide is not driven to suicide but is drawn to suicide.

The literature is rife with suicide associated elements such as depression, a prolonged period of enduring hardship, and hopelessness. These elements may be amplified by substance abuse, lack of friendships, sudden rupture of a relationship or a job, and many other factors.

Based on profiles of others who were in similar situations and who did suicide, we can say that an individual is 'at risk' of suicide. But we are continually faced with an almost accusatory reality that for a given set of risk factors, one individual will suicide, and another will not. We still can neither explain nor predict who will fall on which side of the line.

The Blind and Visually Impaired

Per a Finnish study by Meyer-Rochow, Hakko, Ojamo, Uusitalo, and Timonen (2015), the determination of suicide rates for individuals who are blind or visually impaired (B/VI) is only possible in Finland because all Finnish death certificates collect data concerning pre-existing conditions regardless of the manner of death. "[Prior to this study] a cohort-based study of suicides, focusing exclusively on the visually impaired and blind has neither been undertaken in Finland, nor anywhere else in the world" (Meyer-Rochow, et al., 2015, p.2).

With data about pre-existing conditions for every death, the Finnish study had relatively easy availability to suicide data with respect to visual impairment (VI) by age, gender, age at onset of VI, method of suicide, time of the year (related to the amount of seasonal daylight periods potentially fostering depression), and other variables. (Note: The Finnish study employs the inclusive form of visual impairment which encompasses individuals who are blind.) Their results indicate there were 91 observed suicides of individuals with VI while based on the general population for the same time period, the expectation was calculated to be 69.3 suicides. This yields a Standardized Mortality Ratio (SMR) of 1.31. (The SMR is calculated as the observed number of VI deaths by suicide divided by the expected number of deaths of suicide in the general population.) This study indicated that the suicide rate for VI individuals is greater than that of the general population, a significant finding.

The findings of a study by Lam, Christ, Lee, Zheng, and Arheart (2008) do not completely align with those of the Finnish study. They found that being B/VI in and of itself does not significantly increase the suicide rate for those individuals; however, they did find that there is a higher risk of suicide for individuals who are B/VI linked to indirect factors such as manifesting two or more non-ocular health issues. This finding of the involvement of two or more factors resonates with current suicide theory that the number of adverse factors plays a role in suicide.

Harnessing data from the National Center for Health Statistics (NCHS) and applying structural equation modeling, Lam et al. (2008) determined that "the direct effect of visual impairment on death from suicide was elevated" but was not significant, however "the indirect effect of visual impairment on death from suicide" (p. 975) was significant.

The NCHS survey does not speak to depression, considered to be amongst the most significant suicide risk factors. This is a serious omission which Lam et al. (2008) acknowledge

but do not address. While the intent of the Lam et al. (2008) study is a noteworthy incursion into the fog of suicide, the study also left unaddressed whether this population is susceptible to the same suicide risk factors as for the general population. Lam et al. (2008) assert that it is the low incidence of suicide that accounts for the absence of population-based studies addressing suicide for this population, which does agree with Meyer-Rochow et al (2015).

Empirical data suggests that suicide rates in the United States for individuals who are B/VI may be higher than for the general population, but that continues to be a guess.

Delving deeper into the suicide fog, significant questions are encountered. How do risk factors for individuals who are B/VI compare in their severity, duration, and quantity to those in the general population? Might there be risk factors to which the B/VI are particularly susceptible, such as irregular sleep patterns due to interrupted circadian rhythms? Are there risk factors to which individuals who are B/VI are immune, such as seasonal daylight changes and the link to depression?

Research in this area is clearly warranted.

Elucidation on the Absence of Suicide Data for the Blind and Visually Impaired

Presently, in the United States, pre-existing conditions are officially recorded only for natural deaths, making data collection for pre-existing conditions in other types of death, such as suicides, scarce if nonexistent. The renders the possibility of finding correlations between pre-existing conditions and suicide very difficult. This pertains to our area of interest; suicides by individuals who are blind or visually impaired (B/VI). With such a data vacuum, the mapping of profiles encounters an impasse.

The most appropriate means to gather such data is the statutory contact of a death with authorities which is the issuance of a death certificate by a medical examiner or a certifying physician. A familiarity with the death certificate process is germane to our purposes.

When encountering a death, police make no determination of death and leave that finding to the expertise of the medical examiner, as was explained by the Macomb County Sheriff Department, Public Relations Liaison (telephone interview, November 6, 2019).

The Macomb County Deputy Medical Examiner, Dr. M. E. Pietrangelo, M.D., in both a personal interview and a telephone interview (July 1, 2019, and November 20, 2019, respectively) explained the death certificate process:

Death certificates are required for multiple reasons: releasing a body, mortuary procedures, access to records, insurance, estate management, etc. Dr. Pietrangelo explained that every death, whatever the cause, generates a death certificate, which is the statutory contact for a death and is within the purview of the medical examiner (ME).

The ME determines the cause of death to be one of the following: natural, accidental, homicide, suicide, indeterminate, and pending.

It is only in natural deaths and autopsies that pre-existing conditions of the deceased are addressed, and then only if they are contributory to the cause of death. Death certificates are not intended to be a list of health problems.

Dr. Pietrangelo indicated that when trying to establish preexisting conditions, medical records are typically "atrocious", and Dr. Pietrangelo attributes this situation to the completion of death certificates not being included in the M.D. curriculum. Dr. Pietrangelo stated that many physicians are unable to accurately complete the 'chain of events' leading to death for death certification purposes.

Death certificates are unique to each state, but they are all in conformity with requirements of the Center for Disease Control (CDC), a federal agency.

There are seven main headings on the Michigan Certificate of Death Rev. 05/2015:

- Decedent
- Parents
- Informant
- Disposition

- Certification
- Cause of Death
- Medical Examiner

The Certification section is completed by either a Certifying Physician or the Medical Examiner who enter data such as the time and place of death.

The Cause of Death section is of particular interest to this study. It is composed of two parts and several additional questions.

Part I requires the certifier to: "Enter the <u>chain of events</u> – diseases, injuries, or complications – that directly caused the death. DO NOT enter terminal events …." (Emphasis is as found on the form.)

Distinctions are made on the death certificate as to causes being immediate or underlying. Immediate cause is defined as the final disease or condition that directly caused the death. An underlying cause is regarded as the disease or injury that initiated the events resulting in death. One of the additional questions (#39) is the MANNER OF DEATH. This is indicated as being either:

- Accident
- Suicide
- Homicide

- Natural
- Indeterminate
- Pending

As evidenced by Parts I and II, and question #39, the nature of the data being collected is related to diseases, injuries, and complications that directly cause death or lead to death. Existing

conditions, for example blindness or visual impairment that are of interest to us here, are not addressed anywhere on the form.

While it appears highly unlikely that either blindness or visual impairment would be an underlying condition leading to a death, a case is to be made for the collection of preexisting conditions in all manner of deaths as the data could be of considerable value. Are individuals who are B/VI more susceptible to be a homicide victim, perhaps linked to increased vulnerability inherent to the disability? Perhaps individuals who are hearing impaired are more prone to accidental deaths as a pedestrian?

Without data we remain uninformed and given current death certificate parameters, we are unlikely to be enlightened anytime soon. Without data, the determination of the suicide rate for individuals who are B/VI will remain problematic.

Rationale for the Hypothesis

There are 7,536,691 individuals in the United States with a vision disability which represents 2.4% of the 2017 population (Lauer, & Houtenville, 2019). This minority is distinct from the general population in that these individuals do not see well, or they are unable to see at all. They live in a world geared to the sighted and are on an uneven playing field that frequently, if not constantly, requires compensatory workarounds. These individuals often work harder and longer than their sighted peers to reach a comparable point, and that is a decidedly distinct characteristic of this population.

It is hypothesized that a group whose members manifest distinct defining characteristics (in this instance blindness or visual impairment) will likewise evince distinct *factors* that accompany those characteristics, in this instance suicide risk. Substantiating the latter requires first giving substance to the former.

We will evince B/VI distinctness with an exercise in *sensitization* to blindness and visual impairment, which the sighted privileged may not have had the occasion to either process or integrate the implications of the loss of a sense. It will be remarked that the reverberations that accompany a partial or total loss of a sense are often pervasive.

The approach to this sensitization exercise will be to concretize for the reader two elements often present in the lives of individuals who are B/VI: braille, and orientation and mobility (O&M). The reader is requested to adopt a wide-angle perspective to internalize the lessons that are being transmitted. Caution: This exercise is not a solicitation of pity, sympathy, nor admiration as to anyone serving as an inspiration to us all. My experiences indicate those sighted emotional reactions emanate from stereotypes this B/VI population is forced to endure and, in some cases, have even come to resent.

Our society can be characterized as a visually orientated society, which is not unexpected as the largest proportion of our society, 97.6%, is sighted. While B/VI accommodations are mandated by law, they are sometimes poorly done or not done at all. This does not imply that the lack of accommodation stymies B/VI individuals from achieving what sighted individuals are able to achieve; but it is just one of many obstacles that accrue and require the B/VI having to work harder. Having to work harder is precisely what is distinct about this condition. A pertinent illustration is braille.

There is no intent here to provide a comprehensive treatise about braille due to multiple variables such as levels of sophistication and efficiency (e.g., Contracted Braille and the Nemeth Code for Mathematics and Science Notation). The intent is to make clear that being a braille reader entails working harder. A valid sensitization entails more than a superficial grasp that braille

involves reading bumps on a sheet of paper. What follows is a mini exposé of some of the impositions inherent in being a braille reader.

To begin, a braille sheet is the same size as a print sheet, 8.5" x 11". A braille sheet is heavier because it needs sufficient rigidity to ensure the integrity of the dots, that they do not get squashed. Braille sheets are 140 to 150 grams per square meter (gsm). To provide a reference, low grade copy paper is 80 gsm and good quality letter head is 120 gsm.   Braille is usually (but again not always) embossed on only one side of the braille sheet. This immediately doubles the page count when going from print to braille. This is the first of two doublings of page counts. We will address that second doubling below.   Because of the two doublings, there arises concern as to the weight, size, and bulk of those braille sheets. Of necessity, the braille sheets are often kept in thick binders and the sheets are punched for three-hole binders.

Our typical braille sheet provides one thousand places for braille *cells*. A braille cell is the place occupied by six braille dots stacked two by two, three dots high. A braille cell requires a larger footprint on a sheet than does the footprint of a printed character. For comparison this printed paragraph has one thousand places. While these one thousand print places occupy approximately only one half of this printed page, in braille they would require one full braille page, representing yet again a doubling as braille is typically limited to one side of a sheet and not both sides as for print. This print into braille augmentation may easily run into two or three hefty binders for one text. The braille textbook footprint on a typical student's desk, in their locker or backpack, even media center storage are not inconsequential effects. (There are marvels of electronics available that permit text into braille. They are expensive and the speed of reading remains an issue.)

While braille is a very effective system of reading and writing, it is much more than a way to read words and serves multiple and critical functions to individuals who are B/VI. One primary function is that braille serves congruent functions as does print for sighted individuals. Braille allows for the cognitive organization of concepts and both braille and O&M are so crucial for cognitive development that they are included in nursery school programs for students at age three (Flavier, 1997) but "should be begun as early as possible" (Bryan, 1989, p. 474).

Audio recordings, while beneficial, do not provide the same indispensable attributes as does braille.

An area rife with data concerning braille and O&M is education. We will focus on aspects of braille and O&M and their effects in an educational context. We will see that while braille and O&M are remarkable tools of adaptation, they are not without a downside nor are they able to overcome all too frequently toxic learning environments.

Braille readers pay a price, particularly when individuals who are B/VI are included in general education classrooms (National Braille Press, 2019). While that price could be minimized in special (segregated) schools, it would be at the substantial cost of forgoing to live and participate in mainstream (non-segregated) society.

While digital technology abounds in education, it is highly visually orientated which is of marginal if of any use at all to this visually challenged population. Audio technology has its own multiple limitations and is far from being a substitute for the literacy benefits of braille on many levels.

The preparation of visual materials into braille or tactile form (text, maps, charts, pictures, etc.) takes considerable advance planning (Lewin-Jones, & Hodgson, 2004; Orsini-Jones, 2009) especially as concerns textbooks and reference materials. Should textbooks and reference

materials be available to the student in braille, does the braille reader have access to them where and when needed; in class, during study hall, and at home? This implies multiple copies of a text or more likely the transporting of a text which due to size and weight is not inconsequential. But it is not just braille textbooks that concern us but more particularly teacher prepared materials, which are the lingua franca of today's classrooms.

Teacher planning time available for the preparation of materials is a scarce and valuable resource and today's general education teachers are already spread very thin (Ajuwon, Sarraj, Griffen-Shirley, Lechtenberger, & Zhou, 2015). However well-intentioned the teacher may be, the teacher encounters a cost/benefit analysis of the prep time divvied up to prepare materials for one B/VI student weighed against the time to prepare materials for the other 96% (assuming a class size of thirty students) of the sighted class.

From the perspective of a B/VI student, a particularly adverse scenario is to find themselves confronted with a video presentation, printed handouts, or a quiz or test, none of which were adapted. This situation is most likely to arise when a lesson should rhizome, typically in response to a question raised by a student during the lesson. If a blackboard, white board, or a projector and screen are employed in a response, our B/VI student is left in the dark (McJames & Royal Victoria Institute for the Blind [RVIB], 1992; Orsini-Jones, 2009). Should our student scramble and attempt to take notes, keeping up with a fast-talking lecturer (Jessup, Bundy, Broom, & Hancock, 2017) whether with a braille slate and stylus or a 16-pound braille writer, is an additional frustration.

Braille users regard the lack of adapted materials as a denial of their right to an education. (Bamu, Van de Putte, & Van Hove, 2016; McJames & RVIB,1992; NBP, 2019; Nhemachena,

Kussangaya, & Gwitira, 2012; UNESCO, 1994.) For students who are B/VI, working harder starts by seeking compliance with the inalienable right to an equal education.

In situations where braille materials are available, braille takes more time to be read than does print. It is similar for audio recordings. Audio cannot be listened to as quickly as print is read. In class, this lag will inevitably and continually put the braille reader behind his or her sighted peers (Lewin-Jones, & Hodgson, 2004). Outside of class, this longer braille reading time increases study and homework times, again adding to work overload (Orsini-Jones, 2009) as the student must once again expend extra effort to keep abreast of his or her sighted peers.

Teachers typically have a repertoire of instructional materials which they maintain and refine throughout their careers. Once the semester is over and the B/VI student moves on, the teacher may not have another B/VI student, and this reduces the incentive to keep any materials that were adapted current. This is usually of little consequence unless another B/VI student should show up in a subsequent class.

Braille takes on the characteristics of a code (NBP, 2019). Despite best intentions, general education classroom teachers have little time to learn that code. If they do, their use of braille is fraught with mistranslations (Bamu, et al., 2016). Translation responsibility, by default, typically falls into the lap of the braille teacher to render materials and tests from print to braille for the student, and then translating the student's assignments and test responses from braille back again to print for grading by the teacher (Bamu et al., 2016). Often there is an unavoidable and "enormous" (Bamu et al., 2016, p.624) translation time-lag. This is understandable given the amount of material that flows to and from a student in each six class/five-day week during the span of an academic year. The delay varies but because of the inevitable translation lag issues, the delay means the B/VI student does not get his or her test or assignment results at the same time as the

rest of the class. Being left out (again) as the teacher goes over the test with the sighted students in the class leaves our student once again waiting, often for considerable time periods, how they did on the test or assignment. Sometimes students feel their good work is not recognized because it was in braille (Jessup, Bundy, Broom, & Hancock, 2017).

While the translation function provided by braille teachers is paramount, time allocated to braille instruction is often spread very thinly (Ajuwon, et al., 2015), as little as an hour per week (NBP, 2019) due to what appears to be a chronic shortage of braille, O&M, and visual impairment teachers (National Association of State Directors of Special Education, 1999; NBP, 2019; Winton, & Buysse, 2002). It is not uncommon that a student's braille instruction time is sacrificed to braille translation time (Bamu, et al., 2016) and even then, translation demands may still go unmet. (Empirical data indicates braille instruction in some cases does not take place at all.)

Should a B/VI student be fortunate enough to receive braille lessons, when should those lessons take place? In saturated high school schedules, should a required class be sacrificed, that decision means extra effort once again to make up the surrendered class.

If the braille lessons should be shifted to after scheduled class times, they impact extracurricular activities. After school activities provide indispensable socialization opportunities for this B/VI population who already characterize high school as an experience of lacking friends and being lonely (Jessup, et al., 2017). Perhaps the braille lessons are at the cost of participation in sports; blind wrestlers are very competitive. Clubs such as chess and bowling are particularly beneficial as they give our students a rare competitive even footing with sighted opponents (Aydin, 2015). Once the after-school braille lessons are over, how is our student getting home? These are students who cannot drive themselves and school buses do not typically function as taxis.

Braille lessons can be moved to the summer and would obviate the need to miss required curriculum offerings, but how appealing is the prospect of taking classes during summer vacation while one's peers are at the beach or earning money?

There is no avoiding that the pervasiveness of instructional overtime impacts the B/VI student's homework, recreation, relaxation, socialization, and even sleep times; these students must work harder.

While "I'm bored" may be one of an adolescent's most annoying refrains, coming from a B/VI student elicits professional and ethical cringing. Boredom was characterized by these students as being "the worst" (Jessup, et al., 2017, p. 12). The circumstances provoking boredom in class include: no braille textbooks, untranslated teacher power point presentations, fast talking lecturers that make braille note taking difficult, use of white or black boards, quizzes and exams not put into braille, movies shown in class, sitting on the sidelines in physical education class, attending assemblies, and eating lunch alone (Jessup, et al., 2017). Given the effort entailed in keeping their smoldering frustration from igniting and simultaneously attempting to maintain a positive self-image in the face of the unrelenting onslaught of noxious messages being hurled at them, are vivid case in points of the additional effort required by the B/VI.

The resources available to this study are entirely too limited to address the multiple effects of being B/VI that continually jolt the student. But we would have failed to accurately portray the pervasiveness of this situation without having alluded to the pile of other issues inherent to the education of individuals who are B/VI, specifically teaching considerations.

The B/VI student is unable to detect body language and non-verbal social cues. This requires adaptations of conventional classroom procedures such as the teacher giving the floor to students with a nod or other non-verbal acknowledgement and instead calling upon students by

name, so the B/VI student is aware of who is talking and when they themselves are being recognized to speak. Forming students into the inevitable work groups is impacted: peers may not want to sit near a student using a braille machine because of the noise (like that of a manual typewriter). Vision impaired readers often need to get very near to materials making it difficult or impossible for students to share materials (Korir, 2015). If a teaching assistant is provided, it is important that when they are reading or explaining to the student that it does not disrupt the educational process. Maintaining lesson flow involves balancing time spent in individualized instruction with the student who is B/VI and the time spent with the remainder of the class.

Giving a test orally, especially achievement tests orientated towards the sighted, is very problematic as concerns the validity of the results (Ekstrom, 2001; Herold & Dandolo, 2009; Orsini-Jones, 2009). Indeed. "The idea of standardized outcomes is being replaced by a differentiated approach working with scales of achievement" (Flavier, 1997, p. 32). But the assessment issue is not just problematic, it raises profound ethical issues as well. These are but some of the many considerations that include teacher techniques, styles, philosophy, and classroom management that merit scrutiny considering each of the B/VI students in the class and their individual learning styles (Lewin-Jones, & Hodgson, 2004). Next is a sampling of considerations from the student perspective.

As for most adolescents, the student who is B/VI does not want to stand out or be made to feel different from his or her peers but desires to be treated in the same manner as other students (Jessup, et. al, 2017; McJames, & RVIB, 1992; Orsini-Jones, 2009). This is often denied by the presence of a teaching assistant assigned to assist the student and who functions more as a de facto no trespassing sign to other students. Concerning friends, the B/VI student typically lacks friends

and particularly other B/VI students as peers and as friends. Similarly, there is a paucity of teachers who are B/VI to serve as role models (Jessup, et al., 2017; UNESCO, 1994).

Having to work harder is not limited to braille, it is also required in orientation and mobility (O&M). O&M provides instruction to B/VI individuals allowing them to navigate their environment effectively and safely, but it is considerably more than that.

Interacting with the environment is critical to child development and for that reason it is preferred to start as soon as possible in a child's life (Bryan, 1989) with individual lessons, four to five times per week. These lessons evolve as the student ages and places them in ever widening environments incrementally demanding ever increasingly sophisticated skill sets.

O&M faces many of the same difficulties as does braille, and for that reason it is unnecessary to examine it to the same extent as we have for braille. Here is an overview touching on a few of the O&M issues involved.

As for the circumstances surrounding braille teachers, O&M teachers are also scarce and getting scarcer. Federally mandated individual educational plans (IEP) for a student's O&M instruction are sometimes unable to be met due to the lack of an O&M teacher. If instruction should take place, it may once again be a matter of which scheduled class will be the next to surrender its time slot. (Hopefully it is not the braille lesson that is forfeited.) General education teachers can be reluctant or uncomfortable assuming responsibility for students who are B/VI on school community experiences (Penrod, Haley, & Matheson, 2005). Teachers may be ill at ease with students having a cane in the classroom or on the playground and request they do not use them. Since the cane is the B/VI students' way of connecting with their environment, interfering with cane use is congruent to requesting a sighted person to wear a blindfold. For liability reasons, schools may be reluctant to allow community traveling skills instruction to take place off campus

and out in the community, precisely where it is most needed. It is emphasized that O&M skills are not merely a handy way to find the cafeteria; these are indispensable life skills with trajectories that impact the self-actualization abilities of a future adult to navigate our sighted world and as such those skills wield a crucial hold on long-term quality of life.

This low incidence condition subjects this population to unique impositions that the typical high incidence sighted individual has little if any empathy, not because they are unfeeling, but rather because they are unaware. This sensitization exercise addressed but two typical adaptive skills and we limited it to the context of an educational setting. Before we conclude this sensitization exercise, let us very briefly look beyond an educational environment and contemplate real life environments and the skills required.

If one were to acquire a vison condition, how would you set about: showering, grooming, applying makeup, going food shopping, cooking, doing the laundry, house cleaning, medical appointments, getting a university degree, taking classes, holding down a job, dealing with a cranky boss, attending a conference, paying bills, using a cell phone, going out to have a drink, dating, going to a concert, child rearing, parenting, getting the kids off to school, handling a domestic spat, grandparenting, taking a cruise….?

This disability requires those affected to work harder than sighted individuals all day and every day in virtually everything they do. This is very distinct. It is both reasonable and logical to expect that a distinct condition will manifest distinct elements such as distinct suicide risk factors.

(The blind and visually impaired may be working harder but they are not all working [McDonnall, & Sui, 2019]. The percentage of non-institutionalized male or female persons *with a visual disability*, ages 18-64, in the United States of all races, of all education levels, regardless

of ethnicity, who were employed in 2017 was 44% [Erickson, Lee, & Van Schrader, 2017]. The *sighted* equivalent employment rate is 60%. This leaves the B/VI striving to make head way against a 16% employment gap with the sighted.)

Human Cognition

Life is made up of many behaviors. How we behave is affected by how we think, so just how do we come to think the way we do?

How we think is the outcome of how we process our experiences. In addition to experiences to which we attend, or ignore, also include events that pass us by and deny gifting us with their teachings. Those events are our data for fashioning our theory of the world. But how does the data that we accrue engender a thinking process leading to self-termination?

The riveting conundrum of that self-destructive thinking process is that most people would never entertain any such thought.

We have ascertained that suicide is not the outcome of a fixed formula to a particular set of experiences. "There is no single reason why individuals commit suicide, and suicide is the outcome of multiple influences that bear on it" (Stoff, & Mann, 2006, p. 8).

My quest to examine the manner in which we experience life, how those experiences are transformed into data, how the data molds our thinking, and how our thinking shapes our behaviors, immediately proved to be problematic. While there are profuse resources available that examine the phenomenon of our existing, they divide life into a collection of eclectic constituents and the lenses employed are microscopic and do not take in the 'big picture'. Furthermore, the studies evince little agreement as to what should even be on the 'what-life-is' packing list.

Trying to create a tableau of what we are all doing on this planet (us being the same species sharing the same space), I began with ontology, the science of being or reality, and encountered

this: "(human) action and interaction has potential for unpredictability, agency, growth, change" (Pinnegar, & Hamilton, 2011, p. 487). While that captures one view of existence, what we humans do with this planet as our stage, it is as generic a description as I might imagine. It says to me, "We are here, we do things. Maybe." While that is a start, my dissatisfaction with that description for being so broad goaded me to seek a more explicit portrait.

Lawrence, Samsi, Banerjee, Morgan, and Murray (2010) found the life elements most valued by individuals with dementia. Their stated appreciation for life and its constituent elements was intensified by those individuals' awareness of their impending loss of memory. The individuals in the study valued: independence, a "good brain", a happy family, helping others, attending to practical tasks, pride in appearance, and relationships. While this is in the direction of coming up with a list of human behaviors, and despite the sympathetic image, the elements appeared pedestrian and, on the surface, they do not appear to be of sufficient magnitude to keep one from ending their life.

McLeod (2007) held out promise with a discussion of the iconic Maslow, and Maslow's hierarchy of human needs. Moving from five human needs (biological/physiological, safety, social, esteem, and self-actualization) thence to eight in an expanded version (adding cognitive, aesthetic, and transcendence) was opportune because five basic human needs appeared far from being able to capture the scope of human experience. Eight was better in the sense it was more, but eight still seemed to be lacking given the complexity of our existence and certainly insufficient to justify self-termination. Maslow, again per McLeod (2007), next extends his attention to 'self-actualization'. If we include the behaviors leading to self-actualization, we now have twenty-two elements that compose life. My search results were looking up and while that list still appears on the short side, the categories contained within those elements were enormous such as "concerned

for the welfare of humanity" or "strong moral/ethical standards" (McLeod, 2007, pp. 5-6). Morality and ethics have been a topic of human interest for a good part of our existence as a species, certainly at least since the Greeks, dating from six or seven centuries B.C.E. (Given the amount written about morals and ethics, one would expect there to be considerable agreement on those topics but there is not.)

But I persisted. To establish the field, I was able to construct two arbitrary end points; the Greeks at one end, and today at the other end; a time span that neatly includes, but not limited to: Agnostics, Buddha, Confucius, Gnostics, Jesus, Manitou, Mohammed, Moses, and Sufism.

This broad timeline is sliced into three organic and manageable segments by Johnson (1982):

- A Greek and medieval period attributing a divine influence on humans. We act within parameters set for us by the gods.

- The Newtonian period situates humans in a causal world. Life and human behaviors are in response to events that are viewed as predictable and based upon scientific rules and laws formulated to explain how life works. We exist in a scientific universe.

- The Einsteinian era explores the relationship between science and existence, addressing time, space, and relativity. Our existence is relative to us, and presumably our thinking process is an integral element of our existence.

Things were looking up. I had a timeline that captured the evolution of human awareness and our own position in the grand scheme of things.

However, there was a problem. When truth or ethics are put on the list of things in life, they inflate like a hair triggered automotive airbag, a controlled explosion, ballooning into a glut of discussion points and interpretations. These details were taking me farther from the creation of

a conceptualization framework underpinning the goal of finding out how people arrive at the decision to suicide.

I was experiencing a phenomenon described by Pirsig (1974). He found that the scientific testing of hypotheses generated even more hypotheses leading him to conclude: "the number of rational hypotheses that can explain any given phenomenon is infinite" (Pirsig, 1974, p. 107). For Pirsig, science is not convergent in the sense it arrives at a given explanation for a certain experience. Science is divergent. This meshed with Kuhn's finding that paradigms are relative and situational (as cited in Crotty, 1998).

Thus, the more I attempt to define life, to nail down what it consists of, the harder it becomes. It is like squeezing a long balloon. When I squeeze it in one place, the balloon on either side bulges. The more I squeeze the more it bulges. While I was not finding what I was looking for, I did find out that life functions in a divergent manner which is a very useful finding, especially as to its possible application to suicide ideation.

The lesson I take from Maslow is that what is significant about human life, as opposed to the lives of owls, mold, and dragonflies, is our human behavior. In a given situation we may behave in a statistically predictable manner, such as making impulse purchases from strategically placed items while wending our way to and from the dairy department in the absolute farthest corner of the supermarket. But I have yet to encounter two human beings that think or act in an identical manner or behave with absolute predictability.

Is there anything that describes us humans better than our behaviors? While chimps use straws to extract termites from mounds and whales communicate with each other, we as a species engage in more language and tool-use than any other living things. Other species do not build

microchips or train language arts teachers as well as homo sapiens…nor do other species engage in suicide as do we.

There are 7,613,000,000 humans in the world (Worldometer, April 2018) each with an individual packet of behaviors. I could not possibly categorize all those behaviors, especially across cultures, but I could examine some of the elements of life in Western cultures.

We might start with the Freudian category of behaviors: oral, anal, phallic, latency, and genital stages in our first twenty years of development (Garcia, 1995). But things have moved on since Freud's contributions.

Jean Piaget enjoys a certain following. "Assessing the impact of Piaget on developmental psychology is like assessing the impact of Shakespeare on English or Aristotle on philosophy" (as cited in Beilin, 1992, pg. 191). Scholnick (1999) characterizes Piaget as a genetic epistemologist, which is someone who seeks to understand scientific knowledge especially from its psychological origins. Piaget directs his attention to conceptual development in children (adults presumably being not as desirable as children because adults are already farther along the developmental scale and thus more distant to when conceptual development is presumed to take place). Piaget asks how do children learn to think and thence behave the way they do? The implication of this question was profound: how we *behave* depends on our *thinking*.

Garcia (as cited in Scholnick, 1999) distills the sequence of Piaget's developmental psychology to the following: movement and action produce experience. From experience we notice (perhaps intuit might be included here) things like cause and effect (touching something "hot" produces pain) or we accumulate sufficient events to venture a prediction that something will occur (the cat will scratch if it is pinched). This data bank of experiences yields knowledge. Garcia (as cited in Scholnick, 1999) contends that this experiencing is a part of the nature of being.

We observe the relationship between things and from that we construct meaning about them. Those meanings become our reality and people's reality is very central to the issue of suicide.

To paraphrase: life is movement, action, growth, learning, and evolving. What stands out is that we are dealing with verbs. Actions let us gather experience handing us data with which to make internal connections. Those connections that we formulate between things and between events is theory, not in any formal sense, but more of an operational theory. With that operational theory we can generalize about things and generalizing is a characteristic of human development.

Generalization includes instilling protective mechanisms in response to trauma when 'bad' generalizations are formed, and they prove very difficult to 'unform'. Each of us develops our own individual theory about how life works based on our experiences and what we learned from them. From movement we create experiences. We process those experiences by finding *logic strands*. These configure our perspectives (reality bubble) and influence our behavior. Of course, this is the world according to me. I do not have any pretentions that this model is universal. But with allowances for terminology and specifics, this model captures the general process of how we come to think and thus behave.

Ojemann (1972) had the idea that by teaching human behavior to students from preschool to twelfth grade, the student's development would be more efficient and save time by avoiding pitfalls such as drug experimentation and delinquency. His idea does not appear to have been widely embraced, but what is interesting is Ojemann's (1972) presumption that we may deliberately teach experience or more accurately, replace experience with teaching. Presumably the student learning about life as if it was a spelling lesson, did not quite work that way. It appears that to learn about life we must needs experience life. While that appears to be an inefficient manner to learn about life, that appears to be how it works.

Garcia (as cited in Scholnick, 1999) holds that Piagetian theory includes psychogenetic, biological, historical, cultural, social, logical, empirical, and scientific components, and in so doing Garcia joins the crowd in introducing ever more life elements significant to the list of what is life. While the addition of those domains is rather astute, we are once again witnessing that in compiling this list of what life contains, we find it necessary to add ever more areas of human discipline.

Sheehy (1976) presents us with a list of human behaviors arranged in a developmental sequence. While noting that the life stages from infancy up to adulthood were studied in considerable depth, Sheehy found there was a tendency to perceive reaching adulthood as the final plateau of the developmental process. It was as if, "OK. You're 21 years old now and are an adult. You're good to go." Sheehy examined the birth to death human life cycle from the perspective of each gender as well as the interaction of the two genders. She demonstrated that we are always developing throughout our lifespan, and each gender wends a very different path through life.

Sheehy finds that the birth to death life cycle consists of developmental stages, hence the title of her work *Passages*. Each stage of life is no less complex or less drama laden whether it comes before or after the arbitrary and over simplified milestone of 'adulthood'. Of course, lifelong development is not guaranteed. For a variety of reasons growth may be curtailed at any time, such as by external circumstances, fatigue, or lapse of effort. Growth needs effort.

We remain far from a concise list of the elements of life that contribute to our reality bubbles, and Sheehy (1999) summarizes why that might be. "People who explore the human personality are dealing not with science but with art, observation, hunch, insight" (Sheehy, 1999, p.17). Life will not be confined to a taxonomy. As we continue to live, we continue to add to our experiences and are able to develop new thinking and consequently fine tune our behaviors. The

implication is that the suicide thinking process is a moving target and may potentially emerge at any time.

Life is complex and if we do not formulate a minimal survival system/operational theory to navigate life, we are going to get knocked around and have our corners rounded off for us. And if those corners do not get rounded off, society is historically eminently equipped to deal with non-conformists, deviants, and law breakers.

We create an ongoing data bank of experiences that we edit throughout our life cycle. Oh, I do not think we spend all our days trying to make sense of life. After a certain number of years, we most likely have arrived at an operational theory that lets us get on with our lives, stay out of trouble, and enjoy a nice walk. When we fix a toy or bake a pie, part of that feel-good feeling we experience might just come from the satisfaction of once again re-validating an operational theory we generated in the past, retracing, and savoring a successful learning process pleasurable in its repetition and fostering a sense of security based on replicability.

My reality bubble does not encompass all of life. How could it? I cannot experience all of life. I do not know the circumstances in which you were raised. I can only experience my life, and my reality bubble reflects that as does your reality bubble does yours. Our reality bubbles may interface and overlap like a three-dimensional Venn diagram and as a society we agree to share some constructs about time, space, and money so when I put a coin in a parking meter, I avoid a ticket. But not everyone feeds the meters or chooses to live.

We are each the center of our individualized universe. Reality bubbles remain permeable, and new experiences can edit, overwrite, and even delete our experience database.

While we find shared social conventions very useful, our interpretation of an event is formed by the reality bubbles we carried with us going in. Our reality bubble may be modified by

an experience as we attempt to process and integrate it with previous learning, but it is unlikely anything could prepare us to process events such as the 9-11 attacks on the World Trade Center. Our data is traumatized by such events.

There is an element of randomness in all this. Some things we may never know anything about, like Pangolins, while other people may have grown up with them.

