**T.R.N.C**
**NEAR EAST UNIVERSITY GRADUATE INSTITUTE OF HEALTH SCIENCES**

# EVALUATION OF STIGMATIZING ATTITUDES OF NURSING STUDENTS TOWARD PEOPLE WHO COMMIT SUICIDE

BOLUTIFE .O. AJETOMOBI

MASTER'S DEGREE IN
DEPARTMENT OF NURSING

NICOSIA
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ASSIST.PROF.DR. MELTEM MERİÇ

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## THESIS APPROVAL CERTIFICATE

The thesis study of Nursing Department graduate student Bolutife .O. Ajetomobi with student number 20184186 titled EVALUATION OF STIGMATIZING ATTITUDES OF NURSING STUDENTS TOWARD PEOPLE WHO COMMİT SUİCİDE has been approved with unanimity / majority of votes by the jury and has been accepted as a Master of Master of Nursing Thesis.

**Thesis Defense Date:** 24/12/2019

**Jury Members Signature:**

| | |
|---|---|
| Head of Jury | Serap TEKBAŞ |
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Professor K. Hüsnü Can BAŞER
Director of Graduate Institute of Health Sciences

## DECLARATION

**Name and Surname:** Bolutife .O. Ajetomobi

**Title of Dissertation:** Evaluation of Stigmatizing Attitudes of Nursing Students Toward People Who Commit Suicide

**Supervisor:** Assist. Prof. Dr. Meltem MERİÇ

**Year:** 2019

I hereby declare that all information in this document has been obtained and presented in accordance with academic rules and ethical conduct. I also declare that, as required by these rules and conduct, I have fully cited and referenced all material and results that are not original to this work.

**Date: 24.12.2019**

**Signature:**

**ACKNOWLEDGEMENT**

I would like to express my gratitude to my Parents and my sister for giving all financially, emotionally and spiritually through prayer to support all that I do.

Also am greatly honored to be supervised by such a humble, kind and highly intelligent person Assist.Prof. Dr. Meltem Meriç, whose contribution, support and encouragement helped in the success of this project.

**ABTRACT**

**Objective:** The study was planned as a descriptive research with aim to evaluate stigmatizing attitudes of nursing students toward people who commit suicide using the stigma of suicide scale.

**Methods:** A quantitative and descriptive study was conducted at the Faculty of Nursing among the international students enrolled for the English Nursing program, 300 willing participant had questionnaires administered to collect the personal information to determine the sociodemographic characteristics of the student and the Stigma of suicide scale were used.

**Results:** The 300 participants in the study majority female 79.9%,ages of 18-23years (45.3 %), 3rd year (36%), have no family history of suicide 89.70%, never visited a psychiatrist 95.70, never has suicide ideation 85.30%, do not know victim of suicide 57.30%, and those victim known by people are strangers making 53.30% of the total. The mean scale total score of the students was 49.61 ±9.34, the mean score of the stigma sub-scale was 24.33±7.23, the mean of depression sub-dimension score was 14.79±4.08, the glorification sub-scale mean score was 10.49 ±4.30. There was a significant difference between the total scores of students' stigmatization attitudes towards a suicide based on nationality, knowing anyone with suicide acts and area of residence.

**Conclusions:** Students have a high stigmatizing attitude towards people who commits suicide. This may affect the type of care they give to patients with mental illness or suicide attempts and ideation. Therefore, developing trainings and early introduction of courses related to mental health and a positive, good practical and theoretical training can help reduce the stigmatizing attitude of student that helps the care they give, and patient receive from them in future and also willingness to take up the speciality.

**Keywords:** Attitude; stigma, suicide; nursing student

**LIST OF CONTENTS**

## LIST OF ABBREVIATIONS AND SYMBOLS

| | |
|---|---|
| **WHO** | World Health Organizations |
| **APA** | American Psychiatric Association |
| **CDC** | Centre of Disease Control |
| **DSM** | Diagnostic and Statistical Manual of Mental Disorders |
| **SOSS** | Stigma of Suicide Scale |
| **LGBT** | Lesbian, Gay, Bisexual and Trangender |

## LIST OF TABLES

# 1. INTRODUCTION

## 1.1 Definition of problem

Mental illness and mental health issue have been on the increase due to various reasons such as increased environmental pressure, economic crisis, and social pressure and so on. This prevalence and serious consequences arising from it seems to have no effect or positive attitude change in seeking of treatment or follow-up even after seeking the help needed and one of the main factors recognized is stigma (Corrigan et al, 2014). That often complicates and sabotage mental health/psychiatry care providers' efforts to prevent, and treat people with these disorders. Stigma do not only prevent the attitude of seeking help or speaking up but causes the problem to deteriorate causing complication of various form such as chronic depression and eventually individuals attempting to or successfully taking their own life known as suicide. One million people die of suicide every year worldwide, and it has been estimated that it will rise to over 1.5million by 2020 (WHO 2019). This figure may seem small or insignificant when compared to death arising from other illnesses or diseases but suicide is a preventable and falls under the primary care sector as compared to the other tiers secondary and tertiary that involves treatment and rehabilitation respectively and can be reduced or eradicated by a reduced stigma rate. Suicide is an act of intentionally taking one's life using various means such as ingestion of insecticide, firearms, drowning among other numerous ways (Kimberly et al, 2015).

Stigma can be been defined as a "sign of disgrace or discredit, which sets a person apart from others". It is also referred to as a cluster of negative attitudes and beliefs that motivate fear, reject, avoid, and discriminate against people who have mental illnesses (Natan et al 2015). Stigma is sometimes extended to family members of people with mental illness or has family history of this illness or disorder as the case maybe(Kakuma et al, 2010). Most individuals would rather keep up with the pressure rather than face consequences like losing their job related to seeking help which may cause them to be tagged psychological or mentally incompetent in fact people with irresistible symptoms will rather check into general medical hospitals with complains of headache., pains and fatigue which occurs as a result of continuous subdued mental or psychological stress or related disorders and never check back if they cannot be

diagnosed or are been referred to the psychiatric\ mental health unit (O'Connor et al, 2014).

Therefore, people do not usually seek help on time and in psychological distress and may rather prefer to take their own life to avoid or save their family from the shame, issue such as loneliness related to loss of spouse in older people, divorce, work pressure or failure in exams that requires psychotherapy, counseling or a good coping mechanism can lead to depression due to the stigma of been termed weak (Rurup et al, 2011). When this issues can't be dealt with or surpass mental capacity as a result of different tolerance rate that can be biological which is due to gene or upbringing suicide may become the last result for people in this situation, even though some to give pre informed information or even have failed attempt they are still able to successfully commit suicide because of the negative attitude they receive rather than support that help prevent suicide, which makes it very important and necessary to look into this situation(Kucukalic and Kucukalic, 2017). People who die of suicide are still further stigmatized after death directly by comments or indirectly towards attitudes given to family member. Stigma is understood in term of three components: stereotypes, prejudice and discrimination and also constructed to be consisting of lack of knowledge, negative attitude and belief, and voiding behaviour towards a certain group of people (Natan et al., 2015). This attitude are also shaped by the individuals, beliefs about mental illness or by knowing and interacting with someone living with mental illness, the media, and cultural stereotypes. People who commit suicide are sometimes described as weaklings, cowards or wicked. In some cases, such act is passive such that suicide is said to be preceded by possession of the body by evil spirit. Meanwhile, different reasons such as depression, loneliness and even stigma towards verbalizing emotional and mental break down or illness can be the major cause (Maithison, 2016).

A good way to educate or create awareness is my role modelling as health workers. Nurses are the centre of the health team serving as an advocate for patient and communicate patient feelings and need to other health care member so the attitude and perception of a nurse which is originally modelled by the family, society and culture can be modelled to professional standard and improved through proper education, training and clinical exposure to help improve a good and positive attitude to people with mental illness which affects people around them and spread a more

positive belief. Nursing students are exposed to this theoretically by teaching and clinically during practice.

