INFORMATION TO USERS

This reproduction was made from a copy of a document sent to us for microfilming. While the most advanced technology has been used to photograph and reproduce this document, the quality of the reproduction is heavily dependent upon the quality of the material submitted.

The following explanation of techniques is provided to help clarify markings or notations which may appear on this reproduction.

1. The sign or "target" for pages apparently lacking from the document photographed is "Missing Page(s)". If it was possible to obtain the missing page(s) or section, they are spliced into the film along with adjacent pages. This may have necessitated cutting through an image and duplicating adjacent pages to assure complete continuity.

2. When an image on the film is obliterated with a round black mark, it is an indication of either blurred copy because of movement during exposure, duplicate copy, or copyrighted materials that should not have been filmed. For blurred pages, a good image of the page can be found in the adjacent frame. If copyrighted materials were deleted, a target note will appear listing the pages in the adjacent frame.

3. When a map, drawing or chart, etc., is part of the material being photographed, a definite method of "sectioning" the material has been followed. It is customary to begin filming at the upper left hand corner of a large sheet and to continue from left to right in equal sections with small overlaps. If necessary, sectioning is continued again—beginning below the first row and continuing on until complete.

4. For illustrations that cannot be satisfactorily reproduced by xerographic means, photographic prints can be purchased at additional cost and inserted into your xerographic copy. These prints are available upon request from the Dissertations Customer Services Department.

5. Some pages in any document may have indistinct print. In all cases the best available copy has been filmed.

University Microfilms International
300 N. Zeeb Road
Ann Arbor, MI 48106

LIMBACHER, MARY ELIZABETH

ATTITUDES TOWARDS SUICIDE AMONG PREVIOUS SUICIDE ATTEMPTERS, THOSE WITH SUICIDAL IDEATION, AND NON-ATTEMPTERS

THE UNIVERSITY OF ARIZONA M.A. 1983

ATTITUDES TOWARDS SUICIDE AMONG PREVIOUS SUICIDE ATTEMPTERS, THOSE WITH SUICIDAL IDEATION, AND NON-ATTEMPTERS

by

Mary Limbacher

A Thesis Submitted to the Faculty of the

DEPARTMENT OF PSYCHOLOGY

In Partial Fulfillment of the Requirements
For the Degree of

MASTER OF ARTS

In the Graduate College

THE UNIVERSITY OF ARIZONA

1 9 8 3

STATEMENT BY AUTHOR

This thesis has been submitted in partial fulfillment of requirements for an advanced degree at The University of Arizona and is deposited in the University Library to be made available to borrowers under rules of the Library.

Brief quotations from this thesis are allowable without special permission, provided that accurate acknowledgment of source is made. Requests for permission for extended quotation from or reproduction of this manuscript in whole or in part may be granted by the head of the major department or the Dean of the Graduate College when in his judgment the proposed use of the material is in the interests of scholarship. In all other instances, however, permission must be obtained from the author.

SIGNED: [signature]

APPROVAL BY THESIS DIRECTOR

This thesis has been approved on the date shown below:

[signature]
G. DOMINO
Professor of Psychology

6-30-83
Date

ACKNOWLEDGEMENTS

There are many people who helped make this research possible. I would like to thank the members of my committee: George Domino for all of his support, suggestions, judgment, and the use of his Suicide Opinion Questionnaire, and Hal Arkowitz and Bob Wrenn for their ideas and intellection. I would also like to thank George Knight for all his assistance and guidance with my statistics.

The Office of Instructional Research and Development (IRAD) was of invaluable help in scanning and processing my data, and Dean Lee Jones from the Graduate College provided funds to make the use of IRAD possible. I also want to acknowledge Diversified Data Systems for allowing me to use their word processor, and Jim Carbone, my research assistant, who was a great help with data collection and editing.

My deepest gratitude is extended to my husband, John, whose support, patience, understanding and assistance encouraged me every step of the way.

TABLE OF CONTENTS

LIST OF TABLES

ABSTRACT

This study tested Goffman's hypothesis that familiarity with deviants tends to increase tolerance towards deviance. The Suicide Opinion Questionnaire was administered to 649 undergraduate volunteers from the University of Arizona. The students' responses were factor analyzed using a principle component rotation. Seven factors emerged, composed of 31 questions and accounting for 24.2% of the total variance. Results from discriminant function analyses revealed that previous suicide attempters were significantly more likely than those with suicidal ideation and those who had never attempted suicide to be more accepting of suicide, see the suicide attempt as an impulsive behavior not due to mental illness or lack of personal control, and believe that suicide attempters really intend to kill themselves. There were no significant differences in attitudes towards suicide among males and females, and individuals with an immediate family member, a close relative, a close friend, or an acquaintance who committed suicide.

INTRODUCTION

The present study examines the attitudes towards suicide held by individuals whose prior histories include suicide attempts, suicide ideation, or no history of suicide. Seven issues considered to be important dynamics of suicide are examined. The first variable considered is the acceptability of suicide. Due to the amount of social stigma surrounding suicide, the importance of identifying and utilizing individuals who understand and accept the suicidal person may reduce the number of future suicide attempts (Ansel & McGee, 1971). Based on Goffman's (1963) theory of deviance, which states that familiarity with deviants tends to increase tolerance towards deviance, the hypothesis of the present study is that previous suicide attempters are the most accepting and understanding of the suicidal. The current study also evaluates whether association with suicide through a family member, relative, friend, or acquaintance increases tolerance towards the act of suicide or the suicide attempter.

Many people believe that suicide attempters do not really mean to kill themselves (Domino, Gibson, Poling & Westlake, 1980; Ginsberg, 1971; Sale, Williams, Clark & Mills, 1975; Ansel & McGee, 1971). The second variable investigated concerns an individual's perceptions of the suicidal person's intention to die. This issue is related to how previous suicide attempters differ from non-attempters in their

perceptions of the degree of lethality associated with a suicide attempt. Whether a suicide attempt is seen as a sincere wish to die or as a manipulative behavior designed to attract attention may also relate to how understanding, sympathetic, and tolerant one feels towards a person who attempts suicide.

A third area to be examined concerns the belief that the suicidal person is seen as mentally ill or out of control. Marks and Riley (1976) hypothesized the importance of this issue and suggested that whether or not a suicide attempter is seen as in control of his or her behavior may have an impact on the way others view the suicide attempter. This study contrasts the attitudes of those who have previously attempted suicide, those with suicidal ideation, and those who have never attempted suicide, to differentiate those individuals who see the suicidal person as mentally ill and out of control from those who see the suicidal person as sane and in control of his or her behavior. The question of how one's perception of mental illness and degree of personal control influence one's acceptance of the suicide attempter is also examined.

