DOCUMENT RESUME

ED 359 476 CG 024 940

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TITLE Attitudes toward Child Suicide.
PUB DATE Mar 93
NOTE 24p.; Paper presented at the Annual Meeting of the Southeastern Psychological Association (39th, Atlanta, GA, March 24-27, 1993).
PUB TYPE Reports - Research/Technical (143)

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS *Adolescents; Age Differences; *Children; College Students; Death; Higher Education; Parent Child Relationship; *Parent Role; Sex Differences; *Student Attitudes; *Suicide
IDENTIFIERS *Blame

ABSTRACT

Previous research has shown that parents of children who commit suicide receive reduced emotional support from their community. More research in the area of attitudes toward child suicide may aid professionals in helping grieving friends and families and help pinpoint areas where more education may be needed. This study examined the differences between male (N=52) and female (N=72) college students in their blaming of parents for a child's suicide. Ages of the victim were varied to see if the age of the victim would influence both blaming attitudes and attitudes toward the victim's mental health. Subjects completed a demographic questionnaire, read one of three scenarios on child suicide which varied by age of the child but not be sex (all victims were boys), and answered the Youth Suicide Scale (YSS). Results revealed men to be more blaming of parents of a child suicide than were women. There was no main effect for the age of the victim in the scenarios when using the total YSS score, but when using only question four, "To what degree do you blame parents for their child's death?", subjects blamed the parents of the 10-year-old more than they blamed parents of the 13-year-old or the 17-year-old. (Author/NB)

Attitudes Toward Child Suicide

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Running head: CHILD SUICIDE

Abstract

Previous research has shown that parents of children who commit suicide receive reduced emotional support from their community. More research in the area of attitudes toward child suicide may aid professionals in helping grieving friends and families and help pinpoint areas where more education may be needed. This study examined the differences between young men and women in their blaming of parents for a child's suicide. Ages of the victim were varied to see if the age of the victim would influence both blaming attitudes and attitudes toward the victim's mental health. A total of 124 people (52 men; 72 women) participated in this study. Each person answered a demographic questionnaire, read one of three scenarios, and answered the Youth Suicide Scale (YSS). Results revealed men to be more blaming of parents of a child suicide than were women. There was no main effect for the age of the victim in the scenarios when using the total YSS score, but when using only question four, subjects blamed the parents of the 10 year old more than the other two age groups.

Attitudes Toward Child Suicide

Suicide is a major health problem in this country. It is estimated that 30,000 people commit suicide in the United States each year (Centers for Disease Control, 1986). Between 1970 and 1980, a total of 287,322 persons committed suicide in the United States which translates to approximately a suicide every 20 minutes (U. S. Department of Health and Human Services, 1985). Among adolescents and young adults, between 15 and 24 years, the suicide rate tripled between 1950 and 1982. For young males in this age group, suicide rates increased by 50% from 13.5 to 20.2 suicides per 100,000 population (U. S. Department of Health and Human Services, 1986). In the 15-24 age category, suicide is the second leading cause of death exceeded in frequency only by accidents (Holinger, 1979; & Rudd, 1989). For children under 15 years, suicide is the tenth leading cause of death. These sobering statistics reflect a need for more research on suicide. As this problem continues to grow, humanity is robbed of lives that could have been productive. Family and friends of the victims also have their lives disrupted. Since attitudes toward suicide may tend to influence suicide rates, culture and history are important areas to explore.

In modern time, attitudes toward suicide have varied according to the culture of the area in which the victim lived. In India beginning hundreds of years ago and

continuing into the 1900's, widows threw themselves on their husbands' funeral pyres. This practice of suttee was encouraged by Hindu priests as an atonement for their husbands' sins. Among the Japanese hara-kiri, an elaborate form of disembowelment, was a frequent suicide method to regain honor. Even though it was outlawed in 1868 this glorified form of suicide may be partly responsible for the high rate of suicide among the Japanese (Klagsburn, 1976). Even though the romanticization of suicide continues today, during the 1900's, interest in suicide shifted from studying the moral and religious arguments to investigation into its cause and prevention.

Superstitious beliefs and myths have developed over the years affecting current beliefs and attitudes about suicide. People tend to believe things about suicide that allow them to "fool" themselves about the truth or allow them to take on an attitude of complacency to counteract the nervousness they feel about the subject (Klagsburn, 1976). One of the most excepted fallacies about suicide is that people who talk about killing themselves do not actually do it. Indeed, those who threaten often have serious suicidal ideation (Grollman, 1971).

