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Social Responses to  
HIV Positive  
Suicide Ideators

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A thesis  
presented to  
the faculty of the Department of Psychology  
East Tennessee State University

In partial fulfillment  
of the Requirements for the degree  
Master of Arts in Psychology

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by  
Saborah L. Bishop  
May 2001

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Dr. Jon Ellis, Chair  
Dr. Peggy Cantrell  
Dr. Jim Bitter

Keywords: AIDS, Attribution Theory,  
HIV Positive, Suicide

## ABSTRACT

### Social Responses to HIV Positive Suicide Ideators

by

Saborah Bishop

The purpose of the present investigation was to examine responses to suicidal ideation by an HIV positive male described as heterosexual/homosexual in a promiscuous/monogamous relationship.

Men (101) and women (137) enrolled in introductory psychology courses participated in the study. Participants completed a short demographic questionnaire, read one of four scenarios, and completed the Attitudes and Helping Behavior Scale (AHBS) designed to measure the participants' emotional responses, attributions, and willingness to help the target subject. Present research involved a 2 (sex of subject) x 4 (scenarios) independent groups factorial. Independent ANOVAS were performed to interpret the significance of the main and interaction effects.

Results revealed a main effect for gender on total attitude scores on the AHBS. There was no main effect for gender on anger towards the scenario subject as originally hypothesized. Future researchers should use a more heterogeneous sample than the present one to obtain more applicable results.

INSTITUTIONAL REVIEW BOARD

This is to certify that the following study had been filed and approved by the Institutional Review Board of East Tennessee State University.

Title of Grant or Project      Social Responses to HIV Positive  
Suicide Ideators

Principal Investigator      Saborah L. Bishop

Department      Psychology

Date Submitted      February 12, 2001

Institutional Review  
Board Chairman

\_\_\_\_\_

## DEDICATION

This thesis is dedicated to my family and friends, with a special dedication to my mother who has always provided me with a sense that I could accomplish anything if I tried hard enough.

## ACKNOWLEDGMENTS

I would like to acknowledge every person who offered a word of encouragement when I insisted that I would never complete this project. I would also like to give a special thanks to my friend, Tiffany Scott, for not only proofreading my copies but for her continued encouragement and friendship. I am sure that I would not have made it through graduate school without meeting Carrie Tucker who never fails to find the humor in all situations. Last, but certainly not least, I would like to thank my graduate committee members, Dr. Cantrell and Dr. Bitter, for their time and valuable input in this project. Thank you, Dr. Ellis, for chairing my thesis and freely offering your support.

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## CHAPTER 1

### INTRODUCTION

Suicide is a complex phenomenon that warrants proper investigation to enhance current preventive measures. In fact, the Surgeon General, David Satcher, plans to bring together the nation's leading experts in 2000 from different fields to address suicide, which he considers a national health problem. This project is called the Surgeon General's Call to Action to Prevent Suicide (Satcher, 1999).

In a recent meeting of this group, the Surgeon General presented statistics that illuminated the need for urgency in dealing with this problem. For example, for every two homicides that occur in the United States there are three suicides. Moreover, this nation faces an average of about 85 suicides a day and nearly 2000 attempted suicides.

#### Suicide Statistics

Other statistics support the need for a national response to suicide. According to the National Institute of Mental Health, 30,903 people committed suicide in the United States in 1996 making it the ninth leading cause of death. In the United States, a person commits suicide about every 15 minutes, and it is estimated that a suicide attempt is made about once a minute (NIMH, 1996).

Empirical research has identified gender, race, age, and regional differences in suicide. More men than women commit suicide. The gender ratio is 4.5:1 (NIMH, 1996). Part of the difference in suicide rates between men and women may be because men often use more violent and lethal methods of suicide. For example, in 1990 per 100,000 persons, men used firearms to commit suicide at the rate of 13.4 % while women used firearms at the rate of 2.04 %. In fact, white men commit 79 % of all firearm suicides in the United States (Blumenthal & Kupfer, 1989).

The United States is the only country in the world where firearms are the most common method of suicide (Blumenthal & Kupfer, 1989). Empirical studies show that accessibility to firearms or possession of firearms in the homes of suicidal individuals increases suicide risk (Blumenthal & Kupfer; NIMH 1996; "Regional Differences in Suicide", 1997). Suicides account for 83 % of all gun-related deaths in homes. Often in these homes, someone other than the gun owner commits suicide. Furthermore, fewer than 10% of people who commit suicide buy a gun for this purpose (NIMH, 1997).

There are also age differences in suicide rates. The suicide rate for men remains mostly constant from ages 20-64, and increases significantly after age 65. In fact, white men over 50 make up about 10 % of the population but are responsible

for 33 % of all the suicides. The suicide rate for women peaks between ages of 40 to 54 years old, and again rises after age 75 (NIMH, 1996).

Overall, women and youth have higher attempted suicide rates than men and the elderly. According to research, women attempt suicide more than males with a gender ratio of 2:1 (NIMH, 1997). This gender difference may be because men typically choose more lethal methods of suicide.

Suicide is the second leading cause of death among college students and the third among those aged 15-34. Suicide is the fourth leading cause of death in children aged 10 to 14 years old. In fact, the rate has more than doubled for this age group over the last 15 years (NIMH, 1997).

As well as age and gender differences in suicide, there are racial differences. The suicide rate for young black males aged 15 to 24 has risen by 2/3 over the past 15 years (NIMH, 1997). From 1979-1992, the suicide rate of Native Americans was 1.5 times higher than the national suicide rate. Young Native American males, aged 15 to 24 made up 64 % of this rate (Satcher, 1999).

In fact, there are many geographical differences in suicide rates. In a recent report of geographical differences, statisticians determined the suicide rate per state using the final mortality data from the Center for Disease Control's Cause

of Death files for each year from 1990 to 1994. In addition, these rates were adjusted for age, race, and sex.

Even after these adjustments, regional differences in suicide rates were identified ("Regional Variations", 1997). Between 1990-1994, 154,444 persons in the United States committed suicide. Of this number, 37 % occurred in the South, 25 % in the West, 22 % in Midwest, and 15 % in the Northeast. After the adjustments for age, race, and sex were performed, the West had the highest crude suicide rates, followed by the South, Midwest, and the Northeast. In addition, there were also regional differences in the method of suicide. Firearms were the leading method of suicide for all regions. The suicide rates by all other methods such as cutting, strangulation, and overdose etc. were highest in the West. The overdose suicide rates were 100 % higher in the West than the Northeast. While the adjusted firearm suicide rates were 130 % higher in the South than the Northeast.

It is difficult to explain regional differences in suicide rates. One problem inherent in these studies is that mortality files used for statistical analyses offers limited information about the different variables that may explain these differences. In addition, the information listed on mortality files often differs by state.

These findings cannot be simply explained or dismissed for their complexity. This research clearly highlights and expands other empirical data concerning suicide. Perhaps, one of the most significant findings was that firearms accounted for more than half the suicides committed in every region except for the Northeast. This research also supports that accessibility to firearms increases suicide risk highlighted in other statistical research (NIMH, 1996/1997). In addition to firearm possession or accessibility, empirical research has identified many different risk factors for suicide.

