EXAMINATION OF ATTITUDES ON YOUTH SUICIDE AMONG FIRST-YEAR COLLEGE STUDENTS

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By
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CERTIFICATION OF APPROVAL

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Dr. Shradha Tibrewal Professor of Social Work	Date
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DEDICATION

In memory of Filmmaker, Writer, and LGBT Activist, Eric James Borges. Thank you, EJ, for everything. You will always be with us.

While doing the literature review for my thesis, I came across this poem written by Colleen Hitchcock. I would like to share it with you, the reader.

Ascension

And if I go,

While you're still here …

Know that I live on,

Vibrating to a different measure

Behind a thin veil you cannot see through.

You will not see me,

So you must have faith,

I wait for the time when we can soar together again,

Both aware of each other.

Until then, live your life to its fullest.

And when you need me,

Just whisper my name in your heart,

… I will be there.

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ABSTRACT

Research on college students' attitudes towards suicide is very limited. The current study was limited to first year college students, as the research available highlighted that the rates of suicide tended to spike more significantly during the transition period from high school to college. The present study examined the attitudes of first year college students toward suicide based on the eight clinical scales of the Suicide Opinion Questionnaire. The Suicide Opinion Questionnaire (SOQ) is a 100-item survey that was developed to evaluate attitudes toward suicide. There were 70 respondents who took part in the survey, aged from 18 to 20 years old. The two most consistent and therefore reliable scales provided the lowest agreement scores indicating that the respondents tend to disagree with Scale 3. Right to death items and Scale 4. Importance of religion. This means that first year college students who took part in the survey do not think that people have the right to die, that religion can play an important role in suicide, and lack of religiosity can cause higher incidence of suicide. To add more details to the analysis a per item frequencies analysis was run to indicate the statements that received the highest and lowest support among the respondents. An overview of most agreed and disagreed statements of the SOQ-C showed that the students first of all speak of importance of therapy and help to those who had a suicide attempt, because they tend to consider a suicide as "a cry for help."

CHAPTER I

INTRODUCTION

Statement of the Problem

On March 10, 1978, American politician and LGBT rights activist, Harvey Milk, delivered a message that became known as "The Hope Speech." In it, he spoke among other things of the importance of embracing the diversity that is around us and to offer hope to those that are struggling in life. "And you…and you…and you…you gotta give 'em hope…you gotta give 'em hope." That message of hope becomes important when looking at complex issues such as suicide. Suicide is a phenomenon in which individuals experience what Seligman (1975) termed *learned helplessness*. This suggests that repeated exposure to environmental change, inconsistency in life, and uncontrollable events, result in internalizing a sense of being helpless in changing significant life situations and even day-to-day situations. Death by suicide is encompassing of learned helplessness, as individuals will stop trying to avoid the stimulus affecting their lives and behave as if it is utterly helpless to change their situation (Cherry, 2010). When individuals feel that they have no control over their situation, they also begin to behave in a helpless manner. When looking at suicide, this helpless manner or inaction is what contributes to individuals overlooking the opportunities that can bring about personal relief or positive change (Cherry, 2010). Furthermore, even when opportunities to escape are presented, this learned helplessness will often prevent any action.

Joiner (2005) reported that blinded by feelings of self-loathing, hopelessness, and isolation, an individual with suicidal ideation cannot see any way of finding relief from pain except through death. According to Joiner (2005), defining suicide is not an easy task and is something that has been debated over many years. The debate focuses on whether or not suicide truly is part of a continuum, ranging from mild suicidal ideation all the way to death by suicide, or whether the different methods of suicide make them categorically different from one another. The Centers for Disease Control (2012) has also weighed in on the discussion and has reported that there needs to be consistency with the terminology so that research is consistent across the board. Suicide is defined by the Centers for Disease Control (2012) as death caused by self-directed injurious behavior with any intent to die. The World Health Organization (2010) reported that approximately one million people die each year from suicide in general.

The Centers for Disease Control (2010) reported that, in the United States, more than 34,000 people kill themselves each year, which is the equivalent of 94 suicides per day. This number equates to one suicide every fifteen minutes or 11.26 suicides per a 100,000 population (Centers for Disease Control, 2010). It is estimated that for every completed suicide, there are approximately twenty-five attempts and for every attempt, there are countless others who suffer with suicidal thoughts or ideation (Goldsmith, Pellmar, Kleinman, & Bunney, 2002). Suicide before the age of 12 years old is rare, but increases with every year past puberty (Centers for Disease Control, n.d.). Research showed that death by suicide was the third leading cause of death for

young adults ages 18-24 (Arias et al., 2003; Romer & Jamieson, 2007). And among college students, death by suicide is the second leading cause of death (Caruso, n.d.).

Suicide is a major, complex, and preventable public health problem. Suicide in general, continues to be a serious problem as evidenced by a 2010 report in which the American Academy of Child and Adolescent Psychiatry refers to suicide as a nationwide epidemic. According to previous research, more than 1,600 teenagers (ages 13-19) die each year in the United States, and more than 72,000 teenagers are treated in emergency rooms each year for self-inflicted injuries (Centers for Disease Control, 2009). According to the American Academy of Child and Adolescent Psychiatry (2008), suicide is the sixth leading cause of death for 5- to 14-year-olds. The Youth Risk Behavior Surveillance Survey conducted by the Centers for Disease Control (2009) found that in a 12-month period, almost 13.8% of high school students had seriously considered suicide, 10.9% of high school students had made a suicide plan, and that 6.3% of high school students had tried to kill themselves at least once. The findings of the survey also showed that females were more likely to attempt suicide, and that 15- to 19-year-old males were four times more likely to die from suicide than their female peers. Furthermore, Shaffer et al. (2009) reported that up to 90% of youth who made a suicide attempt had a history of a treatable psychiatric, behavioral, or substance use disorder.

Youth suicide is a national problem that affects college students severely. According to the National College Health Assessment (2010), 30.7% of undergraduate students “felt so depressed it was difficult to function,” 6.2% of

undergraduate students reported that they "seriously considered attempting suicide," and 1.3% of undergraduate students reported that they had "attempted suicide." These statistics reflect on a problem that only until recently began to gain national attention, as between 1,100 to 1,300 students commit suicide on college campuses in the United States every year (JED Foundation, 2010; SPRC, 2010).

For the first half of the 20th Century, there was little research done on adolescents and youth regarding suicide. From the 1950s to until the 1980s, the United States' suicide rate among men and women ages 15 to 24 tripled, which caused a new area of research on suicide to emerge, including research on college students (Hass et al., 2003). Suicide on college campuses occurred at a rate between 6.5 and 7.5 per 100,000 students (Drum et al., 2009; Silverman et al., 1997). Westefeld et al. (2005) conducted a study with 1,865 college students. Their findings were that 24% of the college students had thought about attempting suicide and 5% of those students had attempted suicide.

In California, the issue of death by suicide was addressed through the implementation of a 5-year state funded study (Nelson, Farberow, & Litman, 1988). The study was broken down into three areas: family related factors, intrapersonal factors, and interpersonal factors. When examining family related factors, Nelson et al. (1988) found that approximately 28% of youth respondents believed that suicide was the result of "family problems, family instability, and lack of family support." Twenty-three percent of youth respondents believed that "problems with parents and parental pressure" contributed to death by suicide. When examining intrapersonal

factors, 17% of youth respondents cited depression as the cause of suicide, while approximately 13% of youth respondents reported that low self-esteem was the cause of suicide. As for interpersonal factors, 21% believed that drug abuse contributed to death by suicide and 18% of youth respondents believed a contributing factor of suicide was "school problems." Wellman et al. (1988) reported that few studies have been conducted with college students when it comes to youth suicide. Thus, the present study is being conducted to examine the attitudes on youth suicide among first-year college students.

Statement of Purpose

The present study focuses on examining the attitudes of first-year college students in regards to youth suicide. Research on college students' attitudes toward suicide is very limited. Although, typically, youth is a term often used to refer to individuals under the age of 18, the consensus in research is to define youth suicide as suicide involving 15- to 24-year-olds. This study is limited to first-year college students, as the limited research available highlighted that the rates of suicide tended to spike more significantly during the transition period from high school to college. This study was guided by the following question: What are the attitudes of first year college students in regards to youth suicide? The present study examined the attitudes of first-year college students toward suicide based on the eight clinical scales of the Suicide Opinion Questionnaire.

Significance of Study

This study is relevant to the social work profession in that it has the potential to bring new awareness to the social work field as well as other disciplines such as psychology as to how first-year college students regard youth suicide. The findings of this study have the potential to help in potential treatment and program development when looking at ways to assist with youth suicide. By knowing the attitudes of first year college students when it comes to youth suicide, the information is critical for the social worker knowledge base and practice. In addition, this study adds to the knowledge base that suggests a lack of information and research on college students in regards to youth suicide. Having this knowledge on student attitudes and awareness could potentially lead to prevention efforts across the board from school settings to community-based organizations. For example, findings from this study could help identify specific areas of youth suicide that college campuses need to focus on in their suicide awareness programs or efforts. This study also has the potential to assist the social work field and other disciplines in implementation of services that would assist in decreasing rates of youth suicide.

CHAPTER II

LITERATURE REVIEW

Youth suicide is a complex issue. Over the past 3 decades, youth suicide has become a mental and public health problem of epidemic proportion. Currently, documented cases make suicide the second leading cause of death among youth, ages 15 to 24, in the United States. Suicide is also a serious problem among children and young adolescents (Felner, Adan, & Silverman, 1988). It is also important to note that suicide rates are especially high among college students (Centers for Disease Control, 2007), and suicidality is increasing on college campuses (Szewcow, 2010). Death by suicide represents approximately 1% of the total undergraduate population of 17.5 million (U.S. Department of Education, National Center for Education Statistics, 2008). Furthermore, suicide among college students currently ranks number two in the cause of death among college students, following accidental death (Applebaum, 2006; Francis, 2003). This chapter explores youth suicide in general; examines available information in regards to some of the risk factors associated with youth suicide, examines some of the barriers to seeking help by college students, as well as examines the role that peers can play when it comes to youth suicide among college students.

