YOUNGER AND OLDER GROUPS ATTITUDES AND BELIEFS TO SUICIDAL BEHAVIOUR

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ABSTRACT

Research into the complex and disturbing social problem of suicidal behaviour has been allied with the attitudinal literature since the 1970's. These investigations propose that attitudes and beliefs toward suicidal behaviour vary between different social groups and that these variations may have a relationship to the nature and occurrence of suicidal behaviour. This review highlights the rates and characteristics of suicidal behaviour in the young (16-26 years old) and the older (50 years and over) population and notes that they are at particular risk. While the attitudes of many social groups have been explored in relation to attempted and completed suicide limited research has selected these two high risk groups for direct comparison. The literature reviewed suggests that increasing knowledge concerning the attitudes and beliefs about suicidal behaviour may assist in the understanding, management and prevention of this behaviour.

CONTENTS

SECTION A:

LITERATURE REVIEW

CHAPTER 1

A compelling research focus in clinical psychology has been that of suicidal behaviour, likewise one of social psychology's most popular areas of research and debate is that of attitudes (Thomas, 1971). The investigation of attitudes toward and about suicidal behaviour is the blending of these two prolific and complex areas of psychological research. A major focus of this combined research is on how differing attitudes, often in specific target groups, may relate to the occurrence of suicidal behaviour (e.g., Domino, Gibson, Poling & Westlake, 1980; Ghodse, Ghaffari, Bhat, Galea & Qureshi, 1986; Platt, 1985; Goldney & Bottrill, 1980; Sale, Williams, Clark & Mills, 1975; Wellman & Wellman, 1988).

Suicidal behaviour is a disturbing social problem and has been recognised as such for centuries. A significant focus of investigations has been on the younger age group (15 - 29 year olds) due to the high frequency of the behaviour, the drain it has on medical and community resources and the concern such acts engender (Haines, Hart, Williams, Davidson & Slaghuis, 1989). Prior to this age suicidal behaviour is less common. While rates of suicidal behaviour vary over the adult life span, investigators have repeatedly recognised the continued high rate of completed suicide in individuals of advanced age. The increasing rate of young male completed suicide (Haines et al., 1989), the high levels of youth attempted suicide, especially for females (Diekstra, 1985) and the continuing high levels of completed suicide for the aged (Manton, Blazer & Woodbury, 1987) are of concern to researchers for two reasons. First, especially in relation to the young, previous suicide attempts are the best predictors of completed suicide (Diekstra, 1985) and, second, the aged population is an increasing proportion of the total population (Haas & Hendin, 1983). These factors will ensure suicidal behaviour continues to be a major problem in the future if steps are not taken to influence current rates.

Despite a wide range of preventive programmes there is little substantive evidence in support of their efficacy (Frederick & Resnik, 1971; Hawton et al., 1981; Hirsch, Walsh & Draper, 1982). A number of researchers (e.g., Henderson & Williams, 1974; Mills, Williams, Sale, Perkin & Henderson, 1974) have proposed that an avenue to prevention may

lie in the alteration of community attitudes and beliefs with regard to suicidal behaviour. Henderson and Williams (1974) proposed a skilful media campaign, employing high status models emphasising more adaptive coping strategies. A number of authors (e.g., Frederick and Resnik, 1971; Henderson & Williams, 1974) have cautioned that media campaigns may have the opposite effect to that intended. It is argued that prior to any media campaign it is necessary to have an understanding of current community attitudes and beliefs and their relationship to the occurrence of suicidal behaviour.

Due to the extent of the literature and the changing definitions of the terms 'suicidal behaviour' and 'attitudes', they are defined here for the purpose of this research as follows:

> Suicidal behaviour includes attempted suicide (also termed parasuicide) and completed suicide. This definition does not include suicidal ideation nor does it distinguish between acts of deliberate self-harm without a.clear intention of self killing and attempted suicide.

> Attitudes are the "... disposition to respond favorably or unfavorably toward an object...." (Ajzen, 1984, p.100) and affect, cognition and behaviour are three domains in which attitudes are expressed in observable responses.

The following chapters are designed to provide a background to the relevant literature. Chapter 2 introduces the concepts of causal attributions and attitudes and reviews the relationship of attitudes to behaviour. A central issue is whether or not a valid connection can be made between how people think and feel about a particular behaviour and the actual way they act. Chapter 3 presents the attitudinal literature as applied to the study of suicidal behaviour. Investigations into the attitudes of the general population are reviewed to assess the attitudinal milieu in which decisions to act in a suicidal manner are made. The final chapter describes the rates and characteristics of two particularly high risk groups for suicidal behaviour, that is, the young (16-26 year age group) and the older group (50 years and

over).

Based on the arguments outlined in the previous chapters it will be proposed that the attitudes and beliefs concerning suicidal behaviour and the extent of contact with the act will differ between the younger and older groups. Such information may assist in the understanding, management and prevention of suicidal behaviour.

CHAPTER 2

ATTITUDES AND BEHAVIOUR

The study of attributions and attitudes in Psychology has an enduring history. This emphasis has often rested on the implicit assumption that there is a simple causal relationship between the attributions and attitudes individuals hold toward an object and their behaviour towards that object. This simple relationship is assumed irrespective of the many variables of the situation (Thomas,1971). Modern approaches to these concepts highlight their complexity and the difficult relationship they have to behaviour. Despite their complexity, however, they are still useful terms to employ in investigations of social behaviours (Berkowitz,1986; Feather, 1990).

The literature reviewed in this chapter defines attitudes and addresses the attitude-behaviour relationship. The literature includes Attribution Theory which assesses causations ascribed to behaviours and the Theory of Reasoned Action which highlights the role of feelings that people have about particular actions toward particular objects. Research based on these theories has generally shown a correspondence between the attitudes and beliefs held, and behaviour (Eiser & Pligt, 1988).

2.1 Definition Of Attitude

The concept of attitude has changed over the last seventy years. Simple traditional conceptualizations argued that an "...attitude is the affect for or against a psychological object" (Thurstone, 1931, p. 261). That is, favourable or unfavourable orientations to an object or issue. A broader more contemporary usage generally comprises a constellation of cognitive (consciously held thoughts or beliefs), affective (emotion or feeling) and conative (disposition for action) elements. There is dispute as to which of these components is the most important, so that the exact use of the term in the literature is largely dependent on the theoretical orientation of the writer (Reber,1985).

2.2   The Relationship Between Attitudes And Behaviour

A question that consistently challenges attitudinal theorists is: 'How do attitudes predict or cause behaviour'? Two theoretical approaches that have influenced the direction of empirical research have been Attribution Theory and the Theory of Reasoned Action.

2.2.1   Causal Attributions And Behaviour

Attribution Theory deals with the perceived causes of other people's, or one's own, behaviour (Eiser & Pligt, 1988). That is, it is the notion that people interpret behaviour in terms of its causes and that these interpretations play an important role in determining reactions to the behaviour. Common-sense psychology proposes that people explain behaviour by internal - external (locus) causes and stable - unstable causes (Lalljee & Abelson, 1983). The behaviour is ascribed to either factors attributable to the person or the situation and these factors may remain consistent or fluctuate over time (Weiner, 1985). Internal stable causes, are dispositional attributions and refer to explanations based on emotions, attitudes, personality traits, abilities or motives. Situational attributions explain a person's actions as due to the factors in the situation or the environment (Avery & Baker, 1990). A third dimension of causality, that of controllability (the degree that a behaviour is considered under volitional control), has also been suggested by Weiner (1985). For example, terminal illness, an external causal attribution which is not considered under the control of the individual, can be interpreted as the reason or cause of an individual's attempting or completing suicide (Domino, et al., 1980; Johnson, Fitch, Alston & McIntosh, 1980).

Attributional research has shown that attributions of causation affect people's feelings about past events and behaviours (McFarland & Ross, 1982), expectations about the future (Abramson, Seligman & Teasdale, 1978), attitudes towards other people (Weiner & Perter, 1973) and reactions to their behaviour (Jones, 1979). In relation to attributions and consequent responses Bem (1972) suggests that for people making attributions it is likely that researchers can expect that they will then think, act or feel in certain ways. Researchers anticipate that the way people interpret the reason for an act, such as complex suicidal behaviours, will help to

determine those individual's reactions, feelings and expectancies to that behaviour.

Due to the numerous variables affecting attributional research, the link between attributions and behaviours has yet to be conclusively established (Kelley & Michela, 1980). For example, attributions cannot be manipulated directly, so research on the consequences of attributions involves variations in the antecedents of attributions (i.e., information and beliefs). The study of these mediating attributions predominantly by self-report is limited by the quality of the methods for eliciting and analysing these verbal reports (Kelley & Michela, 1980). A failure to find a relationship between attributions and behaviours may, therefore, be due to the insensitivity of the measurements or the targeting of inappropriate antecedents for the consequences being studied.

The a priori assumption that there is a link between attitudes and behaviour, such as postulated in attribution research, was seriously questioned in the 1960's by the now often cited review of Wicker (1969). Wicker concluded that only a minority of studies found a close relationship between an individual's attitudes and both their verbal expressions and overt behaviour. He concluded from his review of 33 studies, for the years 1937-1969, that there was only a weak relationship between attitudes and subsequent behaviour. That is, less than ten percent of the variance in overt behavioural measures could be accounted for by attitudinal data. While the research on which Wicker's review was based is now dated, his proposition was clearly damaging for theorists and researchers who claim attitude research allows the possibility of better behavioural predictions.

2.2.2   The Theory Of Reasoned Action

One group of researchers who have challenged Wicker's conclusions are Fishbein and Ajzen (1974) and Ajzen and Fishbein (1977). Taking a largely methodological approach these authors argued that an assessment of behavioural intentions will lead to the most accurate behavioural predictions. They proposed that if attitudes and behaviour of comparable levels of specificity are measured then attitudes alone will be excellent predictors of behaviour. They pointed out that the studies reviewed by Wicker (1969) used general verbal measures of attitude

to predict specific kinds of behaviour. The low level of relationship found, therefore, may be due to a mismatch between the level of specificity in the measures of attitudes and behaviour.

The argument of reasoned action as proposed by Ajzen and Fishbein (1977) emphasized that most socially significant behaviours are deliberately carried out for a particular purpose. Any attempt to predict a certain kind of behaviour would be more successful if it determined how people *feel* about the specific action towards some object or person rather than their general attitudes toward that object or person. While this yields a better predictor of behaviour, the relationship between behaviours and attitudes is still not direct (Eiser & Pligt, 1988). Ajzen and Fishbein (1977) suggest that the intervening variable is intention which is determined by a) the attitude toward the particular behaviour in question and b) subjective norms which are the social pressures or expectations on the person to engage in the given action.

When measuring an attitude or subjective norms on an issue the best prediction of a behaviour is when there is a correspondence in the level of specificity between the attitudes and the behaviour. That is, the prediction of a general behaviour is best when a general set of beliefs are assessed. The more specific the behaviour to be predicted the more specific the attitudes assessed have to be. For example, when measuring an attitude or subjective norms on an issue such as class attendance the best prediction will not be from some general set of beliefs about, say, education, but about oneself going to a particular class at the particular time of 8 o'clock in the morning (Ajzen & Madden, 1986).