Suicide is considered to violate the protocol of most religions (Domino, Cohen & Gonzalez, 1981; Minear & Brush, 1981). Thus, how previous suicide attempters see themselves within a religious framework, and how others see the integration of religion into the lives of the suicidal individual are examined. Is a person who attempts suicide necessarily less religious than someone who has not attempted suicide?

The attitudes of the group members about religious issues are investigated in the current study.

Another area of interest is the degree to which suicide is considered an impulsive act. The three groups are compared on the basis of whether they consider the suicide attempt to be well thought-out and carefully planned, or whether they see the attempt as an impulsive irrational act.

The suicidal person is often considered to be angry and commit suicide as a vengeful act. This study evaluates the role of anger in suicide and attempts to discriminate between previous suicide attempters, those with suicidal ideation, and non-attempters based on each group's perceptions of whether or not the suicide attempter is angry and seeks revenge.

The last area to be considered concerns the role of social influences, or factors external to the individual, on the suicidal person. This variable focuses on the influence of environmental and familial factors which contribute to personal development. The individuals in the three groups in this study are examined on the basis of whether they perceive a suicide attempter as reacting to an internal or external locus of causation.

The incidence of suicide in the United States is increasing, and experts estimate that approximately 4,000 people between the ages of 15 and 24 commit suicide every year (Minear & Brush, 1981). In the past few years, the rate of attempted suicides has also increased

considerably. Previous research has focused on suicide prevention and compiled profiles for high risk individuals, but the topic of attitudes towards suicide has been virtually ignored. The current study takes a two-fold approach: (1) an empirical survey to determine relevant attitudes and (2) a theoretical approach based on the theory of Goffman (1963), who postulates that familiarity with deviants tends to increase tolerance of deviance.

Stigma of Suicide

Despite the prevalence of suicide in the United States, suicide is still surrounded by considerable social stigma. Klagsbrun (1976) reports that inaccuracies in suicide data often result from an attitude of shamed secrecy. Goffman (1963) writes, "In general, the tendency for a stigma to spread from the stigmatized individual to his close connections provides a reason why such relations tend either to be avoided or to be terminated, where existing" (p. 30).

Although a "successful" suicide act arouses pity and sympathy for the victim's family, an unsuccessful suicide attempt often arouses negative and hostile attitudes. In The Psychology of Suicide, Shneidman, Farberow and Litman (1970) write, "by far the most prevalent attitude, especially in Occidental cultures, has been negative, and suicidal behavior has been met with hostility, censure and condemnation" (p. 541). These negative attitudes often interfere with a person's ability to help or understand a suicide attempter (Ansel & McGee, 1971). Groups with the main responsibility for helping suicide attempters had predominantly

negative attitudes towards them. If suicide is a cry for help as many people believe, these findings are disturbing; for if suicide attempters are betrayed by those most likely to help, they may have nowhere else to turn. Ansel and McGee (1971) admonish, "it may be these negative attitudes which cause attempters to perform further suicidal acts, since these attitudes may stand in the way of changes desired by attempters, or be experienced as further rejections" (p. 27).

Perceived Personality Characteristics

What are some of the underlying assumptions about suicidal behavior that cause people to react with hostility? A common belief held by many is that suicide attempters do not really want to die, and that those who threaten to commit suicide seldom do so (Domino et al., 1980). A study done by Ginsberg (1971) yielded similar results: out of 208 respondents, 62% believed that the majority of people who threaten to kill themselves will not. Sale et al. (1975) also found that people with hostile attitudes towards suicide believe that suicide rarely ends in death, possibly because many attempts occur in the presence of others. Kalish, Reynolds and Farberow (1974) found that one out of eight college graduates they sampled were unsympathetic towards those attempters who had little or no intention of committing suicide. Furthermore, subjects with the least amount of education were more angry with repeated suicide attempters and were more likely to believe "that the presumably suicidal persons should either be serious or stop pretending" (p. 303). Ansel and McGee (1971) also found that people

expressed more negative attitudes toward those who seem less intent upon killing themselves.

Another issue involves the concept of degree of control. Those who see suicide as an attempt to manipulate others have more negative attitudes than those who see suicide as something that "happens" to a person (Sale et al., 1975). In personal interviews, Ginsberg (1971) found that many people did not believe suicide involved intention, but that the act just "happened" to a person because of sorrow or unhappiness. Although suicidal behavior is often seen as beyond the control of the individual, Domino et al. (1980) found that the majority of their respondents did not see suicide attempters as mentally ill and out of control. Kalish et al. (1974) report that people do not see the suicidal as mentally ill, but rather as suffering from extreme pressure. It is interesting to note that while only 39% of Ginsberg's sample (1971) would feel ashamed if a family member was mentally ill, 66% would be ashamed if a family member committed suicide. The respondents saw suicide as more of a family disgrace than mental illness. In contrast, Domino et al. (1980) found that more than half of his subjects would not feel ashamed if a family member committed suicide.

Attitudes towards suicide among religious and cultural groups vary widely. In a study comparing Jewish and Christian attitudes towards suicide, Domino et al. (1981) found that more Jews than Christians believe that those who commit suicide are mentally ill. However, the majority of both groups disagreed with this statement. Domino et

al. (1981) also found that more Jews than Christians believe suicide is acceptable in cases of an incurable illness. On the other hand, more Jews than Christians believe people should be prevented from committing suicide.

Cultural differences in attitudes towards suicide were studied by Domino (1981) in a sample of Mexican-Americans and Anglos. He found that more Mexican-Americans than Anglos believe that suicide attempters are mentally ill, lonely and depressed, irrational, and chronically suicidal. Mexican-Americans more often believe that attempters are responsible for their actions and that people who threaten to commit suicide rarely do so. Fewer Mexican-Americans than Anglos believe that suicide is an acceptable alternative to dying from a terminal illness and more Mexican-Americans would feel ashamed if a family member committed suicide. These beliefs seem to tie in with the opinion of the Mexican-American respondents that suicide is related to a lack of religious values. For example, in the Domino (1981) study, 59% of Mexican-American respondents agreed with the belief that those who attempt suicide are less religious than those who do not attempt suicide, as opposed to 39% of the Anglo respondents.

