DISSERTATION

THE INFLUENCE OF SEXUAL ORIENTATION ON JUDGMENTS OF SUICIDAL BEHAVIOR AND SUICIDAL INDIVIDUALS

Submitted by

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WE HEREBY RECOMMEND THAT THE DISSERTATION PREPARED UNDER OUR SUPERVISION BY JENNIFER E. CATO ENTITLED THE INFLUENCE OF SEXUAL ORIENTATION ON JUDGMENTS OF SUICIDAL BEHAVIOR AND SUICIDAL INDIVIDUALS BE ACCEPTED AS FULFILLING IN PART THE REQUIREMENTS FOR THE DEGREE OF DOCTOR OF PHILOSOPHY.

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ABSTRACT OF DISSERTATION

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Sexual minority young persons are more likely to engage in nonfatal suicidal behavior than their heterosexual peers. A frequently cited precipitant of nonfatal suicidal behavior among sexual minority youth is the personal and interpersonal turmoil associated with coming to terms with one's sexual identity. This study explored sexual minority (N =104) and heterosexual (N =145) university students' reactions to a suicidal decision and suicidal peer who became suicidal in response to one of the following precipitants: coming to terms with one's sexual orientation, being rejected by one's parents following "coming out," a relationship loss, an achievement failure, and a physical illness.

Respondents evaluated the suicidal decision in terms of its valence and its activity/passivity. Consistent with past studies of attitudes about suicidal behavior, only physical illness was singled out as a relatively understandable precipitant for suicidal behavior. Sexual minority respondents viewed the suicidal decision less negatively than heterosexual respondents, independent of precipitant. Male respondents were more critical of the suicidal decision than were females, but not when past suicidal ideation and lifetime number of suicidal acts were controlled for. Persons who had recently engaged in suicidal behavior were less accepting of the suicidal decision.

Respondents also evaluated the suicidal individual with regard to character, emotional adjustment, femininity/masculinity, and perceived suicidal intent. Persons who engaged in suicidal behavior as a result of a physical illness were perceived as less maladjusted than persons who became suicidal in response to any other precipitant.

Sexual minorities rated the suicidal person as having more character and being more emotionally adjusted than did heterosexual respondents, independent of the precipitant of the suicidal behavior. Previous suicidal ideation enhanced this effect.

Overall, the attitudes revealed in this study suggest a greater acceptance, on the part of sexual minority individuals, of suicidal behavior as a way to cope with a range of adversities, as well as more positive evaluations of suicidal peers.

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TABLE OF CONTENTS

CHAPTER 1

INTRODUCTION

Sexual minority (lesbian, gay, bisexual, and those who are unsure/questioning of their sexual orientation (LGBQ)) young persons are more likely to engage in nonfatal suicidal behavior than heterosexual youth (Cochran, 2001; McDaniel, Purcell, & D'Augelli, 2001). Sexual minority youth have been found to have rates of nonfatal suicidal behavior that are at least two times higher than those of their heterosexual peers. It has been estimated that one in three sexual minority young persons has a history of suicidal behavior (D'Augelli, Hershberger, & Pilkington, 2001; Remafedi, Farrow, & Deisher, 1991; Safren & Heimberg, 1999). High rates of nonfatal suicidal behavior have been particularly well-documented among gay males (Bagley & Tremblay, 1997; Garofalo, Wolf, Wissow, Woods, & Goodman, 1999; Nicholas & Howard, 1998).

The experiences contributing to the high risk for nonfatal suicidal behavior among sexual minority individuals are complex. It appears that factors associated with risk for nonfatal suicidal behavior among young persons in general also predicts suicidal behavior among sexual minority individuals. For example, for all young persons, suicidal behavior is associated with interpersonal difficulties. Many of these stressors (e.g., conflict with parents), however, are intensified in the lives of sexual minority youth. A frequently cited precipitant of nonfatal suicidal behavior among sexual minority youth is the personal and interpersonal turmoil associated with one's sexual orientation identity (D'Augelli, Hershberger, &

Pilkington, 2001). Coming to terms with one's sexual orientation can be challenging. Research suggests that young people who begin the process of exploration of their sexual orientation may become depressed long before they "come out" to others, due to their internal struggle with accepting minority status (Friedman, 1999). At this vulnerable time, sexual minority youth are often rejected by key persons in their lives, such as family, teachers and friends. In a sample of young adults aged 14-21, 26% of the respondents reported paternal rejection, 10% experienced maternal rejection, and 15% had experienced sibling rejection (D'Augelli, Hershberger, & Pilkington, 1998). These experiences likely tax sexual minority youth's capacity for coping; and problems with depression and substance abuse may emerge.

At the same time, we know that suicidal behavior is not simply a function of adversities. In other words, suicidal behavior is not necessarily more common among individuals who experience adversities (Canetto & Lester, 1995). In fact, in some cases, suicidal behavior is particularly rare among persons who are most socially disadvantaged (e.g., African American women in the United States).

Studies suggest that the likelihood that someone would respond to adversity with suicidal behavior is influenced, among other things, by cultural factors, including social beliefs and norms about the meaning and permissibility of suicidal behavior. The social meanings of suicidal behavior are the social interpretations of the suicidal act. For example, in the United States, suicidal behavior tends to be viewed as a symptom of a mental disorder, while in Sri Lanka it is not (Marecek, 1998). Cultural norms of suicidal behavior can be inferred from the forms that suicidal behavior typically takes in different cultures. These norms or scripts define the protagonist, the scenario, and the method of

the suicidal act. For example, in one cultural group, suicide may typically involve the use of guns, as is the case among European Americans (Canetto & Sakinofsky, 1998), whereas in another group, guns may rarely be used in suicide, despite their accessibility, as is the case among the Inuit of Canada (Kral, 1998). These meanings and scripts of suicidal behavior are said to influence the social consequences of the suicidal act (e.g., whether the suicidal person is hospitalized or not). They also likely affect the choices people make when a suicidal act is considered (Canetto & Sakinofsky, 1998). As Rubinstein (1987) has argued, based on his research on suicidal adolescents in Micronesia, "individuals draw upon these cultural meanings in choosing their course of action and in giving this course of action some public legitimacy" (p. 145).

Past studies have revealed that situational (e.g., the precipitant of the suicidal act) and individual variables (e.g., the sex of the evaluator) affect reactions to the suicidal behavior and the suicidal individual. There is also evidence that the people evaluate the suicidal decision differently than the suicidal person. Thus, in the following section, studies on factors affecting attitudes toward the suicidal decision are reviewed. Following that, the findings of the research on factors influencing reactions toward the suicidal person will be described.

Evaluation of the Suicidal Decision

The precipitant of the suicidal act has been found to be an influential factor in attitudes toward the suicidal decision. The kinds of suicide precipitants that have been typically studied include illnesses, relationship problems, and achievement problems. A physical illness has been found to be the most acceptable reason for engaging in suicidal

behavior, both fatal and nonfatal (Cato & Canetto, 2003b; Dahlen & Canetto, 2002; Deluty, 1988-1989a, 1988-1989b; Droogas, Siiter, & O'Connell, 1982-1983; Hammond & Deluty, 1992; Ingram & Ellis, 1995; King, Hampton, Bernstein, & Schichor, 1996; Lester, Guerriero & Wachter, 1991; LoPresto, Sherman, & DiCarlo, 1994-1995).

Only one study so far has examined attitudes toward suicidal behavior in response to parental rejection following coming out as lesbian or gay. This study compared attitudes toward nonfatal suicidal behavior in response to parental rejection following coming out to attitudes to suicidal behavior in response to other well-studied precipitants (Cato & Canetto, 2003b). In this study, as in previous studies, only physical illness was singled out as a relatively powerful and sound reason for suicidal behavior. This study also found that evaluations of the activity/passivity of the suicidal decision depended on both the suicide precipitant and the sex of the suicidal person. Specifically, a woman's suicidal decision was rated as the most active when it was precipitated by "coming out," as compared to the same decision following a physical illness, a relationship loss, or an academic failure. A man's suicidal decision was rated as more active if it was in response to a physical illness, as compared to other precipitants (i.e., coming out, a relationship loss, and an academic failure).

Previous research examining whether reactions to nonfatal suicidal behavior differ depending on the sex of the suicidal person has yielded mixed findings. For example, one study showed that, compared to suicidal women, suicidal men received less sympathy for their suicidal behavior, especially from other men (White & Stillion, 1988). In another study, however, it was older adult suicidal women who received the least sympathy for their "suicide attempts." In this second study, suicidal behavior in men, regardless of age,

obtained intermediate amounts of sympathy (Stillion, White, Edwards, & McDowell, 1989). A limitation of the latter studies is that it was not clear whether the respondents were making judgments about the suicidal person or the suicidal decision. In contrast, two more recent studies found that suicidal behavior was evaluated negatively in both women and in men (Cato & Canetto, 2003b; Dahlen & Canetto, 2002).

Responses to suicidal behavior also vary across types of respondents. In general, males are more likely than females to agree with, and accept, the suicidal decision (Cato & Canetto, 2003b; Dahlen & Canetto, 2002; Deluty, 1988-1989b; Limbacher & Domino, 1985-1986). Males more than females tend to view the decision to suicide as an individual right (Eskin, 1995; Marks, 1988-1989; Sorjonen, 2002-2003; Wellman & Wellman, 1986).

Respondent gender-identity is another factor related to attitudes toward suicidal behavior. Dahlen and Canetto (2002) reported that androgynous persons were less accepting of the suicidal decision than were undifferentiated, conventionally masculine, or conventionally feminine persons. Similarly, Cato and Canetto (2003b) found an association between gender identity and perception of the suicidal decision. Specifically, androgynous persons were most likely to rate the suicidal decision as unsound, as compared to other gender identity groups.

Religiosity also plays a role in attitudes toward suicidal behavior. In particular, individuals who describe themselves as religious tend to have more critical attitudes toward suicidal behavior (fatal and nonfatal) than those who do not (Domino, Gibson, Poling, & Westlake, 1982; Domino, & Leenaars, 1989; Domino & Miller, 1992; King, Hampton, Bernstein, & Schichor, 1996; LoPresto, Sherman & DiCarlo, 1994-1995;

Minear & Brush, 1980-1981; Neeleman, Halpern, Leon, & Lewis, 1997; Stein, Witzum, & DeNour, 1989; Stein, Witzum, Brom, DeNour, & Elizur, 1992; Stillion McDowell, & Shamblin, 1984). For example, Stillion and colleagues (1984) found that, among high school and college students, those who described themselves as low in religiosity agreed more with all motivations for a nonfatal suicidal act than those who had higher religiosity self-ratings. Similarly, in a study by King and colleagues conducted in the United States (1996), college students who were not religiously affiliated were significantly more likely than religiously affiliated persons to accept suicide as a way of coping, both for themselves and others, particularly in the case of chronic or terminal illness and family difficulties. LoPresto, Sherman, and DiCarlo (1994-1995) reported that the higher the respondent's religiosity (defined by degree to which the respondent practiced religious teachings), the more unacceptable the suicidal decision was perceived to be. Finally, in a study investigating the effects of religiosity on views toward suicide, Stack and Wasserman (1992) identified particular denominational characteristics that further delineate views toward suicide. Using the General Social Survey, they obtained information about religious orientation and attitudes toward suicide. Specifically, they found that individuals associated with theologically conservative denominations (e.g. Protestant), non-ecumenical (i.e., those churches emphasizing their own domination over unity among denominations) denominations (e.g. Latter-Day Saints, Southern Baptist Convention, Church of God), or denominations with a significant amount of tension between their teachings and the secular culture (e.g., Church of God, Seventh Day Adventists, Pentecostal Holiness Church) were less accepting of suicide than other denominations.

Studies suggest that a personal history of suicidal ideation or behavior plays a role in attitudes toward, and beliefs about suicidal behavior (DeWilde, Kienhorst, Diekstra, & Wolters, 1993; Feifel & Schag, 1980; Ingram & Ellis, 1995; King, Hampton, Bernstein, & Schichor, 1996; Lester, Guerriero & Wachter, 1991; Limbacher & Domino, 1985-1986; Minear & Brush, 1981; Stein, Brom, Elizur, Witzum, 1998). For example, Ingram and Ellis (1995) found that suicide ideators perceived a suicidal action as more justified than non-ideators. Similarly, in a study by Stein, Brom, Elizur, and Witzum (1998), individuals with suicidal ideation showed more accepting attitudes toward suicide, such as the belief that society should not prevent suicide, that suicide is not a symptom of mental illness, or that suicide should be talked about openly. Consistent with these findings, Limbacher and Domino reported that persons with a history of nonfatal suicidal behavior perceived the suicidal act to be a serious attempt to die, while persons without that history viewed the suicidal behavior as manipulative. King and colleagues (1996) found that respondents with a history of suicidal behavior were significantly more likely to accept suicide for themselves in all situations, except job difficulties. DeWilde and colleagues (1993) found more accepting attitudes toward suicide among adolescents with a history of suicidal behavior and those who were depressed but not suicidal, as compared to non-depressed, non-suicidal controls.

Finally, some evidence suggests that a peer or family history of suicidal behavior is associated with more permissive attitudes toward suicidal behavior (Stein, Brom, Elizur, & Witzum, 1998). The study by Stein and colleagues found that previous exposure to suicide (as defined by knowing someone who had engaged in suicidal behavior or threatened to suicide) was associated with more accepting attitudes toward

suicidal behavior, including disagreeing that suicide is a shameful act. However, it is important to note that some studies did not find this association (Limbacher & Domino, 1985-1986; Marks & Riley, 1976; Norton, Durlak, & Richards, 1989). For example, in Limbacher and Domino's study, attitudes held by individuals who had been exposed to a death by suicide in their family or among friends and acquaintances did not differ from attitudes (as measured by the Suicide Opinion Questionnaire) held by those had not had that experience.

Evaluation of the Suicidal Individual

Past studies have revealed that situational factors affect judgments of suicidal persons. One of the most robust findings of this literature is that suicidal persons are perceived less negatively if their suicidal behavior (nonfatal as well as fatal) occurs in the context of a serious physical illness (Dahlen & Canetto, 1996; Ellis & Hirsch, 1995; Range & Martin, 1990). For example, in one study, individuals who engaged in suicidal behavior because of an incurable physical illness were judged as less passive, less cowardly, less poorly adjusted, and more masculine than those who became suicidal because of other reasons (Dahlen & Canetto, 1996). The same study also found that individuals who were suicidal following an illness were perceived as more serious about killing themselves than those who had become suicidal following other precipitants.

So far, only one study (Cato & Canetto, 2003a) has explored attitudes toward persons who became suicidal following a uniquely sexual-minority stressor—that is, being rejected by one's parents following coming out as a sexual minority. In this study, attitudes about a peer who became suicidal after being rejected by one's parents were

compared to attitudes about peers who became suicidal in response to other well-studied stressors (e.g., a physical illness). Individuals who became suicidal because of an incurable illness were the only ones to be perceived as relatively less emotionally maladjusted, as compared to individuals who engaged in the same behavior as a result of other precipitants.

