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Attitudes toward Suicidal Women Based on Gender of the Participant and Race of the Target Figure.

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by

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ABSTRACT

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The purpose of this study was to examine the effects of gender on attitudes toward Black and White suicidal females.

Participants included 37 Caucasian graduate students who completed demographic questionnaires, Suicide Behavior Questionnaires (SBQ) (Ellis & Jones, 1996), and one of two scenarios with a modified version of the Suicide Attitude Vignette Experience Scale (SAVE) (Stillion, White, Edwards, & McDowell, 1989). The research design was a 2 (sex of participant) x 2 (suicide ideation of participant) x 2 (race of target figure) independent groups factorial. Independent ANOVAS were performed to interpret the significance of main and interaction effects.

No main effects were found. Two 2-way interaction effects were revealed. Women presented with the White female target figure had the highest mean score. Suicide ideators had the highest mean on rating the target figure as a close personal friend.

None of the hypotheses proved to be significant. Future researchers should use a more heterogeneous sample.

DEDICATION

This paper is dedicated to my parents, Dr. E.B. Smith, Jr. and Miss Carol Brown. I am so very lucky and grateful to have such wonderful parents. Thank you for all the support, encouragement, and love throughout my life.

I would also like to thank my husband for all his support and understanding. Thank you for never once complaining about my endless hours spent on the computer. Your patience has meant more than you know.

Also, a thank you to my very special grandparents who are always so proud of me.

I love each and every one of you very much. I am truly blessed to have such a caring family and loving husband.

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CHAPTER 1

INTRODUCTION

Suicide is a major health concern in the United States. The National Institute of Mental Health (1997) estimated that approximately 32,000 people kill themselves every year. Suicide, accounting for 1.4% of all deaths, is the 9th leading cause of death in the U.S. A person commits suicide about every 15 minutes, but it is estimated that an attempt is made about once a minute. Researchers such as Davidson and Rokay (1986) estimated that there are 8 to 30 suicide attempts for every completed suicide. Another major concern surrounding suicide is the need for more research on attitudes toward suicidal individuals. Attitudes have been found to vary according to an individual's gender (Parker, Cantrell, & Demi, 1997) and race (Bishop & Richards, 1987). Mental health professionals need to be capable of providing intervention when confronted with a suicidal client, and the awareness of their own attitudes toward suicide will allow them to better assist the client in their time of need.

Risk Factors for Suicide

The period of intervention between a mental health professional and a suicidal client can be critical, so it is

important to recognize patterns of behavior and symptoms. The National Institute of Mental Health (1997) has identified five important risk factor domains for suicidal behavior: 1) a history of mental or addictive disorder; 2) psychosocial and environmental factors such as physical or sexual abuse, decreased familial or social support, loss of a parent, exposure to suicidal behavior, general negative life events, chronic physical illness, pregnancy in adolescent females, or being a runaway; 3) a family history of suicidal behavior or mental illness; 4) biological correlates including certain hormonal factors and a deficiency in the neurotransmitter serotonin; and 5) high risk epidemiologic and demographic features such as being male, between the ages of 15 and 24 or over 65, and being single, widowed, separated, or recently divorced. The overlap of risk factors from several domains increases the risk of suicide. It also appears to occur when multiple overlapping factors are present in the absence of protective factors such as strong social support, hopefulness, obtaining treatment for mental illness, not experiencing losses or disappointments as humiliating, and having a safer environment with restricted access to highly lethal methods of suicide.

Suicide and Mental Illness

Over 60% of all people who commit suicide suffer form major depression. If alcoholics who are depressed are included, this figure rises to over 75%. About 15% of the population will suffer from clinical depression at some time during their life. Thirty percent of all clinically depressed patients attempt suicide, and half of them succeed. Ninety-six percent of alcoholics who commit suicide continue their substance abuse up to the end of their lives. Alcoholism is a factor in about 30% of all completed suicides of which 87% are male. The highest suicide rates occur in those over 50, and in more than half of these deaths, medical illness plays an important role in the motivation to commit suicide (National Institute of Mental Health, 1997).

Suicide and Gender

The highest suicide rates are found among White men over 50, which represent 33% of suicides. The suicide rates for men are relatively constant from ages 20-64, but increase significantly after age 65. The suicide rate for women peaks between the ages of 40-54 years old, and does so again after age 75. There are 4 male suicides for every female one; however twice as many women as men attempt suicide (National Institute of Mental Health, 1997).

There are several explanations for the male/female differences in the rate of completed suicides. The first explanation centers around mental illness and risk factors associated with suicide. Women's higher rate of attempted suicide may be related to their elevated rate of mood disorders such as dysthymia, seasonal affective disorder, and rapid cycling bipolar disorder. However, men's higher rate of completed suicide may be due to the overlap of other risk factors that make up the "lethal triad of suicide" including impulsive and aggressive personality traits, substance abuse, and depression (The National Institute of Mental Health, 1997). Another explanation involves the various methods of attempted suicide. For example, women are more likely than men to be prescribed and to take medically prescribed psychotropic drugs (Copperstock, 1982; Fidell, 1982) which is the most frequently used method in acts of attempted suicide. Men, on the other hand use more violent and lethal means of suicide, such as handguns (The National Institute of Mental Health, 1997). Lastly, the male/female discrepancy in rates of suicide may be due to the role of intervention by a mental health professional. Women are more likely than men to use outpatient psychotherapy (Russo, 1990) and make up the majority of those who contact suicide prevention services (Woldersdorf, Nelson, & Dalton-Taylor, 1989).

Women's health issues have received more attention in recent years. This has increased awareness in gender differences in the cause, progression, and treatment of mental disorders. This has certainly been true for suicide, where few studies have compares the suicidal behavior of men and women. Because more than 90% of individuals who commit suicide suffer from some type of mental illness, this new attention to the study of gender differences in mental disorders holds great promise for increasing our understanding of suicide attempts and completions (The National Institute of Mental Health, 1997).