Prior research has placed little emphasis on the importance of attitudes towards impulsivity and anger in relation to the act of suicide. Domino's (1981) study comparing Mexican-American's and Anglo's attitudes towards suicide found that "more Mexican-Americans perceive anger, an aggressive and destructive nature, impulsivity, and

suddenness as being relevant to suicidal behavior" (p. 392). The association of anger or impulsivity with suicide, especially among previous suicide attempters, may indicate the need to provide an outlet (such as suicide prevention hotlines) for the expression of these feelings in crisis situations. An understanding and accepting listener may also reduce the possibility that a potential suicide victim actually attempts an impulsive act.

In general, research supports the view that social influences, or external factors, are secondary to the individual influences, or internal factors precipitating a suicide attempt (Ginsberg, 1971; Kalish et al., 1974). In Ginsberg's (1971) survey, 40% of the respondents believed suicide occurs as a result of internal causes (mood, unhappiness, or loneliness), as opposed to the 12% who believed societal influences are at the core of suicidal behavior. Calhoun, Selby and Gribble (1979) examined the effects of the perceived locus of cause of suicide (internal or external) on the stigma surrounding the surviving family members but found no significant effects. The surviving family members were perceived in the same way, regardless of whether the cause of the suicide seemed to stem from internal or external difficulties. Thus, while social influences are generally seen as contributing minimally to a person's decision to attempt suicide, research supports the view that this does not significantly affect society's attitudes toward the victim's family.

Current Unresolved Issues

The area of attitudes towards suicide is obviously complex. Individual differences, religious differences and cultural differences all contribute to the myriad of attitudes. The fact remains however, that the incidence of suicide is increasing. Results from the literature (Ansel & McGee, 1971) indicate that traditional helpers may have negative attitudes that interfere with their ability to help suicide attempters. Who, then, is the best person to accept and understand the suicidal? Allon (1975) writes, "people who share a stigma often are comfortable only with each other about their problems, including those caused by the stigma, because relationships with the non-stigmatized are colored and distorted by attitudes towards the stigma" (p. 59). Korchin (1976) argues that people with different life experiences "can best be served by clinicians of their own communities, who share their identities, experiences, and problems" (p. 157). Goffman (1963) has suggested that familiarity with deviants tends to increase tolerance towards deviance. Specifically, people who know from personal experience what others are going through can offer helpful suggestions and a sympathetic ear.

Marks and Riley (1976) tested four hypotheses related to Goffman's theory of deviance. Their hypotheses were: (1) Acquaintance with a suicide attempter increases tolerance towards suicide. (2) The closer the relationship to an attempter, the greater the tolerance will be. (3) Acquaintance with a suicide attempter increases the person's

acceptance of suicide, and (4) a person acquainted with a suicide attempter will be more likely to have thought about suicide than a person who does not know a suicide attempter. None of their hypotheses was supported, nor was Goffman's theory of deviance confirmed. However, Marks and Riley suggested that the degree of control attributed to the suicide attempter may have an effect on a person's attitudes. Will people think less of a person if he or she is considered to be in control of his or her self but still attempts or commits suicide? This study examines this issue.

Marks and Riley's results have not been unanimously confirmed, however. Feifel and Schag (1980) found that the more a person had seriously considered suicide, the more he approved of the idea. Minear and Brush (1981) also found that those who had considered, threatened, or attempted suicide accepted suicide more than those who had never considered suicide. Sale et al. (1975) found that attitude scale scores assessed by a questionnaire were not correlated with the degree of personal contact with a suicidal individual. These investigators found that most people with some contact with suicide attempters were more likely than those with no contact with suicide attempters to have hostile attitudes and to see suicide as manipulative. People with contact with suicide attempters were also less likely to see the attempt as due to mental illness. Those with more sympathetic attitudes believed that suicidal behavior was intended to cause death.

The inconsistent results of studies assessing attitudes towards suicide illustrate the complexity of the issue and indicate the need for an objective assessment device which will yield consistent results in diverse research settings. Domino, Moore, Westlake and Gibson (1982) have developed the Suicide Opinion Questionnaire (SOQ)--a device that measures both attitudes towards suicide and factual knowledge of various aspects of suicide (see Appendix). The SOQ has been used to identify factors underlying attitudes towards suicide (Domino et al., 1982), to evaluate college student's attitudes (Domino et al., 1980), and to investigate the role of religious factors and ethnic membership on attitudes towards suicide (Domino et al., 1981; Domino, 1981). The SOQ is used in the current study to help consolidate and solidify the issues surrounding the attitudes of college students towards suicide.

METHOD

Subjects

The SOQ was administered to 738 University of Arizona undergraduate volunteers from both psychology and humanities classes. Of the total sample, 89 subjects were excluded: 15 had incomplete answer sheets, 40 did not follow directions and 34 admitted to answering the questionnaire dishonestly and indicated that their answers should be disregarded. The analyses were based on a total of 649 subjects--236 males and 413 females.

On several demographic questions, 35 subjects indicated that they had previously attempted suicide, 131 had seriously considered attempting suicide, and 483 had no history of any previous suicide attempt or ideation. Twelve subjects indicated they had an immediate family member commit suicide, 34 a close relative, 63 a close friend, and 173 an acquaintance commit suicide. The remaining respondents denied any association with someone who had committed suicide. In order to ensure anonymity, age and other potentially identifying information was not requested.

Instrument

The SOQ is comprised of 100 attitudinal questions and seven items concerning demographic information. Approximately two-thirds of the items reflect the respondent's attitudes, while one-third reflect

his or her factual knowledge of suicide. For this study, the following additional items were included in the questionnaire:

101. A person who attempts suicide has lost control of himself.
102. Most people who attempt suicide do not try to actually kill themselves.
103. Suicide attempters are trying to make other people feel sorry for them.
104. Most suicide attempters are in total control of themselves.
105. Most people attempt suicide when there is a high probability they will be found.
106. Most people attempt suicide to make their families notice them.
107. A person who attempts suicide doesn't know what he is doing.
108. Attempted suicide is actually a "cry for help" rather than a sincere wish to die.
109. Suicide is a way of manipulating other people.
110. Most people know what they are doing when they attempt suicide.
111. People who attempt suicide really want to die.
112. A person who commits suicide is not responsible for his actions.

For each of the 112 questions, the subject chose one response from five response categories: (A) Strongly Agree (B) Agree (C) Undecided (D) Disagree (E) Strongly Disagree. Subjects who indicated they had previously attempted suicide were asked to answer these three additional questions:

120. How many times in the past ten years have you attempted suicide? A. Once B. Twice C. Three times D. Four times E. Five or more

121. On the back of your answer sheet, please list the method or methods you used in your previous suicide attempts.

122. Also on the back of your answer sheet, please describe the last time you attempted suicide. (Tell about what led up to it and what happened afterwards.)

