Stigmatising Attitudes Towards Suicide by Gender and Age

Actitudes Estigmatizadoras Hacia el Suicidio por Género y Edad

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Abstract

This cross-sectional study aimed to analyse the association between gender, age, and stigmatising attitudes towards suicide. We collected a non-probabilistic sample of 344 Portuguese individuals aged 16 to 66. The data were collected via questionnaire and then analysed with frequency analysis and chi-squared test. Results suggest that more men revealed stigmatising attitudes. However, the gender effect was more evident within adolescents than within adults. An age effect was also found, revealing that adults hold more stigmatising attitudes than adolescents, but this effect was more evident within female gender. Furthermore, all participants considered that suicide attempters should undergo psychotherapy. These results suggest that gender and age are relevant variables in the development of suicide prevention measures focused on reducing stigma and promoting help-seeking.

Keywords: Suicide, Stigma, Gender, Age, Attitudes.

Resumen

Este estudio transversal tuvo como objetivo analizar la asociación entre el género, la edad y las actitudes estigmatizadoras hacia el suicidio. Se seleccionó una muestra no probabilística de 344 individuos de la población portuguesa de entre 16 y 66 años. Los datos fueron recogidos a través de un cuestionario y posteriormente analizados con análisis de frecuencias y la prueba del Chi-cuadrado. Los resultados sugieren que más hombres revelaron actitudes estigmatizadoras. Sin embargo, el efecto de género fue más evidente en los adolescentes que en los adultos. También se encontró un efecto de la edad, mostrando que los adultos tienen actitudes más estigmatizadoras que los adolescentes, pero este efecto fue más evidente dentro del género femenino. Además, todos los participantes consideraron que los que intentan suicidarse deberían someterse a psicoterapia. Estos resultados sugieren que el género y la edad son variables relevantes en el desarrollo de medidas de prevención del suicidio centradas en reducir el estigma y promover la búsqueda de ayuda.

Palabras clave: Suicidio, Estigma, Género, Edad, Actitudes.

Introduction

The World Health Organisation (WHO, 2014) peremptorily recognises suicide as an alarming phenomenon on a global level, with economic, social, and community impacts, which make suicide a public health issue. In fact, current data show 800.000 annual deaths by suicide worldwide, which amounts to one death in every 40 seconds (WHO, 2014) with more than 20 non-lethal attempts for each one of such deaths (Crosby, Han, Ortega, Parks, & Gfroerer, 2011; WHO, 2014).

Suicidal behaviour reveals some relevant demographical patterns. If we consider analysis by gender, literature refers to a phenomenon called gender paradox in suicide (Canetto & Sakinofsky, 1998): men have a lower frequency in suicidal ideation, but use more lethal suicide methods and kill themselves three to four more times than women (Bilsker & White, 2011; Canetto & Sakinofsky, 1998; Centers for Disease Control and Prevention [CDC], 2013; WHO, 2014), whereas women reveal greater levels of suicidal ideation and of suicide attempts (Bilsker & White, 2011; Kaess et al., 2011; Pereira & Cardoso, 2015; WHO, 2014).

Another demographic pattern of interest relates to age differences in suicidal behaviour (Crosby et al., 2011). Adults and the elderly tend to have greater suicide rates, both in absolute and relative numbers (DeLeo, Bertolote, & Lester, 2002; Nock et al., 2008). In turn, adolescents and young adults try to kill themselves more often than adults and the elderly, but they complete suicide less often: between 100 and 200 attempts are made for each consummated suicide compared to the 4:1 ratio in the elderly (DeLeo et al., 2002; Drapeau & McIntosh, 2015). Even so, it is important to mention that suicide is considered the second leading cause of death in adolescents and young adults, being surpasses only by unintentional injuries (CDC, 2013; WHO, 2014).

On the other hand, research suggests that suicide rates and help-seeking behaviour are affected by attitudes towards suicide (Stack & Kposowa, 2008; WHO, 2014). The dimension and nature of suicide make this phenomenon a sensitive topic, which gives rise to sometimes quite different individual and social attitudes and beliefs. Ever since the pioneering work by Bayet (1922), who differentiated individuals who tolerate suicide under certain circumstances (*morale nuancée*) from those who invariably charge suicide with a negative character and condemn it under any circumstance (*morale simple*), a relevant amount of literature on attitudes towards suicide has been published, particularly focusing on the impact of negative attitudes towards suicidal behaviours and on the implementation of preventive and interventive measures to promote help-seeking in suicidal individuals. Negative attitudes towards suicide are expressed both by considering it a wrongful or undesirable action and by a stigmatising perspective according to which the suicidal person is seen as disturbed, weak or selfish (Batterham, Calear, & Christensen, 2013; Pompili, Mancinelli, & Tatarelli, 2003).

On an individual level, stigma manifests itself through the internalisation or self-stigmatisation coming from the personal belief that social stereotypes and prejudice are true, transforming such individual into a devaluated/unworthy person, a misfit in relation to others (Corrigan, Kerr, & Knudsen, 2005). Furthermore, individuals with a psychiatric and suicidal history reveal a strong internalisation of the stigma (Oliffe et al., 2016), which eventually accentuates the severity of the symptoms and significantly conditions the search for help and adherence to therapeutic approaches (Livingston & Boyd, 2010; Oliffe et al., 2016; Reynders, Kerkhof, Molenberghs, & Van Audenhove, 2014). The social level relates to the stereotypes a group, normally a majority,

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develops and expresses towards the stigmatised group. Social stigma also significantly impacts the search for help. Among the main reasons that condition the search for help are prejudice (negative cognitions and emotions) and discrimination (expressed behaviour) towards the stigmatised individual (Henderson, Evans-Lacko, & Thornicrof, 2013), which eventually aggravates the life of these individuals through social exclusion, avoidance, and limiting employment opportunities, among others. For these reasons, the impact of stigma has to be framed in the individual's social and cultural context. This context may restrict or enhance suicidal behavior, depending on the frequency and intensity of stigma, as well as the formal and informal mechanisms of support available to the suicidal person (Goldsmith, Pellmar, Kleinman, & Bunney, 2002).