Very little empirical research has been conducted regarding suicide ideation among youth and college students. The relatively few researchers who have investigated attitudes toward suicide attempted to correlate attitudes with suicide with

suicidal ideation as they pertain to suicide rates among various groups (Eshun, 2003; Neeleman, Wessely, & Lewis, 1998). The majority of that research groups individuals by country of residence and compares attitudes toward suicide across national boundaries (Domino & Leenaars, 1989; Domino, MacGregor, & Hannah, 1988; Renburg, Hjelmeland, & Koposov, 2008). Conducting such research across nations is important because previous research has suggested that the dominant culture in the United States has more accepting attitudes toward suicide compared to other nations (Cabassa, 2003; Eshun, 2006; Range et al., 1999; Tsai et al., 2000; Walker, 2007). Although this previous research addressed suicide in general and not youth or college students specifically, it was implied that young adults in the United States conform to the pressures the dominant culture may have to incorporate the dominant culture's more accepting attitudes toward suicide (Eshun, 2006; Range et al., 1999; Tsai et al., 2000; Walker, 2007; Zayas, Bright, Alvarez-Sanchez, & Cabassa, 2009). Thus, this may account for the suicide rate quadrupling for males 15 to 24 years old, and doubling for females of the same age group in the last 60 years (American Association of Suicidology, 2006). Whereas suicide accounted for 1.4% of all deaths in the United States annually, death by suicide comprised 12% of all deaths among 15- to 24-year-olds (American Association of Suicidology, 2006).

Risk Factors that Contribute to Youth Committing Suicide

Risk Factor of being a College Student

Norton et al. (1988) found that research examining adolescents' knowledge of risk factors when it comes to youth suicide was virtually nonexistent. Suicide continues to be a major cause of death of college students in the United States (Hirsch et al., 2007). Hirsch et al. (2007) reported that the risk for suicide ideation was greater among college students than for same age counterparts not attending college. Curtis (2010) also concludes that the college population may have higher rates of suicidal behavior than the general population. In addition, Curtis (2010) found that this could be attributed to a range of social factors; among them, the high number of important and potentially stressful life transitions during this period of a person's life. Life transitions such as the change in educational realms (high school to college), transitions such as adolescence to adulthood and, lastly, increasing independence and responsibilities can attribute to the higher risk for suicide among college students. The highest suicide rates are among young adults, the group who make up the majority of university and college students. This is why social factors that contribute to suicide among college students may include academic stress and changing or lacking social networks (Hirsch & Ellis, 1996; Konick & Gutierrez, 2005). Such transitions in college life can also result in perceived losses such as identity, loneliness, and isolation, as well as financial stress (Scanlon et al., 2007).

Risk Factor of Intrapersonal and Interpersonal Conflicts

The California Department of Mental Health in 1986 funded a 5-year study looking at youth suicide. This study was conducted to assist with the increase of suicide rates, as well as to provide data that would assist in improving the development of program evaluation and available interventions. This study looked specifically at California youths within the ages of 12 to 20 years old to better understand what youths felt were factors that contributed to youth suicide. The study was also conducted to evaluate programs and interventions that could be created as a result of the findings. The study had survey findings from five sample groups: (a) young people 12-15 years of age (*n*=318), (b) young people 16-19 years of age (*n*=326, (c) students from California high schools (*n*=1000), (d) psychological autopsy data on California youth who had committed suicide (*n*=44), and (e) parents of California youth 12 to 19 years of age (*n*=465).

The researchers (Nelson et al., 1988) found that among the five sample groups, respondents answered similarly to open-ended questions such as, "What do you think are the major causes of youth suicide today?" In examining the response patterns, it was evident that all of the sample groups thought that intrapersonal problems such as depression, feelings of hopelessness, stress, and low self-esteem were major causes of youth suicide. Other patterns seen in regards to intrapersonal problems leading to youth suicide involved family instability and problems with parents. Various interpersonal factors such as drug abuse, school problems, and peer

related pressures and conflicts were also frequently mentioned. Each of the five sample groups also most frequently mentioned family and parental problems as the major cause of youth suicide relative to the other factors (Nelson, et al., 1988).

This study-highlighted risk factors contributing to youth suicide. Among them, youth reported problems with low self-esteem, social alienation, family dysfunction, substance abuse, and the presence of serious emotional disorders. Respondents believed that youth suicide was the result of a combination of factors including family problems, problems in peer relationships, and psychological difficulties such as depression and low self-esteem (Nelson et al., 1988). School-related problems were often mentioned by those respondents who were themselves of school age. In contrast, the two sample groups composed primarily of adult respondents made no mention of problems in school as a potential cause of youth suicide.

Risk Factor of History of Previous Suicide Attempts

A history of attempting suicide in the past has been shown to raise the risk level for both college students and the general population (Hawton & Sinclair, 2003; Westefeld et al., 2000). Realizing that past suicide attempts present a higher risk for students is beneficial in seeing how colleges and universities treat risk level for enrolled students. One quarter to one-third of individuals, who die from youth suicide, make suicide attempts prior to their completed suicide. With each successive attempt, the risk of completed suicide increases—for male adolescents the risk is

thirty times higher, whereas for female adolescents the risk is three times higher (Shaffer et al., 1996).

Risk Factor of Substance and Alcohol Abuse

Substance abuse as well as alcohol abuse has been identified as risk factors of youth suicide and these issues of abuse are an issue that colleges and universities have struggled with for many years (Westenfeld et al., 2000). Various researchers have established a link between substance abuse and suicidal risk (Rogers, 1993; Shaffer et al., 1996) as well as alcohol use and suicidal risk (Windle, 1999). Substance abuse is also a significant risk factor when it comes to youth suicide, especially for older adolescent males (Shaffer et al., 1996) and when co-occurring with an affective disorder (Gould & Kramer, 2001).

Risk Factor of Sexual Orientation

Compared to their heterosexual peers, gay, lesbian, bisexual, and transgender (LGBT) college students are at an elevated risk for suicide (McDaniel, Purcell, & D'Augelli, 2001). Isolation, family rejection, and discrimination lead LGBT youths to experience possible depression as well as other possible mental health issues. Depression in itself elevates the risk for LGBT youth for suicidal ideation and self-harm (Almeida, Johnson, Corliss, Molnar, & Azrael, 2009).

Risk Factor of Depression

Depression is a risk factor for youth suicide in college students (Kisch et al., 2005). Lester (1995) found that college students that are experiencing depression might tend to view suicide as less morally wrong. Thus, not only is depression in

itself a risk factor, but it is also the case that depression may lead to other attitudes that may increase the risk of youth suicide.

Risk Factor of Psychopathology

The majority of youth and college students who have completed suicide had significant psychiatric problems, including depressive disorders and substance abuse problems (Otsuki et al, 2010). Of these, major depression has been seen as the most prevalent condition. Although many mental health disorders increase the odds of suicide ideation, disorders characterized by anxiety and poor impulse control increase the odds of actual suicide attempts (Kwoy & Shek, 2009). Additionally, the intensity of a person's suicidal intent is associated with a history of depression and anxiety and current stress from a mental disorder (Koutek, Kocourkova, Hladikova, & Hrdlicka, 2009).

Risk Factor of Hopelessness and Helplessness

Hopelessness and helplessness are other risk factors contributing to college student suicide (Furr et al., 2001; Kisch et al., 2005; Westefeld & Furr, 1987). The risk for youth suicide increases in college students when they feel that they have no control over their lives. There is one area of research that continues to receive substantial attention when looking at youth suicide and that is the implications of psychological problems of hopelessness and depression in relation to suicidal ideation (Leenars, 2003).

Risk Factor of the Immigrant Experience

Among Latinos, being born in the United States is associated with a higher risk of youth suicide than foreign-born Latino youths (Fortuna et al., 2007; Zayas, Bright, Alvarez-Sanchez & Cabassa, 2009). Otsuki et al. (2010) explained that this could be so in that immigrant youths often experience stress associated with acculturation. Being an immigrant in itself presents a risk factor for college students when it comes to youth suicide. Vega et al. (1993) reported that both the association between psychopathology and suicidal behavior and the association between drug use and suicidal behavior are dependent on the degree of acculturation stress.

Risk Factor of Stressful Life Events

Adolescents who attempt or complete suicide have experienced multiple negative life events (Reinhertz et al., 1995). The events may have occurred in childhood, such as physical and sexual abuse, neglect, separation life and previous suicide attempts (King, O'Mara, Hayward, & Cunningham, 2009). Kaminski and Fang (2009) found that life events associated with risk of youth suicide included interpersonal losses such as breaking up with a boyfriend or girlfriend. They also found that legal and disciplinary problems as well as victimization by peers were life events associated with higher level of youth suicide risk.

What Do We Know about Youth Suicide?

The Big Ten Study

The Big Ten Study (1997) explored the issue of suicide among college students. This study also examined all known completed suicides among undergraduate and graduate students from September 1, 1980, to August 31, 1990, on the main campuses of schools affiliated with the Big Ten University Athletic Association (10 public Midwestern universities and two private institutions). The findings of this study showed that the rate of suicide for college students was 7.5 per 100,000 students. The findings of this study also showed that one in twelve college students had made a suicide plan, as well as that it was estimated that there are more than 1,000 suicides on college campuses each year. The Big Ten Study (1997) found that two groups of college students might be at higher risk for suicide. One group was students with a pre-existing (before college) mental health condition, and the second group was students who developed a mental health condition while in college (Hass, et al., 2003).