The evidence on whether suicidal women and men are evaluated differently is mixed. Most studies do not report an effect for target sex (Ansel & McGee, 1971; Cato & Canetto, 2003a; Dahlen &Canetto, 1996; VanWinkle, Calhoun, Cann, & Tedeschi, 1998). The one study that did find a target-sex effect noted that young suicidal women tended to receive more sympathy than older suicidal women or suicidal men of any age (Stillion, White, Edwards, & McDowell, 1989). However, in this study, it was not clear whether the respondents were making judgments about the suicidal person or the suicidal decision.

Respondents' characteristics also affect judgments of suicidal persons. Research suggests that young males are more critical of suicidal individuals than are young females (Cato & Canetto, 2003a; Dahlen & Canetto, 1996; Eskin, 1992; Norton, Durlak, & Richards, 1989; Stein, Witztum, Brom, DeNour, &Elizur, 1992; Stillion, McDowell, & Shamblin, 1984). For example, in the study by Cato and Canetto (2003a), males perceived the suicidal person more negatively in terms of character than females. It has also been reported that young males express less concern for the suicidal person than young females (Kalafat, Elias, & Gara, 1993). In addition, in one study, males were particularly negative toward suicidal males, as compared to their attitudes toward non-suicidal troubled males (White & Stillion, 1988). In yet another study, young males were

more opposed to seeking adult help for a suicidal peer than young females (Kalafat & Elias, 1992).

Finally, studies indicate that the respondent's gender identity affects evaluations of the suicidal individual (Cato & Canetto, 2003a; Dahlen & Canetto, 1996). For example, in one study, androgynous persons were more likely than gender-undifferentiated persons to view the suicidal person as emotionally maladjusted (Dahlen & Canetto, 1996). In another study (Cato & Canetto, 2003a), androgynous and conventionally feminine persons evaluated the suicidal person's character less negatively than did conventionally masculine respondents. Androgynous and conventionally feminine persons also interpreted the suicidal person as having more serious suicide intent than did conventionally masculine and gender-undifferentiated respondents.

Attitudes toward suicidal peers are also influenced by religiosity. Stein, Witztum, Brom, DeNour, and Elizur (1992) compared attitudes toward suicide based on religiosity. In a study of Jewish Israeli men and women, they found that respondents who were religious but did not practice held more accepting views toward suicidal persons than did practicing religious respondents. In a study using undergraduate students, Marion and Range (2003) also found a negative relationship between religiosity and acceptability of a suicidal person. The acceptability of the person was evaluated using the Suicide Opinion Questionnaire (SOQ).

There are contrasting theories and findings on whether persons with a history of suicidal thoughts or behavior may be more accepting of other suicidal individuals than those who do not have that history. One theory is that persons who have a history of suicidal thoughts or behavior may be especially accepting of other suicidal individuals

because they have experience with the same situation. In a study evaluating attitudes toward a suicidal peer, Stein, Witztum, Brom, DeNour, and Elizur (1992) found that adolescents exposed to suicide (those who reported being "familiar with people who have committed suicide or attempted suicide or threatened to kill themselves," p. 956) held more accepting attitudes toward a suicidal peer than those who had not been exposed to suicide. In another study examining reactions toward suicide, Norton, Durlak, and Richards (1989) found that respondents who had known someone who had died by suicide were more likely to be knowledgeable about suicide. However, they did not hold more or less accepting views toward suicidal peers. Finally, Stein and colleagues (1998) found that persons with previous exposure to suicide were more willing to befriend a suicidal peer than were persons without exposure to suicide.

Another theory would posit that persons with a history of suicidal thoughts or behavior may be less accepting of other suicidal persons because of affective and cognitive style problems that may increase their self-absorption (Doron, Stein, Levine, Abramovitch, Eilat, & Neuman, 1998; Hughes & Neimeyer, 1993; Knott & Range, 2001; Rohde, Seeley, & Mace, 1997). It has also been argued that if the suicidal ideation and behavior is recent, individuals may be negative toward other suicidal persons because of their lingering depression (Rohde, Seeley, & Mace, 1997) and limited coping skills (Hughes & Neimeyer, 1993). Alternatively, persons with a history of suicidality may be "emotionally numb" to suicide. Doron and colleagues (1998) found that respondents with a history of suicidal behavior were less physiologically anxious (i.e., lower heart rate, respiration rate) in response to a film about suicide than were respondents with no suicidal history or a history of only suicidal ideation. In a study using adults from a

community mental health center, Knott and Range (2001) noted a linear relationship between history of suicidal behavior and attitudes toward suicidal persons. Specifically, they found that persons with no suicidal history were more accepting of suicidal persons than were moderately or severely suicidal persons.

A study offering a glimpse on the attitudes and beliefs of sexual minority youths about suicidal peers was conducted a few years ago by Russell, Bohan, and Lilly, (2000). These researchers interviewed more than 60 sexual minority high school students in Salt Lake City, Utah, following a controversial decision by the Salt Lake City School Board and the state legislature to ban all ex-curricular clubs rather than allow the establishment of a Gay/Straight Alliance Club. The interviews dealt broadly with the experience of sexual minority youths in Salt Lake City during this time of crisis. One unexpected finding was that many of the respondents reported being suicidal or having suicidal peers. Suicidal behavior was described by these sexual minority youth as inevitable, almost as a rite of passage. Many respondents referred "with casual familiarity" to their own past suicidal behavior, "as well as to late-night conversations with suicidal friends" (p. 80). Talk about suicide was described as ordinary and "mundane" (p. 81). One of the interviewees was quoted as saying: "We all wear our stripes on our sleeves and on our wrists, so to speak" (p. 80). In fact, the authors of the study concluded that "some youth may actually feel inadequate as queers if they have not attempted suicide" (p. 80).

The Utah study provided a much needed first glance into suicidal behavior experiences among sexual minority youths. Its limitation is that the data were collected at a time of community turmoil. Apparently, the founding of the Gay/Straight Alliance club's and the School Board's decision "ignited a media storm that reached international

proportions" (Russell et al., 2000, p. 70). The cultural location of the study also raises questions about generalizability of the study's findings. Furthermore, the Utah study did not actually focus on attitudes and beliefs about suicidal behavior in sexual minority youths; it was designed as a qualitative research project exploring LGB adolescents' lives. Finally, the Utah study focused on sexual minority individuals only. A full assessment of attitudes about suicidality following sexual minority-specific precipitants would require surveying both sexual minority and heterosexual respondents.

Limitations of Previous Studies

Research on attitudes toward suicidality among adolescents and young adults has been ongoing for several decades. However, this research has limited itself to implicitly or explicitly heterosexual questions and to heterosexual respondents, despite the growing evidence on a uniquely high risk for suicidal behavior for LGBQ young persons.

This literature review found only one study dealing with attitudes and reactions to LGB suicidal behavior (Cato & Canetto, 2003b), and one study exploring attitudes toward LGB suicidal individuals (Cato & Canetto, 2003a). These two studies represent an important first step in documenting beliefs and attitudes about suicidal behavior and about the suicidal individual following a LGB-specific stressor (i.e., coming out). A limitation of the above-mentioned studies, however, is that they surveyed primarily heterosexual (97%) respondents. Undoubtedly, heterosexual youths' attitudes about sexual minorities' suicidal behavior are important because heterosexual youths, as a majority, are likely to influence the values and beliefs of sexual minority youths. At the same time, one needs to examine sexual minority individuals' own attitudes about sexual

minorities' suicidal behavior. Another limitation of these two studies is that they focused on one sexual-minority specific situation, being rejected by one's parents after revealing to them one's sexual minority identity. Research suggests that another potential precipitant of suicidal behavior for sexual minority youth is personally coming to terms with one's sexual minority identity (Bagley & Tremblay, 1997; Hershberger, Pilkington, & D'Augelli, 1997). This is a potential precipitant that has yet to be examined in studies of attitudes toward suicidal behavior.

This Study: Its Background and its Unique Contributions

The Surgeon General recently issued a Call to Action and Prevent Suicide that encouraged researchers to study populations that are both are high risk and understudied, such as LGBQs (U.S. Public Health Service, 1999). In response to that call, this study explores the influence of sexual orientation on attitudes toward suicidal behavior and persons.

This study is a replication and extension of Cato and Canetto's (2003a; 2003b) studies of situational and individual factors influencing university students' attitudes about nonfatal suicidality. Consistent with Cato and Canetto's previous studies, this study examines attitudes toward both the suicidal decision and the suicidal person. Also, as in Cato and Canetto's previous studies, this study considers the role of events that are known risk factors for suicidal behavior among college students (i.e., a physical illness, an academic failure, a relationship loss, and being rejected after coming out to one's parents), the sex of the suicidal person, the respondent's sex, and the respondent's gender identity may play in evaluations of the suicidal decision and the suicidal individual.

Building upon Cato and Canetto's previous studies, both LGBQ and heterosexual respondents were interviewed in this study. Extending upon Cato and Canetto's studies, this study also expanded the sexual minority focus by adding one vignette dealing with the personal turmoil associated with "exiting the heterosexual identity" (D'Augelli, 1998, p. 192). One new feature of this study, as compared to Cato & Canetto (2003a; 2003b) is that it recorded respondents' religious background, current religious affiliation, and attendance at religious functions. The factor of religiosity was added in consultation with the literature, which has suggested a significant relationship between religiosity and attitudes toward suicide (LoPresto, Sherman & DiCarlo, 1994-1995; Stein, Witzum, Brom, DeNour, & Elizur, 1992; Stillion, McDowell, & Shamblin, 1984). Another improvement of this study is that it measured the respondent's history of suicidal ideation and behavior, as this history may correlate with attitudes toward suicidality. Finally, this study includes the important element of the participants' peer and family history of suicidal behavior, since this history may also be associated with attitudes about suicidality (Limbacher & Domino, 1985-86; Norton, Durlak, & Richards, 1989; Stein, Brom, Elizur, & Witztum, 1998).

Hypotheses

The hypotheses of this study were guided by the findings of previous research. One set of hypotheses relates to attitudes toward the suicidal decision. Based on past findings (Cato & Canetto, 2003b; Dahlen & Canetto, 2002; Deluty, 1988-89; Ingram & Ellis, 1995; Lester, Guerriero, & Wachter, 1991), it was expected that respondents would be relatively more accepting of a suicidal decision following a physical illness as

compared to suicidal decisions following other precipitants. It was also hypothesized that this main effect would be qualified by an interaction between suicide precipitant and respondent's sexual orientation. Specifically, based on the observations by Russell and colleagues (2001) that many LGB youth "accepted (suicide) as a fact of their everyday existence" (p. 80), it was expected that sexual minority respondents may rate the suicidal decision in the "exiting heterosexuality" and in the "coming out" situations less negatively than the same decision in other situations, as compared to heterosexual respondents, who, it was thought, may judge the suicidal decision less negatively only in the physical illness condition. Furthermore, based on the findings by Cato and Canetto (2003b) and those by Dahlen and Canetto (2002), it was expected that male respondents would view the suicidal decision less negatively than female respondents. In addition, it was hypothesized that androgynous persons would be most critical of the decision to engage in suicidal behavior, as compared to other gender-identity groups. Additional hypotheses were considered with regard to the role of respondents' religiosity, personal history of suicidality, and family history of suicidality. First, it was expected that there would be a negative association between type of religious affiliation (e.g., describing oneself as Catholic) and religiosity (e.g., measured as religious attendance) and acceptance of suicidal behavior, consistent with similar findings in the literature (Domino, Gibson, Poling, & Westlake, 1982; Domino, & Leenaars, 1989; Domino & Miller, 1992; King, Hampton, Bernstein, & Schichor, 1996; LoPresto, Sherman & DiCarlo, 1994-1995; Minear & Brush, 1980-1981; Neeleman, Halpern, Leon, & Lewis, 1997; Stein, Witzum, & DeNour, 1989; Stein, Witzum, Brom, DeNour, & Elizur, 1992; Stillion, McDowell, & Shamblin, 1984). Second, it was theorized that respondents with a

history of suicidal ideation or behavior would be more accepting of suicidal behavior than those without a history of suicidal ideation (DeWilde, Kienhorst, Diekstra, & Wolters, 1993; Feifel & Schag, 1980; Ingram & Ellis, 1995; King, et al, 1996; Lester, Guerriero & Wachter, 1991; Limbacher & Domino, 1985-1986; Minear & Brush, 1981; Stein, Brom, Elizur, Witzum, 1998). Finally, it was expected that attitudes toward the suicidal behavior would be affected by respondents' knowledge of a suicidal family member or peer (Houston, 1990; Limbacher & Domino, 1985-198 LoPresto, Sherman, & DiCarlo, 1994-1995; Marks & Riley, 1976; Norton, Durlak, & Richards, 1989; Stein, Witztum, Brom, DeNour, & Elizur, 1992).

There were also hypotheses about attitudes toward the suicidal person. Based on past findings (Cato & Canetto, 2003a; Dahlen & Canetto, 2002; Deluty, 1988-1989a, 1988-1989b; Droogas, Siiter, & O'Connell, 1982-1983; Hammond & Deluty, 1992; Ingram & Ellis, 1995; King, Hampton, Bernstein, & Schichor, 1996; Lester, Guerriero & Wachter, 1991; LoPresto, Sherman, & DiCarlo, 1994-1995), it was expected that respondents would perceive individuals who became suicidal after a serious physical illness less negatively than those engaged in suicidal behavior following an achievement failure, a relationship loss, rejection after "coming out" to one's parents, or the crisis of realizing one is a sexual orientation minority. It was also expected that this main effect would be qualified by an interaction between suicide precipitant and the respondent sexual orientation. Specifically, based on Russell, Bohan, and Lilly (2000) it was expected that LGBQ respondents would be most understanding of sexual minority suicidal individuals (i.e., in the sexual orientation self awareness crisis and in the "coming out" to one's parents situations), while heterosexual respondents were expected

to be most understanding of individuals who were suicidal in physical illness situation only. Additionally, based on Cato and Canetto (2003a), it was expected that female respondents would be less critical of the suicidal person but more likely to view that person as emotionally maladjusted. Consistent with previous findings (i.e., Cato & Canetto, 2003a; Dahlen & Canetto, 2002), a main effect for gender identity was expected. Specifically, it was expected that androgynous respondents (as compared to other gender-identity groups) would be less critical of the suicidal person, but more likely to consider the suicidal person as serious in their suicidal intent.