But we are more than walking data banks. I visualize the process of creating meaning as the connecting of data with those logic strands. We formulate logic strands using observations, arguments, theories, and maybe memories fit in here too, seeing if they hold together and 'make sense'. Of course, some data banks may be corrupted or defective and we end up with a serial killer.

There is a visual of what those logic strands might look like. It is from a scene in the movie "A Beautiful Mind" (Grazer, & Howard, 2001). The main character, Nobel laureate mathematician John Nash played by Russell Crowe, keeping his efforts out of sight of his wife, covered the inside walls of the tool shed behind their house with a collection of photos, newspaper articles, and other artefacts in overlapping layers, with string and drawn lines going every which way trying to document a spy network that existed only in his schizophrenic mind. The impact of the photograph below does not do justice to the impact of the scene as it unfolds in the context of the film. While the movie intended to portray the mania of a paranoid schizophrenic, perhaps the scene is incidentally a valid representation as to how we make connections in our minds, albeit we use neurons and synapses and not string and markers.

Figure 1. From a scene in the movie "A Beautiful Mind" (Grazer & Howard, 2001).

In a similar manner, with this study I am bringing you into my tool shed. I am making connections with data in my reality bubble and using those logic strands to compose what I hope is a unique perspective, a unique meaning about a particular issue, that will be of value for individuals who are blind or visually impaired.

While I may make provisions for things of which I am unaware, I cannot derive meaning from something I do not know. Might this be operative in a suicide? It is not so much that the lives of people who suicide lacked meaning, but maybe they were unaware of the absence of something. Maybe it is the cognitive variation of color blindness? Do suicides lack a thinking process that counters whatever it is that says go ahead and end it all?

The concept that I am advancing is lucidly represented by the People, which is how Plains Native Americans refer to themselves. In this scenario of the Medicine Wheel, we are sitting on the prairie, in a circle with others.

   If the thing I were to place within our circle should be an abstraction, such as an idea, a feeling, or a philosophy, our perceptions of it would then be even more complicated

than if the object had been a tangible thing. And further, the number of different perceptions of it would become greater and greater as more and more people were added to our circle. The perception of any object, either tangible or abstract, is ultimately made a thousand times more complicated whenever it is viewed within the circle of an entire People as a whole. The understanding of this truth is the first lesson of the Medicine Wheel, and it is a vital part of Sun Dance Teaching. (Storm, 1972, p.4)

That is the essence of my conceptual framework. Everything is data. I focus on things and their connections that I become aware of and that I find important (McLeod, 2007), and I filter out things that I do not find helpful and then there are the things to which I have not been exposed. What I might focus on does not mean it is important to anyone else, nor would what another person might focus on necessarily resonate with me.

Any theory I advance is ultimately a construct. It is my construct at this moment in time, based upon things that I studied and of which I am conscious. My conceptual framework is a polaroid of the logic strands within my bubble. In the preceding pages I am sharing with you the strands I use to create my reality bubble. Some experiences are below my threshold of consciousness and while you may see them, I do not. But the logic strands that formed from having gone through that learning experience have been most fruitful.

I will present my theory of suicide. It is my hope that the reality snippets that I have herded together and connected with logic strands as to the relationship between humans and suicide engenders alternative thinking patterns about suicide. "No one suicides in a historical vacuum…their biographies…are always relevant" (Maris, 1981). And what are biographies but documentation of the lived experiences in our reality bubble and how we got there?

Referring to how we humans think and suicide; a case may be made that the fuse for a suicide goes back in time. The fuse winds its way back to the creation of the thinking process that leads one to suicide. That thinking process may be logical, but it is not rational. It is not so much that because of their current circumstances individuals somehow wind up a suicide as it is they are

locked into a thinking process that (irrevocably?) leads them to suicide as if in an infernal subliminal hypnosis. The roots of that thinking process, or perhaps the lack of a counteracting or neutralizing thinking process, is a product of their reality bubble.

My intention is to reduce the number of suicides by individuals who are blind or visually impaired. I will attempt to do so by studying the suicide risk of that population and examining their thinking processes relative to suicide.

Chapter Three – Methodology

Statement of the Situation

This study is important because it has the potential to save lives. Suicide is relative to the individual. While the causes of suicide are highly resistant to stereotyping, suicides nevertheless manifest commonalities. These commonalities are gathered and utilized to assemble profiles that coalesce into identifiable groups. The members within that group share exposure to that set of suicide risk factors. The profiles allow implementing pertinent suicide identification, prevention, and intervention measures. (Keep in mind that while suicide risk factors are related to suicide, they are not predictors of suicide.)

This study neither sought nor excluded individuals who have attempted suicide.

Research Purpose

Given the gaping void in the literature pertaining to individuals who are blind or visually impaired and suicide, this study indicates areas of interest and significance for additional research.

Acknowledgement of Research Limitation

This study did not generate a definitive, all-inclusive portrait of individuals who are B/VI in relation to suicide; the variables attached to blindness, visual impairment, and suicide are too multifarious. There are variables within the disability (no light perception, partial light perception, narrow field of vision, night blindness, etc.) and to the etiologies as well; congenital and adventitious, onsets that were gradual and abrupt. These variables required efforts at generalization that were done with caution to prevent parenting distortions.

This study is characterized as a probe into the relationship between individuals who are blind or visually impaired and suicide. One outcome is the initiation of a framework for subsequent research.

Response to the Research Question

This study was able to collect self-reported responses of individuals who are blind or visually impaired to CDC data elements recommended for inclusion in a surveillance system that was designed to collect information on suicide.

Ancillary Issues

While the goal of this study did not include the following ancillary issues, they are being reported out.

- The nature of suicide risk and protective factors for individuals who are blind or visually impaired.

- The commonality of suicide risk and protective factors of individuals who are blind or visually impaired and sighted individuals.

- The commonalty of exposure to suicide risk and protective factors of individuals who are blind or visually impaired and sighted individuals.

- Determining a correlation between suicide risk and protective factors and a particular visual condition (congenital or adventitious, visually impaired, or blind, etc.)

- The status of suicide attempts for this population.

Research Hypotheses

- It was hypothesized that individuals who are B/VI share some risk factors with the general population.

- It was hypothesized that individuals who are B/VI have either heightened or lessened susceptibility to particular suicide risk factors intrinsic to their condition.

- It was hypothesized that individuals who are B/VI are exposed to pervasive and distinct elements which manifest themselves as suicide risk factors unique to this population.

- What are the effects of insomnia and its stablemate disturbed circadian rhythms upon disrupted sleep patterns, which has been found to be a suicide risk factor for sighted individuals? DeLeo, et al. (1999) found that sight loss increases insomnia.

Method of the Study

Immutable Parameters of Suicide

The nature of suicide exacts a methodology that is its measure. Suicide is not typically an impulsive or spontaneous act; it is an act that is concocted over time. As to the thinking process that leads to the act, the suicides take that with them, and we are left guessing as to the meaning of the suicide and the reasoning that led to it. While this is such an obvious property of suicide, paradoxically it is rarely broached, yet the ramifications are significant and bear discussion.

Suicidology as a science can gather data only after the primary sources are no longer available to researchers; the respondents are unable to respond (Maris, 1981). Hence the concept that understanding suicide is like trying to read a letter that was never sent. Suicide is a very explicit communication, but we are confronting a cypher.

The decision to suicide is typically taken after some degree of reflection, but the suicide leaves little if any clues as to what those deliberations might be. The primary sources take that invaluable information with them when they go. "The data base…is conspicuously absent" (Maris, 1981, p.6). This is an immutable parameter.

Other branches of knowledge are also unable to interview subjects about their deaths (e.g., anthropology), but typically those deaths are incidental to those bodies of knowledge. Such is not the case with suicidology where the death of the subject is the central focus.

The situation is compounded by the inability to predict who might suicide which precludes any pre-emptive gathering of data; and suicidology remains at its inherent remove from its subjects.

There is a second immutable parameter of suicide that thwarts all discussion: there is no cure (Farberow & Shneidman, 1961). Without a cure, there is no gathering primary data after the fact.

While this study has not be able to breach those immutable parameters, this study has uncovered a population whose relationship with suicide is virtually undocumented.

Research Goal

The goal of this research was to study the relationship between individuals who are blind or visually impaired and suicide.

Conceptual Framework

The difference between an opinion and a justified belief (epistemology) is the presence of data. The data collected in this study is ascribed meaning (Constructionism) by me. That meaning is my interpretation of the situation (Interpretivism). My interpretation is a construct that derives from the conscious and unconscious processes in my reality bubble, which has previously been discussed.

The data culled from the verbal interactions with the participants evinces meaning, understanding, and the creation of a portrait or snapshot of the participant and their situation (Symbolic Interactionism). The data allows the construction of a theory based on the emergent data that was gathered (Grounded Theory).

Ultimately, it is my reality that catalyzes my interpretation of the data concerning the relationship between individuals who are blind or visually impaired and suicide.

EPISTOMOLOGY	CONCEPTUAL PERSPECTIVE	METHODLOGY
Constructionism (Crotty, 1998.)	Interpretivism (Crotty, 1998.)	Grounded Theory (Charmaz, 2014.)
	Symbolic Interactionism (Mead, n.d.)	

Selection of Methodology

Grounded Theory (GT) capacitates research without imposing preconceptions as to findings and results. "Grounded Theory methods offer a set of general principles, guidelines, completed by the strategies, and heuristic devices" (Charmaz, 2014, p. 3) and is a segue to an essential element of GT: gathering data to generate a theory in contrast to gathering data to support an already preconceived theory. There was no glare from an initial hypothesis to dazzle perception, and the data that emerged laid the foundation for a theory.

This study employed a survey instrument to mine data. The survey instrument involved each participant providing spoken responses to the Primary Investigator and the Licensed Professional Counselor. Given the sensitivity of the topic, all sessions were under the supervision of a Licensed Professional Counselor (LPC).

During the completion of the survey instrument, data unique to the participants emerged and gave rise to follow up questions.

Licensed Professional Counselor

Due to the sensitive nature of the subject, a Licensed Professional Counselor (LPC) was present throughout each interview session, as required by the Institutional Review Board (IRB).

The study greatly benefited from the involvement of the LPC having years of experience, specifically as a Suicide Prevention Coordinator for a large, urban, state university, amongst her multiple other qualifications. Her involvement was most fortuitous as evidenced by her remarkable ability to connect with the participants in a very short time frame and elicit meaningful responses to very sensitive questions.

The LPC observations concerning the study are in the Appendix.

Survey Instrument

The study utilized the CDC Self Directed Violence Surveillance (CDC, 2011) document as a survey instrument. This instrument was selected because it provides a developed, standardized format from a nationally recognized federal agency for collecting data concerning suicides. Of particular interest to this study is that the SI specifically addresses suicide risk factors and protective supports.

The CDC indicated that the sequence of the data elements in the survey instrument was flexible, and the script was arranged in the following order:

The PI would ask survey elements 3 to 11.

3. Sex	8. Urban/rural classification.
4. Age in years.	9. Education.
5. Race	10. Occupation.
6. Ethnicity.	11. Economic activity.
7. Marital status.	

The LPC would attend to the following survey elements:

32. Military service.	34. Protective factors.
26. Somatic history.	35. Risk factors.
27. Mental history.	29. Previous suicide thoughts.
30. Family medical/psychiatric history.	28. Previous suicide behaviors.
31. Sexual orientation.	

Statement as to Participant's Responses

All the data collected from the participants is self-reported. The study did not attempt to verify the participant's responses. None of the participants gave any cause to doubt the credibility of their responses.

Transcribing

The sessions were transcribed in real time by the PI.

Data Collection Method

The survey instrument was administered to twenty (20) individuals seeking data *of interest* and/or *of significance*. Within the confines of this study, of interest is defined as responses that contribute in either a general or incidental manner to the study goal. Responses considered to be of significance refers to more substantial responses that impart a more focused and fuller image of the situation being studied.

The data incorporated the theories by the participants themselves (Maxwell, 2013). "Many… plans have failed because their authors designed them according to their own personal views of reality, never once taking into account … the men-in-a-situation towards whom their programme was ostensibly directed" (Freire, 1972, p. 66).

"Not too many of us embark on a piece of social research with epistemology as our starting point: 'I am a constructionist. Therefore, I will investigate…'" (Crotty, 1998, p.13). Research typically scrutinizes a situation and pinpoints gaps in the data that thwart the comprehension of

the situation, as was done in this study. As concerns the study of suicide, "What is needed is something like a movie of the life and death styles of the suicidal individual" (Maris, 1981. p. 6). While that did not occur, the survey instrument did allow for the opportunity to gaze into the reality bubbles of the participants.

There was no expectation of generating a definitive study of this very complex situation. The study was successful in contributing to the establishment of the field and indicating a direction for further research. The study did so by administering a survey instrument and posing follow up questions triggered by emergent elements.

The survey instrument (SI) was from the Center for Disease Control (CDC): Self-directed Violence Surveillance: Uniform Definitions and Recommended Data Elements (.

This SI obtained data pertaining to suicide related issues such as: suicide ideation, suicide attempts, suicide prevention, and suicide risk factors. This was in conformance with, "The need for improved and expanded surveillance systems is highlighted as one of the central goals of the National Strategy for Suicide Prevention, U.S. Dept. of Health and Human Services" (as reported in CDC, 2018, p.17). Adopting the SI from the CDC aligns this study with national data collection efforts and does not detract from credibility.

This SI was considered serviceable to this study.

The PI and the LPC administered the SI to the participants. The PI transcribed the participant's responses and made an audio recording of each session.

Follow up questions that emerged were followed up on and are discussed below.

Follow up questions.

Follow up questions were formulated in situ as part of the interview session. The questions focused on those responses that reflected the unique perspectives of the participants.

Initial Coding

The handwritten transcriptions were put into MS Word format. Each statement was initially coded from the codes suggested by the CDC, but those codes quickly demonstrated themselves to be insufficient; they were too few and too broad to accommodate the richness of the data that was emerging. A more substantial scaffolding was required. Subsequent passes through the data birthed additional in-vivo codes. With each pass the need for additional codes progressively decreased until all comments were covered by an appropriate code.

Memo Writing

Particularly during the coding process, a considerable number of 'memos to self' were generated during the sifting of the emergent data. The memos grappled with whether the coding of a particular data bit was based on how it presented itself or if the prima facie coding was a shroud for more reclusive and potentially more significant data.

A suitable example is individuals who are blind or visually impaired ordering food in a restaurant. For the blind or visually impaired, this scene borders on being a cliché. Our blind or visually impaired diner is seated at the table with his companion, and braille menus may or may not be available. When the server returns to take the food orders, the server may well ask the companion to the B/VI individual what will "they" be having. If the companion or the B/VI individual were to inform the server that they will be ordering for him (or her) self, it is quite possible that the server would speak at an elevated volume.

Initially this situation presents itself as a scenario that reflects poorly on the order taker. The lack of opportunities for the sighted to interact with B/VI individuals appeared to capture the situation and some explanation could be due to B/VI being a low incidence condition.

Addressing the effect of the situation upon the B/VI individual submitting to this scenario, it is certainly embarrassing if not humiliating and might be coded as 'being in a socially awkward public situation while B/VI', but there is more going on.

The pervasiveness of being B/VI in a sighted world has once again been triggered and the message is clear; there are no 'off' hours from being blind or visually impaired. Vulnerability has been evoked and is once again chipping away at self-esteem with naggings of inadequacy and incompetency. The frustration and anger fuse is lit and unjustness reappears.

Not all participants manifest this entire stereotypical reaction to this dining situation, but this is an experience that some B/VI have reported and to which other B/VI can relate.

Focused Coding

After the initial coding, most of the data elements had been assigned an existing CDC code or a code was fabricated for them. Those data elements that defy easy classification require more scrutiny as to what they are trying to communicate. Typically, those hard to classify data elements are the emissaries of the emerging concepts.

The initial coding organically morphed into focused coding. The terminal coding was precisely that with previous coding being intermediary.

This coding process was like reupholstering an old easy chair. One would tug a little this way to smooth a wrinkle here and pull a little that way to eliminate a wrinkle there; the goal being to ensure that everything is covered in as smooth and as craftsperson-like a fashion as feasible. The coding is characterized by continued concept refinement, in a tug of war with one code being too inclusive with another code being too exclusionary.

The coding evolved from the initial twenty-six CDC codes to a total of seventy-nine codes: an additional fifty-three codes.

Coding Guidelines

The term *definition* projects too strict an image for the sorting, grouping, and labeling (coding) of human attributes. To move to a more humanistic vocabulary, however slightly, the study will use the term *guideline* as the label for coding criteria.

The starting point for the coding guidelines was CDC Data Element #33, Proximal Risk Factors, and then subsequently progressing to Data Element #34, Protective Supports. As contained in the CDC document, the factors for those two Elements are rudimentary and not particularly informative. As concerns Protective Supports, the CDC states: "This classification is an exploratory classification among the data elements". Being exploratory the structure is necessarily rudimentary which allows greater scope in creating a more appropriate framework.

The coding coalesced into the following concepts:

Suicide Risk Factors

Protective Supports

       Internal

       External

       Internal/External

Except for the addition of the Internal/External support, which is a critical contribution of this study in fleshing out the rudimentary CDC framework, this framework is that of the CDC.

Suicide Risk Factor Guidelines

In the absence of medical examiner data documenting pre-existing conditions, this study inquired as to the sources of stress experienced by the participants, and subsequently how they dealt with that stress.

The LPC drew upon several approaches. For example, the LPC might ask the participant if they ever felt lonely. After discussing how that made them feel, the LPC would inquire as to what the participant did when they felt those feelings.

Stress was defined by the participant, such as feelings of depression, anxiety, etc. In the feeling lonely example, while many of the participants live alone, that living situation was not necessarily assumed to be a source of stress. Only if a participant were to indicate that they felt isolated or lonely would that living situation be examined as a possible cause of stress.

Appropriate measures were in place should there have been any indication of suicide ideation or behavior, for which thankfully there were none.

The first group of risk factors are applicable to individuals whether B/VI or sighted. The second group of risk factors are linked to B/VI situations.

List of risk factors (CODE: Label).

The data in Chapter Four is organized according to the following groupings.

- CUR: Current Events – Not Otherwise Specified.
  Generic, catch-all category.
- CUR1: Current Events - Pandemic.
  The effects of the Pandemic such as limited or no social opportunities, refraining from going shopping or to gyms, not eating in restaurants, etc.
- CUR2: Current Events - National and/or International Political Situation.
  The effects of the world situation and its effects on uncertainty, hostility, and/or instability.
  CUR3: Current Events - United States 2020 Presidential Election.

- EMP: Employment Issue – Not Otherwise Specified.
  Generic, catch-all category.
- EMP1: Unemployment Issue.
  This issue encompasses matters associated with not having a job.

- EMP2: Job Issue.

  CDC Suicide Risk Factor Code #4 of 12.

  This category involves issues associated with a job such as job layoffs, job pressure, situations at work, etc.

- FIN: Financial Issue.

  CDC Suicide Risk Factor Code #6 of 12.

  Situation with a financial component such as bankruptcy, debt, foreclosure, selling or buying a house, etc.

- LEG1: Legal Issue - Criminal.

  CDC Suicide Risk Factor Code #9 of 12.

  This includes criminal situations such as an impending arrest, a police pursuit, committing a crime, being in jail, criminal court date, etc.

- LEG2: Legal Issue - Family.

  A legal situation that involves the family. The experience that was cited was the desegregation/integration of two schools for the blind with which the family of the participant was involved.

- LEG3: Legal Issue – Not Otherwise Specified.

  CDC Suicide Risk Factor Code #10 of 12.

  Unspecified legal action involving situations such as a custody dispute, civil lawsuit, committal to a hospital, ward of the court, or class action lawsuit.

- MH: Mental Health issue - Not Otherwise Specified.

  For want of a more appropriate category, this is a generic, catch-all code for unspecified stress from a mental health issue. Phobias were incidentally included in this factor.

- MH1: Depression Issue.

  Depression, sadness, grief, worry, crying.

- MH2: Mental Stress Issue.

  Anxiety, stress, distress, frustration, anger, resentment, hostility, feeling upset. Physically distancing oneself from an adverse situation.

- MH3: Personal Adjustment Issue. B/VI Specific.

  Mental health issues stemming from personal adjustment to being blind or visually impaired.

- MH4: Self-Concept Issue.

  Issues related to self-esteem, self-worth, or insecurity.

- MH5: Feeling of Inadequacy Issue. B/VI Specific.

  Issues related to feelings of inadequacy. While feelings of inadequacy are hardly unique nor restricted only to B/VI, this was a significant factor for this study. This code reflects the internal state of a participant when they encounter an absolute block to an activity due to their blindness or vision impairment. An example would be the feeling of being unable to qualify for a driver's license, which in the United States is not only an essential mode of transportation, but is a culturally significant rite of passage, amongst multiple other cultural factors such as freedom and independence. This contrasts with many European countries where public transportation is highly available, is depended upon by most of the public, and is integrated into the culture to the incidental benefit of the B/VI. This is significant because the use of public transportation does not require passing exclusionary criteria as does a driver's license, and at least in Europe, inadequacy issues related to driving an automobile are moot.

  Another situation that was divulged was not having a braille ballot made available. This issue is not identical to not being able to drive a motor vehicle. Unlike a driver's license, the B/VI have the constitutional right to a secret ballot. However, if one is not available, they are once again facing an impasse, albeit in this instance an avoidable impasse which has implications of unjustness. Whatever the cause of the impasse, the sense of inadequacy experienced by the individuals who are blind or visually impaired is commensurate.

  Feelings of inadequacy are distinct from feelings of incompetency (below). Inadequacy has an element of being structural while feelings of incompetency typically result from actions by others to which the participant is subjected, such as the previously discussed ordering in restaurants.

- MH6: Mental Health Issue Involving Family.

  These are mental health issues related to family. This encompasses the effects of a family member's mental health issue(s) upon the participant or something about the participant's collective family provokes a mental health issue for the participant.

- OII: Ideation to Injure Others.

    Self-explanatory.

- OIA: Action to Injure Others.

    Self-explanatory.

- SA: Substance Abuse - Unspecified.

  Generic catch all category. Undifferentiated and or combined alcohol and drug abuse.

- SA1: Substance Abuse - Alcohol.

- SA2: Substance Abuse - Drug(s).

- SCH: School Related Issue.

  CDC Suicide Risk Factor Code #5 of 12.

  This category includes issues such as academic pressure, failing, bullying.

- SIB: Self Injurious Behavior – Without Suicidal Intent.

  During the sessions, participants were asked about any previous, nonfatal, events of self-directed violence, which can be utilized to determine the presence of suicidal issues. There were a few instances of behavior that while self-injurious, they did not appear to rise to the level what could be characterized as violence, nor was it apparent that the behavior was indicative of the presence of suicide ideation. SIB was adopted as a category to ascribe to such situations, but further refinement of this code is warranted as the CDC differentiations are unwieldly.

- SOC1: Death of a Friend or Family Member.

  CDC Suicide Risk Factor Code #8 of 12.

- SOC2: Stress from Social or Public Situations.

- SOC3: Stress from a Social Situation Involving Peers.
- SOC4: Stress from an Isolation Issue.
- SOC5: Issue Involving Significant Other.

  CDC Suicide Risk Factor Code #2 of 12.

  Stress arising from a situation with an intimate partner such as divorce, breaking up, relationship discord.
- SOC6: Relationship Issue - Not Otherwise Specified.

  CDC Suicide Risk Factor Code #3 of 12.

  This category addresses relationship issues not already covered such as a family argument.
- SOC 7: Feeling of Incompetency. B/VI specific. A situation that leads one to feel a sense of incompetency associated with being blind or visually impaired. In employment situations, job responsibilities and duties may be withheld from the B/VI individual.

- SOM: Physical Health Issue.

  CDC Suicide Risk Factor Code #1 of 12.

  This is a generic catch-all code. Stress may accompany a physical health issue. Also included in this broad category are all health concerns including debilitating conditions or terminal disease.

- SU: Suicide Issue – Not Otherwise Specified.

  Generic, catch-all category.
- SU1: Suicide Ideation.

  This category is limited to having thoughts about suicide.
- SU2: Suicide Behavior.

  This category is defined by actions directed towards suicide.
- SU3: Suicide in the Past by a Family Member or by a Friend.
- SU4: Recent Suicide by a Family Member or by a Friend.

  CDC Suicide Risk Factor Code #7 of 12.

- TRA: Trauma – Not Otherwise Specified.

  Generic catch all category.

- TRA1: Childhood Trauma - Out of School.

  Includes bullying, teasing, neglect by caretakers, verbal / emotional / physical abuse, parents divorcing, etc. Incidents that were reported occurred at the neighborhood playground, the home of a family related caretaker, etc.

- TRA2: Non-Childhood Trauma.

  Self-explanatory.

- VIO: Interpersonal Violence – Not Otherwise Specified.

  Generic, catch-all category.

- VIO1: Participant as Perpetrator of Interpersonal Violence.

  CDC Suicide Risk Factor Code #11 of 12.

  E.g.: Incident involving an intimate partner, child maltreatment, sexual violence, etc.

- VIO2: Participant as Victim of Interpersonal Violence.

  CDC Suicide Risk Factor Code #12 of 12.

  E.g.: Incident involving an intimate partner, child maltreatment, sexual violence, etc.

Emergent codes applicable to B/VI.

While the following categories are not unique to B/VI, what does stand out is that individuals who are blind or visually impaired may have a greater predisposition to be in the following situations:

- PRV: Inescapable Pervasiveness of the Condition. B/VI Specific. As one individual put it, their vision was involved in every decision they ever made about their life, but this also alludes to recurring B/VI issues such as the chronic lack of services or mobility issues stemming from having to rely on public transport, which in the United States is often marginal.

- STG: Stigma or Onus of Being Blind or Visually Impaired. B/VI Specific. There are at least two facets to being blind. One facet pertains to the 'mechanics' of being blind. This would include learning braille, finding one's way around campus, earning a degree, using technology. Typically, most individuals who are blind or visually impaired do quite well in adapting to their condition. The second facet of being blind is living in a sighted world. This manifests itself as employment discrimination or suffering from the myths of gaining

superhuman senses or possessing a superhuman drive to persevere in the presence of virtually insurmountable aversity. The onus of being blind also includes being misunderstood, exploited, patronized, and needing to continually explain oneself to the sighted.

- UNJ: Unjustice. B/VI Specific. This emerges in situations that are not morally right or fair. One example is doing poorly in school and being characterized as lazy when the underlying cause is an undiagnosed vision issue. Another example is the failure to provide B/VI aids. Unfair. Prejudice. Bias. Discrimination. Sighted Preference. Slanted. Bigoted. Wrong. Undeserved. Victimization (the action of singling someone out for cruel or unjust treatment). Includes effects of Ableism.

- VUL: Feeling of Vulnerability. B/VI Specific. Being disrespected, mugged, or assaulted. This affects multiple personal areas such as self-esteem and is a potential segue to a sense of inadequacy, incompetency, and trauma. Contrary to Über Protective Supports, VUL may become a possible über risk factor because of the possible multiple negative effects.

Protective Support Guidelines

Terminology influences perception. For this study, the term *Suicide Protective Factors* has been superseded by the term *Protective Supports*. Protective Supports contribute to an individual's well-being in multiple ways besides protecting one from suicide. The term protective supports more accurately portrays the positive role supports play in reinforcing the general well-being of the participants.

Consideration was given to the terms 'protective' and 'preventive', with preference given to protective. Without data, it would be difficult to establish that any given support 'prevented' a suicide, with the sense of keeping something from happening. The term protect, in some interpretations, provides for the nuance of being less than absolute and hence more reflective of the role being played by these supports.

The CDC definition for Protective Factors (sic) is: "…internal or external factors that interact with a risk factor to reduce or nullify its effect among at-risk individuals or populations" (CDC, 2011. p. 66).

This study found it necessary to take a considerably broader view of protective factors. Protective factors fulfill many more functions than merely "interact with a risk factor". Supports superbly portray how humans define the good in their lives. Supports make us happy and provide us with meaning. These protective supports comprise 'owner's manuals' that these individuals have compiled for themselves over the years. They provide socialization opportunities and much more. Do these supports also prevent suicide? Yes, they certainly do that too, but that is a restricted perspective that undervalues these supports. These supports reinforce the idea that the best way to avoid suicide is to live a good life.

These supports represent a significant finding. The emphasis of suicidology may not lie in finding out the cause of suicide so much as what prevents people from suicide. Indeed, the CDC indicates that fewer studies have been done on protective supports than have been done for risk factors.

The CDC states to record all protective supports that apply and to specify which type. The protective supports indicated by the participants to address stress are classified into three areas:

- Internal
- External
- Internal/External

Internal protective supports.

- Esprit domain (Code: PI-EX). Having to do with the soul, life, heart, belief.

Guideline: One's raison d'être (Fr.: reason for being). Why reinvent a term that needs no improvement? This is the reason someone gets up in the morning. Mindfulness, self-monitoring,

and the theory of mind suggest themselves here, as well as altruistic manifestations. Perhaps this is where a 'reason' for NOT suiciding may best be found.

Internal supports are found within or emanate from the participant. The supports in this domain are what an individual taps into to justify their actions, the beliefs they hold, and their philosophical positions. These supports effectively blunt further inquiry seeking a "why" or a justification. The individuals who invoke these supports give the impression that if you were to mine deeper, they would hunch their shoulders and say, 'that's just the way it is.' There is a sense that we are just a baby step from an ontological discussion.

An example might be: "I believe that we are put on this earth for a reason."

- Temperament domain (Code: PI-TEMP). Where an individual's values manifest themselves and are made operational.

Guideline: Protective supports in the Temperament domain consist of character attributes that provide criteria or guidelines to an individual as they proceed on their journey through life. If the Esprit domain is the explanation for *why* people act the way they do, then the Temperament domain is how they manifest it. Temperament guides *what* they do, or in some cases what they do not do, to protect themselves.

This is characterized by an "I feel blessed." attitude.

- Associative domain (Code: PI-ASSOC). This is identifying with someone or something.

Guidelines: The internal suicide protective supports that fall into this domain reflect an individual's felt need or desire to reach out to feel connected, to being loved, to have a sense of belonging. This support originates from within the participant. The lack of a feeling of belonging or of connectedness is widely recognized as being a significant suicide risk factor.

While the concept of *associate* includes the imagery of *hanging out* with someone, there is a more profound meaning involving the cognitive process of *identifying with* someone or something. It is this later meaning that is invoked in capturing the supports in this domain.

The vector associated with this dynamic is initiated from within the participant to the outside, with the goal, whether articulated or not, for the participant seeking to feel connected, needed, or loved. To identify, and to be recognized, as a participating member of humanity. There is the need for being appreciated, recognized, belonging, and feeling included, as opposed to just fitting in. This need to connect may manifest itself as provisions being made in some manner for the participant. The participant's recognition of their existence and connectedness is the result of activities that are generated to their benefit, such as someone going grocery shopping for them. The activity becomes a concrete manifestation not just of their existing, but the recognition of their existence by the actions of another person or persons doing something for the benefit of the B/VI individual.

As will be seen below, this desire to feel connected is distinct from wanting to be around others. A clear example of this is the difference between a daily telephone call with a friend or family member (internal) and a stereotypical social activity such as bowling with work colleagues (external). The telephone call is an intentional and unique action to the unique benefit of the participant while the bowling is a standing date that would take place with or without the participant.

Included in this support is not just the fulfillment of the need to feel connected. What surfaces is that the participant has the need to feel connected in common with others. Needing to feel connected is a human trait.

While there is no typical vocabulary to this 'state' of desiring or needing association, the conceptual terminology would include terms such as linking, connecting, attaching, and joining.

An example would be: "I want to provide my grandchildren with the grandfather presence I never had."

- Tangible domain (Code: PI-Tan). These are actions people take; things they do or avoid doing.

Guidelines: This internal protective domain contains specific activities with which individuals engage to re-center themselves. This includes not only doing something but sometimes also avoiding something by intentionally not doing a particular action because to do so might produce undesirable effects.

While there is no typical vocabulary to this domain, the conceptual terminology would include terms such as: concrete, material, palpable, plain to see, clear, definite, real, able to be experienced.

"I will usually read a book or if I am antsy, I will go for a walk."

- Demonstrating competency (Code: PI-TAN-C).

Guidelines: This internal protective support is congruent to the Tangible Domain above with the distinction that the activity being undertaken includes an element of manifesting competency.

While the need to demonstrate competency is not unique to blind and visually impaired individuals, it appears to resonate more with a theme that emerged during this study that is linked to blindness and visual impairment. This competency domain is a significant finding of this study.

For a variety of reasons, blind and visually impaired individuals are involved in situations where their adequacy or competency (not identical terms) may be called into question or where

they feel called upon to demonstrate to themselves or others that they are self-actualizing, independent, competent, and adult human beings.

One example from the study is: "I do not have to worry about money. I have my own full-time driver and a vehicle."

External protective supports.

External protective supports are outside the individual. Two types of external protective supports surfaced in the study: Social Milieu and Remedial.

Social milieu external supports.

A striking finding in this study is the importance of other people upon the lives of this population. While this is not unique to B/VI, but the virtual omnipresence of the social milieu is conspicuous. The term milieu, borrowed from the French (ambiance, setting, environment, context), is not new to either anglophone countries or academia. It is often used to refer to a social context associated with a particular social-economic stratum. But the term also refers to a smaller or particular social setting. In this sense, it could be said that a bowling alley or beer garden each provides a milieu. It is in this latter sense that this term is used.

Also notable are the multiple distinctions made as to the relationship between the participant and the 'other(s)' present, where that relationship takes place, the activities that are being engaged in, how often, etc. These precisions reflect and signal the importance of the element to the individual.

These social milieux reflect a considerable range of activities. In all but three cases they each share the attribute that the activity involves other human beings. (CODE)

- Significant Other. (PE-SO)
- Progeny. (PE-PROG) Includes grandchildren and great-grandchildren.

- Parent or Parents. (PE-PAR)

- Siblings. (PE-SIB)

- Friends. (PE-FRI)

- Peers. (PE-PEER) Co-workers, peers, colleagues, clients, 'peeps'.

- Religious. (PE-REL) This includes a group such as a choir or a pastor/minister/preacher who is gregarious. This support captures the 'organizational' nature of religion as a social activity. Expressions of faith or belief are included in PE-GOD or in PI-EX.

The code for this protective support divulges the evolution of my coding, which may be of interest to the reader.

During the data gathering phase of the study, some of the participants would explicitly state their reason for attending church activities to make clear that it was for either spiritual enlightenment or to socialize. (For most church going participants, it is likely a blend of the two.)

To reflect this emerging situation, I needed to separate the two and come up with a second code in addition to PE-REL (protective external-religion). I settled upon the rather unimaginative 'PE-GOD' code to label the enlightenment seeking group, leaving PE-REL to do duty for the social church goers. To amplify the distinction between the two groups, I settled upon the unwieldy label 'non-secular community'. The reader will notice that the ultimate label for some supports will have similarly evolved.