American College Health Association

The American College Health Association (2000) surveyed 16,000 college students from 28 campuses. They found that 9.5% of college students surveyed had seriously contemplated suicide, while 1.5% of those surveyed reported that they had made a suicide attempt. In the 12-month period prior to the survey, half of the sample reported feeling very sad, one third reported feeling hopeless and 22% reported

feeling so depressed as to not be able to function. Furthermore, of the 16,000 students surveyed, 6.2% of males and 12.8% of females reported a diagnosis of depression. Therefore, large numbers of college students are not receiving adequate treatment and/or who remain undiagnosed of mental health issues (National Mental Health Association and the Jed Foundation, 2002; 2004).

National Research Consortium of Counseling Centers

Denmark et al. (2012) looked at exploring college students' perspectives and experiences at times of crisis. Self-reported reasons for concealing suicidal ideation by students was explored using data from a national survey of undergraduate and graduate students. Of the total participants, 558 students in this study reported that they had seriously considered attempting suicide during the previous year and did not tell anyone about these thoughts. Furthermore, when asked the question, "Why did you choose not to tell anyone about these thoughts?" content analysis of students' qualitative responses generated nine theme areas (Burton Denmark, Hess, & Becker, 2012). Those nine themes given by students were (a) perceived low risk, (b) concern for others, (c) dispositional privacy, (d) pointlessness of help-seeking, (e) others' negative reactions, (f) personal negative reactions, (g) repercussions, (h) interference, and (i) perceived isolation (Burton Denmark, Hess, & Becker, 2012).

This study was an analysis of archival data from a larger study by Consortium of Counseling Centers in Higher Education. This larger study consisted of a random sample of approximately 108,500 undergraduate and graduate students across 70

participating U.S. colleges and universities. In total, 26,451 undergraduate and graduate students responded to the online survey. From that larger group, archival data were analyzed to study the reasons college students have for concealing suicidal ideation.

The most common of the themes observed as to why college students conceal suicidal thoughts was that they perceived themselves to be low risk for attempting suicide or perceived low risk. Concern for others was the second most prevalent theme examined in student responses. The study found that college students concealed suicidal ideation because they thought others would feel burdened or overwhelmed if they knew about the suicidal thoughts. Within this theme, college students also reported that they concealed suicidal thoughts because the student wished to spare others any feelings of guilt or responsibility that could result from having known about the student's suicidal thoughts in advance of his or her death (Burton, Denmark, Hess, & Becker, 2012).

What Do College Students Know about Youth Suicide and its Causes?

Seeking Help

According to Curtis (2010), youth suicide is an issue of concern and the college population may have a considerably higher rate of suicidal behavior than the general population, yet seeking help for suicidality is uncommon. Curtis (2010) sought to understand college students' knowledge of suicidal behavior and attitudes to help seeking, in a New Zealand university. The researcher utilized a mixed method approach utilizing a survey and interviews. Curtis (2010) found that approximately

one-fifth of participants had been suicidal, were aware of another student's suicide and had supported a student who had been suicidal. Another finding from this study was that students expressed willingness to seek help for another, but far fewer were willing to seek help for themselves. And when students did express greater willingness to seek help for another, the study found that students would do so if they were not a close friend.

Knowledge of Youth Suicide

Norton et al. (1988) found that adolescents desired more information when it came to youth suicide. Interestingly enough, Morrison (1987) noted that school personnel resist the formal introduction of suicide education programs into school curriculums in the mistaken belief that such discussions will precipitate more completed or attempted suicides. Wodarski and Harris (1987) reported that such reluctance might also be due to the educators' own discomfort with the dynamics of suicide.

Reactions to Youth Suicide

Norton et al. (1988) looked at students' knowledge of risk factors that identify potential suicidal behavior in peers, attitudes toward peers who attempt or commit suicide, and lastly the ability to respond appropriately to suicidal messages from peers. The sample size consisted of 120 students and their findings showed that overall, few students possessed accurate information, and many more had misinformation concerning various warning signs of suicide. Furthermore, student respondents also expressed negative attitudes toward peers who attempted or

committed suicide, and generally, it was observed that students were not able to respond sensitively and appropriately to suicidal communications or thoughts. This study also concluded that 82% of the sample of students knew someone who had completed suicide. Of those, only 16% of females and 13% of males knew that a suicidal adolescent is likely to threaten suicide or have made a previous suicidal gesture (Norton et al., 1988). In fact, 42% of females and 43% of males inaccurately believed such behaviors were not related to suicide. This becomes a problem in that if students are not able to identify warning signs and risk factors among their peers, many of these students contemplating suicide will remain unidentified and those suicidal students are more likely to initiate self-destructive behaviors (Nelson et al., 1988).

Barriers to Seeking Help by College Students

Stigma

Stigma is definitely a barrier to help seeking that is reflected in existing literature (Kirk & Kutchins, 1992; Lapsley et al., 2002; Link & Phelan, 2006). For example, in the New Zealand study (Curtis, 2010), students responded with comments such as, “It’s difficult to say ‘you need to see a mental health professional’ in a tactful way,” “… it’s seen as a weakness (help-seeking),” “It’s hard to reach out and if someone suggests it, you think you must be crazy,” and, lastly, another example of a student’s comments was, “Imagine if someone found out or they told your parents … your friends would think you were mental.” Previous research by Curtis (2003) suggested that campaigns aimed to increase help seeking, featuring a

well-known and respected athlete like a rugby player, had had some success. This becomes important as findings in an Australian study (Gilchrist & Sullivan, 2006) also found that young Australians viewed help-seeking as being "weak" or "uncool."

Student Discomfort

Denmark et al. (2012) found that college students reported an inability to tolerate the discomfort of talking about feelings, having others know about them, or receiving attention or sympathy from others. Students felt that others would not be able to provide useful help, and many students expressed the belief that other people would not care, understand, or take them seriously. Students reported that they concealed suicidal ideation from others because they feared being stigmatized for having mental health problems, responses also mentioned that they feared negative reactions from others such as rejecting them, fearing them, blaming them, judging, or otherwise treating the student differently (Denmark et al., 2012). Lastly, another theme that was analyzed was that of "perceived isolation." Responses from students reflected the perception that students felt that no one was available to confide in regarding the suicidal thoughts. Some college students' responses expressed genuine isolation, while others reported that there were people in their lives who could be potential confidants. Of the latter, students rejected their potential confidants because of lack of trust, proximity, comfort, or perceived availability. Many college students did express that if an appropriate confidant were to have been available, that they would have disclosed their suicidal thoughts to them.

Role Peers Can Play in Regards to Youth Suicide

Social Connections

It is crucial to examine the role that peers play in relation to help seeking among those that contemplate self-harm or who have had suicidal ideation. Curtis (2010) pointed out that young people contemplating suicide were more likely to seek help from friends and family than from formal services. Similarly, De Leo and Heller (2004) found that among their sample of school students, less than half of those who had engaged in deliberate self-harm behaviors had sought help, but of those that did, 81% of students had approached a friend. Thus, peers can play a vital role in decreasing rates of youth suicide among college students. The social connection aspect is relevant in any suicide prevention program.

Campus Cohesion

Students can play an active part in addressing issues such as isolation on college campuses. Denmark et al. (2012) found that there is a need and importance of increasing social connectedness on campuses, which has also been promoted as a key strategy for national suicide prevention efforts (Suicide Prevention Resource Center, 2004; U.S. Department of Health and Human Services, CDC, 2008). Programs for first time freshman and transfer students would also be beneficial as many of these students have few pre-existing social supports on campus. Denmark et al. (2010) reported that by enhancing the quality of students' campus and classroom relationships would not only bolster students against emotional distress and suicide,

but also increase the likelihood that students who do become overwhelmed and experience suicidal ideation would be able to identify potential confidants and avenues to receiving help.

Peer-to-Peer Trainings

Training peers (college students) to respond to their friend's emotional or suicidal distress offers one promising approach to decreasing rates of youth suicide, given that friends are the primary source of support sought by students who do disclose their suicidal thoughts (Drum et al., 2009). College students contemplating suicide are more likely to confide in informal sources, such as friends and family, than to confide in professional helpers, and among their informal sources of support they show the greatest preference for confiding in peers (Barnes, Ikeda, & Kresnow, 2001; Cauce et al., 2002; Drum et al., 2009; Molock et al., 2007). Barnes et al. (2001) found that friends and family were consulted by nearly half of the individuals who later attempted suicide, suggesting that improving responses by informal help sources has great potential for saving lives.

Additionally, peer-response training to facilitate help seeking across a college campus is something that needs to be advocated for inclusion in first year student orientation (Sharkin et al., 2009). Exposing all incoming students to training focused on helping peers in distress has benefits of communicating both explicit messages, such as the promotion of counseling resources on campus, and implicit messages about the appropriateness and usefulness of reaching out for help (Burton et al., 2012). For example, if students know that their peers have had the same trainings as

them, then those students will see them as skilled in being able to assist them should they have issues themselves. Knowing that peers have been trained also sends the message that disclosure of suicidal ideation will be acknowledged and responded to with help from others. Another benefit from having entering students experience this type of training would be that it is emphasized that they are now members of an inter-dependent community and are thus responsible for supporting and looking out for one another. Denmark et al. (2012) pointed out that there needs to continue to be further suicide prevention efforts in strengthening students' sense of belongingness and social connectedness as this is believed will increase help-seeking by distressed students and also reduce the numbers of college students who will reach suicidal levels of distress.

Conclusion

This chapter explored youth suicide in general, examined available information in regards to some of the risk factors associated with youth suicide, examined some of the barriers to seeking help by college students, as well as examined the role that peers can play when it comes to youth suicide among college students. The truth is that regardless of the various assessment results or psychological theories and diagnoses purported to reflect overall continence, it is unmistakable that individuals who contemplate or follow through with suicide, have suffered a great deal in their lives. It is also evident that this suffering has had some significant impact on their ability to fully function on many levels. That is why this current study was looking to examine the attitudes of first-year college students in

regards to youth suicide. This researcher is building from the initial study that saw the development of a suicide opinion questionnaire (Domino et al., 1978) that could be used in research and applied studies of attitudes towards suicide.