This approach has led to the successful prediction of behaviours in a wide range of areas such as blood donation (Bagozzi, 1981), alcohol use (Budd & Spencer, 1984) and the use of contraception (Pagel & Davidson, 1984). For example, Manstead, Proffitt and Smart (1983) applied Ajzen and Fishbein's (1980) theory to the prediction of infant feeding. Over 200 women were asked to indicate how they were intending to feed their babies. In keeping with the theory of reasoned action the women's behavioural beliefs (i.e., concerning the likely consequences of breast and bottle feeding and their evaluations of each of these outcomes) and subjective norms (i.e., what were the expectations placed on them by others and what was their motivation to meet those expectations) were highly correlated with their feeding intentions

before delivery. These intentions successfully forecast whether or not they did try to breast-feed their infants in the six weeks after the babies were born.

While the theory of reasoned action has been important in stimulating research and hence advancing the understanding of how attitudes can be used to predict behaviours, it has not escaped criticism. A prominent objection concerns the role of previous behaviour. Sherman et al. (1982) extending the attitude accessibility work of Fazio and Zanna (1981) dispute Fishbein and Ajzen's (1981) proposition that experience should not strengthen the attitude-intention relationship to behaviour. In a study of smoking intentions in adolescents Sherman et al. (1982) found that direct smoking experience increased the predictability of intentions from the attitude component. Sherman et al. suggest that attitudes based on experience are more accessible and are, therefore, more likely to guide behaviour. Such a proposition may explain why staff, with more years service in general hospitals, increasingly show their negative attitudes to suicide attempters (Suokas & Lonnqvist, 1989). While staff generally held unfavourable attitudes towards patients who attempt suicide approximately 50% of staff with five years experience reported sometimes showing their irritation towards persons who had attempted suicide as compared to 28% of staff in their first year at the hospital.

In recognition of the need to address the issue of past experience Ajzen (1986) has modified the Reasoned Action Theory to include perceived behavioural control. This modified theory termed The Theory of Planned Behaviour proposed that intentions to perform a behaviour are determined not only by attitudes and subjective norms but also perceived behavioural control. This volitional control of a behaviour is assumed to reflect past experience, beliefs about resources and opportunities, and anticipated constraints and obstacles. Such modifications to the Theory of Reasoned Action increase the proportion of variance accounted for in the attitude-behaviour relationship (Ajzen, 1988; Ajzen & Madden, 1986; Chaiken & Stangor, 1987).

2.2.3   Changing Attitudes And Behaviours

The relationship of attitudes to behaviour has been investigated not only by assessing

whether certain attitudes predict certain behaviours but also by assessing whether altering specific attitudes will affect specific behaviours. Applied research focusing on whether altering attitudes affects behavioural change can best be illustrated in relation to the employment of the mass media in preventative medicine. It is assumed that if a large number of people can be persuaded to change their attitudes to risk behaviours then they will be motivated to change to healthier habits (Taylor, 1991). The mass media is used as a means of reaching large numbers of people cost effectively.

The effectiveness of mass media interventions was tested in the Stanford Heart Disease Prevention Program which aimed to reduce the risk of coronary heart disease (Meyer, Maccoby & Farquhar, 1980). Three communities matched for size and socioeconomic status were compared on risk factors associated with heart disease before and after the intervention campaigns. The first town served as a control community and received no intervention. The second town received, over a two year period, a multifaceted media campaign informing people of the effects of smoking, exercise and diet on heart disease. The third town was exposed to the media campaign plus face-to-face instruction of individuals, at high risk for coronary heart disease, on reducing specific risk factors. The results showed only modest attitude and behaviour changes in the condition with mass media only exposure. Greater and more lasting changes were found when the mass media campaign was combined with individual behavioural instruction.

Transitory decreases in targeted behaviours likewise appear in antismoking mass media campaigns (Warner, 1977). Adolescent smokers alerted to risks may develop attitudes and intentions that favour giving up smoking but their smoking behaviour may be only slightly affected (Leventhal & Cleary, 1980). Taylor (1991) suggests that media campaigns, such as antismoking campaigns, create a receptive milieu for efforts to give up smoking. "Thus the media are effective primarily in inculcating, enhancing, or maintaining people's motivation to quit." (Taylor, 1991, p. 172). The mass media is not, however, able to relate specific instructions of how to modify specific behaviours to specific individuals and without such explicit instructions an attitudinal message may not be as effective (Taylor, 1991).

The preceding research does suggest that there is a relationship between attitudes and behaviour, although the mechanisms that influence the ability to predict an individual's behaviour from their stated attitudes are not yet clear. Notwithstanding these difficulties, attitudinal measures have been employed to investigate a range of specific clinical behaviours, such as attempted and completed suicide. Attitudes, it is proposed, are important in relation to this behaviour as differences in subcultural or community attitudes to suicide may influence individuals and subgroups to engage in suicidal behaviour (e.g., Sale et al., 1975).

CHAPTER 3

ATTITUDES TOWARD, AND THEIR INFLUENCE ON, SUICIDAL BEHAVIOUR

If the premise is accepted that attitudes do indeed exert an influence on behaviour, no matter what the mechanisms, then it is proposed that the attitudes that people hold in relation to suicidal behaviour could have implications for aetiology, treatment and prevention. A number of researchers have investigated the proposition that prevailing community attitudes and beliefs may influence the occurrence of self destructive behaviours (Bagley & Ramsay, 1989; Diekstra & Kerkhof, 1989; Domino, Moore, Westlake & Gibson, 1982; Farberow, 1989; Ghodse et al.,1986; Johnson et al., 1980; Kerkhof & Diekstra 1985; Platt, 1985; Ramsay & Bagley, 1985; Sale et al., 1975; Singh, Williams & Ryther, 1986).

The following chapter outlines the attitudes held toward suicidal behaviour from the broader community perspective to more specific attitudes held by particular groups. The chapter proposes that the attitudes held by a milieu may affect the suicidal behaviour of individuals and that influences within the community, such as the media, may predispose individuals to suicidal behaviour. The possible mechanisms for the subcultural transmission of suicidal behaviour, such as operant conditioning, modelling and contagion are also discussed. It is acknowledged, however, that any relationship between attitudes and behaviour will be quite complex.

3.1   The Influence Of Changing Societal Attitudes

Attitudes in general society have varied greatly over the past centuries, depending on a range of factors such as culture, information and education (Farberow, 1989; Stein, Witztum & Kaplan De-Nour, 1989). Boldt (1989) suggests that currently there is a trend to reject the traditional 'religious-moral framework' that has greatly influenced societies. 'We are moving from predominantly negative conceptions of suicide, toward a common view that there is a time and a situation when suicide is acceptable if not appropriate' (Boldt, 1989, p. 7). These

more lenient attitudes and related cultural influences may, in part, be responsible for an increase in the frequency of suicide attempts and deliberate self-harm behaviour, especially in the younger age group (Boldt, 1989). Milcinski (1977) supports such a proposition and suggests that changes in the attitudes against the taboo of suicidal behaviour over the past 70 years have contributed to an increase in suicide rates.

In a study investigating general community attitudes in the Netherlands, it was found that community attitudes had changed between 1975 and 1980 (Diekstra & Kerkhof, 1989). Generally, there was a greater acceptance of both suicide and euthanasia in cases of physical impairment, but not in cases of social problems or difficulties in coping. Of the four attitude clusters the young, less educated, lower occupation, non-religious people showed the most positive attitudes to suicide. This was also the group, as compared to younger, well educated, non-religious and older religiously inclined groups, that had the highest rate of attempted suicide. These authors conclude that, whilst the specific relationship between attitudes and suicidal acts is difficult to determine, there is at least a correlational trend to suggest that people who have permissive attitudes toward suicidal behaviour, and who are in crisis, would be the people most likely to respond with self-destructive behaviour. Reasoned Action Theory would support such a proposition although social norms would also need to be determined, that is, the social pressures or expectations on the person to engage, or not, in such suicidal behaviour.

3.2 The Sub-Cultural Context Of Attitudes To Suicidal Behaviour

While it is recognised that attitudes in society are altering it has only been since the 1970's that research has attempted to clearly delineate the cultural context within which suicidal behaviour occurs. Kalish, Reynolds and Farberow (1974) in an early study of attitudes of 434 individuals of different ethnic communities in Los Angeles, reported that one third of all respondents thought mental illness was the primary reason for suicide. The better educated, that is, college students or graduates, were less likely to consider mental illness as a cause but rather ascribed extreme emotional stress as the primary motive. That is, factors external to the individual were attributed as causing the behaviour. While the causes

attributed by the age groups to the attempted suicide were different it was acknowledged by half of the younger group (20-39 years of age) and nearly 40% of the other age groups to be deserving of professional intervention.

These results have generally been supported and extended by other authors (Bagley & Ramsay, 1985; Domino et al., 1982; Johnson et al., 1980; Ramsay & Bagley, 1985; Ruiz Ruiz, Serrano, Padilla & Pena, 1986). The findings of these studies attest to the complex and often contradictory nature of the attitudes held by the general community to suicidal behaviour. They range from acceptance in circumstances such as age and illness, where suicidal behaviour is perceived as an understandable response to an untenable situation, to the converse view that perceives suicide as evil and immoral. This latter view attributes the motives of cowardice or attempts to gain sympathy from others as reasons for the act or mental illness.

While the evaluation of the wider general community is important to understand overall attitudes to suicide, specific subgroups in the community have also been investigated. The suicidal individual makes his decisions in a cultural context and, if the attempt is unsuccessful, returns to that culture. The societal norms related to self destructive behaviour may reflect, or run counter to, the meaning attached to suicide in that individual's subculture. Two of the primary authors who have investigated the subcultural attitudes toward suicidal behaviour are Sale et al. (1975) and Platt (1985).

The subcultures defined by both Sale et al. (1975) and Platt (1985) consisted of geographic areas that had incidences of either high or low suicidal behaviour rates. Sale et al. (1975) proposed that suicidal behaviour would be positively reinforced by a sympathetic attitude and hence there would be the likelihood of such behaviour increasing. Individuals within the high rate suburb would be more likely to have the risk of contact or know of the occurrence of suicidal behaviour and hence would be at greater risk of suicidal behaviour. Sale et al. predicted that subcultural groups which held positive attitudes to suicidal behaviour would be characterised by a high risk to perform that behaviour.

Contrary to Sale et al.'s prediction, the results, derived from their scale measuring attitudes on a sympathy-hostility dimension, revealed that the high risk suburbs had the most hostile attitudes to suicidal behaviour. Infact, the researchers found that, irrespective of suburb, attitudes were closely related to beliefs regarding actual mortality. Attitudes concerning attempted suicide appeared, therefore, to be related to the respondents' perceptions regarding the usual consequences of the act. That is, hostile attitudes predominated if suicide attempts were rarely seen as leading to death. In relation to attitudes and beliefs, low-risk suburbs held significantly greater sympathy for suicidal behaviour than the high risk populations, although both samples were relatively favourable and sympathetic toward such behaviour. Sale et al. cautioned the uncritical acceptance of their results due to sampling restrictions.