However, some of the students are sometimes noticed to exhibit some fear, nursing students who are studying or working within the healthcare disciplines often come into contact with people with mental illness and some of this fear can not only be taken off through the class teaching because it has been developed over time and even longer than the training years (Emul, 2011; Rivera-Segarra et al, 2018). However, they have the responsibility indirectly or directly to serve as role model or educate people through their action or by education in advocating mental health a way through to prevent suicide, as they are part of the patient care team and even play vital role in the provision of both physical and mental Healthcare, meanwhile some still tend to hold negative attitudes towards individual's (Corrigan et al, 2014). These attitudes related to different factors that include cultural upbringing, orientation, knowledge or belief on mental health reflected in unwillingness to consider psychiatric nursing as a specialty of choice or preference. It is of extreme importance to understand the reasons for these negative attitudes and make attempt to clarify the myth and superstitious beliefs(Towsend, 2009).

This perspective will be evaluated Suicide stigma (measured using the Stigma of Suicide Scale) was comparable across the samples to evaluate their attitudes through the words they use in describing people who commits suicide. A Research was previously conducted among university students (n=1100) to assess the' stigmatizing attitudes toward suicides and level of knowledge about suicide using the Stigma of Suicide Scale (SOSS) to shows the stigma attitude towards people who commits or attempt it and result shows that psychoeducational activities for university students need to be developed because them was a high level of negative perception towards people who commits suicide. Suggestions such as developing trainings to increase awareness about the warning signs of suicide by community mental health nurses, specialist psychiatric nurses, or school psychologists maybe effective for suicide prevention (Özturk and Akın, 2018). It is therefore of extreme importance to understand the level of negative attitudes to be able to take actions towards them using the aforementioned scale. The scales divide into stigma, depression and glorification of suicide as an act (Knizek, 2011).

## 1.2 Significance of the problem

At the end of the thesis study, the attitudes of nursing students towards people who commits suicide will be evaluated, using the stigma of suicide scale.

## 1.3 Aim of study

The aim of this study would be to evaluate stigmatizing attitudes of nursing students toward people who commit suicide using the stigma of suicide scale.

## 1.4 Research question

1. What the stigmatizing attitudes of nursing students towards people who commit suicide are?
2. What is the correlation between socio-demographic characteristics of students and stigma attitude?

## 2. LITERATURE REVIEW

### 2.1. Definition of Suicide

Suicide is used to describe death that occurs as a result of self-directed violence at with the intent to end ones live. It can also be defined as an accident that occurs when unwanted situation simultaneously occurs with the thought (Kann et al,2013; Vladeta et al,2019). Successful suicide is the action that leas ads to death without or wit failed intervention (Klonsky, 2016).

Self-directed injuries or violence that do not result to death as planned is termed suicidal attempt, the death may be averted by external intervention recorded as failed attempt which is mostly the case and sometimes aborted suicide attempt occurs when individual stops the action before injury occurs or it results to death, until the there is a successful self-directed and inflicted injury or violence that meets the aim a of ceasing to live it is referred to as attempt and such individual are suicide survivors. Suicidal attempt is described is a non-fatal, self-directed, potentially injurious behaviour with the intent to die as a result of the behaviour (Klonsky, 2016). Suicide attempts sometimes do not result in injury. This action known as suicidal behaviour or action takes plans as a result of suicidal thought or ideation meaning refers to thinking about, considering or planning suicide (WHO, 2012). Deliberate self-harm—willful self-inflicting of painful, destructive, or injurious acts without intention to die is also a non-fatal form that may proceed actual or successful suicide.

The difference between suicidal behaviour and non-suicidal self-injury is clear because the intentions and results are usually different as such the Diagnostic and statistical manual for mental disorder (DSM-5) took this into consideration making it two independent diagnosis based on the intentions of the action of the patient in addition to this it has been determined that non suicidal self-injury is more common and frequently seen than suicidal attempt even though people who attempt to harm them self with no intention to die are more likely to later attempt to end their own life according to American psychiatric association. The methods used also vary as cutting and burning is more frequent in NSSI causing scars, poison in ingestion is a method of suicide attempt or successful suicide (Klonsky et al, 2013).

## 2.2. Suicide Epidemiology

Suicide rate has continued to increase and close to 800,000 people die every yearly that is about 1 person every 40 seconds (WHO, 2016). Even though this may be considered low as compared to death arising from other contagious and highly infective disease, but suicide is preventable and usually can be prevented with a good primary (preventive) through education and tertiary (rehabilitation). Suicide is the 10th leading cause of mortality in the United States of America (Ivey-Stephenson, 2017). Suicide rate has doubled over the past decade for both military and veteran personnel and a very high-risk death rate for members of National Guard and predicted to increase to 1 every 20seconds with about 20 attempting at each death. Suicide is not associated primarily or directly to a virus, bacteria or micro-organism despite this the life lost from this has continued to increase and the recorded are not completely accurate and assumed to be lower than the recorded cases a most death are not reported in under developed countries due to low record, keeping technology or stigma in fact most as reported by relative to be related to other medical illness (Scocco et al, 2012). In every 1000 person in turkey about 58 have mental illness and there is an estimated 500,000 psychiatric patient in the countries that suffer from severe mental disorder (Crabb et al, 2012). In addition to this of every 100 youth about 25 of them attempt suicide and it was established by a research done by the institute of medicine (Bernert et al , 2015).

## 2.3. Socio Demographic and Environmental Factors for Suicide

Suicide rate, tendencies and success is based on different criteria although it can be more peculiar and familiar with some group, certain characteristics or combination of one or two increase the risk for suicide. Such includes the distribution according to gender, status, socio economic status to mention a few; Male gender are more likely to die from suicide as compared to the female gender due to the unwillingness to seek or remain in treatment (Yu and chen, 2019; Wen et al, 2017).

Although females have higher tendencies to commit suicide due to high sensitivity and increase severity of post-traumatic stress disorder among women in the military or veteran. The highly aggressive personality of males as compared to females and ego is said to be rated to the high successful suicide rate even though females have higher attempt tendencies but use a more subtle means such as ingestion of pesticides and can cause filed attempt if quick intervention occurs (Kattimani et al, 2015). Ingestion of pesticides, hanging and fire arm s are among the most common methods

of suicide globally and the fatality is related to the method chosen a factor assumed to be the reason for more mortality of male due to suicide as they are most likely going to assume a more violent way such as use of firearm(WHO, 2019). Men account for roughly three times the number of suicides than women, and this gender disparity is even greater in high-income countries (Kimberly et al, 2015).

Age also is also an important factor that may affect the suicide tendencies and attempt. The suicide incidence increases with age because of increased pressure, tension, social responsibility and also guilt related to success rate which is supported by the Erik Erikson psychosocial developmental stage level seven which focuses on the adult phase of live during which one focus on career and family responsibilities and a failure to meet up causes a feeling of unproductivity seen as a form of stagnation which triggers a feeling of hopelessness, reduces esteem and this may cause depression one of the leading cause of suicide (Antretter et al, 2009; Robinson et al, 2016; Soor 2012). Dan Hamermesh an economist, wrote a model to determine the conditions under which suicide might be considered a rational choice He had three predictions for this model and it includes that suicide rate increases with age, falls as income increases and, and decreases if one desire to live is high using some data on suicide by the world health organization as bases, but smith believes that age is never enough as criteria for an assumption tendencies to commit suicide, other factors such as the social economic (financial status) may be a very grate contributing factor to this (Kann et al , 2018).

Developed countries with population having high-income is said to have higher suicide rate as compared to the developing or underdeveloped otherwise although the lower income country account for 79% of the global suicide population 12.7 versus 11.2 per 100,000 respectively. Suicide is gradually leading cause of death in the united states of America and according to centres for disease control and prevention (CDC) leading causes of death report 2017 (Natan,et al, 2015).

### 2.4. Risk factor or Prevention of suicide

#### 2.4.1. Risk factors of suicide

Risk factors refers to a measurable characteristic of each subject in a specific population that precedes the outcome of interest, suicide can be precipitated by more than one actor for instance a young lady with history of trauma and family history of

depression can have both biological and psychological factor coming to play as the cause or precipitating factor for suicide (Bernert et al, 2015).