Procedure

The SOQ was administered on both a walk-in basis and in group testing sessions. Approximately 40 subjects took the questionnaire home and returned it the next day. The last two questions asked the subjects to write on the back of their answer sheet, and those questions were made optional.

Because the population of this study was considered significantly different than the one used by Domino et al. (1982), a factor analysis was done on the data using a principle component analysis with varimax rotation. The SPSS FACTOR program could handle only 100 of the 112 variables at a time. Therefore, the factor analysis was performed

in two stages: (1) An initial run was made using variables 1 through 100. Twelve variables that did not load significantly on any factor were removed. (2) A second run was made adding variables 101 through 112 to the remaining 88 variables.

Using the significant factors that emerged, each subject received a subscale score computed by assigning numerical values to each response in the following way: (A) Strongly Agree = 5, (B) Agree = 4, (C) Undecided = 3, (D) Disagree = 2, (E) Strongly Disagree = 1. For items with negative factor loadings, the assigned numerical values were simply reversed. For every factor, each subject's scores (for every question comprising the factor) were added together to yield a subscale score. Each subject's subscale scores were then used to perform a discriminant function analysis to maximize the differences between the following groups: (1) males who had never attempted suicide (2) males who had seriously considered suicide but had never attempted suicide (3) males who had previously attempted suicide (4) females who had never attempted suicide (5) females who had seriously considered suicide but had never attempted suicide and (6) females who had previously attempted suicide. A second discriminant function analysis was performed to maximize the differences between those individuals with an immediate family member, a close relative, a close friend, or an acquaintance who had committed suicide. The discriminating variables were the factor subscale scores. The grouping variables were the sex and suicide attempt history interaction, and the degree of closeness to someone who

had committed suicide. The SPSS FACTOR program and DISCRIMINANT program were used to analyze the data.

RESULTS

The factor analysis yielded ten factors which accounted for 32.6% of the total variance. Three of the ten factors, comprised of only two, highly correlated, questions each, were eliminated. The remaining seven factors used in the discriminant function analysis accounted for 24.2% of the total variance.

Factor I consisted of eight items with factor loadings ranging from .73 to .57 (a .2 range from the highest factor loading to the lowest factor loading was used as a cut-off point). This factor accounted for 8.0% of the total variance. Two representative questions comprising Factor I are: (18) Suicide is an acceptable means to end an incurable illness, and (25) Suicide is acceptable for aged and infirm persons. The eight questions are related to circumstances or situations in which suicide is an acceptable alternative to living; thus, "Acceptability" was the label chosen for Factor I.

Factor II accounted for 5.5% of the variance and consisted of four items with factor loadings ranging from .75 to .56. Representative items for Factor II are: (7) The higher incidence of suicide is due to the lesser influence of religion, and (81) People who commit suicide lack solid religious convictions. All four questions suggest that the suicidal are less religious than the non-suicidal. The label "Religion" was chosen for Factor II.

Factor III consisted of three items with factor loadings from .74 to -.54. These questions accounted for 3.0% of the total variance. Because these items are related to the belief that those people who attempt suicide do not really intend to die, the label "Degree of Intent" was chosen for Factor III. Question 96 is representative of the three items in Factor III: Most people who attempt suicide fail in their attempts.

Factor IV was composed of five items with loadings from .62 to .46 and accounted for 2.3% of the variance. Representative items from Factor IV include: (19) People who commit suicide are usually mentally ill, and (101) A person who attempts suicide has lost control of himself. Items concerning both mental illness and degree of personal control loaded on Factor IV. These items were considered to be closely related so the factor was named "Mental Illness/Degree of Control."

Factor V accounted for 2.0% of the total variance and consisted of three items with factor loadings from .70 to .51. "Anger and Revenge" was the label chosen for Factor V because the items reflect a belief that suicide attempters are angry and want to "get even" with someone. Question 8 is an example of those items comprising Factor V: Many suicide notes reveal substantial anger towards the world.

Factor VI was composed of four questions with loadings from .60 to .41. These items accounted for 1.8% of the total variance. Representative questions include: (40) Social variables such as overcrowding and increased noise can lead a person to be more suicide prone.

Because the four items are related to social or familial influences on individuals, Factor VI was labeled "Social Influences."

Factor VII accounted for 1.6% of the total variance and consisted of four items with factor loadings ranging from -.61 to .52. These questions are related to the belief that suicide is an impulsive act, and Factor VII was labeled "Impulsivity." Question 32 is a representative item of this factor: Suicide happens without warning. A summary of the factor analysis of the SOQ is presented in Table 1.

The first discriminant function analysis yielded two significant functions (χ_1^2 (35) = 155.93, $p < .001$ and χ_2^2 (24) = 58.72, $p < .001$) which maximized the differences between groups on the basis of sex and suicide attempt history. The eigenvalues indicate that Function 1 accounted for 16.4% of the total variance and Function 2 accounted for 7% of the variance between groups.

The structure coefficients revealed that Function 1 was most highly correlated with Factor 1, Acceptability, ($r = .52$, $p < .001$) and Factor 7, Impulsivity, ($r = .83$, $p < .001$). Thus, the results suggest that previous suicide attempters and those who had seriously thought about suicide were more accepting and more likely to think that suicide is an impulsive behavior than non-attempters. Male non-attempters were more accepting of suicide than female non-attempters and were more likely than females to believe suicide is an impulsive act.

The structure coefficients for Function 2 indicated that this function was most highly correlated with Factor 3, Mental Illness/Degree

Table 1. Summary of Factor Analysis of the SOQ.

	Factor	Number of Items	Percent of Variance Accounted For
I.	Acceptability	8	8.0%
II.	Religion	4	5.5
III.	Degree of Intent	3	3.0
IV.	Mental Illness/Degree of Control	5	2.3
V.	Anger and Revenge	3	2.0
VI.	Social Influences	4	1.8
VII.	Impulsivity	4	1.6

of Control, ($r = -.39$, $p < .001$) and Factor 4, Degree of Intent, ($r = .87$, $p < .001$). This suggests that those who had previously attempted suicide were more likely than those with suicide ideation to believe that suicide attempters are not mentally ill or out of control. Those with suicide ideation, in turn, were more likely than those who had never considered suicide, and males were more likely than females, to believe that suicide attempters are not mentally ill or out of control. Those subjects who had never attempted suicide were more likely to think that suicide attempters do not really mean to die, while those who had previously attempted suicide were most likely to think that suicide attempters are serious about committing suicide. The discriminant function based on a sex and suicide attempt history interaction was able to correctly predict group membership 36.6% of the time. The classification results are presented in Table 2.

