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Attitudes Toward Suicide in Peers Affected by a Point Cluster of Suicides as Adolescents

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Attitudes Toward Suicide in Peers Affected by a Point Cluster of Suicides as Adolescents

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Abstract

This thesis aimed to study how exposure to peer suicide may relate to current adjustment and attitudes towards suicide. Eight-five young adult graduates of the same public high school in the northeast who were exposed to multiple peer suicides as adolescents filled out an Attitudes Towards Suicide Scale, Scale of Perceived Social Support, reported their level of agreement with Thomas Joiner's suicide myths, and completed the Texas Revised Inventories of Grief for each peer lost to suicide. Grief was relatively low in this sample, but related to number of peers lost to suicide and closeness to those peers. Exposure to suicide (measured by grief scores and closeness ratings) was positively correlated with the belief that suicide is not preventable. Social support moderated both the relationship between closeness and grief, and the relationship between closeness and attitudes towards suicide; closer individuals with higher social support reported *more* grief than those with low social support, but *less* endorsement of certain suicide myths. Comparison of this sample to a sample of 63 students who had attended various public high schools in the northeast but had not been exposed to multiple suicides revealed that those who had not been exposed to multiple suicides were more likely to believe that suicide is not normal and were more likely to report feeling unprepared to prevent suicide than those with high exposure. The cumulative impact of suicide on peer cluster survivors, the self-protective function of certain suicide myths, and the role of peer support in coping with peer suicide emerge as important themes for discussion and for future research on this topic.

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This thesis is dedicated to those lost to suicide,

to their family and friends who will miss them forever,

and to my best friend, Sam,

whose memory holds my past and inspires my future.

"We need to get it in our heads that suicide is not easy, painless, cowardly, selfish, vengeful, self masterful or rash… that it is partly genetic and influenced by mental disorders, themselves often agonizing; and that it is preventable and treatable. And once we get all that into our heads at last, we need to let it lead our hearts."

- Thomas Joiner (2010)

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Attitudes Toward Suicide in Peers Affected by a Point Cluster of Suicides as Adolescents

In one of the most famous and tragic love stories of all time, Shakespeare's

Romeo and Juliet, Juliet awakes to learn that Romeo has killed himself out of his grief at

the thought of having lost her. Juliet then desperately tries to kill herself by drinking his

poison, and, when unsuccessful, she cries out, "O happy dagger! This is thy sheath; there

rust, and let me die" (*Romeo and Juliet*, V, iii, 169-170). Juliet stabs herself and dies

next to her lover. Through their dual suicides, Romeo and Juliet have become two of the

most famous tragic heroes of literary history. The two have been immortalized because

they made the ultimate sacrifice for their love, even at such a young age. Why in this case

is suicide embraced? And what constitutes a valid reason to take one's own life? There

are many different attitudes toward suicide and often those attitudes are determined by

the circumstances.

This thesis examines attitudes towards suicide in young adults exposed as

adolescents to a cluster of peer suicides. There is little research on cluster suicides

because of their rarity, but related research suggests that these affected peers are

especially important to study due to increased risk of mental ailments including

complicated grief and suicidal ideation. The stigma of suicide in the United States can

also make the grieving process even more difficult for the friends and families survived

by the suicide victim, referred to in this thesis as 'suicide survivors.' To build a

foundation for this investigation, this thesis reviews cultural attitudes toward suicide,

adolescent attitudes toward suicide, cluster suicides, and how exposure to suicide can

affect the adolescent peer suicide survivors. This review will build an understanding of

the factors that may influence attitudes toward suicide in peer survivors of adolescent cluster suicides.

Nock et al. (2008) defined suicide as "the act of intentionally ending one's own life" (p. 135). They distinguished this from "suicidal behaviors," which fall into three categories. These categories include "*suicide ideation*, which refers to thoughts of engaging in behavior intended to end one's life; *suicide plan*, which refers to the formulation of a specific method through which one intends to die; and *suicide attempt*, which refers to engagement in potentially self-injurious behavior in which there is at least some intent to die" (p. 135).

Suicide is one of the leading causes of death around the world. Approximately one million people worldwide and 30,000 people in the United States die by suicide each year (World Health Organization, 1996). Suicide is the 14th-leading cause of death worldwide, accounts for 1.5 % of all deaths, and the incident rate has increased by 60% in the past 45 years (World Health Organization, 1996, World Health Organization, 2012). Worldwide, almost one million people die by suicide each year (World Health Organization, 2012). Suicide rates are highest in Eastern Europe and lowest in Central and South America. North America, Western Europe, and Asia fall in the middle. Cross nationally, the rate of suicide is higher among men than women except for mainland China and India where no gender differences have been documented (Nock et al., 2008). Although there are other circumstances for which a person may commit suicide, most suicides are caused by depression or other psychological disturbances. It has been estimated that over 90% of suicide victims had a significant psychiatric illness at the time of their death; these illnesses are often undiagnosed and untreated, and are most

commonly mood disorders and substance abuse (Gould, Jamieson, & Romer, 2003). Even if suicide seems a response to events such as dissolution of a romantic relationship or the loss of a job, usually a significant underlying psychological disorder is present (Barraclough & Hughes, 1987).

In the United States, suicide is the 11th leading cause of death, accounting for 1.4% of all American deaths (National Center for Injury Prevention and Control, 2008). According to Nock et. al.'s 2008 study, when suicide results are examined by sex, age, and race/ethnicity, there are no differences until middle adolescence (ages 15—19 years old). During this age period, the rate of suicide among boys dramatically increases. Among Native Americans and Alaskan Natives, the rise during adolescence and young adulthood is the greatest, increasing more than fivefold. The rates for White boys/men also peak during adolescence and then rise again during older age. For girls, the rates of completed suicides are much lower in general than for boys, except with Native American/Alaskan Native girls during adolescence and for White women during middle age.

According to Nock et al. (2008), suicidal behavior has been reported in children as young as 4 years old, although it is debatable whether children this young can truly understand death and, therefore, actually be suicidal. "It was once assumed that young children were not capable of either contemplating or performing suicidal acts; however, a growing body of research has shown that young children do plan, attempt, and successfully commit suicide (Tishler, Staats Reiss, & Rhodes, 2007, p. 810). Prepubertal children generally do not have abstract thinking skills and rely mainly on concrete operational thinking. Consequently, children may not have the cognitive abilities to

problem solve or understand the consequences of their actions. An estimated 250 children between the ages of 5 and 14 die by suicide each year in the U.S. (Pompili, Mancinelli, Girardi, Ruberto, & Tatarelli, 2005). Gould et al. (1998) found that 1.9% of a randomly selected sample of children between the ages of 7 and 12 reported suicidal ideation, and Thompson et al. (2005) found that 10% of 8 year olds who were at high risk for maltreatment/ abuse displayed suicidal ideation. Although it is more rare, suicidal ideation and suicide attempts do occur in children under the age of 12, and this kind of behavior can serve as a precursor to future psychological problems and suicide attempts (Pompili et al., 2005). More commonly suicidal behavior starts around adolescence (12 years old), peaks at 16 years old, and stays elevated into early adulthood. Consistently, suicide has been the second or third leading cause of death among adolescents ages 13 to 18 years old (Bondora & Goodwin, 2005).

Historical Definitions and Types of Suicide

Historically, different types of suicide have been distinguished based on intent and contexts. With such distinctions, attitudes toward and acceptance of suicide can vary from circumstance to circumstance. Emile Durkheim (1897/1951) was one of the first people to study suicide scientifically, and he argued that there are four basic types of suicides. The first type is "egoistic." Durkheim defined this type as "excessive individuation." In this case, the individual is apathetic and can no longer find a reason for living. The second type of suicide is "altruistic," which he described as an action of passion or will due to "insufficient individuation." Included in altruistic suicides are "heroic suicides," which are committed with the intent of sacrificing for someone else's well-being and suicides that are based on the belief that existence is established in the

afterlife. The third type of suicide is "anomic" which is described as "deregulation." Durkheim wrote that anomic suicides are acts of intense emotion, usually anger, are often violent and unrestrained, and are due to a lack of control over another individual. People who commit anomic suicides generally feel isolated from society. The last type, "fatalistic," is characterized by excessive regulation and poor life circumstances (Maris, Berman, Maltsberger, & Yufit, 1992).

Menninger (1938) and Freud (1917) suggested that all suicides have three fundamental dimensions: hate, depression, and guilt. These dimensions create three interrelated types of suicide: revenge (a wish to kill), depression (a wish to die), and guilt (a wish to be killed). Freud theorized that suicidal thoughts originally were directed toward someone else and the wish for someone else to die (e.g., a parent, lover, spouse). Freud also discussed civilization's effects on suicide and said that our culture made people repress sexuality and aggression (Maris, Berman, Maltsberger, & Yufit, 1992).

Baechler's (1975/1979) theory categorized suicide into four categories: escapist, aggressive, oblative, and ludic. With escapist suicides, the intention is "to take leave," including flight (escape a situation), grief (escape dealing with a loss), and punishment (escape punishment). According to Maris (1981), 75% of completed suicides are escapes. The second category is aggressive suicides, which are directed at another person or multiple people. The four aggressive subtypes are vengeance, crime (murder-suicides), blackmail (threaten suicide to put pressure on a person), and appeal (sound an alarm). Maris estimated that 20% of completed suicides are a result of aggression. Oblative suicides are the same as Durkheim's description of altruistic suicides. The two subtypes of oblative suicide that Baechler described are sacrificial (to gain a greater value for one's

life) and transfigurational (to obtain martyrdom). Ludic suicides involve people who want to live life to the fullest even if it means death and is also labeled "indirect self-destructive behavior." The two ludic subtypes are ordeal (to prove something) or game type (to play with/ risk death) (Maris et al., 1992).

Other classifications of suicide were suggested by Schneidman (1968) who is known as a founding father of suicidology in America. He argued that suicides could be classified into three categories: egotic, dyadic, and ageneratic. Egotic suicides involve a narrow focus of attention, rigid thinking, depression, and are psychologically based. Dyadic suicide "results from unfilled needs or wishes related to his or her most important interpersonal partner" (Maris, Berman, Maltsberger, & Yufit, 1992, p. 73). Ageneratic suicides also involve significant others, but are distinguished by a total loss of connection with the human race.

In addition to these different theoretical categories of suicides, there are more specific groupings of suicide types. Some of these types are more common than others, and some are more accepted than others. There are also many different attitudes toward the acceptability of suicide. These attitudes can vary by religion, by culture, and from individual to individual. Attitudes towards suicide vary greatly with the context or situation in which the suicide takes place. One type of suicide that is widely debated cross culturally is assisted suicide, also known as voluntary euthanasia. Euthanasia comes from the Greek roots "eu" (good) and "thantos" (death) and is the practice of ending a life in order to end suffering. There are two types of assisted suicide: passive (deny treatments necessary for survival) or active (use of lethal substances). Assisted suicide is illegal in the United States, with the exceptions of Oregon, Montana, and Washington. Oregon has

a Death with Dignity Act that allows "an adult, who is an Oregon resident and is suffering from a terminal disease that will cause death within six months, to terminate his or her life through the use of medication" (Taylor, 2004, p. 1). According to a 2004 report, 15 people in Oregon used the life-ending prescription in the first year after the bill's passing in 1997. The rate of use rose steadily, and in 2003, 42 patients used the drug.

The choice-in-dying movement can be traced back to the early 1900s in America. Compassion & Choices is an organization that is dedicated to the right to death for terminally ill patients. On a personal level, they support patients in end of life decisions, help with pain and symptom management, and can help patients get information about "self-determined dying." They also attempt to educate the public and health care professionals and advocate for legal and legislative initiatives (Compassion & Choices, 2011). However, assisted suicide is controversial and, as mentioned earlier, is not widely accepted in the United States. Many politicians have made the "slippery slope" argument. This argument is the prediction that if assisted suicide becomes accepted for people who are terminally ill, it might become acceptable for people with other ailments or disabilities and would become continually more acceptable for more and more people (Douthat, 2009). Other reasons to oppose assisted suicide are that "it transforms a healing profession into a killing profession [and] it encourages relatives to see a loved one's slow death as a problem to be solved, rather than a trial to be accepted" (Douthat, 2009, para. 12). The interesting moral and psychological question to debate is whether it is healthier for a person to be able to end his/her suffering and die when he/she is ready or is it better to let nature take its course?

Unlike the controversy surrounding assisted suicides in America, one type of suicide that seems to be accepted and even honored in some societies is a suicide attack. These are acts of war in which the individual knows that he/she will die during the operation. Attackers generally believe that their actions are moral because they are fighting against something they view as unjust. They are doing it, in their own minds at least, for the greater good. Suicide attacks include suicide bombings, plane/automobile hijacking, kamikazes, and insurgent attacks. These acts of suicide are promoted by different militaries and organizations around the world and are generally thought of as being honorable because the individuals are giving up their lives for their country, religion, or their cause. The first large scale use of suicide attacks was by Japan in World War II. Kamikazes were Japanese planes that were filled with explosives and purposely flown into an enemy target. Suicide attacks are still used in battle today, most commonly by radical Islamists and the liberation group of Tamil Eelam in Sri Lanka (Yonghe, 2004). Workers from two Palestinian Muslim organizations, Hamas and Islamic Jihad, which send out suicide bombers, say they get many candidates for early death and "there is no shortage of men willing to sacrifice themselves to the cause" (Philps, 2001, para. 5). Although Islamic scholars deem suicide a sin, suicide bombers become Palestinian martyrs and gain prestige. Their families are even rewarded with monetary compensation. Suicide is denounced by Islam; for that reason, the term "suicide bomber" has now been changed within the community to "martyrdom operation" (Philps, 2001, para. 14). Atron (2006) made the argument that there is much more to suicide bombing than just politics, and we too quickly "ignore the underlying moral values and group dynamics that drive

jihadis to suicide terrorism" (p. 144). In America, we generally denounce suicide attacks, but elsewhere they are accepted and even praised.

Although not formal suicides or planned ahead, we often hear stories of soldiers sacrificing their lives to save a friend or their unit. This type of altruistic death differs from suicide attacks in that it is not meant to kill others but instead to save others. An example of this is 19 year old Ross Andrew McGinnis, who died in combat when he threw his body on a grenade to protect the four U.S. soldiers it could have killed or injured (Somashekhar, 2007). Although not many people would label this type of death a suicide, it technically is if we follow the definition that suicide is "the act or an instance of taking one's own life voluntarily and intentionally especially by a person of years of discretion and of sound mind" (Merriam-Webster, 2012, para 1).

Another type of suicide is a mass suicide. Mass suicides have been dated back to the 16th century when tens of thousands of "Old Believers" in Russia killed themselves collectively at hermitages or monasteries over a period of several decades (Robbins, 1986). They did so to avoid religious prosecution and to reach a "state of religious ecstasy" (Robbins, 1986, p. 2). One of the most famous and more recent accounts of a mass suicide is the Jonestown Massacre carried out by the People's Temple movement. The People's Temple was a religious group created in 1953 and led by Reverend Jim Jones (Barker, 1986). In 1978, Jones successfully convinced over 900 of his followers to kill themselves by drinking a cyanide laced drink and then killed himself. Jones and his members called the act a "revolutionary suicide." After having murdered Congressman Leo Ryan, the commune realized that they would not be able to continue functioning and decided to die in dignity and preserve their church. Another mass suicide in the 1990s

involved the Order of the Solar Temple, which was a European cult that was associated

with mass suicides and mass murders around equinoxes and solstices (Introvigne, 1995).

Another act of mass suicide was Heaven's Gate which took place in 1997. That group

was led by Marshall Applewhite, who convinced 38 of his followers to commit suicide in

order to escape the soon arriving end of the earth and allow their souls to ascend in a

UFO that would take them to a new spiritual level (Ayres, 1997). In March 2000, 780

people died in a mass suicide in Uganda. The deceased were members of the Movement

for the Restoration of the Ten Commandments of God (Mayer, 2001). Mass suicides are

large-scale examples of how suicidal ideation and planning are not always secretive and

personal.

In some cases, like with mass suicides, suicides can be discussed, planned, and

even rationalized between people. Similar to mass suicides, suicide pacts are agreements

made between people to kill themselves at the same time. Generally with suicide pacts,

one person is coercive and the other is extremely dependent, demonstrated through

analyses of online communications. Suicide pacts are rare and are not simply the act of

two individuals who do not wish to be separated (Fishbain, D'Achille, Barsky, &

Aldrich, 1984). In fact, suicide pacts can occur between two people who do not even

know each other. With the popularity and accessibility of the Internet, suicide pacts have

even been arranged over the Internet by strangers and have been planned via special

suicide websites (Rajagopal, 2004). According to Rajagopal (2004), advocacy for suicide

exists on the Internet, although neutral and preventative websites are more common. One

extreme, unfortunately true example was in 2010 when William Francis Melchert-Dinkel

was convicted for pretending to be a female nurse who initiated conversations online with

strangers who were contemplating suicide (Davey, 2010). He admitted to encouraging dozens of people to commit suicide and was charged with two counts of aiding suicide. Unfortunately, this is not the only time that suicide persuasion has happened. Between 1994 and 2000, there were 12 charges of aiding suicide in Minnesota alone. A suicide prevention website in Britain said it has tracked 39 cases where young people have died after visiting pro-suicide chat rooms (Davey, 2010). The largest pro-suicide website is called alt.suicide.holiday, or ASH, and it gives visitors advice and specific instructions and methods to kill themselves (Scheeres, 2003).