1. **Physical factor**

Functional impairment and individual that inflict self-harm have high risk of later committing suicide (Chan, 2016) as self-harm inflicting individual may try more traumatic and dangerous methods of inflicting this pain on their selves. For instance, an amputee whose major work is driving may become depressed as a result of lack of functionality and take his or her own life. The Lesbian, gay, bisexual and transgender (LGBT) community also experienced stigmatizing and high suicide rate due to battle with acceptability (Mizock and Mueser, 2014).

2. **Biological factors**

The make-up of a man sometimes contribute in a way to their level of tolerance, adaptation and adjustment to certain situations; women are likely to commit suicide during menstrual cycle due to hormonal fluctuation and the level of stress tolerance in medical student causing more stress hormone increases the suicide rate and risk (Conner, 2009). Some hormones such as serotonin, histamine and norepinephrine reduction is said to be associated with depression, some sleep disorders which are associated with suicide or seen in people who commits suicide (Townsend, 2014). Low weight individuals are said to have higher suicidal tendencies as compared to normal weight or overweight individual, as opposed to public opinion that obessed person have more tendencies due to weight issues although the correlation between low weight and increased suicide rate is not established yet (Geulayov, 2019). With growth lot of things change in the biological make up of an individual just like changes that occurs in the integumentary system (skin) which start to lose it elasticity such occurs also in the reproductive system with women attaining menopause, with age also study previous research revealed that older adults of age 65 and above have high suicide rate which may be due to loneliness syndrome attributed to children leaving home, loss of friend or even spouse. They may result to alcohol or substance abuse, dementia and even depression.

3. **Social, psychological and socio-economic factor**

Previous history of traumatic situations or event such as rape or any form of abuse, divorce, war loss of loved ones or failure in example that results in stress of any type which a good coping mechanism is not adopted for the stress or situation can cause and such individual at risk of committing suicide(Oliffe et al, 2016). This is an evidence of high suicide rate in veteran (military) especially people who are usually at the war front. They also suffer usually initial may suffer from post-traumatic stress before coming suicide if help is not seek (Geulayov, 2019).

4. **Psychiatric illness**

The presence of psychiatric illness if help is not gotten can precipitate a high suicide risk and such includes depression, schizophrenia, delirium and borderline personality disorder. A study done in Denmark revealed that about 50% of individuals who committed suicide had been or currently were psychiatric inpatients Most commonly people with depression, schizophrenia and sleep disorders that includes hypersomnia, nightmare and any form of sleep disorder that causes difficulty to fall asleep or remain asleep form a large percentage of people at risk of committing suicide in an attempt to achieve sleep or rest (Videbeck, 2011).

5. **Previous attempt**

Suicide attempt, ideation and behaviour does not necessary indicate or amount to the number of actual successful suicide but there is a great chance of someone who initially attempted suicide to eventually complete the action. Most times they will try a stronger, easier and quicker way which make attempt a red light and sign to be taken into consideration to avoid another incidence of suicide. Therefore, restriction in the accessibility to substances such as pesticide, firearm and certain medications have to be checked, In fact most attempter may try again after two weeks (14 days) of previous attempt (Townsend, 2014).

### 2.4.2. Prevention of suicide

This explains the ways to which suicide can be prevented or averted, some of the interventions includes. Suicide prevention research faces specific challenges

related to characteristics of suicide attempts and attempters. Educating on high risk suicidal behaviour and mental health to reduce if not to stop stigmatization.

Using the Maslow hierarchy of needs, the plan to prevent suicide should be safety and security after attending to the need to be physiologically stable regulation of sales of suicide aiding substances such as pesticides which is a common way adopted in committing suicide, and so the accessibility and restricted open market sale of this substance can be away to reduce the suicide rate as it account for about 14 to 20% of the means used by people who commits or had committed suicide.

1. Media reporting can help spread the information on the occurrence and means to help create awareness (Cabiati and Raineri, 2016)
2. Provision of psychological alongside medical treatment for people with functional impairment, abuse or trauma and even in cases of bully when reported (Robinson et al, 2016).
3. School based intervention to reduce cases of bully, counsel students who fail or has gone through one abuse or the other. (Bartik et al, 2013).
4. Divorce or loss of loved one's counselling should also include psychological care for involved parties and children (Doi and Fujiwara, 2019).
5. Introducing alcohol policies to reduce the harmful use of alcohol( Fleischmann and De, 2014)
6. Cheap and affordable mental health institutions should be provided to help improve health seeking behaviours of individuals. ( Natan et al, 2015)
7. Job security and good rehabilitation for people with disability and ex-convict must also be consider, most ex-prisoners end up taking their own life due to difficult to start a normal live as they may be denied access to good jobs and even opportunities that is ready available (WHO, 2012).
8. A good diagnosis method is also important, and this includes taking into consideration of warning signs such as the words, substance use and behaviour changes after a traumatic event (Townsend, 2014).
9. A good geriatric service or nursing home that may include support home for early may help reduce the suicide rate in this age group and give a sense of belonging and important part of life according to Maslow hierarchy of needs also supported by Erik Erikson which state the importance of intimacy and isolation. This support group

can be reinforced from early adulthood and it helps into adulthood. This is done in most Africa society in religious centres and community at large (Aguirre et al , 2010; Lapierre et al, 2011).

### 2.5. Definition of Stigmatization

This is the process of negatively marking or setting person apart from others as a result of assumed deviation from normal referred to as 'virtual social identity including the way you are supposed to think, live and even react to circumstance; for instance depression is not the solution for failure, it is mere weakness (Chesney et al, 2014). Stigma is a complex and multifaceted construct and often results from misunderstandings and misperceptions society has about people with mental illnesses or endorsing prejudice (Fokuo et al , 2017; Picco et al, 2019).

Another way to definition which was formulated during the united nations convention centred around the right of people with disabilities state that stigma is a form of social oppression that blocks or bars people with mental illness from having privilege to social interaction by discrimination, exclusion and this is pure denial of fundamental human and social right, It occurs when individuals or society agree with a given stereotype and apply it to people in the group to evaluate they wrongly, this act is preceded by or occurs as a result of prejudice that is described as differential treatment of one group as compared to others mostly involving limitation or restriction of right or life opportunities for the group members. Stereotyping is a strict and rigid cognitive phenomenon (Gouthro, 2009).

Stigma is experienced by both victims seen by the method of burial given such as throwing into water or burning of corpse, suicide survivors and families of victims may also experience this due to their association terms as associative or courtesy stigma even it is extended to workers in psychiatric unit. Stigma also damage people's self-image and worth which cause the individual to put the judgment on their ability to attain skills, work or even be successful, most mental ill people end up dropping out of schools or quitting job because of the psychological effect of this process (Gouthro, 2009).

In actual sense sometimes the stigma may come from friends and family and in the united kingdom a study done revealed that 56% of the people who were stigmatized

experienced it from their own families and 52% from friends when compared to those gotten from strangers (Hanschmidt,2016, Lang, 2013).

### 2.5.1. Stigmatizing attitude towards people who commits suicide

The reactions which form the attitude towards people that commits suicide can be expressed in different way usually the way the burial is done, relatives are labelled and they are described. They are said to be weak and in cases of successful suicide their relative experience the stigma and when unsuccessful such individual are sometimes secluded or isolated because they are said to be possessed with evil spirit.

They usually do not get befitting services and the family maybe compulsory forced to have cleansing because of the suicide history. This attitude maybe formed to seclude them from the social or avoid society from having physical contact with them (Fokuo et al, 2016; Gouthro, 2009).

Initially people with mental illness were tattooed, imprisoned even though that has changed they are still get served through the attitude they get from people that includes verbal labelling, separation or isolation and inferior treatment they get. Some jobs have exceptions which cannot be logically explained rather than to be tagged stigma that includes job termination, divorces and family isolation. They are assumed to have behavioral switches therefore will not be invited to social gathering, unfortunately most of this attitude are due to myth and superstitious beliefs that people who have suffered mental breakdown are incompent, not strong, irresponsible, unpredictable and dangerous all which is been evaluated using scales where word that people use to describe people with mental illness were listed. All this contributes to the problem with housing.

