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NURSING STUDENTS' ATTITUDES TOWARD SUICIDE AND INDIVIDUALS WHO HAVE ATTEMPTED SUICIDE

HEMŞİRELİK ÖĞRENCİLERİNİN İNTİHARA VE İNTİHAR GİRİŞİMİNDE BULUNMUŞ BİREYLERE YÖNELİK TUTUMLARI

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Abstract

Background: While suicide continues to be an increasing public problem today, the attitudes of health professionals affect individuals with suicidal tendencies and who have attempted suicide to receive health services.
Aim: This study aimed to determine nursing students' attitudes toward suicide and individuals who have attempted suicide.
Methods: The sample of the cross-sectional study consists of 791 nursing students. The study data were collected using the personal information form, Attitudes Toward Suicide Scale and Attitudes Toward Suicidal Individual Scale.
Results: The highest mean score in the participants' attitudes towards suicide was the Punishment of Suicide in the afterlife subscale. The highest mean score in attitudes towards individuals who have attempted suicide was the Social Acceptance subscale. Attitudes towards suicide and suicidal individuals varied based on sex, age, and year. It was found that beliefs and attitudes of seeing suicide as a mental illness, explaining psychological problems, and punishing suicide in the afterlife were positively correlated with social acceptance, help, understanding and emotional support attitudes towards individuals who attempted suicide.
Conclusions: Nursing students' beliefs and perceptions about suicide affect their attitudes toward individuals who have attempted suicide. Nursing students should be trained in establishing awareness of suicide and therapeutic relationships with suicidal individuals to provide an effective mental health service.
Keywords*:* Suicide, Attitudes toward suicide, Nursing Students, Mental health.

Özet

Giriş: İntihar günümüzde giderek artan bir halk sağlığı sorun olmaya devam ederken, sağlık çalışanlarının tutumları intihar düşüncesi olan ve girişiminde bulunmuş bireylerin sağlık hizmeti almasını etkilemektedir.
Amaç: Bu çalışma, hemşirelik öğrencilerinin intihara ve intihar girişiminde bulunmuş olan bireylere yönelik tutumlarının belirlenmesi amacıyla gerçekleştirilmiştir.
Yöntem: Kesitsel tipteki araştırmanın örneklemini 791 hemşirelik öğrencisi oluşturmaktadır. Araştırmanın verileri kişisel bilgi formu, İntihara Karşı Tutumlar Ölçeği ve İntihar Eden Bireye Karşı Tutumlar Ölçeği kullanılarak toplanmıştır.
Bulgular: Katılımcıların intihara karşı tutumlarında en yüksek puan ortalaması İntiharın Öbür Dünyada Cezalandırılması alt boyutudur. İntihar eden bireye karşı tutumda en yüksek puan ortalaması ise Sosyal Kabul alt boyutudur. İntihara ve intihar eden bireylere yönelik tutumlar cinsiyet, yaş ve sınıf düzeyine göre farklılaştığı bulunmuştur. İntiharı bir ruhsal hastalık olarak görme, psikolojik sorunları açıklama ve intiharın öbür dünyada cezalandırılması inanç ve tutumları ile intihar girişiminde bulunan bireylere yönelik sosyal kabul, yardım, anlayış ve duygusal destek tutumları ile pozitif yönlü ilişkili olduğu bulunmuştur.
Sonuç: Hemşirelik öğrencilerinin intihara ilişkin inanç ve algıları, intihar eden bireylere yönelik tutumlarını etkilemektedir. Hemşirelik öğrencilerinin intihar eden bireylere yönelik etkili bir ruh sağlığı hizmeti sunabilmeleri için intihar konusunda farkındalıklarının artırılması ve intihara eğilimli bireylerle terapötik ilişki kurma konusunda eğitilmeleri gerekmektedir.
Anahtar Kelimeler: İntihar, İntihara karşı tutumlar, Hemşirelik öğrencileri, Ruh sağlığı.

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INTRODUCTION

Suicide has existed throughout history and is a type of death, is increasingly becoming a public health problem today. More than 700,000 people die every year from suicide attempts, which is the deliberate act of ending their own life (1). Likewise, suicide in the United States (USA) is the second leading cause of death in individuals aged 15-34, and suicide rates have increased by 30% worldwide in the last 20 years (2). Suicide is classified into three groups: suicide, suicidal ideation, and suicide attempt, by the US National Institute of Mental Health (3). According to the World Health Organization (WHO) (2021) (1), suicide attempts are higher than those who commit suicide. In a study conducted in the USA, 11.3% of individuals between the ages of 18-25 had suicidal thoughts, and 1.9% attempted suicide (3). The suicide rate in Turkiye was 4.11 per 100,000 in 2018, and 4.88 per 100.000 in 2022. Contrary to global data, 75.6% of those who committed suicide were men and 24.4% were women (4). Intervening effectively in risk factors requires determining the risk groups and risks first and developing and planning protective interventions for these groups. "We Must Work Together to Prevent Suicide" was used by those in 2019 as the theme for World Mental Health Day to raise awareness of suicide. Therefore, healthcare professionals and nurses have important roles and responsibilities in the prevention of suicide and in the formulation of protective policies for suicide. In the absence of effective assessment and intervention by healthcare professionals and nurses, suicide rates are increasing.