There were also hypotheses about attitudes toward the suicidal persons based on respondent religiosity, personal history of suicidal behavior, and a friend or family member's history of suicidal behavior. First, it was expected that there would be a negative relationship between religiosity and character of the suicidal person (King et al., 1996; Stein, Witztum, Brom, DeNour, & Elizur, 1992). Second, it was expected that there would be a relationship between a personal history suicidal ideation and behavior and attitudes toward suicide. Research in this area is mixed, so the direction of the hypothesis was unknown. On one hand, some evidence would lead to the prediction that respondents with a personal history of suicidal behavior or ideation would view the suicidal person as more emotionally adjusted (Stein, Brom, Elizur, & Witztum, 1998) and more serious in their intent (Limbacher & Domino, 1985-86) than would respondents who did not report a history of suicidal behavior or ideation. On the other hand, one study found that persons with a history of suicidal behavior are not more accepting of a suicidal person (Norton, Durlak, & Richards, 1989). Finally, it was expected that there would be a relationship between attitudes toward the suicidal person and experience with suicidal behavior in

one's family member or friend circle (Knott & Range, 2001; Norton, Durlak, & Richards, 1989; Stein, Witztum, Brom, DeNour, and Elizur, 1992), though the direction of the relationship is unknown, given the mixed reports in the literature.

CHAPTER II

METHOD

Stimulus Materials

The Suicide Attitude Vignette Experience (SAVE) (Stillion, McDowell, & Shamblin, 1984) form A, as modified by Dahlen and Canetto (2002), was used as the stimulus material. These vignettes describe a young person engaging in nonfatal suicidal behavior following events likely to be challenging for young individuals: an incurable physical illness, the loss of a significant intimate relationship, and a major academic failure. The vignette about coming out to, and being rejected by one's parents and developed by Cato & Canetto (2003a) was also used. Finally, a vignette about exiting the heterosexual identity was developed to capture the personal turmoil associated with the personal realization of being lesbian, gay or bisexual. The latter vignette, which is similar in wording and length to the other four vignettes, was created in consultation with the LGBQ literature (D'Augelli, 1998; D'Augelli, Hershberger, & Pilkington, 1998; Rotheram-Borus & Fernandez, 1995), and with a local expert in LGBQ concerns (J. Bigner, personal communication, March 2002).

In sum, the vignettes varied on two dimensions: the sex of the suicidal person (two levels) and the precipitant of the suicidal act (five levels), for a total of ten vignettes. The five precipitants were as follows: (1) exiting heterosexual identity; (2) being rejected by one's parents upon informing them about one's sexual minority orientation; (3) an

incurable but nonfatal physical illness; (4) the loss of an important intimate relationship; and (5) a significant academic failure. The vignettes can be found in Appendix A.

Measures

Evaluation of the Suicidal Behavior. Respondents were asked to describe their reactions to the suicidal decision using seven-point semantic differential scales developed and validated by Deluty (1988-1989a, 1988-1989b), as adapted by Dahlen and Canetto (2002). These scales focused on the following dimensions: "wise-foolish," "right-wrong," "selfish-unselfish," "weak-strong," "brave-cowardly," and "active-passive." To reduce response set influences, the location of the positive adjectives were varied (e.g. "wise-foolish," "selfish-unselfish"). In addition, respondents were asked to indicate, on seven-point Likert scales, their perception of the permissibility of the suicidal decision as well as their agreement with the suicidal decision. Finally, Stillion and colleagues' (1989) scale to measure degree of sympathy for the suicidal decision was included. The 5-point scale was expanded to 7 points and formatted to fit with Deluty's scales. The measures can be found in Appendix B.

Evaluations of Suicidal Peers. Respondents were asked to describe their reactions to the suicidal peer described in the vignette using six 7-point semantic differential scales developed and validated by Deluty (1988-1989a, 1988-1989b), as adapted by Dahlen and Canetto (1996). These scales focused on the following dimensions: "wise-foolish," "right-wrong," "selfish-unselfish," "weak-strong," "brave-cowardly," and "active-passive." Once again, to reduce response set influences, the location of the positive adjectives was varied (e.g., "wise-foolish," "selfish-unselfish"). In addition, respondents were asked to

indicate their perception of the suicidal person's emotional adjustment, based on a scale developed by Lewis and Shepard's (1992), as modified by Dahlen and Canetto (1996). Finally, participants were asked to assess the seriousness of the suicidal person's intent as well as rate the suicidal person on a femininity/masculinity (F/M) scale. The latter two seven-point scales were used in a previous study of attitudes toward suicidal persons (Dahlen & Canetto, 1996). The F/M measure is based on a scale developed by Linehan (1973). The measures can be found in Appendix B.

Gender Identity. Gender identity was measured using the short form of the Personal Attributes Questionnaire (PAQ) (Spence & Helmreich, 1978). The PAQ uses 5-point semantic differential-type items to assess agreement with bipolar personal attributes (See Appendix C for a copy). It is composed of two eight-item sub-scales labeled Femininity (F) and Masculinity (M). The F subscale contains items perceived as desirable for both sexes but more common among women (e.g., kindness and understanding). The M subscale includes items judged to be socially desirable for both women and men but more common in men (e.g., confidence and independence) (Cook, 1985; Helmreich, Spence, & Wilhelm, 1981; Spence & Helmreich, 1978). The PAQ classifies respondents into one of four categories: feminine, masculine, androgynous, or undifferentiated. Persons classified as feminine score high on the F subscale and low on the M subscale, while those identified as masculine score high on the M subscale and low on the F subscale. Androgynous persons score above the median on both the F and M subscales. Finally, persons classified as undifferentiated score below the median on both subscales. The psychometric properties of the PAQ have been particularly well-tested in young

adult college samples (Beere, 1990). The PAQ's internal consistency for college students has been reported to be between .61 and .76 (Helmreich et al., 1981).

Demographic Questionnaire. Respondents were asked to complete a short demographic questionnaire. The information asked included: age, year at the university, sex, sexual orientation, relationship status (e.g., single/attached), ethnicity, past religious background, current religious beliefs, current religious attendance and frequency, and personal and family history of suicidal ideation and behaviors. The demographic questionnaire can be found in Appendix D.

Two questions were used to assess the participant's sexual orientation. First, the participants were asked to select which word best described them: bisexual, gay, heterosexual, lesbian, transgender, or unsure. This question was based on a similar question used by Garofalo and colleagues (1999) to determine sexual orientation identity. Second, the participants were asked to describe their sexual attractions and fantasies as well as their sexual behavior by rating themselves along Kinsey's two 7-point scales, ranging from "exclusively homosexual" (Kinsey 6) to "exclusively heterosexual" (Kinsey 0) (Kinsey, Pomeroy, & Martin, 1948). Kinsey's scale was included based on recommendations by Savin-Williams (2001), who has argued that Kinsey's measures provide a more sensitive measure of sexual orientation because they include people who engage in same-sex fantasies or behaviors but may be hesitant to identify as lesbian, gay, or bisexual. The intent was to use Kinsey's measures as a manipulation check, as in Safren and Heimberg (1999).

As noted above, respondents were asked about their history of suicidal behavior. We asked seven questions about past suicidal behavior. The seven questions were based

on a review of the literature and included questions asked in previous studies (D'Augelli, Hershberger, & Pilkington, 2001; Garofalo, et al., 1999; Safren & Heimberg, 1999). The first question asked about exposure to suicidal behavior via a friend or family member. This question was based on similar questions used by Russell and Joyner (2001), who inquired about whether either a family member or friend had tried to kill themselves in the past year. The next two questions inquired about suicidal ideation, either in the last year or at any point during their life. These questions represent a slight modification of questions (to make more applicable to the present study) about suicidal ideation used in a study by D'Augelli, Hershberger, and Pilkington (2001). The modification was completed by the author, along with four research experts (C. Asmus, J. Bigner, S. Canetto, W. Viney, personal communication, March 2002). The fourth and fifth questions asked if the respondent had engaged in suicidal behavior (either in the past year or at other times in life, excluding the past year) as was done in studies by Garofalo and colleagues (1999) and Safren and Heimberg (1999). Finally, respondents were asked about the total number of suicidal acts over the lifetime and if any of these suicidal acts required medical attention (i.e., all did, some did, or none did). These last three questions represents a modification of questions used by D'Augelli and colleagues (2001) According to these researchers, asking about medical care following suicidal behavior is important because it is a way to assess how life-threatening the suicidal act was, especially considering the possibility that young adult respondents may overestimate the life-threatening potential of their suicidal acts.

Procedure

Data were collected from five universities in the Rocky Mountain region of the United States. Respondents were undergraduate psychology students earning class research credit as well as persons recruited from the Gay, Lesbian, Bisexual, and Transgendered (GLBT) Student Services Offices and functions at the various universities.

The respondents who participated in the research as part of class credit filled out the questionnaire in a large classroom to ensure confidentiality. Participants were given a packet containing: an informed consent form, one of the ten possible vignettes, a rating scale for the vignette, a copy of the Personal Attributes Questionnaire (Spence & Helmreich, 1978), and a demographic questionnaire. Respondents were told to complete the information in the packet as honestly as possible and to return the packet to the front of the room when finished. Upon completion, each respondent received a debriefing form.

In an effort to collect data from as many LGBQ individuals as possible, the researchers, in collaboration with the Colorado State University GLBT Student Services Director, contacted GLBT Student Service Directors at other universities in the region. As a result of that effort, data were collected from students associated with the GLBT Student Services Office on four other university campuses. Many GLBT offices hold weekly meetings, guest lectures, and/or special events on campus. These meetings are voluntary and are open to anyone who would like to participate. On a pre-established date, students were alerted through their voluntary list serve email that the researchers would be present at the meeting or event to recruit participants. Participants picked up a

packet from the researcher upon leaving the meeting /event. They were told they could complete the packet when and where they choose to do so. The participant was informed that completing the packet would take approximately 15 to 20 minutes. The packets contained the four-page stapled questionnaire with one of the ten possible vignettes, a rating scale for the vignette, a copy of the Personal Attributes Questionnaire (Spence & Helmreich, 1978), and a demographic questionnaire. Additionally, the packet contained a debriefing statement. Paper-clipped to the outside of the envelope were the instructions for completing the packet and two copies of the informed consent (one for them to keep and one to return to the researchers). Also clipped to the outside of the packet was an entry form that participants could complete to potentially win one prize of $100 or one of two $50 prizes. The participant was asked to complete the questionnaire as honestly as possible before reading the debriefing form, then take the debriefing statement envelope and read it, seal the envelope, and drop it in the mailbox. The envelope had one of the researchers' name and address, and included sufficient postage to be mailed. All questionnaires, whether completed or not, were mailed back to the researcher via the United States Postal System. After all packets were returned, two winners were randomly selected (by a colleague unaffiliated with the study) to win the prize and were mailed their money.

Participants

Two hundred forty-nine university students participated in this study. One hundred and sixteen (46%) of the respondents were female, 129 (52%) were male and 4 (2%) did not disclose their sex.

As noted above, sexual orientation was assessed through questions about identity (bisexual, gay, heterosexual, lesbian, transgendered, other/unsure), fantasies (from exclusively homosexual to exclusively heterosexual) and behavior (from exclusively homosexual to exclusively heterosexual). There were only 4 discrepancies (out of 249) between declared sexual orientation and sexual behavior and/or fantasies. Specifically, on the Likert-type scale measuring sexual behaviors, 137 out of the 145 respondents who had described themselves as heterosexual rated their sexual behaviors as a "1.0," indicating that their behavior was "exclusively heterosexual." Of those 8 persons who categorized themselves as heterosexual while reporting other than exclusively heterosexual contact, all of them rated their sexual behaviors as a "2.0," which is described as "almost exclusively heterosexual" sexual behavior. Similar trends were noted with regard to the relationship between self-reported sexual orientation and sexual fantasies. On the sexual fantasies rating scale, 113 persons who described themselves as heterosexual also rated their fantasies as being "exclusively heterosexual" (1.0). Twenty-eight persons described their fantasies at the "2.0" level, which is considered to be "almost exclusively heterosexual." Four respondents who had classified themselves as heterosexual reported having sexual fantasies at the "3.0" level. No respondent who had rated themselves as heterosexual reported having sexual fantasies at or above the "3.5" level ("half heterosexual, half non-heterosexual). Therefore, it was decided to use the participant's sexual identity as the criteria for inclusion in the sexual minority or heterosexual category. This follows the example of Garofalo and colleagues (1999), who argued that declared sexual orientation is a more genuine measure of sexual orientation than sexual behavior or fantasies.

Using the sexual identity responses, one hundred and four respondents (42%) were classified as LGBQ: 15% gay males, 12% lesbians, 9% bisexual, 4% transgendered and 2% other/unsure. The remaining 145 respondents (58%) were classified as heterosexual. In the LGBQ group, 59 (57%) respondents described themselves as female, 41 (39%) as male, and 4 (4%) chose not to disclose their sex. In the heterosexual group, 70 (48%) were female, and 75 (52%) were male.

The respondents' age varied from 17 years to 59 years, with a mean age of 23 years (SD = 8.3 years). The LGBQ respondents tended to be older (M = 25.7 years) than the heterosexual respondents (M = 21.3 years), F (1, 247) = 37.85, $p < .001$. In the LGBQ sample, 82 (79%) respondents were 30 years or younger, 9 (9%) were between 31 and 40, and 13 (12%) were 40 or older. In the heterosexual sample, 138 (95%) were 30 years or younger, 2 (2%) were between 31 and 40, and 5 (3%) were 40 or older. About half (53%) of the participants were single and unattached and about one fourth (27%) were single and attached. In terms of year at the university, 85% of respondents reported being in 1st through 4th years of college, 7% in "5th year and beyond," and 8% did not answer the question.

Most of the respondents described themselves as European Americans (81%). Six percent classified themselves as Hispanic, 3% as Asian American, 3% as American Indian/Native American, 3% as "other", and 2% as African American. Respondent religious background (i.e., religious background within which the respondent was raised, based on the religious affiliation of parents and parental family members) varied, with more than half reporting Roman Catholic (31%) or Protestant (24%). Twenty percent reported their religious background as "other," 15% reported it as "none," and 6%

described it as Jewish. A majority of the respondents described their current religious beliefs as "other" (37%) or "none" (27%). The rest reported Roman Catholic (16%), Protestant (13%), or Jewish (3%) current religious beliefs. Most respondents (71%) reported that they did not attend religious services regularly. Twenty-seven percent of respondents said that they never attended religious services, 11% said they attended once a year, 25% said they attended 2 to5 times a year, 15% said they attended once a month, and 16% said they attended once a week. Heterosexual respondents were more likely than LGBQ respondents to report that they attended religious services regularly (32% heterosexual, 19% LGBQ), χ^2 (1, 239) = 4.87, p = .03.