Examining those attitudes toward youth suicide is crucial, as suicide on college campuses and among college students in the United States has been an issue of concern for many years (Kraft, 1980; Westefeld & Furr, 1987; Westefeld et al., 2000; Westefeld, Whitchard, & Range, 1990). In 1990, more than 25 years ago, Westefeld et al. emphasized the need to take action both reactively and proactively when it came to youth suicide among college students. Today, that need for action remains as youth suicide among college students remains a major concern, and it is an issue that continues to require a strong national response.

CHAPTER III

METHODOLOGY

Research and current literature on the subject of youth who die of suicide illustrate what the American Academy of Child and Adolescent Psychiatry (2010) stated is the need to reduce the suicide epidemic nationwide. For the present study, the researcher utilized a survey design to examine the attitudes on youth suicide among first-year college students at California State University, Stanislaus. The current research was guided by the following question: What are the attitudes of first-year college students in regards to youth suicide? Although suicide rates are high among college students, there is currently little research exploring college students' attitudes toward suicide. The current study examined the attitudes toward youth suicide among first-year college students utilizing the eight clinical scales of the Suicide Opinion Questionnaire.

Design

A quantitative research design was utilized for this study that was descriptive by nature in order to gather data that examined the attitudes of first year college students in regards to youth suicide. The nature of the descriptive design helped address the research question based on the eight clinical scales of the Suicide Opinion Questionnaire. A descriptive design was utilized for this study as this type of design is aimed at describing variables or characteristics among variables such as those found in a questionnaire (Rubin & Babbie, 2010). As the current study focused on

describing the attitudes of first year college students in regards to youth suicide, the descriptive design was appropriate in that this type of design allowed the researcher to analyze multiple variables simultaneously. In addition, conducting a quantitative study is appropriate since a quantitative study only measures what it is designed to (Rubin & Babbie, 2010). A quantitative study relies on numbers, and as Balnaves and Caputi (2001) stated, a quantitative design is all about the process of taking data, quantifying the collected data, and then turning that data into an analysis or findings. For the present study, the researcher utilized self-administered surveys that were comprised of standardized instruments to collect data for the study.

Sampling

For the present study, nonprobability purposive sampling was used to recruit participants. This type of sampling is not based on random selection; rather, the researcher selected participants who met certain criteria that the researcher believed would achieve an understanding of the study's purpose (Rubin & Babbie, 2011). For the purpose of this study, the participants were first year college students at California State University, Stanislaus. Participants included all students on campus who met this requirement. The Office of Institutional Research at California State University, Stanislaus was contacted by the researcher and they provided assistance in providing this researcher with a sample of students. The Office of Institutional Research at California State University, Stanislaus screened for first-year college students. After receiving approval from the University Institutional Review Board (IRB), a link to the survey and informed consent on Survey Monkey was forwarded to the pool of

students identified as having met the criteria for the present study. This researcher did not have access to the names or identifying information of the students, other than their e-mail addresses. The target sample size was comprised of 300 students, and the researcher expected a thirty percent response rate.

Data Collection

After receiving approval from the Institutional Review Board at California State University, Stanislaus, this researcher began the data collection process. Data were collected using self-administered surveys. Balnaves and Caputi (2001) defined surveys as a technique by which researchers converted data to a numerical form and subjected it to statistical analysis. This study also followed what Balnaves and Caputi (2001) referred to as multi-item scales that had been developed to provide a more sophisticated way of measuring people's underlying attitudes. The survey and the informed consent were sent electronically to the student e-mail addresses provided by the Office of Institutional Research. The surveys were sent via Survey Monkey, which allowed the protection of the participants' anonymity. The participants were informed that the survey would take approximately 30 minutes to complete.

The participants received an email with a link to the survey within the email. Participants were offered the opportunity to be included in a raffle to win one of two $25 pre-paid gift cards, which served as an incentive for their participation. Participants were informed that in participating in the raffle their anonymity would be annulled; therefore, they were reminded that the raffle was optional. The two raffle winners were contacted by the researcher, and their gift cards were mailed to them.

Instrumentation

The participants completed the Suicide Opinion Questionnaire, which the researcher obtained permission to use for the present study. The Suicide Opinion Questionnaire (SOQ) is a 100-item survey that was developed to evaluate attitudes toward suicide. The Suicide Opinion Questionnaire (Domino et al., 1980) contains 100 answers on a five-point scale of strongly disagree, agree, undecided, disagree, and strongly disagree. The 100 items were those that survived logical and statistical analyses from an initial pool of approximately 3,000 items derived from a comprehensive survey of the literature (Domino et al., 1978). For the purpose of the present study, only the eight clinical scales (64 items) were utilized to examine the attitudes toward youth suicide among first-year college students. Domino and his colleagues developed eight clinical scales from the initial Suicide Opinion Questionnaire (SOQ) that are referred to as the SOQ-C. Instead of using the original 100 questions, the SOQ-C utilizes 64 of the original 100 questions, thus reducing the length of the questionnaire. Table 1 provides a description of the eight clinical scales.

Table 1

Suicide Opinion Questionnaire-Clinical Scales (SOQ-C)

Clinical Scales	Definition for Each
1. Mental Illness	Suicide reflects mental illness and people who commit suicide are usually mentally ill
2. Cry for Help	Suicide threats represent a cry for help, they are not real and perceive suicidal acts as manipulative in nature
3. Right to Die	People have the right to take their own lives and if someone wants to commit suicide, it is their business and we should not interfere
4. Importance of Religion	Lack of religiosity plays a role in suicide and the higher incidence of suicide is due to the lesser influence of religion
5. Impulsivity	Suicide and suicide attempts are impulsive acts and most suicide attempts are impulsive in nature
6. Normality	Everyone is potentially capable of suicide and suicide is a normal behavior
7. Aggression	Suicide is an aggressive act and suicide is clear evidence that man has a basically aggressive and destructive nature
8. Morally Bad	Suicide is a morally bad action and in general, suicide is an evil act not to be condoned

Note. Domino et al., 2000; Domino, MacGregor & Hannah, 1988; Domino & Su, 1994.

All 64-items were answered using 5-point Likert scale questions; higher scores indicated stronger agreement with that particular statement. For each scale, a total score was derived by summing across all items, and obtaining a mean score. Higher scores

(larger means) on any scale indicated greater agreement with that attitude toward suicide. In the appendix section, permission to use the Suicide Opinion Questionnaire and the Suicide Opinion Questionnaire-C items are presented.

Data Analysis

Survey results from the Suicide Opinion Questionnaire-C (SOQ-C) were collected from Survey Monkey. The researcher exported the data into the IBM SPSS Statistics software. Univariate analyses were conducted to describe the sample and how the participants answered in regards to the questions asked of attitudes on suicide. Scores were calculated for each of the eight clinical scales of the Suicide Opinion Questionnaire. For each scale, the scores were summed and the mean score was calculated. Higher scores reflected a higher agreement with the particular scale being answered. For example, if the question asked if suicide is a result of mental illness, a higher score would indicate that the respondent agreed with that particular belief. Data were presented using tables and charts.

Protection of Human Subjects

This researcher began the data collection process upon receiving approval from the Institutional Review Board at California State University, Stanislaus. The electronic surveys were emailed to the students by this researcher; therefore, this researcher had access to the students' email addresses. In the email, the participants were instructed on how to follow the link to Survey Monkey. Furthermore, the email included information about the survey, such as the number of questions and the time

it would take to complete the survey. Contact information was included in the instruction email for the researcher and the thesis chair of the current study.

The informed consent form (see Appendix A) preceded the survey within Survey Monkey. The informed consent form included the following information: the purpose of the study, participants' rights, instructions for completing the survey, and the researcher's and thesis chair's contact information. The informed consent form assured participants that the survey was voluntary and that no identifiable information would be required. Furthermore, the participants were informed that all information would be protected from inappropriate disclosure under the law and only aggregate results would be published. The participants were informed that the survey was intended for first year college students at California State University, Stanislaus.

Participants were not required to provide any personal information on the survey as the surveys were submitted directly online. Thus, participant anonymity was retained. However, at the end of the survey, participants were given the option of being entered into a raffle for a chance to win one of two $25 pre-paid gift cards. Participants who wished to be included in the raffle, were required to provide their first name along with their e-mail address for notification. For this reason, participants were once again reminded that the raffle was optional. The participants were advised that participation in the raffle annulled their anonymity. The participants were also advised that only the researcher would have access to the survey results, and that the e-mail addresses would only be used for the raffle and would therefore be permanently deleted upon completion of the raffle. If participants experienced any

discomfort as a result of completing the survey, they were informed that they could contact the CSU, Stanislaus Counseling Center free of charge at (209) 667-3381.

CHAPTER IV

RESULTS

Descriptive Statistics

There were 70 respondents who took part in the survey (see Table 2), aged from 18 to 20 years old (mean age M = 18.4, SD = 0.56). The majority of the respondents were females (n = 53, 75.7%) and only 10 respondents were males (14.3%), another 7 respondents (10.0%) missed this question. More than half of the respondents said they were Hispanic or Latino (n = 36, 51.4%) followed by almost equal shares of White/Caucasian/European American (n = 13, 18.6%) and Asian or Asian American (n = 11, 15.7%). There were only single respondents who said they belonged to American Indian and Black or African American and 8 respondents (11.4%) missed this question, which can be interpreted as a refusal to answer.