To further investigate the notion that high risk subcultures would be more tolerant of suicidal behaviour, Platt (1985) also studied subcultural attitudes to parasuicide. He proposed that suicidal behaviour could be seen as part of the repertoire of behaviours available to the high risk subculture. As with Sale et al., Platt's findings were not consistent with the prediction, that is, the high risk group had more negative attitudes to suicidal behaviour.

Platt (1985) argued that the difference between the attitude of hostility and the high frequency of suicidal behaviour reflected the difference between the expectations and the aspirations of the subculture. The suicidal act, while seen as deviant, was also seen as widespread and so less likely to invoke community sanctions. Unlike Sale et al., however, Platt found no evidence of any relationship between prior contact with suicidal behaviour and attitudes to parasuicide. This disparity could be explained by the difference in criteria for 'high risk', that is, twice as many people per 100,000 attempted suicide in Sale et al's high risk area as in Platt's high risk area.

3.3   Attitudes To Suicidal Behaviour By Specific Target Groups

Investigation of attitudes towards suicidal behaviour have not been limited to general

community studies and subcultural comparisons. The attitudes of a number of distinct societal groups have also been examined. Research has focused extensively on the attitudes of professional health care workers and college students and to a lesser degree on high risk groups such as the younger age group and the older age group in society.

3.3.1 Professional Health Care Worker's Attitudes To Suicidal Behaviour

The proposition that the attitudes that suicidal individuals encounter may affect the frequency of suicidal behaviour is the main reason attitude research has focused on health care professionals. The attitudes and beliefs of this group are important due to the worker's close temporal proximity to the suicidal act. Attitudes and behaviours of health professionals have an influence on the therapeutic atmosphere and quality of treatment and, therefore, an influence on repeated attempt. That is, it is argued that the individual may feel rejected and so attempt again. Research has yet to confirm or reject this proposition (Suokas & Lonnqvist, 1989).

Professional groups, as with the general community, display considerable attitudinal variation. Findings, however, tend to suggest generally more negative attitudes to parasuicidal patients when compared to other medical interventions (Goldney & Bottrill, 1980; Ghodse et al.,1986; Ramon, 1980). These studies postulate that differences between professionals are based on the level of professional training (Goldney & Bottrill, 1980), their perception of their own ability to help suicidal individuals and the intentions they ascribe to the attempt (Ghodse et al., 1986; Ramon, 1980). The latter view is consistent with attitudinal research (Ajzen & Fishbein, 1977).

The findings of Goldney and Bottrill (1980) described a non sympathetic attitude toward parasuicidal individuals especially in those professionals with initial contact, that is, interns and registrars. Ghodse et al. (1986) suggested that the nurses were also particularly hostile to individuals who attempted suicide by overdose but there was no difference between the professionals' attitudes when the overdose was perceived as accidental. Therefore, the

staff's interpretation of the intention behind the act, as might be expected from Reasoned Action Theory and the Theory of Planned Behaviour, affected the attitudes held by health care workers to the suicidal behaviour.

Differing on the basis of causal attributions, Ghodse et al.'s (1986) findings reflect the different attitudes engendered by different perceived motives. Health professionals perceive a cry for help and depression as the main causes of suicidal behaviour (Ramon, 1980; Reimer & Arentewicz, 1986). Indeed an act classed as genuine, that is, really wanted to die, correlated positively with the greatest degree of sympathy, readiness to help and understanding by professionals (Ramon, 1980). Platt and Salter (1989) found that staff, more than the general community, saw suicidal attempts as understandable and as a possible way of solving problems. In general, therefore, the attitude to suicidal behaviour literature for health care professionals parallels the contradictory nature of general societal attitudes towards suicidal acts.

3.3.1 College Student's Attitudes To Suicidal Behaviour

College students are a focus of research into suicidal behaviour for a variety of reasons - they are in the young age group (15 - 24 years) which has increasing rates (Weissman, 1974), they tend to be easily accessible and the literature suggests that young people are more likely to admit suicidal ideation to peers (Murry, 1973). The attitudes and beliefs of college students are important to understand, therefore, as they affect the response given to individuals who express a wish to, or attempt, suicide.

A noticeable sex difference occurs in the college population with females responding with more positive attitudes than males to those who express suicidal ideation. Leshem and Leshem (1977) presented a hypothetical advertisement in which the writer indicated a wish to commit suicide. Female subjects expressed significantly more positive concern than male subjects. Such responses could be predicted almost totally on the basis of the subject's education and religious preference. Males who were religious were strongly negative toward the suicidal individual.

College students, as with health care professionals, ascribe causes to explain other people's suicidal behaviour. The types of causes investigated mainly include mental illness, 'cry for help' and personality traits (Domino et al., 1980; Domino & Leenaars, 1989; Selby & Calhoun, 1975; Stein et al. 1989). Suicidal individuals were seen as predisposed to attempt suicide as a consequence of depression but this was distinguished from mental illness. A 'cry for help' motive was endorsed by the majority of students with few believing the myth that people who threaten do not commit suicide. However, they also agreed that 'most people who try to kill themselves "...don't really want to die" (Domino et al., 1980, p. 128). The motives of attempted suiciders are perceived to be caused by personality traits and characteristics (internal attributions) to a greater extent than those that complete suicide (Selby & Calhoun, 1975).

Attitudes related to the morality of suicidal behaviour indicate that the majority of students see suicide as an acceptable behaviour but they also consider that interference is warranted if someone wants to commit suicide (Domino et al., 1980). Wellman and Wellman (1986), in their second survey on undergraduate's beliefs and attitudes concerning suicide found that the majority of respondents agreed that no one should be allowed to commit suicide but, when confronted with the case of the terminally ill, 40% agreed they should be permitted to commit suicide.

A summary of the research into college student's attitudes indicates, therefore, that females respond more positively to suicide attempters, that depression and care-eliciting behaviour are seen as motives for completed suicide and that the majority of students do not agree that completed suicide should be allowed to happen. Such orientations suggest that college students would respond positively to peers expressing suicidal ideation. As education has, however, been noted to influence attitudes to suicidal behaviour (Diekstra & Kerkhof, 1989) it is important for research to investigate non college populations. The positive attitudes expressed may be based, not on age, but on as yet undelineated factors related to higher education.

3.3.3   Young And Old People's Attitudes To Suicidal Behaviour

As will be discussed more fully in the following chapter, the young and the older age groups are at particular risk of suicidal behaviour. Research, however, has yet to directly compare matched samples of younger and older age groups and assess their attitudes and beliefs related to the behaviour of suicide. The majority of studies assessing the positive or negative attitudes that are held by the 18-25 year old and 50 years and over age groups are predominantly gleaned from the college student population (e.g., Domino & Leenaars, 1989; Stein et al., 1989), the general community (e.g., Johnson et al., 1980; Kalish et al., 1974) and general health survey research (e.g., Bagley & Ramsay, 1989).

Particularly with the older population's attitudes and beliefs the research was often based on cluster or factor analysis. That is, the attitudes of the elderly are inferred by their preference for certain of the target research questions, for example, their religiosity (Bagley & Ramsay, 1989). Diekstra and Kerkhof (1989), in the development of the suicide-attitude questionnaire (SUIATT) for comparing groups with different suicide rates, used canonical correlation analysis for a range of demographic variables, including age, to assess the validity of their questionnaire. They found that those who strongly rejected the idea of commiting suicide either for themselves or others were often "....older persons, are less well educated, more highly religiously affiliated, ... more often politically right wing and have lower occupations" (p. 103). Hence the attitudes held by the older population are understood by their affiliations with other demographic variables and not by their direct comparison to the attitudes of a separately defined social group.

From this disparate research some general conclusions relating attitudes to suicidal behaviour have been postulated. Adolescent and young adult attitudes to suicidal behaviour have generally been positive. That is, they do not regard it as a shameful act and ascribe motives that denote a 'cry for help' metaphor rather than negative terms such as 'cowardice' (Kalish et al., 1974; Stein et al., 1989). Whilst the attitudes are generally positive the majority of the samples construe suicide as an abnormal behaviour (Wellman & Wellman, 1986, 1988) requiring treatment (Stein et al., 1989; Wellman & Wellman,1986). Older

people, conversely, are considered to hold more conservative attitudes which influence such views as rejecting the idea of assisting others to commit suicide or denying the right to commit suicide for themselves or others for any reason (Diekstra & Kerkhof, 1989). They are also more often politically right wing (Diekstra & Kerkhof, 1989) and hold conservative religious values (Bagley & Ramsay, 1989). Predominantly they are seen as holding negative attitudes to suicidal behaviour (Johnson et al., 1980).

3.4   The Processes Of Subcultural Transmission: The Role Of Modelling And Contagion

Researchers propose that individuals within a subculture share a common meaning of the concept of suicidal behaviour (Platt, 1985; Sale et al., 1975). Kreitman, Smith and Eng-Seong (1970) argued that in some subcultures suicidal behaviour is seen as an acceptable means of coping with distress. While such views were presented within the framework of a communication perspective, the results of this study are often understood in the light of subcultural norms concerning suicidal behaviour. They proposed that suicidal behaviour was subculturally transmitted as it was significantly more common in the relatives of suicidal persons than in a representative sample of the population. Operant conditioning, modelling and contagion are processes which may explain how shared meanings within subcultures can develop (Bandura, 1971).

The mechanisms of how the subculture transmits attitudes to suicidal behaviour which would increase the likelihood of that behaviour were not explored by Kreitman et al. (1970). The research of Sale et al. (1975) and Platt (1985) on subcultural attitudes did suggest one mechanism, that is, operant conditioning. They proposed that it is the nature of the response by the subculture to the suicidal act that will increase the frequency of suicide behaviour. This purely operant conditioning approach to explain suicidal behaviour is perhaps naive as it has difficulty in accounting for the range of situations that may influence suicidal behaviour.

Alternative mechanisms to explain subcultural transmission have been explored in the modelling and related media literature. These mechanisms include contagion via direct

modelling and imitation via the media as well as operant conditioning (Avery & Baker, 1990). Diekstra (1985) suggests that the subcultural meaning of suicidal behaviour is "...acquired in a process of socialization (models, reactions, and expectations which stem from the social environment of the individual) or social learning" (Diekstra, 1985, p. 31). Hence modelled or imitated behaviour can occur when circumstances resembling those of the modelled situation are present even if there is an appreciable time delay between them (Bandura, 1971).

The proposal of a mechanism linking exposure to suicidal behaviour to the act of suicide is supported by a considerable body of research. This exposure may be by either contact with the behaviour directly, that is, an individual knowing another who has attempted or completed suicide (Diekstra, 1985, 1987), or by media representation of that behaviour, which can affect the suicidal behaviour rates in a society (Schmidtke & Hafner, 1988). A group who are particularly vulnerable to imitation and modelling are adolescents and young adults (Diekstra, 1981; Evans, 1967). Indeed almost half of the reported cases of adolescent suicidal behaviour have had direct contact with others displaying the same behaviour, with a particularly high incidence within the family (Choquet & Davidson, 1975; Diekstra, 1985).