The Role of Race and Gender of Clients in Counseling

The U.S. Bureau of the Census (1991) reported that people of color constitute the fastest growing segment of the population. As of 1990, the three largest groups of color in the United States were African Americans (12.4%), Hispanic/Latinos (8.1%), and Asian and Pacific Islanders (3.0%). It is estimated that by the year 2056, more than half of U.S. residents will trace their descent back to Africa, Latin America, and Asia – almost anywhere but White Europe (Henry, 1990). The knowledge of future changes in the population and recent trends in research concerning females, Blacks, and their relationship with therapy constitutes an even higher need for understanding attitudes. Although Black women have the lowest

suicide rate, they are not guarded against suicide but rather have fewer fatal suicidal efforts. In fact, the suicide rate of Black women is virtually the same as the suicide rate of White women (Nisbet, 1996). Furthermore, evidence suggests that Black patients may be treated differently from White patients with regard to medication, diagnosis, and politeness of treatment (Carter, 1983; Coles, 1969; Levy, 1985).

Theoretical Aspects of Suicide

Emile Durkheim, founder of the Sociological Study of Suicide, postulated that suicide rates increase with more social isolation. Durkheim (1951) posited three basic types of suicide: egoistic, altruistic, and anomic. Egoistic suicide occurs when the individual has too few ties with the community. Causal factors include severe depression and those who are no longer able to experience the pleasures in life. Most suicides in the United States are considered egoistic. Durkheim (1951) proposed that immunity to suicide, or protective factors, increase with strong integration of the religious community and with the size of the family. Durkheim's (1951) second type of suicide, or altruistic suicide, is characterized by the serene conviction that the individual is performing one's own duty. An example would be a follower or servant who commits suicide upon the death of their chief. Durkheim's last category was anomic

suicide, which occurs when an individual feels anger or disappointment at aspirations unfulfilled. Anomie, the temporary condition of social deregulation, was further divided into two types. The first type, economic anomie, occurs when trade and industry fail to exercise moral constraints on an increasingly unregulated capitalist economy. The second type of anomie, domestic anomie, afflicts widows and widowers as well as those who have experienced separation and divorce (Durkheim, 1951).

Theoretical Aspects of Attitudes and Empathy in Counseling

Carl Rogers offered a humanistic perspective relating to the concept of attitudes and empathy in a counseling relationship. In his book On Becoming a Person: A Therapist's View on Psychotherapy (1961), Rogers stated that being genuine, accepting, and understanding are important parts of creating a helpful relationship between the client and therapist. Being genuine comes from knowing one's inner feelings and not "presenting an outward façade of one attitude, while actually holding another attitude at a deeper unconscious level" (p. 33). Rogers also said that being able to accept the client provides an environment of warmth and safety. Rogers stated:

> By acceptance I mean a warm regard for him as a person of unconditional self-worth – of value no matter what his

> condition, his behavior, or his feelings. It means a respect and liking for him as a separate person, a willingness for him to possess his own feelings in his own way. It means an acceptance of and regard for his attitudes of the moment, no matter how negative or positive, no matter how much they contradict other attitudes he has held in the past. (p. 34)

In addition, Rogers stated that a continuing desire to understand the client is a significant portion of creating a helping relationship. He wrote that for a therapist to truly understand the client, the therapist must have "a sensitive empathy with each of the client's feelings and communications as they seem to him at the moment" (Rogers, 1961, p. 34).

Empirical Findings Regarding Gender Differences In Attitudes Toward Suicide

Stillion, White, Edwards, and McDowell (1989) conducted a study to investigate the attitudes of young people (17 to 22 years of age) and older people (57 to 86 years of age) toward suicide and to determine if attitudes toward suicide varied according to the sex and age of the target figures in the vignettes. Participants consisted of 20 men and 20 women from the young group and 20 men and 20 women from the older group.

Attitudes were assessed by the Suicide Attitude Vignette Experience (SAVE) Scale which consists of hypothetical situations in which the target figure experiences a problem and attempts suicide. The scale also required the participants to rate the extent to which they sympathized and empathized with the target figure and the extent to which they agreed with their decision to attempt suicide. In this particular study, 20 vignettes were given to each participant in which 10 of the vignettes contained a young target figure and the other 10 vignettes contained an older target figure. There were 5 men and 5 women in each group. The results showed that young female target figures received the highest levels of sympathy from young and old men and women, while old female target figures received the least amount of sympathy from young and old men and women. However, each age and sex group empathized with the target figures most like them with the exception of old men, who empathized more with young men and women than with older subjects.

Parker, Cantrell, and Demi (1997) compared attitudes toward suicide (empathy, sympathy, and agreement with action) of older Black and White men and women. They hypothesized that older Whites would express more empathy with suicidal target figures and agreement with suicidal actions than would older Blacks, and that older women would express more empathy toward suicidal

target figures and more agreement with suicidal actions than would older men. The 54 participants ranged in age from 65 to 94 in which 9 were Black men, 8 were White men, 26 were Black women, and 11 were White women. The SAVE Scale was used to assess the attitudes of the participants. The results indicated that there was no significant difference in attitudes toward suicidal older people based on the race or gender of the participant. Although neither hypothesis was supported, women tended to be more empathetic than men, and Blacks tended to be more empathetic than Whites.

Lester, Guerriero, and Wachter (1991) used a modification of the SAVE scale to examine the attitudes of 51 men and 118 women based on the gender of the participants and the gender of the target figures in the vignettes. The scale was modified by asking the participants to rate the suicidal choice as inappropriate vs. irrational thinking. Also, the vignettes included a target figure who completed suicide rather than just attempting suicide. The results showed no association between the overall rating of rationality or appropriateness and the sex or the age of the participant.