Cultural Attitudes Toward Suicide

When is suicide an acceptable act? According to Battin (2011), "Most suicides are preventable, perhaps, but it is not so clear that each single one should be prevented" (p. 257). However, she does admit that telling the difference between a rational and an irrational suicide is extremely difficult. For many people, suicide is never an acceptable act. For some who have conservative views on end-of-life decisions, suicide is repudiated for "any primary emotional, traumatic, or financial reasons in the absence of terminal illness" (Battin, 2011, p. 255). Others believe that people have the right to end their own lives whenever they choose. This decision of acceptability is also an individual decision. With so many types of suicide in so many different contexts, attitudes toward it vary greatly. Acceptability of suicide can vary based especially on culture and religion.

One culture that has a unique view on suicide is China through Confucianism. Confucianism teaches that "one should give up one's life if necessary, either passively or actively, for the sake of upholding the cardinal moral values of *ren* and *yi*" (Lo, 1999, p. 626). *Ren* (benevolence) and *yi* (justice) are to be upheld at all times, and it is "morally

wrong to preserve one's own life at the expense of ignoring *ren* and *yi*" (p. 626). As long as the act is intended to uphold these two values, suicide is morally permissible and is even honorable. Examples from Chinese history of instances in which suicide was admired and praised include suicide for the sake of the country, the master, a benefactor, a friend, the sake of keeping a secret, the sake of saving other lives, or the sake of avenging one's parents, husband, or master. These deaths expressed utter commitment and dedication to another and were seen as self-sacrificial (Lo, 1999). Another Confucian thesis is that "one should actively terminate one's life for the sake of avoiding humiliation or upholding one's dignity," which includes suicide in order to avoid execution, to maintain dignity after being defeated in battle, to avoid the indignity of being tried in court (regardless of whether one is guilty of not), or to avoid imprisonment (Lo, 1999, p. 631).

However, Confucianism does not promote suicide under all contexts. Confucian teachings do state that "when there is no threat to one's life, and when the calling in life is clear, one should live on to fulfill one's vocation in spite of personal tragedy and undignified treatment" and "one should broaden the scope of one's commitment; instead of dying for a rather limited cause, one should live and die for an object of a higher order" (Lo, 1999, pp. 632-633). Confucian values also stress that other-regarding suicides are more admirable than self-regarding suicides and that self-regarding suicides are only acceptable to avoid humiliation and disgrace (Lo, 1999).

Like Chinese culture, Japanese culture also seems to have a liberal view toward suicide. One form of suicide that is uniquely Japanese is seppuku, a stylized ritual for disembowelment. Seppuku is "an honour reserved only for the samurai, Japan's

traditional military aristocracy" (Fuse, 1980, p. 57). Although it is no longer a common practice, the honor associated with seppuku means that "its philosophy is a clue to understand Japan's moral values on life and death widely held by the Japanese" (Fuse, 1980, p. 57). According to Young (2002), there is a current contradiction between Japan's liberal attitudes toward suicide and ideals of Western medicine. Like Chinese culture, Japanese culture accepts and even admires suicide in certain situations, yet Japan has adopted Western psychiatric and medical views, which stress the idea that suicide is an irrational response to psychological problems. Therefore, Western theories and treatments may not be appropriate within their cultural context.

Stigma of Suicide in the United States

Although some cultures have accepting views toward suicide, this does not seem to be the case in America. For example, Christianity is the most popular religion in America, and the Catholic Church defines suicide as a sin. The Bible says "If any man defile the temple of God, him shall God destroy; for the temple of God is holy, which temple you are" (1Corinthians 3:17). According to Dante's *Inferno*, people who die by suicide are contained in the seventh circle of Hell along with people who commit murder, blasphemy, sodomy, and usury. Although in Ancient Rome suicide was an acceptable act when in response to political defeat or personal disgrace, Dante emphasized the belief that suicide is a sin without exception (Rafa, 2011). Thomas Aquinas warned, "suicide violates the natural law of self-preservation, harms the community at large, and usurps God's disposition of life and death" (Rafa, 2011, para. 1).

In addition to Catholic attitudes toward suicide, in the developed Western world, the legality of suicide demonstrates our general attitudes toward it. Unlike Japan and

China, North America and Europe have a history of condemning suicide, and it was

illegal in the United Kingdom up until 1961 (Suicide Act 1961, 2011). The Suicide Act

of 1961 *decriminalized* suicide and *criminalized* complicity in another's suicide.

Regardless of one's attitudes towards the acceptability of suicide, laws and religions that

are not accepting of suicide and deem it illegal or a sin, can contribute to the social

stigma of suicide. Although it is a common opinion in America that suicide is neither a

good nor a rational decision, saying it is illegal and a sin makes the *victim* seem bad,

instead of making the *decision* seem bad.

In Joiner's (2010) *Myths about Suicide,* the author explored different stigmatizing

myths about suicide that contribute to the negative feelings and attitudes people have

toward individuals who contemplate, attempt, and/or complete suicide. These myths

include the ideas that suicide is an easy escape, cowardly, an act of anger or revenge,

selfish, and done 'on a whim.' Two of the most dangerous stigmatizing myths are that if

people want to die by suicide we cannot stop them and that talking about killing oneself

is just a cry for help. Both of these myths are dangerous because if a person is truly

suicidal and decides to disclose this ideation to someone, those thoughts or threats need

to be taken seriously and brought to the attention of an appropriate authority. The stigma

of suicide is a complicated topic because most people, at least in our culture, agree that

anomic suicide (acts of intense emotion usually based on anger and social isolation) is a

poor decision and should be avoided at all costs. We are taught that suicide is bad and

that it should never be contemplated nor attempted. This disapproval of suicide could be

beneficial because it may keep some people from doing it; however, stigmatizing suicide

may make suicidal individuals feel even worse about themselves; it may prevent them

from disclosing and seeking help; and stigmatizing suicide can make an already painful experience even harder for the survivors.

Attitudes Toward Suicide

    Suicide Acceptability. It has been suggested in the literature that there is a causal link between attitudes toward suicide and suicidal behavior (Farberow, 1989). However, some research has shown that the relationship between suicide acceptability and suicidal behavior is complex and is influenced by a variety of mediating and moderating factors, including culture. Social acceptability of suicide can "increase or decrease community members' consideration of suicide as a solution to life problems, it can increase or decrease the willingness of suicidal individuals to seek help, and it can affect the accuracy of reports of suicide as a cause of death" (Li & Phillips, 2010, p. 183). One explanation for past reports of strong correlations between suicide acceptability and suicide rates could be report issues. For example, in countries that demonstrate low social acceptability of suicide because of strong religious values or strict laws, people may underreport or misclassify suicides leading to a much lower frequency than actual rates of deaths by suicide (Gajakakshmi & Peto, 2007). In general, results have been mixed about the correlation between suicidal acceptability and suicidal behavior; some show a positive relationship, some show a negative relationship, and some show no relationship at all (Li & Phillips, 2010).

    In one study conducted in China, the results did not indicate a correlation between acceptance of suicide and suicide rates. Li and Phillips (2010) asked college students, rural adult residents, and urban adult residents to complete an Acceptability of Suicide Scale. The Acceptability of Suicide Scale asked the participants to rate how likely they

would be to consider suicide given a variety of hypothetical stressors and situations. This scale measures how reasonable or understandable the participants think suicide is given certain circumstances. The results showed that college students had the most permissive attitudes toward suicide. However, there was no clear relationship between acceptance of suicide and suicide rates. Different results were found in regard to the relationship between attitudes toward suicide and suicidal behavior in a study of Lithuanian school children. Zemaitiene and Zaborkis (2005) evaluated suicidal tendencies and attitudes towards the freedom to choose suicide. Over 15,000 students (ages 11, 13, and 15) were surveyed in 1994, 1998, and 2002. The results showed an increasingly positive correlation between suicide attempts and the children's attitudes toward suicide over time. By 2002, 62.5% of respondents answered that they thought a person has the freedom to choose between life and suicide. The researchers also found a positive correlation between an approving attitude toward suicide and suicidal ideation/behavior. Zemaitiene and Zaborkis (2005) mentioned that suicide has become a problem among Lithuanian youth, but "a lack of data do not allow estimating a degree of spread, intensity and dynamics of suicidality among young people" (p. 83). In a separate study of adolescent Israelis, approving attitudes toward suicide were correlated with greater suicidal ideation than less approving attitudes (Brom, Elizur, & Witztum, 1998). The results from these three studies suggest that attitudes about the acceptability of suicide can indeed be associated with suicidal ideation and behaviors.

It is clear that there is some relationship between a person's acceptance of suicide and his/her feelings about it. This relationship may be greatly affected by culture as we have seen through the mixed results from studies on attitudes towards suicide from across

the world. In America, suicide is generally not an acceptable act, especially when anomic

(Joe, Romer, & Jamieson, 2007). In an American study on the relationship between

anomic suicide acceptability and suicide planning, Joe et al. (2007) found that

adolescents and young adults between the ages of 14 and 22 who had stronger accepting

attitudes towards suicide were more than 14 times more likely to think about killing

themselves than were young people with less accepting attitudes. Acceptability of suicide

was measured by the use of two items that were highly correlated: "I think it's ok to end

your life if you are tired of living" and "I think it's ok to end your life if you don't see

any reason to keep on living" (Joe, Romer, & Jamieson, 2007, p. 169). The adolescents

were given the Youth Risk Behavior Survey to assess suicidal ideation and behaviors.

This study also showed that Asian American adolescents were more likely to endorse

suicide acceptance than were White adolescents and that boys were more likely than girls

to endorse acceptance. Joe et al.'s results suggest that attitudes toward anomic suicide are

highly correlated with suicidal plans. Thus, attitudes toward suicide may have an

important influence on suicidal behavior and could be important to target in suicide

prevention. It makes sense that adolescents who might be contemplating suicide would be

more willing to discuss their *opinions* of suicide in general than they would be to discuss

their own suicidal thoughts or plans. Therefore, if research continues to show a link

between attitudes of acceptance and planning behavior, this knowledge could be very

helpful for suicide prevention.

  Adolescents' Attitudes Toward Suicide. In general, adolescents have a more

accepting view of suicide than adults do. One study showed that 22.5% of adults believed

that a person who died by suicide would go to heaven, whereas 42.5% of adolescents

believed that person who died by suicide would go to heaven (Bondora & Goodwin, 2005). One theory for why this difference between adult and adolescent attitudes may be is that "some adolescents may misread societal or peer values and attitudes regarding suicidal behavior due to faulty reality testing or a romanticized image of what suicide is supposed to mean to one's self and others" (Curran, 1987, p. 108). In the United States, suicide is also generally most accepted by young adult, male, White, urban, better-educated, non-Catholic people (Singh, Williams, & Ryther, 1986). Similar results were found in a Chinese study, with higher education levels, urban residency and younger age being associated with the most accepting attitudes toward suicide; however, this study found that women were more accepting than were men (Li & Phillips, 2010).

Adolescents also seem to have different theories toward death in general. Patros (1988) offered his theory and argued that children and adolescents "often see death glamorized by television, movies, books, and magazines. In many cases adolescents romanticize death and the way it will affect loved ones as well as people in general" (p. 43). Patros (1988) named common views that adolescents had toward death including that death is a peaceful sleep, a way to express love, to be reunited with deceased loved ones, and an escape from hopelessness. The author mentioned media as having a great impact on children and adolescents' attitudes toward death in general.

Bondora and Goodwin (2005) looked more closely at the possible influences that popular media can have on adolescents' attitudes and behaviors concerning suicide. The authors mentioned that suicide taboos have lessened, as suicide is commonly portrayed in the media nowadays. For example, heavy metal music lyrics often talk about and even advocate suicide (Stack, 1998). Earlier studies found that there may be a correlation

between metal music and suicidal attitudes (Arnett, 1991; Stack, Gundlach, & Reeves, 1994). However, Stack (1998) argues that this relationship does not exist when controlling for religiosity and that metal fans may be at risk for suicide due to both low religiosity and high suicide acceptability. Bondora and Goodwin (2005) also discuss how suicide's appearance in the media can have a contagion effect.

   Adolescent Responses to Suicidal Behavior in Peers. When children enter adolescence, they are at a much greater risk for depression and suicidal behavior than during their childhood years (Gould & Kramer, 2001). It is important to study adolescents' attitudes towards coping and help seeking in the context of suicide and suicide prevention because suicidal adolescents are more likely to tell a peer about their suicidal feelings than an adult (Gould et al., 2004). Further, the friends of these suicidal adolescents are not likely to report their friend's suicidal feelings to an adult (Kalfat & Elias, 1992). However, Kalfat and Elias (1992) found that girls were more likely to seek an adult's help for a suicidal peer than boys were. The authors also reported that peers' responses to a suicidal peer had to do with diffusion of responsibility and ambiguity of the situation. Therefore, it is possible that peers are less likely to seek help for a friend because they do not feel that they know enough about the situation and/or that they don't feel they have the authority and responsibility to decide it is crisis and seek help for someone else.

   Gould et al. (2004) found that most adolescents in their sample of 2,419 high school students had healthy attitudes toward coping and help seeking; however, students who were at risk for suicidal behavior were more likely to endorse suicidal thoughts and isolation as a coping mechanism for depression than were students who were not

depressed. In fact, they found that "approximately one third of at-risk students with serious suicidal ideation and behavior, depression, or substance problems thought people should be able to handle their own problems without outside help" (Gould et al., 2004, p. 1129). This coping mechanism is a very maladaptive because it can prevent these students from seeking help when they may need it. Suicidal adolescents are also likely to endorse the use of drugs and alcohol as a "good way to stop depressive feelings" (Gould et al., 2004, p. 1129; Shaffer at al., 1990). One contributing factor to the low rates of help seeking in suicidal adolescents and their peers may be the stigma of suicide. This stigma not only prevents help seeking, but it can also have negative effects on grieving a suicide.

Suicide Survivors' Attitudes Toward Suicide. Brent et al. (1993) found that within their sample, there was no increase in suicidal behavior in adolescent peer suicide survivors. They concluded that "the friends and acquaintances of suicide victims were inhibited from engaging in suicidal behavior by being exposed not only to the suicide but also to all the painful after-effects of the suicide on friends and family" (p. 515). Their study interviewed social networks of 26 adolescent suicide victims, and the authors argue that their exposure to suicide was protective because they witnessed the negative impacts that suicide can have. However, other studies have found a positive relationship between exposure to suicide and attitudes towards life and death.

Stein et al. (1992) found that people who experienced a loved one's suicide or attempted suicide as a child had more accepting views toward suicide than did those not affected by suicide. Similarly, Gutierrez, King, and Ghaziuddin (1996) found that adolescents who had lost a friend or family member to suicide reported a weak attraction to life and a strong attraction to death, an indication of increased suicidality. Interestingly,

this effect was even stronger for the adolescents who had been exposed to an *attempted* suicide of a close friend or family member than those who had actually lost a loved one to suicide. The authors offer two explanations for their findings: 1) adolescents become attracted to the idea of suicide because they witness the attention that it garners, and/ or 2) exposure to completed and attempted suicides increases depression in the survivors therefore increasing risk for suicidal ideation.

Brent et al. (1989) intervened with a group of peers after two completed suicides and seven attempted suicides had taken place in the course of 18 days within one high school's population. They found that attendance at the funeral did not play a role in increased psychopathology, and that the pathological impact of exposure to the suicide seemed to have been strongest when the survivor witnessed the suicidal act or discovered the body. They concluded that peers who were close to a victim of suicide (especially if they were directly exposed to the suicide) and/or had a history of affective disorder and/or previous suicidality should be closely screened for suicidality after exposure.

Cluster Suicides and Suicide Contagion

The contagious effects that suicide may have on people have been noted for centuries. Johann Wolfgang von Goethe's novel, *The Sorrows of Young Werther,* told the story of Werther who was a very passionate and sensitive young man (Swales, 1987). At the end of the novel, young Werther's heart is broken by the girl he loved, and he ultimately shot himself in the head. The novel became immensely popular, and, following the book's popularity, there was a wave of emulation suicides. This rise in suicide rates following a highly publicized suicide became known as the "Werther Effect," a term coined by Phillips (1974). This effect is also known as a type of "copy cat suicide."

Phillips documented the Werther Effect again after the suicide of Marilyn Monroe.

Following her death, there was a 12% increase in the U.S. suicide rate. Japanese culture

has a more accepting view of suicide, and it also shows the Werther Effect. This was

shown when 33 Japanese adolescents killed themselves after a teen idol, Yukiko Okada,

was rescued following a failed suicide attempt (Robbins, 1998).

Insel and Gould (2008) defined and distinguished the frequently used terms

"contagion," "imitation," and "clusters." Suicide contagion is the "process by which one

suicide facilitates the occurrence of a subsequent suicide," usually through direct

exposure to a suicide or through media coverage (p. 293). Imitation is defined as "the

process by which one suicide becomes an influential model for successive suicides" (p.

294). Insel and Gould (2008) argue that imitation is the underlying theory that explains

the contagion effect. Suicide clusters refer to multiple suicides happening in close

geographic or temporal proximity.

The contagion effect may be especially worrisome for the adolescent population.

One reason that contagion may be a problem for adolescents is that they take in more

media than adults do and are generally more influenced by it (Strasburger & Donnerstein,

1999). Curran (1987) provided multiple examples of studies that indicate the

susceptibility of adolescents to media influences, especially in suicides that have actually

occurred. One study showed a 6.9% increase in teenage suicides following TV news

coverage of suicide, but only a 0.5% increase in adult suicides (Goldney, 2001).

Although the contagion effect has been studied widely in regard to the media, it

also seems to be applicable to real-life suicide exposure. The contagion hypothesis

"suggests that an adolescent suicide may trigger a cluster of subsequent suicides among

peers" (Bondora & Goodwin, 2005, p. 6). Gould, Wallenstein, and Klienman (1990)

found evidence that supports the contagion hypothesis. They found trends of suicide

clusters and unusual rises in suicidal behavior in localized geographical regions.