According to the International Association for Suicide Prevention (2013), the efficiency of stigma reduction programmes depends, among other things, on the development of new methods focused on specific groups, since broad-based programs have been of limited effectiveness. To that extent, in addition to the differences in suicidal behaviour referred above, gender and age may play an important role in this matter by contributing to the clear definition of the groups that may benefit the most from these programmes and the most appropriate lines of action to reduce stigma.

In fact, stigma is a major risk factor for suicide, since, on the one hand, it negatively impacts the search for help as the individual is hesitantly planning to kill himself and, on the other hand, it limits the implementation of prevention and intervention strategies, both individually and socially (Niederkrotenthaler, Reidenberg, Till, & Gould, 2014; WHO, 2014). The impact of stigma towards suicidal behaviours has motivated the development of different social marketing programmes and campaigns, although there is a large margin to improve the structure and efficiency of such programmes (Niederkrotenthaler et al., 2014). According to the International Association for Suicide Prevention (2013), the efficiency of stigma reduction programmes depends, among other things, on the development of new methods focused on specific groups, since broad-based programs have been of limited effectiveness. To that extent, in addition to the differences in suicidal behaviour referred above, gender and age may play an important role in this matter by contributing to the clear definition of the groups that may benefit the most from these programmes and the most appropriate lines of action to reduce stigma.

If we consider gender differences in stigma toward suicide, previous research suggests dissimilar conclusions. Some studies point out that men are more reluctant to seek help for suicide-related problems (Bjerkest, Romundstad, & Gunnell, 2008) and hold more negative and stigmatising attitudes toward suicide than women (Batterham et al., 2013; Colucci & Minas, 2013), like considering the suicidal person a coward or stupid (Oliffe et al., 2016). However, other studies suggest that men are more tolerant (Arnautovska & Grad, 2010), hold more pro-preventive attitudes (Poreddi et al., 2016) and show less negative appraisals toward the suicidal person (Lee, Tsang, Li, Phillips, & Kleinman, 2007). It is also possible to find studies suggesting that gender has no impact on stigmatising attitudes toward suicide (Eskin, 1995; Zou et al., 2016).

Age differences have also been studied in previous research regarding attitudes toward suicide. In an interesting cross-generational study, Boldt (1983) noted that the younger generation was less stigmatising and more accepting of suicide than the older generation. Also, the younger generation was more likely to see suicide as a result of societal malfunction than an individual failure. More recently, Li and Phillips (2010) confirmed part of this results, by finding that suicide acceptability decreases with age. However, these conclusions are not consistently supported, since Batterham et al. (2013) found conflicting results, suggesting that young adults are more stigmatising of suicide, despite showing higher levels of suicide literacy than older adults.

Considering the conflicting results reported in previous research and the negative impact of stigmatising attitudes on the well-being, social integration, and help-seeking of individuals who consider or attempt suicide, the present study aims

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to analyse the association between gender, age and stigmatising attitudes toward the suicidal person and suicide by determining the gender and age groups (men or women, adolescents or adults) in which such attitudes are more frequent/prevalent. For this purpose, this study uses a methodological design intended to establish clearly distinct group classifications regarding stigmatising attitudes, which will be explained in the data collection procedures. Therefore, this study establishes three specific goals that aim to analyse the association between gender, age and:

1) Stigmatising attitudes towards suicidal people, which characterise these individuals as weak, cowards, or disturbed;

2) The judgment of suicide as a shameful/sinful act;

3) The Importance given to psychotherapy in interventions for suicidal behaviour.

Method

Participants

We collected a non-probabilistic sample of 344 participants from the Portuguese general population, with ages between 16 and 66 (M = 28.4; SD = 11.5), of which 114 (33.1%) were male and 230 (66.9%) were female. The vast majority of participants were single (n = 244; 70.9%), being followed by married (n = 75; 21.8%), divorced (n = 12; 3.5%) and widowed individuals (n = 3; 0.9%). It should also be noted that 10 (2.9%) participants did not revealed their marital status. Regarding education, 37 (10.8%) had completed primary education, 183 (53.2%) had completed secondary education, 66 (19.2%) had a degree, 55 (16%) a master's degree and 3 (0.9%) had a doctoral degree. A total of 293 (85.2%) participants reported some kind of religious belief, while 45 (13.1%) reported being atheist or agnostic and 6 (1.7%) did not answered this question.

Instruments

Socio-demographic questions

Participants were asked to state their age, gender, marital status, full education and religious belief. Age and gender formed the basis for the data analysis, as will be seen further on in the data analysis section.

Questions regarding attitudes towards suicide

Five closed-ended questions were used to measure stigmatising attitudes towards suicidal persons and suicide. These questions were based on a set of items proposed by Lester & Bean (1992) to measure personal disapproval of suicide and supported by other scales that also use items with equivalent content for assessing stigma towards suicide (Batterham, Calear, & Christensen, 2012). Participants were asked whether they considered suicide: 1) a sinful or shameful act; and whether they considered people who die by suicide: 2) weak, 3) cowards, 4) or psychiatrically disturbed. A final item regarding personal attitudes toward psychotherapy for suicide attempters was used. This item was retrieved from Lester & Bean (1992) and asks participants whether individuals who attempt suicide should undergo psychotherapy to understand their inner motivations. Answers were given in a dichotomous scale, in which participants should answer whether they agreed or disagreed with each statement.

No psychometric data are presented because the items are analysed individually and their content validity has already been confirmed by the studies referred above.

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Procedures

Data collection

We conducted an analytic study, using quantitative data collected cross-sectionally. The research was publicly announced through social networks, asking individuals to report their interest in participating. This announcement included a brief description of the aims of the study, a statement regarding the relevance of this research field and a declaration of the participants' rights. The individuals interested in participating were later contacted to complete an online survey with measures presented in the following order: sociodemographic information; and attitudes towards suicide. After presenting the aims of the study, the participants' rights (confidentiality and anonymity, the possibility to not participate and/or cancel participation at any time) and obtaining their informed consent (including the parental consent to survey minor participants), we proceeded with the data collection itself, asking them to be as honest as possible to ensure the usefulness of the study.