When the requirement for discrimination between sexes is disregarded, however, and the function must only predict group membership on the basis of suicide attempt history, the percent of grouped cases correctly classified increases to 57.3%. The classification results on the basis of suicide attempt history alone are presented in Table 3.

A second discriminant function analysis maximized the difference between groups based on the degree of closeness to someone who had committed suicide. The analysis did not yield any significant functions. The functions were only able to correctly predict group membership 35.11% of the time. The classification results are presented in Table 4.

Table 2. Comparison of predicted vs. actual group membership on the basis of a discriminant function analysis of a sex and suicide attempt history interaction.

Actual Group	Number of Cases	PREDICTED GROUP: Males with No Suicidal Attempt	Males w/Suicidal Ideation	Males w/Previous Suicide Attempt	Females with No Suicidal Attempt	Females w/Suicidal Ideation	Females w/Previous Suicide Attempt
Males with No Suicide Attempt	181	67	23	18	47	16	10
		37.0%	12.7%	9.9%	26.0%	8.8%	5.5%
Males with Suicidal Ideation	45	8	7	10	7	5	8
		17.8%	15.6%	22.2%	15.6%	11.1%	17.8%
Males with a Previous Suicide Attempt	10	1	0	5	2	1	1
		10.0%	0%	50.0%	20.0%	10.0%	10.0%
Females with No Suicide Attempt	302	69	15	30	136	28	24
		22.8%	5.0%	9.9%	45.0%	9.3%	7.9%
Females with Suicidal Ideation	86	11	8	17	16	17	17
		12.8%	9.3%	19.8%	18.6%	19.8%	19.8%
Females with a Previous Suicide Attempt	25	2	6	4	4	3	6
		8.0%	24.0%	16.0%	16.0%	12.0%	24.0%

PERCENT OF GROUPED CASES CORRECTLY CLASSIFIED: 36.67

Table 3. Comparison of Predicted vs. Actual Group Membership on the Basis of a Discriminant Function Analysis of Suicide Attempt History.

	Number of Cases	PREDICTED GROUP		
		No Suicide Attempt	Suicide Ideation	Previous Attempt
No Suicide Attempt	483	319	82	82
		66.0%	17.0%	17.0%
Suicide Ideation	131	42	37	52
		32.1%	28.2%	39.7%
Previous Suicide Attempt	35	9	10	16
		25.7%	28.6%	45.7%

PERCENT OF GROUPED CASES CORRECTLY CLASSIFIED: 57.3

Table 4. Comparison of Predicted vs. Actual Group Membership on the Basis of a Discriminant Function Analysis of Degree of Closeness to Someone who Committed Suicide.

Actual Group	Number of Cases	Immediate Family Member	Close Relative	Close Friend	Acquaint-ance
Immediate Family Member	12	8	3	1	0
		66.7%	25.0%	8.3%	0%
Close Relative	34	11	9	7	7
		32.4%	26.5%	20.6%	20.6%
Close Friend	63	16	12	21	14
		25.4%	19.0%	33.3%	22.2%
Acquaintance	173	37	31	44	61
		21.4%	17.9%	25.4%	35.3%
Ungrouped Cases	367	85	70	88	124
		23.2%	19.1%	24.0%	33.8%

PERCENT OF GROUPED CASES CORRECTLY CLASSIFIED: 35.11

DISCUSSION

The results of this empirical analysis partially confirm Goffman's (1963) theory that familiarity with deviants tends to increase tolerance towards deviance. Previous suicide attempters and those who had seriously thought about suicide were more accepting of suicide than those who had neither thought about nor attempted suicide. On the other hand, the attitudes of those familiar with suicide because an immediate family member, a close relative, a close friend or an acquaintance committed suicide, did not significantly differ from each other, or from others having no association with suicide. Thus, while the proximity of an individual's immediate, personal experience with suicide lends support to Goffman's theory, mere association with suicide through a relative, friend or acquaintance does not seem to be related to one's acceptance of it.

These results also confirm the findings of Marks and Riley (1976), who found that mere acquaintance with a suicide attempter did not increase a person's acceptance and tolerance of suicide. The present study supports Marks and Riley's conclusions that the degree of tolerance did not significantly increase as a function of degree of closeness to a suicide attempter, with one exception. In an effort to predict group membership, those individuals with an immediate family member who committed suicide were correctly classified 66.7% of the

time. The overall prediction results were accurate only 35.11% of the time. Perhaps the attitudes of individuals with an immediate family member who has committed suicide are similar in many ways to those held by individuals who actually attempt suicide themselves. Goffman's (1963) theory may be accurate only as long as the association with the deviant is either immediate and personal, or associated with an immediate family member. The greater the distance between an individual and the deviant, the less acceptance and tolerance there seems to be.

The structure coefficients from the discriminant function analysis reveal that previous suicide attempters were more likely to believe that those who attempt suicide really intend to die, compared to those individuals who have seriously considered suicide, but have never actually made an attempt. Those who have never attempted or considered suicide were the least likely to consider a suicide attempt lethal. Thus, suicide attempters tend to see their behavior as a serious wish to die, while most non-attempters see a suicide attempt as manipulative behavior. Perhaps a great percentage of subjects of prior research (Domino et al., 1980; Ginsberg, 1971; Sale et al., 1975; Kalish et al., 1974; Ansel & McGee, 1971) had never attempted suicide, and as a result, saw the attempt as a manipulative behavior not intended to cause death. Consequently, these individuals may have viewed the suicide attempter with hostility. On the other hand, the respondents in the current study who admitted they had attempted suicide in the past saw their behavior and motives as serious and earnest, at least at the time they participated in this study.

Those respondents who had previously attempted suicide were more likely than those with suicidal ideation to believe that suicide is an impulsive behavior, which is not due to mental illness or lack of personal control. Those who had never attempted suicide, in turn, were more likely than those with suicidal ideation to see suicide as due to mental illness or lack of control. Previous attempters saw themselves as the masters of their own fate, and tended to see their behavior as purposeful, but impulsive. In general, those students who were the least personally associated with the act of suicide were the most likely to perceive suicide attempters as lacking the ability to control their behavior or having some type of mental aberration. In response to Marks and Riley's (1976) proposition that the degree to which suicide attempters are seen as in control of their actions has an effect on society's attitudes towards the suicidal, results indicate that those individuals who had never attempted suicide were the most likely to see the suicide attempter as out of control, as well as simultaneously having the least accepting and tolerant attitudes towards the suicide attempter.