Even Mental health nurses sometimes receive cold shoulder as a result of their interaction and affiliation with people with mental illness because they are believed to possess or have been influenced by the patients. Outside verbally stating, distance and avoidance are ways of stigmatizing people, so the attitude are sometimes direct (physical) or indirect by isolation and cutting communication (Picco et al, 2019).

### 2.5.2. Nursing Roles for people who commits suicide

The role of a nurse is dynamic and depends on the people, society needs and problem which is done using a good nursing process to be able to get the real problem in the society, stigma also regarding mental illness has also discredit the valuable

contributions of mental health nurses but most importantly people who seek mental health nursing care, therefore the role and work of a psychiatric nurse may vary from community psychiatric nurse that work primarily to educate on the cause, risk factor and prevention of mental illness and play important role in public health and rehabilitation of discharged patient from psychiatric facilities (Chan et al, 2009).

This involves history taking in other to know the basic problems such as stigma, poor public image, economic status, cultural belief and religious beliefs that affect or influence the mental health status and help seeking attitude of the people this aids proper assessment on the perceptions, nature of stigma and discrimination between groups, Strategies for decreasing stigma and promoting affirmation (Fokuo et al , 2017). Diagnosis of the risk factors and the main problem that aids proper planning raining from education to helping to adopt a better coping mechanism or lifestyle that will be implemented during the cause of treatment or education that aids good outcome that is measured by evaluation(Hollinger, 2016).

**1. Education**

This is a very broad, important and crucial part of mental health because it helps in a two-way communication where patients, family and society can verbalize their fear. Also education mental health is given generally on the risk factors, signs and treatment to boast people's health seeking behaviour and reduce stigma. A method of media presentation can be used by Nursing educators and this may help students put their fears into acting and help create positive image such as the research done having students write and act short films that can be used to also educate the public (Chan et al, 2009).

**2. Role modelling**

Walking the talk is sometimes the best way to reinforce and reduce stigma. If the patient did not bite the patient as opposed to what the public fiction is, some people are also given confidence to come closer. Can range from low service availability that psychiatric nursing was not a desirable career choice for undergraduate nursing students therefore education of students on the role maybe an effective way to improve the services provided. (Rusch et al, 2005; Carlson et al, 2010; Happell 2009).

## 2.6. Attitude

The way which people react to people with mental illness sometimes is due indirectly and in disguise. Even though the old way of stigmatizing that includes tattooing and imprisonment of people with mental health is not as rampant due to civilization. Modern stereotypes still portray the mentally ill as guilty, unpredictable and violent and done indelible signs through deprivation from civil right, criminalization and unemployment. Observational studies report how healthcare professionals, including nurses, are often part of the stigma (Ross, 2009).

## 2.7. What Affects Attitude of Student Nurses

Humans generally like to deal in their comfort zone and there is a tendency to behave differently if danger is perceived and these dangers can be initiated by what is heard or has been seen. Student nurses were seen to exhibit a level of anxiety and fear when posted to the mental health unit which reduced their performances, the anxiety which was also triggered by the way they were mentally groomed for the practice, such instruction include been told to be very vigilant to avoid attack by paranoid and delusional patient (Carlson, 2010).

Therefore, students do not want to associate with patient which is a reflection in the attitude they have towards people who commits suicide some of which are result from an underlying psychiatric condition (Chesney et al 2014).This affects their choice nursing students are unwilling to choose psychiatric nursing as their career, and very few students prefer psychiatric nursing as their area of expertise when compared with other fields of nursing; studies shows that they have unconsciously been endorsed and do not want to say or do ‘the wrong thing’ and ‘set them off’ into some explosion of uncontrollable behaviour (Ross, 2009).

An individual is the sum total of both the culture that includes the religion., tribe and belief of a person that is gotten from the family, friend and society therefore the students have a pre-formed perception about mental illness and patient which is express sometimes subconsciously (Fakuo et al , 2017).

Students do not only become scientific or theoretically oriented during the nursing program but there are attitude are directly and indirectly influenced by clinical exposure which is a realistic way to clear doubt and reduce stigma rate, a good clinical exposure has a reasonable amount of positive impact on the reaction and attitude of

this students. Most of their doubts which are superstitious are ruled out thereby allowing them more open to mental health, illness and the patient (Ozturk and Akın, 2018).

Preparation before exposure is also very important and may aid the willingness students to be open to taking this route of specialty, courses like psychology and public health can also help boast the understanding and knowledge of the student to understand the cause, diagnosis and course of mental illness a good way to start of good attitude (Chesney et al 2014).

## 3 . METHODOLOGY

This chapter presents research methodology employed in carrying out the study. It is discussed under the following sub-headings: -Research design, setting of the study, target population, sampling technique, instrument for data collection, method of data collection and ethical consideration.

### 3.1. Study Design

The research project employed descriptive design to examine the stigmatizing attitudes of the nursing student towards people who commit suicide

### 3.2. Study Setting

This study was conducted at Near east university in Turkish Republic of North Cyprus among the students of Faculty of Nursing which has 320 international registered students as at the time the study. The international students are from different nationalities.

### 3.3. Sample Selection

The study was conducted at the Faculty of Nursing. The Faculty of Nursing has two educational programs. These are nursing programs in Turkish and English. Only students in English program were included in our study. No sample selection was done, and the aim was to reach all students. There is a total of 320 international registered students in a faculty of nursing. 300 students who were willing to participate in the study made up the study sample. The sample constituted 94% of the total student.

### Data Collection

Data was collected using a descriptive form and scale between 01 June 2018 and 30 July 2018. The questionnaires were collected in the classroom environment before or after the lecture with self-completion methods. To collect the data the Personal Information Form determining the sociodemographic characteristics of the students and Stigma of suicide Scale were used. The completion of the questionnaire and scale took about 15 minutes.

### 3.5. Study tools

#### 3.5.1 Data Collection Form

This form has been developed by the researcher with the support of the literature in order to collect the introductory information of the students. Includes information such as age, gender, marital status, academic year, parents educational level , place of residence, family history of suicide or psychiatric illness and knowing anyone who died from committing suicide and evaluating the stigma by assessing their level of stigma with their level of agreement with word used in describing people who commit suicide which includes brave, isolated, disconnected, lonely, lost and so on (Appendix 1).

#### 3.5.2. Stigma of suicide Scale (SOSS)

It was developed by Batterham et al. (2013) it assesses the stigmatization of people who died by suicide. It has two forms the SOSS (long or short form), the long form consists of 58 items and the short form consists of 16 items. We used short form in this study. Each item consists of a one-word descriptor of a person who dies by suicide. A person completes the scale by rating how much they agree with each item being a descriptor of someone who takes their own life.

The SOSS has three subscales: one that assesses stigmatization of people who died by suicide; another analysing the relationship between suicide and isolation/depression; and the final one on the normalization of suicide or its sublimation.

This scale includes a set of statements with one or a few words that describe someone who committed suicide (e.g., ‘s/he is selfish’, ‘s/he is a coward’, ‘s/ he is brave’).based on the mean (average) of all items within the subscale. The scores are calculated using a Each item is to be rated on a 5-point Likert scale from a response of strongly disagree is scored 1, up to strongly agree is 5. The mean scores will consequently range from 1-5, with higher scores indicating higher stigma, greater attribution to isolation/depression or greater normalization/glorification. This study Cronbach alfa values of 0.66 (Appendix 2).

### 3.6. Analysis of data/Result

The data was analysed using IBM statistical packages for social sciences (SPSS) Version 20 software. Descriptive methods were used to obtain frequency tables. Multiple analyses were used to analyse variables with multiple responses.