Blumenthal and Kupfer (1989) identified the following six risk factors for suicide: (1) mental or addictive disorder...(2) personality traits such as aggressivity, and impulsiveness...(3) psycho-social and environmental factors: such as lack of social support...(4) family history of suicidal behavior or mental illness...(5) biological correlates such as having reduced serotonin levels in the brain...(6) high risk epidemiologic and demographic factors.....(p.10)

According to Blumenthal and Kupfer (1989), it is an overlapping of those risk factors from the six different areas without protective factors against suicide that increases individual risk. In addition, several protective factors were identified: a strong social support network, hope, mental health treatment, a more positive adjustment to loss and

disappointment, and safe environments with restricted accessibility to highly lethal methods of suicide.

### Evolution of Attitudes toward Suicide

Suicidal behavior is influenced by how society views suicide (Ingram & Ellis, 1995). For example, negative views of suicidal individuals may influence a person experiencing suicidal ideation to not seek treatment. Researcher and author Dr. Stillion has completed over 50 articles (e.g. Attitudes toward suicide: Past, present, and future, 1999) and chapters (e.g. Premature Exits: Understanding Suicide, 1995) dealing with attitudes toward suicide. This author has examined how current views of suicide in the Western world are influenced by the historical evolution of attitudes concerning this phenomenon.

Most societies of the Western world have disapproved of suicide with a few notable exceptions. Stoicism as a philosophical school of thought greatly influenced the ancient societies of Greece and Rome. Stoicism placed a great importance on rationality and control in all aspects of life. From 300 B.C. to 300 A.D., suicide was viewed as rational act establishing personal control of the time and manner of one's death due greatly to the influence of Stoic thought (Stillion & Stillion, 1999). Stoic influence is evident even in modern day arguments supporting euthanasia or "rational suicide". The advent of Christianity profoundly affected attitudes towards suicide.

In fact, early on in Christian era, suicide as an act of martyrdom was accepted and supported by early believers. The early works of the Bible addressed suicide. Most of the earliest recordings of suicide involve themes of atonement or remorse. For example, in the Old Testament, Samson commits suicide as a self-induced punishment for failing to remain faithful to the Lord. In the New Testament, Judas commits suicide due to betrayal of Jesus Christ (Stillion & Stillion, 1999).

However, leaders of the Church were troubled by the followers' extreme willingness to die for their faith. To discourage suicide, the Church leaders issued a series of proclamations declaring suicide as a sin, violating the sixth commandment, "Thou shall not kill". In 400 A.D., St. Augustine instructed that suicide was a sin because it took power over life and death and placed it under human control.

In the sixth century, the Church outlined specific punishments for the victim as well as their family members. The bodies of suicide victims could not be buried in consecrated ground. In fact, it was not unusual for suicide victims' bodies to be publicly desecrated. In some cases, family members of suicide victims could not inherit estates or enter into certain religious orders (Stillion, 1995).

In the thirteenth century, St. Thomas Aquinas described suicide as violation against God's most precious gift, life, as

a theft from the community robbing the community of the victim's talents and societal contributions, and as a unnatural act defying the biological laws set by the Creator. Viewing suicide as an immoral act continued for centuries (Stillion & Stillion, 1999).

In the late 1600s, suicide was officially codified as a crime against the state. Persecutions of suicide victims and their families continued. During the Middle Ages, suicide victims were actually tried in court and then their bodies were removed from the cemetery (Aries, 1981).

Philosopher, Thomas Hume, challenged the conception of suicide as an immoral act. Then, in the late nineteenth century, Emile Durkheim furthered this idea in his work, Le Suicide (1951, 1897). Durkheim explained suicide as a result of an individual's isolation from society.

In the twentieth century, attitudes toward suicide were shaped by scientific explanations emphasizing the role of mental health in suicidal behavior. Freud offered intrapsychic explanations for suicidal behavior. First, Freud (1917) explained suicide as a result of unconscious forces, represented by the id, turning against the ego, the rational conscious competent of the brain. Next, Freud (1923) explained how the super-ego, the internalization of societal values, could turn against the ego resulting in self-destruction.

In the twentieth century, suicide and attitudes towards suicide victims were empirically studied. Suicide prevention centers were established mid-century. In addition, debate concerning rational suicide or euthanasia, physician assisted suicide for the terminally ill gained momentum at the end of the twentieth century.

Now as the twenty-first century begins, it is important to understand how the historical evolution of attitudes towards suicide influences the current perception of suicide victims. According to Stillion and Stillion (1999) suicidal behavior is entrenched in the historical moment and culture in which it occurs. Suicidal behavior is intertwined with the value society places on human life.

According to Stillion (1995), current attitudes towards suicide victims can involve pity, empathy, neglect, compassion, and intolerance. Based on these attitudes, suicidal people can be ignored, criminalized, institutionalized, counseled, medicated, or even assisted in committing suicide in today's society.

The AIDS epidemic has sparked debate concerning rational suicide and euthanasia. Moreover, given the high suicide rate associated with the AIDS virus, empirical studies of suicide have begun to explore the topic of AIDS. This study involves the exploration of attitudes towards the suicidal behavior of AIDS

victims. To examine current attitudes towards AIDS sufferers, it is necessary first to understand the illness itself and the historical evolution of the reaction to AIDS sufferers.

Physical Illness and Suicide. Physical illness increases suicide risk for the elderly as well as the young, especially for young people suffering from debilitating or terminal illness such as HIV or AIDS. Physical illness plays a significant motivational role in half of the suicides committed by those over the age of 50. Patients who want an early death during a serious or terminal illness are usually suffering from a treatable depressive condition.

The American Foundation for Suicide Prevention conducted a study of hospice patients' attitudes towards euthanasia and assisted suicide. Of all the factors examined, depression was the only predictor of positive responses to euthanasia and assisted suicide by the terminally ill participants (NIMH, 1997).

Individuals diagnosed with AIDS have 20 times the suicide risk of the general population. The degree of social and medical support available to those with AIDS is as important as the physical symptoms in determining subsequent suicide ideation (NIMH, 1996). The suicide rate for men with AIDS aged 20-59 is about 36 times the rate of men without AIDS in this age group (NIMH, 1997).

Domino and Shen (1996) investigated attitudes of HIV positive males towards suicide. The Suicide Opinion Questionnaire, the Beck Depression Inventory, and the Hopelessness scale were administered to HIV positive gay men with diagnosis of AIDS or AIDS Related Complex (ARC), HIV negative gay males with no evidence of AIDS or ARC, and heterosexual males with no evidence of AIDS or ARC.

The HIV positive sample scored highest on measures depression and hopelessness. The HIV positive sample was more likely than the HIV negative homosexual and heterosexual samples were to endorse the right to die and view suicide as normal.

Beckett and Shenson (1993) reviewed literature concerning suicide, suicidal behavior, and suicidal ideation and people with HIV or AIDS. Results of the review indicated that people with HIV/AIDS do have increased risk of preoccupation with suicide, suicide attempts, and suicide.

According to this review, treatable psychiatric conditions like depression often influenced suicidal behavior. In addition, suicidal ideation often occurred during a treatable medical condition.

Sexual Orientation and Suicide. Sexual orientation has also been considered as a risk factor in suicide and attempted suicide. A report by the federally funded Task Force on Suicide indicated that lesbian and gay youth are anywhere from two to

six times more likely than heterosexual youth to attempt suicide. In addition, completed suicides among gay and lesbian youth account for 30 % of the suicide rate among teens (Gibson, 1989).