This code wrangling is a lesson learned quite early in coding. Going back to change already labeled data with a new label is rife with complications and is fertile ground for errors.

- Cultural. (PE-CUL) Parties, dining out, ethnic restaurants, music (concerts), dancing, art, movies, bowling, shooting range.

- School. (PE-SCH) Education, training, dance lessons, in-service training.

- Social Services. (PE-SS) Rehabilitation services / Alcoholics Anonymous / organizations for the blind / support groups. (In this study Alcoholic Anonymous was portrayed by the participants as primarily being social.)

- Extended Family. (PE-EXT) Includes aunts, uncles, nephews, nieces, sons-in-law, daughters-in-law, sisters-in-law, brothers-in-law.

- Higher Being. (PE-God)

- Job. (PE-JOB) Employment.

- Family. (PE-FAM) Utilized collectively or generically.

  The two categories that do not include other human beings follow.

- Pets (generic). (PE-PET) It is remarked that pets provide companionship which is also an attribute of human socialization.

- Other. Specifically includes an appreciation for clothes, shoes, and fashion in general. Includes miscellaneous or unspecified. (PE-OTH)

Remedial external supports.

External supports that do not involve socialization were classified as remedial and involve elements associated with health care. Remedial refers to those supports that counteract something and are not limited to conditions related to being blind or visually impaired. These supports range from diabetes medication, physical therapy, B/VI specific rehabilitation, and aids such as a cane, or special lens.

- Medical. (PE-MED) Medication pump, dialysis, etc.

- Therapy. (PE-THER) Counselor, therapist, psychiatrist, social worker.

- Hospitalization. (PE-HOSP) Both voluntary and involuntary.

- Rehabilitation. (PE-REHAB) Rehabilitation services and facilities. This remedial element stands out because of the universally positive reaction to attending a rehabilitation facility for the blind. It was characterized by one participant as "life changing".

- Physician. (PE-MISC) Health care professional or primary care.

- Adaptations. (PE-ADP) Cane, adaptive lenses, assistive devices, etc.

Internal / external protective supports.

The Internal/External Protective Supports domain is an emergent composite that cuts across multiple areas and elaborates on the concept of über supports.

- Teaching (PIE-TCH).

Several participants indicated that teaching was a significant support for them. While they did not articulate why teaching might be so, examination reveals that some supports are composed of a dense package of multiple supports and qualifies them as über supports.

This phenomenon is discussed in greater detail in Chapter Five.

- Advocacy (PIE – ADV).

This protective support is also an internal/external element. It is internal because it represents a skill set that assumes self-actualization and self-confidence sufficient to externalize itself when summoned in the sometimes-toxic sighted environment that B/VI face.

Advocacy is a vehicle for various doses of multiple domains: Esprit, Temperament, Tangible, and Competency.

Advocating for oneself often meshes with advocacy for the B/VI as a group. When a B/VI individual advocates for oneself, they typically find they are countering a stereotype that is directed towards B/VI as a group. In an advocacy situation, the B/VI individual is typically aware of advocating for all B/VI individuals as a group, and they often articulate it as they are doing so.

Advocacy contains multiple elements, is very empowering, and qualifies as an über support.

Account of Study Components Utilized in This Study

Site selection.

The participants reflect a variety of residential situations. The data concerning individual residences was collected since some suicide risk factors have been identified with housing types (NIMH, 2018) and it was opportune to collect this data during the interviews. However, there was no intent to recruit participants from a particular geographical location or residential setting.

Given the limitations imposed by the Pandemic, sessions tool place over the phone in a three-person conference telephone call. There was no video imaging nor video recording.

Participant selection guide.

Participant visual status criterion.

The participant selection criterion regarding vision was based on the legal definition for blindness employed by the U.S. Government.

The legal definition of blindness is stated as vision being 20/200 or less, in the better eye, with the best possible correction, or that the visual field is twenty degrees or less. This specifies that an individual with 20/200 needs to get to within 20 feet to be able to see, with whatever aids are effective, that which an individual who is not vision impaired is able to see when they are 200 feet away. The criteria as to a visual field refers to the loss of peripheral vision and the need for objects to be close to the field of view if they are to be perceived. This has been sometimes referred to as 'tunnel vision'.

There are considerable variations of blindness and visual impairments contained within the legal definition of blindness. For individuals with eye disorders, 85% have some vision while 15%

are without any light perception (American Foundation for the Blind, 2019). Terms such as partial sight, partial blindness, and poor vision are now disused and are clustered into the term low vision. Low vision encompasses parameters such as visual acuity, visual field, the ability to detect the presence or absence of light, the ability to detect the source and direction of light, lack of night vision, etc. More functional terms are now being proposed and employed such as "not enough vision to do whatever it is you need to do" (AFB, 2019, A Functional Definition of Low Vision, second bullet point). These variations are subsumed under the study participant selection criteria in toto.

The term visually impaired is sometimes utilized to include individuals who are blind (without any light perception). Objections exist as to this inclusive use of visually impaired and those are based on the contention that having no vision whatsoever merits distinct and special consideration.

This study maintains the distinction between blind and visually impaired.

Participant selection was not based in any manner upon whether an individual was blind or visually impaired.

Participant gender criterion.

The worldwide ratio of male to female individuals who are B/VI is 55% female to 45% male. The higher number of B/VI females is attributed to females outliving males which effectively provides more time in which to acquire an eye condition and more time to remain alive to be counted. In some countries, women may have less access to eye care and presumably are more likely to acquire a vision condition.

When age-standardized, the male to female ratio for B/VI is 1 male to every 1.07 females (Bourne, Resnikoff, & Ackland, 2015). This study has a ration of 50% Male: 50% Female.

Participant age criteria.

This study selected individuals who are between eighteen and seventy years of age. The lower figure was linked to participants having at the minimum attained adult legal status.

Sources of participants.

The study employed the snowball technique whereby each contact was solicited for referrals to additional contacts as potential participants and was very effective in obtaining participants.

Adapted non-discrimination statement.

Individuals who are neither legally blind nor visually impaired were excluded from this study as not meeting participant selection criteria. Also excluded from consideration were individuals who are less than eighteen years of age and individuals who are more than seventy years or age. With those exceptions, the criteria for participation in the study is otherwise non-discriminatory.

Discrimination based on the following factors was prohibited in this study: an individual who is blind or visually impaired with an additional disability or disabilities and, "race, color, national origin, religion, sex, gender identity (including gender expression), sexual orientation, marital status, family/parental status, income derived from a public assistance program, political beliefs, as a reprisal or retaliation for prior civil rights activity, or requiring alternative means of communication." (United States Department of Agriculture, n.d.)

Institutional review board (IRB) study information.

Concurrence of Exemption, IRB-20-03-1932-B3 Expedited. August 05, 2020.

Scheduling the Interview Sessions

During the study, the LPC, continued to provide counseling sessions to her regular clients. However, the LPC made available a variety of dates and times for participant sessions in her schedule. The participants were then presented with a choice of available sessions and scheduling the sessions presented little problem.

Investigation Guide

The CDC survey instrument (CDC, 2011) served as the investigation guide. The SI allowed the data to be gathered in a methodological manner, kept the sessions focused, and provided structure keeping the sessions on track.

Field Notes

Field notes were also taken to assist in analyzing and interpreting the data that was collected.

Reflexivity Journal

The Reflexivity Journal provided a vehicle for reflections precipitated by the study but not integral to the study.

Study Steps as Experienced by the Typical Participant

- An initial list of three potential participants was compiled through a social media website of a handful of individuals who were alumni from a state school for the blind and who were relatively certain to conform to the Participant Selection Guide as to age and vision status.

- Those individuals were contacted, the study was explained to them, and they were invited to participate in the study.

- The Information Sheet explaining participant rights and safeguards was read to each individual (with one exception who preferred reading it for himself) and the information sheet was sent to all the participants via email as well. At the very beginning of each

session, with the LPC on the line as a witness, each participant acknowledged both having had the information sheet read being read to them and having received the information sheet. Each participant confirmed that they understood and agreed with the Information Sheet and that they gave informed consent to participate in the study.

- Participants were typically requested for referrals to other potential participants. That technique proved very effective in recruiting participants.

- Meeting dates and times were mutually agreed upon between the participant and the PI for appointments made available by the LPC in her schedule.

- The sessions were transcribed by the PI and audio recorded.

- Participants were verbally administered the survey instrument over the telephone in three-way conference mode. The more routine questions (year of birth, sex, etc.) were posed by the Principal Investigator (always under the supervision of the LPC) and the more sensitive questions (e.g., Did you ever want to hurt yourself or others?) were posed by the LPC.

- Emergent data was followed up by either the Principal Investigator (continually under LPC supervision) and/or the LPC during the session.

Data Analysis

Participant responses to items on the survey instrument were transcribed by the PI and the sessions were also audio recorded. That data is reported out in Chapter Four. Discussion of the data is in Chapter Five.

The CDC Data Elements below are not included in this study. These data elements seek data surrounding a suicide event. Fortunately, no suicides were encountered during this study rendering these specific data elements extraneous.

CDC Data Element # 12
CDC Data Element # 13
CDC Data Element # 14
CDC Data Element # 15
CDC Data Element # 16
CDC Data Element # 17
CDC Data Element # 18
CDC Data Element # 19
CDC Data Element # 20
CDC Data Element # 21
CDC Data Element # 22
CDC Data Element # 24
CDC Data Element # 25
CDC Data Element # 3

B/VI Cognition

We are unable to examine the inside of reality bubbles; we are limited to observing their external manifestations. We collected and examined B/VI statements about themselves that were made during the interview sessions that were not necessarily responses to the survey instrument questions, but did revolve around the issues of suicide risk factors and protective supports.

When the statements were grouped by commonalties, themes emerged very similar to the structure of the themes in the data elements. The themes, or tropes, provide us with clues as to the nature of the participants' cognitive processes concerning suicide risk factors and protective supports.

Those emergent tropes are of considerable interest and significance to the study.

Chapter Four - Results

Data

Session Duration (This data is unique to this study. It is not a CDC Data Element.)

Session Duration in Minutes		
Mean	**Median**	**Mode**
39.8 minutes	43.5 minutes	45 minutes

Please note: The duration for two of the sessions were not logged due to PI error such as entering a 'start' time and then not recording a 'stop' time. Those two sessions and are not included in the above calculations.

CDC Data Element #1: Case ID

This Data Element refers to the in-study identifier assigned to each Participant to provide for confidentiality. The identifier is the date of the interview session (e.g., 9-14-20). On those days where there was more than one session, a letter suffix was added (e.g., 11-19-20-B…).

CDC Data Element #2: Data Source

CDC Code: 11: Other agency or data source

The Data Source identifies the agency or source of the Participant data. In this study the Data Source is the Principal Investigator.

CDC Data Element #3: Sex

Sex of Participants		
Gender	**# Of Participants**	**% Of Participants**
Male	10	50%
Female	10	50%
Total	20	100%

CDC Data Element #4: Age

Ages of Participants												
Age	28	36	40	47	53	58	62	64	66	67	68	69	70
n	1	1	1	1	1	1	2	4	2	1	1	3	1

Ages of Participants		
Mean	**Median**	**Mode**
59.35	64	64

CDC Data Element #5: Race

Per the CDC: "The Office of Management and Budget prefers that data on race and ethnicity be collected separately."

Race of Participants		
Race	**# Of Participants**	**% Of Participants**
Black	8	40%
White	11	55%
Declined to Specify	1	5%
Total	20	100%

CDC Data Element #6: Ethnicity

The OMB Statistical Policy Directive Number 15: Race and Ethnic Standards for Federal Statistics and Administrative Reporting provides for two basic ethnic categories – *Hispanic* and *Not of Hispanic Origin.*" (CDC, 2011, p. 32)

Ethnicity		
Race	**# Of Participants**	**% Of Participants**
Hispanic	0	0%
Not of Hispanic Origin	19	95%
Declined to Specify	1	5%
Total	20	100%

CDC Data Element #7: Marital Status

Marital Status of Participants		
Status	**# Of Participants**	**% Of Participants**
Separated	0	0%
Divorced	6	30%
Married	4	20%
Single	7	35%
Widowed	2	10%
Cohabitating	1	5%
Total	20	100%

CDC Data Element #8: Residence

This study adopted the residence criteria from the U.S. Census (2020).

Residence of Participants		
Type	**# Of Participants**	**% Of Participants**
Urbanized Area	18	90%
Urban Places	0	0%
Rural Places	2	10%
Total	20	100%

CDC Data Element #9: Education

Participant Educational Levels		
Educational Level in Years	**# Of Participants**	**% Of Participants**
12	2	10%
13	3	15%
14	3	15%
15	1	5%
16	2	10%
Greater Than 16	9	45%
Total	20	100%

Participant Educational Levels	
Median	**Mode**
16 years	Less Than 16 years

CDC Data Element #10: Occupation

Description of Occupation / Status	# Of Participants	% Of Participants	O*NET Industry Code
Summary of Participant's Occupations			
College Student	1	5%	-
Disabled. Never employed.	1	5%	-
Caretaker and Building Maintenance	1	5%	37
Executive Assistant	1	5%	43
Legal Services	1	5%	23
Residential Care Aide	1	5%	31
Security	1	5%	33
Management	2	10%	11
Health Care and Social Assistance	2	10%	21
Sales and Related Occupations	3	15%	41
Therapeutic Services	3	15%	29
Professional Support Services	3	15%	25
Total	20	100%	

The participants were coded as to their current employment or their employment immediately prior to their retirement.

CDC Data Element #23: Self Directed Violence (SDV) Category

<table>
<tr><td colspan="4">Classification of Participants in Self-Directed Violence Categories</td></tr>
<tr>
<th>Participant</th>
<th>CDC Data
Value Code</th>
<th>Description</th>
<th>Narrative</th>
</tr>
<tr>
<td>a.</td>
<td>3</td>
<td>Non-fatal undetermined SDV.</td>
<td>Admits to hurting self "every once in a while."</td>
</tr>
<tr>
<td>b.</td>
<td>3</td>
<td>Non-fatal undetermined SDV.</td>
<td>Ingested 5 to 7 aspirin as teenager (54 years ago).</td>
</tr>
<tr>
<td>c.</td>
<td>1</td>
<td>Non-suicidal SDV.</td>
<td>Tried to intentionally break arm at age 19-20 (45 years ago) as a "cry for help".</td>
</tr>
<tr>
<td>d.</td>
<td>3</td>
<td>Non-fatal undetermined SDV.</td>
<td>Took razor to wrists "but not deep" (48 years ago).</td>
</tr>
</table>

CDC Value Code 1: Non-suicidal self-directed violence.

CDC Value Code 3: Undetermined self-directed violence.

The CDC indicates that self-directed violence (SDV) is a behavior that deliberately results in injury or the potential for injury to oneself irrespective of suicidal intent. The determination of the category of a SDV event is critical to treatment and prevention decision making. In the case of four of the participants:

- One event was non-suicidal as the SDV was not life threatening.

- Two events were coded as suicidal based solely on participant stated intent.

- One event was undetermined because the connection to SDV was not clear.

Of all the Data Elements, this element was singled out by the CDC (2011): "Sensitivity, and confidentiality must be exercised in collecting information from persons who have already undergone trauma from a violent event. Persons who gather injury information must be empathetic and well-trained" (p.53).

CDC Data Element #26: Medical/Somatic History

Self-Reported Presence of Medical / Somatic History		
Participants Responding:	**# Of Participants**	**% Of Participants**
Yes	19	95%
None	1	5%
Total	20	100%

CDC Data Element #27: Psychiatric History

Self-Reported Presence of Psychiatric History		
Participants Responsing	**# Of Participants**	**% Of Participants**
Yes	12	60%
No	8	40%
Total	20	100%

CDC Data Element #28: Previous Non-Fatal Self-Directed Violence

The CDC defines this data element as being *the actual number* of previous events of non-fatal self-directed violence.

Presence of Non-Fatal Self-Directed Violence		
Responses	**# Of Participants**	**% Of Participants**
Yes	4	20%
None	16	80%
Total	20	100%

Of the four participants responding "yes" to non-fatal SDV episodes, the actual number of SDV events follow:

Episodes of Non-Fatal Self-Directed Violence		
Participant	Actual Number of Reported SDV Events	CDC Response Code
a.	Unknown	Code 9
b.	1	Code 1
c.	1	Code 1
d.	1	Code 1

Code 1: Individual has engaged in 1-2 events of SDV ever.

Code 9: Unknown how many events of SDV have occurred.

Nonfatal self-directed violence refers to actions that may be either suicidal or non-suicidal. Per the CDC (2011), "A history of one or more incidents of self-directed violence is a risk factor for subsequent fatal and nonfatal suicidal behavior" (p. 59).

Any self-reporting of SDV is non-fatal and this study did not encounter any incidences of fatal SDV. A brief narrative concerning the four participants who did report previous SDV follows:

- One participant (now in her 60s) when asked if she ever intentionally hurts herself reports that she does "every once in a while". It was not specified how she hurts herself. She describes thoughts to hurt herself as "a bit longer than fleeting". She had seen a psychiatrist in the past. She is currently on medication for depression. She has been seeing a therapist for an extended period. While presently the therapy is not on a regular basis, she is able to reach out to the therapist over the phone due to the pandemic and has indicated that she has done so. (Mental health support was extended.)

- An attempt took place at sixteen years of age (participant is now in her 60s, so at least forty-four years previously) after a breakup with a boyfriend. The participant took "five to seven aspirin" causing her to "sleep for a while".

- At the age of nineteen or twenty (participant is now in her 60s, so at least forty years ago), participant attempted to break her arm as a self-described "cry for help".

- At fifteen years of age (participant is now in her 60s, so at least forty-five years earlier) the participant took a razor to both wrists. The cuts were "not deep". She fell asleep. Upon waking "I cleaned myself up." The participant gave no indication of subsequent treatment, therapy, or parental reaction.

CDC Data Element #29: Previous Suicidal Thoughts or Ideation

Participants Reporting Previous Suicidal Thoughts or Ideation		
Participant Responding:	**# Of Participants**	**% Of Participants**
Yes	9	45%
No	11	55%
Total	20	100%

Participants responding 'yes' to having had suicide ideation.

- Suicide ideation occurred "years ago". Participant called a hotline and the impact of the effects of suicide that were revealed to her during that telephone conversation were sufficient to end her ideation episode. The impression that was transmitted is that she was 'scared straight'. Current age: 40s.

- "Happened in high school." Current age: 30s. Ideation episode estimated to have taken place approximately fifteen years prior to the time of the study interview session.

- "The thoughts to hurt myself are a bit longer than fleeting. They come and go." Current age: 60s.

- "Over six years ago. I had no plan." Current age: 60s. The comment about not having a plan is interesting because it was neither solicited nor prompted. It would imply that the participant was perhaps aware of the various elements of suicide.

- "Eight years ago, when I first lost my sight, I thought about it a lot. But it is not really an 'out'." Current age: 50s.

- "It happened years ago" while in elementary school, current age: 60s. The ideation episode is estimated to have taken place no less than forty-six years prior to the session.

- "I was 17 and in high school, I heard (a song) on the radio and changed my mind." Current age: 60s. The ideation episode is estimated to have taken place no less than forty-three years prior to the session.

- "At age twenty-eight…" Current age: 60s. Ideation episode estimated to have taken place approximately thirty-two years prior to the session.

- "When I lost my vision (eight years ago) the thought came and went; it didn't linger."

A sampling of participants responding 'no' to having had suicide ideation.

- "No Way."

- "It was a sporadic, random thought. It went away. How did I think of that? A moment translated into negativity."

- "Never. Me? I love me. Never. Ever. Maybe someone else (laughing)."

- "I never thought of suicide."

- "No suicidal issues except with chronic pain. I understand intellectually but emotionally I find it hard to understand." This response is of interest as it captures the dialectic of the logical and rational perspectives towards suicide.

The participants who were not asked or did not report suicide ideation.

- One participant, age 69, is a recurring outlier previously discussed and was described as "Buddha-Like". He is listed as 'Not Asked – None Reported'.

- This participant in her 50's indicated having no psychiatric history. Her only reported stress factors are recent and are centered around the Pandemic, specifically not being able to go out to movies, job being shut down, and not seeing friends as often. Referring to this specific participant the LPC stated that "normal stress (referring to the effects of the Pandemic) is not a mental health issue" and that the participant "has lots of preventive factors." She is listed as 'Not Asked – None Reported."

- This participant in her 60's had spontaneously indicated she had "never thought of suicide". She has been listed as 'Not Asked – None Reported."

- This individual, in their 60s, had one suicidal "…thought that came and went and didn't linger." This episode took place eight years prior to the session. This participant has been listed as 'Not Asked – None Reported."

As previously discussed, the last participant presents not so much as having suicide ideation as it might be characterized that they had a passing thought of 'not living'.

Discussion as to 'not asked / none reported'.

Based on participant factors such as number of protective supports as well as participant comportment and demeanor during the session; some questions would risk rupturing the relatively

fragile rapport that had been established between the participant, the LPC, and the PI. This is congruent to asking a vegan their favorite hamburger restaurant. The nature of the question would certainly surprise the vegan and lead them to question if the other party had been listening to anything they said. In the context of an initial meeting, the rapport would be significantly damaged, certainly for the remainder of that session. In the instance of four of the participants, that is like asking if they ever thought about suicide. Certainly, a point could be made that the vegan may have had a favorite hamburger place prior to becoming a vegan, and these four participants may have passed through a phase of thinking about suicide to get to the point they are at. That information is of considerable interest and would be best harvested in a subsequent session.

The fragility of the rapport is solely due to the short amount of time of the interview sessions. Keep in mind that while the sessions averaged forty minutes, constructing the rapport had to be initiated considerably early in the session, typically within the first five minutes. It is a testament to the skill and experience of the LPC to be able to go from a first introduction to a point where the participant is comfortable responding to questions such as asking if they ever considered hurting themselves or others; and this over the phone.

Fragile also because the study was delving into what are unquestionably very personal questions with potentially significant emotional impact, so much so that a Licensed Professional Counselor was an IRB requirement of the protocol. Establishing a degree of rapport and trust was critical. Several participants indicated that they had never admitted some responses to anyone, ever. To mechanically ask an interview question that was incongruous to the aura of trust that had been established would have been counterproductive to gathering rich and thick data.

In addition to respecting the participant's individuality, heeding the contextual considerations addressed above, and the presence of protective supports are additional justification for not asking those four participants if they had ever engaged in suicide ideation.

CDC Data Element #30: Family Medical / Psychiatric History

Self-Reported Medical / Psychiatric Family History		
Response	# Of Participants	% Of Participants
Yes	16	80%
No	2	10%
Not Addressed	2	10%
Total	20	100%

The CDC indicates:

> Research has established associations between parental psychopathology and their offspring's suicidal behavior. There is also limited evidence to suggest that a family history of suicidal behavior is associated with increased risks of suicidal behavior among a variety of relatives. (p. 61).

As we have seen for the two previous elements, without criteria and/or without professional certification, the responses reflect the various interpretations of the participants.

CDC Data Element #31: Sexual Orientation

<table>
<tr><td colspan="3" align="center">Participant Sexual Orientation</td></tr>
<tr><td align="center">Orientation</td><td align="center"># Of Participants</td><td align="center">% Of Participants</td></tr>
<tr><td>Heterosexual</td><td align="center">16</td><td align="center">80%</td></tr>
<tr><td>Homosexual</td><td align="center">-</td><td align="center">-</td></tr>
<tr><td>Bisexual</td><td align="center">-</td><td align="center">-</td></tr>
<tr><td>Transgender</td><td align="center">-</td><td align="center">-</td></tr>
<tr><td>Something Else</td><td align="center">-</td><td align="center">-</td></tr>
<tr><td>Unknown/Not Stated</td><td align="center">4</td><td align="center">20%</td></tr>
<tr><td>Total</td><td align="center">20</td><td align="center">100%</td></tr>
</table>

The responses from four members of this older population appear attributable to the ambiguity of the question as to sexual orientation which anticipated responses such as 'heterosexual' or 'homosexual'. Here, it was as if the participants interpreted the question of sexual orientation to be inquiring as to "Which gender do you belong?", to which they indicated "I am male" or "I am female" which belies the intent of orientation. Those four individuals were included in the 'Unknown/Not Stated' category.

CDC Data Element #32: Military Service

None of the study participants served in the military.

CDC Data Element #33: Proximal Risk Factors

<table>
<tr><td colspan="3" align="center">Participants Indicating the Presence of Proximal Risk Factors</td></tr>
<tr><td align="center">Presence of Risk Factors</td><td align="center"># Of Participants</td><td align="center">% Of Participants</td></tr>
<tr><td align="center">Yes</td><td align="center">19</td><td align="center">95%</td></tr>
<tr><td align="center">No</td><td align="center">1</td><td align="center">5%</td></tr>
</table>

The number of proximal risk factors expanded from the fifteen (15) suggested by the CDC to forty-eight (48) as the result of coding that evolved during the sessions with the participants.

		Rank Order of Stress Factors by the Number of Participants Reporting That Risk Factor At Least Once			
I.D.	**Code**	**Risk Factor**	**Rank Order**	**n**	**%**
i	SOM	**PHYSICAL HEALTH ISSUE.** Health concern, debilitating condition, terminal disease. (CDC Risk Factor Code: #1 of 12.)	1st	18	90%
ii	MH2	**MENTAL STRESS ISSUE.** Includes terms such as: stress, anxiety, distress, frustration, anger, resentment, hostility, upset, fear, panic, avoidance, impulsivity, desire to escape.	2nd	15	75%
iii	MH1	**DEPRESSION ISSUE.** Includes terms such as: sadness, grief, crying, worry, guilt.	3rd	14	70%
iv	CUR1	**CURRENT EVENTS: PANDEMIC.** Limited social opportunities, sorties, mobility.	4th	13	65%
v	MH	**MENTAL HEALTH ISSUE: NOT OTHERWISE SPECIFIED.** Includes phobias.	5th	12	60%
vi	MH6	**MENTAL HEALTH ISSUE INVOLVING FAMILY**. Family as the cause of the participant's health or mental health issue(s) or a family member's health or mental health issue(s) affecting the participant.	5th	12	60%
vii	SU1	**SUICIDE IDEATION.**	6th	10	50%
viii	SOC1	**DEATH OF A FRIEND OR FAMILY MEMBER**. (CDC Risk Factor Code #8 of 12.)	6th	10	50%
ix	UNJ	**UNJUSTICE**. B/VI Specific. Not being provided with mandated adaptations, being taken advantage of, victimization.	6th	10	50%
x	VUL	**FEELING OF VULNERABILITY.** B/VI Specific. This factor affects self-esteem and a potential segue to trauma, which renders this an über factor.	6th	10	50%

		Rank Order of Stress Factors by the Number of Participants Reporting That Risk Factor At Least Once (continued)			
I.D.	**Code**	**Risk Factor**	**Rank Order**	**n**	**%**
xi	SOC7	**FEELING OF INCOMPETENCY**. B/VI Specific. This is typically due to being put in a position to be portrayed as incompetent or deemed incompetent by association with being blind.	7th	9	45%
xii	SOC4	**STRESS FROM AN ISOLATION ISSUE**. Includes: living alone, unable to socialize due to the Pandemic, mobility, or transportation issue.	8th	8	40%
xiii	MH3	**PERSONAL ADJUSTMENT ISSUE**. Issues involving adjustment to B/VI condition.	9th	7	35%
xiv	TRA1	**CHILDHOOD TRAUMA: OUT OF SCHOOL.** Bullying, teasing, neglect, parent divorce or illness, verbal/physical/emotional abuse.	9th	7	35%
xv	SOC5	**ISSUE INVOLVING SIGNIFICANT OTHER.** Social situation involving intimate partner such as a divorce, breakup, discord. (CDC Risk Factor Code #2 of 12.)	9th	7	35%
xvi	STG	**STIGMA OR ONUS OF BEING BLIND OR VISUALLY IMPAIRED.** B/VI Specific. Not being understood, being overprotected, not being accorded respect.	9th	7	35%
xvii	MH4	**SELF-CONCEPT ISSUE.** Issue involving self-esteem, self-worth, insecurity.	10th	6	30%
xviii	MH5	**FEELING OF INADEQUACY ISSUE.** This is often linked to another issue such as B/VI Stigma and Onus.	10th	6	30%
xix	TRA	**TRAUMA: NOT OTHERWISE SPECIFIED**. Participant as a victim of trauma unspecified elsewhere.	10th	6	30%
xx	SOC6	**RELATIONSHIP ISSUE – NOT OTHERWISE SPECIFIED.** E.g.: family argument. (CDC Risk Factor Code #3 of 12.)	11th	5	25%

		Rank Order of Stress Factors **by the Number of Participants Reporting That Risk Factor At Least Once** **(continued)**			
I.D.	**Code**	**Risk Factor**	**Rank Order**	**n**	**%**
xxi	PVAS	**INESCAPABLE PERVASIVENESS OF THE CONDITION.** B/VI Specific. Continual, insidious, unrelenting element. Includes exposure to or effects of Ableism.	12th	4	20%
xxii	SU3	**SUICIDE IN THE PAST BY A FAMILY MEMBER OR BY A FRIEND.**	13th	3	15%
xxiii	SA	**SUBSTANCE ABUSE: UNSPECIFIED.**	13th	3	15%
xxiv	SA1	**SUBSTANCE ABUSE: ALCOHOL.**	13th	3	15%
xxv	SU2	**SUICIDE BEHAVIOR.**	13th	3	15%
xxvi	SOC3	**STRESS FROM A SOCIAL SITUATION INVOLVING PEERS.**	13th	3	15%
xxvii	LEG3	**LEGAL ISSUE - NOT OTHERWISE SPECIFIED.** Includes: custody dispute, civil lawsuit, committed to hospital, ward of the court, class action suit, civil rights. (CDC Risk Factor Code #10 of 12.)	13th	3	15%
xxviii	FIN	**FINANCIAL ISSUE.** Includes: bankruptcy, debts, foreclosure, selling/buying house. (CDC Risk Factor Code #6 of 12.)	13th	3	15%
xxix	CUR2	**CURRENT EVENTS: NATIONAL AND/OR INTERNATIONAL POLITICAL SITUATION.**	13th	3	15%
xxx	EMP1	**UNEMPLOYMENT ISSUE.** Self-explanatory. This is concerned with not having a job or not being able to get a job.	14th	2	10%

		Rank Order of Stress Factors by the Number of Participants Reporting That Risk Factor At Least Once (continued)			
I.D.	**Code**	**Risk Factor**	**Rank Order**	**n**	**%**
xxxi	TRA2	**NON-CHILDHOOD TRAUMA.** Participant as a victim of trauma.	14th	2	10%
xxxii	SA2	**SUBSTANCE ABUSE: DRUGS.**	14th	2	10%
xxxiii	SIB	**SELF-INJURIOUS BEHAVIOR – WITHOUT SUICIDAL INTENT.** Includes: cry for help.	14th	2	10%
xxxiv	SOC2	**STRESS FROM SOCIAL OR PUBLIC SITUATION(S).**	14th	2	10%
xxxv	VIO2	**PARTICIPANT AS VICTIM OF INTERPERSONAL VIOLENCE.** Includes: intimate partner, child maltreatment, sexual violence, etc. (CDC Risk Factor Code #12 of 12.)	14th	2	10%
xxxvi	EMP	**EMPLOYMENT ISSUE – NOT OTHERWISE SPECIFIED.**	14th	2	10%
xxxvii	CUR	**CURRENT EVENTS – NOT OTHERWISE SPECIFIED.**	14th	2	10%
xxxviii	CUR3	**CURRENT EVENTS: UNITED STATES 2020 PRESIDENTIAL ELECTION.**	14th	2	10%
xxxix	EMP2	**JOB ISSUE.** Includes: layoff, job pressure, situations at work. (CDC Risk Factor Code #4 of 12.)	15th	1	5%
xl	OII	**IDEATION TO INJURE OTHERS.**	15th	1	5%

		Rank Order of Stress Factors **by the Number of Participants Reporting That Risk Factor At Least Once** **(concluded)**			
I.D.	**Code**	**Risk Factor**	**Rank Order**	**n**	**%**
xli	OIA	**ACTION TO INJURE OTHERS.**	15th	1	5%
xlii	SU	**SUICIDE ISSUE – NOT OTHERWISE SPECIFIED.**	15th	1	5%
xliii	LEG1	**LEGAL ISSUE: CRIMINAL.** Includes: recent or impending arrest, police action, committing a crime, jail, criminal court date. (CDC Risk Factor Code #9 of 12.)	15th	1	5%
xliv	LEG2	**LEGAL ISSUE: FAMILY.** Includes being the progeny of a plaintiff in a civil lawsuit for integration.	15th	1	5%
xlv	VIO	**INTERPERSONAL VIOLENCE - NOT OTHERWISE SPECIFIED.**	15th	1	5%
xlvi	SCH	**SCHOOL RELATED ISSUE.** Includes: academic pressure, bullying, failure. (CDC Risk Factor Code #5 of 12.)	15th	1	5%
xlvii	SU4	**RECENT SUICIDE BY A FAMILY MEMBER OR BY A FRIEND.** (CDC Risk Factor Code #7 of 12.)	-	0	0%
xlviii	VIO1	**PARTICIPANT AS PERPETRATOR OF INTERPERSONAL VIOLENCE.** Includes: intimate partner, child maltreatment, sexual violence, etc. (CDC Risk Factor Code #11 of 12.)	-	0	0%

Number of Participants Reporting a Given Risk Factor At least Once		
Mean	**Median**	**Mode**
5.13	3	2

As employed in this study, proximal risk factors refer to situations that produce stress and/or anxiety as reported by the participants. A larger perspective is gained if the data is tallied by groups, such as adding all SUs (suicide), or LEGs (Legal issues). It is left to the reader to pursue that course, should they so choose.

Not a Drive Thru

In some ways, charts and tables are the fast food of research. Instead of chicken or beef, they process data and package summaries that are eminently suited for obtaining a global perspective of a particular phenomenon. They get the job done. But that two-dimensional data is typically thin and poor in capturing and transmitting human portraits from whence the data emanates.

To capture the experience of a Moroccan lamb tagine with preserved lemons and Kalamata olives requires savoring. This is beyond just getting the job done. This is seeing behind the data and connecting with the people who are overcoming inhibitions and are sharing their lives, some admitting to it being the first time they have shared certain particulars of their lives. To confine their data to a table would not be to honor them.

Their sharing is more than an academically sanctioned nosy peek into other people's business. It will rapidly become apparent how much more their statements transform the data to being thick and rich (Charmaz, 2014), at which Grounded Theory excels.