The differences in the relative dynamics of attitudes towards suicide among males and females were minimal and did not increase the ability to predict group membership. Predictions based on suicide attempt history alone increased the number of individuals correctly classified into their respective groups to 57.3%. Introduction of the sex variable tended to cloud, rather than clarify, the results. The

data did produce a few interesting trends, however, and the most noticible difference was that males were more accepting of suicide than females. This was true for non-attempters, those with suicidal ideation, and previous attempters. This is somewhat surprising, because the modal suicide attempter is female (Shneidman et al., 1970), yet males actually commit suicide more often (Lester, 1972). Thus, one might expect males to be more likely to see a suicide attempter's behavior as manipulative, and therefore have a less accepting and more hostile attitude towards the suicide attempter. On the other hand, males who had previously attempted suicide and males who had never attempted suicide were slightly more likely than females to believe that those who attempt suicide really intend to die. This perception of suicide as a lethal act supports the finding that males may be more accepting of suicide than females. Males may believe that because the attempt is intended to cause death, the suicide attempter feels there is no hope for improvement in his or her life, and suicide is therefore an acceptable alternative to living.

Just as the attitudes of males were not found to be significantly different from females, the attitudes of the respondents who had seriously considered suicide but had never attempted suicide were not well differentiated from those who had previously attempted suicide or those who had never attempted suicide. It seems likely that of those individuals with suicidal ideation, many have attitudes similar to those who actually attempt suicide, while many (perhaps those who are less serious) have attitudes similar to those who never attempt suicide. The

word "serious" itself may mean different things to different people. Those respondents with suicidal ideation undoubtably have characteristics of both previous attempters and non-attempters; the fact that this group is not uniquely different from previous attempters and non-attempters is not really surprising.

The present study offers additional evidence to the accumulation of previously unresolved issues surrounding suicide, but there are still some questions left unanswered. For example, Goffman's (1963) theory about the relationship between the degree of closeness to deviance and acceptance of deviance was not totally confirmed in the current study. Perhaps the breakdown of respondents into four groups eliminated whatever small deviation from the mean there was initially. Maybe the number of individuals in each group was too small. Another possibility is that Goffman's theory is partially wrong. It seems possible that people with a relative, friend, or acquaintance who committed suicide have feelings of embarrassment, shame, and resentment. These survivors may perceive themselves as stigmatized and may have angry and hostile feelings towards the victim. A less extreme possibility may be that the attitudes towards suicide of those with relatives, friends, and acquaintances who committed suicide are as diverse as the individuals themselves. Some may accept suicide, while others do not. The passage of time since the death may also be a pertinent variable. Those who have had time to grieve and accept the suicide victim's death may also accept suicide itself more. At any rate, there are many possible variations

for expansion on this part of Goffman's theory. At this time, however, the hypothesis that the tolerance and understanding of a suicide attempter increases as a function of the degree of closeness to someone who committed suicide is unsupported.

Possible Weaknesses of the Study

Although the hypothesis that previous suicide attempters are more tolerant and accepting of suicide than non-attempters was supported, there are a few troubling aspects of this study. First of all, the percent of total variance accounted for (24.2) is relatively low. Furthermore, each factor accounted for 8.0% of the total variance or less. These findings could be the result of error variance, or different interpretations of the questions by the respondents. The low variance accounted for could also be due to weaknesses in the questionnaire itself. Domino et al.'s (1982) factor analysis yielded 15 factors accounting for 76.6% of the variance. The current study used a more conventional, stringent, .2 range, from the highest to the lowest factor loading as a cut-off point. This cut-off point also reduced the number of items in each factor. Because the factor analysis yielded seven factors composed of only 31 of 112 questions, it is possible that each question measures a unique variable of some kind, or that many items are highly correlated with each other and do not lend themselves to a clean division into relevant factors. Further revisions and possible condensation of the SOQ into distinct, uncorrelated, clusters of issues considered to be important dynamics of attitudes towards suicide may

alleviate the small number of items comprising the factors, the low percentage of total variance accounted for by each factor, and the moderate percentage of total variance accounted for by all seven factors. Hopefully, these revisions would also increase the percent of variance accounted for by each function in the discriminant function analysis.

In addition to improvements in the SOQ, a few additional changes in procedure could be made to ensure accurate results in the future. The number of previous suicide attempters is relatively small. Conditions that would ensure anonymity and privacy might increase the number of respondents that would admit they had previously attempted suicide. While provisions for anonymity were strictly followed, respondents answered the questionnaire in a room with other students. They were also asked to write on the back of their answer sheet if they had previously attempted suicide. This appears to have discouraged the self-disclosure of several previous suicide attempters, because answers to the question, "Have you ever attempted suicide?" were changed from "yes" to "no" when the respondents read the following question asking them to describe their experience. Thus, by eliminating any noticeable differences in instructions between groups or providing environmental conditions that foster self-disclosure, the probability that a subject will answer honestly may be increased and may ultimately increase the sample size of previous suicide attempters.

Implications of Results

This study is part of an ongoing program of research using the Suicide Opinion Questionnaire. Although this device is an objective, useful tool for fostering consistency in attitudes towards suicide, the findings of this study suggest the need for further refinement to produce the most optimal and accurate results. The factor analysis done in the current study identifies a large amount of the total variance unaccounted for. Rectifying this by reducing the number of highly correlated questions and sampling a large number of respondents from diverse populations could enhance the utility of this measurement device.

Previous suicide attempters were found to be more accepting and tolerant of suicide, more likely to believe that a suicide attempt is intended to cause death, less likely to see a suicide attempter as mentally ill or out of control, and more likely to see a suicide attempt as an impulsive behavior than non-attempters. Previous suicide attempters understand the similar experiences of other attempters, and simultaneously respect the intent and impulsivity of their behavior. More importantly, they do not have the negative and hostile attitudes towards suicide and the suicide attempter that characterize the average non-attempter. This information supports the position that previous suicide attempters could be the most effective population to work with the suicidal. Tolerance, sympathy, and understanding may significantly reduce the rapidly growing number of suicide attempts and help alleviate the stigma associated with suicide. Awareness of the potential

lethality associated with a suicide attempt may also prevent potential victims from performing an impulsive act. Furthermore, previous attempter's recognition that a suicide attempter is not mentally ill or out of control fosters a respect for their current life situation and hopeless outlook for the future.