Similarly, Gutierres, King, and Ghaziuddin (1996) found a relationship between exposure

to an attempted suicide and negative attitudes toward life and an attraction to death. It has

also been noted that people who have attempted suicide have a large number of suicidal

friends (Kreitman et al., 1969). This relationship could be due to a peer contagion effect

where suicidal attitudes are imitated among friends or it could be because suicide or

depression-prone people may choose each other as friends.

Contagion via real-life suicide exposure may be related to the social learning

theory, which suggests that most human behavior is learned through modeling and

observing others. Kreitman, Smith, and Tan (1969) found some support for the

hypothesis that suicidal ideation and attempts would cluster in socially linked individuals

because they may use suicidal behavior as a form of communication and social learning.

A related theory that is most relevant for adolescents who rely heavily on peer groups for

social learning is the "peer contagion effect." Dishion and Tipsord (2010) defined peer

contagion as a "mutual influence process that occurs between an individual and a peer

and includes behaviors and emotions that potentially undermine one's own development

or cause harm to others" (p. 190). There is also evidence to suggest that peer contagion

can affect depressive symptoms. For example, it has been found that depressive

symptoms could be predicted in adolescents based on friends' depressive symptoms

(Stevens & Prinstein, 2005). Peer contagion may affect adolescents' suicide and self-

harm, but it is hard to test this idea systematically because of the low base rate of cluster suicides (Dishion & Tipsord, 2010).

In Insel and Gould's (2008) literature review on modeling of adolescent peer suicidal behavior, they report some interesting gender differences from two studies. Bjarnason and Thornlindsson (1994) found that both genders had differing reactions to a peer's suicidal ideation in a population of Icelandic adolescents. Their results showed that a friend's attempted or completed suicide had similar effects across gender, but receiving information about a friend's suicidal ideation was much more distressing for the male adolescent friends than for the female adolescent friends. In a separate study, Culter et al. (2001) found that American adolescent girls were more likely to make a suicide attempt if a peer made an attempt, whereas boys were more likely to make an attempt if their peer had actually completed suicide. These findings may suggest gender differences in the way peers react to suicidal behavior, attempts, and attitudes, as well as differences in the potential modeling of these phenomena. In some cases, these peer reactions to suicides can result in suicide clusters.

The Centers for Disease Control defined a suicide cluster as "a group of suicides or suicide attempts, or both, that occurs closer together in time and space than would normally be expected in a given community" (O'Carroll, Mercy, & Steward, 1988, p. 1). A "contagious cluster" has been defined as three or more cases in a geographic area (Johansson, Lingqvist, & Eriksson, 2006). Exposure to suicide, as we have learned through the contagion hypothesis, increases one's risk for suicidal thoughts, and the risk of suicide following exposure to another suicide is 2 to 4 times higher in teenagers than in any other age group (Gould, Wallenstein, Kleinman, O'Carroll, & Mercy, 1990). It has

been estimated that between 1-2% of adolescent suicides occur in clusters, and they are very rarely seen in age groups over 24 (Gould et al., 1990).

Thomas Joiner (1999), a noted expert on suicide, defined two different types of suicide clusters: mass clusters and point clusters. Mass clusters are media-related and are usually in response to a publicized suicide. They can be based on fictional or actual suicides. However, Joiner claimed that the evidence for mass clusters is equivocal, and he cited Kessler, Downey, Milvasky, and Stipp (1998), who went back through records and found no reliable correlation between media coverage and suicide rates. Therefore, mass clusters may be more complicated than other research that supports the existence of media-related mass clusters may suggest. Joiner seems to believe that mass clusters probably do not exist but that point clusters do. Point clusters are local and generally involve institutions such as hospitals and schools. Point clusters are not common in families and are not common outside of institutions. Joiner also criticized the use of the term "contagion" in regard to suicide because it is too vague. The medical and biological definition cannot be applied to what we know of suicide, as nobody has articulated a biological agent of contagion for suicide.

Thomas Joiner provided an alternative view to explain point clusters at a deeper level than just saying that suicide is contagious. Joiner's view involves four sets of findings. The first is that severely painful events are, in themselves, risk factors for suicide. Just like any kind of death of a loved one, the loss of a friend or peer qualifies as a severely painful event that can increase rates of depression, complicated grief, and suicidal ideation The second finding is that social support can be a beneficial buffer against suicidal thoughts and behaviors, and the loss of a friend to suicide erodes that

buffer. Not only is the peer suffering from a severely painful event, but he/she is also left to grieve without the deceased peer's social support. In addition, the social support from the rest of the peer group may also be damaged through their own grief. The third finding is that risk factors for suicide are often person-based, such as the presence of a psychiatric disorder. The fourth finding is that people who are similar, are more likely to be friends, so adolescents with similar risk factors such as personality, behaviors, and family backgrounds may choose to be in the same peer group due to these personal similarities. Therefore, the friends of a person who dies by suicide may already be at risk for suicide. Joiner says that when all of these factors combine, it can help explain the phenomenon of point-clustered suicides. He explained the rarity of point clusters in families, because when families are mourning, they get increased social support. This point is interesting because clustering is most common in peers and friends of the victim, and grieving friends do not get as much sympathy and/or social support from others as the family members do. Therefore, friends may not receive as much of this socially supportive buffering. Another reason why suicides may cluster more often in adolescent peers is because adolescents are not as responsible for their peer's well-being as a parent would be. Therefore, if there are emotional disturbances within a peer group, help-seeking behaviors may be different in a group of peers than if it were a parent seeking help for a child. This diffusion of responsibility may make help seeking, and intervention, less common.

The Effects of Stigma on Suicide Survivors

It is generally accepted in the literature that grieving a death by suicide is different than grieving a death by a different cause. Placing blame on oneself and/or others for the

loss of the loved one is a feeling that is especially common in those bereaving loss by suicide. Society generally views a death by suicide as a failure by the victim and his/her family to work through emotional problems (Cvinar, 2005). As a reaction to this stigmatizing blame that is placed on the suicide survivors, family members of suicide victims generally feel that they are more blamed and avoided than are family members of someone who died under a different circumstance (Ness & Pfeffer, 1990). It has also been found that suicide survivors have more negative attitudes toward themselves and are viewed more negatively by others than are people grieving a loss by a different cause of death (Jordan, 2001). A death by suicide also can cause problems within a family that is suffering the loss. Families experience "more estrangement, anger, and conflict and less openness, support and concern for each other as they tried to cope with loss" than do family members bereaving a non-suicide loss (Nelson & Franz, 1996, p. 142). There are four specific bereavement experiences that are unique to the suicide survivors: stigma, blame, search for meaning, and being misunderstood (Harvey, 1998). Although these experiences may be present in the bereavement of other types of death, Harvey (1998) explains how it is unique for suicide survivors because these four bereavement experiences generally occur simultaneously. These experiences often make the grieving process harder and can make support systems weaker.

Suicide survivors also receive less social support than do people bereaving a non-suicide loss of a loved one. One of the reasons for this difference may be that suicide is a difficult topic to talk about so supporters might not bring it up or know what to say. They may also assume that the bereaved would not want to talk about it. Although it is becoming less taboo to talk about suicide, it is still a sensitive subject because it is so

emotionally charged and stigmatized. The suicide survivors themselves may also contribute to this lack of social support because they may not seek it out, or they may deny it when it is offered because it is so hard to talk about their loved one and how he or she died. They also may fear disclosing their loss because they are afraid that they will receive stigmatizing, insensitive, and unsympathetic responses. In general, however, disclosing and discussing the death of a loved one can be therapeutic for many people. This insufficient social support can be extremely painful for suicide survivors and can delay the grieving process (Lukas & Seiden, 2007).

Psychological Effects of Suicide on Family Survivors

Family Survivors. Several studies have shown that soon after bereavement, the suicide rate of bereaved persons is higher than it is in those who are not grieving. One single suicide, on average, immediately and intimately affects at least six other people. If the suicide occurs in a school, it can impact hundreds of people (World Health Organization, 2000). There has also been a lot of research showing that suicide is more common in spouses and family members of individuals who have died by suicide than in non-suicide loss controls (Agerbo & Aarhus, 2003; Runeson & McIntosh, 1996; Qin, Agerbo, & Mortensen, 2002). MacHahon and Pugh (1965) found that in the first year after the death of a spouse, the risk of suicide is significantly higher than average and continues to be higher for about 4 years after the death. Youth who had lost a parent to suicide showed higher rates of depression and substance abuse as compared to youths who had lost a parent due to a natural death (Brent, Melhem, Donohoe, & Walker, 2009).

Agerbo (2005) looked at spouses and children of adults who had died by suicide between the ages of 25 and 60 years old. The results showed that husbands and wives are

at a greater risk for suicide if their spouses had been admitted to a hospital due to a diagnosed mental illness, however the authors note that this correlation may be due to assortative mating, the likelihood that a person will choose a partner with similar characteristics to oneself. Agerbo (2005) also found that spousal suicide was higher in those who had lost their spouse to suicide than in those who lost a spouse by another cause of death. Similarly, bereavement of a child's death by suicide was more predictive of parental suicide than was loss of a child by another cause. These results reinforce the idea that bereavement of suicide is different than other causes of death, and that the loss of a family member to suicide may increase the survivor's risk for suicide.

In their study on family members of suicide victims, Brent et al. (1993) found that mothers of suicide victims showed higher rates of new onset depression than did the control group of mothers (20% vs. 0%). The findings were similar for mothers' rates of PTSD (15% vs. 0%). The fathers in this study showed the same effect, although it was much weaker than that of the mothers (6% vs. 0% for depression), with none of the fathers showing PTSD. Interestingly, none of the mothers of suicide victims had attempted suicide, whereas 6% of the fathers had. This difference is congruent with Agerbo's (2005) findings that being a mother may be a protective factor against suicide. However, the focus of this study was on the siblings of suicide victims. Brent et al. (1993) also found that adolescent siblings were at the greatest risk for developing depression, with 28% of them reporting new onset depression after the death of their siblings (compared to 4% in the control group). Siblings of suicide victims were also much more likely than the control group to exhibit symptoms of depression including

weight changes, sleep disturbances, social withdrawal, anhedonia, and suicidal ideation although there were no significant differences in suicidal behavior or attempts.

Adolescent Peer Survivors. Brent et al.'s (1992) findings on depression in friends and acquaintances of suicide victims showed results similar to those of their study with siblings (Brent et al., 1993). The new onset depression rates for siblings of a suicide victim compared to the control group was 28% versus 4%, and the rates for friends and acquaintances were 29% versus 5% (Brent et al., 1993). The authors argued that peer bereavement might be more similar to sibling bereavement than to parental bereavement because the relationship between friends and siblings is more comparable than a parent and a child's relationship. In a different study, Brent et al. (1992) studied adolescent peers of a suicide victim and found that they were at an increased risk for major depression, post-traumatic stress disorder, and suicidal ideation compared to adolescents who had not lost a peer to suicide. However, there were no significantly different rates of actual suicide attempts among them than in the general population. In a study involving 146 friends and acquaintances of adolescent suicide victims, Brent et al. (1993) found that the friends who had a new onset of depression after the suicide has a closer relationship with the victim and showed more severe grief.

Peer Suicide Survivors and Grief

It is important to study the grieving process in peer suicide survivors due to their increased risk of psychological disturbances and potential suicidal ideation. In a longitudinal study, Melhem et al. (2004) looked at the incidence of traumatic grief in adolescents exposed to a peer's suicide. The 146 participants ranged in age between 11 and 23 years old and were interviewed about 7 months after the suicide, then again 12-18

months later, and then again at 36 months from the initial interview. Melhem et al. (2004) found that adolescents are similar to adults in their experience of a traumatic grief reaction after the death of a peer by suicide. The authors defined traumatic grief as being distinct from anxiety and depression and as including "symptoms of yearning, crying, numbness, preoccupation with the deceased, functional impairment, and poor adjustment to the loss" (p. 1414). Although there was quite a bit of overlap between the development of depression and the expression of traumatic grief, they were not dependent on each other. In other words, although traumatic grief can predict depression and posttraumatic stress, it is a distinct effect of exposure to suicide.

In a separate study, Melhem et al. (2003) produced findings that are important to predicting individual differences in response to suicide exposure. Using the same sample of adolescents as Melhem et al. (2004), Melhem et al. (2003) investigated predictors of complicated grief in adolescent suicide survivors. The authors used the Texas Inventory of Grief (TIG), a scale designed to measure unresolved grief (Faschingbauer et al., 1987) in order to measure complicated grief. They found that "complicated grief was significantly associated with sex, participants' feeling that they could have done something to prevent the death, interpersonal conflict, previous history of depression, and family history of anxiety" (pp. 25-26). Interestingly, complicated grief tended to cluster within specific social networks which, as the authors argue, further reinforces the evidence that complicated grief is distinct from depression and PTSD and may have a social contagion component.

The Current Study

Research on the general population has examined the relationship between attitudes toward suicide and suicidal behavior, and research on survivors of peer and family suicide has explored the effects of these losses on survivors' attitudes, suicidal behaviors, and psychological adjustment. Peer cluster studies have been documented and described, but less is known about the relationship between attitudes towards suicide among survivors of peer cluster suicides and their adjustment. Additionally, the process through which adolescent cluster suicide exposure might influence attitudes and adjustment in peers who have suffered these *multiple* losses is not yet well understood.

Past research shows that there are notable individual differences in people's responses to suicide exposure so it is possible that different outcomes would be observed across different people depending on the circumstances (Brent et al., 1996). Relational closeness to the suicide victim and complicated/unresolved grief may be important predictors of response to cluster suicides, just as they are in responses to individual suicides (Melhem et al., 2003). These factors have shown to be extremely important in predicting the wellbeing of suicide survivors.

The stigma that peer cluster suicide survivors experience also causes concern and may be related to the grieving process. Suicide survivors generally deal with stigma, blame, and being misunderstood during the bereavement process; in order to grieve and find meaning, suicide survivors must navigate the blame and guilt of not doing enough to prevent the suicide (Harvey, 1998). In the case of multiple peer deaths to suicide, stigma, blame, search for meaning and being misunderstood may be even worse. However, stigma, blame, search for meaning and misunderstanding are all related to attitudes

towards suicide. For example, if an individual believes that he has a duty to prevent suicides, he may feel more blame and guilt. Another individual who believes that suicides cannot be prevented would probably feel less responsibility for the death. Because past research has shown that attitudes towards suicide may play a role in suicidal ideation, it is understandable to think that these attitudes may have a relationship with suicide survivors' grieving. Because grief and other psychological effects may be exacerbated in cluster situations, it is understandable that in order to protect themselves from this intense grief, peers with high suicide exposure may have different attitudes towards suicide.

The current study was designed to investigate the possible relationship between repeated exposure to peers' suicides, grief, and attitudes toward suicide in a sample of individuals exposed to suicides by three members of the same graduating class in high school. In February 2005, while the participants were freshmen in high school, a male classmate died by suicide. In August 2009, two other male students who were members of the class of 2008 also died by suicide. The second and third students who died by suicide were in the same class and social network as the first, but did not end up graduating with the class (one dropped out and one transferred). Also, they died after their class had graduated from high school so participants in this study may or may not have been aware of or affected by all three suicides. All three students died in their homes by hanging and were found by their mothers, therefore no peers had direct exposure to the deaths. All of the participants in this study graduated from the same class to which these three deceased students belonged.

Due to the clear link between unresolved grief and psychological risk in research on survivors of both single peer suicide and family suicide, this study sought to explore

the possible relationship between attitudes toward suicide and the grieving process in this sample of peer cluster suicide survivors. This study measured relational closeness to the victim at the time of each peer suicide, perceived social support, past and current grief, attitudes towards suicide, and acceptance of stigmatizing suicide myths.

Based on past research, it was first hypothesized that the peers who were closer to the victims would have higher past grief scores. In addition, it was hypothesized that the peers with higher closeness scores would also have higher *current* grief scores than those who were not as close, but that the relationship between closeness and current grief scores would be moderated by perceived current social support. It was also hypothesized that there would be a significant relationship between attitudes towards suicide/ acceptance of suicide myths and the level of grief resolution, with more resolved grief being related to less stigmatizing attitudes. It was also hypothesized that the participants who were relationally closer with the deceased peers and had lower current grief scores would have less stigmatizing views toward suicide than would the students who were not relationally close to the deceased. Conversely, participants who were relationally closer with the deceased students with higher current grief scores would have more stigmatizing views toward suicide. In other words, it is hypothesized that lower stigma acceptance may be part of the process for overcoming grief in individuals who lost close friends in this cluster of suicides. Additionally, it was predicted that the students who were not relationally close with the deceased students would have attitudes toward suicide that were moderately stigmatizing and that those attitudes would not be as closely related to grief scores.

Finally, this study examined the role of social support in peer suicide survivors' grieving process. Because peer suicide survivors may receive little support after the suicide, they may become isolated, especially if the peers lost to suicide were close friends. This effect may be compounded in peer cluster suicides. Current social adjustment and perceived social support is also an indicator of current psychological functioning. Because of this, this thesis will investigate perceived social support and examine its relation to complicated grief and relational closeness to peers who committed suicide in young adults exposed to peer cluster suicide as teenagers. It is hypothesized that social support will be a protective factor for unresolved grief, meaning that those with more social support will report lower current grief scores.

Method

Participants

Participants were graduates from the class of 2008 from a large, public high school in New England. There were 423 students who graduated in this class and 342 students (80.9%) could be contacted through social networking site messaging, and emailing to see if they were interested in participating in the present study. A total of 131 students, or 38.3% of those contacted, started the survey and 92 (26.9% of those contacted) completed it. Therefore, 39 participants dropped out of the survey after starting it. In addition to the 39 participants who dropped out, 7 participants technically completed the survey but skipped most of the questions. In order to be included in the final sample, the participants had to have filled out at least the first Texas Inventory of Grief Scale about grief due to the loss of a peer to suicide and the scale of Perceived Social Support, which was the final measure administered before the demographics.