The research perspective will follow later in Chapter Five, after we have savored what we are being told.

The following sections contain the participants' statements from the interview sessions and are directly referenced to the above table

i. Physical Health Issue - 90% (SOM).

The participants are older with an average of 59 years of age, which is a tendency of the Snowball technique. Health issues tend to accumulate as we age, and they take first place as a stress factor in this older B/VI population.

Rank Order: Number of Participants Reporting the Indicated Health Concern		n
1.	Blindness / vision	9
2.	Diabetes	6
3.	Hypertension	4
4.	Aging (aches and pains)	3
5.	Arthritis	2
5.	Asthma	2
5.	Back Pain	2
5.	Hearing Loss	2
5.	Thyroid	2
6.	Allergies/Sinus	1
6.	Cholesterol	1
6.	COPD	1
6.	Dental	1
6.	Emphysema	1
6.	Heart bypass	1
6.	Heart valve replacement	1
6.	Kidney failure (dialysis)	1
6.	Leukemia, chronic lymphocytic	1
6.	Lymphoma, Hodgkin's	1
6.	Overweight	1
6.	Prostate cancer	1
6.	Tinnitus	1

The grouping of health concerns suggests itself such as Asthma, COPD, and emphysema, or Heart bypass and heart valve replacement. It is left to the reader to pursue that course should they so choose.

ii. Mental Stress Issue - 75%. (MH2)

The number and variety of issues causing stress is indicative of its effect on the participants. Some, like divorce, causing stress is not unexpected. Other B/VI issues may be illuminating for the sighted such as: mobility issues, being misunderstood by the sighted, unjust situations, and anxiety over unstable vision.

- "Dealing with the public may cause distress." (Being misunderstood.)

- "Since I became blind five years ago, I have noticeable generalized anxiety with loneliness, overthinking interactions, and social settings."

- "I have had depression and anxiety most of my life."

- "I turned the world off and went inside myself. I can still do it short term."

- "I was avoiding situations, like divorce (with drugs and alcohol)."

- "Mobility is frustrating."

- "I have asthma and I had to go out wearing a mask. I had my first panic attack. Then I went through a smoking situation, and I had another panic attack."

- (Baby sister moves in with participant due to baby sister's health issues.) "During that time, I went for counseling as I was angry with her for not taking care of herself."

- "My mother passed, and we are cleaning out her house. That's a stressor."

- "Having low vision is an emotional roller coaster; it is always in the back of your mind that you could lose the remainder of your sight."

- "I have had sadness. I have been angry since but not to hurt anyone."

- "I get angry when my ex-wife tries to use me. Stress comes when I make a decision without thinking about it for two to three weeks."

- "I have been diagnosed with anxiety."

- "I had a lot of anger. I am frustrated people don't ask what you can see."

- "There are times I have wanted to smack people. I get angry, frustrated, and annoyed." (Being misunderstood.)

- "I get anxiety related to my visual impairment."

iii. Depression Issue - 70%. (MH1)

There are depression issues related to B/VI, such as losing vision, but there are also indications that the B/VI and sighted share causes of depression such as the death of a loved one and despair.

- "The world and politicians put me in a state of sadness. Elections alone can make me sad."

- "My Dad came into my room and saw me sobbing." (From depression.)

- "I did experience depression prior to losing my vision (five years ago)."

- "I have had depression. I am on medication for depression."

- "When I was at rock bottom I had nowhere to go."

- "I have depression but that is how it is. We had a young lady who didn't want to come to the support group. Both eyes had been removed. A week after she agreed to attend, she died. I get so depressed."

- "The school did a lot of Father/Daughter things that I could not participate in because of the death of my father."

- "I do a lot of crying."

- "I went through the grief process once (after losing vision)."

- "In 2012 (when vision was lost) I thought my life came to an abrupt end."

iv. Current Event: Pandemic - 65%. (CUR1)

Stress and Depression appearing at the top of this list is not surprising but the newcomer

Pandemic elbowing its way in to join them is interesting.

- "Covid has been a little difficult."
- "I consult on phone (with therapist) due to Covid."
- "I am being restrained by Covid."
- "Covid is a little bit (of a suicide risk factor)."
- "I was reluctant to go out."
- "I have asthma and have to wear a mask."
- "I thought it would be a week or two."
- "Covid did change my lifestyle."
- "Covid interferes with my self-care (socialization)."

v. Mental Health Issue – Not Otherwise Specified – 60%. (MH)

The most common antagonists are people, and in several instances, parents.

- "I didn't want to have people around me so they didn't stop hanging about me."
- "It can arise at any time, then something a waiter says or a song line puts me into a (mood)."
- "I wasn't liked by my parents because I was a troublemaker."
- "Both parents worked in the same city (as residential school for the blind) but they didn't visit me."
- "(I lost my hearing in left ear due to virus three years ago.) I waited for it to return but it doesn't."
- "(I tried to break my arm.) It was a cry for help."
- "In 1990 I had a mental melt down." (Due to multiple events.)
- "I had a phobia related to my vision."
- "I did have Seasonal Affective Disorder."

vi. Mental Health Issue Involving Family – 60%. (MH6)

Comments about 'family' includes issues with both immediate and extended family.

- "I was happy to be away from home. My Dad scared the hell out of me. (My parents) talked (her brother) into stopping his insulin."
- "My father was an alcoholic."
- "My maternal aunt had mental issues. It was very stressful on family. I wound up being her caretaker. She had to move in with me."
- "For some aunts, uncles, and cousins, their elevator didn't go to the top floor."
- (Dad said grandfather shot himself.) "An uncle was adamant it was an accident. It was after the Great Depression." (There are reports of suicides by providers during the depression to enable survivors to receive public assistance.)
- "Parents divorced when I was young."
- "My brother has tendencies for suicidal issues."
- "My father was passive, and my mother had issues."
- "Adopted daughter has multiple personality disorder, suicide ideation, suicide attempt, physically and mentally abused by boyfriend, put baby up for adoption, and was cutting self."
- "I was co-dependent with my mother. My son is in recovery. I was molested as a child."
- "My mother was schizophrenic."

vii. Suicide Ideation - 50%. (SU1)

These are, of course, the comments of individuals who did not suicide. It would be of great value to determine why the suicide process did not proceed.

- "I had thoughts of never being here anymore but never acted on it."
- "It was a sporadic, random thought. I was questioning my existence. I would be better if I was not here."
- (Thoughts about hurting myself…) "They come and go."
- "I never had a plan, but I had the means." (Pills.)

- "When it first happened (lost vision), I thought about it a lot." ("But it is not really an 'out'.")

- "I thought about hurting myself, years ago."

- "The only time I even contemplated it was at age sixteen when a boyfriend said we weren't going to talk anymore."

- "I had negative thoughts."

- "I had lots of money, dope, and a gun to choose from."

- "I didn't want my kids or sister to know I was thinking of suicide. The thought came and went and didn't linger."

viii. Death of a Friend or a Family Member – 50%. (SOC1)

Death is a significant event. When it is a friend or family member it often leaves a void to which one must accommodate.

- "When I was three years old my mom passed, and I had separation anxiety for a short period."

- "Mom died when I was in the hospital."

- "Two brothers are dead. (My) baby sister is dead."

- "Lost my dad in January 1984. Lost my only son in 2009…. My Aunt passed four or five years ago."

- "My Father died when I was seven. I have had a few losses. Some friends, my companion. People die alone (Pandemic) and you can't say good-bye."

- "Dad died at eighty-seven. Mom died last year."

- "My Father died last year; his death hasn't healed."

- (Husband passed fourteen months prior to session.) "…I did not think…(it) would happen."

- "Both (of my) parents are deceased. We lost two babies."

ix. Unjustice – 50%. (UNJ)

This is one of five elements that emerged during the study that particularly apply to the B/VI. The quantity of comments is an indication of the prevalence of this item and its significance for this population.

- "When I confront people about how they are acting (towards me), they turn it towards me."

- "Just my luck… (losing vision). I was twenty-three. Others are getting B.A.s. going to Grad school. I had to adapt to adulthood and blindness, it is a lot. I am playing catch-up after taking a year off for (vision skills)."

- "In school, people did not understand (my son's vision problem)."

- "People think they are going to get support (being blind). There is no support from doctors about services available, etc."

- "I was at a party, and someone switched an old worn-out fur hat for my new fur hat. When I was moving, a woman took my ten-speed blender and left me an eight-speed blender."

- "Public schools are not doing their job. I don't know anyone blind under thirty who is working."

- "I have an affinity for Job in the bible." (Job is continuously beset with terrible losses and disasters.)

- "(Blind people) are cheated right out of the gate. (Potential employers ask) …What about Workmen's Compensation if he gets hurt? Will he sue them if he gets hurt?" (Then the B/VI is not offered the position.)

- "There were no braille voting ballots, kids get a raw deal learning science (the B/VI are often marginalized in education due to lack of adapted teaching materials), we need to get blind kids in development (blind are not included in design to ensure adaptations), (blind pedestrians have the right of way but are often found to be at fault when hit by a car)."

- "Due to lack of (educational) accommodations, I was considered to be 'lazy' since I couldn't get my work done."

x. VUL – Feeling of Vulnerability - 50%. (VUL)

This is one of five elements that emerged during the study that particularly apply to the B/VI. Comments in this category ranged from not being able to read the mail to being run over and killed as a pedestrian crossing the street.

- "Dealing with the public (as a B/VI) may cause distress. It becomes confrontational."

- (Participant views loss of vision) "…like being paralyzed, for instance. Being blind is scary."

- "I need help reading mail and writing checks."

- "We can't see to defend ourselves."

- (Being teased about blindness)" …was kind of rough."

- "I was at a party, and someone switched an old worn-out fur hat for my new fur hat. When I was moving, a woman took my ten-speed blender and left me an eight-speed blender."

- "If I am in an accident, there is no one to make decisions for me. I worry that if I cannot communicate, I don't have a person with my desires and preferences in mind."

- "Who can I get to take me somewhere?" (After passing of husband.)

- "I was molested as a child and my mother continued to take us there. I was often left in the care of others. I am visually impaired; I am more vulnerable."

- (Blind with a white cane have the right of way)" …my brother was in a crosswalk, crossing with the light, he had his white cane, and was hit by a car turning right on red. He had a knee and back injury."

xi. Feeling of Incompetency – 45%. (SOC7)

This is one of five elements that emerged during the study that particularly apply to the B/VI. The Feeling of Incompetency is B/VI specific and results from being put in a position to be portrayed as incompetent or deemed incompetent based on stereotypes associated with the B/VI.

- "Ninety per cent of the time people ask to help. I am not used to it. Waitresses don't directly talk to me."

- "Nobody thought I couldn't do anything."

- "You can't ask me, 'Why are you late?'." (Public transportation is so tenuous that asking why a B/VI individual is late is moot.)

- "People grabbing blind people to guide them. Talking to us like we are stupid."

- "Kids called me 'Hawk' or "Hawkeye' because of how I looked for my brother and sister. At 15-16 the big dream to drive a car wasn't possible."

- "Dad felt he had to take care of us."

- "Everyone wants to treat you special. (People would say) …look out for (name)."

xii. Stress from an Isolation Issue - 40%. (SOC4)

Due to the unknown influence of the Pandemic this factor may not be unique to this B/VI population.

- "Institutions (gym, library) have been closed down (Pandemic) that I was looking forward to getting started with."

- "I have generalized anxiety…since becoming blind due to loneliness. My niece and nephew said, 'You don't pray with us anymore.'"

- "I am not as sociable as when I was younger."

- "I stayed at home from March 23rd to May. People are not coming around visiting. I feel bad I have not been in a store this year." (Pandemic.)

- "People die and you can't say good-bye. You're stuck at home." (Pandemic.)

- "I was reluctant to go out. With Covid I don't go out much."

- "I was isolated in the midst of people. Loneliness, isolation are the worst."

xiii. Personal Adjustment Issue – 35%. (MH3)

This refers here to the emotional and psychological adjustment to B/VI.

- "Just because you are blind doesn't mean you can't be successful."

- "You can sit on the sidewalk and watch traffic pass you by or you can go with the traffic." (Traffic being an analogy for life.)

- "Playing catch up (with university studies) after taking a year off for (learning vision) skills."

- "90% of the time people ask to help. I am not used to it."

- "There are tools to use to advocate for yourself and being blind can be a positive experience."

- "Being without eye contact gets to me."

- "Mobility is frustrating."

- "At 15-16 the big dream to drive a car wasn't possible."

- "I entered vision rehab saying life is over…."

- "Mobility was an issue, personal needs was an issue."

- "In 2012 I thought my life came to an abrupt end."

- "I was unable to do football, wrestling, weightlifting. Wearing an adaptive lens contributed to my lack of emotional stability.

xiv. Childhood Trauma: Out of School – 35%. (TRA1)

Trauma is a part of existence and spares no one at any age and vision status.

- "I was diagnosed with a vision problem at age 13, but there were vision concerns since first grade."

- "When I was three years old my mom passed, and I had separation anxiety for a short period."

- "My Dad scared the hell out of me. He left black and blue marks with a belt. Verbal abuse was worse. Mother rejected me, pushed me away."

- (Kids on the playground) "…teasing about blindness." (As reported, this may have been bullying.)

- "Father died when I was seven years of age."

- ("I had a five-hour shootout with police) "…I was 14-15 years of age at the time. Mother put her freedom over the safety of her children (by leaving participant and his siblings in the care of a molesting relative) … it was hard to digest."

- (Mother was schizophrenic) "It was bad."

xv. Issue Involving Significant Other – 35%. (SOC5)

- "I was in a 'terrible' boyfriend relationship." (And had thoughts of never being here anymore….)

- "I was avoiding (abusing) situations, like divorce."

- "My ex-wife wanted a divorce after nineteen years; it was my second marriage. I get angry when my ex-wife tries to use me. I walked from my first marriage; my wife walked from my second marriage."

- (In 1990 I had a mental meltdown.) "…and a long-term relationship ended."

- "My wife moved to Texas." (While participant remains in Michigan.)

- (I am in recovery for thirty-six years.) "…I couldn't keep a relationship."

- (I had counseling related to marriage.) '…Only solution was a divorce."

xvi. Stigma or Onus of Being Blind or Visually Impaired – 35%. (STG)

This is the situation where individuals living life with limited or no vision are put into the position to counter challenges, whether intentional or unintentional, imposed by the sighted.

- "I learned that I have to disprove false beliefs and tell people I am visually impaired, but sighted people don't get 'partially sighted'."
- "(My father) wouldn't let me do anything. Didn't he trust I could (do things)?"
- "(People) talking to us like we are stupid."
- "I am an attorney and when an impatient judge yells at me because I am not doing what it looks like I should be able to do (because I present as sighted), it provokes a lot of old feelings."
- "I am always dealing with misperceptions of me."

xvii. Self-Concept Issue – 30%. (MH4)

While self-concept is an internal element, the comments indicate that self-concept is often a reflection of how we are perceived by others, as in most of the comments below.

- "It (blindness) is scary. But I radiated smiles and happiness, as if everything was fine."
- "My older brother told me Mom cried (about me being blind). Stupidity (in the world) raises my stress." ("Stupidity" was used to indicate lack of knowledge about the B/VI.)
- (I get so depressed when) "…people are not polite to me. When you stop seeing, people stop seeing you."
- "I am waiting for someone to say, 'you are OK'."
- (Being blind.) "I felt I wouldn't get married, have kids."
- "I haven't lived at home since I was thirteen years of age."

xviii. Feeling of Inadequacy Issue - 30%. (MH5)

This factor is linked to the stigma or onus of being blind or visually impaired. It also addresses the role of overprotectiveness.

- "I would get all A's and one B, and he (Dad) would say I could have done better."
- "I am fully functioning, but I cannot see. I value imagery, mirror, color…now not to have that."
- "He (Dad) wouldn't let me do anything. Didn't he trust me? My older brother told me Mom cried (about me).
- "I have performance anxiety."

- "I felt I wouldn't get married, have kids."
- "Without a driver's license, no car; no car no date."

xix. Trauma: Not Otherwise Specified - 30%. (TRA)

Trauma is part of living. It is universal and unavoidable. The B/VI are not exempt as the following various instances of trauma demonstrate.

- Suicide of a brother. "It was hard for me. It was very traumatic."
- Required dialysis sessions. "It's rough. I don't want to go back. I don't have no choice."
- Losing hearing in one ear. "It was pretty traumatic."
- Loss of father. "It was very, very difficult."
- Another with the passing of her father: "I requested counseling…."
- As an adult, due to sibling's health issues, letting younger sister live with participant and resulting issues of resentment that surfaced. "That first year was rough. I was angry with her for not taking care of herself."
- Pandemic impositions. Covid "…started rough."
- Isolation and loneliness are "The worst."

xx. Relationship Issue – Not Otherwise Specified - 25%. (SOC6)

These relationship issues involve a parent, a sibling, or progeny, all family. The omission of significant others and friends is curious and without apparent explanation.

- "I wasn't liked by my parents because I was a troublemaker."
- "My mother rejected me."
- "My son is both a protective factor and a risk factor."
- Anger with father after he passed.
- Not getting along with a brother.
- Sister-in-law interfering with participant establishing a relationship with nephews.
- Argument with sister.

xxi. Inescapable Pervasiveness of the Condition - 20%. (PVAS)

This stress factor is significant to the study.   As one participant put it, every decision in his life was affected by his visual impairment, which explains why this factor is significant

- "It can arise at any time that something…puts me into a mood. Life itself. I feel an expectation from family and society to be better."
- "Living in (city) is a cultural shock." (As a B/VI individual.)
- "My vision was involved in every choice I made. A therapist addressed my non-AA issues." (This second comment bears further explanation and is significant. After years of therapy for a variety of significant issues, the participant finally connected, as an adult, with a therapist who gave priority to the issue of vision impairment. The participant indicated this is when things finally "came together". This is the same participant who indicated that he had anger as the B/VI "…are cheated right out of the gate." The pervasiveness of the condition, apparently once recognized, was the key organizing factor for addressing the participant's other issues. The question arises as to why the previous therapists did not consider this factor. This is not to question their competency, but there are indications of ableism and possible sighted quiddity.)
- "I can't recognize anybody (visually). I am always dealing with misperceptions of me." This participant indicated that when he attended a social event, his buddy would wave or say hi to people using their names ('Hey Judy! How are you?) to provide his B/VI chum with information as to who was at the party. We saw this same technique indicated as a recommended teaching technique for use by teachers with a B/VI student included on their class list.

xxii. Suicide in the Past by a Family Member or by a Friend - 15%. (SU3)

Based on this study, three participants know of a family member or friend who suicided sometime in the past.

- "(My older brother's suicide) "…was very traumatic for me. His suicide was the reason for therapy."
- "My nephew suicided in 1993. My brother-in-law suicided in 2017."
- "My Dad said my grandfather shot himself." (My uncle said no, it was accidental. It was after the Great Depression.)

xxiii. Substance Abuse: Unspecified - 15%. (SA)

The role of substance abuse in suicides is a recognized issue.

- "When I was younger, I got high and did a lot of drugs."
- "I was abusing for a long time prior and the last five years of that I was out of control."
- "I had financial debt due to drugs, which are expensive."
- Uses cannabis when alone.

xxiv. Substance Abuse: Alcohol - 15%. (SA1)

The role of substance abuse, here it is alcohol, in suicides is a recognized issue.

- Participant has been in recovery for six years from alcohol abuse.
- Recognition by participant that alcohol was a B/VI negative coping mechanism.
- Participant is currently in recovery.
- "I got loaded." (…in the past.) (Divulged in psychiatric history.)

xxv. Suicide Behavior - 15%. (SU2)

As previously indicated, self-reported suicide behavior often does not rise to CDC suicide behavior criteria and impacts the accuracy of the data.

When asked about intentionally hurting oneself, one participant responded, "Yeah. Oh god yeah. I do it every once in a while." Another participant reported that as a teenager: "I took 5 to 7 aspirin tablets."

xxvi. Stress from a Social Situation Involving Peers - 15%. (SOC3)

This was characterized by one participant's experience when he and his colleagues (attorneys) would socialize after work and when he went to cash out and go home, he found his colleagues were putting their drinks on his tab without his knowledge.

- "I didn't want to have people around me, so they didn't stop hanging about me."
- "Peer pressure." (When growing up, the participant experienced what is characterized today as bullying. He referred to the bullying as peer pressure.)

- "A co-worker did something really bad to me." (Resulting in ideation and behavior to harm another.)

xxvii. Legal Issue – Not Otherwise Specified - 15%. (LEG3)

The first event is reported by one participant and the remaining three events are reported by a second participant.

- Initiating a class-action lawsuit with a state.
- Being legally committed to a mental hospital.
- Becoming a ward of the court.
- Putting a child up for adoption.

xxviii. Financial Issue - 15%. (FIN)

CDC Risk Factor Code: #6 of 12.

Financial issues such as bankruptcy, debts, and foreclosures are stress producers, but so are buying or selling a house.

- Participant stopped seeing a psychiatrist due to lack of insurance coverage.
- Trying to re-finance a house.
- Financial debts due to drug use.
- In the process of selling a house.

xxix. Current Events: National and/or International Political Situation - 15%. (CUR2)

The United States presidential election that garnered much attention and an international political situation that reflected significant shifts in political orientation merited being a stress factor for participants.

- "World and politicians put me in a state of sadness."
- Politics interfered with relationships and became a risk factor for this participant.
- Political situation in the United States caused anger, and frustration.
-

xxx. Unemployment Issue – 10%. (EMP1)

This factor concerns a participant who does not have a job.

- "I know I need…to first find a source of income."
- "I had been passed over for jobs."
- "I am not working." (Job was shut down due to Pandemic.)

xxxi. Non-Childhood Trauma - 10%. (TRA2)

Trauma is an element of living. Two participants shared the following.

For one participant, the non-childhood trauma involved the individual deaths of an infant daughter and then of an infant son.

Another participant's husband was terminally ill, and the participant could understand very little of what the husband was attempting to communicate concerning his condition.

xxxii. Substance Abuse: Drug(s) - 10%. (SA2)

This issue is like that of Substance Abuse and Substance Abuse – Alcohol, which have been previously addressed. Participants' comments include:

- Use of opiates.
- Participant is in recovery from drugs.
- "I had an addiction."

xxxiii. Self-Injurious Behavior -Without Suicidal Intent - 10%. (SIB)

One participant engaged in a behavior as an adolescent that perhaps might also be characterized as attention seeking. Another, having recently lost his vision, tugs on his hair. This category was created for these events as the other CDC categories were not felt to be appropriate.

As a teenager, one participant attempted to break her arm as a self-described "cry for help". Another participant pulls on his hair (does not pull hair out.) for the feeling of pain it provides.

The behaviors and certainly the intent as communicated, did not appear to rise to the level of being suicidal.

xxxiv. Stress from Social or Public Situations - 10%. (SOC2)

These participants indicated that social or public situations when interacting with sighted individuals, that the participants often felt misunderstood as a B/VI, and this resulted in them feeling stressed.

- Dealing with (sighted) people in general.
- Dealing with the public may cause distress.
- Generalized anxiety in social settings since losing vision.

xxxv. Participant as Victim of Interpersonal Violence - 10%. (VIO2)

CDC Risk Factor Code #12 of 12.

The B/VI are not immune to violence, and physical, sexual, and emotional abuse.

One participant reported a parent using a belt for discipline leaving black and blue marks. Another participant was molested as a child by a relative.

xxxvi. Employment Issue – Not Otherwise Specified - 10%. (EMP)

This is a catch all code concerning employment.

One participant is a rehabilitation counselor and because of the Pandemic all client appointments were suspended, significantly altering the nature of her employment. Another participant reported he was unable to maintain a job but did not provide any reasons.

xxxvii. Current Events - Not Otherwise Specified - 10%. (CUR)

For two participants current events concerns listening to the news.

One participant reported being "addicted to the news" as not being good for them because of the nature of the current news while another participant takes a no news is good news approach and indicated, "News is stressful, so I minimize (listening to) it."

xxxviii. Current Events: United States 2020 Presidential Election - 10%. (CUR3)

A subset of current events affecting the participants following the election.

"Elections alone can make me sad," indicated one participant. A second participant indicated that the election poses a mental health risk for her.

xxxix.   Job Issue - 5%. (EMP2)

CDC Risk Factor Code #4 of 12.

This participant faced the following job issues in his job past:

Participant was offered a severance package when the organization he worked for was being down sized. When he declined the severance, he was then laid off for three years. Another participant was left without employment when his job was shut down due to Pandemic.

xl. Ideation to Injure Others - 5%. (OII)

One participant responded in the affirmative when asked if she had ever thought about harming another. (The following risk factor, xli – Action to Injure Others, involves the same participant)

xli. Action to Injure Others - 5%. (OIA)

One participant responded in the affirmative when asked if she had ever done anything to harm another. (The previous risk factor, xl – Ideation to Injure Others, involves the same participant and is discussed in Chapter 5.)

xlii. Suicide Issue – Not Otherwise Specified - 5%. (SU)

While in counseling for her adventitious vision loss, one participant indicated that she did seek to address the issue of suicide.

"I had counseling (about five or six years ago addressing phobia and anxiety) related to my vision. It was not about suicide that they wanted to talk about."

xliii. – Legal Issue: Criminal - 5%. (LEG1)

The following events involve the same participant.

"I had a five-hour shootout with police. I did a felony as a result of a drug overdose."

The shootout was while he was an adolescent, and the felony was when he was an adult.

xliv. Legal Issue: Family - 5%. (LEG2)

This participant was a student at a segregated school for the blind when a class action suit for the integration of the two schools for the blind, of which her mother was a plaintiff, was initiated.

"My mother was one of the Plaintiffs filing suit" … for the forced integration of the school for the blind while participant was in her senior year.

xlv. Interpersonal Violence – Not Otherwise Specified - 5%. (VIO)

Participant experienced physically abusive parent using belt to beat brother in a context of abuse for the participant and her siblings.

xlvi. School Related Issue - 5%. (SCH)

CDC Risk Factor Code #5 of 12.

While the situation this participant faced is remarkable for its historical significance, it fell on the shoulders of a high school senior who did not prevail unscathed.

" I faced some anger and mistreatment due to integration."

xlvii. Recent Suicide by a Family Member or by a Friend - 0%. (SU4)

CDC Risk Factor Code #7 of 12.

None of the participants responded to this item. It is being reported out because it is a specific CDC data element generally recognized as a potent suicide risk factor.

xlviii. Participant as Perpetrator of Interpersonal Violence - 0%. (VIO1)

CDC Risk Factor Code #11 of 12.

While no participants responded to this item, it is being reported out because it is a specific CDC data element generally recognized as a suicide risk factor.

CDC Data Element #34: Protective Supports

Per the CDC (2011):

This classification is an exploratory classification among the data elements. Less is known about the relationship between self-directed violence (and) some of the factors listed in the classification. Protective factors are believed to operate in three ways: buffering risk factors so that they provide a cushion against negative effects; by interrupting the processes through which risk factors operate; or by preventing the initial occurrence of a risk factor. Fewer studies have been done on protective factors than on risk factors, so many have not been identified making this information somewhat harder to collect.

Self-reporting by the participant for this element is preferred. (p.67)

The number of protective supports expanded from the 11 suggested by the CDC to 29 that evolved as the result of coding that evolved during the sessions with the participants.

		Rank Order of the Number of Participants Responding to a Given Protective Support			
I.D.	**Code**	**Coding Guidelines**	**Rank Order**	**n**	**n/20**
i	PI-TEMP	**TEMPERAMENT DOMAIN.** A person's nature as the basis for their behavior. (Easy going, compassionate, etc.)	1st	19	95%
ii	PI-TAN	**TANGIBLE DOMAIN.** The things people do (or avoid doing) to reduce or evade stress.	2nd	18	90%
iii	PI-EX	**ESPRIT DOMAIN.** Fundamental beliefs that escape explanation, such as a belief in a higher being.	3rd	16	80%
iv	PE-SIB	**SIBLINGS.** Brothers and sisters.	4th	15	75%
v	PI-TAN-C	**DEMONSTRATING COMPETENCY**. Doing something tangible to exhibit competency for oneself, or to demonstrate it for others.	5th	14	70%
vi	PIE-SA	**ADVOCATING FOR SELF.** Advocating for self or B/VI in general in response to a situation.	5th	14	70%
vii	PE-THER	**THERAPEUTIC.** Therapy, counselor, or just having someone with whom to talk about worries, concerns, etc.	5th	14	70%
viii	PIE-TCH	**TEACHING.** In a classroom, as a Rehabilitation Instructor, as a counselor, etc.	6th	11	55%
ix	PE-FRI	**FRIENDS.**	6th	11	55%
x	PE-PAR	**PARENTS.** Mother and Father.	7th	9	45%

		Rank Order			
		of the Number of Participants Responding			
		to a Given Protective Support			
		(continued)			
I.D.	**Code**	**Coding Guidelines**	**Rank Order**	**n**	**n/20**
xi	PE-FAM	**FAMILY.** Family unspecified. Collectively or generically. ("I get together with family to celebrate the holidays.")	7th	9	45%
xii	PE-EXT	**EXTENDED FAMILY.** Aunts, uncles, nieces, nephews, son in-law, daughter in-law, etc.	8th	8	40%
xiii	PE-MED	**MEDICAL.** Medications. Treatments.	8th	8	40%
xiv	PE-ADP	**ADAPTATIONS.** Adaptations such as a cane, leader dog, adaptive lenses.	8th	8	40%
xv	PE-JOB	**EMPLOYMENT.** This specifies being in a job, getting paid.	9th	7	35%
xvi	PE-SO	**SIGNIFICANT OTHER.** Spouse, partner, etc.	9th	7	35%
xvii	PE-PROG	**PROGENY.** Sons, daughters, and grandchildren.	9th	7	35%
xviii	PE-PEER	**PEERS.** Includes co-workers, colleagues, clients, "peeps".	9th	7	35%
xix	PE-SS	**SOCIAL SERVICES.** Alcoholic Anonymous, Support Groups, Organizations for the Blind.	10th	6	30%
xx	PI-ASSOC	**ASSOCIATIVE DOMAIN.** Internal desire to connect with other individuals in contrast to socializing with others.	11th	5	25%

		Rank Order of Participants Responding to a Given Protective Support (concluded)			
I.D.	**Code**	**Coding Guidelines**	**Rank Order**	**n**	**n/20**
xxi	PE-REL	**NON-SECULAR ORGANIZATION**. Religious Group. Pastor. Members. Emphasis is on the social aspect of belonging to a community.	11th	5	25%
xxii	PE-OTH	**MISCELLANEOUS.** Catch-all. Includes one participant's interest in fashion (clothes and shoes).	12th	4	20%
xxiii	PE-CUL	**SOCIAL ACTIVITIES.** Societal such as parties, restaurants, music, dance, art, movies, bowling, shooting range, etc.	13th	3	15%
xxiv	PE-SCH	**EDUCATIONAL.** Attending school, education, training, in-service.	13th	3	15%
xxv	PE-HOSP	**HOSPITALIZATION.** Both voluntary and involuntary.	13th	3	15%
xxvi	PE-REHAB	**REHABILITATION.** Blind rehabilitation services and facilities.	13th	3	15%
xxvii	PE-GOD	**DIVINE.** Mention of a higher being.	14th	2	10%
xxviii	PE-PET	**DOMESTIC ANIMAL.** Cat or dog as pets.	15th	1	5%
xxix	PE-MISC	**MISCELLANEOUS.** Physician. Primary Care.	15th	1	5%

Number of Participants Responding to a Given Protective Support		
Mean	**Median**	**Modes**
8.21	7	3 and 7

i. Temperament Domain – 95%. (PI–TEMP)

Typical wording used by the participants when discussing this support are:

- "I am calm about being misunderstood."
- "Life can change in any given second."
- "I tried to focus on what I could do."
- "I have a great life."
- "Take each day as it comes."
- "Either deal with it or fall apart."
- "I am lactose intolerant, but there is enough food in the world to choose from."
- "Either get busy living or get busy dying."
- "If I can't change it, I don't worry about it."
- "Just suck it up and do it."
- "I haven't found anything wrong with me."
- "You have to keep looking up, the world will drag you down."
- "Things could be worse."
- "I don't let things bother me."
- "I had to do what I had to do as a sense of purpose."
- "I have problems but there is a bigger picture to this."
- "The effects (suicide of nephew) stopped me as I realized it was a selfish act."
- "There is a tomorrow."
- "(I) learned to let things go."
- "When a door closes you have to find a window."
- I think…
- I find/I found…
- "I'm grateful for…"
- "Don't give up. Keep trying."
- I consider…
- I figure…
- "I've had good times."
- "I accept how I am."

ii. Tangible Domain – 85%. (PI-TAN)

. The following are some of the activities that the participants did to manage stress:

- "I vent with my friends. It is therapeutic."
- "Exercise is a stress reliever."
- Going to the gym.
- "Go outdoors. I love nature."
- Laying down.
- Self-time-out.
- Home workshop.
- "Listening to music."
- Cooking.
- "I love dancing."
- Hobby.
- "Woodworking."
- Staying busy or occupied.
- "Read books, magazines."
- Going to the movies. Going shopping.
- Home is "…peaceful and relaxing."
- Travel.
- Swearing (cussing).
- Going to work/job.
- "Change".
- "Taking a computer class and a software class."
- "I love gardening."
- "I like to go shopping."
- "Walks."
- "Hot tub, aroma therapy, and essential oils."
- Bowling.
- Maintaining a schedule, a routine, or structure.
- Going to a shooting range.
- "Read the Bible."
- Cleaning and organizing.
- Controlled breathing or taking deep breaths.
- Watching movies , television, and /or video games.

iii. Esprit Domain - 80%. (PE–EX)

Typical wording used by the participants include:

- Having a passion."
- Faith helps me understand the world."
- "I feel blessed."
- "I believe in a higher power."
- "…Life is not over!"
- "The glass is half full."
- "I could not make it without the Lord as my savior."
- "I am smart enough to know that things are good the way they are."
- "There is a tomorrow."
- "I believe in reincarnation, and I don't want to have to come back."
- "My Great-Grandfather told me to walk by faith and not by sight."
- "It made me realize how important life is."
- "If we don't take care of ourselves, how can we take care of other?

iv. Siblings – 75%. (PE-SIB)

These responses are self-explanatory.

- "I have three sisters and two brothers."
- "I have one sister and five brothers all within ten miles."
- "I have one older sister and one older brother."
- "My brother I was closest with suicided."
- "I have a middle sister." (Two brothers and baby sister are deceased.)
- "My oldest sister was in military and my youngest sister had three heart attacks."
- "I have four older siblings; we meet weekly on (video conferencing)."
- "I was feeling depressed and called my older brother. He phoned my parents who live downstairs, and they came and checked up on me."
- "There are seven of us kids. I have a twin brother."
- "I have one older brother. We talk once per week."