The WHO has determined the measures and strategies to be done until 2030 in its Mental Health Action Plan for reducing suicide rates globally (1). Both WHO and evidence-based studies suggest that interventions to prevent suicide should be carried out to identify risk factors that cause suicide and to conduct studies to eliminate these risk factors (5-7). Suicides are mostly in countries with high socioeconomic levels. However, suicides are also common in countries with low and middle socioeconomic status. In addition, suicide occurs more frequently in individuals and women aged 15-29 (8,9). However, suicide can affect not only individuals of a specific age range or sex but also all individuals at risk in society. Risk factors are usually classified into three groups: individual, familial, and environmental risks. Individual risks can be defined as diagnosis of psychiatric and physical illness, substance use, history of trauma, sexual orientation, experience of violence. Familial risks can be listed as family conflicts, parental attitude, death or loss, family history of neglect and abuse. When environmental risks are evaluated, factors such as low socioeconomic status, social isolation, exposure to bullying, insufficient social support, disasters, migration, and stigmatization should be considered (9-12). Today, the global physical, mental, social, and economic problems caused by the COVID-19 pandemic increased the incidence of post-traumatic stress disorder, depression, anxiety disorders, and other mental disorders. All these negative effects suggest that suicide rates will rise (13,14).

It will be significant to determine the risk factors for suicide and to plan preventive interventions to increase the awareness of suicide among healthcare professionals. False information and myths about suicide can cause problems in the treatment and care of patients admitted to the hospital because of suicide, causing chronic mental issues, recurrent suicide attempts, and even deaths. Therefore, it is crucial to address myths and false beliefs of healthcare professionals about suicide. Individuals who have attempted suicide or apply to health services with suicidal ideation are exposed to stigma, being belittled by healthcare personnel, being ignored, not communicated by and not being deemed worthy of healthcare by personnel, being seen as religiously sinful and guilty, and being more careless in the care of their wounds. These attitudes and beliefs prevent individuals

admitted to hospitals after suicide from receiving qualified care from health professionals (15-20).

For this reason, nurses, who provide uninterrupted service to patients among health workers, and play a key role in preventing suicide. Hospitals are in contact with individuals having suicidal thoughts and suicidal attempts in all steps from primary preventive health services to tertiary rehabilitative services. When the awareness of nurses' attitudes toward suicide and suicidal individuals increases in suicide prevention, intervention, and approaches, the quality of nursing care increases. At the same time, the quality of nursing care increases when they accept individuals with suicide attempts and thoughts and provide the services they need to suicidal individuals without stigmatizing them (21-23). In addition, nurses' knowledge levels, competencies, attitudes, and behaviors about individuals who have attempted suicide and have suicidal thoughts are effective factors for patient outcomes (24). For this reason, this study aimed to determine the attitudes of nursing undergraduates toward suicide and suicidal individuals. Through the findings, it will be significant for nursing undergraduates to realize the myths and lack of knowledge about suicide, suicidal individuals, planning preventive approaches, and planning nursing interventions for individuals hospitalized as a result of a suicide attempt.

Purpose and Type of Study

This study was carried out in a descriptive and cross-sectional manner to determine the attitudes of nursing undergraduates toward suicide and the individuals who have attempted suicide. In line with the purpose of the study, answer the following research questions were sought:

1) What is the level of nursing undergraduate students' attitudes toward suicide and individuals who have attempted suicide?

2) Is there a relationship between the mean scores subscale of attitudes towards suicide and the mean scores subscale of attitudes towards individuals who have attempted suicide of undergraduate nursing students?

3) What is the effect of attitudes towards suicide and descriptive characteristics on nursing undergraduate students' attitudes toward individuals who have attempted suicide?

MATERIAL and METHODS

Participants

The study consisted of university students in the nursing department of the health sciences faculty of a state university. There were 1200 nursing undergraduates in the spring semester of the 2021-2022 academic year in which the study was carried out. In the study, no sample calculation was made in determining the number of samples, and all students were tried to be reached with the convenience sampling method. A total of 775 undergraduates who met the inclusion criteria were included in the study, thus reaching 64.6% of the population. Accepting participation in the research and giving voluntary consent was necessary for inclusion in the study. Nursing undergraduates who did not agree to participate in the study were not included in the study. When the descriptive characteristics of the participants are evaluated 53.5% of the students are between the ages of 18-21 (n=415), 55.2% are women (n=428), 28.1% are first year students (n=218), and 28.1% (n=218) are second years.