About half of all respondents reported a history of suicidal ideation or suicidal behavior. One hundred and two participants (41%) reported having considered suicide in the past, excluding the last year, while 51 (21%) reported that they had engaged in suicidal behavior at some point during their life, excluding the past year. Fewer respondents reported having considered (15%) or engaged in suicidal behavior (6%) in the past year. LGBQ respondents were more likely to have considered suicide in the past year (26%) than heterosexual respondents (9%), χ^2 (1, 232) = 12.14, $p < .01$. Similarly, LGBQ respondents (63%) were more likely to have a history of suicidal ideation, excluding the past year, than heterosexual respondents (32%), χ^2 (1, 231) = 20.80, $p <$ .01. There was no difference between the groups on recent (within last year) suicidal behavior, but there was a significant difference in past suicidal behavior, excluding past year (χ^2 (1, 232) = 26.97, $p < .01$). Forty percent of sexual minority respondents reported a history of suicidal behavior (excluding past year), while only 11% of heterosexual respondents reported the same history. Heterosexual respondents (68%) were more likely

to have never engaged in suicidal behavior than LGBQ (63%) respondents, χ^2 (1, 221) = 20.94, $p < .01$. Twenty-one of all respondents reported that their suicidal act required medical attention; the likelihood of requiring medical attention did not differ based on sexual orientation, χ^2 (1, 132) = 2.01, ns.

More than half of all respondents (57%) reported having a friend or peer who had engaged in suicidal behavior. For about one third (30%) of the respondents, the person with a history of suicidal behavior was a family member. LGBQ respondents (72%) were more likely to have had a friend with a history of suicidal behavior than were heterosexual respondents (56%), χ^2 (1, 226) = 5.67, $p = .02$. Similarly, a greater proportion of LGB respondents had been exposed to suicidal behavior in their family (41%) as compared to heterosexual respondents (28%), χ^2 (1, 219) = 3.84, $p = .05$.

Design

A 5 (suicide precipitant: physical illness, parental rejection following "coming out," achievement failure, recent awareness of sexual orientation, and relationship loss) X 2 (target sex) X 2 (respondent sex) X 2 (respondent sexual orientation) X 4 (respondent gender identity: feminine, masculine, androgynous and undifferentiated) factorial design was utilized to examine all outcome variables. Second, the relationship between key demographic variables (e.g., religious attendance) as well as variables measuring personal and peer/family history of suicidal ideation and behavior to attitudes toward the suicidal decision and the suicidal person was examined. Finally, analyses of co-variance were conducted to adjust for the possible influence of selected suicidal history variables on the outcome variables. An alpha level of .05 was set for all statistical tests.

CHAPTER III

RESULTS

Evaluation of the Decision to Engage in Suicidal Behavior

A factor analysis was conducted on the 9 scales evaluating the decision to engage in suicidal behavior to reduce their number into a smaller set of conceptually and empirically sound composite variables. The items were submitted to a principal factor extraction and then a varimax rotation with Kaiser normalization. Based upon the criterion of using factor loadings of .50 or greater to retain a variable in the factor and discarding those variables that cross-loaded on more than one factor, one factor was obtained (with one item "active-passive" not loading onto that factor) with an eigenvalue of 4.08. This factor, which we called "Valence of the Suicidal Decision," accounted for 45.28% of the variance. The factor loadings of scales evaluating the decision to engage in suicidal behavior are presented in Table 1. Because of their high internal consistency (Cronbach's $\alpha = .84$), the scores on the scales in the "Valence of the Suicidal Decision" factor were averaged to form a composite variable. The "Active-Passive" item did not load onto the factor so it was treated as a separate variable because of its potentially important and unique content.

A five-factor multivariate analysis of variance (suicide precipitant X sex of the suicidal person X respondent sex X respondent gender identity X respondent sexual orientation) was computed for the two dependent variables assessing the suicidal decision

(i.e., valence of the suicidal decision and activity/passivity of the suicidal decision). Evaluations of the valence of the suicidal decision were found to vary depending on the precipitant of the suicidal act, target sex, respondent sex, and respondent sexual orientation (See Figures 2-6). Respondent gender identity was not related to perceptions of the valence of the suicidal decision. Perceptions of the activity/passivity of the suicidal decision were not influenced by the precipitant of the suicidal behavior, target sex, respondent sex, respondent gender identity, or respondent sexual orientation. There were no significant interactions between any of the variables.

Precipitant of the Suicidal Behavior. Perceptions of the valence of the suicidal decision were influenced by the precipitant of the suicidal act, F (4, 243) = 7.55, $p < .001$, $\eta^2 = .11$. Duncan-Range post-hoc tests indicated that the decision to engage in suicidal behavior following a physical illness was viewed less negatively ($M = 4.38$, $SD = 1.06$) than the same decision following the loss of a significant relationship ($M = 5.43$, $SD = 1.06$), coming to terms with one's sexual minority orientation ($M = 5.40$, $SD = 1.96$), an achievement failure ($M = 5.12$, $SD = 1.06$), or being rejected after "coming out" to one's parents ($M = 5.10$, $SD = 1.04$). Respondents did not perceive the suicidal decision to be more or less passive depending on the precipitant of the suicidal behavior (F (4, 238) = 0.88, $p = .48$).

Target Sex. Evaluation of the valence of the suicidal decision varied depending on the sex of the suicidal person, F (1, 246) = 6.60, $p = .01$, $\eta^2 = .03$. Specifically, the suicidal decision was evaluated less negatively when it involved a male ($M = 4.91$, $SD = 1.10$) as

compared to a female in crisis ($M = 5.27$, $SD = 1.10$). However, the evaluation of the activity of the decision was not influenced by the sex of the suicidal person (F (1, 241) = .17, $p = .68$).

Respondent Sex. Male respondents judged the suicidal decision more negatively ($M = 5.25$, $SD = 1.10$) than did female respondents ($M = 4.95$, $SD = 1.11$), F (1, 242) = 4.73, $p = .03$, $\eta^2 = .02$). Females ($M = 4.08$, $SD = 1.92$) and males ($M = 4.05$, $SD = 1.92$) perceived the decision to be average in terms of activity/passivity, F (1, 237) = .01, $p = .91$).

Respondent Gender Identity. Participants were classified into the four gender-identity groups (i.e., feminine, masculine, androgynous, and undifferentiated) using the median split method described by Spence and Helmreich (1978). The medians obtained in the present study were 23 for the Femininity Scale and 21 for the Masculinity Scale. Based on these medians, 34 participants (13.7%) were classified as undifferentiated, 54 (21.7%) as feminine, 54 (21.7%) as masculine, and 107 (43%) as androgynous. These proportions are similar to those reported in recent studies of gender identity and attitudes toward suicidal behavior (Cato & Canetto, 2003b, Dahlen & Canetto, 2002), though there were more androgynous and fewer undifferentiated persons in the present study. Respondent gender identity was not significantly related to perceptions of the valence of the suicidal decision (F (3, 244) = 1.52, $p = .21$) or to the activity/passivity of the decision (F (3, 239) = 0.94, $p = .42$).

Respondent Sexual Orientation. The valence of the decision to engage in suicidal behavior was significantly related to the respondent's sexual orientation, $F(1, 246) = 9.41, p < .01, \eta^2 = .04$. Sexual minority respondents viewed the decision less negatively ($M = 4.83$, $SD = 1.10$), than heterosexual respondents ($M = 5.26$, $SD = 1.10$). Respondent sexual orientation did not affect the perceived activity/passivity of the suicidal decision, $F(1, 241) = 0.5, p = .83$.

A series of additional univariate analysis of variance (ANOVA) was performed to examine the relationship between selected background variables (i.e., current and past religious affiliation, religious services attendance, frequency of religious service attendance, as well as personal and family experience with suicidal ideation and behavior) and the variables measuring attitudes toward the suicidal decision.

Respondent Religious Background and Current Religious Beliefs. Respondent current religious beliefs were significantly related to evaluations of the valence of the suicidal decision, $F(4, 233) = 2.63, p = .04, \eta^2 = .04$. Specifically, current Roman Catholic respondents rated the decision to engage in suicidal behavior significantly less favorably ($M = 5.61$, $SD = 1.09$) than did respondents indicating no current religious beliefs ($M = 4.98$, $SD = 1.09$). Evaluations of the valence of the suicidal decision and the perceived activity/passivity of the decision were not related to respondents past religious background, religious services attendance (yes/no), or frequency of religious service attendance.

Respondent Personal, Peer, and Family History of Suicidal Behavior. Respondents' personal history of suicidal ideation and behavior was related to perceptions of the valence of the suicidal decision. Specifically, respondents who had seriously considered suicide in the past year perceived the suicidal decision less negatively ($M = 4.76$, $SD = 1.09$) than did respondents who had not recently considered suicide ($M = 5.19$, $SD = 1.10$), $F(1, 229) = 4.78$, $p = .03$, $\eta^2 = .02$. Similarly, respondents who had seriously considered suicide in their lifetime, excluding the past year, evaluated the suicidal decision less negatively ($M = 4.78$, $SD = 1.07$) than those who had not ($M = 5.40$, $SD = 1.06$), $F(1, 228) = 19.11$, $p < .001$, $\eta^2 = .08$. Furthermore, respondents who reported engaging in suicidal behavior in their lifetime, excluding the past year, also viewed the valence of the suicidal decision more favorably ($M = 4.75$, $SD = 1.09$) than those who had not ($M = 5.23$, $SD = 1.09$), $F(1, 229) = 7.80$, $p < .01$, $\eta^2 = .03$. Those who had engaged in suicidal behavior one or more times in their lifetime rated the suicidal decision more favorably ($M = 4.60$, $SD = 1.02$) than did those respondents who had never engaged in suicidal behaviors ($M = 5.22$, $SD = 1.05$), $F(1, 219) = 12.71$, $p < .001$, $\eta^2 = .95$.

Evaluations of the valence of the suicidal decision were not related to having a friend or family member with a history of suicidal behavior, having engaged in suicidal behavior in the past year, or having engaged in suicidal behavior that required medical attention. The perceived activity/passivity of the suicidal behavior was not significantly related to any of the personal or family history of suicidal behavior variables.

Additional Analyses

Finally, because a history of suicidal behavior was related to evaluations of the suicidal decision, two five-factor analyses of covariance (suicide precipitant X sex of the suicidal person X respondent sex X respondent gender identity X respondent sexual orientation) were conducted on the valence of the suicidal decision adjusting for seriously considering suicide in the past, excluding the past year, and lifetime number of suicidal acts.

These two analyses yielded interesting results. First, when controlling for suicidal ideation in the past, excluding the past year, and for lifetime suicidal behavior, the results for the target sex and context variables were intensified. For the context of the suicidal behavior, the results stayed exactly the same, but the variance explained went from .11 to .23, when controlling for suicidal ideation and lifetime behavior. Similarly, for target sex, the results stayed the same (suicidal decision was evaluated less negatively when it involved a male as compared to a female in crisis), but the variance explained increased from .03 to .06, for both covariates. In addition to some results becoming stronger, some relationships became weaker when controlling for previous suicidal ideation. Respondent males still viewed the decision to suicide less favorably than females, but the relationship was no longer significant, $F(1,111) = .31$, p = ns. Controlling for lifetime suicidal behavior also diluted the relationship between participant sex and evaluations of the valence of the suicidal decision, $F(1,104) = .211$, p = ns. That is, prior to the covariate, male respondents judged the suicidal decision more negatively ($M = 5.25$, $SD = 1.10$) than did female respondents, but the relationship was weak ($F(1, 242) = 4.73$, $p = .03$, $\eta^2 = .02$). Adding the covariate weakened that relationship even more, to the point where it

was no longer significant. Respondent sexual orientation was also no longer a significant factor in the evaluation of the decision to engage in suicidal behavior when controlling for suicidal ideation in the past, excluding the past year (F (1,112) = 2.62, p = ns) and lifetime suicidal acts (F (1, 104) = 2.644, p = ns). Once again, this is due to the weak initial relationships between those variables. Finally, the introduction of the covariates had no effect on the relationship between respondent gender identity and evaluations of the suicidal decision.

Evaluation of the Suicidal Person

A principal component factor-analysis using varimax rotation with Kaiser normalization was conducted on the six seven-point scales (wise-foolish, unselfish-selfish, strong weak, active-passive, right-wrong, brave-cowardly) evaluating the suicidal person. The result was one factor, called "Character of Suicidal Person," that had an eigenvalue of 3.22, a Cronbach's α = .82, and accounted for 53.59% percent of the variance. The factor loadings of scales evaluating the perceived character of the suicidal person are presented in Table 7. The scores across the six scales making up the "Character" Factor were averaged to get a composite score. The remaining three scales (measuring the suicidal individuals' emotional adjustment, suicidal intent, and femininity-masculinity) were treated as separate variables.

A five-factor multivariate analysis of variance (suicide precipitant X sex of the suicidal person X respondent sex X respondent gender identity X respondent sexual orientation) was computed on the four dependent variables assessing the suicidal individual (perceived character, emotional adjustment, seriousness of suicidal intent and

femininity/masculinity of the suicidal person). An alpha level of .05 was set for all statistical tests. Perceptions of the suicidal person varied depending on the precipitant of the suicidal act, target sex, respondent sex, respondent gender identity, and respondent sexual orientation (see Tables 8-12). Statistically significant interactions occurred for the precipitant of the suicidal behavior and respondent sexual orientation on the femininity/masculinity scale.

Precipitant of the Suicidal Behavior. Perceptions of the emotional adjustment of the suicidal individual were influenced by the precipitant of the suicidal act, F (4, 242) = 5.53, $p < .001$, $\eta^2 = .08$. Persons who engaged in suicidal behavior as a result of a physical illness ($M = 4.96$, $SD = 1.18$) were perceived as significantly less maladjusted than were persons who engaged in a suicidal act as a result of the loss of a significant relationship ($M = 5.95$, $SD = 1.18$), an achievement failure ($M = 5.89$, $SD = 1.18$), being rejected by one's parents after "coming out" ($M = 5.81$, $SD = 1.18$), or coming to terms with one's sexual orientation ($M = 5.78$, $SD = 1.18$). This main effect was qualified by an interaction between context and respondent sexual orientation on the F/M variable, F (4, 240) = 2.68, $p < .05$, $\eta^2 = .08$. In the vignettes describing individuals becoming suicidal in response to becoming aware of their minority sexual orientation, heterosexual respondents rated the suicidal person as more feminine ($M = 3.14$, $SD = 1.47$) than did sexual minority respondents ($M = 3.68$, $SD = 1.47$). Conversely, in the physical illness context, heterosexual respondents rated the suicidal person as more masculine ($M = 3.41$, $SD = 1.47$) than did sexual minority respondents ($M = 4.10$, $SD = 1.47$). See Figure 1 for a graph of this interaction. There was also an interaction between target sex and

respondent sexual orientation on the F/M variable, F (1. 240) = 4.76, $p < .05$, $\eta^2 = .04$. Heterosexual respondents rated the target female as being more feminine ($M = 2.79$, $SD = 2.59$) while sexual minority respondents rated the target female as being more masculine ($M = 3.38$, $SD = 3.38$). Similarly, heterosexual respondents rated the target male as being more feminine ($M = 4.15$, $SD = 2.69$) than did sexual minority respondents ($M = 4.19$, $SD = 3.14$).