Another fallacy about suicide is that people who kill themselves must be experiencing psychopathology or "be crazy." Most people who commit suicide cannot be labeled as experiencing severe psychopathology (Patros & Shamoo, 1989).

Until twenty years ago, published research on attitudes toward suicide was sparse. In 1969, Farberow cited only one reference on attitudes toward suicide, out of 3,469 entries in the Bibliography on Suicide and Suicide Prevention. Ginsberg (1971) conducted a sample survey of 208 residents of the Reno, Nevada area. He found suicidal behavior by others to be personally familiar to 74% of the respondents. Fifty three percent personally knew someone who committed suicide. Four national surveys in 1977, 1978, 1982, and 1983 have been conducted to examine suicide opinions (Singh, Williams, and Ryther 1986) . The four situations examined were suicide due to incurable disease, bankruptcy, family dishonor, and being tired of living. The results indicated that suicide due to incurable disease was approved by slightly less than 43%, being tired of living by about 13%, and the other two situations by 7%. In these surveys the highest approval rating was from the Pacific region and the lowest from the Southern region.

Probably the best known prevalence study (Paykel, Meyers, Lindethal, & Tanner, 1974) surveyed 720 adults and found that approximately 10% reported having thought life was not worth living at some point in their lifetime. Two and one-half percent reported having thought of attempting suicide and 1% reported having actually made an attempt. Similar results (Vandivort and Locke, 1979) and higher

incidences (Schwab, Warheit, and Holzer, 1972) of suicidal behaviors have been found.

Mishara (1982) found that over 90% of a student sample had known a fellow student who had talked of suicide or had attempted it. Of this same sample, 13% reported that they had attempted suicide themselves.

Young people, the same age group which is at increased risk of suicide, are also particularly likely to attend college. Recent studies have shown that college students are at higher risk of suicide than their noncollege counterparts (Hawton, Crowle, Simkin, & Bancroft, 1978; Rudd, 1989; Smith & Crawford, 1986; Westefeld & Furr, 1987; and Westefeld & Patillo, 1987). Thus, while it is important to study suicide among all age groups, young people are a particularly relevant group for suicide research.

Another study of adolescent attitudes toward suicide, (Stillion, McDowell, & May, 1984) tested the hypothesis that gender would make a difference. The study compared suicide attitudes by assessing responses to vignettes depicting reasons for suicide. Ages of subjects ranged from 9th graders to college undergraduates. Results indicated that women sympathized more with reasons for suicide than did men. In another study investigating gender differences, (White & Stillion, 1988) women were shown to be more sympathetic than men toward suicidal figures. Men were most sympathetic to suicidal male figures. The

Singh et al. (1986) study found that approval for suicide was higher among males, better educated people, and people who do not attend church services regularly.

Wellman and Wellman (1986) conducted two surveys assessing attitudes toward and beliefs about suicide among undergraduate college students. Even though the majority of both men and women did not judge suicidal people harshly, men's attitudes were more negative than women's attitudes.

Research has attempted to help bereaved families of suicide. Family members of suicide victims often receive reduced emotional support from their community (Cain & Fast, 1972; Calhoun, Selby, & King, 1976; Calhoun, Selby, & Faulstich, 1980; Rudestam & Imbroll, 1983). Parents of children who commit suicide have to deal with intense grief and the reactions of persons outside the family can exacerbate the grieving process and be another source of stress (Cain & Fast 1972; Calhoun et al., 1980, Rudestam, 1977). Calhoun et al. (1980) found that parents are blamed more for the death and liked less when a child dies from suicide than from natural causes. These findings were replicated in three other studies (Range, Bright, & Ginn, 1985; Range & Coggin, 1990; Rudestam & Imbroll, 1983). It was found that in cases of violent child suicide, male subjects were more likely to blame the parents than were female subjects (Rudestam & Imbroll, 1983). Blaming the parents may be one way in which people answer a frequently asked

question, "How could this tragedy possibly have happened?" (Calhoun, et al., 1980; Whitis, 1972).

Survivor-victims of attempted suicide have been viewed as negatively as survivor-victims of completed suicide (Ginn, Range, & Hailey, 1988). This means the number of families receiving reduced community support is higher than previously thought. Another important finding in this study was that respondents reported that the unsuccessful attempt at suicide should have been kept within the family. These community attitudes may restrain the family from getting the help they need.