Data Collection Tools

The research data were collected using the Personal Information Form, the Eskin Attitudes Toward Suicide Scale, and the Eskin Attitudes Toward the Suicidal Individual Scale.

Personal Information Form

This form was prepared by the researchers and consists of three questions evaluating the descriptive characteristics of the participants, such as sex, age, and year.

Eskin Attitudes Toward Suicide Scale (E-ATSS)

Developed by Eskin (2004) (25), and consisting of 24 items, E-ATSS measures individuals' attitudes toward suicide. The answers to each question in the scale are five-point Likert-type, rated between Completely Disagree (1) and Completely Agree (5). E-

ATSS has six subscales: Acceptability of Suicide, Punishment of Suicide in the Afterlife, Seeing Suicide as a Mental Illness, Explaining Psychological Problems, Hiding Suicide, and Explicitly Writing and Discussing Suicide. As the scores from the subscale increase, it corresponds to the individuals' higher information content in that subscale. Cronbach's alpha values of the original scale were changing between 0.53 and 0.89 (25). Cronbach's alpha values for this study ranged from 0.60 to 0.93.

Eskin Attitudes Toward Suicidal Person Scale (E-ATSPS)

Developed by Eskin (1999) and consisting of 20 items, E-ATSPS was developed for a scale of emotions and reactions of individuals who have attempted suicide. The answers to each question in the scale are on a five-point Likert scale, rated between Completely disagree (1) and Completely agree and (5). The scale consists of four subscales: Social Acceptance, Help and Prevention, Social Rejection, and Understanding and Emotional Support. As the scores obtained from the subscales increase, the attitude of the individuals towards the individual who have attempted suicide also increases in that subscale. Cronbach's alpha values of the original scale were between 0.78 and 0.93 (25, 26), whereas Cronbach's alpha values for this study were between 0.60 and 0.77.

Data Collection

The data started to be collected after obtaining the permission of the ethics committee and the institution. First, the purpose of the study was explained to the undergraduates, and the research link was sent via whatsapp to the participants who agreed to participate in the study and gave their consent to volunteer. The study data were collected through the online form. Data collection was between March and April 2022, and 775 participants were in the study. Participants completed the study data forms within an average of 20 minutes.

Data Analysis

Study data were analyzed in SPSS (Statistical Package for Social Sciences) 24.0 statistical software program. Descriptive statistics are shown as numbers, percentages, means, and standard deviations. While the t-test was used for two variables to determine whether the mean score of the measurement tools changed according to the independent variables, the one-way ANOVA test was used for more than two independent variables. The LSD post hoc test determined which group caused the difference between three or more variables. The relationship between measurement tools was analyzed by Pearson correlation analysis, and the effect of independent variables on dependent variables was analyzed by multiple linear regression analysis. In the regression analysis, the enter method was used and all independent variables were entered into the model at the same time. In all statistical analyses, $p<0.05$ was determined as the significance value.

RESULTS

The mean scores of the nursing undergraduates who participated in the study were evaluated from the subscales of E-ATTS and E-ATSPS. The E-ATSS subscale mean scores of nursing undergraduates were 18.25±4.96 for Punishment of Suicide in the Afterlife, 15.45±3.30 for Explaining Psychological Problems, 11.47±4.37 for Acceptability of Suicide, 7.16±3.16 for Seeing Suicide as a Mental Illness, 5.29±2.00 for Hiding Suicide, 5.27±1.98 for Explicitly Writing and Discussing Suicide. Considering the nursing undergraduates' mean scores of the E-ATSPS subscales, they were 25.21±5.04 for Social Acceptance, 21.88±3.68 for Help and Prevention, 12.66±3.86 for Understanding and Emotional Response, and 11.07±3.70 for Social Rejection.

Table 1 shows the distribution of the mean scores of the E-ATSS and E-ATSPS subscales according to the descriptive characteristics of the participants. Men undergraduates had higher mean scores in Punishment of Suicide in the Afterlife, Seeing Suicide as a Mental Illness,

and Hiding Suicide subscales of E-ATSS ($p<0.05$). The mean scores of Social Rejection and Understanding and Emotional Response, subscales of E-ATSPS, were higher in men ($p<0.05$). The mean score for Punishment of Suicide in the Afterlife and the mean score for Social Acceptance and Help and Prevention of the undergraduates aged 18-21 were higher than the undergraduates aged 22 and over ($p<0.05$). However, when the effect size of all significant differences were evaluated, all effect sizes were below 0.02, indicating a low effect size (Table 1).