Empirical Findings Regarding Suicidal Ideation and Nonideation in Attitudes Toward Suicide

Ingram and Ellis (1995) investigated the perceptions and feelings of suicide ideators and nonideators with suicide victims in different situations. The participants consisted of 141 women and 87 men ranging in age from 18 to 59. Suicide ideators were described as individuals who had attempted suicide or seriously considered suicide in the past. Nonideators were described as individuals who had never seriously considered suicide. Suicide ideators and nonideators were differentiated by administering the Suicide Ideation Questionnaire. The participants were then required to read four identical scenarios with the exception of the diagnosis of the target figure who committed suicide (Cancer, AIDS, schizophrenia, and depression), and completed the Perception Rating Questionnaire (PRQ). The results indicated that no more women than men classified themselves as suicide ideators, although suicide ideators scored a higher mean than nonideators on the PRQ, meaning they evaluated the victims more positively.

Ellis and Jones (1996) examined the difference between suicide ideators and nonideators to identify the adaptive reasons for living that are lacking in male and female college-age suicide ideators. A total of one hundred thirteen participants, ranging in age from 17 to 51, participated in the

study. Each participant was required to complete a Suicide Questionnaire and a Reasons for Living Inventory (RFL). The results indicated that suicide nonideators scored higher on the RFL than suicide ideators.

Empirical Findings Regarding Gender Differences in Attitudes Surrounding Therapy

Research has found that male and female therapists differ in regards to their assessment and attitudes of clients as well as their overall in-session experience. This raises the question as to whether male and female clients are receiving proper and equal treatment in their therapy sessions. For example, in an early study, Howard, Orlinsky, and Hill (1969) examined differences in male and female therapists' self-reported reactions to a female client population. They found that male therapists reported greater degrees of personal discomfort and uneasy intimacy in response to clients' painful self-exploration. Female therapists indicated greater degrees of confidence and sympathy and a greater degree of responsivity to clients.

Male and female therapists have also been found to differ in their appraisal of clients. Jones and Zoppel (1982) found that female therapists rated their clients, regardless of gender, significantly higher than male therapists on change in

personality structure, satisfaction with treatment, and overall outcome. Overall, the female therapists described their female clients in a much more positive or socially desirable fashion than the male therapists, and the male therapists described both male and female clients in a negative or more derogatory fashion than did the female therapists.

Empirical Findings Regarding Racial Differences in Attitudes Surrounding Therapy

The function of race in counselor-client relationships has received increasing attention over the years. The effects of racial bias on diagnostic judgments in the counseling process continue to be a controversial issue. For example, Sattler (1977) concluded that there was no systematic bias in favor of or against Black clients whereas Abramowitz and Murray (1983) challenged that conclusion and emphasized that subsequent research does suggest the presence of certain racial biases in diagnostic judgments. Although many articles have examined the problems that may be anticipated in cross-cultural counseling, few have been designed to produce data that demonstrate how such variable operate.

Bishop and Richards (1987) compared the diagnostic judgments made by intake counselors in a university counseling center about their White and Black clients. Participants

consisted of 112 White and 42 Black students who requested individual counseling during a recent academic year. Each student was randomly assigned to counselors who consisted of 5 White women, 1 Black woman, 6 White men, and 1 Black man who were all trained at the doctoral level in counseling psychology. After each client completed a 30 minute intake interview, the counselors made judgments about the severity of each students' problems in three categories – vocational, personal, and educational. Ratings were made on a 5-point scale ranging from (1) simple to (5) very severe. The counselors were also asked to judge the level of anxiety that the client had about talking to a counselor, the client's potential for change, the ease with which the client was able to express him or herself, the degree to which the client was motivated to overcome the presenting problem, and how realistic the client's stated goals were in regard to the probable outcomes of counseling. All of these judgments were made on a 5-point rating scale ranging from (1) none to (5) very high. In addition, counselors were asked to provide a rating of the client's physical appearance (very unattractive to very attractive) and to indicate their personal feelings toward the client (strongly dislike to strongly like) on a 5-point rating scale. Finally, counselors attempted to predict the number of interviews that clients would attend after the initial intake interview.

Intake counselors did not make significantly different intake judgments about White and Black clients on 10 of the 11 variables. They did, however, judge their Black clients more favorably than their White clients in terms of judged potential for change. These results parallel those of Merluzzi and Merluzzi (1978) which reported that 86 counseling graduate students rated cases significantly more positively when they thought the clients were Black than when they thought they were White. One view proposed by Mercer (1973), suggests the possibility of a kind of paternalism in which Black clients are regarded more favorably because they are not expected to meet the same standards as White clients.

In addition to differences in attitudes toward clients based on their race, there is also evidence of differences in diagnosis of mental illness in Whites and Blacks. Alleged racism in psychiatry has been blamed for Black patients being overdiagnosed in some categories and underdiagnosed in others. Statistics of various diagnostic categories from individual clinical settings show that higher rates of schizophrenia are usually accompanied by low rates of affective disorders in Blacks (Steinberg, Pardes, & Bjork, 1977).

In a study conducted by Raskin and Crook (1975), Blacks and Whites who had been examined by clinicians using the same instruments still received a similar patter of different

diagnosis despite almost identical psychopathology. They compared 159 Black and 555 White depressed patients on a wide variety of rating scales. Two psychiatrists or one psychiatrist and one psychologist independently rated patients on three 5-point scales measuring amount of depression in verbal report, behavior, and the secondary symptoms of depression. For entry into the study, a patient had to achieve a total score of at least 9 from each rater which would be indicative of at least a moderate amount of depression. Age, sex, and social class were controlled. Despite the absence of significant differences between the two groups or clinical features that would be necessary for a diagnosis of schizophrenia in making pretreatment clinical diagnoses, they found that White patients were more often given a diagnosis of psychotic depression, but Black patients were more often given a diagnosis of schizophrenia.

Statement of the Problem

Research has found that women are more likely than men to seek professional help outside of friends and family when faced with suicidal intentions. This information provides a logical point to begin preventing suicidal individuals from committing such a devastating act. Research has also suggested that gender and race may affect the dynamics of a counseling relationship.