These inclusion criteria brought the final sample number to 85 participants, which was the group used for most analyses.

Statistical analyses were performed to describe the 46 participants who dropped out or provided incomplete data and to compare them to the 85 participants with complete data. Unfortunately, the demographics of this group are not known because the demographic items were located at the end of the survey. However, it is important to note where in the survey the participants dropped out. Thirty-five of the participants answered the question about closeness to the first peer and twenty-four of them went on to complete the Texas Inventory of Grief for the first peer. However, participation dropped dramatically after the first TIG with a maximum of two or three participants completing measures after this up until the end of the survey. Interestingly, participants who had lost a family member to suicide in addition to the loss of peers were more likely to complete the survey than those who had not lost a family member, χ^2 (1, $N = 123$) = 6.38, $p = .012$. There was also a marginal difference in closeness to the first peer with those who dropped out having higher closeness ratings ($M = 2.63$, $SD = 1.09$) than those who completed the survey ($M = 2.16$, $SD = 1.22$), $t(118) = 1.95$, $p = .054$. Those who dropped out also had higher scores of present grief ($M = 3.03$, $SD = 1.18$) than those who completed the survey ($M = 2.44$, $SD = .90$), $t(101) = 2.39$, $p = .019$. However, there were no significant differences between drop out rates based on past grief scores. Therefore, participants were more likely to drop out if they had higher present grief scores for the first peer lost to suicide.

The average age of the participants who completed the full survey was 21.2 years old ($SD = .44$). Out of the 85 participants, 20 were men and 65 were women. The

majority of the participants (90.5%) identified as being White, one participant identified as being Black, two as Latino/a, one as American Indian/Alaska Native, zero as Asian and two as multiracial.

A comparison sample was also used in this study. This sample was comprised of 67 participants. Thirty-eight (60.3%) were women and 25 (39.7%) were men. All participants reported being between the ages of 21 and 23 and that they had attended a public high school in the northeast (Massachusetts, Connecticut, Rhode Island, New Hampshire, Vermont, Maine, New Jersey, New York, Pennsylvania). The average age was 21.5. The majority of the participants (87.3%) identified as being White, one identified as being Black, one as Latino/a, three as Asian, zero as American Indian/Alaska Native, and three as multiracial.

Materials

Closeness Questionnaire. This five item self-designed measure was used to assess participants' relationship with anyone they had known who died by suicide. They were first asked if they have had any family member die by suicide. They were then asked if they had ever lost a peer to suicide and if yes, how many. They were then asked to fill out one relational closeness form per peer they had known who died, up to three peers which consisted of two items. This form asked about their relationship with each person and how close they felt they were with each person on a Likert scale of 1-5 (1 not close at all, and 5 very close) (see Appendix D).

Texas Revised Inventory of Grief (TRIG). The Texas Revised Inventory of Grief was used in order to measure unresolved grief (Faschingbauer, DeVaul, & Zisook, 1977). The participants were asked to fill out one TRIG per peer they had known who

died by suicide (up to three people). This scale presented statements and asked the
participants to rate on a 5-point Likert-type scale how true the statement is by circling
one of five possible choices: completely false, mostly false, both true and false, mostly
true, completely true. There were 21 items, and they were broken up into two sections:
past life disruption and present emotion of grief. The first section about past life
disruption consists of 8 items and asks the participants to rate the statements based on
how they were feeling at the time the person died. Statements include "I was unusually
irritable after this person died" and "I found it hard to sleep after this person died." The
Cronbach's alpha for the first half of the measure is .77 (Faschingbauer et al., 1987). The
second section asks about present emotion of grief and has 13 items. Statements in this
section include "I still get upset when I think about the person who died" and
"Sometimes I very much miss the person who died." The Cronbach's alpha for the
second section of the scale is .86 (Faschingbauer et al., 1987). For the sample used in this
study, the Cronbach's alpha for the past scale was .926 and it was .935 for the present
scale (see Appendix E).

      Attitudes Towards Suicide Scale (ATTS). The Attitudes Towards Suicide Scale
(Salander, Renberg, & Jacobsson, 2003) is a 37 item and 10 factor scale that measures a
person's feelings about and attitudes toward suicide. The 10 factors are: suicide as a right,
incomprehensibility, noncommunication, preventability, tabooing, normal (common),
suicidal process, relation, preparedness to prevent, and resignation. The items are
statements that the participants are asked to rate on a 5-point Likert scale by choosing one
of the following options: strongly agree, agree, undecided, disagree, strongly disagree.
Statements include "It is a human duty to try to stop someone from dying by suicide" and

"Most suicide attempts are caused by conflicts with a close person." The overall Cronbach's alpha as measured by the authors is .60. The ATTS has been modified for this study in order to reduce potential emotional distress of the participants who may be vulnerable. Some factors had multiple items that were repetitive, so the scale was shortened to reduce the possible distress of answering repetitive questions about an emotionally evocative topic. First, all questions that asked the participants to reflect on their own suicidal ideation (for example, "I could say that I would take my own life without actually meaning it") were removed due to the sensitive nature of the study. Second, the two items with the highest factor loading were extracted from each of the 10 factors to create a shortened 20-item scale (see Appendix F).

Stigma Toward Suicide. This self-designed measure was used to assess how much each participant agrees with Thomas Joiner's stigmatizing myths about suicide (Joiner, 2010). The statements are from Joiner's book *Myths about Suicide* and include statements like "Suicide is selfish" and "If people want to die by suicide, we can't stop them." These statements more directly target the stigma that Joiner describes in his book than the ATTS does. The participants were asked to rate how much they agree with each of the six statements on a 5-point Likert scale ranging from "strongly disagree" to "strongly agree" (see Appendix G).

Multidimensional Scale of Perceived Social Support (MSPSS). The Multidimensional Scale of Perceived Social Support (Zimet, Dahlem, Zimet, & Farley, 1988) is designed to measure present perceived social support. The participants were asked to rate how much they agree with each statement on a 7-point Likert scale ranging from "very strongly disagree" to "very strongly agree." Past use of this scale has

demonstrated high internal consistency with a Cronbach's alpha of .86 (Edwards, 2004).

Examples of statements on the MSPSS include "My family really tries to help me" and "I

can count on my friends when things go wrong." The 12 items are broken up into three

domains of social support: family, friends, and significant others. In the current sample,

the Cronbach's alpha for the family subscale was .896, the alpha for the friends subscale

was .944, and for a special person it was .955 (see Appendix H).

Demographic Questionnaire. This short questionnaire asked the participants

about their demographics including age, sex, race/ethnicity (see Appendix I).

Procedure

The potential participants received a recruiting letter through email or social

network website messaging (see Appendix A). Because many of the participants were

enrolled in college at the time, emailing and social networking were the easiest modes of

contact. They were asked to participate in a study about attitudes towards suicide and to

forward the email to other members of their class. The email message contained a link to

a survey made with Survey Monkey. Survey reminders were sent 9 days after the initial

email was sent and then again one month after the initial email (see Appendix A)

reminding potential participants about the survey opportunity, and encouraging them to

complete it if they chose to do so. When they first opened the survey they were asked to

read a welcoming letter (see Appendix B). The letter's intention was to clearly state that

the survey would ask them questions about suicide and that the entire survey was

optional. The individuals who agreed to participate were then asked to electronically sign

the informed consent (see Appendix C). The first measure they were asked to fill out was

the author-created closeness questionnaire for the first peer (see Appendix D). They were

then asked to fill out the Texas Revised Inventory of Grief (TRIG) for the first peer (see Appendix E). This sequence of completing the closeness questionnaire followed by the TRIG was repeated for up to 3 peers they had known who died by suicide. Then, the participants were asked to fill out the single Attitudes Towards Suicide Scale about their general attitudes (see Appendix F) and the single stigmatizing myths questionnaire about their general beliefs (see Appendix G). Finally, they filled out a Multidimensional Scale of Perceived Social Support assessing their current social adjustment (see Appendix H) and a demographics questionnaire (see Appendix I). After completing the survey, the participants received information about the study and resources they could use if they found the questionnaire to be distressing (see Appendix J). These resources included a resource located near the high school they all attended, hotline phone numbers, helpful websites, and the link to a website that would help them access counseling services on their own college campus. This information was also provided to anyone who exited the survey early. Participants who completed the survey also received a debriefing form (see Appendix K).

The comparison sample was collected after the initial survey had been administered and completed. This sample was sent the same survey without the Texas Revised Inventory of Grief measures. The participants in the comparison sample were recruited in a few ways. All senior psychology majors were asked via email to forward the survey to friends they may have from northeastern public high schools. These students were be seniors and were asked if they wanted to participate. If they said yes, they provided their email addresses and the survey was sent to them. They were also contacted through social networking sites and asked to forward the survey to their own

friends who meet criteria. Lastly, participants were recruited through asking participants from the original sample via email to send the survey to college friends who went to high school in the northeast, but went to a different high school than their own. The link and recruitment text was sent via social networking websites and email. Twenty-six (41.3%) of the comparison sample participants were students at Connecticut College. The participants who were not Connecticut College students were entered into a raffle for a gift certificate.

Ethical Issues

Research on suicide is important in that the more we know about it, the more we can help individuals who are suicidal. However, suicide is a very serious topic and there are ethical concerns to researching it. One fear involving suicide research is the assumption that researching suicidality may "prime" participants who are already vulnerable and may lead to an even greater risk for suicidality in these individuals (Pearson, Stanley, King, & Fisher, 2001). In general, distress after completing a mental health survey is relatively low; however, for this study a number of participants may have been vulnerable because of their previous exposure to suicide (Reynolds, Lindenboim, Comtois, Murray, & Linehan, 2006). Reynolds et al. (2006) concluded that research on suicide with high-risk individuals (chronically suicidal and mentally ill people) is safe if it is conducted with care and expertise. The present study was not conducted with extensive expertise, but it was also not conducted within a population of openly suicidal individuals. Reynolds et al. (2006) claimed that their findings "should reassure those interested in suicide research that assessing suicide does not typically lead to increased suicidality" (p. 33). A different study distributed a mental health survey and then asked

the participants if the survey had made them feel distressed or depressed, if they felt it was intruding on their privacy, or if it had made them feel better (Jacomb et al., 1999). Only 5% felt distressed by the survey and 35% actually felt better. In a separate study, interviewers were asked to rate the reactions of participants after an interview about a stressful event and its related psychopathology (Turnbull, 1988). Only 3% displayed distress, while 6% expressed relief and 14% wanted to continue talking. This latter study is more relevant to the present study because it might have brought up stressful memories for those participants who had been exposed to suicide. However, while some participants may have been expected to be uncomfortable or distressed by thinking about suicide, at least as many others would be expected to feel better after having thought about it.

To address potential concerns about distress/ elevated risk, the study's recruitment materials make sure that the participants knew that the survey was about suicide. That way, if suicide were a topic they wanted to avoid, they could choose to do this by not participating. Although the upfront information and optional questions certainly caused self-selection within the potential participants, it was important that participants not be surprised by questions about such an emotionally charged topic. The study also made it clear that they could drop out at any time and could skip any question they did not wish to answer. This option was explained in the consent form and introductory letter. Participants were also reminded of this option to drop out on the top of each form they were asked to fill out. These reminders made sure that nobody felt forced to talk about this topic if they didn't want to and that they could stop at any time. The participants received information for mental health and counseling resources in the introductory email

as well as at the end of the survey, which included national (suicide hotlines and websites), local (suicide prevention coalition located near high school), and individual campus information (a website that provides available campus information) and encouraged them to seek support if they wanted to discuss this topic or their responses to it in greater depth. The participants also received this information if they decided to exit the survey before finishing.

Results

Descriptive Analyses and Plan for Data Analysis

Table 1 presents descriptive information for all primary study variables. Participants in the main sample for the study ($n = 85$) provided ratings of closeness and grief for at least one peer suicide and completed all other measures. These 85 participants reported experiencing an average of 3.39 peer suicides. Seventy-seven participants (90.59% of the full sample) reported on a second peer suicide and 61 (71.76% of the full sample) participants reported on a third. Individual past grief levels showed a wide range; scores ranged from the scale minimum of 1 ("completely false" for grief experience statements) to the scale maximum of 5 ("completely true") over the three possible peers. Overall, past grief levels were low to moderate with the average grief scores being between 2 and 3 over the three peers. Present grief levels ranged almost as high (1.00-4.62 over the three peers), and were somewhat higher than were past grief scores, but were still not elevated past the midpoint of the scale ("both true and false"). It is important to note that the past and present scales of grief do not contain identical items.

Table 1

Descriptive Statistics

Variable	*n*	*M*	*SD*	min	max	range
# of Peers Lost to Suicide	85	3.39	1.10	1.00	5.00	4.00
Grief and Closeness						
Peer One						
TIG Past	85	2.19	0.95	1.00	4.25	3.25
TIG Present	85	2.44	0.90	1.08	4.69	3.61
Closeness	85	2.16	1.22	1.00	5.00	4.00
Peer Two						
TIG Past	77	2.29	1.18	1.00	5.00	4.00
TIG Present	77	2.58	1.06	1.00	4.85	3.85
Closeness	77	2.47	1.30	1.00	5.00	4.00
Peer Three						
TIG Past	61	2.23	1.23	1.00	5.00	4.00
TIG Present	61	2.51	1.09	2.00	4.92	2.92
Closeness	61	2.32	1.35	1.00	5.00	4.00
Overall						
TIG Past	85	2.17	0.99	1.00	4.17	3.17
TIG Present	85	2.47	0.92	1.05	4.62	3.57
Closeness	85	2.22	1.10	1.00	4.67	3.67
Attitudes Towards Suicide						
ATTS Factor 1	85	3.26	0.91	1.50	5.00	3.50
ATTS Factor 2	85	3.05	0.90	1.00	4.50	3.50
ATTS Factor 3	85	2.51	0.72	1.00	4.50	3.50
ATTS Factor 4	85	3.81	0.89	2.00	5.00	3.00
ATTS Factor 5	85	2.12	0.63	1.00	4.00	3.00
ATTS Factor 6	85	3.67	0.78	1.00	5.00	4.00
ATTS Factor 7	85	2.61	0.66	1.50	4.50	3.00
ATTS Factor 8	85	2.32	0.62	1.00	4.00	3.00
ATTS Factor 9	85	4.08	0.63	2.50	5.00	2.50
ATTS Factor 10	85	2.06	1.06	1.00	5.00	4.00
Suicide Myths						
Myth 1	85	2.28	1.16	1.00	5.00	4.00
Myth 2	84	2.54	1.04	1.00	5.00	4.00
Myth 3	85	3.32	1.12	1.00	5.00	4.00
Myth 4	84	2.46	1.02	1.00	5.00	4.00
Myth 5	85	1.96	0.84	1.00	4.00	3.00
Myth 6	85	2.78	1.26	1.00	5.00	4.00
Social Support						
Family PSS	85	5.99	1.16	2.00	7.00	5.00
Friend PSS	85	6.01	1.07	2.75	7.00	4.25
Special Person PSS	85	6.20	1.12	1.75	7.00	5.25

All of the 85 participants completed the Attitudes Towards Suicide Scale (ATTS). Individual scores on the 10 ATTS factors covered nearly the entire scale range of 1 "strongly disagree" to 5 "strongly agree" and the means ranged from 2.06 showing general disagreement with the attitude factor "Resignation," to 4.08 showing general agreement with the attitude "Preparedness to Prevent." For each of six Joiner suicide myths, there were either 85 or 84 participants due to a small number of missing values. Individual myth scores spanned the entire range from 1 to 5 (using the same scale labels) for all but Myth 5 "If people want to die by suicide there is nothing we can do to stop them." Means for the Myths ranged from 1.96 showing general disagreement with Myth 5 to 3.32 showing neutral feelings about Myth 3 "Suicide is selfish." For the Scale of Perceived Social Support, there were also 85 participants. For family, peer, and special person support, individual scores spanned nearly the entire 1-7 range, with little use of the "strongly disagree" scale point of 1. Means were high for these measures and indicate strong agreement with social support items across relationship partners. Thus, this sample of young adults that has been exposed to multiple peer suicides reported low to moderate levels of grief and high levels of social support overall, with individual differences over both dimensions, and a range of attitudes and myth endorsements about suicide.

Analyses of the main sample ($n = 85$) are presented for Peer 1 Grief and Peer 1 Closeness, Overall Grief and Closeness (averaged over all peers reported on), Attitudes towards Suicide, Suicide Myths, and Social Support. In order to streamline the results, only Peer 1 and Overall Closeness and Grief are presented. Preliminary analyses of Peer 2 and Peer 3 Closeness and Grief were consistent with the findings reported here, but smaller sample sizes affected significance testing. Additionally, participants were not

asked to report on their grief about peers lost to suicide in any particular order; for that reason, the grief scores for individual peers beyond the first peer become the most meaningful when they are averaged to represent overall or cumulative grief. Repeated measures analyses of past and present Grief for Peer 1, 2 and 3 revealed no differences in grief levels over the three peers.

Although there were not many men in the sample (there were 64 women and 21 men for most measures), exploratory analyses were conducted to examine possible gender differences in Grief, Closeness, Myths, and Attitudes Towards Suicide. There were significant gender differences for Past Grief scores with women having higher Overall Past Grief scores ($M = 2.29$, $SD = 1.03$) than men ($M = 1.82$, $SD = 0.80$), $t(40.80) = 2.11$, $p = .041$. This pattern was the same for Present Grief Scores, with women's scores ($M = 2.58$, $SD = 0.91$) being significantly higher than men's scores ($M = 2.06$, $SD = .86$), $t(82) = 2.26$, $p = .026$. There were no significant differences by gender for Overall Closeness.