The mean scores of the subscales of E-ATSS and E-ATSPS differed according to the year of the undergraduates. The mean score of Acceptability of Suicide, one of the subscales of E-ATSS, was higher in the fourth-year undergraduates than the first and second-year undergraduates, and the third-year undergraduates score was higher than the second-year undergraduates ($p<0.05$). The mean score of the Punishment of Suicide in the Afterlife subscale was higher than the students in the third, and fourth-years were lower than the first-year undergraduates, and the undergraduates in the second year scores were higher than the undergraduates in the fourth-year ($p<0.05$). However, when the effect size of the significant differences that emerged in the two subscales according to the year was evaluated, it was found that the effect sizes were below 0.02, which indicates a low effect size. The mean score of the subscale Explicitly Writing and Discussing Suicide was higher in fourth-year undergraduates compared to other years. Although the effect value of the difference here is slightly above 0.02, it can be said that the effect is still low. The mean scores of the subscales of E-ATSPS Social Acceptance, Help and Prevention, Understanding, and Emotional Response of fourth-year undergraduates were lower than those of first-, second-, and third-year undergraduates ($p<0.05$). Although the effect size for the Social Acceptance subscale is low, the effect size for the Help and Prevention, Understanding, and Emotional Response subscale is between low and medium (Table 1).

In table 2, the relationship between the measurement tool subscales was evaluated with Pearson correlation analysis. There was a weak negative relationship between the Acceptability of Suicide score, which is one of the E-ATSS subscales, and the Social Acceptance ($r= -0.12$) and Help and Prevention ($r= -0.18$), the subscales of E-ATSPS, and there was a weak positive correlation with the Social Rejection subscale ($r= 0.11$). A weak positive correlation was present between the Punishment of Suicide in the Afterlife from the subscales of E-ATSS, and Social Acceptance ($r= 0.11$), Social Rejection ($r= 0.08$), Help and Prevention ($r= 0.16$) and Understanding, and Emotional response ($r=0.15$). A weak positive correlation was present between Social Rejection ($r= 0.17$) and Understanding and Emotional Response ($r=0.11$), and Seeing Suicide as a Mental Illness, a subscale of E-ATSS. A weak positive correlation was present among the subscales of Explaining Psychological Problems from the E-ATSS and Social Acceptance ($r= 0.22$), Social Rejection ($r= 0.08$), Help and Prevention ($r= 0.30$), and Understanding and Emotional Response ($r=0.10$). A weak positive correlation was present between Hiding Suicide, one of the subscales of the E-ATSS, and Social Rejection ($r= 0.18$) (Table 2).

In Table 3, the effects of participants' attitudes toward suicide and their descriptive characteristics on their attitudes toward the suicidal person were analyzed with multiple linear regression analysis. Four models analyzed the effect of each independent variable on the subscales of E-ATSPS (Table 3).

First model, established to determine the effect of independent variables on Social Acceptance was significant ($F=6.308$, $p=000$), and the independent variables explained 7% of the social acceptance subscale (Table 3).

Punishment of Suicide in the Afterlife ($ß= 0.074$) and Explaining Psychological Problems ($ß= 0.195$) had significant effects on Social Acceptance, and the subscale of Explaining Psychological Problems had more predictive power. To put it in another way, a one-unit

Table 1: Distribution of E-ATSS and E-ATSPS subscales **mean scores on the Descriptive Characteristics of Nursing Undergraduates**