During data collection, participants were confronted with a dichotomous choice requiring a clear decision of agreement or disagreement with different statements concerning stigmatising attitudes towards suicidal persons and suicide. At this point, given the content of the questionnaire and the possible interference of social desirability, we reinforced their right to not participate or cancel participation at any time if the questions were forcing an answer they didn't know/were not sure or didn't wanted to give. By asking participants to report their personal opinion using two obviously opposite alternatives, this methodology requires a clear manifestation of their attitudes. Such an approach ensures more clearly distinct group classifications and intends to overcome the limitations of other studies, such as Arnautovska & Grad (2010), regarding the tendency of answering *I don´t know*.

Data analysis

Two statistical procedures were used to analyse the data: frequency distribution and chi-squared test. Frequency distribution allows for the analysis of the quantity and percentage of answers for each category. In turn, the chi-squared test allows for the analysis of the association between categorical variables, by analysing discrepancies between expected and observed values of a given variable; this test indicated whether or not two groups behave similarly.

We analysed the attitudes and beliefs towards suicide according to gender (male or female) and age (up to 25 years or 26 or over). The cut point for age was based on the growing body of research that suggests that effective entry into adulthood does not occur before the age of 25 (Arnett, 2000; Wallis, 2013).

No participants were excluded from the analysis due to missing data, since all items regarding the three main objectives of the study were completely answered. All the analysis were performed using SPSS 22.

Ethical Norms

This study was approved by institutional review board (Proc. 67/2017). All ethical norms to protect participants have been taken into account. Before initiating their participation, they were informed about the purpose of the research, the expected duration, and their right to not participate or to stop participation in any moment. Participants were also informed that, if they had any questions and if they were thinking about killing themselves, they could contact the authors. To ensure anonymity, no personal data were requested.

Results

Gender Association with Stigmatising Attitudes Towards Suicide

The first analysis of the association between gender and stigmatising attitudes towards suicide was performed within the total sample. Results showed that a larger proportion of male participants than of female participants considered that people who die by suicide are weak ($\chi^2(1) = 20.22$, $p < .001$), cowards ($\chi^2(1) = 14.86$, $p < .001$) and that suicide is a shameful/sinful act ($\chi^2(1) = 11.01$, $p < .001$).

There was no statistically significant association between gender and the belief that most people who die by suicide are psychiatrically disturbed ($\chi^2(1) = 0.21$, $p > .05$). The data obtained indicate that 79% of male individuals and 78% of female individuals agreed with this statement (Table 1).

Table 1. Stigmatising Attitudes Towards Suicide by Gender

Attitudes	*Gender*			
	A or D	*Male n (%)*	*Female n (%)*	X^2
People who die by suicide are basically weak people	A D	57 (50%) 57 (50%)	59 (25.7%) 171 (74.3%)	20.22***
Only cowards kill themselves	A D	45 (39.5%) 69 (60.5%)	46 (20%) 184 (80%)	14.86***
Suicide is a shameful/sinful act	A D	55 (48.2%) 59 (51.8%)	69 (30%) 161 (70%)	11.01***
Most suicides are psychiatrically disturbed	A D	90 (78.9%) 24 (21.1%)	180 (78.3%) 50 (21.7%)	0.021

Note. A = Agree; D = Disagree.
***p < .001

Gender Association with Stigmatising Attitudes Towards Suicide by Age Group

A between gender analysis was performed for the younger and the older group separately (Table 2). Considering the group aged 16 to 25, there was a statistically significant association between gender and stigma in three of the four variables analysed. There was a higher proportion of males that considered suicidal persons weak ($\chi^2(1) = 6.14$, $p < .05$), cowards ($\chi^2(1) = 6.62$, $p < .05$), and suicide a shameful/sinful act ($\chi^2(1) = 4.44$, $p < .05$). On the other hand, no significant association was found between gender and the belief that suicidal persons are psychiatrically disturbed ($\chi^2(1) = 0.01$, $p > .05$).

Within the group aged 26 to 66, the only statistically significant association between gender and stigma revealed a higher proportion of males believing that suicidal persons are weak ($\chi^2(1) = 8.15$, $p < .01$). No significant associations were found between gender and the belief that suicidal persons are cowards ($\chi^2(1) = 3.47$, $p > .05$), psychiatrically disturbed ($\chi^2(1) = 0.00$, $p > .05$) and that suicide is a shameful/sinful act ($\chi^2(1) = 2.86$, $p > .05$).

Table 2. Gender Association with Stigmatising Attitudes Towards Suicide by Age Group

Attitudes	Aged 16 to 25				Aged 26 to 66			
	A or D	Male n (%)	Female n (%)	X^2	A or D	Male n (%)	Female n (%)	X^2
People who die by suicide are basically weak people	A D	19 (38%) 31 (62%)	31 (20.5%) 120 (79.5%)	6.14*	A D	38 (59.4%) 26 (40.6%)	28 (35.4%) 51 (64.6%)	8.15**
Only cowards kill themselves	A D	15 (30%) 35 (70%)	21 (13.9%) 130 (86.1%)	6.62*	A D	30 (46.9%) 34 (53.1%)	25 (31.6%) 54 (68.4%)	3.47
Suicide is a shameful/ sinful act	A D	20 (40%) 30 (60%)	37 (24.5%) 114 (75.5%)	4.44*	A D	35 (54.7%) 29 (45.3%)	32 (40.5%) 47 (59.5%)	2.86
Most suicides are psychiatrically disturbed	A D	39 (78%) 11 (22%)	117 (77.5%) 34 (22.5%)	0.01	A D	51 (79.7%) 13 (20.3%)	63 (79.7%) 16 (20.3%)	0.00

Note. A = Agree; D = Disagree.
*p < .05, **p < .01

Age Association with Stigmatising Attitudes Towards Suicide

The analysis of the association between age and stigmatising attitudes towards suicide within the total sample revealed that a greater proportion of individuals aged 26 to 66 that considered that people who die by suicide are weak ($\chi^2(1) = 16.93$, $p < .001$), cowards ($\chi^2(1) = 18.14$, $p < .001$), and that suicide is a shameful/sinful act ($\chi^2(1) = 12.40$, $p < .001$).