Because there were multiple myths and attitudes to test, MANOVAs were used. The MANOVA on gender differences in endorsement of Suicide Myths did not reveal a significant multivariate effect, $F(6, 75) = 1.26$, p = .286. Univariate tests were examined for exploratory purposes, but only one was significant. Women tended to disagree more ($M = 2.13$, $SD = 1.13$) with Myth 1 ("Suicide is an easy escape, one that cowards use") than did men ($M = 2.91$, $SD = 1.07$), $F(1, 80) = 4.67$, $p < .034$. Similarly, there was no multivariate effect for gender on $F(10, 73) = 1.31$, $p = .240$. No attitudes were significantly different in univariate analyses.

Preliminary Correlations of Grief with Peer Suicide Exposure, Closeness, and Social

Support

As hypothesized, there was a positive correlation between exposure to suicide and

grief. The number of peers lost to suicide was positively correlated with Past and Present

Grief scores on the Texas Revised Inventory of Grief (TRIG) for Peer 1 and for Overall

Grief (see Table 2). Reported Closeness to the lost peer(s) was also positively correlated

with Past and Present Grief scores on the TRIG for Peer 1 and for Overall Grief (see

Table 3); a closer relationship with the peers who died was related to higher levels of

both Past and Present Grief.

Table 2
Correlations between Grief Scores and Number of Peers Lost to Suicide

Variable	*n*	*r*	*p*
Peer One			
TIG Past	85	.411	.000 **
TIG Pres	85	.409	.000 **
Overall			
TIG Past	85	.389	.000 **
TIG Pres	85	.395	.000 **

** $p < .01$ (2-tailed)

Table 3
Correlations between Grief Scores and Closeness to Peers Lost to Suicide

Variable	*n*	*r*	*p*
Peer One			
TIG Past	85	.671	.000 **
TIG Pres	85	.657	.000 **
Overall			
TIG Past	85	.796	.000 **
TIG Pres	85	.743	.000 **

** $p < .01$ (2-tailed)

With regard to social support, there was only a significant negative correlation between Past Overall Grief and Perceived Social Support from Family ($r = -.273$, $p = .012$). In other words, those with better current social support from family had less overall past grief. Friend support and Special Person support were not significantly correlated with Past or Present Grief. For this sample, it seems like family support had the most important relationship with the grieving process, at least for past grief, and at this level of analysis.

Preliminary Correlations of Peer Suicide Exposure with Attitudes Towards Suicide and Suicide Myth Endorsement

Next, correlations were used to examine the relationships between exposure to suicide (Closeness and Grief for Peer 1 and Overall) and suicide beliefs (Joiner's Myths and Attitudes Towards Suicide). Joiner's myths were examined first. Overall Closeness to peers lost to suicide was positively correlated with endorsement of the suicide myth "If people want to die by suicide, we can't stop them" ($r = .255$, $p = .019$). In other words, the closer the participants were to the peers in general the more likely they were to endorse the belief that suicide can't be prevented. This same myth was also positively correlated with Closeness for Peer 1 specifically ($r = .215$, $p = .048$). No other Suicide Myths had significant correlations with Overall Closeness or Closeness towards Peer 1.

For grief, Past Overall Grief was also related to the myth that "If people want to die by suicide, we can't stop them" ($r = .293$, $p = .077$). In other words, the higher their past grief, the more likely participants were to endorse the myth that suicide can't be prevented. This is the same myth that was correlated with closeness, which makes sense

as grief levels were highly correlated with closeness scores. No other significant

correlations were found for Overall Grief, Past or Present.

When looking at Peer 1 grief specifically, Past Grief scores were negatively

correlated with the myth "Suicide is just a cry for help" ($r = -.271, p = .012$). Past Grief

for Peer 1 was also positively correlated with the myth "If people want to die by suicide,

we can't stop them" ($r = .301, p = .005$). No other correlations with Peer 1 grief and

suicide myths were significant. In general, the higher the past grief scores for Peer 1, the

less likely it was that the participant thought suicide is a just a cry for help and the *more*

likely it was that the participant believed that suicide is not preventable. Therefore, those

with high grief believed that suicidal behavior is serious, but that it cannot be stopped.

Next, correlations with the Attitudes Towards Suicide Scale (ATTS) were

examined.   Overall Closeness was negatively correlated with ATTS Factor 1 ($r = -.224$,

$p = .039$). Factor 1 was about 'suicide as a right' and included the questions "I can

understand that people suffering from a severe, incurable disease die by suicide" and "A

person suffering from a severe, incurable, disease expressing wishes to die should get that

help to do so." Therefore, closeness with the peers who died by suicide was related to

being less accepting of assisted suicide in the case of incurable illness. Overall Closeness

was also negatively correlated with Factor 4 ($r = -.323, p = .003$). Factor 4 was about

preventability and included the questions "It is always possible to help a person with

suicidal thoughts" and "Suicide can be prevented." Therefore, those who had higher

overall closeness ratings were less likely to believe that suicide is preventable than were

those with lower closeness. This pattern is congruent with the earlier finding that

closeness was positively correlated with belief in the myth "If people want to die by

suicide, we can't stop them." Peer 1 Closeness was not significantly correlated with the ATTS Factors.

Overall Past and Present Grief scores were also negatively correlated with ATTS Factor 4 (preventability) ($r = -.285$, $p = .008$; $r = -.214$, $p = .049$). Peer 1 Past Grief was also negatively correlated with ATTS Factor 4 ($r = -.277$, $p = .010$). Thus, higher past (overall and Peer 1) and present grief scores were related to stronger beliefs that suicide is not preventable.

Together, these analyses of exposure to peer suicide (closeness and grief) with suicide attitudes and myth endorsement revealed that exposure to peer suicide is consistently related to participants' attitudes towards preventability, with greater closeness and grief being related to a stronger belief that suicides are not preventable. Exposure also had some relation to beliefs about the seriousness of suicide and people's right to commit suicide, with greater grief (Peer 1) being related to lower endorsement of the cry for help myth, and higher closeness being related to lower endorsement of suicide as a right.

Regression Analyses of the Joint Contribution of Grief and Closeness to Suicide Attitudes

To clarify the unique contributions of grief and closeness to suicide myths and attitudes, a multiple regression was run for each ATTS Factor and Myth that had a significant univariate correlation with one or the other predictor. For these analyses, closeness and grief were used as the independent variables. The results of the regression for Myth 5 ("If people want to die by suicide, we can't stop them") indicated the two predictors (Past Grief for Peer 1 and Closeness for Peer 1) explained a significant amount

of the variance, R^2=.09, $F(2,84)$ =4.09, p = .020 It was found that grief made a significant

independent prediction of myth endorsement (β = .285, t = 2.01, p < .048), but that

closeness did not (β = .024, t = 0.17, p = .868). For Myth 6 ("Suicide is just a cry for

help"), the two predictors (Past Grief for Peer 1 and Closeness for Peer 1) explained a

significant amount of the variance (R^2=.08, $F(2,84)$ =3.36, p = .040). However, there

were no significant independent contributions for grief or closeness. For ATTS 1 (Suicide

as a Right), the two predictors (Past Grief Overall and Overall Closeness) explained a

marginally significant amount of the variance, R^2=.07, $F(2,84)$ = 3.11, p =.050. For this

regression, it was found that closeness significantly predicted this ATTS score (β = -.411,

t = -2.34, p = .022), but that grief did not (β = .234, t = 1.33, p = .187). The multiple

regression for ATTS 4 (Preventability) indicated the two predictors (Past Grief for Peer 1

and Closeness for Peer 1) explained a significant amount of the variance (R^2=.08,

$F(2,84)$= 3.41, p = .038), but only grief made a marginally significant impact (β = -.27, t

= -1.86, p = .067). For Overall scores, the two predictors (Past Grief Overall and Overall

Closeness) explained a significant amount of the variance for ATTS Factor 4 (R^2=.11,

$F(2,84)$= 4.89, p = .010), but neither closeness nor grief made a marginally significant

impact.

      In sum, closeness and grief together predicted modest amounts of variance in

attitudes about preventability, seriousness, and individuals' right to suicide, and

sometimes one or the other variable made a significant independent contribution. For

preventability, grief consistently made a significant independent contribution, with higher

grief scores being related to lower beliefs in the preventability of suicide, even when

closeness was included in the model. In contrast, closeness made an independent

contribution to the prediction of attitudes about suicide rights, with higher closeness being related to less endorsement of suicide as a right, even when grief was included in the model.

Present Grief Factors with Suicide Myths and Attitudes toward Suicide

In order to explore participants' current grief scores more deeply, TRIG subscales were formed based on a 3-factor model proposed and tested by Futterman, Holland, Brown, Thompson, and Gallagher-Thompson (2010). These three factors are Emotional Response, Nonacceptance, and Thoughts. All of these grief factors were positively correlated with Number of peers lost, Overall Closeness, and Peer 1 Closeness (see Table 4), with correlations generally higher for closeness than for number of peers lost to suicide, and greater variability of correlations over the different factors for Peer 1 Closeness; lingering grief expressed as current thoughts about Peer 1 were especially related to closeness, with nonacceptance being less related, and emotional response being intermediate.

Table 4
Correlations between # of Peers Lost, Closeness and TRIG Factors

Variable	n	r	p
Lost Peer #			
EmoResp	85	.398	.000 **
NonAccept	85	.268	.013 **
Thoughts	85	.397	.000 **
Overall Closeness			
EmoResp	85	.696	.000 **
NonAccept	85	.509	.000 **
Thoughts	85	.790	.000 **
Closeness Peer 1			
EmoResp	85	.586	.000 **
NonAccept	85	.362	.001 **
Thoughts	85	.730	.000 **

** $p < .01$ (2-tailed)

Analyses of TRIG present grief factors for Peer 1 and Overall showed some significant correlations with myths and attitudes. For Peer 1, current Emotional Response was negatively correlated with the myth that suicide is just a cry for help ($r = -.221$, $p = .042$); a higher current Emotional Response to the death of Peer 1 was related to being less likely to think that suicide is just a cry for help. For the ATTS Factors, Overall current Emotional Response was negatively correlated with ATTS Factor 4 (preventability) ($r = -.235$, $p = .030$). Congruent with earlier findings, higher current emotional grief was related to being less likely to believe that suicide is preventable. This same ATTS factor was also negatively correlated with the Thoughts grief factor ($r = -.252$, $p = .020$); higher present grief expressed as thoughts about the deceased was related to a weaker belief in the preventability of suicide.

These correlational analyses extend earlier analyses by clarifying that the emotional component of current grief is especially relevant to feeling that suicide is not just a cry for help, and that both the emotional component of current grief and current thoughts about the deceased are related to the belief that suicide is not preventable. Nonacceptance did not emerge as a predictor of suicide attitudes and myths in this sample.

Examining the Moderating Role of Social Support in the Relationship between Closeness Present Grief Dimensions

To examine the roles of closeness and social support in predicting dimensions of current grief, a 2 (high/low closeness) by 2 (high/low social support) MANOVA was conducted on the 3 present grief dimensions. These analyses were conducted with Mean Social Support first, and then with Peer, Family, and Special Person social support. Only

Overall closeness and Overall present Grief factors were examined here to reduce the number of analyses. The gender distribution was uneven, and there was insufficient power to detect 2-way and 3-way interactions with gender; for that reason, gender was used as a covariate in these analyses. For Mean Social Support (over all relationship types), there was only a multivariate main effect for Overall Closeness, Wilks's lambda = .508, $F(3,77) = 24.87$, $p < .001$, $\eta^2 = .492$.

At the univariate level, there were main effects of Overall Closeness for each of the three grief factors, Emotional Response ($F(1, 79) = 53.56$, $p < .001$); Nonacceptance ($F(1, 79) = 22.37$, $p < .001$); Thoughts ($F(1, 79) = 74.87$, $p < .001$), with participants who were closer to the peers who died scoring higher on all three grief indices than did those who were less close ($M = 3.04$, $SE = .12$ vs. $M = 1.87$, $SE = .10$ respectively for Emotional Response; $M = 2.98$, $SE = .13$ vs. $M = 2.18$, $SE = .11$ for Nonacceptance; $M = 3.31$, $SE = .13$ vs. $M = 1.86$, $SE = .11$ for Thoughts). There was also a significant univariate interaction between Overall Closeness and Mean Social Support for the nonacceptance grief score, $F(1, 79) = 4.62$, $p = .035$. Simple effects test showed that those who were closer to the peer(s) who died and with higher current social support had *higher* levels of nonacceptance than did those who were closer but had less social support; $F(1,79) = 6.781$, $p < .011$ (see Figure 1). When Closeness was low, social support level did not significantly influence nonacceptance. This finding was somewhat puzzling, and not supported by a multivariate effect; for that reason, social support from specific relationship partners was next examined to see if different types of social support may be influencing this unexpected interaction between closeness and social support.

Figure 1. Nonacceptance scores as a Function of Closeness to the Peer(s) who Died by Suicide and Current Social Support

For Social Support from Friends specifically, there was a significant multivariate effect for Overall Closeness, Wilks's lambda = .476, $F(3,77) = 28.28$, $p < .001$, $\eta^2 = .524$. There was also a multivariate effect for the interaction between Overall Closeness and Social Support, Wilks's lambda = .870, $F(3, 77) = 3.85$, $p = .003$, $\eta^2 = .130$. Univariate tests revealed significant main effects for Overall Closeness for all grief factors, Emotional Response ($F(1, 79) = 57.99$, $p < .001$); Nonacceptance ($F(1, 79) = 28.89$, $p < .001$); Thoughts ($F(1, 79) = 86.00$, $p < .001$), with closer peers being higher on all dimensions than peers who were less close ($M = 3.05$, $SE = .12$ vs. $M = 1.84$, $SE = .10$ respectively for Emotional Response; $M = 3.00$, $SE = .13$ vs. $M = 2.16$, $SE = .11$ for Nonacceptance; $M = 3.31$, $SE = .12$ vs. $M = 1.82$, $SE = .11$ for Thoughts).

Univariate tests also revealed a significant interaction between Closeness and Social Support from Friends for all three grief factors. For Emotional Response ($F(1,79) = 4.57$, $p = .036$), the relationship between social support and grief reversed for the

different levels of closeness, with low social support being related to relatively higher

emotional grief at low levels of closeness and low social support being related to

relatively lower levels of emotional grief at high levels of closeness (see Figure 2)

Although this pattern can be seen in Figure 2, simple effects tests did not reveal

significant differences between those with and without social support within closeness

level.
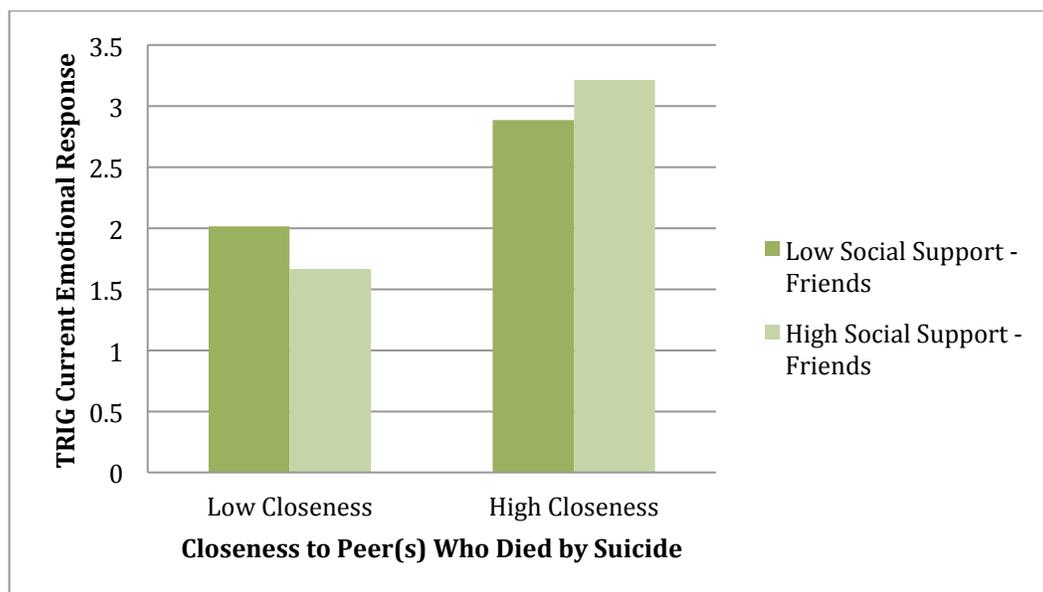
Figure 2. TRIG Current Emotional Response as a Function of Closeness to the Peer(s)
who Died by Suicide and Current Social Support from Friends

This same overall pattern was found for Nonacceptance, $F(1,79) = 7.41$, $p = .008$.

Again, participants with high social support from friends reported less grief related to

Nonacceptance than did those with low social support *if* they were not as close to the

peers who died by suicide (see Figure 3). For participants who were closer to the peers

who died by suicide, having high social support from friends was related to *more* grief on

the Nonacceptance scale than was having low support was. This latter difference was

significant in simple effects tests, $F(1,79) = 5.764$, $p = .019$.