The precipitant of the suicidal behavior was not significantly related to the perception of the character of the person (F (4, 240) = 0.98, $p = .42$), the seriousness of the suicidal intent (F (4, 242) = 0.19, $p = .95$), or the femininity/masculinity of the suicidal person (F (4, 239) = 0.41, $p = .80$).

Target Sex. Suicidal males were perceived to be significantly more masculine ($M = 4.12$, $SD = 1.36$) than were suicidal females ($M = 3.04$, $SD = 1.36$), F (1, 242) = 37.87, $p < .001$, $\eta^2 = .14$. No other main effects for target sex were obtained.

Respondent Sex. Although all suicidal persons were rated as being somewhat feminine, males rated the suicidal individual as more feminine ($M = 3.39$, $SD = 1.45$) than females ($M = 3.81$, $SD = 1.45$), F (1, 238) = 5.09, $p = .03$, $\eta^2 = .02$. Respondent sex was not significantly related to the character of the suicidal person, the perceived emotional adjustment of the suicidal person, or the seriousness of the suicidal act.

Respondent Gender Identity. Respondent gender identity was significantly related to the perceived seriousness of the suicidal act, F (3, 243) = 3.44, p = .02, η^2= .04. Persons with a masculine gender identity (M = 2.80, SD = 1.59) perceived the suicidal act to be significantly less serious than did androgynous (M = 3.30, SD = 1.59), feminine (M = 3.59, SD = 1.62), or undifferentiated respondents (M = 3.79, SD = 1.58). No other main effects were obtained.

Respondent Sexual Orientation. Respondent sexual orientation was significantly related to evaluations of the suicidal person in a number of domains. Sexual minority respondents rated the suicidal person as having a less negative character (M = 3.92, SD = 1.12) than did heterosexual respondents (M = 4.42, SD = 1.12), F (1, 243) = 11.70, p < .001, η^2 = .05. Similarly, sexual minority respondents evaluated the suicidal person as more emotionally adjusted (M = 5.35, SD = 1.19) than did sexual majority respondents (M = 5.92, SD = 1.19), F = (1, 245) = 13.41, p < .001, η^2 = .05. The suicidal person was perceived as more masculine by sexual minority respondents (M = 3.41, SD = 1.44) than sexual minority respondents (M = 3.88, SD = 1.45), F (1, 242) = 6.06, p = .02, η^2 = .02. As noted above, this main effect should be interpreted with caution, due to the interaction between context and respondent sexual orientation on the feminine/masculine measure. Respondent sexual orientation was not significantly related to the perceived seriousness of the suicidal act, F (1, 245) = 0.75, p =.39). See Figure 2 for a chart of the main effects on this variable.

A series of additional univariate analysis of variances (ANOVA) was performed to examine the relationship between key background variables (i.e., current and past religious affiliation, religious services attendance, frequency of religious service attendance, as well as personal and family experience with suicidal ideation and behavior) and the variables measuring attitudes toward the suicidal person.

Respondent Religious Beliefs and Attendance. Respondents who reported currently having Roman Catholic beliefs perceived the suicidal person as less emotionally adjusted ($M = 6.28$, $SD = 1.21$) than did persons reporting no religious beliefs ($M = 5.55$, $SD = 1.21$), persons with Jewish beliefs ($M = 5.50$, $SD = 1.21$), or persons reporting "other" religious beliefs ($M = 5.47$, $SD = 1.21$), $F(4, 232) = 3.50$, $p < .01$, $\eta^2 = .06$. In addition, respondents who reported current Jewish beliefs perceived the suicidal person as more masculine ($M = 4.75$, $SD = 1.43$) than did current Roman Catholics ($M = 3.10$, $SD = 1.42$), current Protestants ($M = 3.82$, $SD = 1.42$), or respondents indicating no current religious beliefs ($M = 3.27$, $SD = 1.42$), $F(4, 229) = 4.86$, $p < .01$, $\eta^2 = .08$. Respondent regular religious attendance (yes/no) was significantly related to perceived seriousness of suicidal intent, $F(1, 236) = 10.44$, $p < .001$, $\eta^2 = .04$. Specifically, respondents who reported attending religious services regularly perceived the suicidal behavior to be more serious in intent ($M = 3.87$, $SD = 1.58$) than did respondents who did not report attending religious services regularly ($M = 3.13$, $SD = 1.58$). No other statistically significant effects were found.

Respondent Personal and Family History of Suicidal Behavior. A past history of suicidal ideation, excluding the past year, was related to perceived emotional adjustment $F(1,$

227) = 12.76, $p < .001$, $\eta^2 = .05$. Respondents who had seriously considered suicide in the past, excluding the past year, perceived the suicidal person to be more emotionally adjusted ($M = 5.41$, $SD = 1.19$) than did those who had not considered suicide in the past, excluding past year ($M = 5.97$, $SD = 1.19$). Previous suicidal ideation, excluding the past year, was not related to any of the other independent variables. Perceived character of the suicidal person, perceived emotional adjustment, perceived seriousness of the suicidal intent, and perceived femininity/masculinity of the suicidal person were not significantly related to recent (within the past year) suicidal ideation, suicidal behavior in the past year or lifetime excluding the past year, number of lifetime suicidal acts, or having engaged in suicidal behavior that required medical attention

Finally, because history of suicidal ideation in the past (excluding the past year) was related to evaluations of the emotional adjustment suicidal person, one five-factor analyses of covariance (suicide precipitant X sex of the suicidal person X respondent sex X respondent gender identity X respondent sexual orientation) was conducted on the perceived character, adjustment, seriousness, and femininity/masculinity of the suicidal person, adjusting for a history of suicidal ideation in the past excluding the past year.

Results indicated that controlling for past suicidal ideation, excluding that occurring in the past year, had little effect on most attitudes towards a suicidal peer. The results for the relationship between target sex and perceived femininity/masculinity remained the same (males were perceived to be more masculine than females) when controlling for previous suicidal ideation, but variance explained increased, from .14 to .20. Participant sex and gender identity did not affect the variables (i.e. perceived

character, emotional adjustment, seriousness, femininity/masculinity) by the introduction of the covariate.

The perceived emotional adjustment of the suicidal person based on the context of the suicidal behavior was slightly changed when past suicidal ideation was controlled. Specifically, without the covariate, suicidal persons were seen as, from most to least, emotionally adjusted in the following order: physical illness, exiting heterosexuality, parental rejection following "coming out", achievement failure, and a relationship loss. With the covariate, the most (physical illness), middle (parental rejection following "coming out") and least (relationship loss) acceptable reasons remain the same, but the achievement failure moved to the second most acceptable reason and the exiting heterosexuality situation moved to the fourth most acceptable reason for suicidal behavior.

Finally, controlling for previous suicidal ideation increased the variance explained due to the relationship between the perception of the character of the suicidal person and participant sexual orientation from .05 to .09. As before the covariate, sexual minority respondents rated the suicidal person as having a less negative character than did heterosexual respondents. Additionally, the suicidal act was perceived to be significantly more serious by sexual minority respondents ($M = 3.82$, $SD = 2.19$) than by heterosexual respondents ($M = 3.17$, $SD = 1.62$), $F(1,111) = 6.21$, $p < .05$.

CHAPTER IV

DISCUSSION

This study examined sexual minority and heterosexual university students' reactions toward a suicidal decision, as well as their attitudes about a peer who became suicidal following various precipitants (i.e., coming to terms with one's minority sexual orientation, coming out to one's parents, a physical illness, a relationship loss, and an achievement failure). Consistent with past research, this study found that attitudes toward suicidal behavior and suicidal individuals are predominantly negative. In addition, this study's findings are congruent with past observations that respondents have distinct reactions to the suicidal decision, as compared to the suicidal person. Finally, this study confirmed that the degree of negativity expressed varies depending on situational factors (e.g., the context of the suicidal behavior) as well as evaluator factors (e.g., the respondent's sex). This study is the first to examine the possible influence of sexual orientation on attitudes toward the suicidal decision and the suicidal person. Other individual variables examined in this study were the respondents' religious background and religious behavior and the respondents' personal and family history of suicidal behavior.

Evaluation of the Decision to Engage in Suicidal Behavior

In this study, the context of the suicidal decision played a role in judgments of

suicidal behavior. When the suicidal behavior occurred in response to a physical illness, it was viewed as a relatively less negative decision than when the suicidal behavior was in response to a relationship loss, coming to terms with one's sexual minority orientation, an achievement failure, or being rejected after coming out to one's parents. This finding is similar to those of numerous past studies, all of which have found that physical illness tends to be the most acceptable, or the least unacceptable, reason for suicidal behavior (Cato & Canetto, 2003b; Dahlen & Canetto, 2002; Deluty, 1988-89a, 1988-1989b; Droogas, Sitter, & O'Connell, 1982-1983; Ellis & Hirsch, 1995; Hammond & Deluty, 1992; Lester, Guerriero & Wachter, 1991; LoPresto, Sherman, & DiCarlo, 1994-1995; Singh, Williams, & Ryther, 1986).

Consistent with previous findings (Cato & Canetto, 2003b), the decision to engage in suicidal behavior following coming out to one's parents was viewed negatively. Respondents in this study did not find that suicidal behavior following coming to terms with one's minority sexual orientation was treated as an acceptable reason for a suicidal act. Contrary to expectation, the suicidal decisions of sexual minority individuals (in both the "exiting heterosexuality" and the "coming out" vignettes) were not viewed in more positive ways by sexual orientation minorities, as compared to heterosexuals. Rather, LGBQ respondents perceived the suicidal decision more favorably than did heterosexual respondents regardless of the precipitant. This suggests that LGBQ individuals may be more accepting of suicidal behavior as a way of coping with adversities than are heterosexual individuals. This may be a factor in sexual minorities' higher rates of suicidal behavior (Cochran, 2001; McDaniel, et al., 2001). Interestingly, when previous suicidal ideation and lifetime suicidal act were controlled

for, the relationship between sexual minority respondents and perception of the suicidal decision was negated. This suggests the finding that sexual minority respondents perceive the suicidal decision more favorably may be confounded by the high incidence of suicidal behavior among sexual minority persons. History of suicidal behavior or ideation seems to be a stronger factor in the evaluation of the suicidal decision than respondent sexual orientation.

Evaluations of the decision to engage in suicidal behavior were related to the sex of the suicidal person. Specifically, suicidal males were perceived as having made a relatively less negative decision than suicidal females. The finding that males were viewed as having made a better decision than females is somewhat surprising, given the research suggesting nonfatal suicidal behavior is considered to be feminine (Linehan, 1973). That is, one could expect nonfatal suicidal behavior in males to be viewed less favorably than the same behavior in females, due to the fact that "attempting" suicide and surviving are considered feminine behaviors in the United States (Canetto, 1997). This study's target sex findings are inconsistent with those of two other studies of attitudes toward the suicidal decision using similar measures (Cato & Canetto, 2003b; Dahlen & Canetto, 2002). In a study that did an effect for target sex, Stillion and colleagues (1989) reported that suicidal men received intermediate amounts of sympathy, as compared to older women, who received the least sympathy. The target sex findings of the present study may be influenced by the sexual minority sample. Studies indicate that gay males have particularly high rates of nonfatal suicidal behavior (Bagley & Tremblay, 1997; Garofalo, Wolf, Wissow, Woods, & Goodman, 1999; Nicholas & Howard, 1998). It is possible that the sexual minority respondents in this study had a personal history or had

been exposed to gay male suicidal behavior, leading to greater acceptance of a suicidal decision in males. Also, the introduction of the covariate may provide an additional explanation. When controlling for previous suicidal ideation and lifetime suicidal acts, the decision of target males to engage in suicidal behavior was perceived even less negatively than target females when suicidal history was not a factor. Once again, the history of suicidal behavior is found to serve as a factor in increasing acceptance of the suicidal decision.

As expected, sex of the respondent was related to attitudes toward the suicidal decision. However, the finding was in the opposite direction as was predicted. In the present study, male respondents were more critical of the suicidal decision than were females. Previous studies have found that males tend to view the suicidal decision more positively than females (Cato & Canetto, 2003b; Dahlen & Canetto, 2002; Eskin, 1995; Limbacher & Domino, 1985-86), a finding that is congruent with the observation that males tend to view the decision to suicide as an individual right (Eskin, 1995; Marks, 1988-1989; Sorjonen, 2002-2003; Wellman & Wellman, 1986). Interestingly, in the present study, the difference in attitudes toward the suicidal act between the respondent males and females was no longer significant when past suicidal ideation was controlled for. The introduction of the covariate seems to have identified a difference in the opinions between males who have and males who have not engaged in suicidal behavior/ideation. This finding speaks to the importance of researchers investigating the impact of respondent suicidal history, as it affects the way that respondents view suicidal behavior and peers.

Surprisingly, gender identity was not significantly related to the perception of the suicidal behavior, as has been found in other studies. However, the non-significant trend in the data was similar to that of other studies (Cato & Canetto, 2003b; Dahlen & Canetto, 2002), where androgynous persons were least accepting of the suicidal decision and undifferentiated persons were most accepting of the target decision. According to Dahlen and Canetto (2002) androgynous persons, by virtue of being high in both conventional femininity and conventional masculinity, may be better equipped to deal with crises and therefore less inclined to believe that there is only one answer (suicide) to a problem. On the other hand, undifferentiated persons may be low in both feminine and masculine coping mechanisms. One reason for the weaker findings concerning gender identity in this study may again be traced to the fact that this study included a sexual minority sample with which the PAQ (Personal Attitudes Questionnaire) may not be a meaningful measure of gender conventionality.

Numerous studies have found that religious beliefs and behaviors are associated with critical attitudes toward suicidal behavior, both fatal and nonfatal (Domino, Gibson, Poling, & Westlake, 1982; Domino & Leenaars, 1989; Domino & Miller, 1992; Durkheim, 1951, as cited in Neeleman, Wessely, & Lewis, 1998; King, Hampton, Bernstein, & Schichor, 1996; LoPresto, Sherman, & DiCarlo, 1994-95; Minear & Brush, 1980-1981; Neeleman, Halpern, Leon, & Lewis, 1997; Stein, Witztum, Brom, DeNour, & Elizur, 1992; Stillion, McDowell, & Shamblin, 1984). The present study found respondents who described themselves as holding current Roman Catholic beliefs viewed the suicidal behavior less favorably than persons who indicated that they did not have current religious beliefs. This finding is consistent with LoPresto, Sherman, and

DiCarlo's (1994-95) finding that Catholic respondents who reported being high in religiosity (defined by adherence to religious practices and beliefs, not necessarily participation in religious services) were less accepting of suicidal persons than Catholic respondents who reported being low on religiosity. The authors argued that, "It appears that these evaluations reflect the taboo against suicide put forth in various religious dogmas (e.g. Catholicism)" (p. 218). In the present study, the level of involvement with the current religious belief, as measured by attendance in religious services, was not a significant factor in attitudes toward the suicidal decision. This seems to be a function of the individual ways that people practice religion or spirituality, as people may adhere to a general set of guiding principles adopted from a religion, but do not necessarily attend a formal place of worship on a regular basis. Also, individuals may be active in religions that are not strict about suicide permissibility.