Previous suicide attempters would be assets to crisis intervention teams or as employees of suicide prevention hotlines. Previous attempters could complement physicians and nurses in emergency rooms, or mental health professionals in their work with the suicidal. They could also help educate the public about the dynamics of suicide, and how negative and hostile attitudes continue to expand the social stigma surrounding suicide. The promotion of understanding and acceptance towards the suicidal could alleviate this stigma and may be our most useful tool for suicide prevention.

APPENDIX

SUICIDE OPINION QUESTIONNAIRE

SUICIDE OPINION QUESTIONNAIRE

This is not a test, but a survey of your opinions; there are no right or wrong answers, only your honest opinion counts.

Indicate on your answer sheet the letter which most closely corresponds to your opinion. PLEASE USE A #2 PENCIL.

A	B	C	D	E
STRONGLY AGREE	AGREE	UNDECIDED	DISAGREE	STRONGLY DISAGREE

1. Most persons who attempt suicide are lonely and depressed.
2. Almost everyone has at one time or another thought about suicide.
3. The suicide rate is higher for blacks than for whites.
4. The actual suicide rate in the U.S. is much greater than reflected by official statistics.
5. Suicide prevention centers actually infringe on a person's right to take his life.
6. Most suicides are triggered by arguments with a spouse.
7. The higher incidence of suicide is due to the lesser influence of religion.
8. Many suicide notes reveal substantial anger towards the world.
9. I would feel ashamed if a member of my family committed suicide.
10. Most suicide attempts are impulsive in nature.
11. Many suicides are the result of the desire of the victim to "get even" with someone.
12. In the U.S., suicide by shooting oneself is the most common method.
13. People with incurable diseases should be allowed to commit suicide in a dignified manner.

A	B	C	D	E
STRONGLY AGREE	AGREE	UNDECIDED	DISAGREE	STRONGLY DISAGREE

14. Those who threaten to commit suicide rarely do so.

15. Suicide is more prevalent among the very rich and the very poor.

16. Individuals who kill themselves out of patriotism do so, not because they are courageous, but because they enjoy taking major risks.

17. Suicide is a leading cause of death in the U.S.

18. Suicide is an acceptable means to end an incurable illness.

19. People who commit suicide are usually mentally ill.

20. Some people commit suicide as an act of self-punishment.

21. The feeling of despair reflected in the act of suicide is contrary to the teachings of most major religions.

22. Suicide rates vary greatly from country to country.

23. I feel sorry for people who commit suicide.

24. John Doe, age 45, has just committed suicide. An investigation will probably reveal that he has considered suicide for quite a few years.

25. Suicide is acceptable for aged and infirm persons.

26. The suicide rate among physicians is substantially greater than for other occupational groups.

27. The Japanese Kamikaze pilots who destroyed themselves by flying their airplanes into a ship should not be considered suicide victims.

28. Different cultural child rearing practices are probably unrelated to suicide rates.

29. Suicide is clear evidence that man has a basically aggressive and destructive nature.

A	B	C	D	E
STRONGLY AGREE	AGREE	UNDECIDED	DISAGREE	STRONGLY DISAGREE

30. Over the past ten years, the suicide rate in this country has increased greatly.

31. Most people who try to kill themselves don't really want to die.

32. Suicide happens without warning.

33. A business executive arrested for fraud or other illegal practices should face punishment like a man, rather than seek suicide as an escape.

34. Most suicide victims are older persons with little to live for.

35. A person who tried to commit suicide is not really responsible for those actions.

36. About 75% of those who successfully commit suicide have attempted suicide at least once before.

37. It's rare for someone who is thinking about suicide to be dissuaded by a "friendly ear."

38. People who commit suicide must have a weak personality structure.

39. The method used in a given suicide probably reflects whether the action was impulsive or carefully and rationally planned.

40. Social variables such as overcrowding and increased noise can lead a person to be more suicide-prone.

41. A large percentage of suicide victims come from broken homes.

42. A rather frequent message in suicide notes is one of unreturned love.

43. People who set themselves on fire to call attention to some political or religious issue are mentally unbalanced.

44. The possibility of committing suicide is greater for older people (those 60 and over) than for younger people (20 to 30).

45. Most people who commit suicide do not believe in an afterlife.

A	B	C	D	E
STRONGLY AGREE	AGREE	UNDECIDED	DISAGREE	STRONGLY DISAGREE

46. In times of war, for a captured soldier to commit suicide is an act of heroism.

47. Suicide attempters are typically trying to get even with someone.

48. Once a person is suicidal, he is suicidal forever.

49. There may be situations where the only reasonable resolution is suicide.

50. People should be prevented from committing suicide since most are not acting rationally at the time.

51. The suicide rate is higher for minority groups such as Chicanos, American Indians, and Puerto Ricans than for whites.

52. Improvement following a suicidal crisis indicates that the risk is over.

53. People who engage in dangerous sports like automobile racing probably have an unconscious wish to die.

54. Prisioners in jail who attempt suicide are simply trying to get better living conditions.

55. Suicides among young people (e.g. college students) are particularly puzzling, since they have everything to live for.

56. Once a person survives a suicide attempt, the probability of his trying again is minimal.

57. In general, suicide is an evil act not to be condoned.

58. People who attempt suicide and live should be required to undertake therapy to understand their inner motivation.

59. Suicide is a normal behavior.

60. Many victims of fatal automobile accidents are actually unconsciously motivated to commit suicide.

61. If a culture were to allow the open expression of feelings like anger and shame, the suicide rate would decrease substantially.

A	B	C	D	E
STRONGLY AGREE	AGREE	UNDECIDED	DISAGREE	STRONGLY DISAGREE

62. From an evolutionary point of view, suicide is a natural means by which the less mentally fit are eliminated.

63. Suicide attempters who use public places (such as a bridge or tall building) are more interested in getting attention.

64. A person whose parent has committed suicide is a greater risk for suicide.

65. External factors, like lack of money, are a major reason for suicide.

66. Suicide rates are a good indicator of the stability of a nation; that is, the more suicides, the more problems a nation is facing.

67. Sometimes suicide is the only escape from life's problems.

68. Suicide is a very serious moral transgression.

69. Some individuals have committed suicide to preserve their honor; these were victims of cultural values rather than disturbed personal attitudes.

70. If someone wants to commit suicide, it is their business and we should not interfere.

71. A suicide attempt is essentially a "cry for help."

72. Obese individuals are more likely to commit suicide than a person of normal weight.

73. Heroic suicides (e.g. the soldier in war throwing himself on a live grenade) should be viewed differently from other suicides (e.g. jumping off a bridge).