Table 2

Respondents' Demographic Characteristics

Demographics		*n*	%
Age	18	39	55.7
	19	20	28.6
	20	2	2.9
	Missing / Refused	9	12.9
Sex	Male	10	14.3
	Female	53	75.7
	Missing / Refused	7	10.0
Ethnicity	American Indian	1	1.4
	Asian or Asian American	11	15.7
	Black or African American	1	1.4
	Hispanic or Latino/a	36	51.4
	White, Caucasian, European American	13	18.6
	Missing / Refused	8	11.4

SOQ-C Analysis

The overall 64 items of the clinical scales of the SOQ response rate was relatively high; 70 respondents who completed the study 80.0% (n = 56) provided answers for all items, another 9 respondents (12.9%) provided answers to almost all items and missed only single questions. Two respondents (2.9%) missed one set of questions (12-13 items), and 3 respondents (4.3%) missed two sets and completed only 38 of the 64 items overall. However, calculating mean values for each scale allowed the researcher to avoid the influence of missing answers on the overall scale score. Before calculating the means scores for each scale, a reliability analysis was

conducted by using Cronbach's alpha value to measure internal consistency of each SOQ clinical scale (see Table 3).

Table 3

Internal Consistency of SOQ Clinical Scales

Scale	Number of items	*N**	Cronbach's alpha
Scale 1. Mental Illness	13	63	.586
Scale 2. Cry for Help	12	62	.620
Scale 3. Right to Die	8	64	.703
Scale 4. Importance of Religion	7	62	.711
Scale 5. Impulsivity	7	66	.146
Scale 6. Normality	7	63	.313
Scale 7. Aggression	6	66	.565
Scale 8. Morally Bad	4	64	.426

Note. *The number of respondents who answered all questions from a subscale mentioned

The results of reliability analysis showed the subscales' internal consistency appeared to be different. Two scales: "Scale 3. Right to Die" and "Scale 4. Importance of Religion" showed high enough internal consistency ($\alpha > 0.7$). There was a group of clinical scales that showed moderate consistency of $\alpha > 0.5$ but less than usual good consistency borderline of 0.7 (Tavakol & Dennick, 2011): "Scale 2. Cry for Help," "Scale 1. Mental Illness," and "Scale 7. Aggression." The remaining three scales, "Scale 8. Morally Bad," "Scale 6. Normality," and "Scale 5.

Impulsivity," showed low internal consistency, and their mean values should be interpreted carefully.

The mean scores for each scale were calculated according to the scoring instructions provided by Dr. Domino and the higher value of the mean score indicates a higher level of agreement with that attitude towards suicide.

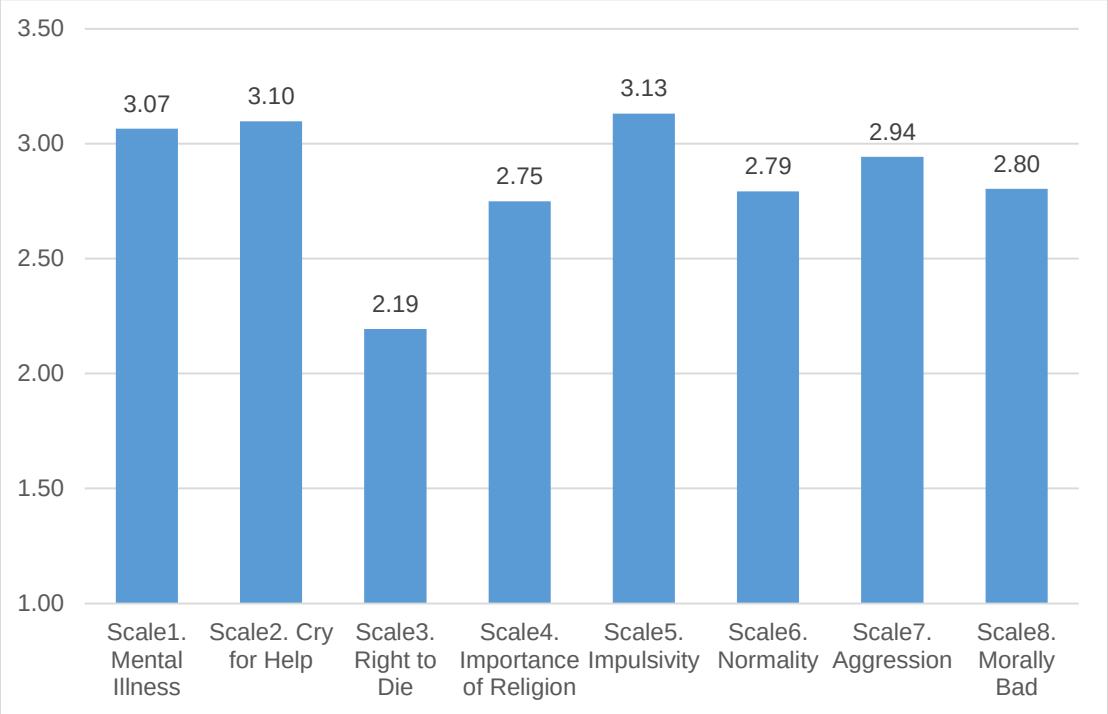

Figure 1. SOQ Clinical Subscales Mean Values

The two most consistent and therefore reliable scales provided the lowest agreement scores indicating that the respondents tend to disagree with "Scale 3. Right to death" items (M = 2.19, SD = 0.54) and "Scale 4. Importance of religion" (M = 2.75, SD = 0.57). This means that first-year students who took part in the survey do

not think that people have the right to die, and that religion can play an important role in suicide, and lack of religiosity can cause higher incidence of suicide.

The highest agreement was measured for “Scale 5. Impulsivity” (*M* = 3.13, SD = 0.40), but this scale showed the lowest internal consistency and thus this result should be treated with caution. Two other scales that lack internal consistency: “Scale 6. Normality” and “Scale 8. Morally Bad” received similar mean scores among the participants (*M* = 2.79, *SD* = 0.49 and *M* = 2.80, *SD* = 0.66 correspondingly). The remaining scales estimating the agreement regarding suicide being a sign of mental illness (Scale 1), “cry for help” (Scale 2), or an aggressive act (Scale 7) scored in the range of *M* = 2.94 (*SD* = 0.54) to *M* = 3.10 (*SD* = 0.42).

To add more details to the analysis a per item frequencies analysis was run to indicate the statements that received the highest and lowest support among the respondents. The next table provides a list of statements, which showed the highest (top 10) rates of those who overall agree with them (“Strongly agree” + “Agree”) and the highest rates of those who disagree with them (bottom 10).

An overview of most agreed and disagreed statements of the SOQ-C questionnaire showed that the students first of all speak of importance of therapy and help to those who had a suicide attempt (*n* = 59, 85.5%), because they tend to consider a suicide as “a cry for help” (*n* = 55, 82.1%). They also believe that depressed people undergo a higher risk of committing suicide (*n* = 53, 80.3%), and they “should be prevented from committing suicide since most are not acting rationally at the time” (*n* = 55, 79.7%). More than two-thirds of the respondents

(68.6% to 71.2%) agreed that “potentially every one of us can be a suicide victim” and “usually, relatives of a suicide victim had no idea of what was about to happen” that fits the idea that “the most frequent message in suicide notes is of loneliness” and that “some people commit suicide as an act of self-punishment.”

The least agreement respondents showed toward refusal to bury people who die by suicide at the same cemetery as those who die naturally (*n* = 59, 89.4%). They also tend to disagree with someone’s right to commit suicide (*n* = 55, 82.1%) and that suicide could be acceptable for aged and infirm persons (*n* = 57, 81.4%). Three-fourths of respondents (*n* = 53, 75.7%) do not believe that “most suicides are triggered by arguments with a spouse” but the share of those who agreed with this statement was also relatively high (*n* = 7, 10.0%) which can indicate a controversial attitude to the role of spouse in triggering suicide. The rest of 10 most disagreed statements were refused by about 70% (67.2% to 71.2%) of the respondents and corresponded to almost all of the subscales: Normality, Importance of Religion, The Right to Die, Impulsivity and Aggression scales (see Table 4).

Table 4

Most Agreed and Disagreed Statements

Statement	Overall Disagree %	Undecided %	Overall agree %	Valid *N**
People who attempt suicide and live should be required to undertake therapy to understand their inner motivation.	4.3	10.1	85.5	69
A suicide attempt is essentially a "cry for help."	10.4	7.5	82.1	67
Individuals who are depressed are more likely to commit suicide.	6.1	13.6	80.3	66
People should be prevented from committing suicide since most are not acting rationally at the time.	5.8	14.5	79.7	69
Potentially, every one of us can be a suicide victim.	12.1	16.7	71.2	66
Usually, relatives of a suicide victim had no idea of what was about to happen.	7.5	22.4	70.1	67
The most frequent message in suicide notes is of loneliness.	10.6	19.7	69.7	66
Some people commit suicide as an act of self-punishment.	11.4	20.0	68.6	70
Most people who attempt suicide are lonely and depressed.	20.3	14.5	65.2	69
Many suicide notes reveal substantial anger towards the world.	14.3	24.3	61.4	70
…				

(Table continues)

Table 4, continued

Statement	Overall Disagree %	Undecided %	Overall agree %	Valid *N**
We should have "suicide clinics" where people who want to die could do so in a painless and private manner.	67.2	20.9	11.9	67
Once a person is suicidal, he is suicidal forever.	69.6	20.3	10.1	69
Many suicides are the result of the desire of the victim to "get even" with someone.	70.0	12.9	17.1	70
Suicide attempters are typically trying to get even with someone.	71.0	21.7	7.2	69
Suicide is a normal behavior.	71.0	24.6	4.3	69
Most people who commit suicide do not believe in God.	71.2	21.2	7.6	66
Most suicides are triggered by arguments with a spouse.	75.7	14.3	10.0	70
Suicide is acceptable for aged and infirm persons.	81.4	17.1	1.4	70
If someone wants to commit suicide, it is their business and we should not interfere.	82.1	13.4	4.5	67
People who die by suicide should not be buried in the same cemetery as those who die naturally.	89.4	7.6	3.0	66

Note. *As some respondents missed single questions in the SOQ, the valid number of answers may be lower than the total sample.