Descriptive Characteristics (n=775)		**E-ATSS**						**E-ATSPS**			
		Acceptability of Suicide	Punishment of Suicide in the Afterlife	Seeing Suicide as a Mental Illness	Explaining Psychological Problems	Hiding Suicide	Explicitly Writing and Discussing Suicide	Social Acceptance	Social Rejection	Help and Prevention	Understanding and Emotional Response
		X±SD	X±SD	X±SD	X±SD	X±SD	X±SD	X±SD	X±SD	X±SD	X±SD
Sex	Women(n= 428)	11.28±4.09	17.91±4.44	6.92±2.99	15.25±3.31	5.09±1.93	5.28±1.98	25.24±5.52	10.82±3.66	21.96±3.95	12.24±3.85
	Men (n= (247)	11.70±4.67	18.68±5.51	7.46±3.34	15.69±3.27	5.54±2.05	5.26±1.96	25.19±5.40	11.38±3.73	21.79±3.32	13.17±3.83
	t test value	-1.305	**-2.217**	**-2.335**	-1.859	**-3.153**	0.159	0.130	**-2.118**	0.620	**-3.318**
	p	0.192	**0.034***	**0.020***	0.063	**0.002****	0.874	0.896	**0.035***	0.536	**0.001****
	η2		**0.007**	**0.008**		**0.014**			**0.006**		**0.016**
Age	18-21 (n=415)	11.18±3.90	18.61±4.35	7.18±3.08	15.45±3.28	5.25±1.91	5.30±1.90	25.61±5.81	10.97±381	22.19±4.13	12.90±4.11
	22-36 (n=347)	11.80±4.83	17.85±5.55	7.14±3.25	15.45±3.32	5.33±2.10	5.24±2.07	24.76±3.93	11.18±3.58	21.53±3.04	12.38±3.54
	t test value	-1.934	**2.108**	0.182	0.001	-0.542	0.433	**2.423**	-0.806	**2.475**	1.907
	p	0.054	**0.035***	0.856	0.999	0.588	0.665	**0.016***	0.420	**0.014***	0.057
	η2		**0.005**					**0.007**		**0.007**	
Year	First [a] (n=218)	11.06±3.97	18.88±3.89	7.44±3.16	15.54±3.50	5.53±1.94	5.28±1.92	25.72±4.03	11.36±3.71	22.12±2.92	13.30±3.75
	Second [b] (n=218)	11.03±4.08	18.72±4.53	7.22±3.11	15.12±3.25	5.05±1.92	5.24±1.99	25.61±7.13	11.07±3.89	22.37±5.13	13.32±4.22
	Third [c] (n=212)	11.85±4.93	17.88±6.23	6.94±3.10	15.52±3.20	5.30±2.17	4.93±1.85	24.99±3.65	11.00±3.60	21.92±2.75	12.66±3.59
	Fourth [d] (n=127)	12.25±4.37	17.00±4.65	6.94±3.33	15.73±3.17	5.25±1.89	5.87±2.14	24.05±4.03	10.67±3.53	20.57±2.86	10.42±2.98
	F test value	**3.312**	**4.960**	1.162	1.094	2.086	**6.604**	**3.609**	0.963	**7.108**	**9.570**
	p	**0.020***	**0.002****	0.323	0.351	0.101	**0.000****	**0.013***	0.410	**0.000****	**0.000****
	Post-hoc	**d>a b c>b**	**a>c d b>d**				**d>a, b, c**	**d<a, b**		**d<a, b, c**	**d<a, b, c**
	η2	**0.012**	**0.019**				**0.023**	**0.014**		**0.027**	**0.076**

X= Mean; SD= Standard Deviation; t test: Independent Samples t Test; F test: One-way ANOVA; η2= Eta Squared; * p<0.05; ** p<0.01

Table 2: Correlation Analysis Findings of E-ATSS and E-ATSPS Subscale

	Measuring instruments		1	2	3	4	5	6	7	8	9	10
E-ATSS	1- Acceptability of Suicide	*r*	1	**0.19**	**-0.08**	**0.20**	0.07	0.06	**-0.12**	**0.11**	**-0.18**	-0.04
		p		**0.00****	**0.02***	**0.00****	0.05	0.10	**0.00****	**0.00****	**0.00****	0.24
	2- Punishment of Suicide in the Afterlife	*r*	-	1	**0.20**	**0.14**	0.03	**-0.08**	**0.11**	**0.08**	**0.16**	**0.15**
		p			**0.00****	**0.00****	0.40	**0.02***	**0.00****	**0.03***	**0.00****	**0.00****
	3- Seeing Suicide as a Mental Illness	*r*	-	-	1	0.05	**0.07**	**0.07**	0.00	**0.17**	0.02	**0.11**
		p				0.18	**0.04***	**0.04***	0.96	**0.00****	0.66	**0.00****
	4- Explaining Psychological Problems	*r*	-	-	-	1	0.01	**0.11**	**0.22**	-0.01	**0.30**	**0.10**
		p					0.70	**0.00****	**0.00****	0.78	**0.00****	**0.00****
	5- Hiding Suicide	*r*	-	-	-	-	1	0.06	-0.05	**0.18**	-0.06	0.06
		p						0.12	0.20	**0.00****	0.09	0.08
	6- Explicitly Writing and Discussing Suicide	*r*	-	-	-	-	-	1	0.05	0.00	-0.05	-0.00
		p							0.14	0.96	0.18	0.84
E-ATSPS	7- Social Acceptance	*r*	-	-	-	-	-	-	1	**0.11**	**0.62**	**0.22**
		p								**0.00****	**0.00****	**0.00****
	8- Social Rejection	*r*	-	-	-	-	-	-	-	1	0.01	**0.27**
		p									0.74	**0.00****
	9- Help and Prevention	*r*	-	-	-	-	-	-	-	-	1	**0.38**
		p										**0.00****
	10- Understanding and Emotional Response	*r*	-	-	-	-	-	-	-	-	-	1
		p										

r= Correlation coefficient, *p<0.05, ** p<0.01

change in the Explaining Psychological Problems subscale leads to a positive 0.195 change in the Social Acceptance subscale (Table 3).