74. The most frequent message in suicide notes is of loneliness.

75. Usually, relatives of a suicide victim had no idea of what was about to happen.

76. Long term self-destructive behaviors, such as alcoholism, may represent unconscious suicide attempts.

A	B	C	D	E
STRONGLY AGREE	AGREE	UNDECIDED	DISAGREE	STRONGLY DISAGREE

77. Suicide attempts are typically preceeded by feelings that life is no longer worth living.

78. Suicide goes against the laws of God and/or nature.

79. We should have "suicide clinics" where people who want to die could do so in a painless and private manner.

80. Those people who attempt suicide are usually trying to get sympathy from others.

81. People who commit suicide lack solid religious convictions.

82. People with no roots or family ties are more likely to attempt suicide.

83. People who bungle suicide attempts really did not intend to die in the first place.

84. Passive suicide, such as an overdose of sleeping pills, is more acceptable than violent suicide such as by gunshot.

85. Potentially, every one of us can be a suicide victim.

86. Suicide occurs only in civilized societies.

87. People who die by suicide should not be buried in the same cemetary as those who die naturally.

88. Most people who commit suicide do not believe in God.

89. Children from larger families (i.e. three or more children) are less likely to commit suicide as adults than single or only children.

90. Suicide attempters are, as individuals, more rigid and less flexible than non-attempters.

91. The large majority of suicide attempts result in death.

92. Some people are better off dead.

93. People who attempt suicide are, as a group, less religious.

A	B	C	D	E
STRONGLY AGREE	AGREE	UNDECIDED	DISAGREE	STRONGLY DISAGREE

94. As a group, people who commit suicide experienced disturbed family relationships when they were young.

95. People do not have the right to take their own lives.

96. Most people who attempt suicide fail in their attempts.

97. Those who commit suicide are cowards who cannot face life's challenges.

98. Individuals who are depressed are more likely to commit suicide.

99. Suicide is much more frequent in our world today than it was in early cultures such as Egypt, Greece, and the Roman Empire.

100. People who are high suicide risks can be easily identified.

101. A person who attempts suicide has lost control of himself.

102. Most people who attempt suicide do not try to actually kill themselves.

103. Suicide attempters are trying to make other people feel sorry for them.

104. Most suicide attempters are in total control of themselves.

105. Most people attempt suicide when there is a high probability they will be found.

106. Most people attempt suicide to make their families notice them.

107. A person who attempts suicide doesn't know what he is doing.

108. Attempted suicide is actually a "cry for help" rather than a sincere wish to die.

109. Suicide is a way of manipulating other people.

110. Most people know what they are doing when they attempt suicide.

111. People who attempt suicide really want to die.

112. A person who commits suicide is not responsible for his actions.

Your responses are confidential and are being studied for research purposes only. It would be helpful to us if you would answer the following questions also (on the answer sheet).

113. Are you: A. Male B. Female

114. Have you ever seriously considered suicide? A. Yes B. No

115. Have you ever attempted suicide? A. Yes B. No

116. Have you personally known someone who committed suicide?
A. Yes B. No

117. If yes to the above question, was the person A. A member of your immediate family (e.g. parent, sibling) B. A relative (e.g. cousin) C. A close friend D. An acquaintance

118. What is the probability that at some point in your life you might attempt suicide? A. Zero B. Less than 10% C. 50-50
D. Somewhat probable E. Highly probable

119. In answering a questionnaire like this, there are many reasons why some people may not be able or wish to be fully honest. In looking over your responses, should we: A. Accept them as fully honest B. Accept them but with some reservation
C. Probably disregard them D. Disregard them as not valid.

If you have previously attempted suicide, please answer the following questions:

120. How many times in the past ten years have you attempted suicide?
A. Once B. Twice C. Three Times D. Four Times
E. Five or more

121. On the back of your answer sheet, please list the method or methods you used in your previous suicide attempts.

122. Also on the back of your answer sheet, please describe the last time you attempted suicide. (Tell about what led up to it and what happened afterwards.)

Thank you very much for your cooperation.

REFERENCES

Allon, N. Latent social services in group dieting. Social Problems, 1975, 23, 59-69.

Ansel, E. L., & McGee, R. K. Attitudes toward suicide attempters. Bulletin of Suicidology, 1971, 8, 22-28.

Calhoun, L. G., Selby, J. W. & Gribble, C. M. Reactions to the family of the suicide. American Journal of Community Psychology, 1979, 7, 571-575.

Domino, G. Attitudes towards suicide among Mexican-Americans and Anglo youth. Hispanic Journal of Behavioral Sciences, 1981, 3, 385-395.

Domino, G., Cohen, A., & Gonzalez, R. Jewish and Christian attitudes towards suicide. Journal of Religion and Health, 1981, 20, 201-207.

Domino, G., Gibson, L., Poling, S. & Westlake, L. Students' attitudes towards suicide. Social Psychiatry, 1980, 15, 127-130.

Domino, G., Moore, D., Westlake, L. & Gibson, L. Attitudes towards suicide: A factor analytic approach. Journal of Clinical Psychology, 1982, 38, 257-262.

Feifel, H. & Schag, D. Death outlook and social issues. Omega, 1980, 11, 201-215.

Ginsberg, G. P. Public conceptions and attitudes about suicide. Journal of Health and Social Behavior, 1971, 12, 200-207.

Goffman, E. Stigma. New Jersey: Prentice-Hall, Inc., 1963.

Kalish, R. A., Reynolds, D. K. & Farberow, N. L. Community attitudes towards suicide. Community Mental Health Journal, 1974, 10, 301-308.

Klagsbrun, F. Too Young to Die. Boston: Houghton Mifflin Company, 1976.

Korchin, S. J. Modern Clinical Psychology: Principles of Intervention in the Clinic and Community. New York: Basic Books, Inc., 1976.

Lester, D. Why People Kill Themselves. Illinois: Charles C. Thomas, 1972.

Marks, A. & Riley, C. Test of Goffman's hypothesis of familiarity and deviance: Attempted suicide and tolerance of deviant behavior. Psychological Reports, 1976, 39, 420-422.

Minear, J. D. & Brush, L. R. The correlations of attitudes toward suicide with death anxiety, religiousity, and personal closeness to suicide. Omega, 1981, 11, 317-324.

Portwood, D. Common-Sense Suicide. New York: Dodd, Mead & Company, 1978.

Sale, I., Williams, C. L., Clark, J., Mills, J. Suicide behavior: Community attitudes and beliefs. Suicide , 1975, 5, 158-168.

Shneidman, E. S., Farberow, N. L. & Litman, R. E. The Psychology of Suicide, New York: Science House, 1970.