In other words, gender and race could affect the quality of care a client receives by impacting a counselor's beliefs and attitudes about that person. Each year increasing numbers of minorities is causing a change in the "American kaleidoscope," and these demographic trends need to be reflected in the planning and delivery of mental health services.

The purpose of the present study is to investigate the attitudes of White men and women toward suicidal Black and White women. Suicidal ideation and nonideation of the participants was determined by administering the Suicide Behaviors Questionnaire (Ellis & Jones, 1996). Attitudes of the participants were determined by the completion of a modified version of the Suicide Attitude Vignette Experience (SAVE) Scale (Stillion et al., 1989). Each participant was requested to read a vignette with either a Black or White suicidal woman as the target figure and rate the extent to which they agree with the woman's proposed actions, how mentally healthy she appears, her moral character, their empathy level, her intelligence, how likable she appears, and how likely she might be a close personal friend.

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

1) Women will report a higher empathy level than men, based on mean scores of the SAVE scale.

2) Suicidal ideators will report a higher level of empathy than non-ideators, based on mean scores of the SAVE scale.

3) Participants will report a higher level of empathy toward White target figures than Black target figures, based on mean scores of the SAVE scale.

4) Female suicide ideators will report a higher level of empathy than male non-ideators, based on mean scores of the SAVE scale.

5) Female suicide ideators who read the vignette with the White target figure will report the highest levels of empathy, based on mean scores of the SAVE scale.

6) Male non-deators who read the vignette with the Black target figure will report the lowest levels of empathy, based on mean scores of the SAVE scale.

CHAPTER 2

METHOD

Participants

Participants consisted of 30 female and 7 male Caucasian graduate students enrolled in courses at East Tennessee State University. All participants were volunteers. The majority were single and in the Counseling program concentrating in Marriage and Family. They ranged in age from 22 to 60 years with 32.4% being either 23 or 24 years of age.

Measures

Participants completed a short self-report demographic questionnaire (See Appendix A). All participants were verbally instructed by the researcher that the study is interested in the participants' attitudes towards a suicidal woman.

Participants were assigned into groups of suicide ideators and non-ideators by using the Suicide Behaviors Questionnaire (Ellis & Jones, 1996) which uses a median split method. This 35-item questionnaire inquires about past, current, and future suicidal ideas and behaviors. Items are rated on a Likert scale, and the ratings are summed for a total score. The SBQ has been shown to be reliable over a two-week interval,

internally consistent and moderately correlated with theoretically similar scales.

Participants' attitudes toward a suicidal woman were assessed by using a modified version of Stillion et al.'s (1989) Suicide Attitude Vignette Experience (SAVE) Scale. The modified version indicates the race of the target figure, whereas the original version does not indicate race, and questions pertaining to participants' attitudes in addition to empathy, whereas the original version asked about only empathy. There are two scenarios (See Appendices C,D), but each participant received only one. Both scenarios are identical except for the race of the target figure as either African American (Black) or Caucasian (White). Both scenarios involve a woman who is experiencing a problem with coping and enters a mental health clinic due to seriously contemplating suicide. After reading the scenario, participants were asked to rate the extent to which they empathized with the target figure in addition to agreement with proposed action, mental health, moral character, intelligence, likability, and likelihood of being a close personal friend. Ratings were made on a 5-point Likert-type scale from 1 (very unempathetic, disagree with proposed action, very mentally unhealthy, very immoral, very unintelligent, very unlikable, and not likely to be a close personal friend) to 5 (very empathetic, agree with proposed action, very mentally

healthy, very moral, very intelligent, very likable, and very likely to be a close personal friend). A high internal consistency of the empathy scale on the SAVE was reported as .95 when the Cronbach Alpha statistic was used (Stillion et al., 1989).

Procedure

Participants were asked to participate at the end of their classes with the instructors' permission. Each participant was given a packet of materials containing a demographic questionnaire, SBQ, and one of two scenarios with the SAVE scale. The packets were sorted to ensure a varied and even distribution. The packets were labeled 1 (Black target figure) and 2 (White target figure) and were sorted in continuous order 1 and 2. All female participants were asked to raise their hands, and the packets were handed out starting with the first female student in the front left row. The female participant was given packet 1, the second female participant was given packet 2, and so on. After all female participants received packets, the men were given packets in the same manner.

After all materials were completed and collected, the researcher answered questions and explained the study's purpose. Participants were told that at the completion of the data analysis, results can be obtained from the researcher.

Experimental Design

The research design is a 2 (sex of participant) x 2 (suicide ideation of participant) x 2 (race of target figure) independent groups factorial with unequal n's. Differences on the SAVE scale and individual SAVE scale items were analyzed using an Analysis of Variance (ANOVA) set at the .05 level.

CHAPTER 3

RESULTS

Thirty women and 7 men participated in this study. All were Caucasian graduate students while the majority was women, single, and in the Counseling program concentrating in Marriage and Family. They ranged in age from 22 years to 60 years with 32.4% being either 23 or 24 years of age. Table 1 lists the demographic data.

Differences on the SAVE scale and on individual SAVE scale items were analyzed using a 2 (sex of participant) x 2 (suicide ideation status of participant) x 2 (race of target figure) analysis of variance (ANOVAS). Hypothesis 1, which stated that women would report a higher empathy level than men, was not confirmed (See Table 2). See Table 3 for SAVE scale mean scores).

Hypothesis 2, which stated that suicide ideators would report a higher level of empathy than non-ideators, was not confirmed (See Table 2). See Table 3 for SAVE scale mean scores). Hypothesis 3, which stated that participants would report a higher level of empathy toward White women than Black women, was not confirmed (See Table 2). See Table 3 for SAVE scale mean scores). Hypothesis 4, which stated that female suicide ideators would report a higher level of empathy than

male non-ideators, was not confirmed (See Table 2). See Table 3 for SAVE scale mean scores).

Hypothesis 5, which stated that female suicide ideators who view the White target figure would report the highest empathy levels, was not confirmed (See Table 2. See Table 3 for SAVE scale mean scores). Hypothesis 6, which stated that male non-ideators who view the Black target figure would report the lowest levels of empathy, was not confirmed (See Table 2. See Table 3 for SAVE scale mean scores).