There was no statistically relevant association between age and the statement that most people who die by suicide are psychiatrically disturbed ($\chi^2(1) = 0.220$, $p > .05$). Seventy eight percent of participants aged 16 to 25 and 80% of participants aged 26 to 66 agreed with such statement (Table 3).

Table 3. Stigmatising Attitudes Towards Suicide by Age

Attitudes	Age			
	A or D	Aged 16 to 25 n (%)	Aged 26 to 66 n (%)	X^2
People who die by suicide are basically weak people	A D	50 (24.9%) 151 (75.1%)	66 (46.2%) 77 (53.8%)	16.93***
Only cowards kill themselves	A D	36 (17.9%) 165 (82.1%)	55 (38.5%) 88 (61.5%)	18.14***
Suicide is a shameful/ sinful act	A D	57 (28.4%) 144 (71.6%)	67 (46.9%) 76 (53.1%)	12.40***
Most suicides are psychiatrically disturbed	A D	156 (77.6%) 45 (22.4%)	114 (79.7%) 29 (20.3%)	0.220

Note. A = Agree; D = Disagree.
***p < .001

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Age Association with Stigmatising Attitudes Towards Suicide by Gender

A within-gender analysis of the association between age and stigma was performed (Table 4). No significant associations between age and stigma were found within male gender, except for the belief that suicidal persons are weak. A significantly higher proportion of men aged 26 to 66 reported that people who die by suicide are weak when compared to men aged 16 to 25 ($\chi^2(1) = 5.13$, $p < .05$).

Within female gender, three statistically significant associations were found between age and stigma. Women aged 26 to 66 revealed a higher prevalence of stigmatising attitudes toward suicide. Specifically, a higher proportion of females in this age group agreed that suicidal persons are weak ($\chi^2(1) = 6.05$, $p < .05$), cowards ($\chi^2(1) = 10.20$, $p < .01$) and that suicide is a shameful/sinful act ($\chi^2(1) = 6.33$, $p < .05$). No age effect was found for the belief that suicidal persons are psychiatrically disturbed ($\chi^2(1) = 0.16$, $p > .05$).

Table 4. Age Association with Stigmatising Attitudes Towards Suicide by Gender

Attitudes	Male				Female			
	A or D	Aged 16 to 25 n (%)	Aged 26 to 66 n (%)	χ^2	A or D	Aged 16 to 25 n (%)	Aged 26 to 66 n (%)	χ^2
People who die by suicide are basically weak people	A D	19 (38%) 31 (62%)	38 (59.4%) 26 (40.6%)	5.13*	A D	31 (20.5%) 120 (79.5%)	28 (35.4%) 51 (64.6%)	6.05*
Only cowards kill themselves	A D	15 (30%) 35 (70%)	30 (46.9%) 34 (53.1%)	3.35	A D	21 (13.9%) 130 (86.1%)	25 (31.6%) 54 (68.4%)	10.20**
Suicide is a shameful/ sinful act	A D	20 (40%) 30 (60%)	35 (54.7%) 29 (45.3%)	2.43	A D	37 (24.5%) 114 (75.5%)	32 (40.5%) 47 (59.5%)	6.33*
Most suicides are psychiatrically disturbed	A D	39 (78%) 11 (22%)	51 (79.7%) 13 (20.3%)	0.05	A D	117 (77.5%) 34 (22.5%)	63 (79.7%) 16 (20.3%)	0.16

Note. A = Agree; D = Disagree.
*p < .05, **p < .01

Attitudes Towards the Importance of Psychotherapy

The results revealed that 100% of respondents considered that psychotherapy is important for individuals who attempted suicide in order to understand their inner motivations.

Discussion

Suicide, broadly speaking, has been giving rise to a broad reflection, as to create conceptual models that allow for its understanding and efficient interventions. Today we know that stigma towards suicide strongly affects suicide prevention and help-seeking in suicidal persons. We also know that gender and age have high impact on the patterns of suicidal behaviour and suicide rates worldwide. For these reasons, this study aimed to contribute towards the understanding of the association between gender, age and stigma towards suicidal persons and suicide.

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The data obtained in this study present significant differences between men and women as far as attitudes towards suicide go. There is a significantly larger proportion of male individuals putting forward a set of stigmatising and condemnatory attitudes towards people who attempt and die by suicide. More male than female individuals consider suicidal persons as cowards, weak, and that suicide is a shameful or sinful act.

The greater stigmatisation by male individuals is also corroborated by other authors who have verified that men manifest a greater stigma towards male suicide (Batterham et al., 2012; Batterham et al., 2013), more often expressing the opinion that people who die by suicide are pathetic, irresponsible, stupid (Oliffe et al., 2016), and cowards incapable of facing the challenges of life (Hollinger, 2016).

It is also important to mention that this study reveals more expressive results than those performed by others with similar analyses. Oliffe et al. (2016) found that the percentage of men who consider suicide to be a cowardly, stupid, irresponsible, pathetic or immoral act ranges from 8% to 19%. In this study, the percentage of male participants who considered people who die by suicide weak and cowards and suicide as a shameful/sinful act ranges from 40% to 50%. Even for female participants, the frequency of stigmatising attitudes is higher than those of the male participants in the study by Oliffe et al. (2016). Notwithstanding, there are methodological differences that may account for the differences found in both studies, in so far as Oliffe et al. (2016) studied only attitudes towards male suicide. Few studies carry out frequency analysis by gender, so more data are needed to support the understanding of this phenomenon.

The interaction between gender and age provides relevant results suggesting that, despite the fact that men reveal more stigmatising attitudes towards suicide and suicidal persons than women in both age groups, the differences between adult men and women are much less evident than among young men and women. This is mainly due to the increased prevalence of stigmatising attitudes among adult women compared to younger women, and not to a decrease in the prevalence of stigmatising attitudes in adult men.