In another study of 4,159 Massachusetts high school students, 46 percent of the students who identified themselves as lesbian, gay, or bisexual reported that they had attempted suicide in the past year compared to 8.8 percent of their heterosexual peers. Of the gay or lesbian youth that attempted suicide, 23.5 percent required medical attention as a result of the suicide attempt compared to only 3.3 percent of their heterosexual peers (Massachusetts Department of Education, 1997).

Current investigations of the correlation between sexual orientation and suicidality are limited and racked with methodological problems according to Muehrer (1995), researcher of the Prevention Research Branch of the National Institute of Mental Health. In addition, Muehrer pointed out that there are very few empirical studies supporting that gay and lesbian youth have increased suicide risk.

In the "Call to Action to Prevent Suicide", 1999, Surgeon General Satcher acknowledged some of the limitations identified by Muerher and other researchers in the investigation of the correlation between sexual orientation and suicide risk.

However, the Surgeon General suggested that there was reason for concern about the correlation of suicide risk and bisexuality or homosexuality for youth, especially for young males.

However, Satcher (1999) addressed the need for empirical based culturally sound research of the association between sexual orientation and suicide. According to reports identified by the Surgeon General, gay and lesbian youth are two or three times more likely to commit suicide than other youth. In addition, 30 % of all suicides and parasuicides committed by youth involve issues of sexual identity (Satcher).

Research is available that examines that empirically investigates differences between suicide risks between heterosexuals and homosexuals. For example, Hirsch and Ellis (1995) conducted an empirically based study comparing the adaptive characteristics that may prevent suicide among homosexuals and heterosexuals. Results indicated that gay men and lesbian students endorsed fewer reasons for living than heterosexual students.

Acquired Immune Deficiency Syndrome. Acquired Immune Deficiency Syndrome (AIDS) is a particular group of diseases or conditions resulting from suppression of the immune system due to infection with human immunodeficiency syndrome (Folks & Butera, 1997). During the course of the illness, an infected person will lose immune cells called CD4 T-lymphocytes. When the

immune system is drastically impaired, a clinical syndrome will develop over time involving opportunistic infections (infections that would not ordinarily cause a person with a normally functioning immune system to develop a disease) or cancers. It does not necessarily mean that person has AIDS if he/she is diagnosed as HIV positive. A person can remain HIV positive for more than ten years without developing AIDS. To be diagnosed with AIDS, a person must develop one of 25 different opportunistic infections that are AIDS defining illnesses or have a CD4 T cell count of less than 200 cells per cubic millimeter of blood (Folks & Butera, 1997).

HIV is spread through the exchange of bodily fluids such as semen, blood, or blood by-products. The most common mode of transmission of HIV is sexual intercourse. HIV gains access to the bloodstream of the infected person via small abrasions that can result from sexual intercourse. HIV is also spread by intravenous drug use and by blood transfusions. However, due to the extensive medical screening of the blood supply, infection via blood transfusion is extremely rare. It is estimated that HIV is present in less than 1 in 450,000 pints of blood.

Currently, 18.8 million people have died from AIDS, and this disease has orphaned over 13.2 million children. In 1999, approximately 2.8 million people died of AIDS. According to

current estimates as many as 34.3 million people are living with HIV/AIDS worldwide (Associated Press, 2000).

Homosexual intercourse accounts for about 50 % of AIDS cases, while intravenous drug use results in about 26%. Transmission of AIDS via heterosexual contact is increasing and transmission from infected males to uninfected females accounts for about 9 % of reported cases. The other 15 % of AIDS cases are caused by blood transfusions (Folks & Butera, 1997).

At first, the drug zidovdine (Retrovir, AZT) seemed to offer great promise for prolonging the life of AIDS patients. However, results from clinical trials concerning AZT's ability to prolong life have proved contradictory. Presently, the most effective AIDS treatment appears to be a combination of three drugs- two nucleoside RT inhibitors and one protease inhibitor, which can lower the blood levels of the virus to undetectable levels.

However, these drugs can cause rather severe side effects such as anemia, diarrhea, and abdominal cramps (Folks & Butera, 1997). In addition to physical suffering, AIDS victims often face stigmatization and discrimination.

Rosenberg (1995) has extensively studied the relationship between medication, science, and society. According to Rosenberg, the AIDS epidemic has elicited similar attitudes from

the public as those epidemics that have historically preceded the AIDS outbreak.

First, there is resentment or resistance to physicians and activists that demand action to counteract the new threat. Then, as a method of coping with randomness of an epidemic the social values of the majority are affirmed and victims are blamed for their illness. Americans want to connect having AIDS with volition, behavior, or pathology (Rosenberg, 1995). Attribution theory as proposed by theorist Heider (1958) has been applied to the study of reactions to AIDS victims.

Attribution Theory & HIV/AIDS. Attribution theory may help to explain how society has reacted to this illness. Heider (1958) proposed attribution theory to explain how people make social judgements about others' behaviors. According to attribution theory, a person observes another's behavior and ascribes it to internal or external causes.

Internal causes are those judged to be within the person such as personality, attitudes, and beliefs. External causes are features of the environment. Personal responsibility for behavior is assigned when an observer judges the behavior to be internally rather than externally caused.

Theorist Weiner (1986) expanded Heider's internal or external analysis of behavior to explain how this process affects motivation, emotion, and helping behavior. Weiner adopts

Heider's original ideas concerning the observer's internal/external analysis of behavior. If the cause for the need of help is viewed as external rather than internal, helping behavior is more likely to occur.

Also, information about the stability of the perceived cause of a need also affects potential responses to those in need. A stable cause is one that is not likely to change, irreversible. An unstable cause is one that is not likely to change. A person is more likely to help if he or she feels that change may occur as a result of the help.

The observer then decides the degree of control a potential recipient of aid has over the cause of the need for help. Observers' decisions concerning controllability affects helping behavior by directly influencing emotional reactions to those in need of help. People have more positive emotional responses and are more likely to help the potential recipient when the cause for the need of help is viewed as uncontrollable by the recipient (Weiner, 1980).

Weiner (1986) suggested that there are connections between control, disgust (anger), and neglect and between lack of control, empathy, and aid. In fact, ideas about controllability will have less of a direct influence on helping behavior the more the observer becomes personally involved in the situation.

However, as a situation becomes more distant to the observer, thoughts play a more important role in helping behavior with feelings having decreasing importance (Weiner, 1986). He also identifies non-attributional factors that influence help giving.

An observer may perform a cost-benefit analysis of a situation. The observer tries to determine the personal cost and potential benefit of offering help. In addition, the observer's expectation of the potential benefit of their help to the recipient also influences help giving (Weiner, 1986).

Weiner has applied attribution theory to understanding the public's reaction to people with AIDS. According to attribution theory, judgments about controllability influence peoples' reactions to AIDS victims. According to Weiner (1993), the lay person primarily links AIDS to homosexual activity and intravenous drug use regardless of the fact that there has been an enormous effort to educate the public about the risk of contracting AIDS via heterosexual intercourse.

In fact, Weiner as well as many other researchers have used the principles of attribution theory to investigate reactions to AIDS victims. The next section of this thesis will examine this research.