Individual SAVE scale items were also analyzed in the same manner. A 2-way interaction effect was revealed on Question 6, $F(1, 29)= 4.36$, $p < .05$. Women who were presented with the White target figure had the highest mean score (See Table 4. See Table 10 for mean scores). Another 2-way interaction effect was revealed on Question 7, $F(1, 29)= 8.76$, $p < .01$. Suicide ideators had the highest mean on rating the target figure as a close personal friend (See Table 12. See Table 11 for mean scores).

It is also interesting to note that suicide ideators had higher means on all questions. Men had higher mean scores than women on Question 1 (agreement with proposed action), Question 2 (mental health of target figure), Question 5 (intelligence of target figure), and slightly higher on Question 7 (likelihood of being a close personal friend) (See Tables 5,6,9, and 11 for

mean scores). Women had higher mean scores than men on the SAVE scale on Question 3 (morality of target figure), Question 4 (empathy toward target figure), and Question 6 (likability of target figure) (See Tables 7,8, and 10 for mean scores).

Black women received higher means than White women from participants on the SAVE scale on Question 1 (agreement with proposed action), Question 5 (intelligence of target figure), and Question 7 (likelihood of being a close personal friend) (See Tables 5,9, and 11 for mean scores). White women received higher means than Black women from participants on the SAVE scale on Question 2 (mental health of target figure), Question 3 (morality of target figure), Question 4 (empathy toward target figure), and Question 6 (likability of target figure) (See Tables 6,7,8, and 10 for mean scores).

Also of interest, individual SAVE scale items were analyzed by mean scores according to participants' field of study. Clinical Psychology students reported the highest means on all questions with the exception of Question 1,2, and 5. Non-applied students had the highest means on Question 1 (agreement with proposed action) while Clinical Psychology and Education students reported the lowest means. Non-applied and Clinical Psychology students tied with the highest means on Question 2 (mental health of target figure). Question 5 (intelligence of target figure) revealed that Non-applied and Education students

had the highest means while Clinical Psychology and Counseling students reported the lowest means (See Table 13 for mean scores).

Table 1

Demographic Information

	FREQUENCY	PERCENTAGE OF TOTAL
SEX		
Female	30	81.1%
Male	7	18.9%
MARITAL STATUS		
Single	17	45.9%
Married	13	35.1%
Divorced	7	18.9%
RACE		
Caucasian	37	100%
SCHOOL		
Applied	29	78.4%
Non-Applied	8	21.6%
FIELD		
Education	1	2.7%
Counseling	26	70.3%
Psychology	4	10.8%
MAT	3	8.1%
MALS	1	2.7%
Non-Declared	1	2.7%
SMAT	1	2.7%
CONCENTRATION		
Marriage/Family	11	29.7%
School Counseling	10	27.0%
Community Agency	5	13.5%
General	1	2.7%
Clinical	3	8.1%
ELPAPPS	1	2.7%
Biology	1	2.7%
HDAL	1	2.7%
Elem Education	2	5.4%
Geriatric	1	2.7%
Geography/Economics	1	2.7%
AGE		
Mean = 31.0	Median = 26.0	Range = 22 – 60

Table 2

ANOVA Summary Table for the SAVE Scale for All Effects

Source of Variation	Sum of Squares	df	Mean Squares	F	Sig. of F
Main Effects	25.184	3	8.395	1.102	.401
Sex	.306	1	.306	.307	.849
Ideator	18.353	1	18.353	2.213	.148
Scene	2.965	1	2.965	.358	.555
2-Way Interactions	32.052	3	10.684	1.288	.297
Sex by Ideator	9.836	1	9.836	1.186	.285
Sex by Scene	26.682	1	26.682	3.218	.083
Ideator by Scene	1.318	1	1.318	.159	.693
3-Way Interactions	.000	1	.000	.000	1.000
Sex by Ideator by Scene	.000	1	.000	.000	1.000
Explained	113.968	7	16.281	1.964	.095
Residual	240.464	29	8.292		
Total	354.432	36	9.845		

Table 3

Mean and Standard Deviation Scores for the SAVE Scale for All Effects

	Mean	sd
Sex of Participant		
Women (n=30)	21.367	3.138
Men (n=7)	21.286	1.976
Ideation of Participant		
Suicide Ideators (n=20)	22.650	3.138
Non-Ideators (n=17)	19.824	2.698
Race of Target Figure		
Black (n=18)	21.000	2.849
White (n=19)	21.684	3.433

Note: Scores range from 7 to 35

Table 4

ANOVA Summary Table for Question 6 (Likability) on the SAVE Scale for All Effects

Source of Variation	Sum of Squares	df	Mean Square	F	Sig. of F
Main Effects	.131	3	.044	.101	.959
Sex	.002	1	.002	.004	.951
Ideator	.002	1	.002	.004	.951
Scene	.121	1	.121	.281	.600
2-Way Interactions	2.184	3	.728	1.684	.192
Sex by Ideator	.378	1	.378	.875	.357
Sex by Scene	1.886	1	1.886	4.363	.046
Ideator by Scene	.404	1	.404	.934	.342
3-Way Interactions	.004	1	.004	.009	.926
Sex by Ideator by Scene	.004	1	.004	.009	.926
Explained	3.897	7	.557	1.288	.291
Residual	12.536	29	.432		
Total	16.432	36	.456		

Table 5

Mean and Standard Deviation Scores for Question 1 (Agreement with Proposed Action) on the SAVE Scale for All Effects

	Mean	sd
Sex of Participant		
Women	1.600	.894
Men	1.714	1.113
Ideation of Participant		
Suicide Ideators	1.850	1.085
Non-Ideators	1.353	.606
Race of Target Figure		
Black	1.667	1.138
White	1.579	.693