Similarly to what happened with the analysis by gender, statistically significant associations were found between age and attitudes towards suicide. Adults tend to bear a greater stigma towards suicide, since there is a significantly greater proportion of these individuals who see people who die by suicide as weak and cowards and suicide as a shameful/sinful act. As far as we know, no other studies analyse the association between age groups and stigmatising attitudes towards suicide from a frequency analysis, which prevents the comparison of the data published here with other samples. Up until now, literature on the association between age and stigma fails to be consensual. As opposed to our data, some authors state that, after adolescence, stigmatisation is less evident (Betterham et al., 2013) and that suicide is seen as a more acceptable option (Segal, Mincic, Coolidge, & O´Riley, 2004).

Other authors, nevertheless, have found that suicide becomes less acceptable with age (Li & Phillips, 2010) and stigmatising attitudes, regarding suicide but also some mental illnesses, become more evident (Park, Kim, Cho, & Lee, 2015). Under a developmental perspective, some authors refer to a non-static vision of attitudes, congruent with the dynamism of the periods and experiences of life, associating adolescence with a more tolerant and less stigmatising period (Curran, 1987). In this sense, the advancement of age may be associated with less tolerance in relation to behaviours that deviate from social norms, particularly within a society with some conservative characteristics (Li & Phillips, 2010). At the same time, from a generational perspective, using the concepts of, it will be important to consider whether *morale nuancée* is gaining ground against *morale simple*, with the successive birth of new generations.

The interaction between gender and age provides relevant results suggesting that, despite the fact that men reveal more stigmatising attitudes towards suicide and suicidal persons than women in both age groups, the differences between adult men and

women are much less evident than among young men and women. This is mainly due to the increased prevalence of stigmatising attitudes among adult women compared to younger women, and not to a decrease in the prevalence of stigmatising attitudes in adult men. Within male gender, no differences were found in the prevalence of stigmatising attitudes between young and adult men, except for the higher proportion of adult men considering people who die by suicide weak. However, the same does not occur within female gender, since adult women showed a statistically higher prevalence of stigma towards suicide and suicidal persons in most of the variables analysed. Considered altogether, these results suggest that in adolescence women tend to less often stigmatise suicidal behaviour compared to their male counterparts. However, while in male gender, the prevalence of stigmatising attitudes seems to be broadly similar in adolescence and adulthood, in female gender, adults show a significant increase in stigma towards suicide and suicidal persons compared to their young counterparts. This increase makes gender differences in the prevalence of stigmatising attitudes considerably reduced in adulthood.

Although some studies suggest a reduction of stigma towards suicide (Witte, Smith, & Joiner, 2010), the majority of studies have found high prevalences of stigmatizing attitudes towards suicidal persons (Batterham et al., 2013; Carpiniello & Pinna, 2017; Pompilli, 2007), as well as a high prevalences of stigma perceived by suicide attempters (Frey, Hans, & Cerel, 2016; Li, Huang, Hao, O'Dea, Christensen, & Zhu, 2015; Park et al., 2015) in culturally different societies. The present study presents data that reinforces these conclusions, suggesting some transversality in stigmatising attitudes towards suicide, although they can be materialized in different types of discrimination and prejudice (Goldsmith et al., 2002; Siau et al., 2017).

The results of the current study reveal that, both by gender and age, the groups defined by the WHO (2014) as being at greater risk for suicide exhibit more stigmatising attitudes towards people who attempt and die by suicide. The stigma interiorised by individuals that are at greater risk is particularly serious, since it may encourage concealment of suicidal ideation and plans, negatively influence the search for support from family members, friends, or health professionals, and promote the use of more lethal methods for the suicidal act, since the prospect of living with the stigmatisation of others and/or the mental representation of oneself as a weak and cowardly individual may lead to a significant and complementary component for distress. For instance, some authors claim that non-lethal suicidal behaviours are socially associated with female individuals, which inhibits male individuals from exhibiting such pattern of behaviour more often, as they would have to deal with the stigma of exhibiting female traits (Andersson, 2009). Simultaneously, they experience a greater social expectation of being successful in suicidal acts, which incentivises male individuals to use suicide methods with a higher mortality prospect (Gold, 2005).

In general, societies appear to differ in terms of social meanings of suicide, suicide rates, motives for suicide, methods used for suicide, social support, health care provided to suicidal persons, suicide precipitants, among others (Lester, 2013; Siau, Wee, Ibrahim, Visvalingam, & Wahab, 2017). However, suicide is, save in specific circumstances, condemned in virtually every culture. The term "committed suicide", still frequently used, is a reflection of the time when suicide was considered a crime or a sin and therefore an abominable act. Currently, suicide no longer has this status, but continues to be strongly stigmatized (Sudak, Maxim, & Carpenter, 2008). Although some studies suggest a reduction of stigma towards suicide (Witte, Smith, & Joiner, 2010), the majority of studies have found high prevalences of stigmatizing attitudes towards suicidal persons (Batterham et al., 2013; Carpiniello & Pinna, 2017; Pompilli, 2007), as well as a high prevalences of stigma perceived by suicide attempters (Frey, Hans, & Cerel, 2016; Li, Huang, Hao, O'Dea, Christensen, & Zhu, 2015; Park et al., 2015) in culturally different societies. The present study presents data that reinforces these conclusions, suggesting some transversality in stigmatising attitudes towards suicide, although they can be materialized in different types of discrimination and prejudice (Goldsmith et al., 2002; Siau et al., 2017).

Some of the attitudes analysed by this study did not reveal significant associations with sociodemographic variables. Particularly, it may be observed that there is a statistically

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similar proportion of individuals, both by gender and by age, that consider that most people who die by suicide are psychiatrically disturbed. From a psychiatric point of view, it is accepted that mental illness has implications in most suicides (WHO, 2014). This does not mean, however, that the general population is duly educated, as was highlighted by Joiner (2010), who observed that myths on suicide are frequent and diverse. Future studies should explore the extent to which, in the general population, the belief that people who die by suicide are disturbed is based on satisfactory understanding of the phenomenon and/or whether it represents and reinforces a stigmatising background, which negatively impacts help-seeking and peer support.