In one of the earlier studies involving this topic, Weiner, Perry, & Magnusson (1988) examined how perceived controllability

and stability of the cause of ten different stigmas affected people's emotional reactions, helping judgments, and the practicality of five different intervention techniques. The researchers defined stigmas as deviations in physical appearance, personality features, and behavior. They used 10 different stigma both mental-behavioral based and physical based: AIDS, Alzheimer's disease, blindness, cancer, child abuse, drug addiction, heart disease, obesity, paraplegia, and Vietnam syndrome.

Subjects were asked to rank their feelings of anger or pity to the scenario subject. In addition, they were asked to rank how likely they would be to offer assistance or charitable donations to the subject. The researchers predicted that mental or behavioral stigmas would be perceived as more controllable and physical based stigmas as less controllable.

In addition, the researchers predicted that subjects would respond with less pity and more anger etc. to target subjects with a mental-behavioral stigma. The results of experiment confirmed the hypotheses. However, the subjects were less consistent in their predicted responses to subjects with Vietnam syndrome and AIDS.

Although Vietnam syndrome is viewed as a psychiatric based syndrome, it was perceived as uncontrollable. Among the four stigmas perceived as onset controllable, AIDS elicited

particularly high ratings of pity and tendencies toward charity.

However, it is important to note that AIDS elicited more anger and less pity than paraplegia and blindness. However, AIDS elicited more positive reactions than child or drug abuse (Weiner, 1993). The researchers suggested that non-attributional properties such as the life threatening and debilitating nature of AIDS might have affected the subjects' responses (Weiner et. al., 1988).

Next, the experimenters manipulated information about the controllability of each of the 10 stigmas in Experiment Two. For example, subjects were given scenarios describing a person contracting AIDS from a blood transfusion or a promiscuous sex life or of a person becoming blind because of an industrial accident caused by a co-worker or an industrial accident caused by the scenario's subject persistent carelessness. For all the scenarios, controllability information increased accountability, blame, and anger and decreased pity, personal assistance, and charity.

Information about controllability had the most drastic influence on the perceptions of and responses to the person with AIDS. Subjects responded more negatively and were less likely to help the scenario subject described as contracting AIDS from a promiscuous sex life than the subject described as contracting AIDS via a blood transfusion.

In examining the results of this study, Weiner (1993) explained that AIDS, contrary to the other stigmas used in the experiment, can be passed on to other people. In addition, AIDS is a terminal disease. It may be that fear also influences reactions to AIDS (Weiner). In addition, based on the data used in this study, it is impossible to determine whether homophobia or the stigma associated with drug use affected the respondents' reactions to the target subjects.

Several empirical studies have reported that locus of control (external, internal) and mode of transmission (controllability) affects perceptions of AIDS victims (Bailey, Reynolds, & Carrico, 1989; Dowell, LoPresto, & Sherman, 1991; Peters, denBoer, Kok, & Schaalma, 1994). Other studies have attempted to ascertain whether homophobia may influence reactions to AIDS victims (Anderson, 1992; Crandall, 1991; Triplet & Sugarman, 1987).

Bailey et al. (1989) investigated college students' ratings of the personality characteristics and appearance of AIDS victims. Based on attribution theory, the researchers predicted that subjects would respond more positively to AIDS victims who contracted HIV via a blood transfusion (external cause) than to those who contracted HIV via sexual intercourse or intravenous drug use (internal causes).

In addition, the researchers were interested in examining the subjects' responses to AIDS victims in a Near Death Condition, manipulated by the researchers. It was predicted that subjects would respond more positively to AIDS victims in the Near Death condition.

To investigate these reactions a male target subject's picture was projected on a screen in front of 30 male and 30 female freshman and sophomore students enrolled in introductory psychology courses. Then, the participants rated the target subject on such variables as "physical attractiveness, general health appearance, intelligence, moral character, trustworthiness, and the extent that they would like this hypothetical person as a friend or co-worker" (Bailey et al., 1989) to gather a base-line measure.

Then, the subjects read one of five scenarios. Four of the scenarios described the target subject as contracting AIDS via homosexual contact, heterosexual contact, intravenous drug use, or a blood transfusion. The fifth scenario described the target subject as having an unspecified genetic deteriorating disease.

After reading the scenario, the subject rated the target subject on the same measures as the base-line condition. Then, the subject viewed a picture of the same subject cosmetically doctored to appear near death. The subjects rated the target subject for a third time.

Male and female college students perceived scenario subjects described as contracting AIDS via sexual contact or intravenous drug use (internal causes) as less moral trustworthy, and less desirable as a prospective friend. The scenario subject described as contracting AIDS via a blood transfusion (external cause) was described more favorably. The researchers based on previous anticipated these results based on past research (Bailey et al., 1989).

However, viewing the subject in the Near Death Condition did not produce a "sympathy effect" as the researchers anticipated. In fact, even the AIDS target subject described as contracting the illness from a blood transfusion received social rejection in the Near Death Condition. Bailey et al. (1989) interpreted this surprising result as result support of Lerner's (1980) just world hypothesis.

In a just world, people get what they deserve. People adopt this hypothesis to avoid dealing with the random nature of existence. Lerner (1966) also explained a victim derogation hypothesis. This hypothesis predicts that observers separate themselves from others' misfortune by blaming the victim for their calamity. According to this hypothesis, AIDS victims would be viewed as responsible for their illness, so that an observer would be able to avoid the fear of the possibility of contracting AIDS.

Triplet and Sugarman (1987) applied the victim derogation hypothesis to their investigation of reactions to AIDS victims. In addition, the researchers predicted that ambiguity surrounding AIDS at the time of the study, 1987, would cause people to fear interaction with AIDS victims. This hypothesis was labeled "fear of the unknown". Furthermore, these researchers wanted to investigate whether homosexuals would be held more responsible for contracting AIDS than heterosexuals.

To examine these variables, Triplet and Sugarman (1987) compared AIDS to genital herpes (both related to sexual transmission; AIDS and serum hepatitis (both related to blood serum transmission); and AIDS and Legionnaire disease where both diseases involve unknown causes.

Scenarios describing eight victims who varied on sexual orientation, homosexual or heterosexual, and disease contraction: AIDS/genital herpes, serum hepatitis, and Legionnaire's disease were given to 58 students (25 male, 33 female) enrolled in a New England state university (Triplet & Sugarman, 1987).

The subjects rated their perception of the mortality rate associated with the disease, and the target subject's responsibility for contracting the illness. In addition, the subjects rated how comfortable they would feel having a close family member share a room with the scenario subject.

According to the results of the experiment, homosexuals were held more responsible for their illness regardless of the diagnosis. In addition, subjects reported less desire to interact with homosexual target subjects. In analyzing the results, the researchers discovered that subjects reported a greater difference in attributed responsibility between homosexuals and heterosexuals for AIDS and serum hepatitis than for Legionnaire's Disease and genital herpes (Triplet & Sugarman, 1987).

The researchers interpreted these results as reflecting "...the fact that AIDS among homosexuals is associated with sexual promiscuity, while among heterosexuals AIDS is more often associated with being the recipient of a blood transfusion" (Triplet & Sugarman, 1987). Another important factor in interpreting the results of this experiment was the fear of the unknown.