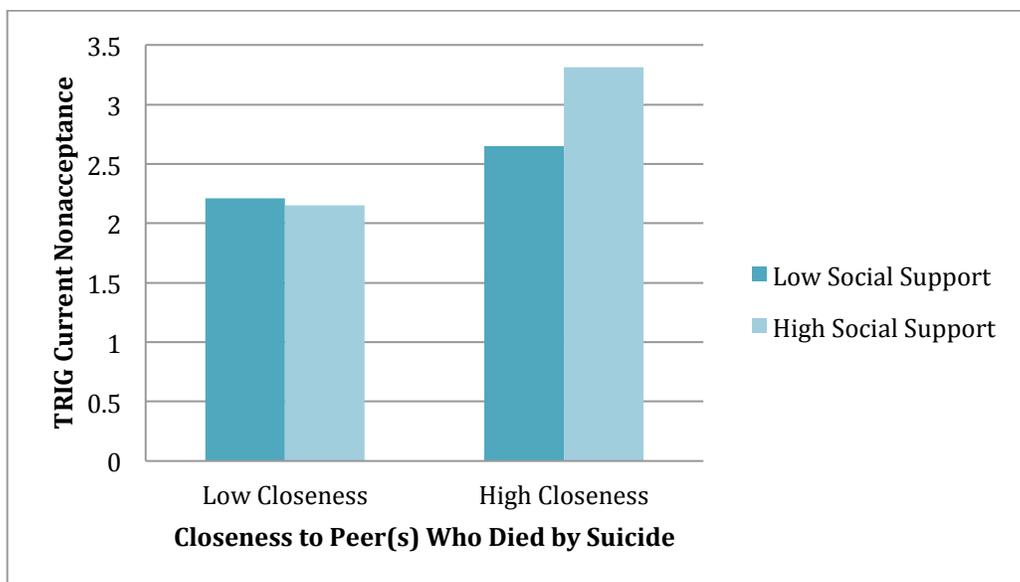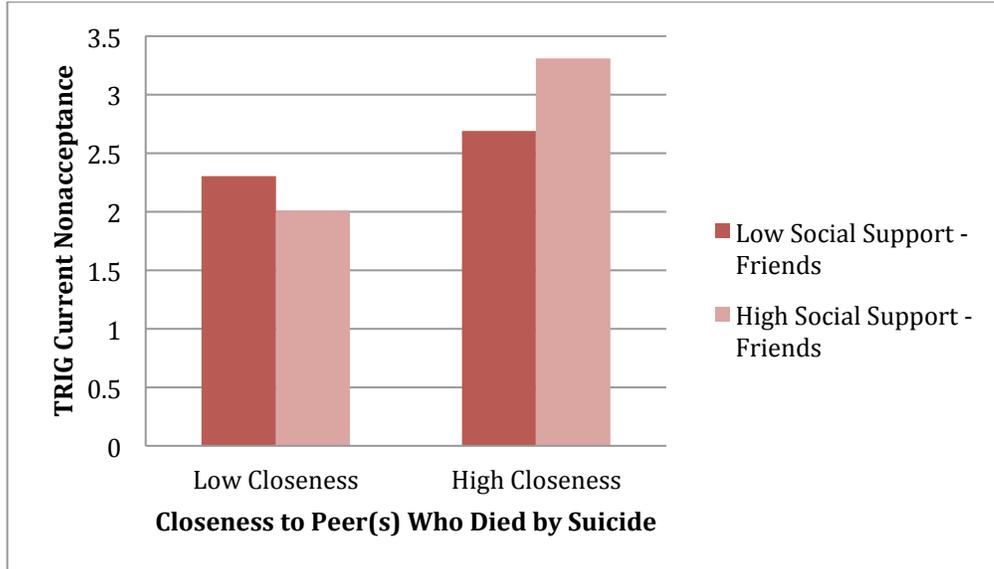*Figure 3.* TRIG Current Nonacceptance as a Function of Closeness to the Peer(s) who Died by Suicide and Current Social Support from Friends

The overall pattern of findings was similar for the third grief factor, Thoughts, $F(1,79) = 9.79$, $p = .002$ (see Figure 4). However, simple effects tests revealed that when Closeness was high, thoughts about the deceased did not differ over low versus high Friend Social Support; but when Closeness was low, thoughts about the deceased were significantly higher for those with low Friend Social Support, $F(1,79) = 7.814$, $p = .007$.
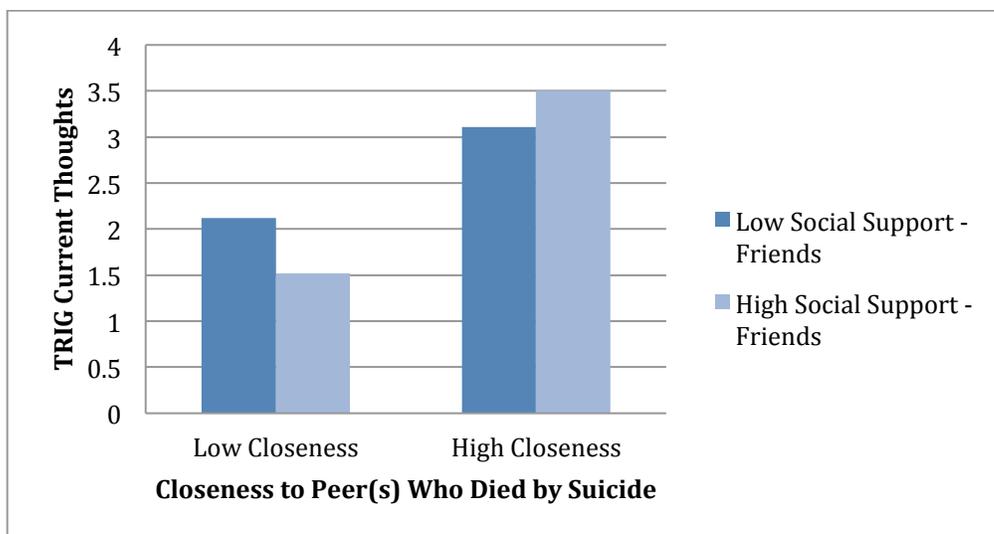
Figure 4. TRIG Current Thoughts as a Function of Closeness to the Peer(s) who Died by Suicide and Current Social Support from Friends

Analyses of Social Support from a Special Person, which in most cases would be a peer, revealed only a main effect of special person social support and not an interaction with closeness. There were significant Social Support effects for the Emotional Response Factor ($F(1,79) = 4.10$, $p = .046$) as well as the Nonacceptance Factor ($F(1,79) = 6.15$, $p = .015$). Peers with low support from a special person ($M = 2.32$, $SE = .104$) reported lower grief on Emotional Response than did those with higher social support from a special person ($M = 2.65$, $SE = .123$). Similarly, peers with low support from a special person ($M = 2.41$, $SE = .110$) reported lower grief on Nonacceptance than did those with higher social support from a special person ($M = 2.83$, $SE = .130$). For Social Support from a Special Person, there was no significant effect for the Thoughts factor of present grief.

Interestingly, none of these findings were replicated in analyses of Family Social Support. There was only a marginal multivariate main effect for family social support ($F(1,79) = 2.61$, $p = .057$, $\eta^2 = .092$) but no univariate main effects were significant, and

there was no interaction with closeness. There was a main effect for Closeness, however, this has been reported in other analyses with closeness being related to higher grief scores.

In sum, it seems that social support from peers is related to increased grief in peers who lost closer friends to suicide. This finding was generally consistent across all three grief factors, although simple effects tests vary in where the effect may be. Special Person support is interesting – but less complicated than friend support. Mean social support reflects both of these patterns, but is weaker and it is apparent that family social support does not reflect this pattern.

Examining the Moderating Role of Social Support from Friends in the Relationship between Closeness and Myths and Attitudes Toward Suicide

In a final set of analyses, the roles of Closeness and Social Support from Friends in predicting myth endorsement and attitudes towards suicide was examined. Two 2 (high/low closeness) by 2 (high/low social support) MANOVAs were conducted on the three present grief factors. Social support from other sources was not examined, to reduce the number of analyses, and because friend social support was highlighted as central in the preceding analyses of grief. For Joiner's suicide myths, there was a significant main effect for Friend Social Support at the multivariate level, Wilks's lambda = .851, $F(6, 72)$ = 2.60, $p = .025$, $\eta^2 = .178$. Univariate tests revealed a significant Friend Social Support effect for Myth 5 ("If people want to die by suicide, we can't stop them"), $F(1, 77) =$ 4.44, $p = .038$. This result showed that those with higher social support from friends tended to have lower belief in the myth that suicide is not preventable ($M = 1.82$, $SE =$ 0.13) than did those with lower friend support ($M = 2.21$, $SE = 0.13$). In general, higher

social support from friends seems to be a protective factor for belief in Myth 5, however, there was no interaction with closeness to peers lost.

For the Attitudes Toward Suicide Scale factors, there was also a significant main effect for Friend Social Support at the multivariate level, Wilks's lambda = .773, $F(10, 70) = 2.05$, $p = .040$, $\eta^2 = .227$. Univariate tests revealed a significant Friend Social Support main effect for ATTS Factors 4 (preventability), 5 (tabooing), 6 (normal), 7 (suicide process) and 10 (resignation) (see Table 5). As shown in Figure 5, for ATTS Factor 4, those with high friend support had *higher* scores of agreement ($M = 4.04$, $SE = 0.14$) with the attitude that suicide is preventable than did those with lower friend support ($M = 3.55$, $SE = 0.13$). For ATTS Factor 5, those with high friend support had *lower* scores of agreement ($M = 1.94$, $SE = 0.10$) with the attitude that suicide should be a taboo topic than did those with lower friend support ($M = 2.26$, $SE = 0.01$). For ATTS Factor 6, those with high friend support had *lower* scores of agreement ($M = 3.48$, $SE = 0.13$) with the attitude that suicidal ideation is normal than did those with lower friend support ($M = 3.85$, $SE = 0.12$). For ATTS Factor 7, those with high friend support had *lower* scores of agreement ($M = 2.41$, $SE = 0.11$) with the attitude that suicide is not impulsive than did those with lower friend support ($M = 2.82$, $SE = 0.01$). Finally, for ATTS Factor 10, those with high friend support had *lower* scores of agreement ($M = 2.41$, $SE = 0.11$) with the attitude that suicide can be a relief than those with lower friend support ($M = 2.82$, $SE = 0.01$).

Table 5

Friend Social Support Main Effects for Attitudes Toward Suicide Scale Factors

Variable	$F(1, 79)$	p	η^2
ATTS Factor 4	6.28	.014 *	.074
ATTS Factor 5	4.95	.029 *	.059
ATTS Factor 6	4.31	.041 *	.052
ATTS Factor 7	7.45	.008 **	.086
ATTS Factor 10	6.13	.015 *	.072

* p<.05, ** *p* < .01 (2-tailed)
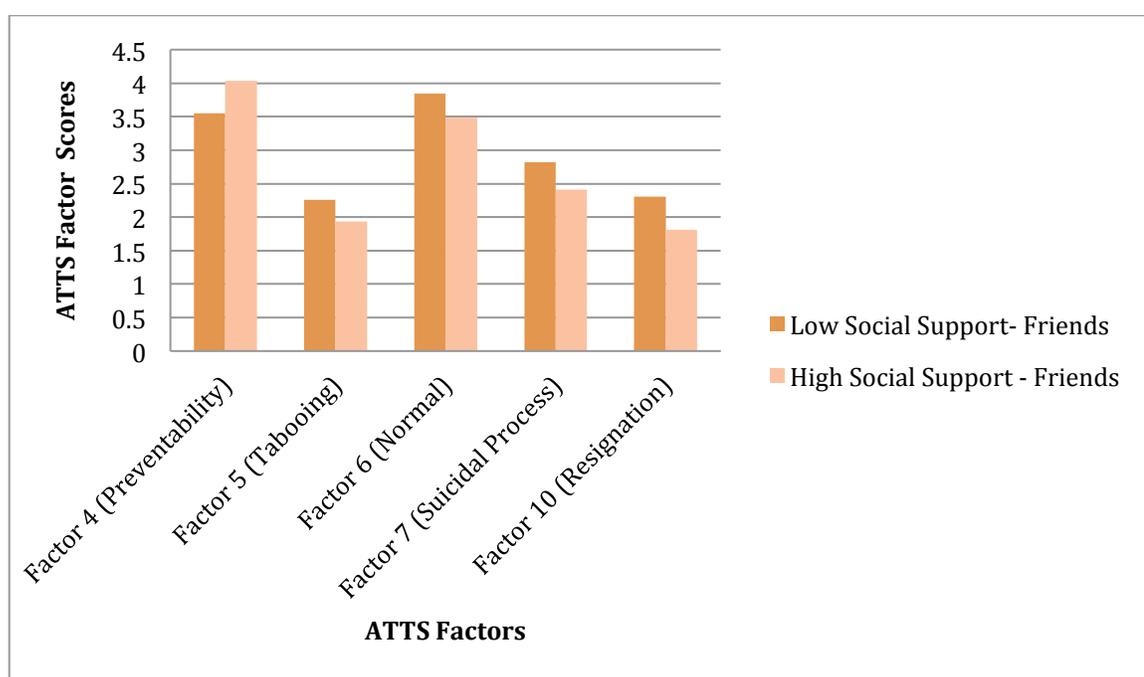
Figure 5. ATTS Factor Scores as a Function of Current Social Support from Friends

In general, it seems that high friend support was related to more comfort in discussing suicide and a more positive outlook on the prognosis of suicidality. Those with higher Friend Social Support were more likely to believe that suicide is preventable, that it is a topic we should talk about, that suicidal ideation is not a normal thought process, that it is not impulsive, and that it is never a relief for those involved than is true of those with lower friend support. In other words, those with high friend support were more

likely than those with less friend support to see suicidal behavior as being serious, a bad decision, and treatable.

There was no significant multivariate effect for Friend Social Support and Closeness on ATTS Factors. The only univariate interaction with Friend Social Support and Closeness was with ATTS Factor 3 (Noncommunication), $F(1, 79) = 4.93$, $p = .029$. Simple effects tests revealed that friendship support affected endorsement of this attitude only for those who were high in Closeness, $F(1, 79) = 7.5979$, $p < .007$. Among participants with high Closeness, those with low Friend Social Support were more likely to believe that suicide threats are not serious, (see Figure 6) than those with high Friend Social Support. In contrast to the grief findings, here social support from friends provided a protective effect for those who were close to the deceased peers; less stigmatizing beliefs about suicide were expressed by those who were close and had high levels of friend support, compared to those with low friend support.
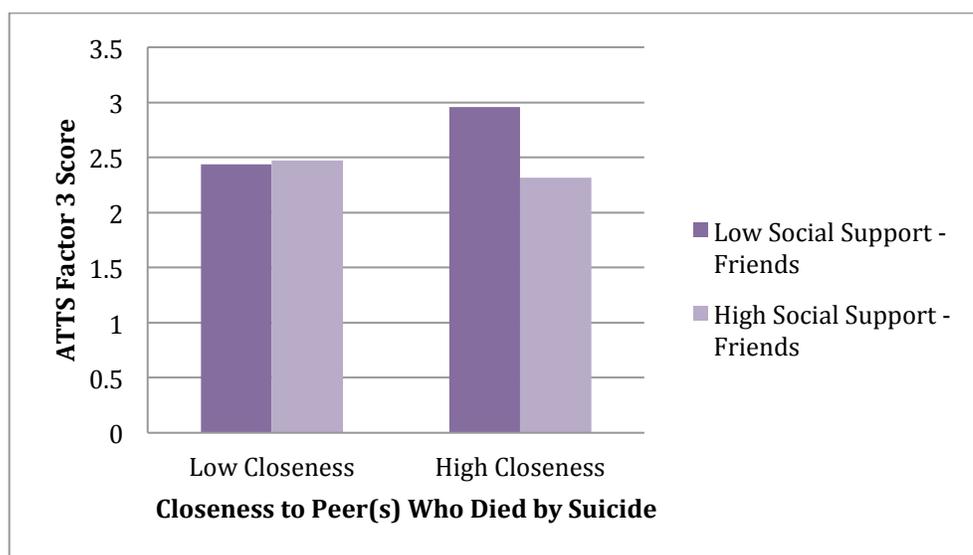
Figure 6. ATTS Factor 3 as a Function of Closeness to the Peer(s) who Died by Suicide and Current Social Support from Friends

Low Suicide Exposure Comparison Sample

In order to determine if there were any differences in myths and attitudes about suicide between this sample and young adults who hadn't been exposed to multiple suicides, a comparison sample was recruited. This sample used some students from a small liberal arts college in New England (all graduates of public high schools in the northeast) and some participants of the same age who did not attend the same college. These other participants were recruited through contacts at this college who attended a public high school in the northeast and were willing to ask members of their graduating class to complete this brief survey. In order to determine if there were any differences between the 26 participants from the liberal arts college and the 37 participants recruited off campus, Chi Square tests were used. There were no gender differences between the two samples. There were also no multivariate differences on myths and ATTS scores between the two samples. Because of this, the two samples were combined to form one comparison sample. For the remainder of the analyses, this low suicide exposure sample was used in comparison to the original sample of peer cluster suicide survivors (high suicide exposure). Although the high exposure sample appeared to have a larger percent of women (74.4%) than the low exposure sample (60.3%), Chi-Square tests showed that this difference was not significant.

To examine the role of suicide exposure in predicting Attitudes Towards Suicide, a MANOVA was conducted. There was a significant main effect for suicide exposure at the multivariate level, Wilks' lambda = .845, $F(10, 142) = 2.60$, $p = .006$. Univariate tests revealed a significant Suicide Exposure effect for ATTS Factor 6 (Normality), $F(1, 151) = 3.57$, $p = .017$. This showed that those with higher exposure to suicide ($M = 3.65$, $SE = $

0.08) were more likely to think that suicide is normal than those with lower exposure to suicide ($M = 3.34$, $SE = 0.10$). Lastly, there was a significant Suicide Exposure effect for ATTS Factor 9 (Preparedness to Prevent), $F(1, 151) = 1.80$, $p = .033$. Those with higher exposure to suicide ($M = 4.10$, $SE = 0.07$) reported being more prepared to prevent suicide than those with lower exposure to suicide ($M = 3.88$, $SE = 0.08$). For the Joiner Suicide Myths, there were no significant differences between the two samples. There were also no significant differences between the groups on social support.