Imitation and contagion effects have also been explored in relation to the influence of the media. While not unanimously supported throughout the literature (Littmann, 1985; Motto, 1967), an impressive body of research dealing with the theme of imitation and the media has provided support for the imitation hypothesis (Bollen & Phillips, 1981; Gould & Shaffer, 1986; Motto, 1970; Phillips, 1974, 1982; Phillips & Carstensen, 1988; Schmidtke & Hafner, 1988). These reports, while varying in degree, have generally found that suicidal behaviour increases in direct correspondence to the amount of publicity given to a suicide. This effect dissipates the further one moves away from the area in which the publication or broadcast was available. It is acknowledged, however, that not all people who are exposed to the modelling of suicidal behaviour display that behaviour so the question arises of just who is most susceptible to such modelling. While there is no compelling evidence that imitation of media presented suicidal behaviour has more influence on specific groups, the young may be particularly vulnerable (Diekstra, 1981).

CHAPTER 4

SUICIDAL BEHAVIOUR CHARACTERISTICS OF OLDER AND
YOUNGER GROUPS

The overall trends, dependent on age, indicate that adolescent and young adult (16 - 24 years) suicidal behaviour is increasing and the elderly (65 + years) show an modest decrease (Davison & Neale, 1989). Proportional to all suicides, however, the elderly group comprise the largest number of completed suicides. The increasing trend in young adults and the existing high rates in the elderly are clinically worthy of investigation (Kirsling, 1986). The following chapter reviews the rates, risk factors and methods of attempted and completed suicide in these two age groups.

4.1 Suicide Behaviour Rates Of The Adolescent And Young Adult

An analysis of the rates has shown that suicidal behaviour has increased since the 1950's for most Western Countries (Holmes, 1991). In the United States and the Netherlands in 1980 the number of suicides per 100,000 (15-29 years) was on average two to three times as high as in 1950 (Diekstra & Moritz, 1987). Even when the birth rate had fallen the increase in the younger age group was apparent. In the United States suicide has become the second leading cause of death among the young, usually preceded only by accidents. In 1980 5,230 suicides were reported in the 15-24 year old age group (Maris, 1985).

Reports analysing age and sex trends in EEC countries have shown that there has been a substantial increase, between the years 1955 to 1979, in completed suicides for 15-29 year olds (Diekstra, 1985). In proportion to all completed suicide, the rates for this age group have increased from approximately one ninth in 1950 to about one-fifth in the 1980's (Diekstra & Moritz, 1987). In both completed and attempted suicide, males in particular have shown a steady increase (Diekstra, 1985; Juel-Nielsen & Kolmos,1980). Adolescent

and younger adults, especially males, are therefore increasingly at risk for completed suicide in many countries in the West (Diekstra, 1985; Haines et al., 1989; Juel-Nielsen & Kolmos, 1980).

The picture is perhaps even more dramatic for the 15-29 year old age group in relation to attempted suicide (parasuicide). In comparison to completed suicide, attempted suicide rates are at least ten times higher in the 15 - 24 year old age group (Maris,1985). Indeed, over 60% of suicide attempts occur in the age group of 35 years and below, although countries vary in the sex and peak age for such attempts (Diekstra & Moritz, 1987). It is estimated that women exceed men in proportion of attempted to completed suicide by between 14:1 and 25:1 (Diekstra, 1985).

While the link between completed and attempted suicides is not definitive, attempted suicide is by far the best predictor of later suicide (Davison & Neale, 1989). Diekstra and Moritz (1987), in summarizing follow-up studies of suicide attempts, highlighted that, on average, nearly 1.5% of young attempters complete suicide within the first twelve months following the initial attempt. Furthermore between 40% to 60% of suicides have been known to have made at least one prior attempt. A future increase in completed suicide based on current suicidal behaviour and birth cohort variables has therefore been predicted by Haas and Hendlin (1983).

In summary, the young are characterised, in a comparison of completed to attempted suicide, by males completing suicide three times more often than females while females attempt suicide at least three times more often than males. This pattern of suicidal behaviour is contrasted with the older age group in the following section.

4.2   Suicide Behaviour Rates Of The Elderly

For the older age group (60+ years) the pattern of completed and attempted suicide is considerably different from that of the young. The elderly represent between 10 to 15% of the general population in most Western countries. Proportional to the suicidal population,

however, they comprise 25 to 30% of all known suicides (Shulman,1978). In the United
States, the incidence over 65 years is 18/100,000 persons or 50% higher than the national
suicide average (Kirsling, 1986). These figures are based on official statistics where it is
accepted that suicide numbers are grossly under reported. Miller (1979) estimated that the
actual number may be 50 to 100% higher. As older persons constitute the fastest growing
segment of the population, the absolute number of elderly completed suicides will continue to
rise.

Durkheim (1951) highlighted both the increasing vulnerability to suicide with age and
the sex differences. As with the young, males complete suicide more than women, however,
the disparity increases in later life. During the ages of 65-69 years male suicides outnumber
same age females by a 4:1 ratio. By the age of 85 years this ratio increases to approximately
12:1 (Miller, 1979). Considering that the U.S. general population suicide rate is
11.9/100,000, figures for the male elderly are disturbing. The rates for elderly male suicide
are 31/100,000 in the 65-74 year age group, 45/100,000 in the 75-84 year age group and
50/100,000 in the age group over 85 years of age (Kirsling, 1986).

While the elderly, especially males, are more likely to commit suicide, they as a group
attempt suicide the least (Miller, 1979). Merrill and Owens (1990) in a comparison of
attempted verses completed suicide in a 65 years and over sample, found that suicidal intent
increased with age. "Elderly patients that attempted suicide resembled elderly patients that
completed suicide and should be considered at high risk of future suicide" (Merrill & Owens,
1990, p. 385). Every attempt by a person over the age of 60 years, therefore, must be
considered a serious suicidal act.

4.3   Risk Factors Associated With Suicidal Behaviour

To begin to understand the differences in the rates of attempted and completed suicide
it is helpful to review the characteristics of the high risk individual. Maris (1985) outlines
some of the characteristics that have been found to be similar between the young and the
older group. These similarities include having few close friends, more experience of

negative social interactions, the use of guns as the method for attempting suicide and the increased likelihood of being diagnosed as mentally ill. While these similarities are interesting many suicidal acts by the young and the elderly are markedly different in nature.

Studies in relation to geriatric suicidal behaviour are rare compared with those investigating the general population and adolescence (Conwell, Rotenberg & Caine, 1990). Merrill and Owens (1990) attempted to provide a current psychological profile of suicide attempters for patients aged under 35 years, 35-64 and 65 years and over. Their findings are consistent with previous research on elderly psychological profiles (Conwell et al., 1990; Frierson, 1990; Gurland, Dean, Cross & Golden,1980; Kirsling, 1986; McIntosh, 1985; Miller, 1979; Osgood,1982; Shulman, 1978). They found that physical illness was a common precipitant of suicide with increasing age. Among the elderly patients, physical illness was invariably chronic, with cardiac, respiratory and arthritic conditions predominating. They also confirmed that psychiatric illness increased with advancing age. Depression was the most common diagnosis with 96% of older patients diagnosed as depressed compared with two thirds in either the young or middle aged groups (Merrill & Owens, 1990). The presentation of depression in the elderly is often atypical, with more somatic symptoms presenting (Zemore & Eames,1979).

Various authors have attempted to describe the psychological characteristics of young adult suicides and the factors that would suggest greater suicidal risk (Brent, 1987; Maris, 1985; Neiger & Hopkins, 1988; Slap, Vorters, Chaudhuri & Centor,1989). These factors include those who have received mental health care, who have attempted suicide in the past or whose parents or siblings have either attempted or committed suicide. There is a higher drug usage, especially alcohol, active conflict with parents or guardians and they are often revenge directed with their attempt motivated by anger and irritability.

4.4   Methods Of Suicidal Behaviour

Conwell et al.'s (1990) research confirmed previous research (e.g., McIntosh & Santos, 1985-86) that there was a significant direct relationship between violent methods of

suicide and age. That is, the elderly are more likely to use violent methods, predominantly firearms, to commit suicide. They suggest that the elderly's use of violent methods is a prominent factor in explaining the higher lethality of suicidal behaviour when compared to that of young adults.

In relation to attempted suicide by self poisoning, Merrill and Owens (1990) suggest that the type of drug taken depended on availability. Young attempters bought proprietary drugs such as codeine and paracetamol. The elderly group used a range of medications which were most often prescribed, such as antidepressants and other psychotropics. Psychotropic drugs accounted for 69% of all substances taken by the elderly compared to only 28% taken by the young.

The suicidal behaviour literature is vast and multifaceted. On the basis of the foregoing review it is argued that a potentially profitable approach to research may lie in a closer examination of community attitudes and beliefs. From the research encompassing attitudes and suicidal behaviour it has been noted that the young and the elderly tend to hold different attitudes and while data provided by epidemiological studies varies as a function of design, variables, data collection methods and other factors, the general trends also highlight differences in the characteristics of the two groups. Future research that directly examines the attitudes and beliefs of the two groups toward attempted and completed suicide may provide data relevant to the understanding, management and prevention of suicidal behaviour.

4.5   Proposals For Future Research

1   The first general proposition is that there will be differences in attitudes to suicidal behaviour between the younger and older groups. Specifically, the younger group will hold more positive attitudes to suicidal behaviour than the older group.

2   The second general proposition is that given there are differences in attitudes as well as the documented differences in terms of characteristics, social and high risk factors, it

is proposed that there will be differences between the two groups on variables such as beliefs about suicidal behaviour, the motives ascribed to it, the information held about it and contact with the behaviour.

Acknowledging the fact that causal inferences are problematic, it is contended that a consideration of these issues may provide some information relevant to the understanding, community-based management and prevention of suicidal behaviours.

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YOUNGER AND OLDER GROUPS ATTITUDES AND BELIEFS TO SUICIDAL BEHAVIOUR

ABSTRACT

An emerging hypothesis in the suicide literature proposes that changes in subcultural group attitudes, particularly along a hostility-sympathy dimension, may alter the likelihood of such behaviour occurring. Two high risk age groups, the young (16-26 years) and the older (50 years and over) group, matched for sex and socioeconomic status were compared, using the Attitudes to Suicidal Behaviour Questionnaire, for differences in attitudes, knowledge and beliefs concerning suicidal behaviour. Results indicated older males were the most hostile to suicidal behaviour. The two groups differed in that the older group perceived suicide as a consequence of mental illness, did not believe people attempted suicide when others could save them, did not see suicide as a right, had more realistic views of what doses of psychotropic medication were likely to be fatal and had not had much contact with suicide attempters. In contrast the attitudes and beliefs of the younger group included not perceiving suicide as caused by mental illness, that people who attempt suicide do so while others are around to save them and that people have the right to commit suicide. Furthermore, they had more unrealistic views of what doses of psychotropic medication could be fatal and had greater contact with others who had attempted suicide. Possible implications for the understanding, management and prevention of suicidal behaviour are discussed.