Respondents who had considered or engaged in suicidal behavior in the past (more than one year ago) were more accepting of the decision than were those without that history. Also, persons with a history of one or more suicidal acts were more accepting of the behavior than those with no history of suicidal behavior. This finding is consistent with the many studies (i.e. Feifel & Schag, 1980; King, et al., 1996; Stein, et al., 1998) that have found that the history of suicidal behavior is positively related to attitudes toward suicide. At initial glance, there seems to be a contradiction between the findings of respondents with a recent history of suicidal ideation (more accepting of the suicidal decision) and respondents with a recent history of suicidal behavior (no effect on attitudes toward decision). However, upon further examination, it seems as though this result parallels the findings of DeWilde and colleagues (1993), who found that suicidal

persons were not as accepting of suicidal behavior as were persons who were depressed but not suicidal. The theory suggested by Stein and colleagues (1992) in regards to the difference in attitudes toward suicide between men and women also seems to apply here. They posited that persons who are less likely to die by suicide (i.e. women) are more accepting of the suicidal behavior because it is not a threat to them, while persons who are at a higher risk to die by suicide (i.e., men) are less accepting of suicide because it is a realistic threat to their survival. In the present discussion, perhaps persons who have recently engaged in suicide are hyper-aware of the threat of suicide because they have engaged in suicidal behaviors and are therefore less accepting of it, while persons who have merely thought of it do not consider it to be a legitimate risk. This becomes more obvious when previous suicidal ideation and lifetime suicidal act were controlled for. The control of these variables served to strengthen the relationships between perception of the suicidal behavior and precipitant of the behavior and sex of the person engaging in the behavior. Conversely, it weakened the relationship between sexual orientation and evaluation of the suicidal decision.

Contrary to expectation, attitudes toward the suicidal decision were not affected by knowledge of a suicidal peer or family member. Previous research has found both a positive (Houston, 1990), negative (Marks & Riley, 1976), and neutral (Limbacher & Dominio, 1985-86) relationship between those variables, suggesting that more research is needed in this area to explore the factors influencing the different findings.

Evaluation of the Suicidal Person

In this study, persons who became suicidal in response to a physical illness were perceived as more emotionally adjusted than those who became suicidal in response to

any of the other precipitants (i.e., a relationship loss, an achievement failure, being rejected by one's parents after coming out, or coming to terms with one's sexual orientation). This finding is consistent with the findings of other studies of attitudes toward suicidal persons, all of which found that persons who engage in suicidal behavior as the result of physical pain are evaluated more positively than those who are suicidal in response to other precipitants (Cato & Canetto, 2003a; Dahlen & Canetto, 1996; Deluty, 1988-89a; Droogas, Siiter, & O'Connell, 1982-83; Ingram & Ellis, 1995; LoPresto, Sherman, & DiCarlo, 1994-95). Contrary to prediction, we did not find that sexual minority respondents rated the suicidal person in the sexual minority vignettes (i.e., "exiting heterosexuality" and "coming out") less negatively in terms of character or emotional adjustment than the suicidal person in other situations, as compared to heterosexual respondents. However, sexual orientation minorities rated the suicidal person as having more character than did heterosexual respondents, independent of precipitant of the suicidal behavior. In addition, sexual orientation minorities evaluated the suicidal person as more emotionally adjusted than did heterosexual respondents, independent of the context of the suicidal behavior. These findings suggest greater understanding and empathy on the part of sexual minority individuals of suicidal persons, independent of the precipitant of the suicidal act—which may translate, for sexual minority youth, into a greater acceptance of suicidal behavior as a way to cope with adversities. One factor in these findings is that significantly more sexual minority respondents reported a history of suicidal ideation (past and present) and previous (excluding past year) suicidal behavior than heterosexual respondents. This was demonstrated when past suicidal ideation was controlled for – sexual minority

respondents viewed the suicidal decision even more favorably. Given that sexual minority respondents were more likely to have engaged in suicidal behavior in the study, it is likely that this personal history with suicidal behavior increased the sympathy across LGB participants.

Similar to Cato and Canetto (2003a), the perceived seriousness of the suicidal person did not significantly vary based on the precipitant of the behavior. However, despite all contexts being perceived as neither serious or non-serious in intention, there was a non-significant trend for the person engaging in suicidal behavior in response to a physical illness, "coming out", or questioning one's sexual identity to be perceived as being more serious in intent than those who engaged in the behavior following a relationship loss or achievement failure. This trend may be related to the distinctiveness of the present sample. "Coming out" and the process of questioning one's sexual orientation are common antecedents to suicidal behavior among LGB youth (Remafedi, 1999; Rotheram-Borus, Hunter, & Rosario, 1994; Schneider, Farberow, & Kruks, 1989). As such, sexual minority respondents may have recognized those precipitants as having been related to serious suicidal intent in themselves or friends.

There was an interaction within the precipitant of the suicidal decision that warrants discussion. Heterosexual respondents rated the suicidal person as relatively more feminine (regardless of the sex of the suicidal person) in the sexual identity crises context than did LGB respondents. In contrast, heterosexual respondents rated the person who engaged in suicidal behavior as a result of a physical illness relatively more masculine than did sexual minority respondents. This difference may be, in part, related to the different levels of suicidal behavior in the two groups. As stated earlier, sexual

minority youth have a significantly higher rate of suicidal behavior than do heterosexual youth (Cochran, 2001). Additionally, sexual minority youth may be exposed to a social script that is permissive of suicidal behavior (Russell, Bohan, and Lilly, 2000). As such, sexual minority youth may be less likely to adopt the dominant views of suicidal behavior (i.e., that suicide in response to physical illness is acceptable and masculine) than heterosexual youth.

While all target persons were perceived as feminine, male respondents perceived the suicidal person as being more feminine, while female respondents perceived the target person as being relatively less feminine – regardless of the sex of the target person. That is, males tended to be more conventional in their ratings of the suicide attempter, while females were less conventional. Thirty years ago, Linehan (1973) found the same result – males tend to have more conventional gender role beliefs than do females.

As expected (Cato & Canetto 2003a; Dahlen & Canetto, 1996), perceptions of the seriousness of the suicidal person varied based on respondent gender identity. Undifferentiated, feminine, and androgynous gender-typed persons viewed the suicidal person as more serious in the intent than did masculine gender-typed respondents. Similarly, Cato and Canetto (2003a) reported that androgynous and feminine gender-typed respondents were more likely to view the suicidal person as being serious in intent than masculine or undifferentiated persons. The present study did not find any other significant relationships between gender identify and attitude toward the suicide persons, but several previous studies have. In one study, females and feminine males were more accepting of suicide than were males and masculine females (Stillion, McDowell, Smith, & McCoy, 1986). In another, androgynous persons were more accepting of the suicidal

person and less likely to view the suicidal person as more emotionally maladjusted than were undifferentiated gender-typed respondents (Dahlen & Canetto, 1996).

As expected, based on previous research (Domino, Gibson, Poling, & Westlake, 1982; Domino & Miller, 1992; LoPresto, Sherman, & DiCarlo, 1994-94), respondent religious beliefs were related to evaluations of suicidal persons. For one, current Roman Catholic respondents perceived the suicidal person as less emotionally maladjusted than persons who reported no religious beliefs, "other" religious beliefs, or Jewish beliefs. There was no difference between Roman Catholic and Protestant perceptions of emotional adjustment – both perceived the suicidal person as maladjusted. Stack and Wasserman's (1992) work sheds some light on possible explanations for the difference between Roman Catholic, Protestant, and the other religious beliefs. In a study using the General Social Survey, Stack and Wasserman discovered that persons who reported being a part of a conservative religion were less accepting of suicide than were persons who reported having no religious beliefs or non-conservative religious beliefs. Perhaps the conservatism of Protestantism and Catholicism separate it from the other religious beliefs in this study and explains the more negative evaluation toward suicidal persons. Another finding about religious beliefs is that Jewish persons perceived the suicidal person to be more masculine than did persons citing Roman Catholic, Protestant, or "no" religious beliefs. Finally, the more regularly a respondent reported attending religious services, the more likely the respondent was to view the suicidal person as being serious in the suicidal behavior.

As would be expected, having a history of suicidal ideation was related to the perceived emotional adjustment of the suicidal person. Stein, Witztum, Brom, DeNour,

and Elizur (1992) found that persons with a history of suicidal behavior were "significantly more accepting" of suicide (p. 956). Similarly, another study echoed that finding and suggested that persons who had engaged in suicidal behavior were more "personally preoccupied" with thoughts of suicide and, therefore, more accepting of it (Stein, Brom, Elizur, & Witztum, 1998, p. 200). It is interesting to note that persons who described themselves as members of a sexual minority were significantly more likely to have considered or have attempted suicide in the past– but being LGB did not affect attitudes toward the perceived seriousness of the suicidal behavior. In fact, there was no relationship between perceived seriousness of the suicidal behavior and any of the variables related to history of suicidal behavior. However, when previous suicidal ideation was controlled for, sexual minority respondents perceived the suicidal act to be significantly more serious than heterosexual respondents. This makes sense, given that more LGBQ respondents reported that they had engaged in past suicidal behaviors, and there is a well-established a relationship between previous suicidal behavior and perceived seriousness of the suicidal act (e.g. Limbacher & Domino, 1985-86).

Limitations

This study was conducted in the Rocky Mountain Region of the United States using introductory psychology students and participants from GLBT campus groups. One question that could be raised concerns its generalizability as there may be regional differences in attitudes toward suicidal behavior. Another limitation of this study is that the heterosexual sample all came from one university while the sexual minority sample came from the same area but from five different universities. The reason for a more

extended recruitment of sexual minority respondents was to have similarly sized sample. However, the different recruitment sites may have increased the diversity of the sexual minority respondents. One final limitation of this study's sample is that is was homogenous with regard to ethnicity. The five universities from which this data came are attended predominantly by students of European American descent. Many of these students are from rural or suburban backgrounds. Additionally, the Rocky Mountain region has some of the highest rates of suicide in the United States. The present sample may have a more extensive history with suicidal behavior than would a sample from the East or West coast.

Contributions

This study is unique in that it introduced a new vignette about exiting the heterosexual identity. This vignette was added to the present study in an attempt to address separately different sexual minority stressors. Contrary to expectation, the "exiting heterosexuality" vignette did not significantly differ from the "coming out" vignette in terms of being seen as a unique stressor. In evaluating the suicidal decision, the "coming out" vignette was viewed least favorably, while the "exiting heterosexuality" vignette was in the middle, above the achievement failure vignette. Conversely, the target person in the "exiting heterosexuality" vignette was viewed as least emotionally adjusted, followed closely by the "coming out" vignette. Further examination could evaluate the two vignettes, in an attempt to understand if a suicidal person is evaluated differently, depending on the context ("coming out" or exiting heterosexuality) of the suicidal behavior.

This study was also unique in that it found that sexual minority college students tend to be more accepting of suicidal behavior and suicidal peers. This is alarming, given that the rate of suicidal behavior is higher in the LGBQ community. Sadly, suicidal behavior among LGBQ youth may be accepted, rather than discouraged. This may be especially true of persons in the LGBQ community that have engaged in suicidal behavior, as this study found that this relationship was strengthened when suicidal history was taken into account.

Finally, the information obtained about history of suicidal behavior and ideation in the respondent and suicidal behavior in respondent friends or family added an additional dimension to this study. It served to add additional evidence to previous findings that persons with a history of suicidal behavior tend to hold more favorable views toward the suicidal decision, suicidal person, and the perceived seriousness of the suicidal act.

Future Research

Knowledge of a peer who had engaged in suicidal behavior (both fatal and nonfatal) has been found to be related to suicidal ideation and suicidal behavior in young adults (Conrad, 1992; Evans, Smith, Hill, Albers, & Neufeld, 1996; Yoder, 1999). Future research may examine the impact of the high rates of suicidal behavior among LGB youth on the attitudes toward suicidal behavior. That is, perhaps there is a relationship between the more favorable views on the suicidal decision and person among LGB youth and the fact that so many sexual minority young adults are likely to know someone who has engaged in suicidal behavior.

Future research may also explore the value of including "coming out" and exiting heterosexual scenarios in research such as this, or whether the two scenarios are a part of the same construct. Although it was not supported here, it is possible that the two scenarios are exclusive constructs, but this study lacked the statistical power to demonstrate that. If a study were able to establish that they are separate paradigms, there would be implications for the types of interventions made during a sexual minority person's development.

Additionally, research may explore the relationship between attitudes on a questionnaire, such as the one used in this study, and behavior in the situation. Understanding how suicidal persons are treated in the community is an important aspect in providing effective treatment, as the environmental impact of a suicidal person's behavior may be so overwhelming that it increases their chances for further suicidal behavior. Collecting information such as this may be more conclusive to qualitative, rather than quantitative, study.

Implications for Suicide Prevention with Sexual Minority Individuals

Individuals who identify as sexual minorities have a challenging journey towards adulthood. Numerous studies have documented the stresses reported by sexual minority individuals, including: prejudice, victimization, social isolation, depression, parental rejection, substance abuse, and anxiety (Diaz, Ayala, Bein, Henne, & Marin, 2001; Friedman, 1999; Garofalo, Wolf, Kessel, Palfrey, & DuRant, 1998; Gilman, Cochran, Mays, Hughes, Ostrow, & Kessler, 2001; Herek, 1991). It is therefore not surprising that many sexual minority youth to feel powerless about their lives, adopting the notion that

the stressors mentioned above are an inevitable part of their lives (Russell, Bohan, & Lilly, 2000). The finding that sexual minority youths view a suicidal person as having a more positive character may indicate that the youths feel that any response to their environment – even if it is a suicidal behavior – is one of power, because it is active. Russell and colleagues (2000) suggested that sexual minority youth have adopted a 'suffering suicidal' script, which may lead them to believe that it is "normal" to engage in suicidal behaviors. As a result of this script, sexual minority youth may perceive suicidal persons as relatively emotionally adjusted – since suicidal behavior is relatively common. The challenge of swaying those unhealthy attitudes and changing adolescent's scripts about suicide is a daunting one. It is one that includes a focus on suicide prevention in a variety of settings, including the health care system, schools, and among peers.

Health Care Providers

The role of the health care provider is complex, involving physical and emotional health. As such, they have the responsibility to explore pertinent issues (including sexual orientation and suicide) that are unlikely to be asked by any other person in a young adult's life. They need to be especially alert to issues about sexual orientation and suicidality and need to understand the relationship between the two.