- "I have two sisters. I have a great relationship with my older sister but not much contact with my younger sister."
- "My sister comes over quite often."
- "Having a brother helps me deal with stress."
- "I have an older sister and two older brothers."

v. Demonstrating Competency – 70%. (PI-TAN-C)

This is one of the codes specifically linked to B/VI and is the behavior of the participant when they evince their autonomy or capability.

- "I am a role model for my clients."
- "Just because you are blind doesn't mean you can't be successful."
- "I am the oldest sibling and the family 'elder'."
- "I have been speaking up and saying more for myself lately and it feels pretty good."
- "I was the only B/VI staff member in a program for high-risk teens."
- "I raised my son by myself."
- "I run a B/VI support group and people say I am doing a good job."
- "With the Pandemic we have to come up with new (on-line) teaching strategies, we are making it work."
- "Just suck it up and do it."
- "I was the best Auntie in the world!"
- "I have my own driver and a vehicle."
- "I was an adrenalin junkie, I worked in an ICU."
- "I am an artist and I also curate art shows."
- "We have a lawsuit pending with the Secretary of State about voting ballots for the blind."
- "I have been to the state legislature to testify."

vi. Advocacy – 70%. (PIE-SA)

Advocacy is not a behavior that is unique to the B/VI, but it appears to manifest itself more frequently than for the sighted.

- "Just because you are blind doesn't mean you can't be successful."
- "When I confront people about how they are acting, they turn it towards me."

- "Advocacy is now."

- "When I am advocating around campus, I say it is to help you. To prevent a lawsuit."

- "I say this is not for me but for the blind students coming after me."

- "You have to do everything yourself. No one does anything anymore."

- "Because I can't see doesn't mean I'm dead."

- "There are tools to use to advocate for yourself and being blind can be a positive experience."

- "Empowerment."

- "Lack of vision doesn't mean I stay away from stores."

- "Being blind, sentimentality is different for me than for my siblings. We were stripping wallpaper at (recently deceased) Mom's house and there are no (memory) triggers for me."

- "I am fashionable. I am easy on the eyes."

- "I am a good cook. I was in a chili cook-off with six sighted and I was voted #1 with the most votes."

- "My school for the blind had the most financially successful students in the country."

- "Once my son brought a friend home. He did not tell his friend that I and my son's mother were both blind." (There was nothing out of the ordinary for the son to give a heads up to his friend about.)

- "I am not afraid to ask anybody for anything."

- "I got in a fight. I wasn't violent but I don't take shit."

- "Someone asked me if all blind people are angry. Yes!"

- "I dealt drugs because no one would give me a job. So, I created my own job. I didn't want to go without things because of the way I was born."

- "I was a guest lecturer at a state university about autonomous vehicles to make them more accessible."

- "I tell people I am visually impaired, to disprove false beliefs."

- "I want to save 5, 500, or 5000 from going through what I went through."

vii. Therapy – 70%. (PE-THER)

- "I had thoughts about suicide and called a suicide hot line."

- "I went to teenage counseling." (Thirties something.)

- "This session took a weight off."

- "I had been seeing a therapist for a very long time. It is over the phone now due to Covid."

- "My brother's suicide was the reason for my therapy."

- "Good treatment got me through recovery." (Substance abuse.)

- "Talking today was fine."

- "I requested counseling in high school when my father passed. I had marital counseling. I had counseling when my elderly sister with ill health moved in. The state offered ten counseling sessions and I called in a couple of them. My church offered counseling."

- "I was always into introspection and saw high school counselors. Out of high school I went to a public clinic. I saw a social worker. I saw a clinical Ph.D. psychologist."

- "I went to marital counseling … but she had already made up her mind."

- "My therapist of twenty-five years retired. It took me years of therapy to get where I am now."

- "I saw counselors because of the effects of the issues my daughter was going through."

- "My therapist addressed my non-AA issues, (which masked his B/VI issues). Thank god I had a lot of therapy."

- "I had counseling related to marriage. I have had counseling related to vision."

viii: Teaching – 55%. (PIE-TCH)

The term teaching is utilized by the participants in its broadest sense, from formal settings in front of a classroom to casual over the telephone intentional role modeling or counseling.

- "I am a role model for my clients that they can relate to, and it motivates them."

- "Kids (high risk students) had no exposure to anyone who was blind."

- "I run a support group. I am helping people get on with their life."

- "I spend a lot of time on the phone helping out other people. I have done some distance teaching over the phone."

- "I use every moment as a teachable moment." (Rehabilitation counselor.)

- "I keep myself available for assisting people in the blind community needing resources."

- "I have to be who I am to spread love."

- "I am a State Itinerant Vision Therapist, I give workshops on VI on-line, in (the capitol), on at the school districts."

- "I help younger/newer blind guys in AA."
- "I teach science to blind youth. Blind kids get a raw deal learning science." (As seen previously, B/VI students are marginalized in education, such as physical education, community experiences, and here, science.)
- "I want to help others.

ix. Friends – 55%. (PE-FRI)

This support requires little explanation.

- "I vent with my friends. It is therapeutic."
- "I talk with my friend every other day."
- "I have a girlfriend."
- "I talk with a buddy in Kalamazoo (Michigan, U.S.A.)"
- "I talk with friends."
- "I planted a garden at a friend's farm."
- "Three or four months later (after losing vision) a friend called and said they (the caller and other girlfriends) were coming to pick me up to go out."
- "Before (Pandemic) I went to the movies with my friend."
- "I have friends since 1958."
- "A male friend helped me get through issues at home."

x. Extended Family - 50%. (PE-EXT)

This protective factor reflects CDC parameters which are very broad and include non-blood relations such as in-laws.

- "I have seven nephews and five nieces."
- "I talk with a niece."
- "I have two aunts in Michigan and one aunt in Florida who we visit every year."
- "I have two nephews and we exchange cards."
- "I have some contact with nieces and nephews with (social media) and telephone."
- "My son-in-law is good to me."

xi. Parents - 45%. (PE-PAR)

The following comments concern the relationship between parents and progeny.

- "My Dad came in my room and saw me sobbing."
- "My Mom said that I am talking to myself."
- "When I was little, I sat on (Dad's) lap when he plowed or drove the car in the country."
- "He was not a nice man, but I cared for him the most."
- "They tried to do as much as they could (to help her, being blind)."
- "I saw my parents on Saturday for the first time since May (five months due to the Pandemic)."
- "I communicate with my father and sister."
- "My mother is older, and we both have underlying conditions."
- "Friend and I both have our mothers, and we don't want to bring anything (Pandemic) home."
- "My 83-year-old mother is out now doing Christmas shopping."
- "Dad felt he had to 'take care' of us. He didn't know about blindness."
- "I had a good relationship with my mother until I was 20 years of age."
- "Both parents are living."

xii. Family - 45%. (PE-FAM)

The criteria for 'family' are fluid. It is a generic term that might include various doses of siblings, progeny, parents, etc.

- "I have lots of contact with family. We are very close."
- "My family saved me. They took me to the hospital." (Suicide ideation.)
- "Family intervention moved me to recovery."
- "Everybody is into their own thing. We meet on holidays and Christmas."
- "Family helps me to deal with stress."
- "I discovered with my therapist for my cancer that my family (progeny) will be ok…."
- "I am still in contact with my family.
- "I am comfortable getting around to seeing family."

xiii. Job - 40%. (PE-JOB)

A job plays a role in stress management by keeping one busy or occupied and provides multiple collateral benefits.

- "It keeps me busy (re: occupied)."
- "I worked twenty-four years in my first employment and sixteen years in my second employment."
- "When I was at rock bottom and had nowhere to go, I was still working."
- "We are doing a lot of innovative stuff in my job."
- "We are working behind masks and sanitizing."
- "My social work background is helpful (to deal with stress)."
- "We would go to people's (rehabilitation clients) homes."
- "Working from home is great!"
- "I was a working person. I had two or three jobs. I was going to sell real estate after I retired."
- "My job helps me when I feel stressed."

xiv. Medical - 40%. (PE-MED)

This population is very pragmatic about their health care needs.

- "For depression I am on medication. I am on meds and that is where I am now."
- "I had an issue with having asthma and having to wear a mask (Pandemic). I had to go out (and wound up) taking off the mask and using my inhaler."
- "I have eyedrops for glaucoma, supplements for diabetes, and diet, exercise, and medication for hypertension."
- "I have a pump for diabetes, medication for Graves' disease (thyroid) and hypertension, and have been using an anti-depressant for three or four years."
- "I take pills for arthritis. I take them reluctantly, but I have to for the pain."
- "I have been on antidepressants for an extended time."
- "This is my second time with cancer. After chemo is harder to do. I went without pain medication, but I just got a prescription (for it)."

- "I am on anxiety medication."

xv. Adaptations - 40%. (ADP)

This population has inevitably benefited from the technological revolution.

- "I need help reading mail and writing checks."
- "After my support group's (that he leads) first trip to (supermarket store) asking for a 'shopper', they git it (empowerment)."
- "Teaching braille to clients by phone."
- "Bureau of Blind Services gave me a teacher for (word processing program)."
- "I have a portable talking Bible. It is five pounds. I take it with me."
- "I have my own driver and a vehicle."
- "I feared rejection with an adaptive lens, but it was the opposite."

xvi. Significant Other - 35%. (PE-SO)

Of the twenty participants, only five indicated they are either married (4) or living with another (1).

- "I am engaged to be married!"
- "When I am at a restaurant with my girlfriend or friends and the waiters or concierge talk to the person that they can make eye contact with, and they ignore me."
- "I talked with (person with whom she was breaking up) a little bit. Then I moved on."
- "I am engaged."
- "I married at forty-one years of age."
- Participant is cohabitating.
- "My nuclear family is a protective factor for me."

xvii. Progeny – 35%. (PE-PROG)

This element includes children and grandchildren.

- "I have an only son, age (adult), who is both a Protective Factor and a Suicide Risk Factor for me."
- "I have five daughters grown and gone. We keep up on (social media)."

- "My granddaughter visits once a week. I have contact with my daughter every day. She hands things to me through the door (Pandemic practice)."
- Participant's progeny are 25-38 years of age.
- "When grandkids come you want to be there. I was looking to moving to Florida, but I realized I missed my kids, so I am looking in (a place near them)."
- "I have great relationships with my three kids. I have three grandbabies."
- "My two sons can be counted on if I need help."
- "I have kids and grandkids."

xviii. Peers, Colleagues – 35%.   (PE-PEER)

Fellow employees, age similar friends, such as from school days, are included in this group.

- Male participant reported feeling stress "When talking to a girl who isn't responding to me. Girls treating me like I am invisible."
- "…and others in my life had ways of motivating me at the time of losing my sight."
- "People say I am doing a good job." (Running a hospital support group for recently blind adults.)
- "I bowl on an equal basis with the sighted."
- "I have a sighted friend from work, we talk each day."
- "Many of my peers at the school for the blind drank pop, smoked cigarettes, drank alcohol, cannabis, and partying. They're dead." (Referring to the effect of life choices on health and longevity.)
- "Before covid, I would join in with groups of other people going to restaurants."

xix. Support Groups, Organizations – 30%. (PE-SS)

- "I am grateful for (blind) organizations and federations."
- "I am in recovery for six years (AA). Debt and family moved me to recovery."
- "I am not particularly religious, but it (group of church women) is a convenient community of self-selected individuals. I participate in a bi-weekly hospice support group. My siblings don't talk about feelings…so I continue with the support group and the church group."
- "The national organization for the blind gave me a work ethic."
- "I am a member of the American Council for the Blind."

- "I am in recovery for thirty-six years with the AA (Alcoholics Anonymous) twelve step program and some therapy."

xx. Desire to Connect – 25%. (PI-ASSOC)

This protective support is characterized as a felt need by the participant to connect with another or others.

- "I need to engage in more social (activities)."
- "We (mother with son) are always in contact. We are always in contact. I am always in contact with (son)." (Same participant comment three times during session.)
- (Participant hosts a support group.) "I give them my (telephone) number. There are twenty-five on my phone. There are forty-five in person."
- "I reach out. I would like a serious relationship."
- "I am part of communities. There is the recovery community (AA), the art community, and a housing community." (He is called "Chef" for his community BBQ's.)

xxi. Non-secular Community – 25%. (PE-REL)

- "I am very active in the Christian ministry. I sing with the ministry."
- "There is a group of church women (I talk with), we (digital meeting). The Pastor is easy to talk to. I was in the church choir but with (recently deceased) Mom's house I withdrew; I put it on pause."
- "I go to church a lot."
- "I attend church activities twice a week."
- "Religion helps sometimes."

xxii. Miscellaneous – 20%. (PE–OTH)

This is a catch all category.

- "I am telling you more than I told them (teenage counseling)."
- "I talked with someone else." (After suicide attempt.)
- "I spend lots of time on the phone."
- "I love clothes and shoe shopping."

- "I have a couple of people I can talk to about my concerns."

xxiii. Cultural context - 15%. (PE-CUL)

"Before (the Pandemic), I went to the movies with my friend." "I would join groups of other people going to restaurants."

xxiv. School – 15%. (PE-SCH)

School is more than a place. It may be a refuge or where one's friends are.

- "My high school senior year was the forced integration of the school for the blind."
- "I am taking classes on-line. The (rehab agency) gave me a teacher for (word processing program). Next will be (computer company) products. The classes give me a schedule (structure)."
- "After I was released from the hospital I moved to the school for the blind and friends."

xxv. Hospitalization - 15%. (PE-HOSP)

Hospitalization is not always voluntary or for physical issues.

- "They (parents) took me to the hospital." (After telling father he wanted to kill himself.)
- "I was hospitalized for treatment in (regional rehabilitation facility).
- "As a youth I spent ten months in a mental hospital."

xxvi. Blind Rehabilitation Center – 15%. (PE – REHAB)

The role of rehabilitation facilities for individuals who are blind or visually impaired is crucial. The rehabilitation facility is where one with little or no vision goes to learn skills for navigating life.

"(State rehabilitation center for the blind) is a blind utopia." I entered vision rehab saying life is over …" I left saying life is NOT OVER!"

xxvii. Higher Being - 10%. (PE-GOD)

This category is self-explanatory.

- "I talk with God."

- "Prayer time…." is part of my daily routine.
- "My church family is very supportive."

xxviii. Pet – 5%. (PE-PET)

This category is self-explanatory.

"I have two cats."

xxix. Physician - 5%. (PE-MISC)

This category is self-explanatory.

"Everything (physical health) is under control. (Medication) is through primary care.

<div align="center">B/VI Cognition</div>

Data of interest and of significance related to suicide emerged during the interview sessions that overflowed the confines of the CDC survey instrument.

This rich and thick data presents a portal to deep understanding and expanding perception as regards the participants. This data does not pretend to speak for all individuals who are blind or visually impaired, but it will disclose what some of these twenty individuals think about the questions that were posed to them. Their responses are outcomes of their cognitive processing and allow us to examine the issues of suicide risk factors and protective supports with a goal of learning from them to construct profiles.

This is not to say that the connection between these comments and suicide are apparent, and nor will those connections be made explicit. Selected comments are being presented because they are indicative of the functioning of cognitive processes related to suicide.

The responses immediately indicated that there are two aspects the participants face.

The first is external to the B/VI, it comes from outside, and is sighted-centric. An example is a sighted person in a position to employ others. Because the person hiring cannot conceive how

they would do a task without having vision, they assume that anyone without vision cannot do the task. This stereotype does not cover all sighted-centric scenarios, but it does communicate the issue.

The second area is B/VI-centric. These tropes manifest a range of themes possessing both negative and positive attributes. One example is a participant who was reluctant to wear adaptive lenses because he assumed it would make him stand out and be avoided by the sighted. He found out that was not the case.

It was a contention of this study that the B/VI must work harder than the sighted to accomplish congruent results. The gestalt of these tropes supports that contention. In the issue of the sighted-centric, the burden is upon the B/VI to overcome the prejudices of the sighted and prove themselves.

The comments of the participants follow and a discussion about them will be in Chapter Five.

The stand-alone parentheses refer to stress factors with a particularly strong connection to the trope.

Advocacy / Assertiveness / Self Image Trope

This is a bundle of related attributes.

- "I see myself as an advocate for the blind."
- "(Advocacy) is not for me but for the blind students coming after me. They should not have to go through the same thing."
- "We have to express competency." (Competency.)
- "We can't change anything unless we get blind kids in development so they have a chance technology will be accessible (for them)."

- "I am grateful for organizations and federations."

- "Public schools are not doing their job. I don't know anyone (B/VI) under 30 who is working."

Altruism Trope

A positive quality of humans is giving back and making things better, a quality to which the B/VI are not immune.

- "I want to help others. I want to save them from going through what I went through." (Teaching.)

- "I spend a lot of time on phone helping out other people."

- "I am a volunteer working with a blind young man (36 years of age) without social skills." (Teaching.)

- "People say I am doing a good job. I am helping people get on with their life." (Teaching. Competency.)

- "I want my grandkids to have a grandpa image, which I did not have."

- "My sister had to live with me due to health reasons, I went kicking and screaming to letting her live with me. I gave up a lot of my independence. That was rough for me. Everybody needs their own independence."

Anger Trope

Resentment, hostility, and feelings generated by Unjustness fit in here.

- "Someone asked me if all blind people were angry? I said, YES."

- "We are all cheated right out of the gate."

- "I had a lot of anger."

- "I get angry at my ex-wife when she tries to use me."

B/VI Mis-Understanding the Sighted Trope

As the sighted may misunderstand the blind and visually impaired, so too the opposite.

- "I feared rejection wearing adaptive lenses, but it was the opposite."

- "When I was first diagnosed, I felt I wouldn't get married and have kids."

Burden Trope

These comments point to an unaddressed dichotomy. On the one hand, B/VI elicits responses such nurturing and protectiveness, on the other hand as witnessed below, not only do the B/VI have to fend for themselves, but they should also try to make sighted people feel comfortable while they are doing it.

- "(B/VI) people think they are going to get support."

- "There is no support from my doctor about services available (for B/VI)."

- "Blindness is a burden. There are expectations from family and society to be better."

- "Blindness is a burden as concerns employment and trying to make (sighted) people feel comfortable (around B/VI)."

- "You have to do everything yourself. No one does anything anymore."

- "In some cultures, the blind are waited upon."

Competency Trope

The larger number of comments is indicative of the richness of the comments as well as their number.

- "I am fiercely independent."

- "I realized I lived my life as I wanted."

- "I do not have to worry about money." (Mobility. Has full time driver.)

- "I bowl *on an equal basis* with the sighted."

- "I was in a chili cook off with six *sighted* people and I got the most votes and was number one."

- "My (sighted) son came home with a friend and did not tell his friend that his father and mother were blind." (This was related to indicate that the parents being B/VI was not remarkable enough to warrant prior mentioning to the visitor.)

- "My son said he never wanted for anything."

- "The school for the blind had the most financially successful students in the country."

- "The cane has power." (Mobility. A cane is a visual signal to sighted individuals that the person with the cane is visually impaired or blind and helps avoid misunderstandings.)

- "Bureau of Blind Services gave me a teacher. I am taking classes online." (Protective Supports.)

- "I was in law enforcement for five years before losing sight."

- "I worked in an ICU (intensive care unit) and I am an adrenalin junkie."

- "I am an itinerant vision therapist, I train students K to Secondary, I present workshops, I belong to a national organization for the blind."

- "I am an artist. I am also a B/VI counselor for AA (Alcohol Anonymous)."

Dependency Trope

While dependency is a consideration, this older and experienced population typically only makes mention of it in passing.

- "I need help reading mail and writing checks."

Employment Encouragement Trope

This trope has liens to the demonstration of competency concept addressed elsewhere.

- "The national (B/VI) organization gave me a work ethic." (Competency.)

- "Working from home is great."

- "I moved to (city) because it was better for transit. Most people (clients) are in the suburbs." (Where public transport is not as available as in a city.)

- "I have had several career changes because of eye condition."

Employment Deterrent Trope

The depressed B/VI employment rate has roots here.

- "I have been passed over for jobs." (Unjustness.)

- "Applying for a job, issues were raised such as how does Workmen's Comp work if (a B/VI is) injured on the job? Will he sue us if he gets hurt?"

- "They would tell me the position is filled."

- "I didn't want to go without things because of the way I was born. If you won't give me a job, I will create my own job. So, I dealt drugs because no one would give me a job."

Esprit Trope

These are the verbal manifestations of internal ruminations.   The substance of the following comments justifies their quantity.

- "The pity party runs from 12 to 12:01."

- "At first I just listened to opera. Then I said I don't want the rest of my life to be like this."

- "My husband recently passed. I either had to deal with it or fall apart."

- "You can sit on the sidewalk and watch traffic pass you by or you can go with the traffic." (Traffic being an allegory for life.)

- "Either get busy living or get busy dying."

- "There is a tomorrow."

- "Life can change in any given second."

- "I am living with asthma; things could be worse."

- "I have problems but there is a bigger picture to all this."

- "If we don't take care of ourselves, how can we take care of others?" (Altruism.)

- "Keep trying. Don't give up."

- "(Covid) made me realize how important life is."

- "Just suck it up (being blind) and do it."

- "I don't take too many things to heart."

- "I don't let things bother me."

- "I try to keep as stress free as possible to avoid flare ups."

- "You turn philosophical. What is the meaning of life?"

- "The glass is half full."

- "You have to keep looking up. The world will drag you down."

- "I always found the word to pull me back."

- "When a door closes you have to find a window."

- "I said I would rather be in a wheelchair than blind, but that meant I could not ride a bike. Then I said I would rather be deaf than blind, but that meant no music or guitar. Then I said I would rather lose an arm than be blind, but that also meant no guitar. I finally realized that if it had to be something, I would rather be blind!"

- "Blindness changes your life; it doesn't kill you."

- "Blindness really only changes your perspective."

- "There was more to do, it was just different."

- "Just because you are blind doesn't mean you can't be successful."

- "Because I can't see doesn't mean I am dead."

- "Being blind can be a positive experience."

- "Sometimes I forget I am blind." (Adventitiously blind five years ago.)

- "It (being blind) was fine. It was ok."

- "Walk by faith and not by sight."

- "I feel blessed."

Inadequacy Trope

This trope is often related to society or others.

- "At 15 or 16 the big dream to drive a car wasn't possible."

- "I can't get a driver's license. No car, no date."

- "I was insecure about my vision (wanting to be like everyone else and fit in)."

- "My eyesight blocks me from things I like to do like video games."

- "Ninety percent of the time people ask to help. I am not used to it."

Mobility Trope

Self-driving automobiles cannot arrive soon enough. Mobility issues are continual impediment.

- "Mobility is frustrating."

- "You can't ask me why I am late." (There are so many mobility variables such as missing a bus that it is ultimately a dependence issue.)

- "(My recently deceased husband) would drive. Now I have to plan ahead."

Parental Trope

These comments are B/VI reactions to their parent's actions toward the participant.

- "I would get all A's and one B, and my father would say things could have been better."

- "My parents did not place much value on emotions. I never saw my mom cry. She said what's the point? There wasn't time to ask about how we (the five progeny) felt."

- "My (older) sister was spoiled and then two blind kids (twins) came along and put an end to that." (The twins were the focus of attention from that point on.)

- "My mother neglected me, pushed me away." (Trauma.)

Personal Adjustment Trope

The loss of a major sense is not without trauma and adaptation, but in most instances it is transitional.

- "I lost vision in my good eye over a year ago. I thought my life came to an abrupt end: no more jobs or being able to drive." (Employment. Inadequacy. Dependency. Mis-Understanding.)

- "Losing my sight, I found I was bargaining with God."

- "When I lost my sight, I had mobility and personal needs issues." (Mobility.)

- "I went through the grief process once."

- "The rehabilitation center for the blind is a blind utopia." (Competency.)

- "I am a person experiencing blind feelings with sighted words." (Recently adventitiously blind.)

Pervasiveness Trope

While the B/VI condition may be pervasive, its limitations are not.

- "My vision was involved in every choice I ever made." (Pervasiveness.)

- "I am always dealing with misperceptions of me." (Pervasiveness.)

Previous-Trauma Trope

This population is not spared from trauma because of their condition. In some situations, it may have been because of their condition.

- "Parents divorced when I was young. I was the only child." (Parents.) (The divorce rate in marriages with a special needs child is high.)

- "Mother was schizophrenic. It was bad. I was 9 or 10 years old. She was in the hospital on and off. After I was 16 years old, she was on meds and could control herself."

- "I was bullied (about being B/VI) in high school." (Vulnerability.)

- "Dad was not a nice man. He scared the hell out of me. He disciplined us with a belt. He left black and blue marks." (Parents.)

"I was abused as a child when my mother continually left me in the care of a relative. She put her own freedom over the safety of her children." (Parents.)

Protective Supports Trope

The themes running through the following activities are characterized as keeping busy, having faith, and keeping your friends and family near.

- "I stay in the moment and maintain mindfulness."

- "I think of positive things I am doing."

- "Exercise, walks, listening to music is a stress reliever."

- "Dancing."

- "I love gardening at a friend's farm." (Competency.)

- "Time out, lay down, breathe."

- "I am in therapy and have a lot of good friends."

- "Meds."

- "The Lord is my savior."

- "I depend on faith, my nuclear family, my brother, and stability."

- "My faith, family, friends, and my background as a social worker was helpful."

- "I have one sister and five brothers. We all live within ten miles of each other. We get together every holiday."

- "I talk to niece, a buddy, and God."

- "I talk with friends and spend more time with children."

- "Three or four months after going blind, my friends called and said they were coming to pick me up and taking me to go out."

- "Whatever comes up."

Risk Factors Trope

Life is not without setbacks, disappointments, trauma, and tragedy.

- "Being stuck at home." (Covid.)

- "Loneliness and isolation are the worst."

- "I am isolated in the midst of people." (Misunderstood.)

- "I have depression but that is how it is. The support group I run is therapeutic in itself." (Teaching. Altruism.)

- "It's rough. I don't want to go back but I have no choice." (Dialysis treatment.)

- "I have been in (Alcoholics Anonymous) recovery for six years."

- "My job is shut down."

- "In the 1990s I had a health issue and a long-term relationship ended. I felt like I was running a race and not getting anywhere."

- "Recent life events have given me more affinity for Job (in the Bible). I am ready for the sunshine to come out."

Sighted Misunderstanding the B/VI Trope

Again, the number of comments is indicative of the importance given this topic: being blind or visually impaired in a sighted world.

- "When you stop seeing, people stop seeing you."

- "Then something a waiter says…puts me into a mood."

- "Blind would get what I am saying."

- "A risk factor for me is when people act funny towards me. Like they don't want to talk to me." (Similar to ordering in restaurant situation but referring here to a social setting.)

- "Dealing with the public causes me distress."

- "Dealing with people in general is confrontational."

- "I am blind, but I am not stupid."

- "I am fully functioning, but I cannot see." (Esprit.)

- "I have learned to remain calm when I am being mis-understood."

- "People are not polite to me. But I have learned to be polite to defuse the situation."

- "I learned that I have to disprove false beliefs and tell people I am visually impaired, but sighted people don't get 'partially sighted'."

- "My students asked me how I was going to teach them."

- "Without my cane, people don't believe I'm blind."

- "I am an attorney and when an impatient judge yells at me because I am not doing what it looks like I should be able to do (because I present as sighted), it provokes a lot of old feelings." (Anger. Incompetency. Unjustness.)

- "I cannot recognize who is at a party. I do not use aids (cane, dog, dark glasses). People would wave at me, not knowing I was blind, and when I did not wave back, they thought I was arrogant."

- "(People) talk to us like we are stupid."

- "How do you explain 'visually impaired'? I am frustrated that people don't ask what you can see." (Anger.)

- "I have to get close to people to see if they have a mask on (covid). (People would reproach him for failing to maintain social distance)." (Misunderstood.)

- "My older brother told me Mom cried about me (being B/VI)." (Parents.)

- "He (Father) wouldn't let me do anything. Didn't he trust I could (do things)?" (Parents.)

- "When I graduated from the school for the blind, someone asked my Dad what was going to happen to the boys (participant and sibling are both B/VI)? My Dad said they would come live with him and their sisters would take care of them. Dad felt he had to take care of us. He didn't know about blindness. I told him I would never return home." (Misunderstood. Parents.)

- "Everyone wants to treat you special. 'Look out (take care) for (participant)'."

- "We adapt to our environment, there is no magical sensory increase."

- "A (sighted) woman said to me, 'you think you are better than me'. I said I am blind, I cannot drive, and I did not have any children. Why do you think I am better than you?"

- "It is our (B/VI) duty to make the sighted world feel comfortable."

Suicide Trope

Suicide ideation is a step in the suicide process. For most individuals, and obviously for these participants, the process went no further.

- "No one wants to hear about this stuff except my support group."

- "I think about it when talking to a girl that isn't responding to me or when girls treat me like I am invisible."

- "When I first lost my sight, I thought about suicide, but it is not really an out."

- "At one point I thought if I got run over by a car it wouldn't be all bad if I died, but I would never act on the thought. And I no longer 'think death isn't so bad' (i.e., the participant is now of the opinion that getting run over is *not* a good idea)."

- "I am smart enough to know that things are good the way they are, it would be foolish to end it."

- "I am a scaredy. I don't have the guts enough."

- "No way." (Hurting self or others.)

- "No. Never had. My mindset isn't like that."

- "Me? Never. Ever."

- "I never thought to hurt myself."

- "I never thought of suicide."

Teaching Trope

These comments are demonstrative of the teaching über effect.

- "I have done some distance teaching over the phone."

- "We are doing a lot of innovative stuff in my job. We have to come up with teaching strategies." (Employment.)

- "I teach science to blind youth."

- "I am a role model for my clients. They can relate and it motivates them."

- "I try to motivate blind people." (Runs support group.) (Altrusim. Truism. Advocacy.)

- "I use every moment as a teachable moment." (Altruism.)

Unjustness Trope

Employing the words of one participant, this trope captures a "raw deal". Phrases such as 'that is just the way it is' volunteer to describe these situations.

- "When I was in elementary school and high school, I was called lazy because of the lack of accommodations that would allow me to do the work." (Anger. Misunderstood. Inadequacy.)

- "Blind kids get a raw deal learning science. It is a social injustice." (B/VI are often marginalized due to lack of academic adaptations.)

- "Law enforcement is lax in pedestrian accidents involving the blind when they are not at fault. Makes me angry. It's an injustice. My (B/VI) brother was hit and injured by a right turn on red vehicle and another (B/VI) individual was run over and killed by a SUV. They said it was his fault, that he had been to a party." (Pedestrians *always* have the right of way. Individuals who are blind or visually impaired with a white cane are granted the right of way by federal law.) (Anger.)

- "When I confront people about how they are acting (ignoring the presence of the B/VI individual) they turn it towards me."

Vulnerability Trope

We are all susceptible in various ways relative to who we are. So too are individuals who are blind or visually impaired susceptible in ways relative to their condition.

- "People grabbing blind people to guide them." (The proper procedure is to ask before assisting.) (Mobility.)

- "We can't see to defend ourselves."

- One sighted person unilaterally switched (upgraded) fur hats at a party with that of the participant. Another sighted person unilaterally switched (upgraded) blenders while helping this same participant move.

- "I didn't want to have people around me (Sought isolation because of how he was treated by peers and members of the opposite gender)."

- "Students with low vision, it is always in the back of their mind that they could lose the rest of their sight. It is an emotional roller coaster."

Chapter Five - Discussion

In Finland, whatever the cause of a death, death certificates include the pre-existing conditions, if any, of the deceased. Elsewhere, it is only in the event of a natural death that pre-existing conditions are recorded; pre-existing conditions are not recorded for suicides, homicides, or accidental deaths. For this reason, Finland lays claim to being the only country able to determine the suicide rate for the blind and visually impaired (Meyer-Rochow, et al., 2015). They can document which suicides involve individuals who are blind or visually impaired.

Despite some indicators, the suicide rate of individuals in the United States who are blind or visually impaired remains unknown. However, we are not totally without recourse. Using Grounded Theory, we can meet with individuals who are blind or visually impaired and gather data as to protective supports and stress producing factors, which are indicators linked to suicide protective factors and suicide risk factors.

The Principal Investigator

The very second participant with whom I made contact commented upon the absence of B/VI representation in this study and pointed out how such an omission was symptomatic of Ableism. The participant increased my awareness of my biases, stereotypes, and discrimination; and thus, my schooling began.

I hope to demonstrate my appreciation and esteem for the trust, openness, and courage of the study participants by faithfully reporting out what they have taught me because ultimately this is their story.

The Participants

A NASA scientist was describing the challenges of deciding where to land a planetary probe. To illustrate the difficulty of that decision, the scientist reversed the scenario. Presume

you lived on Mars and wanted to launch a probe to planet Earth. Where would you aim? Imagine the images retrieved from probes that had landed in Lake Superior, the Grand Canyon, the center of Paris, the Arctic, or Faya-Largeau. This effect is reflected in this sampling of twenty individuals who are blind or visually impaired.

The criterion for our probe were legally blind or visually impaired individuals, between eighteen and seventy years of age. The selection criteria neither sought out nor excluded participants who had any experience with suicide ideation or behaviors. Until we are better able to establish the field, we are unable to assert just how representative our sample is or is not.

The study utilized the Snowball Technique, where each participant is asked if they know another individual who they might suggest to participate in the study. Like a snowball rolling down a hill accumulating snow and growing larger, so too the number of contacts increased as the group expanded.

This technique does however exert its own influence upon the study. Like a snowball passing over fallen leaves, the leaves tend to originate from the same tree and there is a distinct tendency towards homogeneity such as alumni from the same school for the blind or a cohort of vision rehabilitation teachers. The pool of participants that was collected was propitious because one of the traits these individuals shared was that of belonging to a group of rather staunch individuals that defy stereotyping.

The study benefitted from another element trait of this population that was very opportune. The elevated educational level of this group is significant; no participant has less than a high school education and 45% have more than a B.A. While there is cause for concern that the elevated educational level of the group would detract from the heterogeneity of the study sampling, it was fortuitously counterbalanced by three significant factors.

- A byproduct of education is the ability to articulate, which has greatly facilitated the collection of data. The participants' comprehension of the questions typically required very little elaboration or prompting. Participant responses were focused and explicit.

- Articulation is meaningless if there is nothing to articulate. A majority of these twenty participants had much to articulate by virtue of their being employed and the careers that ensued, which is also impacted by educational levels.

- This study benefited from the experiences, advocacy, and even activist experiences these older, educated, articulate, and experienced participants brought to the table. They are/were successful managers, entrepreneurs, and human service professionals. Nine participants are/were blind rehabilitation counselors.

It was as if our planetary probe landed during a topographer's conference or in this instance, a demographer's convention in Atlantic City.

These twenty individuals each manifest data that is significant and of interest to this study, which is a primary criterion for the study goal.