To compare the groups of respondents an Independent Samples *T*-Test for gender groups and one-way ANOVA for ethnic groups were used. To obtain ethnic groups with sufficient number of respondents the initial distribution was revised by merging single answers (American Indian and Black or African American) with "Missing/Refused" group.

Before running the analysis dependent variables—mean scores for each of the scales—were tested to fit the main assumptions of the tests:

- absence of severe outliers
- approximately normal distribution of the variables
- homogeneity of variances across comparison groups

The first assumption was proofed by visual inspection of boxplot graphs that revealed several outliers on "Cry for Help," "Impulsivity," and "Importance of Religion" subscales, a single outlier on "Aggression" and "Mental Illness" subscales. All these outliers were checked for not being obtained due a misprint and as they were not severe, the decision was made to include them in the analysis. The normality of the mean scales scores distribution was checked via Shapiro-Wilk test, which showed insignificant ($p > 0.05$) results for all scales except Impulsivity where the normality was violated due to several cases with high mean scores. However, taking into account that both t-test and ANOVA are considered robust to violation of normality (Pagano, 2004), the tests were used for the analysis. The last assumption concerning the homogeneity of variance across comparison groups tested via

calculating Levene's test for homogeneity of variance, was fulfilled for both gender and ethnic groups ($p > .05$).

The results of mean scores for each of the eight SOQ clinical scales showed no statistically significant difference between male and female respondents' scores (all $p > 0.05$) and the only difference between ethnic groups was revealed for "Scale 4. Importance of Religion" ($F(3,66)=5.540$, $p = .002$) where according to Tukey post-hoc tests the mean score for respondents belonging to Hispanic/Latino group ($M = 2.94$, $SD = 0.56$) were significantly higher than those of Asian/Asian American ($M = 2.44$, $SD = 0.36$) and White/Caucasian/European American ($M = 2.37$, $SD = 0.58$) groups ($p = .031$ and $p = .006$ correspondingly).

At the end of the survey, respondents were asked to answer three additional questions regarding their knowledge of their school offering help and counseling to those who may need support due to feeling distressed. The distribution of the respondents' answers is presented in Figure 2. Sixty-four respondents answered these questions.

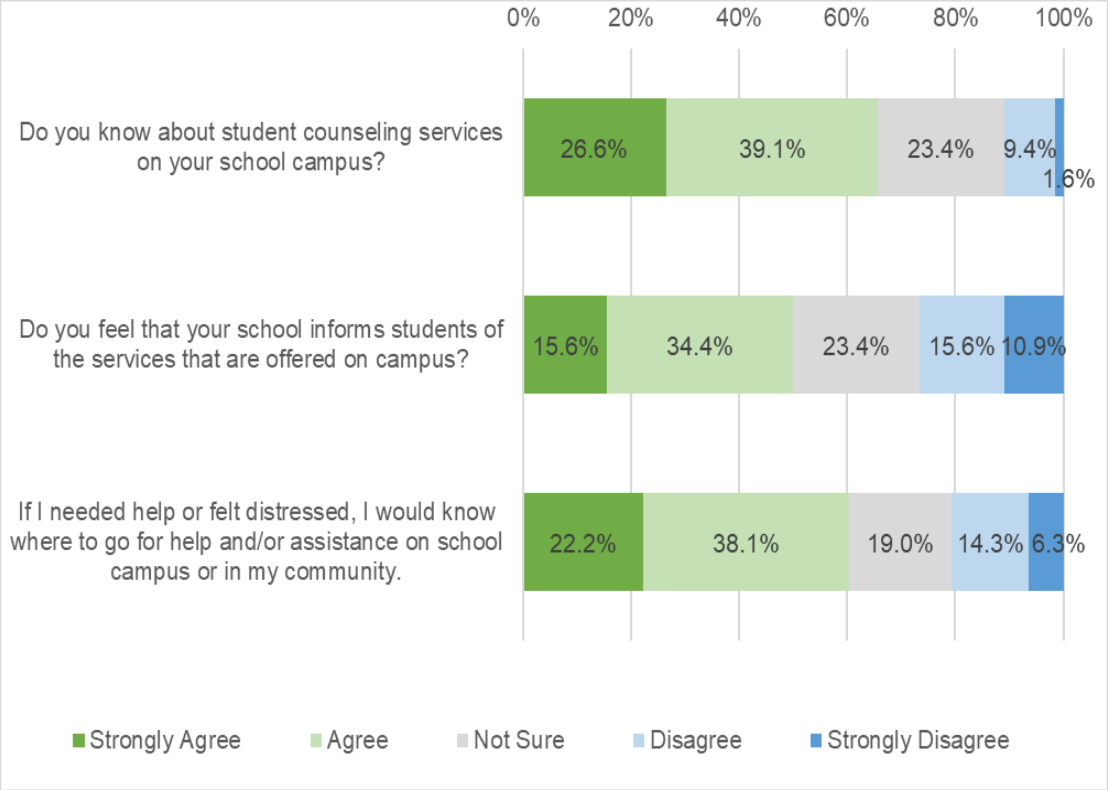

Figure 2. Knowledge of Counseling and Help Sources at School

The results of these questions analysis revealed that over almost two-thirds of the respondents (n = 38, 60.3% and n = 42, 65.6%) are aware of the counseling services available on the campus and would know where to go in case of feeling distressed. In addition, half of the respondents (n = 32, 50.0%) stated they feel that their school informs students of the services offered on campus.

However, there is a potential in improving in schools' informing the students of counseling services on the school campus as over fourth of the participants (n = 17, 26.6%) do not agree that the school provides enough information of the services available. Additionally; a fifth (n = 13, 20.6%) reported that they would not know

where to go for help on school campus or in community in case they needed help of felt distressed.

CHAPTER V

DISCUSSION

Suicide is an increasing problem that is affecting college students. Research in the area of college students' attitudes towards suicide is very limited. Most of the research that examines attitudes of students toward suicide and those who attempt or contemplate suicide, has been performed by Dr. George Domino and his research using the Suicide Opinion Questionnaire. The present study utilized the clinical scales from the Suicide Opinion Questionnaire (Domino et al., 1980).

The main objective of the research was to study the attitudes of first-year college students towards suicide. This research is important considering the high and growing suicide death rates among young adults. Suicide is the third leading cause of death in young adults aged 18-24 (Arias et al., 2003; Joe, Romer, & Jamieson, 2007), and it is particularly higher among college students for whom death due to suicide is the second leading cause (Caruso, n.d.).

The literature review presented in the second chapter of this study revealed a lack of research about attitudes toward suicide, especially among young adults. Most of the research in this field was dedicated to suicide in general, and only few studies implied that young adults in the United States may have to live with the dominant culture of acceptance attitude toward suicide (Eshun, 2006; Range et al., 1999; Tsai et al., 2000; Walker, 2007; Zayas, Bright, Alvarez-Sanchez, & Cabassa, 2009). This could cause further increase in suicide death rates because according to Stein et al.

(1998) more permissive attitudes toward suicide are significantly related to greater suicide ideation among young adults. The present study is a start at in addressing a gap that currently exists in the literature.

The findings of the present study provide a broad picture of students' attitudes towards suicide and allow the exploration of possible effect of different socio-demographical groups of students. There were 70 first-year college students who took part in the survey. They were asked to complete a 64-item version of the Suicide Opinion Questionnaire (SOQ) (Domino et al., 1980) consisting of statements that were grouped into 8 possible clinical scales to measure one's attitude toward suicide: Mental Illness, Cry for Help, Right to Die, Importance of Religion, Impulsivity, Normality, Aggression, and Morally Bad. The SOQ instrument was followed by a set of demographic questions and three questions to assess students' awareness of the counseling and help sources available at the campus.

The response rate to the SOQ scales was relatively high with 80% of the respondents providing answers to all questions. The internal consistency of clinical scales measured by Cronbach's alpha coefficient varied from high enough consistency for "Scale 3. Right to Die" and "Scale 4. Importance to Religion" to relatively low as for "Scale 5. Impulsivity" and "Scale 6. Normality." Although initially the SOQ scales were stated to be reliable and showed high values of internal consistency (Domino et al., 2000), the lack of consistency in the current study can be caused by using a shorter version of the instrument and by using it on a particular

smaller group of respondents (only college student). The results of reliability analysis were taken into account when analyzing the scales.

The results of the SOQ scales analysis showed that the respondents had higher agreement with attitudes to suicide as an Impulsive act (M = 3.13, SD = 0.40) and as a Cry for Help (M = 3.10, SD = 0.42). These results correspond with previous research findings stating that helplessness is an important risk factor for college student suicide (Furr et al., 2001; Kisch, et al., 2005; Westefeld & Furr, 1987). Moreover, the results of the current study showed that first-year college students have an intuitive feeling of this risk factor and treat suicide as a cry for help, sign of helplessness. Although the reliability of "Scale 5. Impulsivity" was low, the high level of agreement with this attitude agree with the results obtained in a study of Kwoy and Shek (2009) that stated that mental health disorders characterized by anxiety and poor impulse control lead to increasing probability of suicide attempt. Moreover, the research conducted among 800 students across the United States showed that 40% of them believe suicide was a spontaneous act (Domino, Gibson, Poling, & Westlake, 1980).