There are also no statistically significant associations by gender or age regarding the importance of psychotherapy in suicide attempts. Furthermore, it was observed that the entire sample considers that suicide attempters should undergo psychotherapy to understand their inner motivations, which suggests, on one hand, the focus on suicide as an eminently individual problem and, on the other hand, the relevance attributed to psychotherapeutic intervention in issues of such nature. On the first aspect, it will be important to emphasise that, despite individual vulnerabilities, suicide is also a social phenomenon (Durkheim, 1897), as societies respond to social transformations and crises with peculiar variabilities in suicide rates, which represent more than the sum of individual behaviours. Starting from this idea, the prevention and intervention approaches cannot merely be individual, but rather holistic and integrating. Recent data reinforce the social perspective proposed by Durkheim. In Japan there has been a very significant reduction in the suicide rate (which has regressed to pre-1998 levels) after increasing successively until 2010. This reduction was achieved through legislative proposals approaching suicide as a social phenomenon. Subsequently, significant changes have been made to social policies that are having relevant effects in reducing the number of suicides (Shimizu, 2016).

Given the results obtained, it seems that prevention of suicide and the promotion of help-seeking, considering the higher frequency of stigmatising attitude in male individuals and adults (of both genders), should be particularly emphasised, mainly since these are the groups at higher risk for suicide and since stigmatising attitudes promote the concealment of individual vulnerabilities and distress that trigger suicidal behaviours.

As for the second aspect, public opinion studies on psychotherapy point towards the data obtained in this study. Issues considered pathological seem to gather a greater consensus around the importance of psychological intervention. More than 90% of individuals consider that psychotherapy is acceptable for disorders such as depression and anxiety, or addictions such as alcohol, drugs, or pathological gambling, but for work problems and for promotion of self-awareness such percentage drops to 72% and 58%, respectively (British Association for Counselling and Psychotherapy, 2010).

Given the results obtained, it seems that prevention of suicide and the promotion of help-seeking, considering the higher frequency of stigmatising attitude in male individuals and adults (of both genders), should be particularly emphasised, mainly since these are the groups at higher risk for suicide and since stigmatising attitudes promote the concealment of individual vulnerabilities and distress that trigger suicidal behaviours. As for men, it is widely known that they struggle to ask for help, particularly from strangers (a category into which health professionals fall), but use family members, friends, or the internet to search for information on mental health (Quinnet, 2014). In this sense, instead of waiting for men to reach out to a stranger to expose their alleged weaknesses, it would be quite relevant to consider procedures that ensure their complete confidentiality (for instance, new technologies) and invest in proximity social networks, in whom the person potentially attempting suicide trusts (e.g., family).

As for adults, it is difficult to find programmes based on strategies specifically directed at this age group. It is easier to find programmes focused on adolescents and

young adults than on adults or the elderly of any gender. Although the investment in programmes for young people is relevant, it is questionable that there is no greater concern in recognising the particularities of the adult population. For example, direct contact with individuals with mental illness tends to be more effective than education/information sessions in reducing stigma in adults, but in adolescents the opposite occurs (Corrigan, Morris, Michaels, Rafacz, & Rüsch, 2012).

In resume, these data exemplify the need to deepen the knowledge on attitudes, beliefs and the potential effectiveness of stigma reduction programs, which should meet group-specific characteristics.

Conclusion

The results of the present study suggest that gender and age are associated with attitudes towards suicide. More specifically, there is a significantly greater proportion of male individuals and adults that consider people who die by suicide weak, cowards, and that suicide is a shameful/sinful act. While stigma towards suicide is clearly more prevalent in adolescent males, in adulthood gender association with stigma is less evident. The lower effect of gender found in the group of adults in mainly due to a higher prevalence of adult women also expressing stigmatising attitudes towards suicide, making gender differences in stigma prevalence significantly reduced in individuals aged 26 to 66. Furthermore, approximately 80% of the sample, regardless of age or gender, considered that people who die by suicide are disturbed. Although these data indicate the presence of significant levels of stigma, particularly in the groups with the highest numbers of deaths by suicide in industrialised societies (men and adults), it is particularly relevant to note that the entire sample considers that survivors of suicide attempts should undergo psychotherapy.

The most relevant limitation of the present study concerns the use of data collection instruments that do not have consistent validity indicators in the Portuguese population. Future studies should focus on validating an instrument for assessing stigmatizing attitudes in this population, which will make it possible to apply more robust and complex statistical analyzes and contribute to a deeper understanding of this phenomenon. Also, this study analyses the social and individual levels of stigma. Nevertheless, its methodological design does not allow for the differentiation between both, since we do not know if the participants ever engaged in suicidal behaviour and the questions regarding attitudes towards suicide were formulated in the third person (e.g. only cowards kill themselves suicide). Therefore, future studies may deepen the relationships between the experience of internalised and social stigma by gender and age and the possible manifestation of suicidal behaviour.

Further research could advance the analysis of sociodemographic variables. That is, they can refine the analysis by gender and age, considering specific issues such as gender (in)equality, problem-solving strategies, help-seeking and commitment towards support, stigma coming from different social spheres, among others, considering national and regional contexts where individuals live.

References

Andersson, T. (2009). Suicide. In O'Brien (Ed.), *Encyclopedia of gender and society* (vol. 1, pp. 816-820). Thousand Oaks: Sage Publications.

Arnautovska, U., & Grad, O. (2010). Attitudes toward suicide in the adolescent population. Crisis, 31(1), 22–29. doi: https://doi.org/10.1027/0227-5910/a000009

Arnett, J. (2000). Emerging Adulthood: a theory of development from the late teens through the twenties. American Psychologist, 55(5), 469-480. doi: https://doi.org/10.1037//0003-066X.55.5.469

Batterham, P., Calear, A., & Christensen, H. (2012). The stigma of suicide scale: psychometric properties and correlates of the stigma of suicide. *Crisis, 34*(1), 13-21. doi: https://doi.org/10.1027/0227-5910/a000156

Batterham, P., Calear, A., & Christensen, H. (2013). Correlates of suicide stigma and suicide literacy in the community. *Suicide and Life-Threatening Behavior, 43*(4), 406-417. doi: https://doi.org/10.1111/sltb.12026

Bayet, A. (1922). *Le suicide et la morale*. Paris: Librairie Félix Alcan.