Second model, established to determine the effect of independent variables on Social Rejection, one of the subscales of E-ATSPS, was significant (F=7.197, p=000), and the independent variables explained 7% of the Social Rejection subscale. The acceptability of Suicide (ß= 0.128), Seeing Suicide as a Mental Illness (ß= 0.149), and Hiding Suicide (ß= 0.155) had a significant effect on Social Rejection, and Hiding Suicide subscale had more predictive power. In particular, a one-unit change in the Hiding Suicide subscale leads to a positive change of 0.155 in the Social Rejection subscale (Table 3).

Third model, established to determine the effect of independent variables on Help and Prevention, one of the subscales of E-ATSPS, was significant (F=12,600, p=000), and the independent variables explained 12% of the subscales of Help and Prevention. On Help and Prevention, the effective E-ATSS subscales are Acceptability of Suicide (ß= 0.089), Punishment of Suicide in the Afterlife (ß= -0.098), Explaining Psychological Problems (ß= 0.28, with the highest predictive power) and Explicitly Writing and Discussing Suicide (ß= - 0.084). A one- unit change in the Explaining Psychological Problems subscale leads to a positive 0.28 change in the Help and Prevention subscale (Table 3).

Table 3: The effects of demographic characteristics, and E-ATSS sub-dimensions on E-ATSPS subscale

E-ATSS Variables	E-ATSPS Subscale											
	Social Acceptance			Social Rejection			Help and Prevention			Understanding and Emotional Response		
	Standardized Coefficients	t	p	Standardized Coefficients	t	p	Standardized Coefficients	t	p	Standardized Coefficients	t	p
Acceptability of Suicide	-0.056	1.533	0.126	0.128	3.516	**0.000**	0.089	-2.520	**0.012**	0.004	0.098	0.922
Punishment of Suicide in the Afterlife	0.074	2.016	**0.044**	0.062	1.697	0.090	0.098	2.737	**0.006**	0.104	2.816	**0.005**
Seeing Suicide as a Mental Illness	0.029	0.815	0.416	0.149	4.150	**0.000**	-0.014	0.402	0.688	0.070	1.919	0.055
Explaining Psychological Problems	0.195	5.341	**0.000**	0.003	0.073	0.942	0.280	7.919	**0.000**	0.075	2.041	**0.042**
Hiding Suicide	-0.043	-1.227	0.220	0.155	4.403	**0.000**	-0.060	-1.767	0.078	0.038	1.057	0.291
Explicitly Writing and Discussing Suicide	0.027	0.751	0.453	-0.004	0.103	0.918	-0.084	2.405	**0.016**	-0.017	0.475	0.635
Age	-0.052	-1.313	0.190	0.041	1.029	0.304	0.059	-1.526	0.128	-0.039	0.981	0.327
Sex	0.002	0.051	0.960	0.029	0.804	0.422	-0.025	0.708	0.479	0.105	2.892	**0.004**
Year	-0.048	-1.209	0.227	0.053	-1.359	0.174	-0.026	0.683	0.495	-0.093	-2.350	**0.019**
F	6.308			7.197			12.600			5.360		
p	0.000			0.000			0.000			0.000		
R^2	0.07			0.07			0.12			0.05		
Durbin-Watson	1.916			2.006			1.936			1.828		

Fourth model, established to determine the effect of independent variables on Understanding and Emotional Response was significant (F=5,360, p=000), and the independent variables explained 5% of this subscale . Punishment of Suicide in the Other World (ß= 0.104), Explaining Psychological Problems (ß= 0.075), sex (ß= 0.15), and year (ß= -0.903) variables, which are subscale of E-ATSS, have a significant effect on Understanding and Emotional Response, and sex parameter had more predictive power. Changing the sex parameter causes a positive change of 0.105 on the subscale of Understanding and Emotional Response (Table 3).

DISCUSSION

To plan preventive interventions for suicide, it is crucial to determine the false information, beliefs, and thoughts of nursing undergraduates about suicide, and it plays a critical role in the delivery of care services for patients who have attempt suicide (24). This study aimed to determine the attitudes of nursing undergraduates toward suicide and individual who have attempted suicide.

More than half of the participants included in this study were women, between the ages of 18-21, in the first and second years. According to their descriptive characteristics, the mean scores of Punishment of Suicide in the Afterlife, Seeing Suicide as a Mental Illness and Hiding Suicide were significantly higher in men. In the mean scores of Social Rejection and Understanding and Emotional Response of man participants were significantly higher. The social norms and cultural characteristics, religious beliefs, and suicidal experiences of individuals have significant effects on the attitudes of individuals toward suicide and who have attempted suicide. In general, suicide can be seen as an emotional weakness and inability to cope with problems in these societies. In the social norms adopted in patriarchal societies, men should be tough and should not express their feelings a lot (27, 28). According to these societies, emotionally inadequate people commit suicide. For this reason, men may have more negative attitudes and beliefs toward suicide and suicidal persons in line with their religious values and social norms. In the literature, the results are mixed based on sex, but they generally support this study's findings. Eskin (2017) (29), in a study conducted with high school and university students in Turkey, found that men had more negative attitudes towards suicide. Poreddi, et al., (2016) (30), stated that most man participants think that suicide and suicidal behavior is a severe and incurable disease, that they avoid talking about suicide, and that they understand individuals with suicidal thoughts emotionally and intellectually and that suicidal thought can be prevented. Eskin et al. (2016) (31), in a study conducted in 12 countries, stated that women's attitudes toward individuals who have attempted suicide are more socially accepting, helpful, and emotional support approaches than men. Contrary to this study, research findings showing that women have higher negative and stigmatizing attitudes toward suicide and individuals who have attempted suicide are also present in the literature (15, 31, 32).