### 3.7. Ethical Aspect

Ethical approval was obtained from the Near East University Scientific Researches and Ethics Committee (YDU/2019/69-829) (Appendix 3) and permission to use the stigma of suicide scale from Prof. Batterham, and approval was gotten before questionnaire was administered to the study area for permission, informed verbal consent was gained from respondent who were approached personally and treated with respect they were provided with needed information about the study. The autonomy of the respondent to either participate or not in the research was respected and all information (data) retrieved from the respondent were treated with confidentiality.

## 4. RESULTS

This chapter is presenting the results of the scale and questionnaires based on the objective of the study.

**Table 4.1. Socio-demographics variables nursing students**

| Variable | Number (n) | Percentage (%) |
|---|---|---|
| **Gender** | | |
| Male | 61 | 20.30 |
| Female | 239 | 79.70 |
| **Age(Yrs.)** | | |
| 17 &Below | 15 | 5.00 |
| 18-23 | 136 | 45.30 |
| 24-29 | 117 | 39.00 |
| 30&above | 32 | 10.70 |
| **Academic Year** | | |
| 1st Year | 63 | 21.00 |
| 2nd Year | 57 | 19.00 |
| 3rd Year | 108 | 36.00 |
| 4th Year | 72 | 24.00 |
| **Mother's Educational Level** | | |
| Illiterate | 9 | 3.00 |
| Primary School | 12 | 4.00 |
| Secondary School | 63 | 21.00 |
| Graduate/Postgraduate | 216 | 72.00 |
| **Father's Educational Level** | | |
| Illiterate | 12 | 4.00 |
| Primary School | 7 | 2.30 |
| Secondary School | 55 | 18.30 |
| Graduate/Postgraduate | 226 | 75.30 |
| **Nationality** | | |
| Nigeria | 154 | 51.30 |
| Zimbabwe | 72 | 72.00 |
| Others | 74 | 74.00 |

Socio-demographics variables of the nursing students are shown in Table 4.1. In terms of gender distribution, 79.9 % of the participants were female. The majority of the nurses had a 18-23years (45.3 %), 3rd year (36%), mother and father level of education as 72% and 75.30% respectively and other nationalities consisting of people from Jordan, Iran, Uganda, Somalia, Tanzania, Kenya and Cameroon made up the

others are (74%).

**Table 4.2. Descriptive characteristics of the nursing students**

| Variable | Number (n) | Percentage (%) |
|---|---|---|
| **Place of Longest Residence** | | |
| Urban | 255 | 85.00 |
| Rural | 45 | 15.00 |
| **Accommodation Facility** | | |
| With Parents | 47 | 15.70 |
| Flat/House alone | 82 | 27.30 |
| Flat/House with Friends | 121 | 40.30 |
| Dormitory | 50 | 16.70 |
| **Biological Mother Alive** | | |
| Live | 276 | 92.00 |
| Dead | 24 | 8.00 |
| **Biological Father Alive** | | |
| Live | 236 | 78.70 |
| Dead | 64 | 21.30 |
| **Family Treatment History** | | |
| Yes | 31 | 10.30 |
| No | 269 | 89.70 |
| **Appointment with Psychiatrist** | 13 | 4.30 |
| Yes | 287 | 95.70 |
| No | | |
| **Suicide Ideation** | | |
| Yes | 44 | 14.70 |
| No | 256 | 85.30 |
| **Any Known Suicide Victim** | | |
| Yes | 128 | 42.70 |
| No | 172 | 57.30 |
| **Victim Identity** | | |
| Family | 16 | 12.50 |
| Friend | 28 | 12.87 |
| Neighbour | 16 | 12.50 |
| Stranger | 68 | 53.12 |

Table 4.2. shows that place of longest residence urban had the highest percentage as 85%,stay in flat with friends (40.30%), biological mother and father are alive with 92% and 78.70% respectively, have no family history of suicide (89.70%), never visited a psychiatrist (95.70), never has suicide ideation (85.30%), do not know victim of suicide(57.30%), and those victim known by people are strangers (53.30%).

**Table 4.3. Distribution of scale and sub- scale score averages of nursing students**

The mean scale total score of the students was 49.61 ±9.34, the mean score of the stigma sub-scale was 24.33±7.23, the mean of depression sub-dimension score was 14.79±4.08, the glorification sub-scale mean score was 10.49 ±4.30.

| Scale and Sub-Scales | M | SD | Median | Min-Max |
|---|---|---|---|---|
| Stigma | 24.33 | 7.23 | 24.00 | 8.00 - 40.00 |
| Depression | 14.79 | 4.08 | 15.00 | 4.00 – 20.00 |
| Glorification | 10.49 | 4.30 | 10.00 | 4.00 – 20.00 |
| Scale Total | 49.61 | 9.34 | 50.00 | 18.00 - 80.00 |

**Table 4.4. The comparison of nursing students' mean scores by gender**

| Gender | Stigma | | Depression | | Glorification | | Scale Total | |
|---|---|---|---|---|---|---|---|---|
| | M±SD | MD(Min-Max) | M±SD | MD(Min-Max) | M±SD | MD(Min-Max) | M±SD | MD(Min-Max) |
| **Male (n=61)** | 24.38±6.40 | 24(8-40) | 19.95±3.78 | 15(4-20) | 9.76±4.23 | 9(4 - 20) | 49.09±10.14 | 50(18 – 80) |
| **Female (n=239)** | 24.32±7.50 | 25(8-40) | 14.80±4.11 | 15(4-20) | 10.61±4.28 | 10(4 - 20) | 49.75±9.14 | 50(26 – 79) |
| **P*** | 0.898 | | 0.918 | | 0.217 | | 0.636 | |

*Mann-Whitney

While the total score of the female nursing students was 49.75±9.14, the score of the male nursing students was 49.09±10.14. The difference between the total score of the students according to their gender was not statistically significant (p> 0.05).

**Table 4.5. The comparison of students' mean score by age category**

| Ages (Years) | Stigma | | Depression | | Glorification | | Total Scale | |
|---|---|---|---|---|---|---|---|---|
| | M±SD | MD(Min-Max) | M±SD | MD(Min-Max) | M±SD | MD(Min-Max) | M±SD | MD(Min-Max) |
| 17&below(n=15) | 28.23±7.93 | 28(14-70) | 13.92±4.91 | 14(4-20) | 9.92±3.97 | 9 (5- 17) | 52.08±12.04 | 49(27–71) |
| 18-23 (n=136) | 24.25±7.20 | 24(8-38) | 15.09±4.26 | 16(4-20) | 10.02±4.12 | 10 (4 – 20) | 49.36±9.04 | 50(28-71) |
| 24-29 (n=117) | 23.98±6.71 | 24(8-40) | 13.95±3.72 | 15(4-20) | 10.99±4.37 | 12 (4 - 20) | 48.92±9.41 | 50(18-20) |
| 30&above (n=32) | 24.17±8.39 | 23.50(8-40) | 16.80±3.32 | 16.5(8-20) | 10.90±4.84 | 11 (4 – 19) | 51.87±9.02 | 50.50(38-79) |
| **P*** | 0.286 | | **0.003** | | 0.260 | | 0.609 | |

*Kruskal- Wallis

Since the p-value > 0.05 in the scale total, stigma and glorification sub-scales respectively, it can be concluded that there is no statistically significant difference relative to age. However, since the p-value < 0.05 in the depression sub-scale, we can conclude a statistical significant effect in the sub-scale relative to age category.