Perhaps most importantly, health care providers need to hold accepting attitudes toward sexual minority persons. There are several ways for health care providers to promote acceptance of sexual orientation. Nelson (1997) suggested that health care professionals use neutral language (such as "partner" rather than "girlfriend/boyfriend") and have posters, pamphlets, and literature pertaining to sexual minority youth in visible

locations throughout the office. Rather than avoiding the issue of sexuality, health care professionals need to recognize that it is an important aspect of many young adults' lives. As such, it needs to be asked about in direct manner that conveys openness to varied sexual preferences and experiences (Kreiss & Patterson, 1997). Many persons would rather disclose their sexual orientation to their health care professional than attempt to keep it hidden. This was especially true in the area of sexual health, as the issues of safe sex and protection vary based on a patient's sexual practices (Lehmann, Lehmann, & Kelly, 1998).

Health care providers are often in an ideal position to assess for suicidality. Young adults may be more willing to disclose suicidal ideation to a doctor or nurse than they would be to discuss their concerns with a teacher or friend. As such, it is imperative that health care providers are educated about suicide and are properly trained in suicidal assessment, as training seems to serve as a buffer against negative attitudes toward suicidal persons (Herron, Ticehurst, Appleby, Perry, & Cordingley, 2001). In a study investigating attitudes toward young adults who have engaged in suicidal behavior, Anderson, Standen, Nazir, and Noon (2000) found that both doctors and nurses tended to believe that suicidal behavior is a "cry for help" and is "attention seeking behavior" (p. 8). This may be especially true for sexual minority suicidal persons, who tend to have a higher rate of suicidal behavior than their heterosexual peers. Psychoeducation about the seriousness of suicide and the reasons that young persons engage in suicide may be helpful in reducing the stigma present in the health care system. After proper training, health care providers can model appropriate attitudes (i.e. acceptance of person, disagreement with decision) toward suicide to sexual minority clients.

School Based Prevention Programs

Schools are a natural choice for suicide prevention programs. The programs should be based on techniques that have been proven to be effective in equipping young adults with practical knowledge related to suicide. These programs should consider allotting time to psychoeducation, role-playing, and peer counseling.

Prevention of suicidal behavior among sexual minority youth needs to begin before students participate in formal suicide prevention programs. Schools need to foster an attitude of acceptance and inclusiveness that is present in all classes and all situations. For example, schools should integrate information about sexual minority persons into classroom activities and teachings – to promote acceptance and understanding of sexual minority students. The less stigmatized a group becomes, the more likely a person is to feel that they have "a place" in society – which leads to better psychological well-being and a decreased risk of suicide. When sexual minority issues are routinely included in the school setting, it is only natural that it should be included as a component of the suicide prevention program.

The psychoeducational components of the prevention programs should include education about a number of areas. First, prevention programs need to include information about the nature of suicide. For example, educating students about the precipitants of suicidal behavior may alert students to situations in which a friend may become suicidal. Numerous studies have found that young adults could not recognize suicidal warning signs other than depression (Lang & Lovejoy, 1997; Norton et al., 1989). Norton and colleagues (1989) reported that only 16% of their sample knew that suicidal youth tend to threaten suicide before engaging in the behavior, and only 13%

knew that peers with a history of suicidal behavior are at risk for repeat behaviors. Second, suicide should be presented as a poor solution to life problems. Sexual minority young adults need to also be taught that suicide is not the only option in the face of hardship. Programs should assist students in brainstorming about constructive alternatives (such as counseling and stress management programs) to suicide when faced with a crisis. Finally, it would be beneficial to share information about attitudes toward suicidal behavior with students, so that they may become aware of the stigma that a peer may encounter after a suicidal act. Mueller and Waas (2002) suggested that programs be designed to promote empathy, rather than judgment about suicide. They found that empathetic respondents were more effective with suicidal peers, suggesting that empathy may serve as a protective factor for suicidal behavior. Educating about suicide also includes educating about the stigmatized groups who are most likely to suicide (Morrison & L'Heureux, 2001).

Although education is a valuable teaching tool, 'hands-on' activities may a necessary component of prevention programs. One of the most effective 'hands-on' activities is role-playing. Role-playing allows students to watch and be a part of discussions about suicidal behavior (Lawrence & Ureda, 1990). Research has indicated that students become more likely to ask a depressed friend about their suicidal intention when they feel emotionally comfortable with the topic. Also, role-playing allows students to practice giving responses to a suicidal peer, which helps the student to feel that they may be helpful in an actual situation.

Peer Support Groups / Counseling Centers

Finally, it may be helpful to establish a peer-counseling center that is easily accessible to all students. Research has shown that adolescents view talking to others about emotional difficulties as helpful in reducing suicide risk (Lang & Lovejoy, 1997). There are several characteristics that may influence the effectiveness of the peer counselors. First, they should be empathetic. Research has found that persons high in empathy are more adept at recognizing suicide risk and responding to suicidal peers (Norton, et al., 1989). Secondly, peer counselors should not hold negative attitudes toward suicidal persons (Herron, et al., 2001), as this may impair the relationship between counselor and suicidal person. Finally, persons who have experience with suicidal behavior (either self or peer) need to be carefully screened. Research has suggested that persons with a personal history of suicidal behavior are not necessarily better at helping suicidal peers (Knott & Range, 2001; Overhosler, Hemstreet, Spirito, & Vyse, 1989). This suggests that the peer counselors who are used in prevention programs should be persons who have not engaged in suicidal behavior themselves. Rather, they should be persons who have struggled with the same concerns as the suicidal peers (i.e. coming out to friends/family, coming to terms with one's sexuality), but have found healthy alternatives (other than suicidal behavior) to deal with their pain.

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Table 1 Factor Loadings of Items Evaluating the Valence of the Suicidal Decision

Item	Factor 1
Wrong-Right	.80
Brave-Cowardly	.79
Acceptable Decision	.79
Wise-Foolish	.71
Selfish-Unselfish	.64
Elicits Sympathy	.63
Strong - Weak	.62
Permission to Suicide	.59

Table 2 Evaluation of the Suicidal Decision: Precipitant of the Suicidal Behavior: Mean Scores, Standard Deviations, and *F* Statistics

	Physical Illness	Achievement Failure	Relationship Loss	Exiting Heterosexuality	Parental Rejection Following Coming Out	*F*
Valence of the Suicidal Decision	4.38 (1.06)	5.12 (1.06)	5.43 (1.06)	5.40 (1.06)	5.10 (1.04)	7.55*[a]
Active/Passive Decision	3.87 (1.93)	4.35 (1.93)	3.83 (1.93)	4.28 (1.93)	3.85 (1.93)	0.88

Note: Physical Illness = Physical Illness; Achievement Failure = Academic Failure, Relationship Loss = Loss of an Intimate Relationship, Exiting Heterosexuality = Coming to Terms with One's Sexual Orientation, Parental Rejection Following Coming Out = Parental Rejection Following Coming Out. Higher numbers reflect perceptions of the suicidal decision as more negative and more passive.

[a] df = 243

*$p < .001$

Table 3 Evaluation of the Suicidal Decision by Target Sex: Mean Scores, Standard Deviations, and *F* Statistics

	Female	Male	*F*
Valence of the Suicidal Decision	5.27 (1.10)	4.91(1.10)	6.60*[a]
Active/Passive Decision	3.98 (1.92)	4.09 (1.93)	0.17

Note: Higher numbers reflect perceptions of the suicidal decision as more negative and more passive.

[a] df =246

*p < .05

Table 4 Evaluation of the Suicidal Decision by Respondent Sex: Mean Scores, Standard Deviations, and *F* Statistics

	Female	Male	*F*
Valence of the Suicidal Decision	4.95 (1.11)	5.25 (1.10)	4.73*a
Active/Passive Decision	4.08 (1.92)	4.05 (1.92)	.01

Note: Higher numbers reflect perceptions of the suicidal decision as more negative and more passive.

[a] df = 242

*p < .05

Table 5 Evaluation of the Suicidal Decision by Respondent Gender Identity: Mean Scores, Standard Deviations, and *F* Statistics

	Feminine	Masculine	Androgynous	Undifferentiated	*F*
Valence of the Suicidal Decision	5.04 (1.11)	5.03 (1.11)	5.23 (1.11)	4.78 (1.11)	1.52
Active/Passive Decision	4.10 (1.92)	3.87 (1.93)	4.22 (1.93)	3.64 (1.92)	0.94

Note: Higher numbers reflect perceptions of the suicidal decision as more negative and more passive.

Table 6 Evaluation of the Suicidal Decision by Respondent Sexual Orientation: Mean Scores, Standard Deviations, and *F* Statistics

	Sexual Minority	Heterosexual	*F*
Valence of the Suicidal Decision	4.83 (1.10)	5.26 (110)	9.41*[a]
Active/Passive Decision	4.07 (1.93)	4.01(1.92)	0.05

Note: Higher numbers reflect perception of the suicidal decision as more negative and more passive.

[a] df = 246

*p < .05

Table 7

Factor Loadings of Items Evaluating the Suicidal Person

Item	*Factor 1*
	Character of Suicidal Person
Brave-Cowardly	.84
Wrong-Right	.76
Wise-Foolish	.74
Strong - Weak	.73
Active-Passive	.67
Selfish-Unselfish	.64

Table 8 Evaluations of the Suicidal Person Depending on the Precipitant of the Suicidal Behavior: Mean Scores, Standard Deviations, and *F* Statistics

	Physical Illness	Achievement Failure	Relationship Loss	Exiting Heterosexuality	Parental Rejection Following Coming Out	*F*
Character	4.27 (1.15)	4.41(1.14)	4.09 (1.15)	3.99 (1.14)	4.26 (1.14)	0.98
Adjustment	4.96 (1.18)	5.89 (1.18)	5.95 (1.18)	5.78 (1.18)	5.81 (1.18)	5.53 *[a]
Suicidal	3.42 (1.63)	3.21 (1.64)	3.22 (1.64)	3.33 (1.64)	3.40 (1.64)	0.19
F/M	3.74 (1.47)	3.54 (1.47)	3.73 (1.47)	3.41 (1.47)	3.63 (1.47)	0.41

Note: Physical Illness = Physical Illness; Achievement Failure = Academic Failure, Relationship Loss = Loss of an Intimate Relationship, Exiting Heterosexuality = Coming to Terms with One's Sexual Orientation, Parental Rejection Following Coming Out = Parental Rejection Following Coming Out. Character = Perceived Character of Suicidal Person; Adjustment = Emotional Adjustment; Suicidal = Seriousness of Suicidal Behavior; F/M = Femininity/Masculinity. Higher numbers reflect perceptions of the suicidal person as having a more negative character, being more maladjusted, more suicidal, and more masculine.

*$p < .001$

[a] df = 242

Table 9 Evaluations of the Suicidal Person by Target Sex: Mean Scores, Standard Deviations, and *F* Statistics

	Female	Male	*F*
Character	4.28 (1.14)	4.15 (1.15)	0.72
Adjustment	5.81(1.22)	5.57 (1.22)	2.44
Suicidal	3.21 (1.62)	3.41 (1.63)	0.95
F/M	3.04 (1.36)	4.12 (1.36)	37.87 *a

Note. Character = Perceived Character of Suicidal Person; Adjustment = Emotional Adjustment; Suicidal = Seriousness of Suicidal Behavior; F/M = Femininity/Masculinity. Higher numbers reflect perceptions of the suicidal person as having a more negative character, being more maladjusted, more suicidal, and more masculine.

[a]df = 242

*p < .001

Table 10 Evaluation of the Suicidal Person by Respondent Sex: Mean Scores, Standard Deviations, and *F* Statistics

	Female	Male	*F*
Character	4.17 (1.16)	4.27 (1.15)	0.48
Adjustment	5.58 (1.22)	5.83 (1.22)	2.60
Suicidal	3.23 (1.62)	3.37 (1.63)	0.47
F/M	3.81(1.45)	3.39 (1.45)	5.09*[a]

Note. Character = Perceived Character of Suicidal Person; Adjustment = Emotional Adjustment; Suicidal = Seriousness of Suicidal Behavior; F/M = Femininity/Masculinity. Higher numbers reflect perceptions of the suicidal person as having a more negative character, being more maladjusted, more suicidal, and more masculine.

[a] df =238

*p < .05

Table 11 Evaluation of the Suicidal Person by Respondent Gender Identity: Mean Scores, Standard Deviations, and *F* Statistics

	Feminine	Masculine	Androgynous	Undifferentiated	*F*
Character	4.19 (1.15)	4.30 (1.15)	4.18 (1.15)	4.23 (1.15)	0.16
Adjustment	5.93 (1.22)	5.37 (1.21)	5.76 (1.21)	5.59 (1.21)	2.09
Suicidal	3.59(1.62)	2.80 (1.59)	3.30 (1.59)	3.79(1.58)	3.44*[a]
F/M	3.42 (1.47)	3.57 (1.47)	3.64 (1.47)	3.82 (1.46)	0.56

Note. Character = Perceived Character of Suicidal Person; Adjustment = Emotional Adjustment; Suicidal = Seriousness of Suicidal Behavior; F/M = Femininity/Masculinity. Higher numbers reflect perceptions of the suicidal person as having a more negative character, being more maladjusted, more suicidal, and more masculine.

[a] df =243

*p < .05

Table 12 Evaluation of the Suicidal Person by Respondent Sexual Orientation: Mean Scores, Standard Deviations, and *F* Statistics

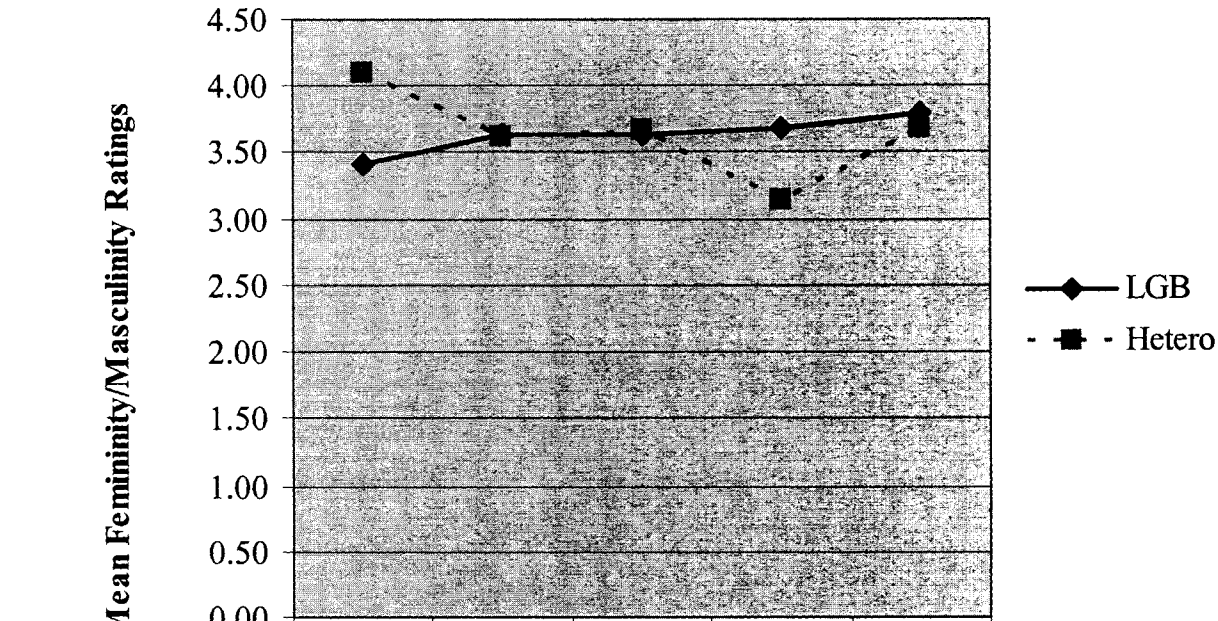
	Sexual Minority	Heterosexual	*F*
Character	3.92 (1.12)	4.42 (1.12)	11.70**[a]
Adjustment	5.35 (1.19)	5.92 (1.19)	13.41**[b]
Suicidal	3.43 (1.63)	3.24 (1.63)	0.75
F/M	3.88 (1.45)	3.41(1.44)	6.06*[c]

Note. Character = Perceived Character of Suicidal Person; Adjustment = Emotional Adjustment; Suicidal = Seriousness of Suicidal Behavior; F/M = Femininity/Masculinity. Higher numbers reflect perceptions of the suicidal person as having a more negative character, being more maladjusted, more suicidal, and more masculine.