The mean scores of the subscales of E-ATSS and E-ATSPS differed according to the year of the participants, and the mean scores of Acceptability of Suicide and Explicitly Writing and Discussing Suicide were higher in the fourth-year undergraduates. The mean score of the subscale Punishment of Suicide in the Afterlife was higher in first- and second-year undergraduates. Social Acceptance, Help and Prevention, and Understanding and Emotional Response score averages were the lowest among the participants at the fourth-year undergraduates. The mental health and diseases nursing course taught in the fall semester of the fourth-year makes a significant contribution to the fact that fourth-year undergraduates' attitudes toward suicide are more positive than other years. However, the low mean scores of fourth-year undergraduates in attitudes towards suicidal people may be due to the fact that suicide is a severe psychiatric condition and

therefore requires medical treatment. Although social and emotional support is crucial for individuals who have attempted suicide, this process requires medical treatment. However, individuals with a lack of knowledge about suicide may think that they will eliminate suicidal ideation by distracting the individual who have attempted suicide, by engaging them in more social relations, or by giving reasons for not attempting suicide. However, these interventions alone are not enough without treatment. Therefore, other year have higher scores for social acceptance, help and prevention, or understanding and emotional response. According to the literature, the education and courses taken for suicide contribute to the more positive attitudes and behaviors of individuals toward suicide, and for those who have attempted suicide, their social acceptance increases, and they tend to understand and help individuals more (15,27,33,34). In their study, Flood et al. (2018) (15), emphasized that students studying in Türkiye had a lower level of acceptability of suicide than students in the UK. They thought that this situation emanated from the fact that the mental health and diseases nursing course was given in a three-year course and practice in the education curriculum in the UK, whereas it was present only in one semester in the nursing curriculum in Türkiye.

Between E-ATSS and E-ATSPS subscales, a positive relationship was present between Social Acceptance and Punishment of Suicide in the Afterlife and Explaining Psychological Problems, and a negative relationship was present between the Acceptability of Suicide and Social Acceptance. As a result of the regression analysis, the subscales of Punishment of Suicide in the Afterlife and explaining psychological problems have a positive and significant effect on social acceptance. The majority of Türkiye's population adopts Islam as their religious belief. According to Islam, suicide is a behavior forbidden by Allah, and it is believed that individuals who have attempted suicide will be punished in the afterlife, so suicide behavior is perceived as unacceptable regardless of the preceding situation. The belief that suicidal behavior will be punished and unacceptable in the afterlife may cause participants to adopt attitudes such as protection, prevention, and support toward individuals who attempt suicide (35,36). Thus, support systems are strengthened so that individuals can explain their psychological problems and find solutions to them. When the literature is examined, it is emphasized that the studies conducted are parallel to the findings of this study and that the belief that suicide will be punished in the afterlife and explaining the psychological problems of individuals affect social acceptance (27,37).

A positive correlation was present between Social Rejection and the Acceptability of Suicide, Punishment of Suicide in the Afterlife, Seeing Suicide as a Mental Illness, and Hiding Suicide. The regression analysis showed that the Acceptability of Suicide, Seeing Suicide as a Mental Illness, and Hiding Suicide had a positive and significant effect on Social Rejection. As stated above, religious belief affects individuals' attitudes toward suicide and those who have attempted suicide. At the same time, individuals' perceptions of mental illnesses also affect attitudes toward suicide and suicidal individuals. Whether an individual has suicidal ideation or not, having a diagnosis of any mental illness causes isolation by society and rejecting attitudes in social relations in all areas of work, friendship, job, and daily life. For this reason, social rejection behavior toward individuals who have attempted suicide increases as the belief that suicide is seen as a mental illness and that suicide should be kept hidden increases. In the literature, it is seen that those who do not approve of suicide, who consider suicide unacceptable or as a mental illness have exclusionary attitudes toward individuals who have attempt suicide (27,37). Because suicide is seen as a mental illness in the literature, individuals who have attempted suicide encounter more stigmatization, and in

this case, individuals who have attempted suicide are exposed to social rejection by other people in society (38,39).