Note: Scores range from 1 to 5

Table 6

Mean and Standard Deviation Scores for Question 2 (Mental Health of Target Figure) on the SAVE Scale for All Effects

	Mean	sd
Sex of Participant		
Women	2.133	.860
Men	2.429	.787
Ideation of Participant		
Suicide Ideators	2.400	.821
Non-Ideators	1.941	.827
Race		
Black	2.056	.873
White	2.316	.820

Note: Scores range from 1 to 5

Table 7

Mean and Standard Deviation Scores for Question 3 (Moral Character of Target Figure) on the SAVE Scale for All Effects

	Mean	sd
Sex of Participant		
Women	3.300	.837
Men	3.000	.577
Ideation of Participant		
Suicide Ideators	3.300	.801
Non-Ideators	3.177	.809
Race of Target Figure		
Black	3.111	.900
White	3.368	.684

Note: Scores range from 1 to 5

Table 8

Mean and Standard Deviation Scores for Question 4 (Empathy Level Toward Target Figure) on the SAVE Scale for All Effects

	Mean	sd
Sex of Participant		
Women	4.267	1.081
Men	4.000	.817
Ideation of Participant		
Suicide Ideators	4.400	.598
Non-Ideators	4.000	1.369
Race of Target Figure		
Black	4.056	1.211
White	4.368	.831

Note: Scores range from 1 to 5

Table 9

Mean and Standard Deviation Scores for Question 5 (Intelligence of Target Figure) on the SAVE Scale for All Effects

	Mean	sd
Sex of Participant		
Women	3.567	.817
Men	3.714	.756
Ideation of Participant		
Suicide Ideators	3.800	.768
Non-Ideators	3.535	.786
Race of Target Figure		
Black	3.611	.698
White	3.579	.902

Note: Scores range from 1 to 5

Table 10

Mean and Standard Deviation Scores for Question 6 (Likability) on the SAVE Scale for All Effects

	Mean	sd
Sex of Participant		
Women	3.367	.718
Men	3.286	.488
Ideation of Participant		
Suicide Ideators	3.450	.759
Non-Ideators	3.235	.562
Race of Target Figure		
Black	3.222	.548
White	3.474	.772

Note: Scores range from 1 to 5

Table 11

Mean and Standard Deviation Scores for Question 7 (Likelihood of Being a Close Personal Friend) on the SAVE Scale for All Effects

	Mean	sd
Sex of Participant		
Women	3.133	1.042
Men	3.143	.900
Ideation of Participant		
Suicide Ideators	3.450	.887
Non-Ideators	2.765	1.033
Race of Target Figure		
Black	3.278	1.227
White	3.000	.745

Note: Scores range from 1 to 5

Table 12

ANOVA Summary Table for Question 7 (Likelihood of Being a Close Personal Friend) on the SAVE Scale for All Effects

Source of Variation	Sum of Squares	df	Mean Squares	F	Sig. of F
Main Effects	1.567	3	.522	.655	.587
Sex	.404	1	.404	.506	.483
Ideator	.081	1	.051	.064	.803
Scene	1.365	1	1.365	1.711	.201
2-Way Interactions	8.061	3	2.687	3.367	.032
Sex by Ideator	6.992	1	6.992	8.762	.006
Sex by Scene	.306	1	.306	.384	.540
Ideator by Scene	2.118	1	2.118	2.654	.114
3-Way Interactions	2.000	1	2.000	2.507	.124
Sex by Ideator by Scene	2.000	1	2.000	2.507	.124
Explained	13.181	7	1.883	2.360	.049
Residual	23.149	29	.798		
Total	36.324	36	1.009		

Table 13

Mean and Standard Deviation Scores for Individual SAVE Scale Items for Field of Study

	Mean	sd
Question 1 (Agreement with Proposed Action)		
Education	1.000	.000
Counseling	1.741	.903
Clinical Psychology	1.000	.000
Non-Applied	2.000	1.732
Question 2 (Mental Health of Target Figure)		
Education	1.750	.957
Counseling	2.222	.892
Clinical Psychology	2.333	.577
Non-Applied	2.333	.577
Question 3 (Morality of Target Figure)		
Education	3.500	1.000
Counseling	3.185	.736
Clinical Psychology	3.667	1.155
Non-Applied	3.000	1.000
Question 4 (Empathy Level Toward Target Figure)		
Education	3.500	1.915
Counseling	4.259	.903
Clinical Psychology	5.000	.000
Non-Applied	4.000	1.000
Question 5 (Intelligence of Target Figure)		
Education	4.250	.957
Counseling	3.444	.698
Clinical Psychology	3.667	1.155
Non-Applied	4.000	1.000
Question 6 (Likability of Target Figure)		
Education	3.500	.577
Counseling	3.333	.620
Clinical Psychology	3.667	1.155
Non-Applied	3.000	1.000
Question 7 (Likelihood of Being a Close Personal Friend)		
Education	3.000	1.633
Counseling	3.074	.917
Clinical Psychology	4.000	1.000
Non-Applied	3.000	1.000

Note: Scores range from 1 to 5

CHAPTER 4

DISCUSSION

The purpose of this study was to examine whether men's and women's attitudes toward suicidal individuals vary according to the race and gender of the suicidal individual. Hypothesis one, stating that women would report a higher empathy level than men was not confirmed. Although there was no significant difference on the total score, mean scores on individual questions revealed that women tended to be more empathetic than men and rated the female target figure as more moral and likable. These results correlate with previous studies that found that women were more empathetic toward suicidal target figures (Parker et al., 1997) and female therapists described their female clients in a more positive manner than male therapists (Jones & Zoppel, 1982). In contrast, men rated the women as more mentally healthy and intelligent and also agreed more with the proposed action. Research reveals that men have a higher suicide rate than women (The National Institute of Mental Health, 1997), so a possible explanation for these findings is that men are more accepting of suicide as a solution to problems and agree more with the action itself. Men also rated the target figures as more intelligent and more mentally healthy. Because women are more likely than men to seek professional help when faced with personal problems

(Russo, 1990; Woldersdorf et al., 1989), men could view the target figure as more intelligent for pursuing a different avenue as a solution. It could also imply that men more than women accept the idea of the target figure committing suicide and, therefore, rate them as more intelligent.