It is important to note that at the time of this study, it was still unknown to the general public that HTLV-III had been isolated as the viral agent involved in the transmission of AIDS (Triplet & Sugarman, 1987). Subjects rated AIDS victims as interactionally undesirable while their casual attributions for the illness were neutral. The researchers interpreted this result as indicative that fear of the unknown influenced subjects' reactions to AIDS victims (Triplet & Sugarman). The

researchers considered other important factors while interpreting the results.

In the case of AIDS, subjects were unable to clearly attribute AIDS to personal or environmental factors, while casual attributions were clearer for genital herpes, Legionnaire's disease, and serum hepatitis. In addition, the four diagnoses differ not only in mode of transmission and severity, but also in symptomology and chronicity (Triplet & Sugarman, 1987).

Finally, Triplet and Sugarman (1987) optimistically hoped negative reactions towards AIDS would lessen, as the causal variables involved with AIDS became clearer to the general public. Theorist Weiner predicted just the opposite. Weiner (1988) predicted that AIDS education programs that emphasized personal responsibility for contracting AIDS would increase negative reactions to AIDS victims.

Crandall (1991) hypothesized that the stigmatization of AIDS victims involved both social and illness sources. In particular this researcher investigated whether the AIDS stigmatization was additive, the illness stigma added to the preexisting social stigma of homosexuality, or multiplicative, an interaction between the illness and social stigma.

To examine these factors, Crandall (1991) presented 393 undergraduates 16 different vignettes describing a target

subject, "Dan". In these vignettes, four disease states (paraplegia, flu, AIDS, and hepatitis) were crossed with methods of contracting the AIDS illness: homosexual behavior, IV drug use, blood transfusions, and health care workers contact with infected blood (Crandall).

Dan received more stigmatization when he was described as having AIDS or hepatitis than the flu or paraplegia. There was no significant interaction between the mode of transmission and the disease state. Crandall (1991) interpreted these results as indicating that the stigma associated with homosexuality or IV drug use adds to the stigma associated with AIDS illness.

In addition, the stigmatization associated with AIDS partly reflects the degree to which the illness is perceived as dangerous and contagious (Crandall, 1991).

Anderson (1992) investigated reactions to AIDS victims without providing information about the mode of transmission of the AIDS virus. Anderson presented scenarios describing "Mark" as homosexual or heterosexual with the AIDS virus. The descriptions did not specifically state that Mark contracted AIDS via homosexual or heterosexual contact.

The results indicated that people who had more negative views of gay men and fear of contact with a person with AIDS assigned more responsibility to the gay man for contracting AIDS. In addition, the subjects rated heterosexual intercourse,

intravenous drug use, and blood transfusions as the most likely methods of contraction of HIV for the heterosexual target subject. Homosexual intercourse was rated as the most likely method of contraction of HIV for the homosexual target subject (Anderson, 1992).

Dowell, LoPresto, and Sherman (1991) conducted an investigation of responses to AIDS victims when the mode of the transmission was clear. Specifically, the researchers examined how the sex of the respondent, the sexual orientation of the target subject, and the mode of transmission of the HIV virus affected respondents' attributions of responsibility to AIDS victims.

The results indicated that homosexuals received more blame for their illness when the mode of transmission was sexual contact. Furthermore, more blame was attributed to the target subject described as contracting HIV via sexual contact than when the mode of transmission was blood transfusion. Women attributed less blame than male subjects to the AIDS victims (Dowell et al., 1991).

To examine this hypothesis, Peters, den Boer, Kok, and Schaalma, (1994) suggest that attitudes towards homosexuality and sexuality may have affected subjects' responses to the scenarios created by Weiner et al., (1988). These researchers designed an experiment to examine these variables.

Peters et al. (1994) gave subjects scenarios describing target subjects with AIDS, Syphilis, Lung Cancer, or Tuberculosis to 104 females and 68 males. The scenario subjects were described as contracting the illness by personally controllable or uncontrollable means. In one condition, no controllability information was offered to the subjects.

The subjects rated their emotional response, perception of controllability, their willingness to provide personal assistance in four different hypothetical situations where their effort and direct contact with target subject increased from low to high (Peter et al., 1994).

In addition, the subjects rated their perception of risk for four different helping situations. Finally, the subjects rated the number of people known with this illness, susceptibility to the illness, willingness to donate money to for the illness, and seriousness of the illness.

The controllability manipulation mostly had the expected effect, decreased pity and willingness to help. However, controllability information did not decrease pity and willingness to help for AIDS and syphilis target subjects. Information about uncontrollability had the expected effect, increased pity and willingness to help. Peters et al. (1994) interpreted these results as evidence that AIDS and syphilis inherently activate conceptions about controllability.

Furthermore, perceptions of risk of infection and negative attitudes or ideas about homosexuality negatively correlated with helping behavior. Negative attitudes towards homosexuality were positively correlated with negative emotional responses. Seriousness of illness, acquaintance with an ill person, and illness susceptibility did not contribute to a significant amount of variance in this study (Peters et al., 1994).

The results confirmed that attributional variables accounted for a significant amount of variance in the subjects' responses. The researchers suggest that AIDS association with homosexuality and fear of infection may be more valuable in interpreting the results of the study (Peters et al., 1994).

Borchert and Rickabaugh (1995) investigated reactions to HIV victims who had contracted the virus by unprotected consensual heterosexual contact or IV drug use. The researchers also predicted that the reactions to people with HIV would vary according to the gender of the person with HIV. To examine reactions to people with HIV, scenarios of male and female target subjects who had contracted HIV via drug use or heterosexual contact were presented to men and women enrolled in Southeastern state university (Borchert & Rickabaugh).

The researchers examined the findings of researchers that applied attribution theory to the study of AIDS victims. However, this research typically involved peoples' reactions to

target victims who were male or non-gender specific. In addition, the researchers also considered past research that highlighted gender roles and reactions to gender role violations. Therefore, it was predicted that females would receive more blame for drug abuse than males as drug-abuse violates traditional female roles.

The researchers investigated the subjects' attributions of blame, emotional reactions, and pro-social responses to the target subjects (Borchert & Rickabaugh, 1995). The results indicated that females were held less responsible than males for their contraction of HIV. Regardless of gender, drug users were held more responsible for contracting HIV, received more negative reactions, and were less likely to receive help from the subjects.

Subjects had more positive emotional reactions to male target subjects who contracted HIV through heterosexual contact than IV drug use.

Empirical findings involving Suicide. A series of norm referenced scenario experiments explored gender differences in response to suicide (Stillion, McDowell, & May, 1984; Stillion, White, McDowell, & Edwards, 1989; White & Stillion, 1988;). In these experiments, subjects read vignettes or brief hypothetical descriptions of target subjects, male and female, who attempted suicide due to a number of situational factors such as having a

terminal illness or failing a college entrance exam. Then, the subject rated their level of sympathy, empathy, and agreement with the action of suicide or a suicide attempt.

Stillion et al. (1984) gave vignettes of suicide attempts by both males and females to students in a southern public high school. Overall, female respondents offered more sympathy to both the male and female target figures. However, females sympathized, empathized, and agreed more with female target figures.

The researchers conducted a second study to examine developmental differences in reactions to suicide attempts. Vignettes of suicide attempts were presented to ninth graders, twelfth graders, and college freshman. Older adolescents of both genders agreed less with any of the motivations for suicide than younger adolescents did. Females of all age groups showed more sympathy than males to the suicidal target subject (Stillion, McDowell, & May 1984).