Discussion

This study investigated repeated exposure to peer suicide and it relationships with grief, and attitudes and beliefs about suicide. Peer suicide survivors are at an elevated risk for suicidal ideation; for that reason, it is important to understand their attitudes toward suicide and their grieving process. Themes emerged from the results of this study that may have important implications. Two of the most important themes involve attitudes surrounding preventability and the role of social support in peers' grief.

General Grief Levels and Attitudes Toward Suicide

As a whole, this sample of young adults exposed to peer cluster suicide can be described as having generally low grief scores. Given the number of peer suicides these participants have experienced (over 3 peers lost to suicide on average), this is a generally positive descriptive feature. Although scores ranged over most of the scale points, the average grief scores indicated mostly disagreement with the various grief items for past and present grief. It is important to keep in mind that although the analyses in this study look at participants who have high versus low grief, these grief levels are relative and that, overall, the grief scores were low. Therefore, those in the high grief group are not all

necessarily dealing with complicated or prolonged grief. Similarly, social support scores for this sample were quite high on average, and very few people reported low social support. This outcome is also an encouraging descriptive feature, as social support can buffer psychological distress. It is important to keep in mind, however, that participants in the low social support group did not necessarily have very low scores of social support. Again, these groups were determined by participants' relative standing on the social support measure.

Meaningful differences in attitudes toward suicide scale scores were also notable in this sample of young adults exposed to peer cluster suicide. The factor with the highest score of agreement was "Preparedness to Prevent." This factor measured the participants' agreement with feeling a duty and a willingness to try to prevent suicide. The factor with the lowest score of agreement was "Resignation," which included statements about suicide being a relief for those involved and that sometimes it is the only option. In general, these two descriptive features show that the sample had pretty conventional attitudes toward suicide, emphasizing that it is not a healthy decision and that it should be prevented. Average myth scores revealed relatively nonstigmatizing attitudes about suicide with the least popular myth being "If people want to die by suicide we can't stop them." The most popular myth was "Suicide is Selfish," but the average score indicated neutral feelings about this myth. With all of Joiner's suicide myths rated somewhere between disagreement and neutrality on average, this sample as a whole did not have very stigmatizing attitudes toward suicide.

Relational Correlates of Grief

The first hypothesis that exposure to suicide and closeness to the peers lost to suicide would be related to grief was supported by the results from this study. Grief and closeness were highly correlated in this group, and number of peers lost to suicide was also correlated with grief, but not as strongly. Therefore, those with more exposure, especially closeness, had both more past and present grief than did those in the low exposure group. In general, these correlations match previous research and accepted conceptions about relational closeness, exposure to peer deaths, and grief (Servaty-Seib & Pistole, 2007; Weiss, 2001). They extend this work by showing the relative importance of closeness to the deceased peers, and the persisting effect of these losses on grief reactions even seven years later.

The hypothesis that social support would be a protective factor against grief was also supported, but only for social support from family. This finding may be related to Thomas Joiner's (2010) theory that suggest peer suicides are difficult to grieve because social support from the affected peer group becomes less effective. Social support from family may be the most impactful for this group also because of their age at the time of the suicides. The first suicide happened during high school, so most of the participants were still under the direct care of their guardians, and therefore, were likely to be highly influenced by their families.

Associations between Grief and Suicide Myths and Attitudes

It was also hypothesized that there would be an interaction between closeness and grief on stigmatizing views with those who were close and had lower grief being less stigmatizing than those who were close and had higher grief. This hypothesis could not

be tested. Specifically, there were not enough participants who reported both a high level

closeness with the peers and low grief because closeness and grief were so highly

correlated in this sample. It is possible that the endorsement of certain stigmatizing myths

(including the myth that suicide is an act of anger or aggression) is more harmful for the

grieving process among those struggling with the loss of a close friend than among those

struggle less, so this hypothesis would be a direction for future research.

Relationships with attitudes and myths about suicide were examined for grief and

closeness separately. The pattern of associations was understandably similar, given the

correlation between grief and closeness. One myth that was commonly positively

correlated with both closeness and grief was the belief that suicide is not preventable.

Those with higher grief were also less likely to endorse the myth "suicide is just a cry for

help." When looking at closeness, those with higher closeness were less likely to believe

in assisted suicide and to believe that suicide is preventable than those with lower

closeness.

When closeness and grief were used to jointly predict attitudes and myths that

were associated in correlational analyses, at times, both variables contributed and at times

only one factor contributed. Consistently, grief was the strongest predictor for

preventability with more grief indicating less belief in preventability. However, closeness

was the strongest predictor for attitudes about suicide as an end of life right. It is possible

that grief is more related to preventability than is closeness because the belief that suicide

is not preventable may alleviate guilt, and therefore grief; those who have high grief may

endorse this myth as a protective factor. Closeness may be the strongest predictor of

attitudes toward suicide as a right because that close relationship and yearning after a death may influence how one feels about an individual choosing to die early.

Analyses of present grief subscales proposed by Futterman, Holland, Brown, Thompson, and Gallagher-Thompson (2010) revealed that different aspects of present grief were related to the endorsement of specific myths and beliefs. Those who are less able to stop thinking about the deceased (thoughts factor) and those with stronger current emotions about the suicides (emotional response) were less likely to think that suicide is preventable than those with lower thoughts and emotional response scores. However, the nonacceptance scale was not related to this attitude. Therefore, those who were more greatly affected by the peer suicides (still emotionally grieving, thinking about the deceased, and not denying the reality of the suicides many years later) were more likely than were those less affected to believe that suicide is not preventable. Those who had higher scores for current emotional response were also less likely to think that suicide is "just a cry for help" than those with lower scores on that scale. These two attitudes (preventability and cry for help) could possibly be related. The myth "suicide is just a cry for help" is one of Joiner's stigmatizing myths and can easily be interpreted to mean "those who attempt suicide don't actually want to die by suicide, they just want to get our attention." However, those with higher emotional grief scores are less likely than those with lower scores to endorse this myth so those with higher scores may be more likely to believe that suicidal behavior represents a sincere wish to die. It is interesting that although grieving peers may be less judgmental in this way, they also are less likely than those with lower grief to believe that suicide is preventable. This contradiction could be interpreted as a sign of hopelessness. Therefore, peers who were more greatly affected by

the cluster of suicides may have a greater combination of realism and pessimism than is true of those who were less affected.

These findings were all correlational; for that reason we cannot assume direction of causation, and other interpretations are possible. It is possible that this attitude of nonpreventability had an effect on the closeness and friendships. The students who died by suicide were friends, so it is likely that those who reported being closest were also in the same peer group. These people were in the same social group; for that reason, they could have been more likely to endorse certain beliefs about suicide simply because they have similar theologies and experiences.

The Role of Social Support in the Adjustment of Grieving Peers

Several analyses examined the influence of social support on current adjustment and attitudes in this sample of peer cluster suicide survivors, specifically whether there was a moderating influence of social support on the relationship between closeness and current functioning. For myths and attitudes about suicide, social support played a predictive role, but did not moderate the relationship between closeness and suicide attitudes. For grief, social support played a more complicated moderating role.

In the analyses of myths and attitudes, social support influenced several beliefs. Those with higher perceived social support from friends were more likely than those with lower social support to think that suicide is preventable and that it is impulsive, and less likely to think that suicide should be a taboo topic, that suicidal ideation is common, and that suicide can be a relief. Therefore, it seems that the participants with better social support from friends believed that intervention is both possible and desirable in order to prevent suicide, and viewed suicidality as a process that should be taken seriously, not

dismissed as normative, and that should be addressed. None of these attitudes is harmful or stigmatizing; it seems in general that social support from friends for individuals exposed to multiple peer suicides can lead to healthy attitudes toward suicide. Of course, these correlational findings could also mean that those who were able to achieve healthier attitudes towards suicide through other means found it easier to attract or maintain positive social supports from friends than those with less healthy attitudes. Either way, this association between high social support from friends and healthy, nonstigmatizing attitudes toward suicide is promising in this vulnerable sample.

The relationship between social support and grief was more complicated. In simple correlations, the hypothesis that social support would be negatively correlated with current grief scores was not supported. However, social support from family members was negatively correlated with *past* grief scores. Therefore, at this level, the relationship between social support and the grieving process was not as strong as was predicted.

When multivariate tests were run examining the moderating role of social support on the relationship between closeness and present grief, social support was related to grief, but in an unpredicted way. There were significant interaction effects with closeness and social support on the present grief factors, and the general pattern of findings was that higher social support was related to relatively higher grief in those who were close to the deceased compared to those with lower social support, but to relatively lower grief in those who were not as close to the deceased compared to those with lower social support. This finding was most clear in analyses of social support from friends, and was observed

in all three factors of grief. This pattern was also seen in mean grief (averaged over relationship partners).

When separated into groups by closeness and level of social support from friends, the group that had the highest grief scores was typically those with high closeness and high social support. This finding was unexpected because it is generally agreed that social support is a protective factor for grieving and psychological wellbeing. However, recent research has challenged this belief in certain social situations. The Scale of Perceived Social Support focuses on comfort with sharing information (e.g., "I can talk about my problems with my friends" and "I have friends with whom I can share my joys and sorrows"); consequently, this finding may be related to bereavement narrative disclosure in that there is a social component to how successful sharing pain with each other can be (Baddeley & Singer, 2009). In this specific social situation, the peers have all experienced the same loss so they may not necessarily be receiving sympathy when they share their bereavement narrative as they would from sharing with an uninvolved third party. This idea is also related to 'corumination,' which has been defined as a repeated focus on negative emotions within friend groups (Rose, 2002). Corumination is related with positive friendship quality and closeness, yet it can also predict an increase in depressive symptoms (Davila, et al., 2012; Rose, 2002). However, when interpreting the Scale of Perceived Social Support, it is important to remember that it measures perceived social support and is not necessarily representative of actual social support received. Therefore, a person may have supportive family and friends but still feel that he/she is not receiving adequate support.

Exploration of Gender Differences

When looking at gender differences related to myths and attitudes, multivariate effects were nonsignificant; all gender differences were weak. The few gender differences related to myths and attitudes toward suicide indicate that the women in this sample may have somewhat less stigmatizing views toward suicide than do men. Women were less likely to think that suicide is cowardly, an act of anger or revenge, and that when people talk about suicide it does not reflect a desire to actually die. It is also important to note that all three of the peers from this graduating class who died by suicide were adolescent men and therefore, there may be differences in relationships for men and women, which could explain these differences in attitudes. It is important to note that there were no gender differences in closeness to the peers lost to suicide. Despite this lack of difference in closeness scores, women did have significantly higher grief scores than did men. This finding could represent a real difference in grief, or it could be a difference in reporting. In other words, due to gender stereotypes, women may feel more comfortable accepting, acknowledging, and sharing their grief and emotions related to the suicides than men do. Gender was controlled for in all MANOVA's that were run.

Low Exposure Comparison Sample

One other way to examine the influence of peer cluster suicide was to compare this sample with a sample of similar young adults who were not exposed to multiple peer suicides. Compared to a group who had little to no exposure to peer suicide, the high exposure group showed some significant differences in attitudes and myths about suicide. The high exposure group was more likely to think that suicide is normal, that anyone can die by suicide, and that most people have thought about suicide than was the low

exposure group. Although these findings are not particularly surprising, they have important implications. If one believes that suicide is normal, one may not take suicidal threats of others or his/her own suicidal thoughts as seriously as when suicide is viewed as atypical. This attitude could be problematic because a person may be less likely to seek help when it may be needed than when suicide is viewed as atypical. However, a belief that suicide is normal can also have positive effects because it is a less stigmatizing thought. If one believes that suicidal ideation is a normal and common thought, one may be less judgmental of those who are suicidal and may offer greater acceptance and comfort to those at risk for suicide. Another difference between the two groups was that the high exposure group was more likely to report being prepared to prevent suicide than was the low exposure group. This outcome also is not surprising as more exposure to suicide may make one feel more comfortable talking about it than would less exposure. Also, after having seen the negative effects of suicide, individuals exposed to this outcome may have a deeper drive to prevent it.

This finding that the members of the high exposure group report feeling more likely to prevent suicide than was true of the low exposure group provides a contradiction with the earlier finding that the peers in the high exposure group who had been more greatly affected by the suicides (high closeness; high grief) were more likely than were the less affected group to think that suicide is not preventable. In other words, the high exposure group as a whole believes more strongly that they are prepared to prevent suicide, whereas a subpopulation of this group believes that it is not preventable. It is possible that those who were more affected by the suicides can hold both beliefs simultaneously by thinking that they will always try to prevent suicide, although they

may not believe they have the power to actually prevent it. Again, it seems there is a certain degree of fatalism within this group about the prospects of helping suicidal individuals.

Limitations

One important limitation to this study was the method of recruitment. This study used online recruitment; for that reason, those members of the same graduating class who do not use social networking websites were not recruited. Therefore the sample is not representative of the class as a whole. Also, it is important to note that the author of this study was a member of the graduating class that was used as the population. Therefore, personal relationships with the author may have influenced participation rates. This could be part of the reason that the sample was not very diverse (60.3% women, 87.3% white). This lack of diversity is not representative of the high school as a whole, as the high school's most recent statistics report being 49.9% women and 81.6% white (National Center for Education Statistics, 2009).

Another important limitation is that the high suicide exposure group had a relatively high drop out rate, with 35% of the participants not completing the survey after having started it. However, this result was expected and understandable based on the sensitive nature of the study. It does not seem that fatigue was a factor in this high drop out rate as most of the participants who did drop out, did so fairly early in the survey. The high drop out rate was also probably influenced by the multiple invitations to stop taking the survey. Although this may have influenced the drop out rate, it was important to avoid triggers for those people who still find suicide difficult to address.

Other factors may have influenced the drop out rate. Statistical analyses showed that closeness and current grief might have been factors in the drop out rate. Those who were closer to the first peer lost to suicide and those who had higher current grief scores had higher drop out rates than did those who were less close and had less grief. This finding is understandable as those participants were probably more likely to find the survey emotionally distressing, especially if they were dealing with unresolved grief than were those participants who were less close and had less grief. Another noteworthy finding was that the participants who had lost a family member to suicide were more likely to complete the survey than were those who had not lost a family member. One reason for this outcome could be that when a family member dies by suicide, the whole family is affected. As adolescents and emerging adults, these participants may have received support from their family structure including family therapy. Therefore, the participants who had lost a family member to suicide may have had better access to supports and therapy as well as more time to grieve the loss and deal with the complex factors involved in the grieving of suicide than was true of those who had lost a family member. Another possibility is that those who had lost a family member to suicide may be more likely to think that this is an important study topic than is true for those who had not experienced that loss.

The drop out rate was relatively high in this study for the high exposure sample; consequently it is important to note that these findings may not be representative. People with higher current grief were more likely to drop out; for this reason, this study may include more people who are more effectively coping in their grief. Therefore, it is likely that those who decided to stay in the study are processing the suicides differently from

those who dropped out. Given this difference in who contributed to the study, caution should be used when interpreting these results. The results are most generalizable to individuals who were able to tolerate multiple questions about the peer suicides.

For most of the analyses, scores for Peer 1 and Overall were used exclusively. Overall scores were important because they accounted for the possibility of multiple peers lost to suicide, but the individual peer scores were not as meaningful because each participant could have filled out the peer sections in different orders. Therefore "Peer 2" became an arbitrary title for whatever peer the participant decided to report on second. However, because Peer 1 emerged as an important factor in the analyses, it may be safe so assume that many participants either reported the first suicide or the most impactful suicide first. The participants were not asked to report on the lost peers in any particular order, which may be a limitation of this study.

Future Directions

For future research, it would be helpful to look at overall grief rather than grief for up to three peers. Different, less individual-oriented grief scales would be helpful to measure overall grief. Also, it would be helpful to use a grief score with identical past and present items so the scores could be compared over time and a change in grief could have been measured. With this, it would be clearer whose grief has improved. In this study, we did not know what the initial level of grief was in comparison to the current grief. A different measure that would more closely capture complicated or prolonged grief would also be valuable.

It would also be helpful to have open-ended narrative assessments that would ask specific questions about the grieving process within the friend group to better understand

how the peers are coping with each other and what type of social support peers are providing. This approach would be especially useful because these results showed that social support in the friend group does not necessarily help relieve grief, at least not for those who are close. It would be important to better understand what kind of social support peers are providing, and why it may not be particularly helpful for moving past grief.

One topic for future studies would be to look at how the stigma of suicide may affect the grieving process in peer survivors. One possibility is that fear of stigma may prevent survivors from disclosing about their loss and therefore prevent them from receiving potentially helpful social support from a third party.

Summary and Conclusions

An important theme from these results concerned attitudes about preventability. Closeness, past grief, and current grief were all negatively correlated with the belief that suicide is preventable. One possible explanation for this recurring finding is that multiple exposures to suicide can make someone more pessimistic about the prognosis of suicidality than when exposure to suicide is less frequent. In other words, such individuals may adopt the belief that "this keeps happening and nobody can stop it." Another explanation could be that the endorsement of this belief is a coping strategy for the bereaved peer. In other words, believing that suicide is not preventable could possibly alleviate some of the guilt that comes with losses by suicide. It is possible that the peers who are suffering the most (and therefore would be feeling the most responsibility for the suicides) adopted this belief to protect themselves in some ways. It is also possible that in order to prevent any guilt others have taught them to support this belief by telling the

bereaved friend that there was nothing he/she could have done to prevent the suicide. Another possible explanation for this finding would be that the peers did attempt to prevent the suicides but it didn't help. This could also create a sense of hoplessness.