Hypothesis two, stating that suicidal ideators would report a higher level of empathy than non-ideators was not confirmed. When individual questions were examined, suicidal ideators reported higher means than non-ideators on all questions. A significant difference between ideators and non-ideators was reported on Question seven, in which suicide ideators were more likely to describe the suicidal woman as being a close personal friend. These findings support those of Ingram and Ellis (1995) who found that suicide ideators evaluated victims in a more positive manner than non-ideators. Because no significant difference was found on total scores for Hypothesis one and two, Hypothesis four which states that female suicide ideators would report a higher level of empathy than male non-ideators was not confirmed.

Hypothesis three which states that participant would report higher levels of empathy toward White women than Black women was not confirmed. Because there was no significant difference in empathy levels toward the women based on race, this outcome can also be attributed to Hypothesis five and six not being

confirmed. On individual questions, White women were rated as more mentally healthy, moral, and likable than Black women and also received more empathy. A significant difference was found on Question six, which asked participants to rate the woman's likability. Women rated the White suicidal woman as more likable in comparison to women who rated Black women, men who rated White women, and men who rated Black women. In contrast, participants rated the Black women as more intelligent, more likely to be a close personal friend, and agreed more with their proposed actions than White women. These results closely relate to the ratings of men versus women. For example, Black women were rated as more intelligent and received more agreement with proposed action than White women, while men also rated the target figures as more intelligent and agreed more with the proposed action than women. These findings could suggest underlying themes of racism or sexism or could suggest a kind of paternalism (Mercer, 1973) in which Black clients are viewed more favorably than White clients because they are not expected to meet the same standards.

Another interesting finding is that in addition to the ratings of men, Non-applied students in comparison to Counseling, Clinical Psychology, and Education also agreed more with the proposed action of the target figure and rated them as more intelligent and mentally healthy. These results could be

due to the perceptions of students who are not in the field of mental health and, therefore, do not have as great an understanding of a therapist/client relationship.

In summary, none of the hypothesis proved to be significant, which from the viewpoint of mental health professionals could be interpreted as very positive results. More specifically, the overall results did not indicate any differences in attitudes based on the gender of the participants or the race of the female target figures. When mean scores on individual SAVE scale items were analyzed, it was found that women tended to be more empathetic than men, suicide ideators were more empathetic than non-ideators, and White women received more empathy than Black women.

Limitations

This study has several limitations that could have had a tremendous impact on the results. First and foremost, this study was conducted using a very small number of participants. More importantly, the female to male ratio was nearly 4:1. These are due in part to the availability of graduate students in an applied program enrolled in the university. One of the major foci of this study examined attitudes based on the gender of the participants. A more balanced sample in regards to gender is needed to obtain more generalizable results.

Secondly, all participants were not in a program of study designed to work with clients in a mental health setting. Twenty-nine participants were in either a Counseling (26) or Clinical Psychology (3) program, whereas 8 participants were in a Non-applied program. Although the mixture of different programs provided interesting results, a consistent population of Applied students would provide results that are more applicable to the purpose of this study.

Finally, the wording of the scenarios and choice of questions on the SAVE scale made the interpretation of results difficult in some aspects. For example, if a participant rated the female target figure high in terms of intelligence, this could imply that the participant thought the target figure was intelligent for seeking help or intelligent for contemplating suicide as a possible solution.

Future Research

The results of this study open up various directions for future research. Although no significant results were obtained from this study, there were overall differences in attitudes on individual SAVE scale items.

It would be interesting to see if the addition of more information about the female clients would have an effect on the participants' attitudes. For example, a pre-existing

relationship with the client could be indicated to the participants. Would attitudes, especially empathy, vary if they had seen this client before for the same thoughts of suicide? Another avenue for researchers could be to include the client's planned method of action for suicide. Men and women in general use different methods when committing suicide (Copperstock, 1982; Fidell, 1982; National Institute of Mental Health, 1997), so it is possible that these gender differences could also be evident in attitudes toward a suicidal client. For example, a male therapist's attitudes toward a client could vary according to the client's planned method for suicide such as a handgun versus an overdose.

There will never be a time when research has been completed on attitudes surrounding mental health or patient/client care. With mental health awareness becoming more evident in today's society, research should continue to focus on every possible variable that could affect a therapist's attitudes to ensure that clients will continue to receive the best care possible.

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APPENDICES

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 remaining pages.

Age: _____

Sex: 1. Female
2. Male

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

Are you Employed? 1. Yes 2. No

What is your field of study?_____Concentration?_____

Race: 1. African American
2. Asian
3. Caucasian
4. Hispanic
5. Other_____

Religion: 1. Baptist
2. Catholic
3. Jewish
4. Lutheran
5. Methodist
6. Presbyterian
7. Other_____

Do you live: 1. Alone
2. With a spouse
3. With a spouse and children
4. With children only
5. With a same sex roommate
6. With opposite sex roommate
7. With parent(s)/guardian

APPENDIX B

Suicide Behaviors Questionnaire

INSTRUCTIONS: Fill in every space with the number that applies to you. Please put only ONE (1) number per space. DO NOT leave any empty spaces. If you have any questions, please ask.

---

1. _____ Have you ever thought about or attempted to kill yourself?

   0 = No
   1 = It was just a passing thought.
   2 = I briefly considered it, but not seriously.
   3 = I thought about it and was somewhat serious.
   4 = I had a plan for killing myself which I thought would work and seriously considered it.
   5 = I attempted to kill myself, but do not think I really meant to die.
   6 = I attempted to kill myself, and think I really hoped to die.