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JOURNAL ARTICLE

The overall trends, dependent on age, indicate that adolescent and young adult (16 - 24 years) suicidal behaviour is increasing and the elderly (65 + years) show a modest decrease (Davison & Neale, 1989). Proportional to all suicides, however, the elderly group comprise the largest number of completed suicides. The increasing trend in young adults and the existing high rates in the elderly are clinically worthy of investigation (Kirsling, 1986).

A wide range of hypotheses have been advanced as explanations for the increase in suicidal behaviour for the young age group and the ongoing high proportion of aged suicides (Achte,1988; Diekstra, 1985; Diekstra & Moritz,1987; Holding, Buglass, Duffy & Kreitman, 1977; Kirsling, 1986; Maris, 1985). While a direct causal relationship between a behavioural act and attitudes held has not been established (Kelley & Michela, 1980), an emerging hypothesis in relation to suicidal behaviour proposes that subcultural changes in attitudes and beliefs increase the risk of suicidal behaviours (Bagley & Ramsay, 1989; Diekstra & Kerkhof, 1989; Domino, Moore, Westlake & Gibson, 1982; Farberow, 1989; Ghodse, Ghaffari, Bhat, Galea, & Qureshi,1986; Johnson, Fitch, Alston & McIntosh, 1980; Kerkhof & Diekstra 1985; Platt, 1985; Ramsay & Bagley, 1985; Sale, Williams, Clark & Mills,1975; Singh, Williams & Ryther, 1986). Attitudes are generally viewed as a 'disposition to respond favorably or unfavorably toward an object' (Ajzen, 1984, p. 100) and affect, cognition and behaviour are three domains in which attitudes are expressed in observable responses.

Milcinski (1977) proposed that changes in attitudes over the past 70 years, that had supported the taboo of suicidal behaviour, have contributed to the increase in such behaviour. This view is supported by Boldt (1989) as he suggests that more lenient attitudes and related cultural influences may, in part, be responsible for an increase in the frequency of suicide attempts and deliberate self-harm behaviour, especially in the younger age group. Platt (1985) and Sale et al. (1975) have also argued that cultural attitudes may affect responses to suicidal behaviour and that this response may have repercussions for further suicidal behaviour.

The messages attached to suicide in the general community are complex. They range from an accepting attitude to suicidal behaviour in circumstances such as age and illness, where suicidal behaviour is perceived as an understandable response to an untenable situation,

to the converse view that perceives suicide as evil and immoral. This latter view attributes the motives of cowardice or attempts to gain sympathy from others as reasons for the act or mental illness (Domino et al., 1982; Johnson, et al. 1980; Singh et al., 1986). Over the centuries these divergent attitudes have varied in their dominion over popular thought (Shneidman, 1973).

Attitudes, either positive or negative, are nurtured within a cultural context. The two primary authors who have investigated subcultural attitudes towards suicidal behaviour are Sale et al. (1975) and Platt (1985). These subcultures were distinguished by geographic areas with high and low suicide rates. Sale et al. proposed that suicidal behaviour would be positively reinforced by a sympathetic attitude and hence the likelihood of such behaviour increases. Individuals within the high rate suburb would be more likely to have the risk of contact or know of the occurrence of suicidal behaviour and hence would be at greater risk of suicidal behaviour. Platt inferred that all the people within a subculture share beliefs about what range of responses to situations are acceptable to the group, that is, high risk groups will have positive attitudes to suicidal behaviour as it is seen as an acceptable response. However, both Sale et al. (1975) and Platt (1985) found that sympathetic attitudes to suicidal behaviour occurred most often in suburbs with a low risk of suicide attempts and high risk suburbs had hostile attitudes.

A long held proposition in the psychological literature suggests that a substantial proportion of people engage in suicidal behaviour to effect positive change in their environment (Bostock & Williams, 1974; Stengel, 1969). If an individual attempter receives a negative reaction, based on the hostile attitudes of those around them, their environment may not alter in a positive way. It is conceivable, under such circumstances, that the likelihood of further attempts is increased in a renewed effort to effect change in the attempter's environment (Hart, Williams & Davidson, 1988). The results of Sale et al. (1975) and Platt (1985) would seem to support such a proposition.

A factor that has been investigated for its potential influence on positive and negative attitudes to suicidal behaviour is the amount of contact an individual has with suicidal

behaviour. The amount of individual contact may influence whether such behaviour is perceived as an acceptable coping strategy. Sale et al. (1975) indicated that unfavourable attitudes were positively related to contact with attempters. Platt (1985) concluded from his data, however, that there was no evidence of any relationship between prior contact with suicidal behaviour and attitudes to parasuicide. Platt's finding may be a function of the criteria chosen to define a 'high risk' area. Twice as many people per 100,000 attempted suicide in Sale et al.'s high risk area than in Platts'.

Investigations of attitudes toward suicidal behaviour have not been limited to general community studies and subcultural comparisons. The attitudes of a number of distinct societal subgroups have also been examined. Research has focused extensively on the attitudes of professional health care workers (Goldney & Bottrill, 1980; Ghodse et al., 1986; Ramon, 1980; Reimer & Arentewicz, 1986) because of their temporal proximity to the suicidal event. More pertinent to the current investigation is the attitudes of young adults as reflected in college student studies. The latter research suggests that students respond positively to peers expressing suicidal ideation and that depression and care eliciting behaviour are perceived as the main motives for suicide (Domino, Gibson, Poling & Westlake,1980; Lesham & Lesham, 1977; Wellman & Wellman,1986). Diekstra and Kerkhof (1989) in a cluster analytic study noted that individuals who rejected suicide for themselves, but saw it as an acceptable option for others, in general were more likely to be persons with higher (college) education.

While the elderly and the young are similar in aspects of their suicidal behaviour (Maris, 1985; Miller, 1979) the differences are striking. Young adults are more likely to attempt than to complete suicide especially in the face of stress (Bagley & Ramsay, 1989), are mainly female, are more likely to be interpersonally motivated (Neiger & Hopkins, 1988), have more problems in the family (e.g., divorced parents, suicide in the family) (Hawton, Osborn, O'Grady & Cole,1982), and are less religious (Bagley & Ramsay, 1989). The elderly, in contrast, are more likely to complete suicide than attempt it, are mainly male, are more religious and conservative, have concomitant physical illnesses, live alone and have suffered a recent bereavement (Kirsling,1986; Merrill & Owens, 1990; Miller, 1979; Osgood, 1982; Shulman, 1978). These differences in suicidal behaviour may reflect differences in attitudes

to the behaviour.

While, as noted, the young and old are considered to be at high risk for suicidal behaviour (Davison & Neale, 1989) research has yet to directly compare matched samples of the younger and older age groups in order to assess their attitudes and beliefs with regard to such behaviours. The research, comparing age factors as one of a number of demographic variables (e.g., Bagley & Ramsay, 1989; Diekstra & Kerkhof, 1989), has suggested that adolescents and young adults are less likely to regard parasuicidal or suicidal acts as shameful (Kalish, Reynolds & Farberow, 1974; Stein, Witztum & Kaplan De-Nour, 1989). Older people, conversely, are considered to hold more conservative attitudes which influence such views as rejecting the idea of assisting others to commit suicide or denying the right to commit suicide for themselves or others, for any reason (Diekstra & Kerkhof, 1989). They are also more often politically right wing (Diekstra & Kerkhof, 1989) and hold conservative religious values (Bagley & Ramsay, 1989). Predominantly they are seen as holding negative attitudes to suicidal behaviour (Johnson et al., 1980).

In summary, there is substantial evidence that the rates of attempted and completed suicides show differential increases in the two age groups (<30 and >60 years) and the nature of the suicidal acts are characteristically varied. Consideration of the interaction between these factors and the positive or negative attitudes to the behaviour may provide insight into the relationship between attitudes and the occurrence of suicidal behaviour. Attitudes to suicidal behaviour exist within a complex network of attitudes and beliefs (Bagley & Ramsay, 1989). Generally, however, the attitudes to such behaviour can be separated into groups which hold either positive attitudes or negative attitudes. These attitudes may be held by people within geographic areas or occupational subgroups. The reasons for the differences in attitudes and how they may affect suicidal behaviour is by no means understood.

Hypotheses
On the basis of this, two propositions are postulated.

1   The first general proposition is that there will be differences in attitudes to

suicidal behaviour between the younger and older groups. Specifically, the younger group will hold more positive attitudes to suicidal behaviour than the older group.

2   The second general proposition is that given there are differences in attitudes as well as the documented differences in terms of characteristics, social and high risk factors, it is proposed that there will be differences between the two groups on variables such as beliefs about suicidal behaviour, the motives ascribed to it, the information held about it and contact with the behaviour.

Acknowledging the fact that causal inferences are problematic, it is contended that a consideration of these issues may provide some information relevant to the understanding, community-based management and prevention of suicidal behaviours.

METHOD

Subjects

The subjects for this investigation consisted of 200 younger and 200 older individuals (young 16 to 26 years; old 50 years and over). There were 136 females and 64 males in each group. The predominance of females in the sample is consistent with the epidemiology of suicidal behaviour in Hobart, Australia (Mills et al. 1974; Koller & Slaghuis, 1976).

Respondents were individually matched on socioeconomic status. Social class was determined using the General Register Office Classification of Occupations (1966). The number and percentage of respondents in each classification of occupation were Class 1 (1%), Class 2 (33%), Class 3 (46%), Class 4 (7%) and Class 5 (13%). The classifications being professionals, intermediate non-manual workers, such as artists, skilled occupations, partly skilled occupations and unskilled occupations respectively.

Instruments

The Attitude to Suicidal Behaviour Questionnaire (A.S.B.) (Sale et al., 1975) employed in this investigation comprised two instruments, the Hostility-Sympathy Scale and the Suicidal Behaviour Questionnaire (See Appendix A).

The Hostility-Sympathy Scale contains a total of 20 items. This scale assesses attitudes to suicidal behaviour along a hostility-sympathy dimension. The respondent is requested to indicate on a five point Likert scale their degree of agreement with the attitude expressed by each question.

The construction of the Hostility-Sympathy Scale involved a modification of the technique described by Edwards and Kilpatrick (1948). A satisfactory interitem reliability (r= .79) was calculated by the Kuder-Richardson method. The scale can be divided into equivalent forms which resulted in a satisfactory equivalent-half reliability (r= .98). Using a Spearman

Rank correlation coefficient the predictive validity was also calculated to determine the relationship between attitude scale scores and behaviour ratings. Key persons who accompanied five individuals, who had attempted suicide by self-poisoning, completed the Likert scale and then visited the patient. The reunion of the respondent and the patient was videotaped and the interaction rated on the degree of hostility or sympathy by two independent judges. The attitude scale scores and the behaviour ratings were significantly correlated with a score of .88 ($p < 0.001$). This suggested that the attitude scale score was a valid predictor of behaviour. Further details of scale construction are available in Clark (1974).

The Suicidal Behaviour Questionnaire contained a set of 14 multiple choice questions. This questionnaire was designed to assess the respondents' opinions and beliefs concerning the lethality of suicidal behaviour, the motives and explanations they ascribed to it, its acceptability, their personal contact with suicidal behaviour and information on how they would act in the event of someone threatening suicide. Responses, indicating the degree to which the respondents believed the stated item was true for suicidal behaviour or suicidal individuals, was selected from one of five or more response categories. Items on the Suicidal Behaviour Questionnaire were derived from a review of the literature pertaining to suicidal behaviour in the young and the elderly.