These findings about the belief in preventability have important implications for adolescents dealing with suicidality. In some ways, it may be important to the grieving process that the bereaved relinquish responsibility for the death, so they do not feel the painful effects of guilt. However, it is also important that the bereaved do not adopt the idea that any future suicides are not preventable. Adolescent peers generally learn about a friend's suicidal ideation before an adult does; consequently, it is extremely important that adolescents believe that suicide is preventable so they have faith that intervening may make a difference and are more likely to report any suicidal ideation or behavior. If a peer is dealing with a suicidal friend but does not believe there is anything that can be done about it, that peer may not take action to prevent the suicide. Of course, it is hard to determine how much responsibility adolescents should accept when dealing with a suicidal peer. Even if a peer tells an adult, suicidal adolescents may not get the help they need or may still seek most of their support from their friends. This load can be a heavy for adolescents who may not know how to deal with suicidal ideation and may feel the need to "save" their friends. This pressure that peers may feel to be a good friend and to take on the problems of their friends may create feelings of responsibility and, if the suicide is completed, guilt. This sequence of events underscores how complicated the grieving process can be for peer suicide survivors. How do we make it clear that suicides can be prevented without making the bereaved peer feel responsible and guilty? By

denying any responsibility, the peer may feel better emotionally, however, it is problematic for people to believe that suicide is not preventable.

Suicide has been a long-standing problem in American adolescents, and the psychological ramifications for peer suicide survivors create a need for more research in this population. This problem is especially true due to increased risk of suicide in adolescents exposed to peer suicide. This study sought to better understand peer suicide survivors who have been affected by repeated exposure to peer suicide as adolescents and young adults. The interactions among relational closeness, grief, social support, and attitudes toward suicide provided insight into the grieving process.

Attitudes toward and beliefs about suicide can vary based on culture, religion, and personal differences. Yet it is also apparent that attitudes can vary based on exposure to suicide. Attitudes and beliefs about suicide are important to understand because they can affect the ways people cope with the suicidal ideation of others, and even their own suicidal inclinations. Our perceptions of suicide can affect how we treat those who are suicidal, how we feel about our own possible suicidal thoughts, how we treat those who are grieving a loss by suicide, and how we ourselves may grieve a possible loss to suicide. Suicide is such a painful topic; for that reason, it is important to understand it better so we may become more skilled at helping those who grieve loss to suicide and those who themselves may be suicidal.

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83

Dear BHS graduate of the class of 2008,

I am an '08 BHS graduate and a senior at Connecticut College majoring in Psychology. For my honors thesis, I am doing a study about attitudes towards suicide. As a member of your graduating high school class who has also dealt with losing friends and classmates to suicide, I am personally invested in this topic and feel it is an issue that deserves more attention.

Because of our unique situation of being exposed to classmate death by suicide, I think it is important to understand how we all feel about and have dealt with it.

I would greatly appreciate your participation in my study. It is an online survey that should only take about 20 minutes. I would also appreciate it if you could send this message and survey link along to other members of BHS's class of '08 so I can reach as many people as possible.

Take the survey here: http://www.surveymonkey.com/s/H87H8PG

Feel free to contact me if you have any questions.

Thank you so much,

Caroline Abbott
(774) 368-0535
cabbott@conncoll.edu
Connecticut College '12
Barnstable High School '08

Thank you to everyone who has completed my survey!

This is just a reminder that the survey is still up online and if you haven't taken it yet but are interested in doing so, I would greatly appreciate it. Thanks again.

You may take the survey here: http://www.surveymonkey.com/s/H87H8PG

If anyone has any questions or is interested in seeing the results, you can email me at cabbott@conncoll.edu.

Caroline

Appendix B

Thank you for agreeing to take this survey.

Before you begin, please note the following:

This will be an online survey that has been estimated to take 20 minutes.

This survey will ask questions about your feelings towards suicide and how you may have dealt with any loss by suicide in the past. Please note that if this topic is too distressing to you, you do not have to participate.

This study is **completely optional** and you may decline to answer any question as you see fit. You may also withdraw from the study without penalty at any time.

*If you or anyone you know is contemplating suicide, please contact a crisis center near you through the National Suicide Prevention Lifeline at **1-800-273-8255 (TALK).***

Please feel free to contact me with any questions.

Thank you,

Caroline Abbott
(774) 368-0535
cabbott@conncoll.edu
cehabbott@yahoo.com
Connecticut College '12
Barnstable High School '08

Appendix C

Informed Consent Document

I hereby consent to participate in Caroline Abbott's research about attitudes toward suicide.

I understand that this research will involve filling out an online questionnaire.

While I understand that the direct benefits of this research to society are not known, I have been told that I may learn more about attitudes towards suicide.

I understand that this research will take about 20 minutes.

I have been told that this questionnaire will ask me about my attitudes towards suicide and my own experiences with a peer suicide, which may cause emotional distress. I have been told that I will receive contact names and numbers in case I feel distressed or want to talk more.

I have been told that Caroline Abbott can be contacted at cabbott@conncoll.edu. I have been advised that I may contact the researcher who will answer any questions that I may have about the purposes and procedures of this study.

I understand that I may decline to answer any questions as I see fit, and that I may withdraw from the study without penalty at any time.

I understand that all information will be identified with a code number and NOT my name.

I understand that this study is not meant to gather information about specific individuals and that my responses will be combined with other participants' data for the purpose of statistical analyses.

I consent to publication of the study results as long as the identity of all participants is protected.

I understand that this research has been approved by the Connecticut College Human Subjects Institutional Review Board (IRB).

Concerns about any aspect of this study may be addressed to Professor Ann Devlin, Chairperson of the Connecticut College IRB (860-439-2333).

I am at least 18 years of age, and I have read these explanations and assurances and voluntarily consent to participate in this research about attitudes towards suicide.

Name (printed) _____

Signature _____

Date _____

Please answer the following questions to the best of your ability.

1. Have you ever lost a family member to suicide?   YES   NO

2. Have you ever lost a peer to suicide?   YES   NO
     (Peers are friends your age, classmates, teammates, someone in your grade, etc.)

3. If yes, how many peers have you lost to suicide? _____

In the next series of questionnaires, you will be asked about three <u>peers</u> who have died by suicide (one set of questions per peer who died). You will be asked to answer the questions for one peer at a time. If you have known more than 3 peers who have died by suicide, please answer the following questions for the 3 that have had the most significant impact on your life. If you have known fewer than 3 peers who have died by suicide, you will be asked to fill out one for each.

PEER 1

What was your relationship with this person? Check the answer that fits best.

_____ Friend

_____ Classmate/ acquaintance

_____ Other (please specify): _____

On a scale of 1-5 (5 being the closest), how close were you with this person? Circle the answer that fits best.

    1   2   3   4   5
Not close at all   Very Close

Remember that you may skip any question you do not want to answer.

Think back to the time this person died and answer all of these items about your feelings and actions **at that time** by indicating whether each item is Completely True, Mostly True, Both True and False, Mostly False, or Completely False as it applied to you after this person died. Check the best answer.

1. After this person died I found it hard to get along with certain people.

    Completely False   Mostly False   Both True and False   Mostly True   Completely True

2. I found it hard to work well after this person died.

    Completely False   Mostly False   Both True and False   Mostly True   Completely True

3. After this person's death I lost interest in my family, friends, and outside activities.

    Completely False   Mostly False   Both True and False   Mostly True   Completely True

4. I felt a need to do things that the deceased had wanted to do.

    Completely False   Mostly False   Both True and False   Mostly True   Completely True

5. I was unusually irritable after this person died.

    Completely False   Mostly False   Both True and False   Mostly True   Completely True

6. I couldn't keep up with my normal activities for the first 3 months after this person died.

    Completely False   Mostly False   Both True and False   Mostly True   Completely True

7. I was angry that the person who died left me.

    Completely False   Mostly False   Both True and False   Mostly True   Completely True

8. I found it hard to sleep after this person died.

    Completely False   Mostly False   Both True and False   Mostly True   Completely True

Now answer all of the following items by checking **how you presently feel** about this person's death. Do not look back at Part I.

1. I still cry when I think of the person who died.

    Completely False   Mostly False   Both True and False   Mostly True   Completely True

2. I still get upset when I think about the person who died.

    Completely False   Mostly False   Both True and False   Mostly True   Completely True

3. I cannot accept this person's death.

Completely False   Mostly False   Both True and False   Mostly True   Completely True

4. Sometimes I very much miss the person who died.

Completely False   Mostly False   Both True and False   Mostly True   Completely True

5. Even now it's painful to recall memories of the person who died.

Completely False   Mostly False   Both True and False   Mostly True   Completely True

6. I am preoccupied with thoughts (often think) about the person who died.

Completely False   Mostly False   Both True and False   Mostly True   Completely True

7. I hide my tears when I think about the person who died.

Completely False   Mostly False   Both True and False   Mostly True   Completely True

8. No one will ever take the place in my life of the person who died

Completely False   Mostly False   Both True and False   Mostly True   Completely True

9. I can't avoid thinking about the person who died

Completely False   Mostly False   Both True and False   Mostly True   Completely True

10. I feel it's unfair that this person died.

Completely False   Mostly False   Both True and False   Mostly True   Completely True

11. Things and people around me still remind me of the person who died.

Completely False   Mostly False   Both True and False   Mostly True   Completely True

12. I am unable to accept the death of the person who died.

Completely False   Mostly False   Both True and False   Mostly True   Completely True

13. At times I still feel the need to cry for the person who died.

Completely False   Mostly False   Both True and False   Mostly True   Completely True

Please fill out the following questionnaire based on your current feelings. Remember that you may skip any question you do not want to answer.

1. It is always possible to help a person with suicidal thoughts.

1	**2**	**3**	**4**	**5**
Strongly Agree	Agree	Neither	Disagree	Strongly Disagree

2. Taking one's own life is among the worst things to do to one's relatives.

1	**2**	**3**	**4**	**5**
Strongly Agree	Agree	Neither	Disagree	Strongly Disagree

3. Most suicide attempts are impulsive actions by nature.

1	**2**	**3**	**4**	**5**
Strongly Agree	Agree	Neither	Disagree	Strongly Disagree

4. Many suicide attempts are made because of revenge or to punish someone else.

1	**2**	**3**	**4**	**5**
Strongly Agree	Agree	Neither	Disagree	Strongly Disagree

5. It is a human duty to try to stop someone from dying by suicide.

1	**2**	**3**	**4**	**5**
Strongly Agree	Agree	Neither	Disagree	Strongly Disagree

6. When a person dies by suicide it is something that he/she has considered for a long time.

1	**2**	**3**	**4**	**5**
Strongly Agree	Agree	Neither	Disagree	Strongly Disagree

7. There is a risk of evoking suicidal thoughts in a person's mind if you ask about it.

1	**2**	**3**	**4**	**5**
Strongly Agree	Agree	Neither	Disagree	Strongly Disagree

8. People who make suicidal threats seldom complete suicide.

1	**2**	**3**	**4**	**5**
Strongly Agree	Agree	Neither	Disagree	Strongly Disagree

9. Suicide is a subject that one should not talk about.

1	**2**	**3**	**4**	**5**
Strongly Agree	Agree	Neither	Disagree	Strongly Disagree

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

1	**2**	**3**	**4**	**5**
Strongly Agree	Agree	Neither	Disagree	Strongly Disagree

11. There may be situations where the only reasonable solution is suicide.

1	**2**	**3**	**4**	**5**
Strongly Agree	Agree	Neither	Disagree	Strongly Disagree

12. Suicide can sometimes be a relief for those involved.

1	**2**	**3**	**4**	**5**
Strongly Agree	Agree	Neither	Disagree	Strongly Disagree

13. Suicides among young people are particularly puzzling since they have everything to live for.

1	**2**	**3**	**4**	**5**
Strongly Agree	Agree	Neither	Disagree	Strongly Disagree

14. A person suffering from a severe, incurable, disease expressing wishes to die should get that help to do so.

1	**2**	**3**	**4**	**5**
Strongly Agree	Agree	Neither	Disagree	Strongly Disagree

15. I am prepared to help a person in a suicidal crisis by making contact.

1	**2**	**3**	**4**	**5**
Strongly Agree	Agree	Neither	Disagree	Strongly Disagree

16. Anybody can die by suicide.

1	**2**	**3**	**4**	**5**
Strongly Agree	Agree	Neither	Disagree	Strongly Disagree

17. I can understand that people suffering from a severe, incurable disease die by suicide.

1	**2**	**3**	**4**	**5**
Strongly Agree	Agree	Neither	Disagree	Strongly Disagree

18. People who talk about suicide do not die by suicide.

1	**2**	**3**	**4**	**5**
Strongly Agree	Agree	Neither	Disagree	Strongly Disagree

19. Most suicide attempts are caused by conflicts with a close person.

1	**2**	**3**	**4**	**5**
Strongly Agree	Agree	Neither	Disagree	Strongly Disagree

20. Suicide can be prevented.

1	**2**	**3**	**4**	**5**
Strongly Agree	Agree	Neither	Disagree	Strongly Disagree

Remember that you may skip any question you do not want to answer.

Please circle the number that represents how you currently feel about the following statements.

1. Suicide is an easy escape, one that cowards use.

1	**2**	**3**	**4**	**5**
Strongly Agree	Agree	Neither	Disagree	Strongly Disagree

2. Suicide is an act of anger, aggression, or revenge.

1	**2**	**3**	**4**	**5**
Strongly Agree	Agree	Neither	Disagree	Strongly Disagree

3. Suicide is selfish.

1	**2**	**3**	**4**	**5**
Strongly Agree	Agree	Neither	Disagree	Strongly Disagree

4. People often die by suicide 'on a whim.

1	**2**	**3**	**4**	**5**
Strongly Agree	Agree	Neither	Disagree	Strongly Disagree

5. If people want to die by suicide, we can't stop them.

1	**2**	**3**	**4**	**5**
Strongly Agree	Agree	Neither	Disagree	Strongly Disagree

6. Suicide is just a cry for help.

1	**2**	**3**	**4**	**5**
Strongly Agree	Agree	Neither	Disagree	Strongly Disagree

Remember that you may skip any question you do not want to answer.

Instructions: Read each statement carefully. Indicate how you feel about each statement.

Circle the "1" if you **Very Strongly Disagree**
Circle the "2" if you **Strongly Disagree**
Circle the "3" if you **Mildly Disagree**
Circle the "4" if you are **Neutral**
Circle the "5" if you **Mildly Agree**
Circle the "6" if you **Strongly Agree**

1.	There is a special person who is around when I am in need	1	2	3	4	5	6	7
2.	There is a special person with whom I can share my joys and sorrows.	1	2	3	4	5	6	7
3.	My family really tries to help me.							
4.	I get the emotional help and support I need from my family.	1	2	3	4	5	6	7
		1	2	3	4	5	6	7
5.	I have a special person who is a real source of comfort to me.	1	2	3	4	5	6	7
6.	My friends really try to help me.							
7.	I can count on my friends when things go wrong.	1	2	3	4	5	6	7
		1	2	3	4	5	6	7
8.	I can talk about my problems with my family.	1	2	3	4	5	6	7
9.	I have friends with whom I can share my joys and sorrows.	1	2	3	4	5	6	7
10.	There is a special person in my life who cares about my feelings.	1	2	3	4	5	6	7
11.	My family is willing to help me make decisions.	1	2	3	4	5	6	7
12.	I can talk about my problems with my friends.	1	2	3	4	5	6	7

Please answer the following questions.

What is your age?
___19
___20
___21
___22
___23
___Other (please specify)

What is your gender?
___Female
___Male
___Transgender
___ I prefer not to answer.

What is your race/ ethnicity?

_____ White (Caucasian)

_____ Black (African- American)

_____ Hispanic, Latino or Spanish origin

_____ Asian/ Pacific Islander

_____ American Indian or Alaska Native

_____ Multiracial

Appendix J

If you or anyone you know if contemplating suicide, please contact a crisis center near you through the National Suicide Prevention Lifeline at: **1-800-273-8255 (TALK).**

If you are currently in college, you may have access to free counseling services. The website www.ULifeline.org can help you find resources on your campus. "ULifeline is an ANONYMOUS online resource where you can learn more about emotional health and ways to help yourself or a friend if you are struggling with your thoughts or feelings." Visit http://www.ulifeline.org/page/main/StudentLogin.html to find resources at your school.

Local Resources:
The Youth Suicide Prevention Project
Community Health Center of Cape Cod
Maura Weir, (774) 392-5420
mweir@chcofcapecod.org

More Resources:

Suicide Prevention Program
www.mass.gov/dph/suicideprevention

The Samaritans
www.samaritanshope.org
1-877-870-6473 (HOPE)

LGBTQ Youth: 1-800-850-8078
Spanish: 1-888-628-9454

Appendix K

Debriefing/ Explanation of Research Form

First of all, thank you for participating in this research dealing with the effects of suicide on peers. I have sent this questionnaire to as many members of Barnstable's graduating class of 2008 as possible. What I am mostly interested in, is first how our exposure to peer suicide has affected the way we view suicide in general. Second, I am interested to see if there is any relationship between our attitudes towards suicide and our grieving process.

There is some interesting research on exposure to and attitudes towards suicide in adolescents and young adults. For example, it has been shown that adolescents have more accepting and compassionate views towards suicide than adults do (Bondora & Goodwin, 2005). The research on whether or not exposure to suicide increases risk for suicide is mixed, although there is evidence that suicide can occur in clusters (as is the case in Barnstable). If you are interested in this topic and want to read the literature in this area please contact me (Caroline Abbott) at cabbott@conncoll.edu.

If you have any concerns about the manner in which this study was conducted, please contact the chair of the Institutional Review Board at Connecticut College, Dr. Ann Devlin, at 860-439-2333.

Listed below are two sources you may want to consult to learn more about this topic:

Guitierrez, M., King, C., & Ghaziuddin, N. (1996). Adolescent attidues about death in

relation to suicidality. Suicide & Life-Threatening Behavior, 26, 8-18.

Joiner, T. E., (2010). Myths about Suicide. Cambridge, MA: Harvard University Press.