While there was a positive relationship between Help and Prevention, Punishment of Suicide in the Afterlife, and Explaining Psychological Problems, there was a negative relationship between the Acceptability of Suicide and Help and Prevention. As a result of the regression analysis, the subscales of Punishment of Suicide in the Afterlife and Explaining Psychological Problems had a positive effect on Help and Prevention, while the subscales of Acceptability of Suicide and Explicitly Writing and Discussing Suicide had a negative effect. According to this finding, the punishment of suicide in the afterlife and the explaining psychological problems lead beliefs and attitudes to be more helpful toward individuals who have attempted suicide and to have an attitude toward preventing suicidal thoughts and actions. At the same time, as the participants think that suicidal behavior is unacceptable, they have more helpful attitudes toward the individual who have attempted suicide and prevents suicidal thoughts and actions. In the studies conducted by Arslantaş et al. (2019) (37) on nursing and midwifery students and Eskin (2017) (27) on young adults, the participants stated that they had attitudes towards helping and preventing suicide against individuals who were considering suicide, and that suicide and psychological problems should be discussed. In studies conducted with Austrian, Slovak and Turkish undergraduates, it has been reported that Austrian and Slovak participants see suicide as a more acceptable and liberal choice, while Turkish participants have a more rejectionist attitude towards suicide and that individuals will be punished after suicide. Turkish undergraduates' belief that individuals will be punished after suicide may lead them to tend to save individuals who have attempt suicide, and to a helpful behavior socially and individually (26,40,41). In a study conducted with Chinese undergraduates, participants supported individuals who have attempted suicide more subjectively, but their level of objective support was low (42).

A negative relationship was present between Understanding and Emotional Response, Punishment of Suicide in the Afterlife, Seeing Suicide as a Mental Illness, and Explaining Psychological Problems. Punishment of Suicide in the Afterlife, Explaining Psychological Problems and the age of the participants had a positive impact on the Understanding and Emotional Response, whereas the year had a negative impact. It is also emphasized above that individuals' religious beliefs, social norms and cultural characteristics, attitudes toward mental illnesses, and attitudes toward talking or expressing emotional problems experienced by individuals are effective in their attempts to understand and emotional responses to individuals who have attempted suicide. In the literature, similar emphases are present, and consequently, the religious beliefs of individuals, their attitudes toward mental illnesses, and their level of knowledge on how to approach suicide and suicidal individuals are effective (31, 42-44).

Conclusion and Recommendations

In this study, significant relationship was found between attitudes toward suicide and attitudes towards individuals who have attempted suicide. The beliefs and attitudes of seeing suicide as a mental illness, explaining psychological problems and punishment of suicide in the afterlife were found to be associated with more social acceptance, help, understanding and emotional support attitudes towards individuals who have attempted suicide. However, beliefs about acceptability of suicide and hiding suicide were associated with increased social rejection scores and decreased social acceptance and helping behaviors towards suicidal individuals. The findings will contribute to the determination of the missing aspects in the education of nursing undergraduates and the reshaping of the educational content. In line with these findings, it is recommended to plan awareness training to change the wrong attitudes, beliefs, and myths

of nursing undergraduates toward suicide and individuals who have attempted suicide and to prevent stigma. In addition, it is recommended to increase students' awareness of the effects of their erroneous beliefs, attitudes, and myths on the care of patients who have attempted suicide or have thoughts. Nursing students should be educated that suicidal behaviors occur due to an underlying mental problem during their education. Finally, undergraduates should be supported in identifying protective interventions for individuals with suicidal tendencies and developing their skills to improve therapeutic communication competencies. It is also recommended to evaluate cultural and religious factors that may be important in the emergence and prevention of suicidal behavior and to include these dimensions in nursing care.

Limitations

This study has various limitations. As a first limitation, the study data were only from undergraduates in the nursing department of a university. The second limitation of the study was that the study data were from a single measurement in a specific period.

Ethical Approval

To carry out the study, approval was first obtained from the Human Research Ethics Committee (Ref: 2022/02.03) for the ethical suitability of the study. Then, institutional permission was obtained from the institution where the study data were collected. During the data collection phase, all participants were informed about the study, and voluntary consent was obtained from them.

Yazar Katkısı

S.A.: Araştırmanın Planlanması, Verilerin Toplanması, Araştırmanın Yazılması;Ö.Z.: Araştırmanın Planlanması, Araştırmanın Yazılması, Kritik Revizyon; Y.K.: Araştırmanın Planlanması, Verilerin Analizi, Araştırmanın Yazılması, Kritik Revizyon

Çıkar Çatışması

Yazarlar herhangi bir çıkar çatışmalarının olmadıklarını beyan ederler.

Fon Bilgisi

Bu çalışmanın gerçekleştirilmesinde herhangi bir kurum ve kuruluştan destek alınmamıştır.

Not

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