In a survey of 400 men and women in Los Angeles, mental illness was cited as the main reason given for suicide. This means people are likely to view suicide victims as crazy or mentally ill (Kalish, Reynolds, & Farberow, 1974). Studies have shown that when a child dies from suicide he is viewed as being more emotionally disturbed than if he dies from illness (Calhoun, et al., 1980; Range et al., 1985; Rudestam & Imbroll, 1983).

There has been some research on the effects of age on perceptions regarding suicide (Range et al. 1985; Range & Coggin, 1990). Results have shown that an older child is seen as more psychologically disturbed than a younger child. They found the child's age to have an important bearing on how the parents and the child are viewed. They also found the parents

of a 17 year old to be better liked than the parents of a 10 year old.

The high rate of youth suicide seems to warrant further study regarding societal attitudes toward suicide. With the parents and victim viewed more negatively by society as a whole, studying differences among groups could benefit helping professionals as well as grieving friends and families.

The purpose of the present study was to investigate attitudes toward child suicide. The age of the child was varied in three scenarios as either 10, 13 1/2, or 17 years of age. These ages were chosen as partial replication of a previous study (Range, et al., 1985). Subjects were categorized according to gender. Questions from the Youth Suicide Scale (YSS) (Calhoun, et al., 1980) were presented after subjects read one of three scenarios. The questionnaire measures the subject's perceptions of the victim and the bereaved family.

Method

Subjects

Subjects participating in this study consisted of 52 male and 72 female college students enrolled in introductory psychology courses at a southern university. All subjects were volunteers. The majority of the subjects were single, white, Baptist, and living with their parents. They ranged in age from 17 years to 42 years with 50 percent being either 18 or 19 years of age.

Instruments

Subjects completed a standard informed consent form and a short self-report demographic questionnaire. All subjects were verbally instructed by the researcher that this study was interested in the subject's perception of a child who committed suicide and of that child's parents.

There were three scenarios, but each subject received only one. Each scenario was identical except for the age of the suicide victim which was varied as 10, 13 1/2, and 17 years of age. Each scenario was made to look and read like a newspaper account of a suicide, except the identifying information was blackened out. The child victim was a boy since gender of the child victim has been found to make no difference in people's reactions (Calhoun, et al., 1980).

The Youth Suicide Scale (YSS) (Calhoun, et al., 1980) contains eight items assessing the respondent's attitudes about the psychological disturbance of a child suicide victim and his/her parents and about whether the parents are to blame for the suicide. The questions are answered on a 7-point Likert scale, from 1 ("not at all") to 7 ("very much"). Test-retest reliability has been established by computing Pearson correlations between individual scale items of 152 subjects who completed the YSS on two different occasions, a month apart (Range, McDonald, and Anderson, 1987). Correlations for the item assessing youth's disturbance was

.61 and for blaming parents was .60. The question asking whether the cause of death should have been reported by the newspaper and asking how long the parents would remain sad following the death were omitted from the YSS as they are not relevant to the present study (See Table 1 for questions).

Insert Table 1 about here

Procedure

Participants were in classroom-size groups, but completed all materials individually. The general purpose of the study was explained as part of the initial informed consent procedure. Consent forms were signed and collected first to protect the anonymity of the subject. Each subject was then given a packet of materials which contained a demographic questionnaire, the YSS, and one of three scenarios. The packets were sorted so there were a varied and even distribution of the three scenarios. The packets were labeled 1-3 depending on the scenario inside. They were asked to complete the demographic questionnaire first. After this was completed, subjects were given verbal instruction and read one of the three scenarios and then completed the YSS.

A 2(sex) X 3(age of victim in scenario) Analysis of Variance (ANOVA) revealed a significant main effect for sex, but no main effect for the age of victims in the scenarios.

There were no interaction effects. Men revealed themselves to be more blaming toward the parents of victims then women, $F(1,122) = 4.155$, $p = .05$.

One interesting result of this study which was not specifically hypothesized concerns how blame was calculated. For this study, blame was defined as the combined score of all the questions on the YSS. If blame is calculated similar to Range et al. (1985) by using only question four, the results reflect different attitudes. When using this definition of blame, there is a significant difference between groups. A one-way ANOVA reveals that people blame parents of the 10 year old suicide victim more than the other parents, $F(2,121) = 3.8695$, $p < .05$ (See Table 2). Mean scores are listed in Table 2.