Bilsker, D., & White, J. (2011). The silent epidemic of male suicide. *BC Medical Journal, 53*(10), 529-534.

Bjerkeset, O., Romundstad, P., & Gunnell, D. (2008). Gender differences in the association of mixed anxiety and depression with suicide. *The British Journal of Psychiatry, 192*, 474-475. doi: https://doi.org/10.1192/bjp.bp.107.045203

Boldt, M. (1983). Normative evaluations of suicide and death: a cross-generational study. *Omega, 13*(2), 145-157.

British Association for Counselling and Psychotherapy (2010). *Attitudes to counselling and psychotherapy: key findings*. Retrieved from http://www.itsgoodtotalk.org.uk/assets/docs/Attitudes-to-Counselling-Psychotherapy-Key-Findings-BACP-June-2010_1331121114.pdf

Canetto, S., & Sakinofsky, I. (1998). The gender paradox in suicide. *Suicide and Life-Threatening Behavior, 28*(1), 1-23.

Carpiniello, B., & Pinna, F. (2017). The Reciprocal Relationship between Suicidality and Stigma. *Frontiers in Psychiatry, 8*. doi: https://doi.org/10.3389/fpsyt.2017.00035

Centers for Disease Control and Prevention (2013). *Web-based Injury Statistics Query and Reporting System (WISQARS)*. Retrieved https://www.cdc.gov/injury/wisqars/index.html

Colucci, E., & Minas, H. (2013). Attitudes towards youth suicide: a comparison between Italian, Indian, and Australian students. In Y. Kashima, E. Kashima, & R. Beatson (Eds.), *Steering the Cultural Dynamics: Selected Papers from the 2010 Congress of the International Association for Cross-Cultural Psychology* (pp. 111-117). Melbourne, Australia: International Association for Cross-Cultural Psychology.

Corrigan, P., Kerr, A., & Knudsen, L. (2005). The stigma of mental illness: explanatory models and methods for change. *Applied and Preventive Psychology, 11*(3), 179-190. doi: https://doi.org/10.1016/j.appsy.2005.07.001

Corrigan, P., Morris, S., Michaels, P., Rafacz, J., & Rüsch, N. (2012). Challenging the public stigma of mental illness: a meta-analysis of outcome studies. *Psychiatric Services, 63*(10), 963-973. doi: https://doi.org/10.1176/appi.ps.201100529

Crosby, A., Han, B., Ortega, L., Parks, S., & Gfroerer, J. (2011). Suicidal thoughts and behaviors among adults aged ≥ 18 years – United States, 2008-2009. *Morbidity and Mortality Weekly Report, 60*(13), 1-22.

Curran, D. (1987). *Adolescent suicidal behavior.* New York: Hemisphere Publishing Corporation.

DeLeo, D., Bertolote, J., & Lester, D. (2002). Self-directed violence. In E. Krug, L. Dahlberg, J. Mercy, A. Zwi & R. Lozano (Eds.), *World report on violence and health* (pp. 183-212). Geneva: World Health Organization.

Drapeau, C., & McIntosh, J. (2015). *U.S.A. suicide: 2013 official final data.* Retrieved from http://www.suicidology.org/portals/14/docs/resources/factsheets/2013data-pgsv2alt.pdf

Durkheim, E. (1897). *Le suicide. Étude de sociologie*. Paris: Les Presses Universitaires de France.

Eskin, M. (1995). Adolescents' attitudes toward suicide, and a suicidal peer: a comparison between Swedish and Turkish high school students. *Scandinavian Journal of Psychology, 36*(2), 201-207. doi: https://doi.org/10.1111/j.1467-9450.1995.tb00979.x

Frey, L., Hans, J., & Cerel, J. (2016). Perceptions of suicide stigma. *Crisis: The Journal of Crisis Intervention and Suicide Prevention, 37*(2), 95-103. doi: https://doi.org/10.1027/0227-5910/a000358

Gold, L. (2005). Gender issues in suicide. *Psychiatric Times, 22*(11), 64-72.

Goldsmith, S. K., Pellmar, T. C., Kleinman, A. M., & Bunney, W. E. (2002). Society and Culture. In S. K. Goldsmith, T. C. Pellmar, A. M. Kleinman & W. E. Bunney (Eds.), *Reducing suicide: a national imperative* (pp. 193-228). Washington DC: The National Academies Press.

Henderson, C., Evans-Lacko, S., & Thornicroft, G. (2013). Mental illness stigma, help seeking, and public health programs. *American Journal of Public Health, 103*(5), 777-780. doi: https://doi.org/10.2105/AJPH.2012.301056

Hollinger, J. (2016). *Adolescent atitudes toward and perceptions of suicide, stigma, and help-seeking behavior* (Doctoral dissertation). Retrieved from http://digitalcommons.pcom.edu/cgi/viewcontent.cgi?article=1362&context=psychology_dissertations

International Association for Suicide Prevention (2013). *Stigma: a major barrier to suicide prevention.* Retrieved from https://www.iasp.info/wspd/pdf/2013/2013_wspd_brochure.pdf

Joiner, T. (2010). *Myths about suicide.* Cambridge, Massachusetts: Harvard University Press.

Kaess, M., Parzer, P., Haffner, J., Steen, R., Roos, J., Klett, M., ... Resch, F. (2011). Explaining gender differences in non-fatal suicidal behaviour among adolescents: a population-based study. *BMC Public Health, 11*(597). doi: https://doi.org/10.1186/1471-2458-11-597

Lee, S., Tsang, A., Li, X.-Y., Phillips, M., & Kleinman, A. (2007). Attitudes toward suicide among Chinese people in Hong Kong. *Suicide and Life-Threatening Behavior, 37*(5), 565-575. doi: https://doi.org/10.1521/suli.2007.37.5.565

Lester, D. (2013). Culture and Suicide. In E. Colucci & D. Lester (Eds.), *Suicide and culture: understanding the context* (pp. 59-90). Göttingen, Germany: Hogrefe Publishing.