Students' reactions to suicidal target figures and non-suicidal target figures were compared to further investigate whether a gender difference would remain when suicide information had been deleted by researches (White & Stillion, 1988). Results indicated that female college students reported more sympathy to suicidal and non-suicidal targets than male college students reported. Furthermore, male college students

reported the most sympathy towards non-suicidal males and the least sympathy towards suicidal males. According to White & Stillion (1988) these results indicate that males stigmatize males who attempt suicide.

Knott and Range (1998) examined the experiences of 40 previously suicidal college students to determine what remarks from others were considered helpful in dealing with suicidal ideation. The students indicated, "...family, friends, and personal resources were most helpful in keeping them alive" In addition, high school students have reported that given a choice of talking to their parents, teachers, or friends about suicidal thoughts that they would be more likely to talk to their peers (Knott & Range). Furthermore, nearly 80 % of people that ultimately commit suicide have talked to someone about their suicidal plans (Fremouw, de Perczel, & Thomas, 1990).

Therefore, it is reasonable to assume that a suicidal person would most likely discuss suicidal ideation with a peer. In addition, the response of the peer would be extremely important in keeping the person alive to get further treatment.

Empirical Findings involving HIV/AIDS and Suicide. Martin and Range (1991) indicated that although there is relative tolerance of illness-related suicide, people respond more negatively to someone with AIDS that commits suicide. Range and Alliston (1995) wanted to investigate whether reactions to

suicide were influenced by the type of disease and the length of time that a person had known about the disease prior to committing suicide.

To study this, the researchers presented four scenarios to college students describing, Pat, a name selected to keep students from being certain of the gender of the target subject, as being diagnosed with AIDS or cancer either 1 week, 1 month, 6 months, or 1 year ago.

The results indicated that time since diagnosis did not seem to have any bearing on the stigma to the target subject. However, subjects responded more negatively to scenarios describing Pat as having AIDS than cancer.

Ingram and Ellis (1995) investigated college students' reactions to four different scenarios describing the suicide of a man, 31 years old, with AIDS, cancer, schizophrenia, or depression. Students read one of four different scenarios and rated the victim on "...mental health, moral character, religiosity, physical health, intelligence, trustworthiness, likability, justification in committing suicide, and likelihood of the victim being a friend of the subject..."(272).

These participants indicated that they were less likely to be friends with the target subjects described as having AIDS or schizophrenia. In addition, they viewed the cancer and AIDS victim as more justified in committing suicide than those with

schizophrenia or depression. This research finding is similar to other empirical evidence that people respond more negatively to the suicide of a person with a mental illness than with a physical illness. This result may reflect that those students were uncomfortable thinking about having a friend with a potential fatal outcome such as AIDS or cancer.

O'Neal and Range (1993) presented four scenarios of a suicidal person who suffered from AIDS, depression, drug abuse, anxiety, or adjustment problems to college students and asked them to write 4-6 statements concerning how they would respond to such a person. The statements were scored according to how helpful they were to the person in the scenario. Subjects responded least empathetically to the AIDS victim.

Statement of the Problem. Since high rates of people with AIDS commit suicide, further research of variables that contribute to this high suicide rate is needed. In addition, empirical studies suggest that people stigmatize HIV positive suicide victims or those who attempt suicide more than suicide victims who suffer from other physical illnesses. Empirical evidence also suggests that people stigmatize AIDS victims because of its association with homosexuality and promiscuity. Attribution theory as applied to the study of attitudes towards persons with AIDS suggests that people respond differently

towards persons with AIDS based on the person's mode of contraction of the HIV virus.

The purpose of the present study is to investigate whether informing college student of how a hypothetical peer contracted HIV influenced affective responses and judgments of a peer who expressed serious suicidal ideation. In addition, helping behavior offered towards the peer was also examined. Finally, the effect of the participant's sexual orientation on affective responses towards, attributions of, and helping behavior towards the target subject will be examined.

To examine these variables, subjects read one of four scenarios describing the target subject, Mark, as being a homosexual or heterosexual, and engaging in both promiscuous and monogamous sexual behavior.

The respondents completed the Attitudes and Helping Behavior Scale designed for this study to measure their affective responses: sympathy, empathy, and anger. The subjects also judged "Mark" concerning the unfairness of the situation, moral character, and trustworthiness. Finally, the subjects ranked their willingness to help Mark. The helping behaviors explored involved low direct contact, referring him to the counseling center; medium direct contact, offering a phone number where they could be reached; and high direct contact attempting to establish a friendship with Mark.

Based on the literature review, the following hypotheses are proposed:

1) Overall, females will have more positive affective responses and judgements of "Mark" regardless of sexual orientation or sexual behavior based on higher mean scores on the Attitudes & Helping Behavior Scale (AHBS).

2) Participants who respond to the scenario that describes the individual as a "monogamous heterosexual" will score higher on the AHBS than the subjects who receive the other scenarios.

3) Men will express more anger towards the scenario target subject (based on question four of the AHBS) than women.

4) Men will express more anger at "Mark" described as a homosexual engaging in promiscuous or monogamous sexual behavior than when Mark is described as a heterosexual, monogamous or promiscuous.

## CHAPTER 2

### METHOD

#### Participants

Two hundred and thirty-eight participants (137 females and 101 males) enrolled in introductory psychology courses at East Tennessee State University participated in this study. The mean age for the participants was 21.01 with a range of 16 to 52 years (See Table 1 for participants' demographic information). All participants were volunteers and offered extra credit in the psychology course for participation in this study. Participants were advised that alternative means to gain extra credit would be provided by the professor if anyone chose not to participate. This was in accordance with university policy.

#### Measures

Each participant received a packet of information containing a self-report demographic questionnaire (See Appendix A), one of four different scenarios (See Appendix B, C, D, E), and an Attitude and Helping Behavior Scale (See Appendix F). This researcher informed the students that this study involved reactions to suicidal ideation by a person with HIV.

Each scenario presented a hypothetical situation where a classmate "Mark" informed the participant that he was HIV positive and had a plan to kill himself. Scenarios were identical except for one sentence explaining "Mark's" sexual

orientation, homosexual or heterosexual, and sexual behavior (promiscuous/monogamous). No other identifying information such as age, race etc. was included in the scenario.

The participants rated their emotional responses, judgments or the scenario subject's character and the fairness of his situation, and their willingness to help the target subject on the ten-item Attitudes and Helping Behavior Scale. The AHBS was constructed for the purposes of this study. Participants rated their responses to each of the items on a four-point Likert type scale from one, strongly disagree, to five, agree.

This scale was mostly based on the scale used by Weiner et al., 1988. These researchers assessed participant's emotional responses to, attributions of, and willingness to help target subjects on Likert type scales. In addition, the present scale was also based on research involving assessing participants' sympathy, empathy, and level of agreement with the action of attempting suicide (Stillion et al., 1989; Stillion, McDowell, & May, 1984; Stillion, McDowell, & Shamblin, 1984)

Procedure. This researcher contacted the introductory psychology professors and obtained permission to test the participants during class time. The participants were contacted near the end of class and asked to participate in research designed to investigate responses to suicide ideation by a person with HIV.