Procedure

Subjects were obtained through contact with social, sporting, industrial and manufacturing organisations, special interest groups within the community such as youth drop-in centres, clubs for retired people and a small group of university students. Following negotiations with administrative staff an acceptable procedure for contacting members was agreed upon. In certain instances members were approached on an individual basis while others were addressed as a group. The investigators attended the particular organization when reasonable numbers of members were in attendance. Following discussion with the group, individuals with the required demographic characteristics were identified. From this pool individuals were randomly selected and over 90% of those approached agreed to participate.

While often approached in a group situation all the questionnaires were filled out individually, that is, there was no group consensus concerning answers to questionnaire items. The individuals had unlimited time to fill in the questionnaires although the average completion time was 10-15 minutes.

While the questionnaire was clearly addressing issues related to suicidal behaviour it was emphasised to the respondents that the research was concerned to assist people within the community who were having difficulty coping. They were unaware of the comparative nature of the study between young and old age groups. In initial negotiations with administrators a protocol was established to manage possible instances in which individual's may express concern about their, or others, suicidal ideation or behaviour. Appropriate clinical agencies were nominated but on no occasion did respondents express such concerns.

RESULTS

The results of the two instruments comprising the Attitudes to Suicidal Behaviour Questionnaire were analysed separately (See Appendix A).

The Hostility-Sympathy Scale

The Hostility-Sympathy Scale measured attitudes to suicidal behaviour along a hostility-sympathy dimension. Measurement, using a Likert scale, provided one overall score by which the groups could be compared. The higher the score the greater the level of sympathy. As the interest was in group differences rather than additivity or non-additivity of age and sex effects the four groups: young males, young females, older males and older females, were compared by one way analysis of variance, $F(3,396) = 5.506$, $p = .001$.

A further analysis of these results using Duncan's Multiple Range Test revealed that older males were significantly more hostile ($p < .05$) toward suicidal behaviour than older females, younger males or younger females. Of the last three groups there was no significant difference between them. Table 1 presents the means and standard deviations for each age group by sex (see Table 1).

Table 1 Respondent's Sympathy To Suicidal Behaviour

		AGE					
		YOUNG				OLD	
	N .	MN	SD		N	MN	SD
MALE	64	72.70	8.29		83	68.13	11.79
SEX							
FEMALE	136	73.54	8.29		117	71.15	10.83

The Suicidal Behaviour Questionnaire

To assess differences between the two age groups in beliefs about suicidal behaviours global chi square calculations were performed on 13 multiple choice questions (excluding questions Qu.s 7a and 7b). A Bonferroni adjustment was made for all multiple choice questions (Hall & Bird, 1985) to control for type 1 errors. The new significance level was $p = .05/15 = .0033$. To elucidate the differences, responses in the significant questions were then aggregated into two by two chi squared tables based on the largest differences between age groups. Further analysis was undertaken using two by two chi squared analysis. Questions 7a and 7b were analysed using One way Analyses of Variance as they yielded quantitative rather than categorical data.

The results of the multiple choice survey questions can be divided into two general areas. The first comprises the perceived motives of suicidal behaviour (Qu.s 1, 3, 8, 9), acceptability (Qu.s 13, 14) and management of suicidal behaviour (Qu. 10). The second area comprises knowledge concerning lethality of (Qu.s 2, 4, 5, 6, 7a and 7b) and contact with (Qu.s 11, 12) suicidal behaviour. All proportions, for the old and the young age groups, for each question, are shown in Appendix B (See Appendix B).

The areas explored in the Suicidal Behaviour Questionnaire resulted in both significant and non significant group differences. Descriptive and inferential statistics on the responses of the older and younger age groups to the questions concerning motivation, acceptability and management of suicidal behaviour are shown in Table 4. To provide an interpretable summation of multicategory responses, however, response categories for each question have been grouped to give just two alternatives which differ between age groups. The percent endorsement for the responses grouped to form the first alternative are displayed.

To illustrate the summation procedure consider Question 3 with the following alternatives and frequencies of endorsement (see Table 2)

Table 2   Question 3 -' People Who Take Overdoses or Slash Their Wrists Do It
While Someone Is Nearby So That Their Lives Will Be Saved'

	Age			
	Young		Old	
Response Category	Frequency	Percent	Frequency	Percent
1. In All Cases	2	1	1	0 .5
2. In Most Cases	63	31.5	39	19.5
3. In About Half of Cases	80	40.0	60	30.0
4. In Very Few Cases	53	26.5	96	48.0
5. Never	2	1.0	4	2.0

The responses were then condensed into two categories, All Or Almost All Cases and
Less than Half of Cases. The summarised frequencies and percents are shown in Table 3
(See Table 3). See Appendix B for all proportions for each question.

Table 3   Summarised Two By Two Table For Question 3 - ' People Who Take
Overdoses Or Slash Their Wrists Do It While Someone Is Nearby So
That Their Lives Will Be Saved'

	Age			
	Young		Old	
Response Category	Frequency	Percent	Frequency	Percent
1. In All or Almost All Cases	65	32.5	40	20.0
2. In Half or Less Cases	135	67.5	160	80.0

The responses are further condensed to a single line in Table 4, indicating that 32.5
percent of the younger group and 20 percent of the older group endorse the categories all or
almost all, and that the global chi squared value is 21.9 with a corresponding probability of
·0002.

Motivation, Acceptability And Management Of Suicidal Behaviour

Motivation of suicidal behaviour.

Respondents were asked to assess the possible motivations that suicidal individuals may have. The older group were significantly more likely than the younger group to endorse, from a range of motives, the idea that suicide attempters were mentally ill and did not know what they were doing (Qu. 8). They were less likely than the younger group to endorse the idea that people attempt suicide only when there was a likelihood of their being saved (Qu. 3). In other words, although small, a significant proportion of the younger group did believe that suicidal acts occurred when other people were around to save them. Amongst the similarities (non significant differences) between the two groups over half of both samples felt that overdoses occur after unbearable stresses rather than minor or moderate stresses (Qu. 9). Slightly less than half of both groups believed that those deliberately taking overdoses were more likely than not to be serious in their wish to die (Qu. 1) (see Table 4).

Acceptability of suicidal behaviour.

A significant difference occurred between the two age groups in relation to the issue of whether or not people have a right to die. A majority of the older group in contrast with the younger group, believed that 'people do not have the right to end their own lives' (Qu. 13). Both groups agreed overwhelmingly, however, to reject the statement that suicide was the only real choice in the face of an intolerable life (Qu. 14) (See Table 4).

Management of suicidal behaviour.

A majority in both groups considered that the best way to handle a person threatening suicide was by talking to that person and seeing if their problems could be addressed (Qu. 10) (see Table 4).

Table 4   <u>Group Differences In Endorsement Of Items Relating To The Motivation,</u>
<u>Acceptability And Management Of Suicidal Behaviour</u>

<u>Item</u>	<u>Percent Endorsement</u>		<u>Global</u>	<u>DF</u>[+]	<u>p value</u>
	<u>Young</u>	<u>Old</u>	<u>Chi</u>^{2} [+]		
PERCEIVED MOTIVES					
Qu 1					
In most cases people who deliberately take an over-dose of drugs are trying to kill themselves	40.5	48.5	15.04	4	.0046
Qu. 3					
In all or almost all cases people who attempt suicide do it while someone is nearby so that their lives will be saved	32.5	20	21.9	4	.0002*
Qu. 8					
Because they are mentally ill and do not know what they are doing.	14.7	41.8	56.27	6	.0001*
QU. 9					
People who take an over-do so after stress that would upset most people	52.3	61.4	15.57	4	.0037
ACCEPTABILITY					
Qu. 13					
Nobody has the right to end their own life	21.3	55.2	40.35	1	.0001*
Qu. 14					
Suicide is the only real choice when life becomes unbearable	14.4	8.7	2.68	1	.1019
MANAGEMENT					
Qu. 10					
The best way to manage someone who is threatening to kill themselves - talk to them about their problems and see if you can help in some way	73.3	66.8	15.17	5	.0097

[+] The Global chi squares and the degrees of freedom presented in the
    table take account of all possible responses.
* Significant at p < .0033

Lethality And Contact With Suicidal Behaviour

The second general area considered in this Questionnaire focused on the issues of lethality of and contact with suicidal behaviour (Table 7 presents the group differences for lethality and contact for the two age groups excluding Qu.s 7a and 7b). In relation to issues of lethality only two of the five questions attained significance (Qu.s 6, 7a and 7b).

Lethality of suicidal behaviour.

The accurate knowledge of drugs and their lethality (Qu. 7a) varied both for age and sex $(F(3, 388) = 6.51, p = .0003)$. The Duncan Multiple Range Test indicated that the older female group were more familiar with a greater number of drugs than the other three groups. The younger males, younger females and older males did not differ significantly amongst themselves (see Table 5).

Table 5 The Number Of Drugs Known By Both Male And Female Respondents Of Both The Young And Older Group

		AGE					
		YOUNG			OLD		
		N	MN	SD	N	MN	SD
SEX	MALES	59	13.03	4.04	61	14.10	4.2
	FEMALES	125	14.09	3.62	102	15.62	4.18

The groups also differed in their knowledge of drug lethality (Qu. 7b) $(F(3, 343) = 4.093, p = .0071)$. Older females differed significantly from males of either age group in believing proscribed drugs to be more lethal. They did not, however, differ significantly from the younger females (See Table 6). The older age group were also more likely to have realistic views of what would constitute a lethal overdose of sleeping tablets (Qu. 6) (See Table 7).

Table 6 The Number Of Known Drugs Believed By Respondents To Be Lethal For Males And Females Of Both The Younger And Older Group

	AGE					
	YOUNG			OLD		
	N	MN	SD	N	MN	SD
MALES	59	5.58	3.32	61	5.90	3.68
SEX FEMALES	125	6.73	4.10	102	7.77	5.32

The two age groups endorsed a number of items in a similar way. Approximately half of both the younger and older groups believed that in most cases, people engaging in suicidal behaviour would die unless they receive medical attention (Qu. 2). A smaller but still substantial proportion of the groups (see Table 7) believe that very few attempters actually die (Qu. 4, 5).

Contact with suicidal behaviour.

Finally, the questionnaire also assessed the level of personal contact between the respondents and other people who have attempted and completed suicide. The older group had significantly less contact with individuals who had attempted suicide by overdose or slashing their wrists (Qu. 12). The two groups did not differ significantly, however, in the degree of contact with completed suicide (Qu. 11). Only a small percentage of either group had actually known a person who had completed suicide (See Table 7).