The least agreement was shown towards appreciating the right to death of those who commit suicide (M = 2.19, SD = 0.54). The respondents did not agree (more than 80% said they disagree or strongly disagree with the statements) that suicide can be acceptable for aged and infirm persons and that if someone wants to commit suicide, it is their business and we should not interfere. Importance of religion had a rather low level of agreement among the respondents with mean scale value being lower than 3 on a 5-point scale (M = 2.75, SD = 0.57). This outcome is in

agreement with some while contradicting other previous studies about relationship of being religious and probability of developing suicide ideation. Some of the research suggested a higher risk of suicide among individuals with particular beliefs and thoughts of an afterlife (Domino & Leenars, 1989; Minto & Spilka, 1976), whereas other studies showed that the more structured a person's belief is and the more frequently they attend religious services, the less chance suicide would be considered as an acceptable alternative (Minear & Brush, 1981). Overall, it can be stated that religion plays a role in suicide behavior; however, the impact it has can differ as the logic of influence. As for college students, they tend to pay less attention to this aspect of life with respect to suicide behavior.

The scale of treating a suicide as being a morally bad act (Scale 8) showed moderate results with a tendency to disagree (M = 2.80, SD = 0.66). The overall findings correspond to those of Minear and Brush (1981) who found that students did not believe suicide was morally wrong and found that students reported that they could not see themselves ever attempting suicide. The standard deviation for this scale was the highest compared to all other scales. This can be treated as a sign of higher variability of students' opinions, with significant groups of those who agree and disagree with the idea that a suicide is a morally bad act. However, the low value of internal consistency for this scale leads to interpreting these results with caution. Probably further research made on larger samples could support or refute this hypothesis.

The overall SOQ scales mean values for all the set of 64 separate items was analyzed to add more detailed information to understand first-year college students' attitude toward suicide. The results of per item analysis correspond well with previous research. Similar to the findings of Nelson et al. (1988), feelings of loneliness, helplessness and being depressed were mentioned by 70% to 80% of the respondents as probable risk factors to commit suicide. These results indicate that students' attitudes toward suicide risk factors overall match research results and thus it can be concluded that overall the students have an idea what kind of life course and life stressors can lead to suicide. However, there is a gap between understanding the overall feelings and ability to help or readiness to look for help if needed.

Although suicide is perceived as a cry for help, (more than 80% agree with such attitude) there is a tendency in concealing suicidal thoughts by young adults, which can result in suicide being a very unexpected act for relatives and friends of the suicide attempter. This aspect of suicide is mentioned in current research by 70% of the respondents who agreed that usually relatives of a suicide victim had no idea of what was about to happen. The reason of not knowing can have two aspects, first, as stated in previous research conducted by Burton Denmark, Hess, and Becker (2012), college students tend to conceal their suicidal thoughts to avoid becoming a concern for others and due their wish to spare others any feelings of guilt or responsibility. Other researchers provided a term to this phenomenon: "help-negation," when students avoid seeking help (Barnes, Ikeda, & Kresnow, 2001; Rudd, Joiner, & Rajab, 1995). On the other hand, people overall do not know which actions can be signs of a

suicide, as stated by Norton et. al. (1988), up to 40% of the students inaccurately believe that the behaviors they observe were not related to suicide.

One more aspect of one's attitude towards those who attempted or committed suicide is the idea that suicide is one's own business or others should interfere. According to the results of the current study, the overwhelming majority (82.1%) of college students do not think they should stay aside and believe they should interfere. However, probably due to low awareness of special suicide behavior signs and lack of understanding how to help a person feeling distressed, helpless and lonely to avoid suicide, the readiness to help cannot be embodied. This could lead to increasing importance of information and training to be provided to college students at campus. According to current study results, only about half of the first-year students know about student counseling services on their campus and would know where to go for help if feeling distressed; whereas over one fourth of the participants (26.5%) stated that lack of information of the services that are offered at campus.

Taking into account that especially first-year students are under stress due to major transitions occurred in their life when attending a college, change in social networks which can result in feeling lonely and isolated (Hirsch & Ellis, 1996; Konick & Gutierrez, 2005), this group should be targeted when providing college training. Moreover, according to previous research despite the general tendency to conceal suicidal thoughts, if young adults choose someone to speak to and seek help in the overwhelming majority of cases it would be a friend (De Leo & Heller, 2004).

Thus, sharing information about available resources of help and assistance is especially important among college students.

One more aspect of the current study was the comparison of suicide attitudes of different gender and ethnic groups of students. The comparison of male and female attitudes showed no significant difference for all SOQ scales, which does not correspond to previous results obtained by White and Stillion (1988), who found that females tend to be more sympathetic than their male counterparts with the issue of suicide. This difference could be due to small sample size of the current study and different instrument used in previous research (Suicide Attitude Vignette Experience scale). The comparison between ethnic groups provided by the ANOVA and post-hoc Tukey tests revealed that students of Hispanic/Latino group agree with Importance of Religion (Scale 4) statement significantly more than their counterparts of Asian/Asian American and White/Caucasian/European American groups.

Limitations

The sample population in the present study is one such limitation. The small sample size makes it difficult to discuss the findings within the context of prior studies that have mostly focused on adults. The current study was conducted in a specific region (the Central Valley of California) and with a convenience sample drawn from a specific population (college students), which both present as limitations as these are not representative of the whole.

Strengths

This study identifies that future research is needed relating to attitudes on youth suicide. The fact that 70 first-year college students participated in a study focused on youth suicide is also a strength in that more work needs to be done in examining attitudes of college students as to be able to provide more effective suicide prevention efforts.

Implications for Social Work Practice

Social workers need to be knowledgeable about youth suicide in order to provide competent and culturally sensitive services. Youth suicide and suicide in general should be addressed in all levels of general and clinical social work curriculum. It is important that the stigma associated with youth suicide and suicide in general be discussed in an open and honest manner in order to dispel any myths and fears that may exist. Reynolds and Cimbolic (1988), as well as Deluty (1989), have suggested that the lack of knowledge about suicide may be a cause for the stigma attached to suicide, which is still pervasive in our times. Attitudes on youth suicide need to be examined as this will ultimately reveal what factors play the largest roles in forming beliefs of those contemplating suicide. Social work practitioners need to utilize that knowledge and in turn develop supportive attitudes of their own towards individuals who are contemplating suicide. By being better in tuned with others, social workers can help reduce suicide trends in society by being better prepared and being able to provide adequate service delivery. The present study came about to begin this process of reducing youth suicide which is highly present in college

students. It is important for social workers to be trained in attitudes of suicide as to be able to better provide preventative efforts as well as clinical support. Social workers will benefit from knowing more about attitudes on suicide. For example, if social workers have an understanding on attitudes on youth suicide, that knowledge might be utilized to modify treatment, assessments, and interventions for possible suicide. It is also in the Professional Code of Ethics for social work practitioners to know about suicide, as social workers have an obligation, as mandated reporters, to assess for safety and risk, as well as to report on the findings. This duty to warn of social workers represents a legal responsibility to the greater society and thus social workers need a knowledge base that will be able to better prepare them for clinical crisis and emergencies. Further social workers have an obligation to practice ethical responsibility towards all clients and consumers that they come across. As part of practicing ethical responsibility, social workers must also serve others with cultural competence and with an awareness of social diversity (National Association of Social Workers).

Although social workers are supposed to serve diverse people and cultures, unfamiliarity can be uncomfortable. That is why as social workers it is our responsibility to be comfortable with the uncomfortable and openly discuss issues such as youth suicide. If, as professionals, we cannot openly talk about it, how are we supposed to reach out to others and provide much needed education? Social workers are in essence conduits for change, which is the very core of social services. One of the most important aspects of being a competent social service professional is in

understanding the commitment to do no harm. At the very least, social workers should have enough information and awareness to know what questions to ask that will assist them when working with issues of youth suicide.

Social workers stand to benefit in knowing more about youth suicide as this will assist the social work practitioners in exploring historical, clinical, protective, and contextual domains to assist a youth who is in crisis. Further, implication for social work practice is that knowing about attitudes towards suicide will prepare social workers in being able to assess for current psychological state, refer to outpatient treatment, refer to psychiatric consultation, or possibly refer for voluntary or crisis hospitalization. The present study offers an opportunity to impact not only social work practice but in being able to address ways to assist college students. Residence/dorm halls as well as counseling center staff may be able to utilize the present study in order to educate students and staff about youth suicide that has the potential to address misconceptions, stigma, and negative attitudes, which students may hold about suicide in general, and about those who attempt or succeed with suicide. Lastly, also important is the advocacy for funding and services that youth who may be contemplating suicide desire and need. There are ways to get involved on many levels that will help build cultural competence, encourage, and support the college student population when it comes to youth suicide. However, in order to help when it comes to youth suicide, social workers must acknowledge that suicide exists, and then make efforts to demonstrate competence in the provision of services that are

sensitive to clients' cultures and to differences among people and culture groups (NASW, 2008).

Recommendations for Future Research

One recommendation for future research would be to attain a larger sample size to explore attitudes on youth suicide. It would be extraordinary if this study could be replicated with a larger population of first year college students. Future studies should also inquire about actual suicide attempts or previous suicide ideation. It might also be beneficial if future research examines factors that represent a more heterogeneous student population and their relationship towards youth suicide: religious beliefs and attitudes, cultural identity, sexual orientation, gender expression, and living environment (dorms versus off campus living); to name a few. Understanding trends in suicide among young adults may help to identify ways to prevent suicide. Little attention has been paid to the possible impact of attitudes toward suicide (Joe et al., 2007). Researchers have also stated that there is a need to study attitudes toward suicide across cultures (Diekstra & Kerkhof, 1989; Domino, 1981; Leenars & Domino, 1993).

Conclusion

This study explored attitudes on youth suicide among first year college students using the clinical scales from the Suicide Opinion Questionnaire. The results indicate that the participants have an overall understanding of suicide risk factors such as feeling of loneliness, helplessness and treat a suicide as a cry for help. They do not appreciate one's right to die by committing a suicide and believe that

interference is required for someone showing suicide behavior signs or thoughts. However, taking into account the phenomenon of “help-negation” and lack of information of suicide signs and appropriate help, the students are not able to provide help and support they hoped to provide. Taking into account only half of the respondents know about the counseling services at their campus, it is important to provide information and appropriate training, especially to first-year college students, who are at higher suicidal risk compared with older students and their counterparts not attending a college.