[a] df = 243, [b] df = 245, [c] df = 242

*p < .05, **p<.001

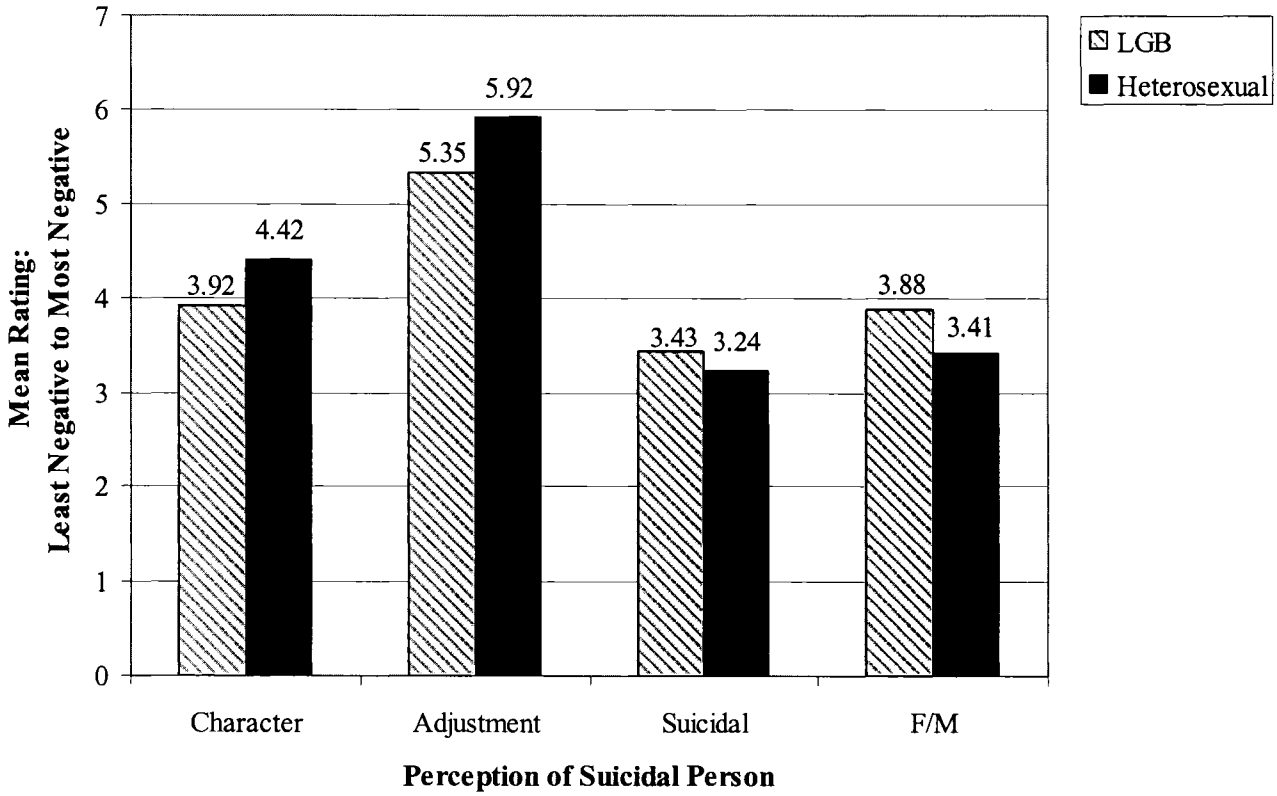
Figure 1 Precipitant of the Suicidal Behavior by Sexual Orientation on Ratings of Femininity/Masculinity



	Illness	Coming Out	Failure	Sexual Orient.	Relat. Loss
LGB	3.41	3.64	3.63	3.68	3.80
Heterosexual	4.10	3.62	3.67	3.14	3.68

Precipitant of the Suicidal Behavior

Figure 2 Perception of the Suicidal Person by Sexual Orientation Identification



Note. Character = Character; Adjustment = Emotional Adjustment; Suicidal = Seriousness of Suicidal Behavior; F/M = Femininity/Masculinity. Higher numbers reflect perceptions of the suicidal person as having a more negative character, being more maladjusted, more serious in suicide intent, and more masculine.

APPENDIX A

Suicide Vignettes

Exiting Heterosexual Identity

Karen, a student in her 20's, has been struggling with her attraction to other women for some time. She has tried to ignore her feelings, but lately they have been getting stronger. Last week, Karen and her friend, Lisa, kissed for the first time. Karen felt confused about the event, but has come to realize that she is not heterosexual. Karen engages in a suicidal act, but survives.

Brian, a student in his 20's, has been struggling with his attraction to other men for some time. He has tried to ignore his feelings, but lately they have been getting stronger. Last week, Brian and his friend, Gary, kissed for the first time. Brian felt confused about the event, but has come to realize that he is not heterosexual. Brian engages in a suicidal act, but survives.

Parental Rejection Following Coming Out

Karen, a student in her 20's, has been in an intimate relationship with her girlfriend, Lisa, for two years. Last week she told her parents about her girlfriend and they got very upset. They threatened to kick her out of the house and to disown her. Karen engages in a suicidal act, but survives.

Brian, a student in his 20's, has been in an intimate relationship with his boyfriend, Gary, for two years. Last week he told his parents about his boyfriend and they got very upset. They threatened to kick him out of the house and to disown him. Brian engages in a suicidal act, but survives.

Relationship Loss

Karen, a student in her 20's, has been going out with her significant other for three years. They are now in their senior year of college and had planned to move in together after graduation. For the past six months they have been arguing frequently. A week before graduation, Karen's partner breaks off the relationship. Karen engages in a suicidal act, but survives.

Brian, a student in his 20's, has been going out with his significant other for three

years. They are now in their senior year of college and had planned to move in together after graduation. For the past six months they have been arguing frequently. A week before graduation, Brian's partner breaks off the relationship. Brian engages in a suicidal act, but survives.

Academic Failure

Karen, a student in her 20's, has wanted to be a lawyer for four years. Her grades have been falling during the last six months. Last week she got back a major exam and found that her score was so low that with her grades, she will probably not be admitted to law school. Karen engages in a suicidal act, but survives.

Brian, a student in his 20's, has wanted to be a lawyer for four years. His grades have been falling during the last six months. Last week he got back a major exam and found that his score was so low that with his grades, he will probably not be admitted to law school. Brian engages in a suicidal act, but survives.

Physical Illness

Karen, a student in her 20's, has been healthy and physically active. Six months ago, however, she was diagnosed with an incurable but nonfatal and painful physical illness. Last week the pain increased to the point where the medication was no longer controlling it effectively. Karen engages in a suicidal act, but survives.

Brian, a student in his 20's, has been healthy and physically active. Six months ago, however, he was diagnosed with an incurable but nonfatal and painful physical illness. Last week the pain increased to the point where the medication was no longer controlling it effectively. Brian engages in a suicidal act, but survives.

APPENDIX B

Measures

Please answer the following questions based on the paragraph on the previous page. For each scale, place a check ___ on one of the dashes indicating your rating.

1. Karen (Brian)'s choosing to kill herself (himself) is:
   a. Wise ___:___:___:___:___:___:___ Foolish
   b. Selfish ___:___:___:___:___:___:___ Unselfish
   c. Weak ___:___:___:___:___:___:___ Strong
   d. Active ___:___:___:___:___:___:___ Passive
   e. Right ___:___:___:___:___:___:___ Wrong
   f. Brave ___:___:___:___:___:___:___ Cowardly

2. The fact that Karen (Brian) survived her (his) suicide attempt shows that Karen (Brian) is:
   a. Wise ___:___:___:___:___:___:___ Foolish
   b. Selfish ___:___:___:___:___:___:___ Unselfish
   c. Weak ___:___:___:___:___:___:___ Strong
   d. Active ___:___:___:___:___:___:___ Passive
   e. Right ___:___:___:___:___:___:___ Wrong
   f. Brave ___:___:___:___:___:___:___ Cowardly

3. Based on what little you know of Karen (Brian), you would say she is:

   Masculine ___:___:___:___:___:___:___ Feminine

4. Karen (Brian) should be permitted to kill herself (himself).

   Strongly agree ___:___:___:___:___:___:___ Strongly Disagree

5. How acceptable to you is Karen's (Brian's) decision to kill herself (himself)?

   Completely ___:___:___:___:___:___:___ Completely
   Unacceptable Acceptable

6. To what degree do you sympathize with Karen's (Brian's) decision to kill herself (himself)?

   Low Sympathy ___:___:___:___:___:___:___ High Sympathy

7. How emotionally adjusted would you say that Karen (Brian) is?

   Poorly adjusted ___:___:___:___:___:___:___ Well Adjusted

8. How serious would you say Karen (Brian) was about wanting to kill herself (himself)?
   Very serious ___:___:___:___:___:___:___ Hardly Serious at all

APPENDIX C

The Personal Attributes Questionnaire

The items below inquire about what kind of person you think you are. Each item consists of a pair of characteristics, with the letters A-E in between. For example:

Not at all Artistic A...B...C...D...E Very Artistic

Each pair describes contradictory characteristics – that is, you cannot be both at the same time, such at very artistic and not at all artistic.

The letters for a scale between the two extremes. Please choose a letter that describes where you fall on the scale. For example, if you think you have no artistic ability, you would choose A. If you think you are pretty good, you might choose D. If you are only medium, you might choose C, and so forth.

1. Not at all aggressive	A...B...C...D...E	Very aggressive
2. Not at all independent	A...B...C...D...E	Very independent
3. Not at all emotional	A...B...C...D...E	Very emotional
4. Very submissive	A...B...C...D...E	Very dominant
5. Not at all excitable in a major crisis	A...B...C...D...E	Very excitable in a major crisis
6. Very passive	A...B...C...D...E	Very active
7. Not at all able to devote self completely to others	A...B...C...D...E	Able to devote self completely to others
8. Very rough	A...B...C...D...E	Very gentle
9. Not at all helpful to others	A...B...C...D...E	Very helpful to others
10. Not at all contemplative	A...B...C...D...E	Very contemplative
11. Very home oriented	A...B...C...D...E	Very worldly
12. Not at all kind	A...B...C...D...E	Very kind
13. Indifferent to others' approval	A...B...C...D...E	Highly needful of others' approval
14. Feelings not hurt easily	A...B...C...D...E	Feelings easily hurt
15. Not at all aware of feelings of others	A...B...C...D...E	Very aware of feelings of others
16. Can make decisions easily	A...B...C...D...E	Had difficulty making decisions easily

17. Gives up easily	A...B...C...D...E	Never gives up easily
18. Never cried	A...B...C...D...E	Cries very easily
19. Not at all self-confident	A...B...C...D...E	Very self-confident
20. Feels very inferior	A...B...C...D...E	Feels very superior
21. Not at all understanding of others	A...B...C...D...E	Very understanding of others
22. Very cold in relations with others	A...B...C...D...E	Very warm in relations with others
23. Very little need for security	A...B...C...D...E	Very strong need for security
24. Goes to pieces under pressure	A...B...C...D...E	Stands up well under pressures

APPENDIX D

Demographic Questionnaire

Please fill out the following information about yourself:

Age: _____ Sex: _____ Your year in college: _____

Ethnicity: (please check ALL that apply, and indicate specific ethnic background)

Asian American ____
Black/African American ____
White/European American ____
Latina/Latino/Hispanic ____
American Indian/Native American ____
Specific Ethnic Background (e.g., Japanese-American, Mexican-American)
_____

Parental education (in years): Mother's Education: _____years Father's Education _____years

Which of the following best describes the area you were raised in?
Metropolitan ____ Rural _____ Suburban _____

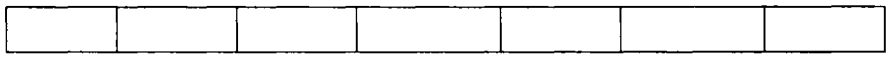
Which of the following best describes you in terms of sexual orientation identity?

Bisexual ____
Gay ____
Heterosexual ____
Lesbian ____
Unsure ____

Place an "X" at the point on the line where your sexual attractions and fantasies falls:

Exclusively Heterosexual — Equally Heterosexual & Homosexual — Exclusively Homosexual

Place an "X" at the point on the line where your sexual behavior falls:



Exclusively Heterosexual | Equally Heterosexual & Homosexual | Exclusively Homosexual

Your relationship status: (please check the situation that best describes you)

Married ____
Cohabitating w/ partner ____
Single/Attached ____
Single / Unattached ____
Other (specify) ____

Your religious background (The religious background you were raised, based on the religious affiliation of your parents and parental family members)
(please check ALL that apply and indicate the specific branch within the broad categories listed)

Jewish ____
None ____
Protestant ____
Specify _____
Roman Catholic ____
Other (specify) _____

Your current religious beliefs

Jewish ____
None ____
Protestant ____
Specify _____
Roman Catholic ____
Other (specify) _____

Do you attend religious services regularly? Yes ____ No ____

Approximately how often do you attend?

Never ____
Once a year ____
2-5 times a year ____
Once a month ____
Once a week ____

Has anyone close to you engaged in suicidal behavior?
Peers (specify relation (e.g., from school): _____) Yes ___ No __

Family (specify relation (e.g., cousin): _____) Yes ___ No __

Did you ever seriously consider suicide in the past year? Yes___ No__

Did you ever seriously consider suicide in your lifetime, excluding the past year?

Yes___ No__

Did you engage in suicidal behavior in the past year? Yes___ No__

Did you engage in suicidal behavior in your lifetime, excluding the past year?

Yes___ No__

How many times have you attempted suicide in your lifetime? _____

Did these suicidal acts require medical attention?

All did ___ Some did____ None did____

Any questions or comments about this study?_____