Insert Table 2 about here

Discussion

This study investigated whether there is a relationship between attitudes of men and women toward child suicide and the age of the victim. There was a significant difference between men and women in their attitudes toward blaming the suicide victim's parents. Perhaps men blame parents more because traditionally they have had a less active role in raising children and underestimate the difficulty of that

job. Or perhaps, since men are frequently the disciplinarian in the family, they may feel the parents are responsible for the child's behavior and should have control of it.

This study defined blame as a combined score for every question on the YSS. Range, et al. (1985) computed only responses to question four for their definition of blame. This difference may be the reason this study did not get similar results with regard to age of victim. When this study defined blame similarly, results were similar with the 10 year old's parents being blamed more than the other two ages. Another reason may be the different ages of the subjects. This study's subjects were all college students with a median age of 18 years and a range from 17 to 42 years, whereas the Range et al. study's subjects were shoppers in a mall with a range of ages from 16 to 65 (no mean or median age given). Perhaps adolescents attribute blame differently than older adults. Younger people may see suicide as a legitimate alternative regardless of age and so do not blame a 10 year old's parents to any greater degree than a 17 year old's parents. This partially replicates research which has shown that younger people see suicide as a legitimate alternative more often than older people.

On a scale of 1 (low) to 7 (high) this study had means for question one (psychological disturbance of child victim) of 5.86 for group 1 (10 year old), 5.36 for group 2 (13 1/2

year old), and 5.34 for group 3 (17 year old), whereas the Range et al. (1985) study had means (for the same question) of 3.80 for group 1, 2.93 for group 2, and 5.07 for group 3. Clearly this study's subjects' perceptions of child disturbance were much higher than the Range et al. (1985) study. Perhaps being enrolled in a psychology course and knowing the study was conducted by a psychologist induced a mind set of "mental illness."

Research on attitudes toward suicide among young people is needed to help caring professionals better help grieving families. More research in this area may help educate people and help professionals know what grieving families can expect from their community. This type of research may even be able to help change people's attitudes as they better understand suicide and the need for more empathy and understanding toward families and suicidal ideators, especially the families of younger children.

Future Research

Future researchers may wish to look at the differences between those subjects who have children and those who do not. It would be interesting to see if having children of their own would make a difference in how negatively they viewed both the parents and the child victim and how supportive they may be of those parents. It is also recommended that a more diverse ethnic group be studied as

this group was 93.5 percent white. Other races and cultures may view suicide differently which may reflect differing suicide rates between different ethnic groups. Comparing different age groups may also prove helpful as attitudes toward suicide may change as one grows older.

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Table 1

Youth Suicide Scale

1. Compared to other persons in this age group, how psychologically disturbed did this child appear to you?

Not Disturbed Very Disturbed

1 2 3 4 5 6 7

2. Compared to other parents, how psychologically disturbed do you think these people are?

Not Disturbed Very Disturbed

1 2 3 4 5 6 7

3. If you met these parents, how much do you think you would like them?

Not at All Very Much

1 2 3 4 5 6 7

4. To what degree do you blame the parents for their child's death?

Not at All Very Much

1 2 3 4 5 6 7

5. How difficult would it be for you to express sympathy to these parents?

Not Difficult Very Difficult

1 2 3 4 5 6 7

6. How tense would you find it to visit these parents.

Not at All Very Difficult

1 2 3 4 5 6 7

7. Compared to the persons who you know in this age group, how likable did this person appear to be?

Not at All Very Likable

1 2 3 4 5 6 7

8. Compared to other persons you know in this age group, how intelligent do you perceive this person to have been?

Not Very Intelligent Very Intelligent

1 2 3 4 5 6 7

Table 2

Mean and Standard Deviation Scores for the YSS

Gender Differences	
Women	3.99 (.70)
Men	4.25 (.72)*
All Subjects Across the 3 Scenarios	
Scenario 1 (10 year old)	4.23 (.68)
Scenario 2 (13 1/2 year old)	4.10 (.68)
Scenario 3 (17 year old)	4.00 (.80)
Question 4 by Scenario	
Scenario 1 (10 year old)	4.29 (1.88)*
Scenario 2 (13 1/2 year old)	3.51 (1.43)
Scenario 3 (17 year old)	3.32 (1.69)
Psychological Disturbance of Victim Based on Scenario	
Scenario 1 (10 year old)	5.86 (1.56)
Scenario 2 (13 1/2 year old)	5.36 (1.62)
Scenario 3 (17 year old)	5.34 (1.74)

Note: Scores range from 1 to 7; * ≤ .05