Table 7   <u>Group Differences In Endorsement Of Items Relating To Lethality And Contact With Suicidal Behaviour</u>

Item	Percent Endorsement		Global Chi^{2+}	DF$^+$	p value
	Young	Old			
LETHALITY					
Qu. 2					
In most cases people who take an overdose or slash their wrists would die unless they receive medical attention	49	54	7.37	4	.1174
Qu. 4 In 10% to 19% of cases people taking an overdose actually die	32	44.2	7.86	4	.0967
Qu. 5 In 10% to 19% of cases people slashing their wrists actually die	41	46.2	12.48	4	.0141
QU. 6 How many sleeping tablets do you think would cause a fatal overdose? (0 to 14 or 70 - 99 tablets)	29	12.6	16.22	3	.001*
CONTACT Qu. 11 Have you had any contact with someone who has actually killed himself?	18.6	30.3	7.3	1	.0069
Qu. 12 Have you personally had any contact with persons who have taken an overdose (or slashed their wrists) and survived?	49.5	23.7	27.5	1	.0001*

* significance p < .0033

DISCUSSION

The general findings of the Attitudes to Suicidal Behaviour Questionnaire (comprising the Hostility-Sympathy Scale and the Suicidal Behaviour Questionnaire) indicated that the younger and the older groups evidenced a range of differences and similarities in attitudes and beliefs to suicidal behaviour. In particular, the younger group displayed more sympathetic and positive attitudes than the older group.

The first general proposition was that there would be differences in the attitudes to suicidal behaviour between the younger and older groups with the younger group holding more positive attitudes to such behaviour. The findings of the Hostility-Sympathy Scale, which specifically assessed the attitude of the respondents to suicidal behaviour, confirmed that the younger group (16 to 26 years of age) held more sympathetic or positive views of suicidal behaviour than the older group (50 years and over). That is, the older group were less sympathetic toward people who attempted to kill themselves. Furthermore, sex differences emerged in that older males were significantly more hostile than the older females, younger females or younger males.

The second general proposition proposed that there would be differences between the two groups on variables such as beliefs about suicidal behaviour, contact with the behaviour, motives ascribed to it and the information held about it. The Suicidal Behaviour Questionnaire results did expose a wide range of differences in beliefs concerning motivations, acceptability, management, lethality and contact with suicidal behaviours held by the young and old groups. A summary of the views held separately by each group are presented in Table 8 (see Table 8).

Table 8   Profile Of Significantly Different Views, From The Suicidal Behaviour
Questionnaire, Held By Age Groups

Item Area	Younger Group	Older Group
MOTIVATION	They see suicide as less related to mental illness	They see suicide as a consequence of mental illness where a person is not in control
	Wrist slashers and overdosers attempt while others are nearby to save them to help them	People who attempt suicide do not do so when others are around
ACCEPTABILITY	People do have a right to end their own lives	Disagree with young - you do not have a right to end your life
LETHALITY	They hold extreme and unrealistic views about how many sleeping tablets can kill you.	They have more realistic views on what doses of sleeping tablet can be fatal
CONTACT	They have greater contact with others who have attempted suicide	They do not have much contact with suicide attempters

It is argued that the attitudes toward suicidal behaviour expressed by the profiles of the younger and older groups in this study are plausible in relation to the rates and risk factors found in the literature (Diekstra, 1985; Maris, 1985). The young have high rates for attempted suicide and would, therefore, be more likely to have greater contact with those who have engaged in suicidal behaviour. As people's attributions and attitudes are effected by direct experience (Fazio & Zanna, 1981) it is understandable that a small but significant proportion of young adults believe attempts to be often less than serious or of low intent to die. Also, consistent with the literature on the positive attitudes held by the young, they are

less likely to attribute suicidal behaviour to motives such as mental illness and believe that people do have the option to commit suicide (Stein et al., 1989). Speculation can only be made as to why they have unrealistic views in relation to the dosage of sleeping tablets likely to have fatal consequences. It is apparent from survey research that the young have less experience with psychotropic drugs compared to the older population (Merrill & Owens, 1990). An alternative proposition is that the older group may just be less likely to select extreme responses on questionnaire items.

The attitudinal profile of the older group is also predominantly consistent with the rates and risk factors outlined in the literature for this age group (Kirsling, 1986; Miller 1979). They have less contact with suicide attempters and this may make them more likely to see attempts as more serious than the younger group. The research literature suggests that the older group are more likely to have been diagnosed as having a psychiatric condition when they attempt or commit suicide (Gurland, Dean, Cross & Golden, 1980; Merrill & Owens, 1990). The older group in this study also believe that people who have a mental illness, where the person is not in total control of themselves, are more likely to attempt suicide. The negative, or conservative, attitudes suggested in previous research for the older group (e.g., Wellman & Wellman,1986) were found in that they do not believe people should kill themselves.

Not all the views of the two groups were significantly different. Whilst the young indicated that attempted suicides were less serious they agreed with the elderly that people who overdose deliberately do have the intention to die. It can only be speculated that more weight was given to the word 'deliberate', that is, as distinct from a motive of manipulation of accident. Both groups believed that attempted suicides rarely ended in death. This belief appears to be linked with the understanding that attempters would die if they did not receive medical attention (Sale et al., 1975). It would appear, therefore, that the majority of respondents think that people who attempt suicide are most often saved by medical intervention. Despite the differences between the groups as to whether people have the choice to commit suicide, both groups did not see suicidal behaviour as the 'only' choice. While the young, therefore, maintain the right to choose suicidal behaviour they do not

advocate it as the sole choice in times of crisis. This may suggest why the two groups selected the same way to manage a person threatening suicide, that is, by talking to the attempter about their problems. Finally, neither group had significant exposure to individuals who later completed suicide. Differences in attitudes and beliefs related to suicidal behaviour may have been more marked if the two groups had differed on this variable.

Sale et al. (1975) and Platt (1985) predicted that high risk groups would have positive attitudes within that community. They proposed that attitudes permitted the occurrence of suicidal behaviour as part of the repertoire of responses to crisis situations. This study did not support Platt and Sale et al's prediction in relation to completed suicides. The literature has repeatedly found that older males as a group are at high risk to complete suicide (e.g., Miller, 1979). The attitudes held by this group, however, do not positively favour suicide.

The question remains as to why there is a strong intolerance for suicidal behaviours in high risk areas. A long held proposition in the psychological literature suggests that a substantial proportion of people attempt suicide to effect positive change in their environment (Bostock & Williams, 1974; Stengel, 1969). If an individual attempter receives a negative reaction, based on the hostile attitudes of those around them, their environment may not alter in a positive way. It is conceivable, under such circumstances, that the likelihood of further attempts is increased in a renewed effort to effect change in the attempter's environment (Hart, Williams & Davidson, 1988). The results of Sale et al. (1975) and Platt (1985) are supportive of such a proposition.

The Sale et al and Platt hypothesis of positive attitudes leading to increased risk is supported in the present research in relation to attempted suicide. The younger group, who have the highest risk of attempted suicide for all age groups (e.g., Maris, 1985), did hold positive attitudes to suicidal behaviour. The question then arises as to whether the link between positive attitudes and high risk behaviour as proposed by Platt (1985) and Sale et al (1975) only applies to attempted suicides. The application of the proposed operant conditioning principles to only one aspect and one age group may be inappropriate, too

specific and narrow to be accepted without reserve.

The preceding results suggest that there is no evidence that community attitudes act as a positive reinforcer of suicidal behaviour. This may be due to a weak relationship between the general attitudes to suicidal behaviour and the behaviour itself, or, and of greater probability, there are other variables that alter the direct relationship between the attitude expressed and the behaviour displayed. Variables may include the exposure to high, negative, life stressors or general response sets (either positive or negative).

Clinical investigations in areas as sensitive and controversial in the general community as suicide confront the ever present problem of difficulties of measurement. The Attitudes to Suicidal Behaviour Questionnaire confounds the act of completed suicide and the act of attempted suicide. As the behaviours are presented in combination it is conceivable that the respondents may have confused attitudes related to attempted suicides with those of completed suicides or conversely completed with attempted suicides. Such a confusion may have effected the respondents ability to classify the fine gradients of judgments demanded by the questionnaire.

It would also be helpful in future research if there is a clarification between the attitudes and beliefs concerning the suicidal act and the suicidal person. Differences may exist between a view generally held for the 'good' of the community, or conservative or religious values and the attitudes and beliefs about people who engage in those behaviours. This distinction between the act and the person may assist in the prediction of what situations would affect the attitudes and actual suicidal behaviour of high risk individuals. For example, in addition to assessing general attitudes to suicide, and employing a vignette format , non suicidal people in high risk groups, who have been exposed to either completed or attempted suicides, could be requested to judge the probability of suicidal behaviour. The vignettes could be manipulated to present an increasing similarity to the respondents, that is, they would become of greater personal relevance based on high risk characteristics for their age group. Such an approach should allow the comparison of general attitudes to the act of suicide and indicate the variables that may alter the individual's attitude to that behaviour. In

this way the respondent could select, whilst minimizing socially desirable responses, the variables that may make the act of completed or attempted suicide more relevant to themselves.

Given the complex and often contradictory nature of the attitudes and beliefs of the young and the older groups in this present study it would appear premature to instigate primary prevention programmes to alter community attitudes with regard to suicidal behaviour, as suggested by Henderson and Williams (1974). Targeting specific attitudes to effect behavioural change, using media campaigns, while showing limited success for well defined health behaviours such as smoking and coronary heart disease (Leventhal & Cleary, 1980; Meyer, Maccoby & Farquhar, 1980) must be approached with considerable caution in less discretely defined and researched areas. The issue still remains therefore as to whether such programmes would increase or decrease suicidal behaviour.

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APPENDIX A
A.S.B. QUESTIONNAIRE

We are conducting research into people's views concerning aspects of suicidal behaviour. It is hoped that findings might assist in helping distressed people.

For this we would like you to complete two short questionnaires. There are some instructions at the beginning of each one.

Age	-------------------------
Sex	-------------------------
Level of education	-------------------------
Occupation - Own	-------------------------
(Check one) - Husband's	-------------------------
- Parents'	-------------------------
- Previous	-------------------------
Suburb	-------------------------

Hostility-Sympathy Questionnaire[+]

We are endeavouring to find out people's attitudes to self-poisoning and self-injury, for example, taking an overdose of sleeping tablets. For this purpose, we would be grateful if you would fill out the following questionnaire. There are no right or wrong answers in this first section. Please circle the phrase which most nearly describes your attitude.

1.   I sometimes feel annoyed at people who attempt suicide.

Strongly Agree . . . Agree . . . Uncertain. . . Disagree . . . Strongly Disagree. . .

2.   People who attempt suicide are misunderstood.

Strongly Agree . . . Agree . . . Uncertain. . . Disagree . . . Strongly Disagree. . .

3.   Attempted suicide is a rather immature behaviour.

Strongly Agree . . . Agree . . . Uncertain. . . Disagree . . . Strongly Disagree. . .

4.   People who take an overdose are genuinely in need of support from others.

Strongly Agree . . . Agree . . . Uncertain. . . Disagree . . . Strongly Disagree. . .

5.   There should be less concern about people who take an overdose.

Strongly Agree . . . Agree . . . Uncertain. . . Disagree . . . Strongly Disagree. . .

6.   Wrist-cutting is just an attempt to frighten the rest of the family.

Strongly Agree . . . Agree . . . Uncertain. . . Disagree . . . Strongly Disagree. . .

7.   I feel very sorry for people who take an overdose and would like to be able to help.

Strongly Agree . . . Agree . . . Uncertain. . . Disagree . . . Strongly Disagree. . .