**Table 4.6. The comparison of students' mean scores by education level**

| Education Level | Stigma | | Depression | | Glorification | | Scale Total | |
|---|---|---|---|---|---|---|---|---|
| | M±SD | MD(Min-Max) | M±SD | MD(Min-Max) | M±SD | MD(Min-Max) | M±SD | MD(Min-Max) |
| 1st Year (n=240) | 25.44±7.14 | 27(9-38) | 15.02±4.14 | 16(4-20) | 9.53±4.20 | 9(4-18) | 50±9.57 | 52(28-71) |
| 2nd Year (n=60) | 24.92±7.02 | 25(8-38) | 15.06±4.13 | 16(4-20) | 9.04±3.87 | 9(4-20) | 49.02±9.44 | 47.5(31-70) |
| 3rd Year (n=2) | 24.44±7.61 | 24(8-40) | 14.73±3.81 | 15(4-20) | 10.74±4.38 | 10(4-20) | 49.92±9.94 | 50(26-80) |
| 4th Year (n=6) | 23.03±6.83 | 23(8-35) | 14.54±4.39 | 15(4-20) | 11.81±4.18 | 12(4-20) | 49.39±8.39 | 51(18-68) |
| **P*** | 0.510 | | 0.865 | | **0.003** | | 0.784 | |

*Kruskal- Wallis

Since the p-value > 0.05 in the scale total, stigma and depression sub-scales respectively, it can be concluded that there is no statistical significant difference relative to education level. However, since the p-value < 0.05 in the glorification sub-scale, we can conclude a statistically significant effect in the sub-scale relative education level.

### 4.7. The comparison of students' response by mother's education level

| **Mother's Education Level** | **Stigma** | | **Depression** | | **Glorification** | | **Scale Total** | |
|---|---|---|---|---|---|---|---|---|
| | M±SD | MD(Min-Max) | M±SD | MD(Min-Max) | M±SD | MD(Min-Max) | M±SD | MD(Min-Max) |
| Illiterate (n=9) | 25.44±6.84 | 23(17-35) | 18.00±2.83 | 20(12-20) | 12.11±4.26 | 12(6-16) | 55.56±8.66 | 53(45-71) |
| Primary School (n=12) | 26.20±7.11 | 25(16-40) | 13.60±4.05 | 12.5(8-20) | 9.60±4.25 | 9.5(4-16) | 49.40±7.80 | 49(40-68) |
| Secondary school (n=63) | 25.33±7.86 | 27(8-40) | 14.84±3.89 | 16(4-20) | 10.51±3.92 | 10(4-20) | 50.69±10.01 | 52(27-71) |
| Graduate (n=216) | 23.92±7.08 | 24(8-40) | 14.69±4.13 | 15(4-20) | 10.45±4.41 | 10(4-20) | 49.07±9.21 | 50(18-80) |
| **P*** | 0.474 | | **0.017** | | 0.592 | | 0.213 | |

*Kruskal- Wallis

Since the p-value > 0.05 in the scale total, stigma and glorification sub-scales respectively, it can be concluded that there is no statistically significant difference relative to mother's education level. However, since the p-value < 0.05 in the depression sub-scale, we can conclude a statistically significant effect in the sub-scale relative to mother's education level.

**Table 4.8. The comparison of students response by father's education level**

| Father's Education Level | Stigma | | Depression | | Glorification | | Scale Total | |
|---|---|---|---|---|---|---|---|---|
| | M±SD | MD(Min-Max) | M±SD | MD(Min-Max) | M±SD | MD(Min-Max) | M±SD | MD(Min-Max) |
| Illiterate (n=12) | 26.58±7.65 | 24.50(17-40) | 16.00±3.36 | 16(11-20) | 13.50±3.50 | 15.00(6-17) | 56.08±9.55 | 53.50(43-71) |
| Primary School (n=7) | 29.83±7.03 | 28.50(21-40) | 14.00±4.94 | 15.5(8-20) | 11.17±6.68 | 10.00(4-19) | 55.00±13.39 | 51.00(41-79) |
| Secondary school (n=55) | 24.76±6.44 | 24(8-40) | 15.48±3.42 | 16(8-20) | 10.33±4.14 | 10.00(4-20) | 50.57±8.71 | 50(31-80) |
| Graduate (n=226) | 23.94±7.33 | 24(8-40) | 14.59±4.22 | 15(4-20) | 10.32±4.26 | 10.00(4-20) | 48.85±9.19 | 50(18-71) |
| **P*** | 0.589 | | 0.683 | | 0.079 | | 0.129 | |

*Kruskal- Wallis

Since the p-value > 0.05 in the stigma, depression, glorification and scale total subscale respectively. It can be concluded that there is no statistically significant difference relative to the father educational level.

**Table 4.9. The comparison of student's means scores by Nationality**

| **Nationality** | **Stigma** | | **Depression** | | **Glorification** | | **Scale Total** | |
|---|---|---|---|---|---|---|---|---|
| | M±SD | MD(Min-Max) | M±SD | MD(Min-Max) | M±SD | MD(Min-Max) | M±SD | MD(Min-Max) |
| Nigeria (n=154) | 25.22 ±7.47 | 25(8-40) | 14.73±4.15 | 15(4-20) | 10.85±4.47 | 11(4-20) | 50.80±9.46 | 52(26-71) |
| Zimbabwe (n=72) | 23.33 ±7.47 | 24(8-40) | 15.84±3.68 | 16(4-20) | 8.97±3.55 | 8(4-19) | 48.14±9.51 | 48(28-79) |
| Others (n=74) | 23.43 ±6.22 | 24(8-40) | 13.87±4.13 | 14(4-20) | 11.22±4.30 | 12(4-20) | 48.52±8.69 | 49(18-80) |
| **P*** | 0.091 | | **0.006** | | **0.005** | | **0.022** | |

*Kruskal- Wallis

Since the p-value > 0.05 in the stigma, it can be concluded that there is no statistical significant difference relative nationality. However, since the p-value < 0.05 in the depression, glorification and scale total sub-scales respectively, we can conclude a statistical significant effect in the sub-scale relative to nationality.

**Table 4.10. The comparison of student's response by residence**

| Residence | Stigma | | Depression | | Glorification | | Scale Total | |
|---|---|---|---|---|---|---|---|---|
| | M±SD | MD(Min-Max) | M±SD | MD(Min-Max) | M±SD | MD(Min-Max) | M±SD | MD(Min-Max) |
| Urban (n=225) | 23.99±7.24 | 24(8-40) | 14.57±4.09 | 15(4-20) | 10.49±4.31 | 10.00(4-20) | 49.06±9.31 | 50(18-80) |
| Rural (n=45) | 26.37±6.89 | 25.5(8-40) | 16.13±3.76 | 16(4-20) | 10.42±4.32 | 10.50(4-16) | 52.92±8.96 | 52(39-71) |
| **P *** | 0.091 | | **0.041** | | 0.601 | | **0.041** | |

***Kruskal- Wallis

Since, the p-value > 0.05 in the stigma and glorification sub-scales. It can be concluded that there is no statistically significant difference relative to residence. However, since the p-value < 0.05 in the depression and scale total sub-scale, we can conclude a statistically significant effect in the sub-scale relative to residence.

**Table 4.11. The comparison of student's response by accommodation facility**

| Accomodation facility | Stigma | | Depression | | Glorification | | Scale Total | |
|---|---|---|---|---|---|---|---|---|
| | M±SD | MD(Min-Max) | M±SD | MD(Min-Max) | M±SD | MD(Min-Max) | M±SD | MD(Min-Max) |
| Parents (n=47) | 25.67±8.24 | 25(8-40) | 15.17±3.64 | 15.50(5-20) | 10.24±4.65 | 10(4-20) | 51.07±10.48 | 50.50(18-80) |
| Alone (n=82) | 24.61±7.25 | 25(9-40) | 13.82±4.49 | 14.00(4-20) | 11.56±4.08 | 12(4-19) | 49.99±9.59 | 51.00(28-79) |
| Friends (n=121) | 22.76±6.39 | 23(8-35) | 14.98±3.92 | 16.00(4-20) | 10.07±4.36 | 10(4-20) | 47.81±8.05 | 49.00(26-68) |
| Dormitory (n=50) | 25.89±7.43 | 24.5(8-40) | 15.67±3.87 | 16.00(4-20) | 9.81±4.00 | 9(4-18) | 51.38±9.98 | 51.50(27-71) |
| **P*** | 0.089 | | 0.079 | | 0.097 | | 0.178 | |

*Kruskal- Wallis

Since, the p-value > 0.05 in stigma, depression, glorification and scale total subscales respectively. It can be concluded that there is no statistical significant difference relative to the type of accommodation facility.