How often have you thought about killing yourself…
0 = Never 1 = Rarely 2 = Sometimes 3 = Often 4 = Very Often

2. _____ in your entire life, including the present? (If 0, go to questions #7-11)
3. _____ within the past year? (If 0, go to questions #7-11)
4. _____ within the last four weeks? (If 0, go to questions #7-11)
5. _____ within the last several days? (If 0, go to questions #7-11)
6. _____ today?

Have you ever told someone that you were going to commit suicide, or that you might do it…
0 = No 1 = Yes, during one short period of time 2 = Yes, during more than one period of time

7. _____ in your entire life including the present? (If 0, go to questions #12-16)
8. _____ within the past year? (If 0, go to questions #12-16)
9. _____ within the last four weeks? (If 0, go to questions #12-16)
10. _____ within the last several days? (If 0, go to questions #12-16)
11. _____ today?

What chance is there that you will consider the possibility, no matter how remote, of killing yourself…
No chance at all 0 1 2 3 4 Very likely

12. _____ in your lifetime? (If 0, go to questions #17-21)
13. _____ within the next year? (If 0, go to questions #17-21)
14. _____ within the next month? (If 0, go to questions #17-21)
15. _____ within the next several days? (If 0, go to questions #17-21)
16. _____ today?

How likely is it that you will attempt suicide…
No chance at all 0 1 2 3 4 Very Likely

17. _____ in your lifetime? (If 0, go to questions #22-26)
18. _____ within the next year? (If 0, go to questions #22-26)
19. _____ within the next month? (If 0, go to questions #22-26)
20. _____ within the next several days? (If 0, go to questions #22-26)
21. _____ today?

If you did attempt suicide, for any reason, how likely is it that you would die as a result…
No chance at all 0 1 2 3 4 Very likely

22. _____ in your lifetime? (If 0, go to questions #27)
23. _____ within the next year? (If 0, go to questions #27)
24. _____ within the next month? (If 0, go to questions #27)
25. _____ within the next several days? (If 0, go to questions #27)
26. _____ today?

27. _____ Would any of your problems be solved if you committed suicide?
No, definitely not 0 1 2 3 4 Yes, definitely

28. _____ Do you currently have a plan for how you would go about killing yourself, if you decided to do it?

0 = No 1 = Yes, a vague plan 2 = Yes, a definite plan

29. _____ Sometimes people who decide to kill themselves want to do it but can't find a way to actually carry through with their plan; the means are not available to them. If you decided to kill yourself at this point in your life, would the means for carrying out such an action be available to you?

0 = No 1 = Yes, possibly 2 = Yes, definitely

30. _____ If you decided to kill yourself at this point in your life, is there someone in your environment who would want to stop you?

0 = No 1 = Yes, to a small degree 2 = Yes, very much so

31. _____ Some individuals say that they cannot even imagine or conceive of the idea of attempting or committing suicide. For these people, suicidal behavior is as alien an idea as the thought of becoming a tree or lifting the Empire State Building. Other people, even though they might never actually consider the idea, can at least imagine the idea of attempting or considering suicide. Which group of people do you belong to?

0 = Group who cannot imagine 2 = Group who can imagine

32. _____ If, in the future, you ever find yourself thinking about suicide, would you consult a psychotherapist?

0 = No 1 = Yes

33. _____ Thinking about the way your life is today (given the good things in your life now and any problems you might be having), IF you knew that the QUALITY of your life would never change (it would not get better or worse), do you feel that you could stand it?

No, definitely not 0 1 2 3 4 Yes, definitely

34. _____ Thinking about the quality of your life today, in general, how would you rate?

Very bad 0 1 2 3 4 Very good

35. _____ If the quality of your life were to get <u>worse</u> (very bad), do you feel that you could cope with that?

No, definitely not 0 1 2 3 4 Yes, definitely

APPENDIX C

Scenario 1

Mary Brown, a 21 year-old African American student has entered a mental health clinic due to overwhelming and persistent feeling of stress and depression. Mary admits that she has seriously been thinking about killing herself.

1. Compared to other persons you know in this age group, how much do you agree with Mary's proposed actions?

Disagree				Agree
1	2	3	4	5

2. Compared to other persons you know in this age group, how mentally healthy does Mary appear to you?

Very Unhealthy				Very Healthy
1	2	3	4	5

3. Compared to other persons you know in this age group, how would you rate Mary's moral character?

Very Immoral				Very Moral
1	2	3	4	5

4. Compared to other persons you know in this age group, how much empathy do you feel towards Mary?

Very Unempathetic				Very Empathetic
1	2	3	4	5

5. Compared to other persons you know in this age group, how intelligent do you perceive Mary to be?

Very Unintelligent				Very Intelligent
1	2	3	4	5

6. Compared to other persons you know in this age group, how likable does Mary appear to be?

Very Unlikable				Very Likable
1	2	3	4	5

7. To what extent do you think this person might be a close personal friend of yours?

Not Likely				Very Likely
1	2	3	4	5

APPENDIX D

Scenario 2

Mary Brown, a 21 year-old Caucasian student has entered a mental health clinic due to overwhelming and persistent feeling of stress and depression. Mary admits that she has seriously been thinking about killing herself.

1. Compared to other persons you know in this age group, how much do you agree with Mary's proposed actions?

Disagree				Agree
1	2	3	4	5

2. Compared to other persons you know in this age group, how mentally healthy does Mary appear to you?

Very Unhealthy				Very Healthy
1	2	3	4	5

3. Compared to other persons you know in this age group, how would you rate Mary's moral character?

Very Immoral				Very Moral
1	2	3	4	5

4. Compared to other persons you know in this age group, how much empathy do you feel towards Mary?

Very Unempathetic				Very Empathetic
1	2	3	4	5

5. Compared to other persons you know in this age group, how intelligent do you perceive Mary to be?

Very Unintelligent				Very Intelligent
1	2	3	4	5

6. Compared to other persons you know in this age group, how likable does Mary appear to be?

Very Unlikable				Very Likable
1	2	3	4	5

7. To what extent do you think this person might be a close personal friend of yours?

Not Likely				Very Likely
1	2	3	4	5

VITA

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