8.   There is so much stress in modern society that it is not surprising so many people are taking overdoses.

Strongly Agree . . . Agree . . . Uncertain. . . Disagree . . . Strongly Disagree. . .

9.   People who take overdoses should be punished.

Strongly Agree . . . Agree . . . Uncertain. . . Disagree . . . Strongly Disagree. . .

10.   I suppose you have to feel a bit sorry for people who take overdoses.

Strongly Agree . . . Agree . . . Uncertain. . . Disagree . . . Strongly Disagree. . .

+ Heading not included in respondents questionnaire

11. People who attempt suicide are thinking only of themselves.

Strongly Agree . . . Agree . . . Uncertain. . . Disagree . . . Strongly Disagree. . .

12. We should be very tolerant of people who attempt suicide and try to understand their problems.

Strongly Agree . . . Agree . . . Uncertain. . . Disagree . . . Strongly Disagree. . .

13. It is the family we should feel sorry for and not the person who takes an overdose.

Strongly Agree . . . Agree . . . Uncertain. . . Disagree . . . Strongly Disagree. . .

14. People who repeatedly take overdoses are wasting taxpayers' money.

Strongly Agree . . . Agree . . . Uncertain. . . Disagree . . . Strongly Disagree. . .

15. People who try to kill themselves should be locked away.

Strongly Agree . . . Agree . . . Uncertain. . . Disagree . . . Strongly Disagree. . .

16. I sometimes feel sorry for people who attempt suicide.

Strongly Agree . . . Agree . . . Uncertain. . . Disagree . . . Strongly Disagree. . .

17. People only pretend to kill themselves; very few are really serious.

Strongly Agree . . . Agree . . . Uncertain. . . Disagree . . . Strongly Disagree. . .

18. People who try to kill themselves need love and understanding.

Strongly Agree . . . Agree . . . Uncertain. . . Disagree . . . Strongly Disagree. . .

19. People who attempt suicide do so out of spite.

Strongly Agree . . . Agree . . . Uncertain. . . Disagree . . . Strongly Disagree. . .

20. I feel sorry for the hosptial staff who have to look after these dreadful people who try to kill themselves.

Strongly Agree . . . Agree . . . Uncertain. . . Disagree . . . Strongly Disagree. . .

Suicidal Attitude Questionnaire[+]

1. People who deliberately take an overdose of drugs are trying to kill themselves.

    (Tick the answer you think is most likely).

    ------------------   In all cases

    ------------------   In most cases

    ------------------   In about half of cases

    ------------------   In very few cases

    ------------------   Never

2. People who take an overdose or slash their wrists would die unless they

    received medical attention.

    ------------------   In all cases

    ------------------   In most cases

    ------------------   In about half of cases

    ------------------   In very few cases

    ------------------   Never

3. People who take overdoses or slash their wrists do it while someone is nearby

    so that their lives will be saved.

    ------------------   In all cases

    ------------------   In about half of cases

    ------------------   In very few cases

    ------------------   Never

+ Heading not included in respondents questionnaire

4.   What proportion of those persons taking an overdose do you think actually die?

------------------   None

------------------   1 - 9%

------------------   10 - 19%

------------------   20 - 39%

------------------   40% and over

5.   What proportion of those slashing their wrists do you think actually die?

------------------   None

------------------   1 - 9%

------------------   10 - 19%

------------------   20 - 39%

------------------   40% and over

6.   If the normal dose of sleeping tablets is two a night, how many tablets do you think would cause a fatal overdose?

------------------   0 - 14

------------------   15 - 29

------------------   30 - 69

------------------   70 - 99 or more

7.   Below is a list of drugs and groups of drugs:-

        (a)   Cross out those you have not heard of.

        (b)   In column 1 tick those drugs which you feel would *be* fatal if a person took 25 of them.

	Column 1
Aspirin	_____
Valium	_____
Amytal	_____
Relaxa-tabs	_____
Mogadon	_____
Panadol	_____
Blood pressure tablets	_____
Tofranil	_____
Antidepressants	_____
Barbiturates	_____
Mandrax	_____
Penicillin	_____
Digoxin	_____
Melleril	_____
Antihistamines	_____
Tranquillizers	_____
Cortisone	_____
Nembutal	_____
Thyroxine	_____
Diuretics (water tablets)	_____
Tryptanol	_____
Sleeping Tablets	_____

8.   What do you consider to be the motives behind attempting suicide:- (tick those possible reasons listed below which you think are the important one(s). If you have ticked more than one, number them in order of importance, 1 being the most important reason). You may be able to think of more reasons - if so write in at the bottom.

   _____   because life is not worth living

   _____   because they feel guilt and are punishing themselves

   _____   because they wish to change the behaviour and attitudes of others toward them

   _____   because they want to make other people feel guilty

   _____   because they are mentally ill and do not know what they are doing

   _____   because they feel they are in the way of others

9.   People who take an overdose, do so (tick which you believe to be most commonly correct).

   _____   after unbearable stress

   _____   after stress that would upset most people

   _____   after stress that most people could bear

   _____   after seemingly minor upsets

   _____   without any obvious stress at all.

10.   What do you think is the best way to manage someone who is threatening to kill himself? (tick those that you would do. If more than one tick, number them in order of importance).

   _____   call the police

   _____   call the ambulance

   _____   call the family doctor

   _____   talk to them about their problems to see if you can help in any way.

11. Have you personally had any contact with someone who has actually killed himself?

    _____ Yes

    _____ No

12. Have you personally had any contact with persons who have taken an overdose (or slashed their wrists) and survived?

    _____ Yes

    _____ No

13. Nobody has the right to end their own life.

    Agree   _____

    Disagree _____

14. If life becomes too intolerable and degrading, then suicide is the only real choice.

    Agree   _____

    Disagree _____

APPENDIX B
SUICIDAL BEHAVIOUR QUESTIONNAIRE

Percent Proportions For The Old And Young Groups For Each Item[+]

Qu 1   People who deliberately take an overdose of drugs are trying to kill themselves. (Tick the answer you think is most likely).

	YOUNG	OLD	Totals
In all cases	0	4.5	2.25
In most cases	40.5	48.5	44.5
In about half of cases	33.5	23.5	28.5
In very few cases	24.5	23.0	23.75
Never	1.5	0 .5	1.0
Totals:	100%	100%	100%
N	200	200	

Qu 2   People who take an overdose or slash their wrists would die unless they receive medical attention.

	YOUNG	OLD	Totals
In all cases	18	10.5	14.25
In most cases	49	54	51.5
In about half of cases	23	20.5	21.75
In very few cases	10	14.5	12.25
Never	0	.5	.25
Totals:	100%	100%	100%
N	200	200	

[+]Results are calculated using the MacIntosh program 'Statview'

Qu 3   People who take overdoses or slash their wrists do it while someone is nearby
so that their lives will be saved.

	YOUNG	OLD	Totals
In all cases	1.0 ^{z}	0 .5 ^{1}	.75
In most cases	31.5	19.5	25.5
In about half of cases	40.0	30.0	35.0
In very few Cases	26.5	48.0	37.25
Never	1.0 ^{2}	2.0 ^{4}	1.5
Total:	100%	100%	100%
N	200	200	

Qu 4   What proportion of those persons taking an overdose do you think actually
die?

	YOUNG	OLD	Totals
None	0.5	0	.25
1 - 9%	29.0	22.61	25.81
10 - 19%	32.0	44.22	38.10
20 - 39%	28.5	22.61	25.56
40% and over	10.0	10.55	10.28
Totals:	100%	100%	100%
N	200	200	

Qu 5   What proportion of those slashing their wrists do you think actually die?

	YOUNG	OLD	Totals
None	5.5	3.52	4.51
1 - 9%	41.0	46.23	43.61
10 - 19%	24.0	30.65	27.32
20 - 39%	22.0	10.05	16.04
40% and over	7.5	9.55	8.52
Totals:	100%	100%	100%
N	200	200	

Qu 6   If the normal dose of sleeping tablets is 2 a night, how many tablets do you think would cause a fatal overdose?

	YOUNG	OLD	Totals
0 - 14	17.0	7.58	12.31
15 - 29	34.5	41.41	37.94
30 - 69	36.5	45.96	41.21
70 - 99 or more	12.0	5.05	8.54
Totals:	100%	100%	100%
N	200	200	

Qu 8   What do you consider to be the motives behind attempting suicide: - (tick those possible reasons listed below which you think are the important one(s). If you tick more than one number them in order of importance, 1 being the most important reason). You may be able to think of more reasons - if so write in at the bottom.

	YOUNG	OLD	Totals
Because life is not worth living.	31.31	29.08	30.2
Because they feel guilt and are punishing themselves	9.09	4.59	6.85
Because they wish to change the behaviour and attitudes of others toward them	20.2	11.73	15.99
Because they do not know whether life is worth living and are leaving their fate to destiny	10.61	.51	5.58
Because they want to make other people feel guilty	8.59	10.71	9.64
Because they are mentally ill and do not know what they are doing	14.65	41.84	28.17
Because they feel they are in the way of others	5.56	1.53	3.55
Totals:	100%	100%	100%

Qu 9   People who take an overdose, do so (tick which you believe to be most
commonly correct).

	YOUNG	OLD	Totals
After unbearable stress	52.31	61.38	56.77
After stress that would upset most people	26.15	13.76	20.05
After stress that most people could bear	8.72	15.87	12.24
After seemingly minor stress	9.23	7.94	8.59
Without any obvious stress at all	3.59	1.06	2.34
Totals:	100%	100%	100%
N	200	200	

Qu 10   What do you think is the best way to manage someone who is threatening to kill himself? (Tick those that you would do. If more than one tick, number them in order of importance).

	YOUNG	OLD	Totals
Call the Police	5.33	8.19	6.85
Call the ambulance	2.67	7.6	5.3
Call the family doctor	6.0	12.87	9.66
Talk to them about their problems to see if you can help in any way	74.33	66.67	69.78
Call their bluff and hand them some tablets	4.0	1.75	2.8
Ignore them because if they were really going to do it they would not talk about it	8.67	2.92	5.61
Totals:	100%	100%	100%
N	200	200	

Qu 11   Have you personally had any contact with someone who has actually killed himself?

	YOUNG	OLD	Totals
Yes	18.56	30.3	24.49
No	81.44	69.7	75.51
Totals:	100%	100%	100%
N	200	200	

Qu 12   Have you personally had any contact with persons who have taken an overdose (or slashed their wrists) and survived?

	YOUNG	OLD	Totals
Yes	49.48	23.68	36.72
No	50.52	76.32	63.28
Totals:	100%	100%	100%
N	200	200	

Qu 13   Nobody has the right to end their own life.

	YOUNG	OLD	Totals
Agree	21.25	55.17	38.92
Disagree	78.75	44.83	61.08
Totals:	100%	100%	100%
N	200	200	

Qu 14   If life becomes too intolerable and degrading then suicide is the only real choice.

	YOUNG	OLD	Totals
Agree	14.38	8.67	11.41
Disagree	85.62	91.33	88.59
Totals:	100%	100%	100%
N	200	200	