**Table 4.12. The Comparison of Students response by biological mother alive**

| **Mother Alive** | **Stigma** | | **Depression** | | **Glorification** | | **Scale Total** | |
|---|---|---|---|---|---|---|---|---|
| | M±SD | MD(Min-Max) | M±SD | MD(Min-Max) | M±SD | MD(Min-Max) | M±SD | MD(Min-Max) |
| Alive (n=276) | 24.14±7.13 | 24.0(8-40) | 14.76±4.07 | 15.00(4-20) | 10.47±4.24 | 10(4-20) | 49.37±9.29 | 50(18-80) |
| Dead (n=24) | 27.00±8.15 | 29.5(9-38) | 15.22±4.26 | 15.50(4-20) | 10.67±5.20 | 10(4-18) | 52.89±9.75 | 51(28-71) |
| **P*** | **0.045** | | 0.438 | | 0.861 | | 0.131 | |

*Kruskal- Wallis

Since the p-value > 0.05 in depression, glorification and sub-total sub-scales respectively, it can be concluded that there is no statistical significant difference relative to mother's education level. However, since the p-value < 0.05 in the stigma sub-scale, we can conclude a statistical significant effect in the sub-scale relative to biological alive.

**Table 4.13. The Comparison of Students response by biological father alive**

| Father Alive | Stigma | | Depression | | Glorification | | Scale Total | |
|---|---|---|---|---|---|---|---|---|
| | M±SD | MD(Min-Max) | M±SD | MD(Min-Max) | M±SD | MD(Min-Max) | M±SD | MD(Min-Max) |
| Alive (n=236) | 24.40±6.93 | 24(8-40) | 14.69±3.99 | 15(4-20) | 10.61±4.26 | 10(4-20) | 49.69±9.21 | 50(18-80) |
| Dead (n=64) | 24.04±8.40 | 24(8-40) | 15.24±4.43 | 16(4-20) | 9.98±4.48 | 9(4-20) | 49.25±9.99 | 50(27-69) |
| **P*** | 0.358 | | 0.155 | | 0.208 | | 0.774 | |

*Kruskal- Wallis

Since, the p-value > 0.05 in the scale total in stigma, depression, glorification and scale total subscales respectively. It can be concluded that there is no statistical significant difference relative to the biological father alive.

**Table 4.14. The Comparison of Students response by Family history of Psychiatrist/Psychological treatment**

| Family History | Stigma | | Depression | | Glorification | | Scale Total | |
|---|---|---|---|---|---|---|---|---|
| | M±SD | MD(Min-Max) | M±SD | MD(Min-Max) | M±SD | MD(Min-Max) | M±SD | MD(Min-Max) |
| Yes (n=31) | 22.29±7.37 | 22.00(8-36) | 16.78±3.62 | 18.00(6-20) | 10.52±4.41 | 11.00(4-18) | 49.59±8.79 | 52.00(28-70) |
| No (n=269) | 24.57±7.19 | 24.00(8-40) | 14.57±4.07 | 15.00(4-20) | 10.48±4.29 | 10.00(4-20) | 49.62±9.42 | 50.00(18-80) |
| **P*** | 0.086 | | **0.016** | | 0.972 | | 0.781 | |

*Kruskal- Wallis

Since the p-value > 0.05 in the stigma, glorification and scale total sub-scale, scale total sub-scale, it can be concluded that there is no statistical significant difference relative to family history of Psychiatrist/Psychological treatment .However, since the p-value < 0.05 in depression sub scale we can conclude a statistical significant effect in the sub-scale relative to mother's education level.

**Table 4.15. The Comparison of Students response by visit to Psychiatrist/Psychological treatment**

| Visit to psychiatrist \ psychological treatment | Stigma | | Depression | | Glorification | | Scale Total | |
|---|---|---|---|---|---|---|---|---|
| | M±SD | MD(Min-Max) | M±SD | MD(Min-Max) | M±SD | MD(Min-Max) | M±SD | MD(Min-Max) |
| Yes (n=13) | 21.33±12.94 | 19.50(8-38) | 16.83±2.92 | 16.50(12-20) | 12.00±5.22 | 13.00(4-18) | 50.17±13.27 | 47.00(31-71) |
| No (n=287) | 24.48±6.85 | 24.00(8-40) | 12.69±4.10 | 15.00(12-20) | 10.41±4.25 | 10.00(4-20) | 49.59±9.15 | 50(18-80) |
| **P*** | 0.470 | | 0.210 | | 0.322 | | 0.843 | |

*Kruskal- Wallis

Since, the p-value > 0.05 in the scale total in stigma, depression, glorification and scale total subscale. It can be concluded that there is no statistical significant difference relative to previous visit to Psychiatrist/Psychological treatment.

| Suicide Ideation | **Stigma** | | **Depression** | | **Glorification** | | **Scale Total** | |
|---|---|---|---|---|---|---|---|---|
| | M±SD | MD(Min-Max) | M±SD | MD(Min-Max) | M±SD | MD(Min-Max) | M±SD | MD(Min-Max) |
| Yes (n=44) | 23.37 ±8.57 | 23.00(8-40) | 16.89±3.23 | 17.00(5-20) | 9.47±3.97 | 8.50(4-18) | 49.74±9.77 | 50.00(18-70) |
| No (n=256) | 24.49 ±6.98 | 24.50(8-40) | 14.44±4.10 | 15.00(4-20) | 10.65±4.34 | 10.00(4-20) | 49.59±9.29 | 50.00(26-80) |
| **P*** | 0.447 | | **0.0001** | | 0.130 | | 0.882 | |

**Table 4.16. The Comparison of Students response to Suicide Ideation**

*Kruskal- Wallis

Since the p-value > 0.05 in the stigma, glorification and scale total sub scale respectively, it can be concluded that there is no statistical significant difference relative to previous Suicide Ideation However, since the p-value < 0.05 in the depression subscale we can conclude a statistical significant effect in the sub-scales relative to previous Suicide Ideation.

**Table 4.17. The Comparison of Students response to knowing anyone with suicide act**

| Anyone in Suicide act | Stigma | | Depression | | Glorification | | Scale Total | |
|---|---|---|---|---|---|---|---|---|
| | M±SD | MD(Min-Max) | M±SD | MD(Min-Max) | M±SD | MD(Min-Max) | M±SD | MD(Min-Max) |
| Yes (n=128) | 23.34±7.30 | 23.00(8-40) | 15.28±4.13 | 16.00(4-20) | 9.57±4.20 | 9.00(4-20) | 48.19±8.97 | 48.00(18-70) |
| No (n=172) | 25.07±7.10 | 25.00(8-40) | 14.43±4.01 | 15.00(4-20) | 11.17±4.27 | 11.00(4-20) | 50.68±9.50 | 51.00(26-80) |
| **P*** | 0.068 | | 0.050 | | **0.0001** | | **0.030** | |

*Kruskal- Wallis

Since the p-value > 0.05 in stigma and depression sub-scales respectively, it can be concluded that there is no statistical significant difference relative to knowing anyone with suicide act. However, since the p-value < 0.05 in the glorification and subtotal sub-scale, we can conclude a statistical significant effect in the sub-scale relative to knowing anyone with suicide act

**Table 4.18. The comparison of student's response to the relationship with the suicide victim**

| Relationship with Suicide Victim | Stigma | | Depression | | Glorification | | Scale Total | |
|---|---|---|---|---|---|---|---|---|
| | M±SD | MD(Min-Max) | M±SD | MD(Min-Max) | M±SD | MD(Min-Max) | M±SD | MD(Min-Max) |
| Family (n=16) | 23.94±6.36 | 24.00(9-36) | 15.63±3.96 | 16.50(7-20) | 9.08±4.25 | 7.50(4-18) | 48.63±9.39 | 48.00(31-70) |
| Friend (n=28) | 20.52±8.23 | 22.00(8-36) | 14.24±5.25 | 14.00(4-20) | 11.04±4.77 | 11.00(4-18) | 45.80±10.19 | 47.00(18-60) |
| Neighbour(n=16) | 24.90±6.95 | 26.50(9-32) | 14.70±4.47 | 15.50(4-20) | 9.80±4.64 | 10.00(4-20) | 49.40±8.50 | 50.00(33-63) |
| Stranger(n=68) | 23.71±6.80 | 22.00(10-39) | 15.48±3.75 | 16.00(4-20) | 9.18±3.89 | 8.00(4-20) | 48.37±8.19 | 49.50(27-68) |
| **P*** | 0.313 | | 0.493 | | 0.236 | | 0.819 | |

*Kruskal- Wallis

Since, the p-value > 0.05 in the scale total in stigma, depression, glorification and subtotal sub-scales. It can be concluded that there is no statistical significant difference relative to the relationship with suicide victim.