Lester, D., & Bean, J. (1992). Attributions of causes to suicide. *The Journal of Social Psychology, 132*(5), 679-680.

Li, A., Huang, X., Hao, B., O'Dea, B., Christensen, H., & Zhu, T. (2015). Attitudes towards suicide attempts broadcast on social media: an exploratory study of Chinese microblogs. *PeerJ, 8*. doi: https://doi.org/10.7717/peerj.1209

Li, X., & Phillips, M. (2010). Cross-sectional survey on the acceptability of suicide among rural residents, urban residents and college students from three locations in China. *Crisis, 31*(4), 183-193. doi: https://doi.org/10.1027/0027-5910/a000024

Livingston, J., & Boyd, J. (2010). Correlates and consequences of internalized stigma for people living with mental illness: a systematic review and meta-analysis. *Social Science & Medicine, 71*(12), 2150-2161. doi: https://doi.org/10.1016/j.socscimed.2010.09.030

Niederkrotenthaler, T., Reidenberg, D., Till, B., & Gould, M. (2014). Increasing help-seeking and referrals for individuals at risk for suicide by decreasing stigma: the role of mass media. *American Journal of Preventive Medicine, 47*(Suppl. 2), S235-S243. doi: https://doi.org/10.1016/j.amepre.2014.06.010

Nock, M., Borges, G., Bromet, E., Cha, C., Kessler, R., & Lee, S. (2008). Suicide and suicidal behavior. *Epidemiologic Reviews, 30*, 133-154. doi: https://doi.org/10.1093/epirev/mxn002

Oliffe, J., Ogrodniczuk, J., Gordon, S., Creighton, G., Kelly, M., Black, N., & Mackenzie, C. (2016). Stigma in male depression and suicide: a canadian sex comparison study. *Community Mental Health Journal, 52*(3), 302-310. doi: https://doi.org/10.1007/s10597-015-9986-x

Park, S., Kim, M.-J., Cho, M., & Lee, J.-Y. (2015). Factors affecting stigma toward suicide and depression: a Korean nationwide study. *International Journal of Social Psychiatry, 61*(8), 811-817. doi: https://doi.org/10.1177/0020764015597015

Pereira, A., & Cardoso, F. (2015). Suicidal ideation in university students: prevalence and association with school and gender. *Paidéia (Ribeirão Preto), 25*(62), 299-306. doi: https://doi.org/10.1590/1982-43272562201503

Pompili, M. (2007). Stigma and suicide risk. In R. Tatarelli, G. Pompili & P. Giradi (Eds.), Suicide in Schizophrenia. Hauppauge, NY: Nova Biomedical Books.

Pompili, M., Mancinelli, I., & Tatarelli, R. (2003). Stigma as a cause of suicide. *British Journal of Psychiatry, 183*(2), 173-174. doi: https://doi.org/10.1192/bjp.183.2.173-a

Poreddi, V., Thimmaiah, R., Ramu, R., Selvi, S., Gandhi, S., Ramachandra, & Math, S. (2016). Gender differences related to attitudes toward suicide and suicidal behavior. *Community Mental Health Journal, 52*(2), 228-232. doi: https://doi.org/10.1007/s10597-015-9913-1

Quinnett, P. (2014). Men and suicide prevention: why can't a man be more like a woman. In D. Lester, J. Gunn III & P. Quinnett (Eds.), *Suicide in men: how men differ from women in expressing their distress*. Springfield, IL: Charles C Thomas Publisher, LTD.

Reynders, A., Kerkhof, A., Molenberghs, G., & Van Audenhove, C. (2014). Attitudes and stigma in relation to help-seeking intentions for psychological problems in low and high suicide rate regions. *Social Psychiatry and Psychiatric Epidemiology, 49*(2), 231-239. doi: https://doi.org/10.1007/s00127-013-0745-4

Segal, D., Mincic, M., Coolidge, F., & O'Riley, A. (2004). Attitudes toward suicide and suicidal risk among younger and older persons. *Death Studies, 28*(7), 671-678. doi: https://doi.org/10.1080/07481180490476524

Shimizu, Y. (2016). How Japan Reduced Suicides: A Law That Changed Society – The Japanese Model. In P. Courtet (Ed.), *Understanding Suicide* (pp. 225-238). Cham, Switzerland: Springer.

Siau, C. S., Wee, L. H., Ibrahim, N., Visvalingam, U., & Wahab, S. (2017). Cross-cultural sdaptation and validation of the Attitudes Toward Suicide Questionnaire among healthcare personnel in Malaysia. *Inquiry: a journal of medical care organization, provision and financing*, *54*. doi: https://doi.org/10.1177/0046958017707295

Stack, S., & Kposowa, A. (2008). The association of suicide rates with individual-level suicide attitudes: a cross-national analysis. *Social Science Quarterly, 89*(1), 39-59. doi: https://doi.org/10.1111/j.1540-6237.2008.00520.x

Sudak, H., Maxim, K., & Carpenter, M. (2008). Suicide and stigma: A review of the literature and personal reflections. *Academic Psychiatry, 32*, 136–142. doi: https://doi.org/10.1176/appi.ap.32.2.136

Wallis, L. (2013, September 23). Is 25 the new cut-off point for adulthood? *BBC News Magazine*. Retrieved from http://www.bbc.com/news/magazine-24173194

Witte, T. K., Smith, A. R., & Joiner, T. E. (2010). Reason for cautious optimism? Two studies suggesting reduced stigma against suicide. *Journal of Clinical Psychology, 66*, 611-626. doi: https://doi.org/10.1002/jclp.20691

World Health Organization (2014). *Preventing suicide: a global imperative*. Geneva: World Health Organization.

Zou, Y., Leung, R., Lin, S., Yang, M., Lu, T., Li., X., ... Hao, Y. (2016). Attitudes towards suicide in urban and rural China: a population based, cross-sectional study. *BMC Psychiatry, 16*. doi: https://doi.org/10.1186/s12888-016-0872-z