The packets were numbered one through four. Women were asked to raise their hands. Beginning on the left side of the room, the first woman received the first packet, and the second received the second packet, and so on. The same procedure was conducted for the men. This procedure was used to insure an even distribution of the four scenarios among men and women.

After the participants completed their packet of information, they were invited to ask any questions or voice any concern that they may have had about their participation in the study. Then, the participants were advised to contact Dr. John

Ellis at 423-439-4424, if they were interested in knowing the results of the study.

Experimental Design. The research design that was used in this study was a 4 (scenarios) x 2 (sex of the subjects) independent groups factorial with unequal ends. Results were analyzed using an analysis of variance for each of the three dependent variables: empathy, attributions, and willingness to help. Post hoc testing procedures were also performed.

## CHAPTER 3

### RESULTS

Hypothesis One which states that women will have more positive affective responses and judgements of "Mark" and be more likely to engaging in helping behavior towards "Mark" regardless of sexual orientation or sexual behavior based on higher mean scores on the Attitudes & Helping Behavior Scale was confirmed,  $F(1, 230) = 13.695$ ,  $p < .01$  (See Table 2). For a breakdown of men's and women's total attitude scores (See Table 2).

Hypothesis Two which states that participants who respond to the scenario that describes the target subject as a monogamous heterosexual will score higher on the AHBS scale than participants who receive the other scenarios was not confirmed,  $F(3, 230) = 2.460$ ,  $p > .05$  (See Table 2).

Hypothesis Three which states men will express more anger towards the scenario target subject than women (based on question four of the AHBS) was not confirmed,  $F(1, 215) = .726$ ,  $p > .05$  (See Table Four). In addition, Hypothesis Four which states that men will express more anger at "Mark" described as homosexual engaging in promiscuous or monogamous sexual behavior than when "Mark" is described as a heterosexual, monogamous or promiscuous was not confirmed,  $F(3, 215) = .718$ ,  $p > .05$  (See Table Four).

Non-hypothesized analyses were also performed and may be of interest. When using only questions six, seven, and eight there was a statistically significant difference in helping behavior offered by men and women,  $F(1, 228) = 18.634$ ,  $p < .01$  (See Table 5).

Participants' attributions of the target subject differed by scene,  $F(3, 216) = 4.467$ ,  $p < .05$  (See Table 6). In addition, men and women differed in attributions of the target subject,  $F(1, 216) = 5.940$ ,  $p < .05$ . For attribution mean scores for women and men (See Table 7). For attribution mean scores for each of the four scenes or scenarios (See Table 8).

Table 1

DEMOGRAPHIC INFORMATION		
	FREQUENCY	PERCENTAGE OF TOTAL
LIVING ARRANGEMENTS		
Alone	048	20.2
With Opposite Sex Roommate	013	05.5
With Parent or Parents	068	28.6
With Same Sex Roommate	081	34.0
MARITAL STATUS		
Divorced	009	03.8
Married	023	09.7
Single	204	85.7
Widowed	002	00.8
SEXUAL ORIENTATION		
Heterosexual	226	95.0
Homosexual	012	05.0
RACE		
African American	023	09.7
Asian	003	01.3
Hispanic (Not White)	001	00.4
Caucasian	200	84.0
Native American	001	00.4
Other	004	01.7
YEAR IN SCHOOL		
Freshman	155	65.1
Junior	022	09.2
Senior	012	05.0
Sophomore	049	20.6

Table 2

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ANOVA

ATTITUDE SCORES BY GENDER AND SCENARIO

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Source	Sum of Squares	df	Mean Squares	F	F Prob
Sex	02.800	001	2.800	13.695	.000
Scene	01.509	003	0.503	02.460	.063
Sex X Scene	00.251	003	0.084	00.409	.747
Explained	04.390	007	0.627	03.068	.004
Residual	47.016	230	0.204		
Total	51.406	237	0.217		

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Table 3

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ATTITUDE MEAN SCORES FOR MEN AND WOMEN

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Sex	Mean	Std Deviation
Men ( <u>n</u> =101)	2.7119	.5076
Women ( <u>n</u> =137)	2.9270	.4108*

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\*  $\underline{p} < .01$

Table 4

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ANALYSIS OF VARIANCE QUESTION FOUR (ANGER VARIABLE)

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Source	Sum of Squares	df	Mean Squares	<u>F</u>	<u>F</u> Prob
Sex	000.117	001	.117	.123	.726
Scene	000.111	003	.037	.039	.990
Sex x Scene	001.280	003	.427	.449	.718
Explained	001.700	007	.243	.256	.970
Residual	204.139	215	.949		
Total	205.839	222	.927		

---

Table 5

---

ANOVA

HELPING BEHAVIOR BY GENDER AND SCENARIO

---

Sources	Sum of Squares	df	Mean Squares	<u>F</u>	<u>F</u> Prob
Sex	006.271	001	06.271	18.634	.000
Scene	002.395	003	00.798	02.372	.071
Sex X Scene	000.840	003	00.280	00.832	.477
Explained	009.225	007	01.318	03.916	.000
Residual	076.735	228	00.337		
Total	085.960	235	00.366		

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Table 6

---

ANOVA

ATTRIBUTION SCORES BY GENDER AND SCENARIO

---

Sources	Sum of Squares	df	Mean Squares	<u>F</u>	<u>F</u> Prob
Sex	002.774	001	02.774	05.940	.016
Scene	006.258	003	02.086	04.467	.005
Sex by Scene	000.693	003	00.231	00.495	.686
Explained	009.918	007	01.417	03.034	.005
Residual	100.866	216	00.467		
Total	110.785	223	00.497		

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Table 7

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ATTRIBUTION MEAN SCORES FOR WOMEN AND MEN

---

Sex	Mean	Std.Deviation
Male ( <u>n</u> =96)	2.5599	.7050
Female ( <u>n</u> =128)	2.7637	.6947*

---

P < .05

Table 8

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ATTRIBUTION MEAN SCORES BY SCENARIO

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Scene	Mean	Std.Deviation
Scene 1 (n=54)	2.1967	.7104
Scene 2 (n=57)	2.7500	.6409
Scene 3 (n=55)	2.4727	.6816
Scene 4 (n=58)	2.5733	.7209*

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\*  $\underline{p} < .05$

## CHAPTER 4

### DISCUSSION

This study involved the application of attribution theory to the analysis of college students' reactions to suicidal ideation by a person with HIV. Based on prior research, it was hypothesized that participants' attributions, emotional responses, and helping behavior towards the target subject would be influenced by information regarding the target subject's sexual orientation, heterosexual or homosexual, and sexual behavior, monogamous or promiscuous.

Past research has indicated that HIV positive homosexuals are stigmatized more than HIV positive heterosexuals (Anderson, 1992; Dowell et al., 1991; Peter et al., 1994; Triplet & Sugarman, 1987). Overall, this research did not support these findings.

Researchers Triplet and Sugarman (1987) suggested that the stigmatization of homosexuals with AIDS may involve the proposition that AIDS among homosexuals is associated with sexual promiscuity while among heterosexuals AIDS is more likely attributed to receiving contaminated blood. This research did not support this assertion. Homosexuals described as contracting the illness due to promiscuous sexual behavior were not

stigmatized anymore than monogamous heterosexuals or homosexuals.