A potential issue of the snowball recruitment technique is that participants are acquainted with each other at least to some degree and that may inhibit their candor. If the community is small and the individuals are aware of each other's life stories, then confidentiality may be at risk. One participant who had attempted suicide, indicated that when approached by someone they knew and was asked to participate in a study connected with suicide, their initial reaction was that somehow their "secret" had gotten out; why else would they be approached? Later, when that same colleague asked the participant how their session went, the participant determined that their secret was still safe.

While the effects of the Snowball Technique may be unavoidable, they are also apparent and manageable. The demographics of the participant pool were relatively easy to monitor and maintaining a balance as to gender, age, and race required only a modicum of effort.

Interestingly, when participants were asked if they had any health concerns, eight of the twenty participants (40%) failed to indicate anything related to blindness or visual impairment. One participant when asked mentioned "My vision, of course." more in the manner of someone versed to anticipate the perspectives of the sighted rather than reflecting any notice he may have given to his own lack of vision. This resonates with the words of another participant; one task of the B/VI is to accommodate the sighted (and presumably their stereotyping).

These B/VI perspectives in relation to their own vision contrast notably with the stereotypical reactions of dread of some sighted with just the thought of losing one's vision.

To arrive at 20 participants, the study contacted or attempted to contact a total of 32 individuals: One individual who declined to participate, indicated that he had attempted suicide. Details of the attempt are unknown. (Even though the individual did not participate in the study, mental health support was extended and declined.) A second individual declined to participate indicating that he did not want to relive past (unspecified) trauma.

To put our sampling of twenty individuals into perspective:

Number and Percent of Suicides per Population Size		
Population Size	**Number of Suicides**	**%**
100,000	13.42	
7,452	1	0.0134%
20	0.002	

The suicide rate in the United States is 13.42 per 100,000 (NSP, 2018).

Number and Percent of Suicide Attempts per Population Size		
Population Size	**Number of Attempts**	**%**
100,000	335.5	
298.04	1	0.335%
20	0.067	

The ratio of suicides to suicide attempts is 1:25 (NSP, 2018).

With twenty study participants, the probability of encountering a suicide attempt is low, but there were two participants in the study who indicated that they did attempt a suicide. One adult individual indicated that as a teenager they cut their wrists, "but not very deep" with a razor. The only indicated after effect was having to wash the blood off the next morning. A second adult indicated having taken "five to seven" aspirin as a teenager. The only indicated after effect was that they "slept well", and they indicated that since then they believe themselves to be aspirin intolerant.

Given the unlikely probability of having not one but two suicide attempts in the same sampling of twenty, future studies would benefit from reconciling the disparities of self-reported suicide attempts with more accepted criteria, specifically such as the degree of intent and the potential lethality of method.

Blind and Visually Impaired Taxonomy

As the study evolved, it became apparent that how quickly one became blind, at what age, the amount of vision remaining, and the stability of the remaining vision all exerted differing influences upon the individual. For an individual who is congenitally blind, there is a degree of acceptance of blindness being the norm, if not unremarkable. Likewise, it is not unexpected for

individuals who are losing their vision or those who recently became blind to demonstrate a higher degree of anxiety.

These are the categories of blindness that surfaced in the study. Each category has given indications of its own etiology and an associated profile.

- Born blind.
- Becoming blind slowly, over a prolonged period of years.
- Becoming blind suddenly.
- Born visually impaired.
- Becoming visually impaired over a prolonged period of years.
- Becoming visually impaired suddenly.
- The emotional roller coaster of an unstable visual impairment.
- Age of onset of blindness or visual impairment.
- Type of blindness: Zero vision. Light and shadows. Night blindness. Narrow field of vision, and others.

Each category is further affected by delays in recognizing the condition, the level of available support, role models, education, and other factors.

The taxonomy implications may be demonstrated by examining two distinct scenarios. First is an individual who was born without vision, the condition was detected very early, and the individual received timely, effective, support and education in mobility and braille. Contrast this to an individual losing vision in their retirement years and needing to adjust to a new set of life parameters.

This was vividly demonstrated at a monthly meeting for individuals who are blind or visually impaired that I attended organized by the services for the blind at my local library. An older woman, who indicated during the introductions that she had only recently begun to lose her vision, with anxiety apparent in her voice asked a middle-aged woman who was born without

vision and had attended a state residential school for the blind (which is significant because of the unparalleled education and training it provided) what was it like being blind?

The middle-aged woman responded, almost serenely, that she arises in the morning, showers, dresses, makes a cup of coffee, and goes into her garden where she smells the flowers and pets her cat.

Commentary Upon the CDC Data Elements Responses

CDC Data Elements #1 to #10

The first data elements consist of case identifying information and participant socio-demographics. As a group the participants were equally represented by sex and with a Black representation of 40%, which is greater than in the general population. This was an older and well-educated group. Their careers tended towards human services.

The above average education level was fortuitous. These individuals were articulate and familiar with research involving surveys which was of benefit to the study.

One element that warrants recognition is marital status. We have seen how important social relationships of all kinds are to this group, yet only one fourth of them are living together in a relationship with a significant other. Six participants are divorced, and one is recently widowed. It could be expected that the six divorced participants, at least in theory, were open to significant-other relationships, but does B/VI play any role in this situation? Given the significance of socialization for this population, what role does living alone exert on the inclination to socialize?

This situation warrants further research to collect and analyze B/VI and sighted data as to marriage rates, divorce rates, and co-habiting rates, for starters. Inquiry into living with others would be revealing. Do B/VI live with kin, progeny, friends more or less than do the sighted?

What indicators might be examined to determine if the B/VI tend to live alone and might be characterized as loners? Social isolation and withdrawal are recognized suicide risk factors.

CDC Data Element #11: Economic Sector

The number of participants in professional support services, therapeutic services, and health care and social assistance reflects the tendency of the Snowball Technique for individuals to refer others who are often colleagues or peers. That is also mirrored to a lesser degree for those in sales and related occupations who were students in the vending stand program (in federal buildings) that was a vocational option at a particular school for the blind.

CDC Data Element # 18: Alcohol Use, and CDC Data Element # 19: Drug Use.

While the SI allows for collecting data as to the presence of these two data elements, the complexity of substance abuse issues exceeds the scope of this study. There is no reason to expect that substance abuse would not be an issue, but if research found the abuse to be greater or less than the general population, what would be its influence as a suicide risk factor for the B/VI? Questions arise as to the causes of substance abuse and if they were B/VI related, such as the B/VI lower employment rate.

CDC Data Element #23: Self-Directed Violence Category

This data element reaffirmed that the involvement of an LPC was not only beneficial but essential to provide a professional level of "sensitivity in collecting data from persons who may already have undergone trauma from a violent event (CDC, 2011)."

The nature of the survey instrument is intended to gather data in an emergency room setting after a SDV episode, or in interviews shortly after an SDV episode. When we asked the participants if they ever harmed themselves, three of the responses dated from 45 to 54 years prior, when those participants were adolescents. Three of the risk ratings do not appear to enter a

significant level of lethality: taking 5 to 7 aspirin, intentionally trying to break an arm (without doing so), and cutting wrists "but not deep" such that the next day she washed the blood off and the cuts apparently escaped all notice from others. Each instance, as reported, required no treatment and "risk reversibility" efforts appear to be not applicable as there was no reported recovery warranted.

The fourth participant alluded to hurting herself "every once in a while" and it was not specified how she hurt herself or how long were the intervals between episodes. This participant was in very long-term care therapy, which was interrupted by the Pandemic, but she indicated that she was able to consult with her therapist as needed by phone. She indicated, somewhat in contradiction to her statement, that she would not hurt herself as she promised her therapist she would not. As for every participant in the study, she too was offered to contact the LPC if she should ever feel the need, the telephone number for doing so was provided, and it was emphasized that she notify her therapist of her participation in this study. At the end of the session the participant was specifically asked how she felt; did she experience any anxiety or such? She indicated she felt "ok".

The preceding elaboration was to signal that these incidents do not appear to rise to the level of SDV for which the SI is intended.

Given the nature of self-reporting based on self-defining, this study would have benefitted if the questions were more precisely defined and structured. Further research would be necessary to refine parameters to obtain less ambiguous results.

CDC Data Element #26: Medical/Somatic History

The complexity of previous medical or somatic issues requires analysis beyond the scope of this study. It was unknown how many health issues are impacting each participant, what is the

severity of each of those health issues, and how long has each issue been present. Are the issues related to B/VI or are they ills that accompany old age and are relatively common to sighted and B/VI alike? What would be of particular interest for future research is the relationship between the health of individuals who are blind or visually impaired in comparison to the health of sighted individuals and the effect on suicide risk factors and protective supports.

The CDC definition for this Data Element allows for both participant self-reporting and a professional health care diagnosis.

The self-reporting of those responding 'yes' (95%) reflects in part their median age of 64 years and the accumulation of age-related maladies. It remains to be seen what the effect on the percentage responding 'yes" would have been the criterion to be a clinician's reported diagnosis.

The CDC signals the limited information available for this Data Element and the need for more data. It is strongly suggested that this Data Element be broken down into two distinct categories and not an either/or scenario. Self-reporting remains important because of its insight into the participant's cognitive process while a professional diagnosis would reveal significant additional data.

We will expand more in Physical Health Issue (i) below the findings of Lam, et al., (2008) that there is a higher risk of suicide for individuals who are B/VI that is linked to indirect factors such as manifesting two or more non-ocular health issues. Research to include health history is needed to determine if there is an accumulative effect of health issues as the number of factors is a demonstrated suicide risk factor.

CDC Data Element #27: Psychiatric History

Psychiatric history presents with similar considerations as for medical/somatic history. The caveat of self-reporting was again evident here. Some participants had their own interpretation

of what constituted a psychiatric history, which would not necessarily correspond to clinical criteria. Ones memory also plays a role. A few participants would initially indicate there was no psychiatric history and later in the interview a memory would be triggered that would contradict their initial response. The data would also be affected if the criteria had required a professional diagnosis. Substance abuse and marriage counseling would warrant further research investigation. This Data Element should include self-reported and professionally diagnosed psychiatric history.

CDC Data Element #28: Previous Non-Fatal Self-Directed Violence

The LPC indicated that some incidents, as reported by some of the participants, are not atypical of adolescent females in the aftermath of breaking up with a boyfriend, which is how one participant identified herself.

What is the role such incidents play in the formation of an individual's reality bubble and the learning role the play in suicide? Are they an initial practice for subsequent incremental attempts, or perhaps the lessons learned as to feelings such as anxiety and guilt preclude ever wanting to go down that road again? Is this a potential fork in the road for suicide ideation and behaviors? This is a topic ripe for further research particularly on how the cognitive process treats the episode.

Decades long time lapses between the time of the incident and the current age of the participant are provided to indicate that the incidents are not recent events.

CDC Data Element #29: Previous Suicidal Thoughts or Ideation

Discussion as to ideation criteria.

The CDC (2011) definition of suicidal ideation is sparse: "Thoughts of engaging in suicide related behavior" (p. 90).

A suicidal thought as defined by the CDC is where thoughts are directed towards suicidal behaviors, such as devising a plan. That plan, as defined by the CDC (2011) is, "A thought regarding a self-initiated action that facilitates self-harm behaviour or a suicide attempt…such as a description of a time frame and method" (p. 90).

This Data Element is representative of the shortcomings of self-reporting. While 45% of the participants indicated they had suicidal thoughts, their individual criteria do not coincide with the more accepted definition of what constitutes a suicidal thought.

One participant in the throes of a divorce indicated that at one point he thought "I wouldn't have minded if I got hit by a car." The participant was not indicating he intended to step in front of traffic. His statement was more in the nature as 'should a car jump the curb….'

As a CDC (2011) key term, Suicidal Ideation involves "thoughts of engaging in suicide-related behavior" (p. 90) such as making a plan to bring about one's own death. That is at a considerable remove from the prior example that did not indicate a plan.

What is worth investigating is if our pedestrian is representative of this class of like thinkers where even having a thought of haphazardly dying is akin to suicide ideation.

The manner and tone in which those participants reveal those passing thoughts about "not living" is worth comment. The participants relayed their thoughts in a solemn and confiding manner which may indicate the weight the participant assigns to the event.

The cluster of suicide ideation episodes that appear in late adolescence also warrant investigation.

What was the thinking process associated with *disconnecting* from such thoughts? In one instance it was hearing a line from the song *I never promised you a rose garden* on a radio. Would additional research point to a lack of a life philosophy that we are failing to instill into our youth?

Addressing human cognition, why does even a thought of 'not living' rise, in the mind of this participant and others, to the level of suicide ideation? And why does the thought of not living produce an aversive reaction such as with that participant? Is it a religious taboo that provokes guilt feelings and unease or is some other cognitive process is operational? How may we plant the stem cells for an aversive reaction to suicide in the reality bubble of a potential suicide? What we should be able to do is introduce protective supports for living.

This trying to 'fix' reality bubbles appears to run contrary to American practice, where we tend to fix things by medication or a procedure rather than living a good life. Does our culture preclude such lifestyle changes?

CDC Data Element #30: Family Medical / Psychiatric History

Family psychiatric history is reported out by the participants more than family medical history.

Some parents reportedly experience trauma when their child is born blind or visually impaired. Parenting is a challenge, and every child has particular needs. If those needs fall outside of a parents' experience, then parental education and support are required. "That's how I was raised" is not always a valid nor optimal approach. Unsuccessful results may produce resentment and frustration for all concerned.

Parents are a child's first coaches and life managers. Research determining how to amplify and maximize the effectiveness of that parental role would benefit parents and child alike in reducing suicide risk factors and promoting protective supports.

CDC Data Element #32: Military Service

One phenomenon that arose in the study was the concept of risk factor 'immunity'. Because the lack of vision is an exclusionary criterion for participation in the military (4-F, unfit

for military service), there would be no risk incurred from serving in the military such as Post Traumatic Stress Disorder. If a B/VI suicide rate is determined, because of this data element it may need to be adjusted to allow comparison with the general population. There may be other suicide risk factors to which the B/VI are similarly immune.

This Data Element should be maintained because other studies may contain participants who became adventitiously blind while in the military or after having served in the military.

CDC Data Element #33: Proximal Risk Factors

Within the confines of this study, proximal risk factors are defined as being external factors that exert stress upon the participants.

This study found seven risk factors to which the B/VI may demonstrate heightened susceptibility and are of interest to the study.

- Effects of the Pandemic (CUR1).

- Issues involving unemployment (EMP1).

- Depression (MH1).

- Anxiety and stress (MH2).

- Personal adjustment (MH3).

- Self-esteem (MH4).

- Feeling of inadequacy (MH5).

It is noted that the B/VI *may* be more susceptible to the above. For example, this very social population has made known how the Pandemic has affected them. We are all still being affected by the Pandemic, but are the B/VI disproportionately impacted because of the apparent importance of socialization? What we can state with confidence is that they have been affected by

the Pandemic in multiple ways. This includes having their socialization curtailed and limits on mobility, as there are fewer places to go to.

Note that being made to feel inadequate does not reflect in any way as to the actual effectiveness or competency of the participant.

The above will be discussed below in section xviii.

Most significantly, this study found five elements of significance to the B/VI that appear to have a disproportionate impact on the B/VI than for the sighted.

- Unjustice (UNJ).

- Feeling of vulnerability (VUL).

- Feeling of incompetency (SOC7).

- Stigma or Onus of B/VI (STG).

- Pervasiveness (PRV).

The above will be discussed below in sections ix, x, xi, xvi, and xxi respectively.

i. Physical Health Issue - 90%. (SOM)

Lam, et al., (2008) found that there is a higher risk of suicide for individuals who are B/VI that is linked to indirect factors such as manifesting two or more non-ocular health issues. This finding of the involvement of two or more non-ocular health issues also resonates with current suicide theory that the number of adverse factors plays a role in suicide.

The Lam, et al., (2008) findings in conjunction with health issues being the most reported stress issue by the participants is of consequence. There are 90% of the participants indicating a health issue, the highest of any other reported stress factors. While some health issues are common amongst the participants, and some are not, it is remarkable that almost all participants have a health issue.

It is probable that the mean age of the participants of 59.35 years is significant. Health issues tend to accumulate as we age, not diminish, unfortunately.

Are individuals who are blind or visually impaired less healthy than the general population and are justified in their health concerns because they have more issues to be concerned about? This is another area ripe for research and might include the following: Crudden, Cmar, and McDonnall (2017) indicated that mobility challenges led to B/VI to tend limiting going out mainly to necessary appointments. Is there a possible scenario unique to B/VI that going out less leads to a more sedentary lifestyle and an increased tendency to being overweight with the associated health issues?

The participants were asked if they had any health issues 'of concern', which left open the question of health issues that may not have been of concern for that participant but may be of consequence in absolute terms. The structure of the Lam, et al. (2008) study did not survey the participants as to any 'concern' they may have had and would benefit from being clarified in future research.

While all health concerns in this study were self-reported, future studies would benefit addressing specific issues of concern and a criterion for each, such as a physician's diagnosis. It is cautioned that not all issues of participant concern may qualify for a medical diagnosis and that too should be taken into consideration.

Research should encompass applying suicide risk factor criteria to B/VI health concerns:

- How many health concerns are there per participant?

- How long has each concern been an issue for the participant?

- What is the intensity of the health concern felt by the participant?

- What is the prognosis? Are things expected to 'get better'?

It was previously remarked that while nine participants mentioned vision and blindness as a health concern, eleven did not.

There are multiple explanations possible. The recently (adventitiously) blind did mention their condition which usually focused on personal adjustment issues. For the participants with long time vision loss, they fit into how one participant characterized it: being blind was more of a lifestyle, and presumably barely rose, for them, to the level of meriting mention. That explains the pride of one participant who said his son brought a friend home and never mentioned to the visitor that both his parents were blind.

One vignette of particular interest, and one of my favorites, was a participant who was visually impaired from birth and, given his employment history, woodworking skills, and inventing, would fit into the 'B/VI as a lifestyle not meriting mention' contingent. Except he did. What was interesting was the manner in which he did.

When asked if he had any health concerns, he listed a few typical of ageing and almost as an afterthought included his vision condition. What was significant was after he indicated his vision as a 'concern', he added "*Of course*".

Of course? Of course, what? Where did that originate?

He is an excellent example of what several participants mentioned as part of the onus of being blind: being blind in a sighted world and "making it easier for them (the sighted)" to be around B/VI individuals.

Our "of course" participant had so integrated theory of (sighted) mind that he was in effect saying, 'Of course YOU as a sighted person expect me to state being blind is a health concern'.

Most likely, unconsciously, he was accommodating the sighted anxiety of losing sight which plays out as: 'While being blind is not really a big deal for me, I know it is a really big deal

for you, the sighted, so much so that if I didn't mention being blind as a concern for me, you would probably doubt my grasp of reality and I would lose credibility for being so oblivious to (what is for you) such a traumatic state of being.'

The opportunity here is for further investigation as to the linkage between a physical health issue and multiple health related suicide risk factors as identified by:

The National Institute of Mental Health:

- Unbearable emotional or physical pain.

- Increase of decrease in eating or sleeping.

- Using drugs or alcohol more often.

- Chronic pain.

The CDC:

- Serious illness.

- Substance use disorder.

- Cultural, social, or physical barriers to health care.

- Lack of availability of physical and mental health care.

Both organizations indicate that depression, anxiety, and agitation are significant suicide risk factors. Those emotional suicide risk factors may be manifestations of physical issues, or the physical issues may be manifestations of an emotional state. In either scenario, the physical issue makes it presence felt.

This is an area ripe for determining the impact of physical health issues on emotional and health related suicide risk factors.

ii. Mental Stress Issue - 75%. (MH2)

This population experiences mental stress as would many of us. One example is a younger sister, who due to health issues, moves with her adult special needs son into the participant's home. The loss of the participants independence took considerable adjustment including counseling.

Divorce, health issues, and death of a parent also exert an effect.

In addition, there is the stress attached to the visual condition such as anxiety due to loneliness and the continual mobility issues.

Linked to the visual condition is stress because of the sighted. Dealing with the ill-informed sighted causes "distress", anger, annoyance, and frustration.

In some situations, not seeing immunizes against stress. One participant indicated that stripping wallpaper in a recently deceased parents' home, preparing the home for sale, the participant was unaffected by the nostalgic effects of the pattern upon her four sighted siblings.

Perhaps a blind and visually impaired awareness campaign would alleviate some of the sighted induced stress. More intriguing is the concept of being emotionally immune to immediate surroundings and raises the question of what are the advantages of being blind or visually impaired?

The B/VI experience much of the same stress as do the sighted. But other B/VI issues arise. For whatever reason, this B/VI population tends to live alone, and isolation is a possible suicide risk factor. While they may sometimes resent living alone, they may equally resent when that independence is infringed upon. This stress is amplified by the continual B/VI issues with mobility, dealing with the ill-informed sighted, the effects of the Pandemic, the lagging employment rate and a litany of other B/VI factors previously discussed that open the door to suicide risk factors.

iii. Depression Issue - 70%. (MH1)

Vision issues appear to always be able to initiate depression. For the adventitiously blind or visually impaired, depression may be even further heightened by the portrayal of vision loss as manifested in the media and the arts as justifying suicide. This is at a significant remove from individuals who are blind or visually impaired saying blindness is more of a lifestyle and even a blessing.

How may we go from a mindset that blindness is so horrible that it justifies suicide, to a mindset that in the words of one participant, "it is a blessing"? One clue may be the effect of vision rehabilitation centers, which play not just a significant role but such an essential role for the adventitiously blind their impact is hard to overstate. In the words of one participant, "After rehab I realized blindness changes your lifestyle. Blindness doesn't kill you. It changes perspective. I entered rehab saying life is over…I left rehab saying, "life is NOT OVER!" In the words of another participant, "Kalamazoo (the location of the Michigan Rehabilitation Center for the Blind) is a blind utopia."

Perhaps a clue to defusing the pull of depression to suicide lies in the rehab centers function to change perspective. Changing perspective fully situates us in impacting cognitive functioning.

Changing perspective opens perceived opportunities. It certainly appears to be a function of education, at least for the B/VI. Instilling new opportunities disrupts the suicide cognitive process based on logic and introduces rationality.

Depression is a virtually universal lethal suicide risk factor. With the B/VI, additional stressors are present and offer additional opportunities for depression to develop.

iv. Current Event: Pandemic - 65%. (CUR1)

The Pandemic not only limits social gatherings, which is a predominant component in the B/VI lifestyle of this population, but further fetters mobility, which is a continual challenge. Adding concern for health issues to the mix and the Pandemic is a potent cocktail.   Both socialization and mobility are key elements to the typical B/VI lifestyle as is concern with health issues.   A possible explanation for Pandemic's ascension into the rankings is the aura of being a possible über risk factor.

v. Mental Health Issue Not Otherwise Specified – 60%. (MH)

These mental health issues have little to do directly with blindness.   While the issues mentioned by these B/VI participants tend to center around health, and people, it is difficult to exclude the presence of mental health issues that are often associated with them and may evolve into suicide risk factors.

Given the significance of health and the importance attached to socialization, these findings lend credence for the need to support parents, the initial coaches of the blind lifestyle.

vi. Mental Health Issue Involving Family – 60%. (MH6)

There is a parent/progeny trend that surfaces in the responses, but it is not clear if it is attributable to the presence of a visual condition. We alluded earlier to issues parents of B/VI children may experience. There are several statements as to a parent having an adverse mental reaction to having a B/VI child, but without documentation those statements are best considered allegations. Tracing that parental situation to a B/VI mental health necessitates further studies to focus on those effects with the intent of determining any possible suicide risk factor influence.

vii. Suicide Ideation - 50%. (SU1)

These are, of course, comments made by individuals who did not suicide. It would be of great value to determine why the suicide process did not proceed beyond ideation. Was there a protective cognitive mechanism involved and if so, how did it function? Those are important subjects for further research.

Further study is required to explore self-defined ideation and clinically defined ideation. How close, or how far apart, is thinking about not living to thinking about how to bring that state about?

viii. Death of a Friend or a Family Member – 50%. (SOC1)

For these participants, death applies to parents, siblings, and progeny while the death of friends is not remarked upon. The death of parents, even in the childhood of the participants, often remains a relatively vivid memory and attests to the magnitude of the impact of the passing. Would research indicate our sampling just happens to not have any friends who passed?

The CDC does consider the death of a friend or family member to be suicide risk factor, which does not predict a suicide but is associated with suicide.

Note Regarding the Following Three Stress Factors: Unjustice, Vulnerability, and Incompetency.

Here is an example of the Grounded Theory premise that significant data will often emerge.

There are five stress factors that appear unique to the B/VI. Two of those will be seen later, but three stress factors appear that are ranked in consecutive order.

There may be other explanations besides coincidence. But these three form a stress triumvirate, suggesting connections amongst themselves.

What is noticeable is their position on the list. The triumvirate is preceded by elements that for the most part may be considered as 'inevitable': physical health issue, family mental health, etc. These three stress factors are the first stress factors that present as 'we do not need to be here.' If the sighted actors on the stage knew their lines better, unjustice and being made to feel vulnerable or incompetent would simply vanish. That could not be said about the Pandemic or the death of a friend and therein lays an intriguing clue that would benefit from further study.

ix. Unjustice – 50%. (UNJ)

This is the first factor unique to the B/VI (A).

With this factor we are initiated to the first of several factors that emerged in direct relation to individuals by virtue of their being blind or visually impaired. While unjustice is not limited to individuals who are B/VI, this factor disproportionately impacts the B/VI.

Unjustice is a study-generated term to describe a unique situation and is distinct from injustice.

An example of an unjustice is having a vision impairment going undiagnosed for years during which time the participant is accused of being lazy for not doing the required schoolwork. Another example is being diagnosed as visually impaired and then not being provided with appropriate and necessary adaptations as required by law to be able to perform the required schoolwork. Each of these scenarios was unfortunately experienced by the same participant and exemplify unjustice.

There is no court of law to hear cases of *un*justness and provide a sense of redemption, such as is available to cases of *in*justice. There is no recompense for the years of frustration, emotional duress, and lost education. There is no way to make up for the mischaracterization of a student.

These are the sort of issues that 'sting' or 'burn'. One recommendation that suggests itself is to learn from the unjust event and address it by making systemic provisions to exclude it from occurring again.

The impact of unjustness manifests itself as potentially multiple NIMH (2018) suicide warning signs related to feelings:

- "Empty, hopeless, trapped, or having no reason to live.

- Extremely sad, more anxious, agitated, or full of rage.

- Unbearable emotional or physical pain."

x. VUL – Feeling of Vulnerability - 50%. (VUL)

This is the second factor unique to the B/VI (B).

Both this data element and Data Element xi, Feeling of Incompetency, merit discussion. Having a 'feeling' concerning vulnerability or incompetency does not imply that the participant is either of those things, but the participant feels that way.

More accurately, the participant is "being made to feel" that way. It is a mistaken belief that no one can 'make' anyone feel a certain way. While we are rather certain suicide is usually the result of multiple factors, in the previously cited suicide of Phoebe Prince, bullying was identified as the trigger for the suicide, which if nothing else *made* Phoebe feel badly enough to suicide. Would anyone contend that an emotionally abused individual is immune to being made to feel a particular way? Yes, words can hurt in ways sticks can never reach.

Feeling vulnerable is the second B/VI specific factor that emerged in relation to blind or visually impaired individuals. This includes being mugged, assaulted, or even just disrespected.

Feeling vulnerable affects self-esteem and is a potential segue to a sense of inadequacy, a feeling of incompetency, and trauma. It may appear to be incongruous that being disrespected

shares equal billing with being mugged or assaulted, the former being "words" and the latter "sticks and stones", but this factor is not to be underestimated. Several participants have reported feeling what they termed as being 'disrespected' when their presence is ignored, such as when food orders are being taken, or when B/VI males are talking to sighted females in a social context and are being treated as if they were "invisible". These nonphysical events were reported with greater frequency than actual physical events.

This being invisible scenario approaches shunning, ostracism, and their cousin excommunication. It is literally dangerous because these actions have been found to be a form of punishment and even torture capable of causing psychological damage with traumatic effects impacting self-worth and self-confidence. Where those produce feelings of emptiness, having no reason to live, and unbearable emotional pain are all suicide warning signs (NIMH, 2018).

The feelings as the result of being invisible needs to be studied as concerns the intense effects and especially the sighted cognitive process that because a person cannot see or give eye contact does not imply they are deaf and insensitive to comments. In the words of one of the participants, "people treat you like you are stupid".

A persistent media campaign to promote awareness of the B/VI and other special needs individuals before us is required to turn this around. If we are able to lower the feeling of vulnerability for the B/VI and other populations, we would reduce this suicide risk factor to the benefit of all.

xi. Feeling of Incompetency – 45%. (SOC7)

This is the third factor unique to the B/VI (C).

It includes situations when a sighted person spontaneously, and without asking, takes the arm of an individual who is blind or visually impaired to cross the street or otherwise guide them.

Likewise, treating B/VI in a manner that presupposes a cognitive impairment such as addressing them in a raised voice. These unfounded assumptions by the ill-informed sighted may provoke reactions in the B/VI such as being a burden, shame, and rage, all warning signs of suicide.

xii. Stress from an Isolation Issue - 40%. (SOC4)

Isolation draws from several factors. For this population there appears to be an underrepresentation of significant others as well as the issue of mobility being a continual challenge to 'getting out' and becoming un-isolated. The Pandemic plays a role because there is not only a lack of people to go out with, but there is a lack of places to go out to. Due to the unknown influence of the Pandemic this factor may not be unique to this B/VI population.

With the issues of mobility already limiting 'getting out', a further decrease in getting out may make its absence more acutely felt.

There are indications that the recently adventitiously B/VI may enter a period of voluntary social withdrawal. While the comments indicate a sense of isolation it appears to be in the physical sense of not going out or people not coming in; socialization struggles on with telephone and email.

Future studies into protective supports could build upon the existing and significant B/VI socialization supports with emphasis and getting connected to those supports to counteract isolation, emptiness, and hopelessness which are recognized suicide risk factors.

xiii. Personal Adjustment Issue – 35%. (MH3)

Most of these responses are from individuals who lost their vision adventitiously. The lack of responses from congenitally blind individuals reinforces the emerging paradigm that B/VI is more of a lifestyle than an unmitigated disaster.

Without being taught and learning a new perspective, the individual has no hope; some participants default to thinking their life has come to an end. A new perspective gives the individual a road map to literally 'getting a life'.

We have seen the critical importance of vision rehabilitation centers to facilitate adopting a new perspective to go forward with life and counteract feelings of being trapped and having no reason to live, which are suicide warning signs. The role of personal adjustment is a powerful indicator of the importance of personal adjustment as a protective support and may be a key indicator in suicide prevention.

xiv. Childhood Trauma: Out of School – 35%. (TRA1)

Do B/VI children incur more trauma than sighted children? The presence of a vision condition that goes undiagnosed for years, not being provided appropriate vision supports, being bullied because of their vision condition, or parents who could not adjust to having a B/VI child presents ample occasions for trauma to manifest itself.

What would research reveal as concerns how this population deals with trauma with a pervasive component attached to it? More significantly, what happens when they do not deal with the trauma? Is this the commencement of a perceptible foundation for a 'suicide career', unresolved trauma? Given the pervasiveness of the B/VI condition, do these elements continue to accumulate until a critical mass is reached? What would research determine that number be?

This childhood out of school trauma issue merits particular scrutiny as to the implications of B/VI vulnerability, either felt or actual.

xv. Issue Involving Significant Other – 35%. (SOC5)

Boyfriends, girlfriends, long-term relationships, breakups, divorces, ex's, significant other relationships play a role in the lives of the B/VI. With this limited sampling, detecting trends

requires caution. Does being blind or visually impaired exact a toll on maintaining relationships? Further studies to determine the role of significant others and how they impact socialization are needed and if the apparent need for socialization does not imply the desire for a significant other. Those findings would be important to reducing feelings of loneliness and isolation to counteract suicide symptoms such as isolation and withdrawing from family and friends.

xvi. Stigma or Onus of Being Blind or Visually Impaired – 35%. (STG)

This is the fourth of five unique B/VI Factors. (D).

As for most challenges in life, individuals who lose part or all their vision adapt to do what they need and want to do. In the words of one participant, "I am fully functioning, but I cannot see."

Difficulties arise when individuals who are blind or visually impaired interface with the sighted public with their B/VI stereotypes. This results in a situation where B/VI individuals are put into the position to counter challenges imposed by the sighted, whether those challenges are intentional or unintentional.

As if to add insult to injury, while the B/VI are facing the sighted challenges, the B/VI are also aware of a sense of obligation to make the sighted feel 'comfortable' being around the B/VI.

Suicide warning signs for this data element would include shame or guilt and being a burden to others. However, this stress factor is unique to the B/VI. There are no corresponding suicide warning signs, identified risk factors, or signs and symptoms that specifically consider these effects upon the B/VI in having to justify and explain themselves to a sighted audience.

xvii. Self-Concept Issue – 30%. (MH4)

Much of the self-concept issue reflects the misconceptions of the sighted towards the B/VI., this would include the 'ex-sighted' (i.e., adventitiously blind) thinking they would not be able to marry and have children.

The litany of suicide warning signs which includes self-concept issues such as guilt and shame, being a burden to others, feeling hopeless or trapped, amongst other signs, are also present here.

xviii. Feeling of Inadequacy Issue - 30%. (MH5)

Some feelings of inadequacy originate outside the B/VI individual and are transmitted to them.

This factor is linked to or is derived from the stigma or onus of being blind or visually impaired stemming from sighted issues such as overprotectiveness and sighted stereotypes which contend, "If I cannot imagine how something may be accomplished without vision, then I certainly cannot imagine how you (the B/VI) could."

We are encountering here an aspect of pervasiveness, the seemingly unremitting sighted stereotypes. B/VI role models and peers exist to counter those stereotypes and encourage our B/VI individual, but this low incidence condition often distances these individuals and this cannot but contribute to feelings of isolation, as one participant put it, "while in the midst of a crowd."

Suicide issues such as job problems and financial problems (CDC, p. 65) and the lagging B/VI employment rate are all potential issues here.

xix. Trauma: Not Otherwise Specified - 30%. (TRA)

Three trauma themes are reinforced here.

- Health (Hearing loss in one ear, dialysis sessions).

- Death (of parent, suicide of sibling).

- Isolation and loneliness.

The participants, without any prompting, characterized these events as being 'hard', 'rough', or 'the worst' to experience. These responses stood out amongst other responses to other questions as these participants were communicating the intensity of the challenge they encountered. Their comments were often stated in slow and muted tones in what appeared to be a reflective manner and as understatements. In some cases, the characterizations were spontaneously stated more than once as if repeating something was 'rough' would more effectively convey the impact of the experience.