As a result of this study’s findings, recommendations for future research have been presented, as well as implications for social work practice. These recommendations emphasize the need for social workers, and other helping professionals to be sensitive to, open to, and supportive of youth contemplating suicide. If not, youth suicide rates will continue to be disproportionately high.

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APPENDICES

APPENDIX A

INFORMED CONSENT

My name is Hilario Ramirez, and I am a graduate student in the Master of Social Work program at California State University, Stanislaus. I am conducting a research study as part of my Master's thesis requirements. My study is looking at attitudes towards suicide among first year college students. It is anticipated that the findings from this study could help identify specific areas of youth suicide that college campuses need to focus on in their suicide awareness programs or efforts to decrease the rate of youth suicide.

As a first-year college student at CSU, Stanislaus, you are being asked to participate in this study. If you decide to partake in this study, you will be required to take a survey; one that examines the attitudes towards suicide. You will not be required to provide any identifying information, which will ensure your anonymity. However, you will be given the option to participate in a raffle for a chance to win one of two $25 gift cards. Then and only then, will you be required to provide contact information, such as your first name and your e-mail address. This will annul your anonymity.

The survey will take approximately twenty minutes to complete. Once the survey is completed, the results will be available to me via a computer software. I will be the only person to have access to the data. Upon completion of the study, all survey results will be permanently deleted from the computer program and only general data results will be published. All information collected will be protected from inappropriate disclosure under the law. The findings will be reported in aggregate.

Your participation is completely voluntary. You may choose to not answer certain questions, or you may also stop taking the survey. If at the end of your participation, you experience some discomfort from answering the survey questions you may contact the CSU, Stanislaus Counseling Center at (209) 667-3381.

You are completing the survey and submitting it implies you have consented to participate in this study. If you have any questions about this research study please contact the researcher, Hilario Ramirez at [—] or the research chair, Dr. Shradha Tibrewal at (209) 667-3951. If you have any questions regarding your rights and participation as a research subject, please contact the IRB Administration at (209) 667-3784.or by email at IRBAdmin@csustan.edu.

APPENDIX B

SUICIDE OPINION QUESTIONNAIRE-PERMISSION FOR USE

Dear Dr. Domino,

Subject: SOQ- Permission for Use

My name is Hilario Ramirez and I am a social work graduate student at California State University, Stanislaus in Turlock, CA. For my thesis, I am researching attitudes of suicide in first year college students, as well as examining the issue of youth suicide. I write to you today, as I would like to use the Suicide Opinion Questionnaire (SOQ) that you developed to assist me with my thesis and research. I greatly appreciate your time and respectfully ask permission to use your SOQ. I would also like to know if a release of permission is required, and if you might provide any information on the subscales and other important information on how to properly use them. I look forward to hearing from you soon. Thank you for your time in corresponding with me.

Hilario Ramirez
Social Work Graduate Student
California State University, Stanislaus

Email #1
From: George Domino
To: Hilario Ramirez
Subject: SOQ Request

The SOQ materials I sent to you includes a memo page and the first item is permission for you to use the SOQ. Let me know if that is sufficient, otherwise I will be happy to send you something a bit more formal.
Regards, George Domino, Ph.D.
Professor Emeritus of Psychology, University of Arizona

Email #2
From: George Domino
Subject: SOQ Request
To: Hilario Ramirez

Hi. Thank you so much for your request. I am sorry I did not reply sooner but have been away for several weeks. In order to save time, I am sending you an electronic form with everything that you need. If you have trouble opening the document, or would prefer a printed version via snail mail, please let me know. Once you have had the chance to look over the materials, if you have any questions do not hesitate to get in touch with me by email. I should warn you however that I travel quite frequently and may not be able to reply promptly.

Buena suerte with your thesis!

George Domino, Ph.D.
Professor Emeritus of Psychology
University of Arizona

APPENDIX C

SUICIDE OPINION QUESTIONNAIRE (CLINICAL SCALES ONLY)

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

Use the letters given below to indicate how much you agree or disagree with each item:

A. Strongly Agree (Score of 5)
B. Agree (score of 4)
C. Are Undecided (score of 3)
D. Disagree (score of 2)
E. Strongly Disagree (score of 1)

---

1. Most people who attempt suicide are lonely and depressed. _____

2. Almost everyone has at one time or another thought about suicide. _____

3. Suicide prevention centers actually infringe on a person's right to take his life. _____

4. Most suicides are triggered by arguments with a spouse. _____

5. The higher incidence of suicide is due to the lesser influence of religion. _____

6. Many suicide notes reveal substantial anger towards the world. _____

7. I would feel ashamed if a member of my family committed suicide. _____

8. Most suicide attempts are impulsive in nature. _____

9. Many suicides are the result of the desire of the victim to "get even" with someone. _____

10. People with incurable diseases should be allowed to commit suicide in a dignified manner. _____

11. Those who threaten to commit suicide rarely do so. _____

Use the letters given below to indicate how much you agree or disagree with each item:

A. Strongly Agree (Score of 5)
B. Agree (score of 4)
C. Are Undecided (score of 3)
D. Disagree (score of 2)
E. Strongly Disagree (score of 1)

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

13. Suicide is an acceptable means to end an incurable illness. _____

14. People who commit suicide are usually mentally ill. _____

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

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

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

18. Suicide is acceptable for aged and infirm persons. _____

19. Suicide is clear evidence that man has a basically aggressive and destructive manner. _____

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

21. Suicide happens without warning. _____

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

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

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

25. People who commit suicide must have a weak personality structure. _____

Use the letters given below to indicate how much you agree or disagree with each item:

A. Strongly Agree (Score of 5)
B. Agree (score of 4)
C. Are Undecided (score of 3)
D. Disagree (score of 2)
E. Strongly Disagree (score of 1)

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26. A large percentage of suicide victims come from broken homes. _____

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

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

29. Suicide attempters are typically trying to get even with someone. _____

30. Once a person is suicidal, he is suicidal forever. _____

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

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

33. Prisoners in jail who attempt suicide are simply trying to get better living conditions. _____

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

35. Once a person survives a suicide attempt, the probability of this trying again is minimal. _____

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

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

38. Suicide is a normal behavior. _____

Use the letters given below to indicate how much you agree or disagree with each item:

A. Strongly Agree (Score of 5)
B. Agree (score of 4)
C. Are Undecided (score of 3)
D. Disagree (score of 2)
E. Strongly Disagree (score of 1)

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

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

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

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

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

44. Suicide is a very serious moral transgression. _____

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

46. A suicide attempt is essentially, a "cry for help." _____

47. The most frequent message in suicide notes is of loneliness. _____

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

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

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

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

52. People who commit suicide lack solid religious convictions. _____

Use the letters given below to indicate how much you agree or disagree with each item:

A. Strongly Agree (Score of 5)
B. Agree (score of 4)
C. Are Undecided (score of 3)
D. Disagree (score of 2)
E. Strongly Disagree (score of 1)

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

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

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

56. People who die by suicide should not be buried in the same cemetery as those who die naturally. _____

57. Most people who commit suicide do not believe in God. _____

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

59. The large majority of suicide attempts result in death. _____

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

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

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

63. Most people who attempt suicide fail in their attempts. _____

64. Individuals who are depressed are more likely to commit suicide. _____

SOC Clinical Scales

Scoring Guidelines

There are two types of items:

1. Usual times are scored: Strongly Agree=5 points
   Agree=4 points
   Undecided=3 points
   Disagree=2 points
   Strongly Disagree= 1 point

2. Reversed items where the scoring is reversed, i.e.: Strongly Agree=1 point
   Agree=2 points
   Undecided= 3 points
   Disagree= 4 points
   Strongly Disagree=5points

Scale #1: Suicide reflects mental illness (13 items)
Usual Items: 1, 14, 22, 25, 26, 27, 37, 47, 53, 58, 61, 64
Reversed Item: 42

Scale #2: Suicide threats are "not real"- i.e. cry for help (12 items)
Usual Items: 11, 20, 33, 35, 41, 46, 51, 54, 63
Reversed Items: 12, 24, 59

Scale #3: The right to die (8 items)
Usual Items: 3, 10, 13, 18, 45, 50
Reversed Items: 32, 62

Scale #4: Importance of Religion (7 items)
Usual Items: 5, 16, 28, 49, 52, 57, 60
Reversed Items: None

Scale #5: Impulsivity (7 items)
Usual Items: 4, 8, 21, 23, 48
Reversed Items: 17, 30

Scales #6: Suicide is Normal (7 items)
Usual Items: 2, 31, 38, 40, 43, 55
Reversed Item: 34

Scale #7: Suicide reflects aggression/anger (6 items)
Usual Items: 6, 9, 15, 19, 29, 39
Reversed Items: None

Scale #8: Suicide is Morally Bad (4 items)
Usual Items: 7, 36, 44, 56
Reversed Items: None

APPENDIX D

DEBRIEFING

Thank you for participating in this study! We are interested in understanding attitudes towards suicide among first year college students. Recent research suggests that youth suicide is increasing.

All the information collected in this study will be kept safe from inappropriate disclosure, and there will be no way of identifying your responses in the data archive. The researcher is not interested in anyone's individual responses; rather, the researcher wants to look at the general patterns that emerge when all of the participants' responses are put together. The researcher asks that you do not discuss the nature of the study with others who may later participate in it.

If you have any questions about the study, you may contact me (Hilario Ramirez) at [—] or my thesis chair, Dr. Shradha Tibrewal at (209) 667-3951. If you have questions about your rights as a research participant, you may contact our Campus Compliance Officer at CSU, Stanislaus, at (209) 667-3747. Lastly, if participation in this study caused you any anxiety, stress, or concern, you may contact the CSU, Stanislaus Counseling Center at (209) 667-3381. Thank you for your valuable contribution to this study.