In addition, results of the present study also contradict the results found by Dowell et al. (1991). These researchers found that homosexuals received more blame than heterosexuals did when the method of contraction of HIV was sexual contact. However, results of the present study support results found by Dowell et al. that women attributed less blame than men did to AIDS victims.

In the present study, women had more positive attributions and emotional responses than men did towards the scenario subjects, and were more willing to help an HIV positive person who was experiencing suicidal ideation than men were. This finding was also in line with previous research that women offered more sympathy than men did to suicidal target figures (White & Stillion, 1988). However, the results of the present study were not completely in line with results that men stigmatize men who are described as suicidal (White & Stillion).

In addition, results of present study did not support the hypothesis that men would report more anger than women did towards the target subject. This hypothesis was based in part on prior research where women had shown more sympathy to target subjects regardless of sexual orientation or the fact that the target subject was experiencing suicidal thoughts.

Finally, the hypothesis that men would express more anger at the target subject described as a homosexual engaging in promiscuous or monogamous sexual behavior than when the target subject was described as a promiscuous or monogamous heterosexual was not confirmed. This prediction relied on relationship proposed by Weiner (1986) between control, anger, and neglect and between lack of control, sympathy, and help.

Weiner (1993) also suggested AIDS association with homosexual behavior influences attributions towards AIDS victims. It was hypothesized that men would view homosexuals as more responsible for contracting AIDS and in turn express more anger towards the homosexual target subject.

#### Limitations

Although this study provides some interesting findings, there are clearly some methodological problems related to this particular study and to studies of this type in general.

First of all, based on the enrollment of psychology courses at this university, women were over-represented in this study. In addition, most of the participants were single, white, young, heterosexual Caucasians. Therefore, a more representative sample is clearly needed to generalize these findings. Furthermore, college students were used in the study due to accessibility. However, college students have considerable differences from people who are not enrolled in college. Finally, it may be that

students enrolled in psychology courses would offer different responses to the scenario than students enrolled in other academic courses.

In addition, experiments involving scenarios as an experimental manipulation propose hypothetical situations where participants are asked to predict responses to these situations. Therefore, these hypothetical situations may be quite different from real world situations. The results are only as accurate as the subjects' responses. Another limitation of this study is that subjects may have been giving more socially desirable responses. The Marlow-Crowne Social Desirability Scale should have been given to the participants to address this problem.

Finally, the Attitude and Helping Behavior Scale was designed for the purposes of this study and did not have reliability or validity data established prior to the study. It may be that the scale itself influenced participants' responses to the scenes or scenarios. However, this scale did show some promise when it was broken down into either separate questions or subscales. It would be interesting to see if this scale reveals similar results in the future. This would help to establish reliability and validity of the scale.

### Implications

Overall, the results of this study imply that information regarding a person's sexual behavior or sexual orientation does

not influence attributions, emotional responses, and helping behavior towards HIV positive suicidal ideators. These results were not anticipated based on past research. It is possible that social responses towards people with AIDS are improving in some regards due to AIDS educational programs or other larger social changes. Literature reviews that examine changes in social responses to HIV/AIDS over time would provide useful information.

Future researchers may want to examine differences between heterosexuals' and homosexuals' responses to people with HIV/AIDS. It may be homosexuals and heterosexuals differ in attributions of, emotional responses to, and helping towards people with HIV/AIDS based on the respondent's sexual orientation. Past research has not investigated the influence of the sexual orientation of the participant or respondent.

Another interesting line of research would involve comparing social responses to people diagnosed with HIV to those diagnosed with AIDS. Furthermore, it would also be interesting to investigate whether having a friend with HIV/AIDS or receiving sexual education about HIV/AIDS influences social responses to those with HIV/AIDS.

It is possible that the lack of validation of the Attitudes and Helping Behavior Scale influenced the results of this study. Future validation studies of the scale are needed and may

provide very useful information in examining responses to people with HIV/AIDS.

Finally, given the relationship between having HIV/AIDS and suicide risk, future studies examining social responses to those who have HIV/AIDS and are experiencing suicidal thoughts are worthwhile and may provide useful information in guiding intervention strategies.

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Appendix A: Demographic Questionnaire

Please fill in the blank or circle the correct answer. Do not put your name on this page or any of the following pages.

Age: \_\_\_\_\_ Sex: 1. Male

2. Female

Race: 1. Caucasian 2. African American 3. Asian 4. Hispanic  
(Not White) 5. Native American 6. Other \_\_\_\_\_

Sexual Orientation: 1. Homosexual  
2. Heterosexual

Marital Status: 1. Single  
2. Married  
3. Divorced  
4. Widowed

School status: 1. Freshman 2. Sophomore 3. Junior 4. Senior

Do you live: 1. Alone  
2. With Parent or Parents  
3. With Spouse  
4. With Same Sex Roommate  
5. With Opposite Sex Roommate

## Appendix B: Classmate Having Suicidal Thoughts

You have noticed that a classmate, Mark, appears sad and withdrawn in class lately. You approach him after class and he tells you that he has contracted HIV while in a monogamous relationship with his girlfriend. He indicates that he has a plan to kill himself.

## Appendix C: Classmate Having Suicidal Thoughts

You have noticed that a classmate Mark appears sad and withdrawn in class. You approach him after class and he tells you that he contracted HIV in a monogamous relationship with his boyfriend. He informs you that he has a plan to kill himself.

## Appendix D: Classmate Having Suicidal Thoughts

You have noticed that a classmate, Mark, appears sad and withdrawn in class. You approach him after class and he tells you that he has contracted HIV by having many sexual encounters with women. He informs you that he has a plan to kill himself.

## Appendix E: Classmate Having Suicidal Thoughts

You have noticed that a classmate Mark appears sad and withdrawn in class. You approach him after class and he tells you that he contracted HIV by having many sexual encounters with men. He informs you that he has a plan to kill himself.

Appendix F: Attitudes and Helping Behavior Scale

Please rate your level of agreement with the following statements from one to four.

1. Mark is a trustworthy person.

(1) Strongly Disagree (2) Disagree (3) Agree (4) Strongly Agree

2. Mark is a moral person.

(1) Strongly Disagree (2) Disagree (3) Agree (4) Strongly Agree

3. I feel sympathy for Mark

(1) Strongly Disagree (2) Disagree (3) Agree (4) Strongly Agree

4. I feel anger towards Mark.

(1) Strongly Disagree (2) Disagree (3) Agree (4) Strongly Agree

5. Mark's situation is unfair.

(1) Strongly Disagree (2) Disagree (3) Agree (4) Strongly Agree

6. I would give Mark the phone number of the university's counseling center.

(1) Strongly Disagree (2) Disagree (3) Agree (4) Strongly Agree

7. I would offer Mark a phone number where I could be reached if he needed to talk.

(1) Strongly Disagree (2) Disagree (3) Agree (4) Strongly Agree

8. I would attempt to establish a friendship with Mark.

(1) Strongly Disagree (2) Disagree (3) Agree (4) Strongly Agree

9. I feel empathy for Mark.

(1) Strongly Disagree (2) Disagree (3) Agree (4) Strongly Agree

10. It is likely that Mark is an intelligent person.

(1) Strongly Disagree (2) Disagree (3) Agree (4) Strongly Agree

VITA

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