We are no more able to spare adults from trauma than we can spare children from trauma such as feeling unbearable emotional pain (NIMH, 2018) or the death of a friend or family member (CDC, p.65) which are suicide risk factors.

Going back and reading from the top of our protective supports list, how do we impact an individual's temperament or nature? What things can they do to 'keep occupied' and what beliefs may be instilled? Would research indicate that risk factors are not elements to be neutralized as they are factors to be pre-empted by protective supports.

xx. Relationship Issue Not Otherwise Specified - 25%. (SOC6)

These relationship issues communicated by the participants involve a parent, a sibling, or progeny. There is one sister-in-law that is mentioned but she was mentioned almost incidentally as being merely an impediment to the participant's relationship with her nephews.

 The absence of responses indicating relationship issues with non-blood-related others is interesting because this is a group that values socialization and this indicates that family

socialization may be more prevalent than friend socialization, or perhaps studies would indicate there are just more issues with family than friends.

There is a situation where the CDC (2011) indicates a "relationship problem (p. 65)" as a suicide risk factor and cites "family argument" as an example, while the NIMH (2018) indicates "withdrawing from friends" as a suicide warning sign. It appears counter intuitive that family, who we have seen may represent sharing a 'history' with B/VI kin, and friends, who may or may not share a history or a vision condition, are interchangeable elements. The literature projects a feeling that family and friends are interchangeable generic elements; but that is belied by a lack of documentation justifying that stance, at least in the literature gathered for this study. Given the importance of socialization as a B/VI protective support, much more data is needed addressing specifics such as: the category of the relationship (family, friend, or a new relationship category), the length of the relationship and shared history, does the relationship involve a vision condition peer, a measure of the intensity of the relationship, and particular emphasis addressing the 'significant others' issue.

Given the demonstrated importance of a feeling of being connected as a protective factor, the vision rehabilitation curriculum should provide for a unit on developing and maintaining relationships.

xxi. Inescapable Pervasiveness of the Condition - 20%. (PVAS)

This is the fifth unique B/VI Factor. (E)

This is one of five elements that emerged during the study that particularly apply to the B/VI. This stress factor meets the study criteria as being of significance.

The qualifier 'inescapable' is included because pervasiveness does not contain that element. This is manifested by a B/VI sensitization exercise long ago in my educational past where

we were given a swimming exercise to perform blindfolded, with a sighted guide, in the deep end of the pool. The presenter indicated unlike him, we can lift the blindfold and peek. That lesson stuck.

As a sighted individual trying to conceptualize this pervasiveness and its effect on an individual, and at the risk of confirming my ableist tendencies, perhaps it is congruent to my career experiences in sub-Saharan Africa. Temperatures in the hot season daily exceeded 100°F and the heat was certainly pervasive. My duties excluded being in an air-conditioned enclosed space. The culture had adapted; the workday began very early to be able to end at 2:00 P.M., the hottest part of the day. While the heat certainly influenced how and when things were done, the heat did not stymy the life activities of the country. A major difference of course is that I could travel to a temperate clime or an air-conditioned environment, so for me, the pervasiveness was escapable. While my memories include the heat (mainly when it exceeded expected parameters), the heat is far from dominating the overwhelming number of rich memories that I maintain. This is not intended in any manner to trivialize the effects of B/VI on an individual, but it is an effort to illustrate the concept of pervasiveness and hopefully increase the awareness of the sighted.

An equally pervasive consideration is the sighted-world context in which the B/VI are situated. The participants indicate that they are often underestimated by the sighted world and are continually having to explain and educate the sighted to counter B/VI stereotypes which in turn leads to the B/VI unique stress factor of the stigma or onus of being B/VI.

My curiosity is engaged with a congruent condition: deafness and hearing impairment. What are the feelings of the students at Gallaudet University in Washington, D.C.? Founded in 1864, it is a federally chartered private university for the education of the deaf and hard of hearing.

There does not appear to be a dedicated university for the blind, although several universities indicate they have programs to accommodate the B/VI.

What are the implications when there is a dedicated university for the deaf and hard of hearing while B/VI are included in university programs?   Does this imply that the B/VI are more apt for inclusion that the deaf and hard of hearing?

Are the deaf students retreating from the world into a segregated setting or are they maximizing learning efficiency while surrounding themselves with role models and peers who 'get it'? Are they embracing a lifestyle or seeking refuge in one?

Our participants have indicated there are times they wish they could disconnect from the demands of living in the world of the sighted and having to make things easy for the sighted.

The suicide risk factors here center on feelings of being trapped in a situation, or feelings of being in a hopeless situation, and the possibility of depression.

xxii. Suicide in the Past by a Family Member or by a Friend - 15%. (SU3)

Three of the twenty participants know of a family member or friend who suicided sometime in the past. In my own experience, one is never too far removed from someone who has been affected by suicide and it would be more apparent if suicide was discussed more.

There is a trend in that those same three participants shared responding yes to having the following:

- A psychiatric history.

- A family medical/psychiatric history

- Proximal risk factors

- Protective supports.

- Previous suicidal thoughts or ideation.

We have emerging a possible suicide risk profile. A suicide profile includes the intensity of suicide risks impacting an individual, how long those risks have been operational, the level of hopelessness for relief from those risks, and specifically the number of risks. The above represents more than coincidence for these three participants and merits further study with the potential for creating a new profile. This also warrants further studies seeking additional risk factor profiles amongst the participants based on shared suicide risks.

xxiii. Substance Abuse: Unspecified - 15%. (SA)

The Venice Effect.

My cousin's daughter married an Italian, from Venice. My cousin goes to Venice to see her daughter as finances allow, and those visits became more frequent after grandchildren came on the scene.

My cousin takes surprisingly good photographs of her visits that she would post on a social media site. Many of her photos show what it is like to live in Venice, as opposed to being a tourist: in the winter, sitting at a café table in knee-high rubber boots during a shin-high 'aqua alto' (high water), waiter and patrons oblivious to the water swirling around them. Another photo was a picture of the grandkids (twins: boy/girl) boarding a school boat to get to school.

Huh? I never thought of it. Of course, the school bus would be a boat!

My cousin informed me that just about everything in Venice is done by boat and she sent additional photos with that theme. The fire department, UPS, ambulances, the mail, taxis, ferries across canals where there were no bridges, garbage pickup, plumbers, taking the family boat to the supermarket, etc. Just about anything you can imagine that runs on a road…floats on the 'moat'. It is not all singing gondoliers.

It was because of the interview sessions that I realized that the blind and visually impaired were a lot like Venice. The blind and visually impaired do just about everything the sighted do. This includes photography, drug addiction, heading up a state agency, wood working, drug dealing, parenting, state supreme court judge, teaching, childcare worker, police shoot out perp, babysitting grandchildren, practicing law, bowling, physical abuse victim, getting mugged, driving, incarceration, dancing, hitchhiking, alcoholism, going to college, firearm range time, traveling, divorce, yoga, etc.

With blindness, the mind and body are quite likely to be in good working order, or at least there is no reason due to blindness for them not to be. As one participant elegantly explained, blindness is more of a lifestyle than it is a disability.

What stands out for me about the Venice Effect is why did I not realize that about individuals who are blind or visually impaired? Does sighted stereotyping explain the lack of data for B/VI suicide? Or did we just did not think of it?

Take for example substance abuse. There are several participants who have struggled with substance abuse in the past. Substance abuse is prevalent in suicides. A study to compare B/VI substance abuse in relation to sighted substance abuse would prove revealing. If the Venice effect should apply, then we would expect a comparable B/VI: sighted substance abuse rates. But should there be elevated substance abuse, would that indicate that the B/VI are experiencing more stress than the sighted and where does that stress originate? The sighted? Would that indicate a corresponding elevated risk of suicide?

xxiv. Substance Abuse: Alcohol - 15%. (SA1)

While the B/VI will face mobility hassles for appointments they consider essential, such as doctors' appointments, they are less likely to go to social activities, even church, as not being

worth the effort. (Crudden, Caml, and McDonnall, 2017.) Would research indicate that a propensity for social isolation impacts substance abuse, or vice versa?

A study examining the combined B/VI substance abuse codes (SA, SA1, and SA2) in comparison with the sighted population, cross referenced with suicide ideation would be warranted as future study.

xxv. Suicide Behavior - 15%. (SU2)

As previously addressed, self-reported suicide behavior often does not rise to CDC suicide behavior criteria and impacts the study findings. An interesting point was raised concerning the significance of self-reported suicide behaviors in relation to CDC criteria and merits consideration as a study.

xxvi. Stress from a Social Situation Involving Peers - 15%. (SOC3)

Stress from a social situation involving peers was exemplified by one participant's experience when he and his attorney colleagues would socialize at a bar after work. When he went to cash out and go home, he found his colleagues were putting their drinks on his bar tab without his knowledge. The stress from this exploitative situation might be magnified because of the involvement of peers. One might expect to be exploited by strangers with whom one had no bonds, but to be exploited by individuals with whom one would expect to have established a modicum of trust would appear to generate greater disillusionment as it is unexpected.

Further studies are needed to reveal if there is additional stress inflicted when a B/VI individual is exploited by peers and what are its effects in relation to suicide risks.

xxvii. Legal Issue – Not Otherwise Specified - 15%. (LEG3)

Whether B/VI or sighted, legal issues have a life of their own with dispositions, court appearances, attorney fees, deadlines, protracted proceedings, and possible trauma depending on the outcome.

As for other proximal suicide risk factors, the CDC indicates the importance of medical examiners and police reports to include details that contribute to self-directed violence, in this instance legal issues.

xxviii. Financial Issue - 15%. (FIN)

In two instances the lack of money was directly linked to mental health issues which are often present in suicide and would justify further investigation.

xxix. Current Events: National and/or International Political Situation - 15%.

(CUR2)

The national and international stage affects us directly, but also impacts our sense of well-being; what sort of world are we living in? The turmoil of the political situation was manifested for one participant, as for society at large, by interfering with relationships.

Relationships are protective supports and counteract suicide risk factors. Situations that impede relationships become significant warranting additional studies.

xxx. Unemployment Issue – 10%. (EMP1)

Employment provides one with a reason to get up in the morning the lack of which is a recognized suicide risk factor. It is empowering and serves as a quantitative measure of success. There is a 16% disparity between the national employment rate (60%) and the B/VI employment rate (44%). This population is not immune to the effects of unemployment such as its impact on self-concept resulting in feelings of inadequacy and depression (one of the most common suicide

risk factors). There is a possible additional effect upon the participant if unemployment is the result of B/VI discrimination. One barrier to employment is sighted stereotypes and may be addressed with an awareness campaign focusing on B/VI capabilities.

xxxi. Non-Childhood Trauma - 10%. (TRA2)

Trauma is an emotional response to a disturbing experience and includes long lasting effects which are possible suicide risk factors. The adventitious loss of vision is traumatic. From the participant responses, a very effective technique to counter the suicide risk is to facilitate the transition and get the individual to a vision rehabilitation center as soon as possible to change the individual's perspective through education.

xxxii. Substance Abuse: Drug(s) - 10%. (SA2)

While unspecified substance abuse (SA), alcohol abuse (SA1), and drug abuse (SA2) each present with a distinct profile, the presence of substance abuse in suicides is well documented. A comparison of B/VI substance abuse compared to sighted substance abuse, would prove particularly revealing, especially when cross referenced with suicide ideation and behaviors as being a possible response to B/VI stress.

xxxiii. Self-Injurious Behavior -Without Suicidal Intent - 10%. (SIB)

The CDC indicates that self-directed violence (SDV) is a behavior that deliberately results in injury or the potential for injury to oneself irrespective of suicidal intent.

Behaviors exist such as repetitively hitting one's head with open hands, closed fists, or other objects such as walls.   In certain instances, the behavior is severe and may result in brain or other injuries. Medication, behavior therapy, and protective helmets are possible interventions. There are multiple theories concerning these behaviors. The question arises, are these deliberate

behaviors? Often, we do not know. We raise this issue because it impacts an apparent gap in the CDC SI.

How deliberate is the behavior of the participant who tugs on (and not pulls out) his hair? Does the lack of injury or potential for injury remove this behavior from consideration for playing a role in suicide? These behaviors lack an appropriate data element to accommodate them. The classification of a behavior is critical to treatment and prevention decision making, but the CDC SDV categories are unwieldy and do not provide for those behaviors that while not violent remain significant. These, and other similar behaviors may more appropriately be categorized as behaviors that are self-injurious. This code was created to provide an appropriate category for certain behaviors that are not already accommodated in existing data elements.

Self-injurious behavior (SIB) is an already existing concept. The only innovation is its application as a data element for behaviors not appropriately accommodated elsewhere in the CDC SI.

Behaviors linked to suicide need to be reexamined with the creation of an appropriate and clarified system of classification.

xxxiv. Stress from Social or Public Situations - 10%. (SOC2)

This item is a manifestation of the stigma or onus of being B/VI. The participants indicated that social or public situations caused them to feel stress. Initially these were perceived as being individuals who may not be social or who preferred solitude. It later became apparent that is not an accurate portrayal of the situation.

The participants indicated that it was when they were in social situations with sighted people that they experienced stress being misunderstood by the sighted. This situation interferes

with the B/VI penchant for socialization and actuates needing to explain themselves to the sighted and having an obligation for making the sighted feeling comfortable around the B/VI.

The net outcome of this situation is a reduction in the influence of protective supports and an increase of stress factors for some B/VI, which raises suicide risk.

xxxv. Participant as Victim of Interpersonal Violence - 10%. (VIO2)

The B/VI are not immune to interpersonal violence and the question is posed if they are even more vulnerable.

It would be useful to establish the field of B/VI vulnerability and to develop an instrument to measure it. With a larger B/VI population than that of this study, it should be possible to determine and compare rates of physical, sexual, and emotional abuse rates with that of the sighted population to determine the level of trauma and its effect on suicide risk factors.

xxxvi. Employment Issue – Not Otherwise Specified - 10%. (EMP)

Every employment has issues, but do those issues rise to the level of being a suicide risk, even indirectly. If an employment cancels all face-to-face rehabilitation client appointments due to the pandemic, then that may be an issue for a rehabilitation counselor who derives satisfaction from the socialization such appointments bring while another individual might consider such a situation to be an in-house vacation.

xxxvii. Current Events - Not Otherwise Specified - 10%. (CUR)

These two participants indicated that simply hearing about current events on the news is stressful. One participant minimizes listening to the news as a pre-emptive protective action. We have seen this technique before in Temperament (i.) that avoiding doing things that cause stress is a protective support. This introduces the concept that not engaging in suicide risk factors is comparable to implementing protective supports.

If that is so, then the pre-emptive engagement of protective supports would indicate their value to not only avoid suicide risk factors, but there may be a neutralizing effect by not allowing those suicide risk factors to gain a toe hold to initiate a suicide cognitive process.

xxxviii. Current Events: United States 2020 Presidential Election - 10%. (CUR3)

The 2020 election year was significant for most all Americans. We previously saw in Current Events: National and/or International Political Situation (xxix) that one participant specifically mentioned politics interfering with relationships. This takes on special significance for this socially orientated population. Isolation and loneliness are suicide warning signs.

xxxix.   Job Issue - 5%. (EMP2)

Job issues are inevitable. Besides the mundane such as short lunch breaks and shorter deadlines, jobs also have a life span which results in significant changes. That may prove extra challenging for the B/VI who historically face issues to becoming employed, irrespective of job demand and their own qualifications. Job problems are considered a suicide risk factor and the 14% employment lag from the sighted merits further study.

xl. Ideation to Injure Others - 5%. (OII)
and
xli. Action to Injure Others - 5%. (OIA)

The participants were asked if they ever had any thoughts to harm themselves or others. One participant indicated that yes, she did have thoughts about harming someone. "A co-worker did something really bad to me." There were no details provided as to what it was that the co-worker did.

The participant indicated that she called two gun stores and inquired as to the procedure for purchasing a firearm. In both instances she was informed that there was a two-day waiting

period to purchase a firearm. The participant reported that because of the two-day waiting period she was dissuaded, and she took no further action.

While other participants have indicated feelings of anger, they did not report intentions to hurt someone. Given the unjustness, discrimination, vulnerability, being made to feel incompetent, and the continual stigma and onus of being B/VI, amongst other issues, it is expected there might be more instances of the B/VI at least thinking about wanting to hurt others.

Wanting to hurt others may be under reported as unlike suicide, there is an air of criminality to thinking about hurting someone other than oneself or taking actions to do so. Admitting it to someone might be perceived as an admittance of guilt. Does wanting to hurt others count as a cry for help? More studies are indicated for this item.

This ideation and action to injure others is directly linked to being a perpetrator of interpersonal violence, as is seeking revenge, which are identified suicide risk factors and a symptom of suicide ideation and behavior.

xlii. Suicide Issue – Not Otherwise Specified - 5%. (SU)

One participant indicated wanting to discuss suicide while in counseling and it was not addressed. The literature mentions that suicide screening questions by physicians may be perfunctory but within the context of counseling it is rather unusual. The participant indicated that the counseling was orientated towards her recent vision loss. It is disconcerting that a participant wanting to discuss suicide in the context of her vision loss was not addressed to her satisfaction. This participant said she was able to raise the issue of suicide in her support group and indicated she was satisfied doing so.

(This participant, as were all participants, was extended the study suicide safety protocol by the LPC which included giving the participant the LPC contact telephone number, an invitation

to call if the participant ever felt the need to talk, and a direct inquiry as to how the participant was feeling after having talked during the session.)

xliii. − Legal Issue: Criminal - 5%. (LEG1)

Criminality is not frequently indicated within this population. This participant indicated that since no one would hire him, he created his own job of being a drug dealer. This situation is interesting because typically employment is a protective support. In this situation it became a criminal legal problem, which is an identified suicide risk factor.

It is noted that being recently released from prison or jail is a suicide risk factor.

xliv. Legal Issue: Family - 5%. (LEG2)

The legal process is not intuitive and involves filings, deadlines, depositions, extended periods of waiting interspersed with periods of frenzied activity. Legal issues can be stressful and likely even more so for an adolescent attending a segregated school for the blind on the eve of integrating. It was not discussed in detail by this participant, but school integration could be contentious and images in the media during that era vividly portrayed highly emotionally charged instances. This participant did not indicate that the integration of the two schools for the blind was emotionally charged, but she was aware of attention directed towards her being the daughter of one of the class action plaintiffs. The integration took place during the participants senior year.

While several participants did mention their parents divorcing, there was no mention by the participants concerning parental divorce proceedings or any other legal situations.

Whether it is due to the emotional trauma or other issues precipitated by legal issues, this is a recognized suicide risk factor.

xlv. Interpersonal Violence – Not Otherwise Specified - 5%. (VIO)

This participant was beaten with a belt, leaving bruises, and she indicated the violent temper of the father.

There was an older brother who was also beaten with a belt by the father, leaving bruises, and that brother was the sibling to whom this participant felt closest. She recounted an episode when apparently for religious beliefs, the parents convinced the brother to stop taking his insulin, with the brother later being taken to the hospital in an ambulance as a result. This same brother later suicided.

This participant considered the residential school for the blind as a refuge, preferring to stay there and not go home on weekends, which she would have been able to do given the proximity of the parent's residence to the school for the blind. (There are two other participants who viewed the residential school for the blind as a refuge and an alternative residence due to their home situations. Those two situations did not involve violence.)

There is a possibility that the categories of violence may be under reported. This is mentioned because the structure of the SI was not particularly conducive to participant narratives outside the SI framework, and they may have felt uncomfortable to confide for other reasons. This is a sensitive area and would require special considerations to mine that data.

Family violence, adverse childhood experiences, in addition to this issue, are each a recognized suicide risk factor. This raises the observation that suicide risk factors appear to run in groups.

xlvi. School Related Issue - 5%. (SCH)

School problems have been identified as a suicide risk factor. Schools for the blind are to the congenitally B/VI as rehabilitation centers are to the adventitiously B/VI. They both change

lives. That is where a visual 'handicap' becomes "a lifestyle." We also saw that residential schools also provide safe refuge.

For one participant, some resentment and hostility about school integration was directed towards her in the form of "anger and mistreatment". It is probable there is an element of trauma connected with the school typically a refuge was not able to shield the participant during her senior year of high school.

Needing further investigation, is it when schools fail at providing a refuge or do not provide new perspectives that they become a suicide risk factor?

xlvii. Recent Suicide by a Family Member or by a Friend - 0%. (SU4)

While there were fortunately no responses to this item, a recent suicide in the family or by a friend is recognized as one of the most significant suicide risk factors ranking with depression and a prior suicide attempt.

While there were no recent suicides, some participants did report suicides or deaths of family or friends in the past. Additional research is required to determine whether this suicide risk factor is comparable between the B/VI and the sighted.

xlviii. Participant as Perpetrator of Interpersonal Violence - 0%. (VIO1)

None of the participants indicated that they perpetrated interpersonal violence, which is a suicide risk factor. Perhaps a relatively short, one-time interview session is not sufficient to establish a level of trust where the participant is comfortable to admit to breaking the law as a perpetrator of violence with the fear of possible legal ramifications.

CDC Data Element #34: Protective Supports

As a group, these participants have very grounded protective supports. These protective supports may prevent the formation of suicide ideation and suicide behavior from forming in the

first place. That is significant. It implies that protective supports are like a force field that disrupts suicide ideation from coalescing.

All 20 participants (100%) indicated that they employed internal, external, and/or internal/external protective supports to reduce the stress that they may experience. It should be noted that the study did not rate the protective supports as to potency. The potency or effectiveness of the supports certainly should be a priority for further studies.

Several participants indicated that they would avoid specific situations or avoid doing things of which they already were aware would cause them stress. This de facto *preemptive* protective support phenomenon is not reflected in the data but merits investigation as being a significant, discrete, protective support category.

These protective supports appear almost mundane, as if you or I had made them, and that is precisely the point. We are all in the same gondola and that reinforces one of the premises of this study. We are not only interested in how being blind or visually impaired affects one's immunity or propensity towards suicide, but we are equally interested in what way do the B/VI and the sighted share commonalities regarding suicide.

These supports present with an aspect of having been acquired through experience. These possess the aura of being skills that the participants have found necessary to be able to act or function.

The percentages (x%) indicate the prevalence of the support factor in question amongst the participants and are taken from the tables on pages 157, 158, and 159.

i. Temperament Domain – 95%. (PI–TEMP)

One's mindset takes first place in protective supports. The temperament of the participants as reflected in their statements would serve as a passable self-help book.

The participants tend to manifest their temperament as if following a code that they themselves compiled from their own acquired experiences and knowledge.

ii. Tangible Domain – 85%. (PI-TAN)

When the participants were asked how they dealt with stress, many reported tangible activities and actions for "keeping busy" or "doing something". From the perspective of the Venice Effect, the list is unremarkable but contains an unexpected B/VI activity or two such as photography or range time with a Glock 9mm.

Included in this domain are participants intentionally *not* doing something to avoid undesirable results. A typical articulation is: 'I learned NOT to even go down that road as it only gets me riled up.'

A mind that is occupied, or kept busy, is a mind that is not thinking about suicide. An occupied mind is also likely not to be a mind that has no reason to live, which is a prime suicide risk factor.

iii. Esprit Domain - 80%. (PE–EX)

This domain has to do with the spirit or soul, life, the heart, and/or a belief. The nature of the verbs found here are more declarative and are distinct from the verbs found in the Temperament Domain (i) which tend to be more reflexive.

Interestingly, while three participants were not coded with any esprit supports, they were compensated for by other participants firmly nested in multiple esprit supports.

The actions taken by the participants that are included in this domain manifest various qualities such as: perspective, resilience, pragmatism, problem solving skills, self-monitoring, positive expectations, and optimism concerning the future. The Esprit terminology addresses feelings that tend to be abstract and employ terms that tend to be absolutes. The attributes are

based on fundamental beliefs that elude explanation. These supports typically allude to higher purposes, are more ethereal, and are indicators of an individual's values.

An observation of the LPC was that these participants were aware of "the bigger picture", which she had encountered with clients in her practice and indicated that concept was a significant support. That awareness situates them in life and living, contrary to the suicide risk factors of emptiness, hopelessness, and feeling trapped.

iv. Siblings – 75%. (PE-SIB)

Participants indicate the importance of siblings, possibly because of the continuity and stability they represent; they 'have history' together. A comparison with the general (sighted) population would prove revealing as to the potency of this item as a protective support to counteract suicide risk factors such as withdrawal and isolation.

v. Demonstrating Competency – 70%. (PI-TAN-C)

This behavior is hardly unique to the B/VI, but the facility with which the participants present their credentials, as it were, indicates that they have had ample practice. This is not to imply defensiveness so much as these B/VI individuals are well habituated to the need for countering stereotypes, which is a pervasive part of both the B/VI landscape and the onus of being B/VI.

Competency counteracts the suicide risk factor of being a burden.

vi. Advocacy – 70%. (PIE-SA)

This Protective Support is one of several that is found in the B/VI tool pouch. While advocacy is not a behavior that is unique to the B/VI, it appears to manifest itself more frequently than for the sighted, and with just cause. These responses are burnished from use, as having to assert oneself is another requirement of the B/VI lifestyle and an element constituting the onus of

being blind. The participants verbalize that while they are *self*-advocating, they are aware that their advocacy extends to the entire B/VI community.

For those who are called upon to self-advocate, they are conscious of and often verbalize their efforts as being directed to the bigger picture. The participant will indicate that their advocacy efforts are on behalf of other B/VI as well as themselves.

This motivation is altruistic and is a counter to the suicide risk factor of having no reason to live.

vii. Therapy – 70%. (PE-THER)

Therapy covers the gamut from scheduled sessions with a mental health professional to having a confidante. In this study, therapy is when a stress producing issue is made less stressful when it is addressed with a person designated by the participant for that purpose. The specific person may be a licensed therapist during regularly scheduled sessions, a confidante, a friend, a family member, or similar.

This protective support taps into the benefits of socialization and counters the isolation and withdrawal risk factors.

viii: Teaching – 55%. (PIE-TCH)

Teaching is classified as a B/VI *über* support. An über support is characterized as a support that embodies a critical mass of protective codes that render it particularly potent, not just because of the number of codes it encompasses, but also due to the intensity of those codes specifically for blind and visually impaired individuals.

The term teaching is utilized by the participants in its broadest sense, from formal settings in front of a classroom to casual over the telephone intentional role modeling or counseling. The

multiple interpretations of teaching are reflected in the various terms associated with rehabilitation: teacher, counselor, therapist, specialist, instructor.

The following analysis demonstrates the intensity of this protective support:

- Teaching is linked to altruism, the goal being 'to make things better.' B/VI are not exempt from motivations to 'give back' and this desire was explicitly expressed by several participants. (Esprit.)

- Nothing quite instills pragmatism as does encountering situations that require what are referred to in the profession as *classroom management skills*. (Temperament.)

- While it may not be the conscious motivation for a participant to seek a role as a teacher, an inherent benefit of teaching is that it provides an avenue for feeling connected with other humans in other than a social role, typically in a mentoring role which has its own specific principles. (Associative.)

- Teaching is most certainly 'keeping busy' such as preparing lesson plans, handouts, paperwork, and materials. Consult any teacher if a more detailed response is desired. (Tangible.)

- There are those participants who regularly connect with other B/VI individuals and do so conscious of being a 'role model' as a function of their employment as a vision rehabilitation teacher demonstrating competency. (Competency.)

- Depending on the context, teaching may make available a supply of colleagues, peers, and co-workers with whom to associate and socialize. (Peers.)

- In more formal settings, teaching provides in-service opportunities. Learning is always empowering, and in-services often contain a social component, even if it is only sitting at the same table together for the buffet lunch. (Educational.)

- Teaching is a job that provides a reliable salary and job benefits for a population that faces above average unemployment. (Employment.)

A perusal of the above will reveal that teaching reverberates with the primordial elements of identity and self-worth and provides a forum where competency is expected and recognized.

Über supports demonstrate that not all protective supports are created equally. It remains

to be seen if this B/VI über support manifests the same potency for all teachers, both B/VI and sighted.

For every protective support that is manifested, a potential suicide risk factor is counteracted. The esprit support takes on depression. A positive temperament resists mood swings and reaching out to connect refutes the tendency to self-isolate. Tangible activities may become occupational therapy to counter mental disorders and demonstrating competency instills pride where there may have been a feeling of shame. Socialization, learning, and employment address isolation and withdrawal, keeping engaged with life, and being productive and giving back.

ix. Friends – 55%. (PE-FRI)

x. Extended Family - 50%. (PE-EXT)

xi. Parents - 45%. (PE-PAR)

xii. Family - 45%. (PE-FAM)

xvi. Significant Other - 35%. (PE-SO)

xvii. Progeny – 35%. (PE-PROG)

xviii. Peers, Colleagues – 35%. (PE-PEER)

The following commentary applies to each of the above seven protective supports.

While this grouping (not in continuous rank order) is based on factors such as blood relations, elected linkage (Significant Other), or linkage by association (Peers, Colleagues); the prevalence of socialization and feeling of being connected and its implied importance as a protective support is a significant finding of this study. These protective supports, if only by their number, play a major role in combatting isolation and withdrawal which are amongst the most serious suicide risk factors.

It is expected that different groups would meet different needs or expectations of the participant, but the draw of socialization is an unmistakable presence and further research is needed to determine what commonalities, and differences, that explain its irresistible allure.

While ninth place Friends cannot hold a candle to Siblings, fourth in rank order in the rankings and not included in this group to preserve its air of uniqueness, Friends heralds in a pack of elements composed of Extended Family, Parents, Family, and further down the list, Significant Other, Progeny, and finally Peers. Brief observations on each support follows.

It is interesting that nieces and nephews are predominant in the Extended Family category and are a genealogical echo of Siblings as a protective support countering suicide risk.

The relationship between the participants and their parents presents us with a considerable range reflecting the gamut from being over-nurtured to being abused and rejected. This too is an area ripe for further investigation. We have seen the challenge of raising a special needs child without resources or specialized knowledge and that is not without lingering effects.

While living with another person does not ensure that they are a significant other, fifteen participants (75%) are either divorced (6), single (7), or widowed (2), which ostensibly precludes the presence of a significant other. While the widowed may be attributable to this being an older age group, the percentage of participants without significant others (65%) is curious.

The Progeny element includes children and grandchildren. From the participants comments, doting grandparents are doting grandparents whatever their vision status.

As concerns Peers and Colleagues, one participant's comment about "bowling on an equal basis" with the sighted recalls other comments such as winning a chili cook-off, wrestling matches, and chess games, against sighted competitors. Winning in competition with the sighted provides the B/VI with a special appreciation as a demonstration of competency.

xiii. Job - 40%. (PE-JOB)

With an employment rate 14% lower than the general U.S. population, a job takes on added significance for individuals who are blind or visually impaired. Job problems are an identified suicide risk with links to other recognized suicide risks such as financial problems, being a burden to others, and having no reason to live.

xiv. Medical - 40%. (PE-MED)

The health status of these participants demonstrates a trend of hypertension and antidepressant medication, which is likely given the mean age of 59 years.

This issue takes on additional significance lending support to the findings of Lam, et al. (2008), using structural equation modeling determined there to be a statistically significant increase in B/VI suicides involving the number of non-ocular health issues. While the role of non-ocular, multiple health issues requires more investigation to determine how prevalent an issue it is, what are we to make of the hypertension indicated in this study? Does the apparently elevated rate of hypertension perhaps indicate something besides an age-related health issue such as stress?

Crudden, Cmar, and McDonnall, (2017) demonstrated that the stress associated with mobility had the effect of limiting non-essential mobility, such as socialization. Does that stress avoidance favor a B/VI sedentary lifestyle that tends to obesity more than the American norm?

Recall that this staying at home is at the cost of a primary protective support, socialization.

This population is intriguing since it requires additional studies seeking explanations that are not obvious, such as the importance of siblings and their progeny in B/Vi lives.

xv. Adaptations - 40%. (ADP)

We all use adaptations and what the sighted may consider to be a B/VI adaptation, for some B/VI it is just the way to do business and may fall into the "of course" syndrome, hardly worth notive.

The adaptations indicated by the participants is a diverse and interesting list, if only for the range of issues addressed.   The technological and medical advancements being made today, of which this investigator is only partially aware, will see a significant increase in adaptations for daily use.

The adaptations are significant because they are what make B/VI in the words of one participant, a "lifestyle".   Adaptations are what allow another participant to state, "I am fully functioning, I just cannot see."

Adaptations facilitate multiple protective supports including Temperament (i), Tangibles (ii), Competency (v), Employment (xv), and counters suicide risk factors Vulnerability (x), Incompetency (xi), and Personal Adjustment (xiii), amongst others.

xix. Support Groups, Organizations – 30%. (PE-SS)

Social services, Alcoholics Anonymous, organizations for the blind, and other support groups are alluded to by the participants because of the social nature of those groups. It was cited as being a benefit to them and a primary reason for belonging, which are attributes of socialization, a significant Protective Support countering suicide risk factors of isolation and withdrawal. Organizations for the blind stood out for the role they play, reminiscent of the role vision rehabilitation centers play.

xx. Desire to Connect – 25%. (PI-ASSOC)

The vector is from inside the participant and expressing a desire to reach out and connect. It is distinguished from socialization by seeking a more meaningful connection with others as opposed to just hanging out with people. It typically involves family but is not limited to them.

This becomes a suicide risk factor when that desire is no longer operational. The individual withdraws and disconnects.

xxi. Non-secular Community – 25%. (PE-REL)

This code identifies a group that prioritizes membership in religious communities for socialization over spirituality, as least in reference to joining choirs and indicating that the pastor is a very nice person with whom to converse. More apparent spiritual issues are addressed under Higher Being (xxvii).

This is another manifestation of protective supports countering the suicide risk factor of isolation.

xxii. Miscellaneous – 20%. (PE–OTH)

This is a catch all category but some of the comments tend towards talking with people either on the phone or in counseling sessions and reinforces once again this being a social population and demonstrating the importance of socialization as a protective support.

xxiii. Cultural context - 15%. (PE-CUL)

This decidedly urban population engages in activities that are characterized as being able to be preceded by the phrase "Going out to…." Before the Pandemic they were accustomed to getting out of the house and doing things such as going to restaurants, the shooting range, bowling, dancing, or visiting kin in other states. No surprises here that these activities are social activities, staving off isolation and withdrawal suicide risk behaviors.

xxiv. School – 15%. (PE-SCH)

Learning is important to everyone for multiple reasons, especially as pertains to formal education. School is more than a place where education takes place; it is where to find friends and B/VI peers, to engage in extracurricular activities on an even footing with sighted peers and is sometimes a welcome refuge from things at home.

School provides multiple protective supports: it changes perspective about B/VI (Temperament.), it fosters tangible accomplishments, competency, advocating for self, and many other positive attributes that qualify as protective supports, deflecting suicide risk factors.

xxv. Hospitalization - 15%. (PE-HOSP)

Hospitals play a role in rehabilitation, intervention, and evaluation, all three which are represented by the participants. In some situations, hospitalization is not elective. This introduces the concept of a lifeboat protective support that rescues individuals from situations with a suicide risk.

This is an area where B/VI and sighted are comparable. When the ship is going down, why it is going down is not a priority. The primary goal is to ascertain the safety and well-being of the individuals. That is an elementary function of protective supports, safeguarding individuals from suicide.

xxvi. Blind Rehabilitation Center – 15%. (PE – REHAB)

For some of the participants, B/VI does not so much limit what an individual can do, but rather how they do it. As one participant averred, "Blindness is less of a disability as it is more of a lifestyle." The individual who advanced this concept indicated a thinking experiment she did and contrasted blindness to missing a limb, being in a wheelchair, or being deaf. She made the argument that those situations impose significantly 'harder' parameters than being blind or visually

impaired because they imposed more limits on what could not be done, compared to blindness. Another participant, after losing her sight, went from thinking "life was over" to the opposite stance, after attending a vision rehabilitation center. What rehabilitation does is teach one a new perspective and teaches how to live the B/VI lifestyle. Without B/VI skills one is virtually marooned and dependent upon others, living in one world with skills from another world.

This support is distinguished because of its significant positive impact on the lives of B/VI. The blind rehabilitation center takes an individual without a lifestyle, which is fertile ground for suicide risk factors, and it provides perspective and skills for creating and living a new lifestyle. In so doing it provides a host of protective supports.

xxvii. Higher Being - 10%. (PE-GOD)

Two participants have indicated that their belief in a higher being is a protective support for them and is how they handle situations that cause them stress or anxiety, known suicide risk factors.

xxviii. Pet – 5%.   (PE-PET)

The American Society for the Prevention of Cruelty to Animals (ASPCA.org) indicates that 44% of American households have pets, so the low representation of cats and dogs among the B/VI stands out with only participant indicating having pets. The study did not seek specific data as to pet ownership and this question would be very significant in a specific study for several reasons. Given the suicide risk factors of withdrawal and isolation, pet ownership apparently has a positive influence on health and longevity, both very positive supports.

Given the prevalence of (non-leader) support dogs in the sighted community, this underrepresentation of pets with the B/VI is somewhat puzzling, except in the instance of felines and their haughtiness where it is perfectly understandable.

xxix. Physician - 5%. (PE-MISC)

Physicians and other health care professionals, both physical and mental, play a protective support role, in the same vein as that of hospitalization, warding off or minimizing noxious suicide risks.

Further investigation might reconcile the apparent anomaly that while health issues are of a primary concern, the professionals who address those issues are not ranked higher.

B/VI Cognition

When an individual confronts a suicide risk factor, we cannot predict how they will react to that factor. How they will react depends on how they process that factor. That cognitive processing is formed, shaped, and created by the individual over time and lends considerable weight to Maris' (1981) concept of a suicide career extending back to for an indeterminate time.

That suicide career appears to be the evolution of a cognitive process. We do not know when the process started and the issues that shaped it that either embrace the logic of suicide or embrace the rationality of dismissing suicide out of hand. Maris (1981) expressed documenting this process very astutely when he said, "What is needed is something like a movie of the life and death styles of the suicidal individual" (p. 6).

While we may be close to capturing our every move in some digital form, despite ourselves, we are not there yet. But what we do have here are statements from the participants that provide us with the opportunity to examine the workings within their reality bubbles. Scripts for that movie, as it were.

While these statements are not letters that were never sent, they are letters that we can read. While they relate to suicide risk factors and protective supports, they do not relate directly to

suicide. We remain at that immutable remove from suicide primary sources, but we are getting closer. The bottom line, this may be as close as we may get, at least for now.

We are unable to examine the inside of reality bubbles; we are limited to observing their externalities. Here we attend to B/VI statements about themselves that were made during the interview sessions but are not necessarily responses to the survey instrument. When grouped by commonalties, themes emerge. The statements provide us with clues as to the nature of the participants' cognitive processes. Statements such as, "The pity party runs from 12:00 to 12:01" and "Either get busy living or get busy dying" reflect cognitive processes that not only generate very powerful protective supports but indicate a focused cognitive process. There is much to learn from these comments, and if we can tap into those cognitive processes with studies focused on them, it would reveal that the right mindset is the basis for a good life and is more effective than countering risk factors that arise because it preempts the risk factors.

The justification for persisting in this cognitive process vein refers to Maris' (1981) comment back in chapter three: in suicide the respondents are unable to respond. But what we do have available to us are the participants comments.

First, these comments are from individuals whose protective supports have demonstrated their effectiveness.

Second, these comments derive from an inquiry into suicide and as a result are focused.

Third, with these participants comments, we have external manifestations of the participants' cognitive processes.

Not every trope will demonstrate distinct links to suicide risk factors and protective supports. These tropes are examined as artefacts of the cognitive process from whence they issue.

An appropriate conceptualization is that these participants may serve as the script for a movie about lifestyles and living the good life, denying suicide a toe hold.

There will not be explicit comments about each trope linking it to protective supports or suicide risk factors. Those links present us with an entire new chapter that manifests an exigency for additional studies to reverse engineer those comments.

The CDC (2011) admits to this being an "exploratory classification" (p.67), and they anticipate that the data collected will contribute to understanding the connection between SDV and protective supports. Specifically, the CDC anticipates that protective factors will "reduce or nullify" (p.67) suicide risk factors.

This study contends that future research will indicate that rather than reduce or nullify suicide risk factors, protective supports will preempt suicide risk factors from forming in the first place. Protective supports will prove to be the vaccine against suicide. Time and research will validate or disprove this contention.

Trope Emergence

While examining the data from the participants, the data splits into various tropes like art fair goers gathering round their favorite food truck.

Some of the tropes share labels with some of the data elements and the acute observer will notice an inevitable degree of repetition.

There are twenty-three tropes.

Advocacy / Assertiveness / Self Image Tropes

As for any self-actualized adult, one needs to advocate for oneself and for any group with which one identifies, as do these participants. In addition, one is sometimes required to assert oneself if only to break free of stereotypes and other limitations that are being unjustly imposed.

Adding to this mix, at least as concerns this study, are one's realizations of what is lacking in one's life and articulating what it may be.

This skill of dealing with the sighted is apparently acquired. This skill would be appropriate in a vision rehabilitation curriculum.

Altruism Trope

The participants in this study articulate a well-developed sense of wanting to pay back/pay forward benefits to others. Two participants have indicated that they specifically want to help other B/VI avoid the situations they themselves faced as B/VI. This would qualify as a protective support because of the positive demonstration of competency.

Anger Trope

Perhaps it is due to the fifty-nine years average age of the participants or perhaps the more than 16 years of education level, but these participants do not usually manifest anger. Most, perhaps with age, have become inured to unjustness and discrimination or learned to deal with it. While they may be inured, that does not imply that they are necessarily acquiescent.

It is significant that some of the comments relate to resentment at their vision condition. In one instance, that resentment at being B/VI went unaddressed by counseling for a considerable length of time. It was only when the B/VI issue was addressed as a keystone issue that the other behaviors was able to see resolution. This was a very significant finding as to how the thinking process behind the anger was instrumental to turn stress factors into protective supports.

Burden Trope

The B/VI perspective on 'burden' has several interpretations and is not what may be intuited. One that stands out is the burden of the B/VI "making sighted people feel comfortable

being around you." It is not so much that the B/VI are a burden on society, but the sighted feelings are a burden on the B/VI.

This issue manifested itself in various ways from various participants and the burden trope is significant as a stress factor.

Competency Trope

This cognitive process results from successful experiences and is a very potent protective support.

It has been said that success promotes success and that is evident with these participants. The participants included in this trope manifested obvious confidence and optimism when discussing their lived experiences. Those experiences formatted their cognitive process to be open to more experiences, more success, more competency, and a cycle of self-actualization forming multiple protective supports.

There appears to be a special appreciation for accomplishments when in competition with the sighted.

Dependency Trope

The tone of most of the participant's responses is that they do not feel they are any more dependent than anyone else and they attach great importance to their independence. If there is something that they do depend on it is for the sighted to respect their rights to things adaptive aides, a secret ballot, and open minds particularly when it comes to employment.

This is another healthy mindset of considerable significance and is counter to several suicide risk factors such as job problems and being a burden to others.

Employment Trope

The positive benefits of employment for these B/VI participants are just as significant as for any population. Employment provides meaning, it is a measure of one's being needed; it is a vehicle for socialization either with peers or clients, etc. While those are each highly appreciated, a job also provides a paycheck. We need not reflect for long what a paycheck provides by remembering what it is like not to have one. These are important protective supports.

The elevated B/VI unemployment rate is unjust and hard to accept for a group that is mentally and physically adept. The discrimination against B/VI has been compared by one participant to that of racial discrimination with connections to suicide risk factors such as job and financial problems.

Employment Deterrent Trope

The sighted, being unable to imagine performing a particular task without vision, likewise lack the ability to imagine anybody else doing it without vision. Besides the sighted inability to conceive of B/VI individual competency, other barriers often raised are issues of liability in the event of injury and complications with workmen's compensation.

This situation and the others that were reported are conducive to producing feelings of unjustness, which is a stress factor that emerged during the study.

Esprit Trope

The B/VI are sometimes said to have superhuman powers and extraordinary determination to overcome challenges. Typically, the B/VI resent being so characterized. The mechanisms involved by the sighted in making such assertions are understandable but invalid and rejected as they are ultimately patronizing.

Suffice it to say that the cognitive processes these B/VI adopted are intriguing because they are representative of how human beings, B/VI or sighted, respond to challenges. From that perspective, it binds us together with a shared human trait, to persevere. These are not super humans set apart from the sighted. We are one.

Many of the participants comments are applicable to anyone facing a challenge and are protective supports.

Inadequacy Trope

The inadequacy trope is demonstrated by the impact of not being able to drive in our car centered culture. It impacts the concept of 'fitting in', wanting to be like everyone else. The driver's license is a time-honored adolescent rite of passage. As reported by a visually impaired adult man, informing a woman that you do not have license leads the woman to assume the license was lost due to driving under the influence of alcohol which contains negative connotations.

The stress or risk of about half of the comments in this trope pertain to interference with social aspects of life, which are a particularly important protective support for this population.

Mobility Trope

Mobility is a continual stress factor for this population. Studies to determine how much mobility issues are related to the amount of mobility training, the availability of public transportation, and the impact of self-driving cars on the stress generated by this factor. Additional data concerning the relationship of mobility to socialization as a protective support.

Parental Trope

For the older participants in this study, their parents pre-dated the information age. Informing oneself was immensely more difficult. People instinctively resorted to what they

already knew, and in most cases what many already knew consisted in how they themselves were raised as a child, which may not have been transferrable.

In the situation of a B/VI child, what the sighted parents sometimes resorted to was based on stereotypes about the blind, such as the B/VI needing to be constantly provided for.

Throughout this study various stereotypes about the B/VI regularly surfaced, and it is germane because how people are raised impacts their entire life. The parents are the very first coaches.

So where do these B/VI stereotypes come from? There are biblical passages containing references to the blind. The arts (Bolt, 2005) typically represent blindness as a tragedy of the first order, setting the tone for a controlled panic when a person is losing their vision.

A natural parental reaction is to protect their child, opening the gate to overprotectiveness and the unintentional denial of developmental opportunities. Parents may also have feelings of guilt.

But there is another deeper psychological process. In the societal zeitgeist is a stereotype that there is nothing worse than being blind. Derived from that same zeitgeist is the (sighted) logic: "My reliance on my vision is so total that I cannot imagine doing anything without it…and… if I cannot imagine doing anything without vision, then neither can I imagine anybody else doing anything without their vision."

The effects of such a mentality are insidious but that mindset becomes especially toxic when it is manifested by the sighted deciding whether to let their child climb a tree or considering B/VI individuals for employment or job advancement.

If educational institutions and society, despite their mandates, funding, and resources, are often ill prepared to provide for the specialized needs of this low incidence population, imagine

how much more so for parents. It is not unusual for parents needing to confront educational institutions to enforce their compliance with their federal mandates. Also, the divorce rate amongst parents of special needs children is elevated and has its effects on the children, special needs notwithstanding

The task is daunting, and parents face continuous dilemmas. As an example, should parents be more demanding of their child to compensate for the impairment? Or maybe they should be less demanding in recognition of the increased hardship imposed on their child by the impairment?

It should be noted that the implementation of mandatory special education (1970s) is within the experience of some of this older population as prior to mandatory special education, school districts could simply refuse admitting special needs children.

What are the formative effects of the above on the development of a B/VI child growing up in such a situation? The participants comments do indicate lasting effects, but this is not to imply that every B/VI child is subject to such turbulent factors.

Understanding for well-intentioned parents trying their best to provide for their child is warranted.

Personal Adjustment Trope

When people encounter an event that impacts their life in a substantial manner, they require time to process the event, learn necessary techniques, and to adopt a new perspective. There is a range of reactions amongst the participants from denial, which is a risk factor, to acceptance as a protective support. The role of a vision rehabilitation as a protective support to instill a new perspective is crucial.

Pervasiveness Trope

When the participants were asked if they had any somatic or health concerns, nine (45%) mentioned nothing about their vision whatsoever. To sighted me, with my preconceived notions, I would expect all the participants to mention vision first and foremost. But I have learned from the individuals in this study. Particularly for the congenitally blind, asking as to effect of their vision status on their lives brings us back to the "of course" vignette.

While blindness may be pervasive, it is not necessarily continuously onerous. One adventitiously blind participant indicated there are times he forgets he is blind and on occasion he leaves his apartment and must go back and get his cane that he left at home.

But those comments belie the exasperation of other participants in their struggles with the sighted and the misunderstandings that accrue and become potential risk factors.

Previous Trauma Trope

Despite mechanisms to protect B/VI from harm, the B/VI are no more immune to bad experiences then the rest of us. Parents of special needs children do experience increased divorce rates, for example, and the effects of divorce on any child is well documented.

There is one report of the parent of a B/VI child being so affected by giving birth to a B/VI child that they suffered two mental breakdowns and fifty shock treatments.

Without documentation it is difficult to ascertain the precise parameters of the situation. There are however other participants who indicated similar parental reactions of a lesser degree. This does not appear unreasonable especially if the parents are laboring under aversive stereotypes and are not provided with appropriate support.

Trauma is an identified stress factor and its effect on this population raises the emergent issue of vulnerability.

Protective Supports Trope

This trope contains the potential to unlock the ability to predict who will not suicide. Perceiving that life is good and that you are living a good life may be the key to not suiciding. Perhaps people who suicide do not have enough or any protective supports. Risk factors appear omnipresent, and the emphasis shifts to how risk factors and processed by the individual. Are the protective supports sufficient, so the individual is immune to suicide risk factors and those factors remain benign?

The primary B/VI Protective Supports are temperament, keeping busy, a positive outlook on life, and keeping siblings close.

Risk Factors Trope

The role of physical health issues is the most significant factor for these participants, followed by mental stress, depression, and the current Pandemic.

While these participants are not exempt from what life has to throw at us, what stands out is their comments as to their perception of their situation. It is as if they are at a remove from the trauma that is unfolding before them. They appear to be engaged in a narrative about their lives, which of course they are being in an interview, but the terms being used are not those of victims but of acceptance and optimism. ("…but that is how it is." "I am ready for the sunshine to come out.") In the words of the LPC, "they see the bigger picture".

The Sighted Misunderstanding the B/VI

This is a major consideration for the participants in this study. There are multiple variants of B/VI being mis-understood; two that stand out are:

This is a very common sighted mis-understanding that will rankle any B/VI who reads this. The B/VI individual is seated in a restaurant with his or her friends and the server is taking the

order. When it is the turn of the B/VI to order, the server will address the companion/date of the B/VI and ask what "he/she" will be having? Whatever assumptions the server adopted; this is a humiliating situation for the B/VI.

The second misunderstanding is complex, but not complicated. It is two sided. Some B/VI individuals do not need to use a cane, a dog, or dark lenses, which are all cues to the sighted that the individual with those aids is vision impaired. Sometimes the B/VI express that they want to fit in and be like everyone else, to not stand out as different and they may not use aids for that reason. Without those cues, however, the sighted then presume the individual in question to be sighted and are then at a loss to explain atypical behavior. The example given by a participant was being at a party and somebody waves to the participant from across the room. The participant being unaware he is being waved at, does not wave back. He is then assumed to be stuck-up. In such instances, B/VI may pass as an invisible disability.

Another side to this issue is a participant who wondered why people do not ask what can I see? While this shifts the burden of the situation onto the sighted, it is possible that some sighted would consider such a question intrusive and insensitive.

So, it is a two-edged sword. Some B/VI do not use aids that signal to the sighted the presence of a visual impairment, but then criticize the sighted for making assumptions that an individual is sighted.

These are just two explanations of the many comments made. This B/VI being misunderstood by the sighted is a significant stress factor that emerged from the data.

Suicide Trope

It is counter intuitive that the main subject of interest of this study would garner few comments from the participants. But that is not a check on the study.

Of interest and significance are that most of the responses reflect a cognitive process that rejects out of hand even the consideration of suicide. It is apparent there is a vigorous protective factor fueled by a proactive cognitive process that is operational here, and results in a very effective protective support.

One participant indicated that while her counselor was open to discuss issues related to her recent vision loss, suicide was not one of them. Another participant indicated that he had suicidal thoughts when girls were not responding to him or treated him as if he was invisible, as if he was not there hearing what they were saying about him, as if he were deaf.

The remainder of the comments were affirmations of how the participants did not even consider suicide as an option. Some indicated they had a thought about it, but they pushed it out almost as soon as it presented itself.

That phenomenon is highly significant. As evidenced in the other tropes, we have seen many more participants dismissing issues that were potential suicide risk factors without a second thought. That appears linked to the many more participants who present with numerous protective factors that provide us with a strong message that suicide prevention is not so much in countering risk factors as it is making life as livable and enjoyable as possible.

Teaching Trope

This trope has already been addressed as an über support because of the multiple benefits that accrue to the teacher that protects the participant from suicide behaviors. Teaching as used here includes more than a teacher in front of a classroom but also mentoring over the telephone and all other scenarios in between. For many of these participants, teaching is altruistic, social, a rewarding job, keeps them busy, engaged, involved, and demonstrates competency.

Unjustness; Sense of

This is the sentiment that results when something is just plain wrong, characterized by "This is not how things are supposed to work!"

This is typified by a student with a vision problem that was not diagnosed nor provided with special adaptations until he was in high school. He was characterized as 'lazy' and a borderline discipline problem. After diagnosis and adaptations, he went on the honor roll, attended college, and is currently a practicing attorney.

Yes, it is too bad, a horrible waste. But what lingers, what burns or stings, is the unjustness. There are multiple comments that refer to unjustness and being B/VI. These comments would merit further study as they are situations that are without a specific remedy and subsequent closure, except perhaps for initiating action to see something does not occur again, but the previous incident remains unaltered. This would qualify them as high on the suicide risk factor list.

Vulnerability Trope

One is left with the impression that for every person who attempts to 'help' a B/VI, there may well be someone else who is ready to exploit them.

Implications for Parents and Guardians of B/VI Children

This section is to leave something concrete in the hands of parents with a blind or visually impaired child to minimize suicide risk. The best approach for both the parents and the child with a vision condition is a pre-emptive avoidance of suicidal issues by emphasizing protective supports. An effective protective support is knowledge: knowing what to do, when to do it, how to do it, and avoiding what not to do.

In a 'No man is an island' scenario, every human asserts their presence upon others, whether it is upon their parents, siblings, family, friends, or society. Children with special

conditions assert a special presence. Those conditions may require awareness, knowledge, and training in techniques for the education of the child with the condition. For a variety of reasons, individuals are not always prepared to accommodate special requirements due to having to raise other siblings, making a living, and other obligations.

Typically, sighted parents are unprepared and ill-informed for raising a blind or visually impaired child. This may result in feelings of stress, guilt, trauma, and may strain a marriage past its breaking point. What sometimes occurs when we lack knowledge in an area is that we intuitively resort to previous experience, "How we were raised". This is frequently observable in educational reform when an individual promotes a practice, which they experienced decades ago, when they themselves were a student. Such an approach is likely to prove dated if not irrelevant, so we next resort to what knowledge we may have. Typically, that knowledge is composed of stereotypes, and as for many stereotypes, that knowledge, too, is often inaccurate and outdated.

One example cited by a participant is illustrative of this situation. The father of twin boys from a school for the blind, when asked at their graduation what would become of his sons, responded that the boys would come back to the farm where their sisters "would take care of them." At that time, it was culturally accepted, and expected, that blind people needed to be taken care of as they would be incapable of taking care of themselves.

Keeping the B/VI child at home was not necessarily the best thing parents could do either. A natural reaction of most parents is to protect their child, and to protect a hurt child even more. When B/VI children are perceived as being "hurt" it results in them being overprotected. That overprotectiveness, with completely understandable good intentions, unintentionally insulates the child from critical developmental learning experiences. This phenomenon is an example of the onus of the B/VI experience of living in a sighted world. The B/VI are perfectly capable of learning

how to live their lives, but issues arise when the sighted impose their pre-conceived notions about the capabilities of the B/VI.

Overcoming those notions takes knowledge. This situation was illustrated by a father during the first meeting of a new school year of the parent association at a school for students with autism. The parents were going around the room introducing themselves and describing their child with autism such as age, verbal/non-verbal, etc. The father stated that after his child had been evaluated and diagnosed, "…the social worker came into the room and said, 'Your son has autism'. That was it. *There was no manual*." That father was the president of the parent-teacher association and was well engaged in writing the needed manual.

While children share many traits, every child is different, and they each need their own manual. For children with special needs, there is that much more to learn, and there is plenty of help available, but it needs to be sought out. Here is a basic guide to get the parent of a special needs child started.

In the United States, the very first contact is the special education department of your local school district (LSD). Each LSD is federally mandated to provide educational programming for every child in its district. For children determined to require special educational, the LSD is required to provide an individualized educational program (IEP) for the child. The IEP is more than a lesson wish list, it is a federally mandated and enforced contract between the LSD and the parent. A parent filing a complaint for failure to honor that contract may invoke federally backed sanctions on the LSD, so IEPs are taken very seriously.

As concerns the IEP, at least once a year, every student who is certified as being special needs has a federally mandated IEP meeting to develop an educational plan which specifies what learning experiences the student will have made available to them. The plan is developed by the

child's teacher with the participation of an administrator and typically has evaluations and reports from a speech and language professional, an occupational therapist, a social worker, and so forth. IEP meetings may be overwhelming, and a parent advocate is very helpful. A mandatory part of the IEP process is making the parent aware of resources available to them, such as parent advocates as well as support groups for the parents of children with special needs.

Support groups are important to not only learn new things but to keep one's perspective. Parent groups often plan activities for families to get together and just have fun. You are not the first parent of a special needs child and nor are you alone. Take full benefit of those who have been down the learning curve before you.

In that same vein are two important resources: the National Federation for the Blind and the American Foundation for the Blind. Both organizations have extensive websites that provide knowledge and include resources for parents of blind children.

To write your manual you will need knowledge and there is plenty out there to be had. There will be much to sort through to find your path. Keep in mind that B/VI children are like other children. To deny them experiences because we are unable to imagine ourselves doing something without vision is restrictive. A rule of thumb is to seek out and demand appropriate services such as instruction in braille, mobility, and the plethora of technological aids; all the while treat your child like the child they are. Remember, no one has all the answers. You just keep being your best.

A New Direction for Suicidology

There is a tendency in science to dismiss things it does not understand, such as the discovery that "junk" DNA is not junk at all. Science just had not discovered its function.

This is congruent to the contention that we are unable to determine who will suicide and who will not. I reject that paradigm. It is antithetical to the role of science. Perhaps it is more accurate to state we have not yet discovered the means to determine who may suicide, and much to its credit, suicidology relentlessly continues to chip away at finding answers. "No", I do not have the answer, but I am able to offer a suggestion of where we could be looking.

Early in my studies of suicidology, I was not able to reconcile that for a given circumstance (risk factor/s), one person may suicide, and another would not. This indicated to me that the risk factor was excluded from being a variable, elsewise a given risk factor would exhibit similar results. By default, the variable in suicide had to be internal, inside one's head. Specifically, the variable is one's thinking process. That was the variable. It is not so much *what* one thinks as it is *how* one thinks. How one thinks is the product of experience and the establishment and maintenance of what I have referred to as one's reality bubble which appears to resonate with Maris' (1981) concept of a suicide career.

How does a suicide construct a thinking process where suicide is "ok" while others construct thinking processes that "would never-ever" even consider suicide as an alternative?

As demonstrated by some of the participants in this study and in the literature, their response to any question as to whether they have any thoughts about suicide is met with incredulity. A stereotypical response is, "Me? Never! It would not have occurred to me." My question is why not? Why did it not occur to you? What is it in your thinking process and how was it formed, that kept you from going there or kept it from coming in?

Indications are, at least in this study, the existence of protective factors. Reading over the protective factors, the best suicide preventative is a good life.

Sound familiar? As we learned from Lawrence, et al., (2010) in the life elements most valued by individuals with dementia: independence, a "good brain", a happy family, helping others, attending to practical tasks, pride in appearance, and relationships.

It sounds simple enough. But what if you are rejected, physically abused, not provided appropriate adaptations, and discriminated against in being hired? Then it would not be so easy.

That brings us back to Shneidman, Faberow, and Litman (1961) that "self-destruction reflects the relationship of the individual to his community and his civilization" (p. 16). It is more like suicide reflects the relationship of the community to the individual who may find she is not having such a good time living there.

The flip side of the coin is, why do some individuals consider suicide? How does their thinking process work? How did that thinking process become receptive to suicide? Or maybe the opposite, why does their thinking process not block suicidal thoughts? The literature indicates that suicides sometimes appear to become locked in on the idea of suicide. There may be other processes at work that promote "locking in" on suicide, but locking in represents a cognitive process, and it appears different from an obsession or compulsion. Suicide has been characterized as being perfectly logical, but it is seriously flawed as a rational act. There is an aura of autism spectrum behavior surrounding this point.

If we are to believe the experiences of Sgt. Briggs (2014) of the Golden Gate Highway Patrol, the surviving jumpers stated they knew they made a mistake the minute they let go of the railing. It is as if the rational eclipsed the logical in the blink of an eye.

A review of the literature as to the kinds of risk factors returns a response that leaves one with the impression that just about anything is capable of being construed to be a risk factor, depending upon the individual.

On the other hand, there are certain elements that appear to be more potent than others and appear more often than others, such as depression and a previous suicide in the family. Perhaps some elements play a different role than that of risk factors.

Those elements are not so much risk factors as they are elements that provide a context for suicide where risk factors find a fecund reception to the ideation of suicide, fertile soil for the idea to take root. Perhaps depression alters the mind, whence logic overthrows rationality. Maybe this suicide context is congruent to Maris' (1981) suicide career? By default, perhaps an exploration into why some individuals would not even consider suicide may reveal an encrypted reciprocal.

"…death certificates of suicides and clinical records are inadequate foundations upon which to build a suicidology. The systematic study of suicide demands life-history data on large, simple, random samples of suicide completers (*sic*)…" (Maris, 1981, p. xviii).

Reflections

The goal of this research is to study the relationship between individuals who are blind or visually impaired and suicide. Within the study parameters significant first steps have been taken.

The Grounded Theory method was very appropriate for this study and is demonstrated by Peter Matthiessen (1981) describing a 1979 last safari with the previous park warden, Brian Nicholson, years after his retirement, into the largest, most isolated, and least known game reserve in east Africa. They were discussing the views of an ecologist regarding periodic burning off the savanna grasses, and Brian expounded: "As a scientist, he has to come up with a theory, and he'll find facts to fit that theory" (p. 83). Mercifully, that is not the situation with Grounded Theory.

My initial imagery was that of going up a river in a dugout canoe into an uninhabited rain forest, to report out on what I would find there. That imagery is now so embarrassing. After my experiences with this population, my imagery is that of conducting person-in-the-street

interviews in Brooklyn and reporting out what people said. Very different than going in with a theory and blinders. GT is going in, talking to people, and seeing what is there.

Had this Primary Investigator been more astute, I would have found a way to include the content of conversations during the initial recruitment contact with the participants-to-be before their agreement to participate and subsequent informed consent was granted. The content generated in a conversational setting was equally significant if not more so to the data that was mined under informed consent and a survey instrument. Live and learn.

The study has reached its primary goal of determining factors that are of interest or of significance concerning the relationship between individuals who are blind or visually impaired and suicide.

The study has identified seven stress factors to which individuals who are blind or visually impaired are at increased susceptibility. The finding of the predominance of physical health issues reinforces the findings of the study by Lam, et al. (2008) concerning the effects of multiple non-ocular health issues and provides a clear direction for further investigation. It was also unexpected that the effects of the Pandemic would take the number four spot on the stress list.

The study has identified five stress factors of particular if not unique significance to the B/VI.

Another significant contribution is the tropes that provide us with specimens of the cognitive processes in the reality spheres of these participants.

Protective supports spotlight having a resilient temperament, keeping busy, and an internal belief system that is the match for the challenges one faces. Being in contact with other people and feeling connected to others surfaced as a very important protective support that stands out for this population.

The ancillary objectives met with mixed success:

- The nature of suicide risk factors and of support factors for individuals who are blind or visually impaired, while not necessarily a ship at sea, the champagne bottle has been burst across the bow and the craft may be said to be on its way down the skidway.

- Individuals who are blind or visually impaired do share the same exposure to risk and protective factors as the sighted (why would they not?) with some qualification but there is a need for further exploration into certain peculiarities.

- The study made no effort, and thus no progress in examining if risk and protective factors were relative to different visual conditions. There was just too much going on in other areas to allow time to pursue that more detail-demanding question and being able to give it the attention it fully warrants. As for many other areas of the study, this question deserves further research.

- The status of suicide attempts for this population appears elevated for the sampling but requires closer scrutiny.

I would personally consider this study to be successful if:

…sighted individuals, after having read the study would state, "I never knew that!"

and

… the participants, after having read the study would state, "Well, yeah. Everybody knows that!"

What I have learned is that for me, research is a learning nirvana.

APPENDIX

I had the pleasure of assisting in interviewing participants and gathering information about participants' mental health history. I am a University Counselor and a Suicide Prevention Coordinator so interviewing individuals everyday about mental health is a part of my job. As part of my education, training, and job, I assess for suicide and self-harm risk within individuals. Interviewing individuals who are blind or visually impaired was a new experience for me. I was curious about which risks and protective factors I would observe in interviews with the participant sample.

As with any self-report data or volunteer interviews, I was already aware that participants of this study may present as more comfortable talking about their mental health history and any mental health concerns, including suicidal ideation. In my work with clients with suicidal ideation and attempts in their mental health history, protective factors can be observed in how clients discuss their past selves. This was observed in participants of this study. Those who reported struggling with mental health concerns such as depression, anxiety, or substance use in their past, were able to talk about these concerns freely, as if participants were talking about other people.

Common risk factors for suicidal ideation such as previous mental health concerns, lack of social support, unstable / insecure family support, and lack of purpose or coping strategies were observed in participants who reported mental health concerns or past suicidal ideation.

What was surprising for me was the protective factors observed from participants. Common protective factors such as social support and hobbies and coping strategies were observed but the protective factors which these participants highlighted were greater sense of purpose and an adaptive mindset. Both protective factors I have presented on and highlighted in my trainings and work as a Suicide Prevention Coordinator.

A greater sense of purpose appeared as spirituality or future orientation in participants who reported it. A common protective factor I look for in my clients as a counselor is future orientation. Participants of this study reported being aware that stress was temporary and reported understanding a greater purpose for themselves.

An adaptive mindset is a protective factor where an individual views an issue not as a problem or a barrier but a challenge to figure out, conquer, and overcome. This adaptive mindset was observed in both participants who were born visually impaired or became visually impaired later in life. As an interviewer, it was inspiring to hear participants' stories and hear participants reflect on their past and future.

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ABSTRACT

AN INQUIRY INTO THE RELATIONSHIP BETWEEN INDIVIDUALS WHO ARE BLIND OR VISUALLY IMPAIRED AND SUICIDE

by

Henry J. Tyszka

December 2021

Advisor: Dr. Thomas Edwards

Major: Education

Degree: Doctor of Philosophy

In the United States, death certificates document pre-existing conditions only when they directly contribute to a death. This precludes generating data in the event of a suicide involving a blind or visually impaired individual and for that reason existing suicide data is scarce for this population.

This Grounded Theory study, with the participation of a Licensed Professional Counselor, interviewed twenty blind or visually impaired individuals utilizing the CDC Self-Directed Violence survey instrument to determine the level of stressors that were experienced by the participants as well as the nature and number of protective supports, amongst other factors.

The study reinforced findings of a study by Lam, Christ, Zheng, and Arheart (2008) that found a primary source of stress for the blind and visually impaired was the number of non-ocular health issues.

The study found seven stressors to which this population has a heightened susceptibility. For example, the effects of the Pandemic magnified the already unremitting constraint imposed by mobility issues.

The study found five additional stressors that affect the blind and visually impaired in a manner unique to them. For example, one onus of being blind or visually impaired is accommodating the sighted and mitigating the sighted unease being around the blind and visually impaired.

The study found this population to demonstrate strong protective supports. For example, manifesting personal attitudes that provide for resiliency and allocating priority for socialization.

Implications for suicidology, for example, is that once a suicide risk factor breaches an individual's cognitive process and makes suicide appear logical, the damage has been done. Effort might be better directed to immunize the individual against toxic cognitive processing leading to suicide ideation by instilling practices that lead to a life-is-good attitude, admittedly easier said than done.

AUTOBIOGRAPHICAL STATEMENT

Henry J. Tyszka earned a B.A. in French (1973) and a M.A. in secondary education and curriculum (1978) at Michigan State University; a M.Ed., in special education (1997) at Marygrove College in Detroit, Michigan; and a Ph.D. in education at Wayne State University in 2021.

Teaching credentials include a special education teaching certificate with endorsements for teaching students with autism and students with emotional impairments. Also certified to teach French and Vocational/Technical (automotive, diesel, and small engines) courses.

Initial special education experience was in a K-12 residential school for the blind teaching auto-mechanics. Twenty years teaching in a center-based program for students with autism.

Seven years of overseas work experience was centered in francophone Africa and required French language ability which facilitated attaining a bilingual language level.

Ivory Coast – Automotive Mechanics Instructor.
Guinea – Heavy Equipment Mechanics Instructor.
Burkina Faso – Turnaround of the first appropriate technology workshop in sub-Saharan Africa.
Morocco – Creation of five pilot training centers for low-income women in non-traditional skills.
Chad – Rehabilitation of the Ministry of Public Works central repair facility.

Publications and reports:

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