## 5. DISCUSSION

This is a Descriptive study on the stigmatizing attitude of Nursing students towards people who commits suicide. A self- administered questionnaire was used during the study, to collect the socio demographic data and evaluates the stigma level using the short form of the stigma of suicide scale (SOSS). Administered to 300 students to provided information about the topic.

### 5.1. The mean scores of respondents in relation to the response on stigmatizing attitude towards people who commits suicide

The mean scale total score of the students was 49.61 ±9.34, the mean score of the stigma sub-scale was 24.33±7.23 and high as compared to that of another study on Turkish university students with subscale stigma level of 14.88±8.18. The mean of depression sub-dimension score was 14.79±4.08, glorification sub-scale mean score was 10.49 ±4.30 is low when compared to the same study with a sub-dimension scale mean of isolation/ depression 26.56±6.42 and glorification of 34.07±4.12 (Özturk et al, 2017). The difference is this result is due to the cultural and high religious among Africans that is reflected in the adoption of the primitive way that includes isolating, tying and beating of people with mental illness, it is also sometimes associated with spirituality and a punishment from God.

In our study, the Second-high mean is depression. Stigmatizing people who commit suicide, linking suicide to depression, and normalizing suicide are higher than other their sub-dimensions. Stigmatizing attitudes can be a difficult situation for people who commit suicide. Incriminating behavior can interfere with their ability to seek help and cause them to be alone. Thus, increases the risk of suicide. Sometimes, been depressed is associated with weakness and committing suicide is seen as avoiding life challenges, people are supposed to natural adjust to the situation. According to a study of racial differences in attitudes toward professional mental health treatment; the mediating effect of stigma, African Americans have the lowest level of agreeing and accepting the need to seek professional help for mental issues as compared to the white races (Conner and Brown, 2009).

The mean of normalization/glorification scores is the lowest. This is important in that suicide is not perceived as acceptable normal behaviour, because more suicide is perceived as normal, the higher the rate of suicide (Priyata et al, 2015).

## 5.2. Discussion of Students' Scale Score Averages and Sociodemographic/Introductory Characteristics

The difference between the total score of the students according to their gender was not statistically significant ($p>0.05$) in our study. And this is in accordance with another study seen in two other studies that stated having a little but not significant effect (Lee et al, 2019; Ozturk et al 2017). Also, during a study examining the Interpersonal needs and suicide risk: The moderating roles of sex and brooding (Lear et al, 2019). Even though comparing the mean score, females have higher depression levels as compared to females and agreed that people who commit suicide may be lonely, isolated. Gender difference with mean having a significantly higher tendency was stated in another study (Kim et al, 2019).

Although women are more diagnosed of depression and they have more reported cases of suicide attempt and easily verbalise suicide ideation men die from suicide more because they will rather bottle do in the fear, anger, and stress with the fear of been tagged weak and this is can be to the traditional and societal role where mean are financially more burden and responsibility for family and sometimes child support and attempt to perform up to or more than expectation, therefore, complaint of stress may easily be tagged irresponsibility (Moore et al, 2018).

It was found that the differences between age and depression subscale were statistically significant in our study. Students age 17 and below followed by 18 to 23 years have the highest stigma score when compared to another study sub-dimension. Students associate suicide with depression, as compared to other causes such as psychiatric illness, also stigma is higher in adolescents age 16-25 when compared to the other age group. (Pereira and Cardoso, 2018). This study also shows significantly affect the suicide level and also students of 17 years and below have higher stigma rate that may be due to inexperience, student of this age are mostly dependent and of the minor group so may most likely not be affected or know about financial, social and emotional stress as compared to the older group and also from the study as compared to other age group 30

and above have higher depression rate (16.80±3.32) agreeing that people who commit suicide may have been disconnected, lonely and so on.

This may be related to relationship, work and experience late to the role that most might have likely assumed as compared to the former age group and usually according to a study most older adult is more involved in substance abuse and have a higher risk of a psychiatric disorder such as depression (Antretter et al, 2009; Robinson et al 2016).

Participant from year four who by the university curriculum had taken psychology, stress management and mental/psychiatric nursing have higher level of normalization /glorification of suicide that may be related to the background knowing and understanding of the cause and factors that can lead to suicide, although they are also Africans majorly from other class and another study also knowledge level could also affect the attitude of students towards people who commit suicide (Özturk et al 2018). Knowledge of major courses on suicidology, coping mechanism and more influences suicide, suicidal attempt and attitude towards mental illness in general (Muzyk, 2017). Supported by another study that states an increase in positive attitude related to increased literacy of nurses in the field (Gholamrezaei et al, 2019).

The mother's educational level is significantly affected attitude and they're a shift towards the depression side among people who have an illiterate biological mother alive. Due to low education and the sympathetic nature of the female gender the mothers usually do not understand the pathophysiology of mental illness or suicide causing and this is expressed to the children creating this feeling and understanding of suicide in terms of a feeling of disconnection, lonely and depression and good mother education is said to reduce suicidal ideation or attempt (Kuhlber et al, 2010 ). It is similar to another study that shows significance depression (Özturk and Akin, 2018) This is most likely to be related to the religious belief or cultural belief of most participate in Africa, religiously only people who have been lost in sin, disconnected or lost in fate commits suicide. Suicide commonly tagged with the beliefs of the victims and this is what parents teach especially if they are uneducated (Gourtho, 2009). The better the more informed parents are the lesser the stigmatizing attitude in the children and it will be significantly affected (Fox et al, 2012).

Students nationality significantly affected the level of depression and glorification of suicide even though it is not significant in the stigma level as most participants are

Africans with a few similar cultures, Nigerians have higher stigma and glorification when compared top others usually because people who die depending on the cause of death can be termed week or strong for instance someone who dies for kills himself for his or her faith or what they believe is termed brave or dies to avoid been shamed if things fall apart and he or she is a leader, they say it is better to die a warrior than a failure in cases where people die as a result of stress or inability to cope with family responsibilities or depression are stigmatized on the other hand countries like Zimbabwe and other countries including Kenya, Uganda, Tanzania and so on have agreed to suicide as related to depression\isolation and this is also seen with the way the parenting style in Nigeria is strictly by the culture and religion that is enforced causing the transfer of believes, myth and even superstition a bit different from that of other countries like Cameroon with an extended way of parenting (Akinsola, 2013).

The residence has significant on the depression level and subtotal scale of the participant which may be related to low information access, educational level, low civilization and culture upholding state. Stigma is higher in the urban area in another study performed at the university (Özturk et al, 2018). Also, low information due to access to amenities like social media may affect the level of knowledge on mental illness or disorders and understanding it as a related factor to suicide. The residential area affects parent education, beliefs and moral that is transferred to the children that affect their attitude towards people who commits suicide as parent education is an important factor (Sylvia and Daniel, 2010).

It is not statistically significant in the stigmatizing attitude related to parents been alive although those whose biological mother is dead have higher stigma and depression levels as compared to those whose biological mother is alive from this study. Usually, children may experience a form of quilt related to the death of a parent as, assuming that the parent (s) will still be alive if they do not have to fend for them and feel responsible for their death and this may affect the stigma and depression level (Albert, 2019: Cha et al, 2018). The way people, family or friends react to death of parents or family who have a history of mental illness or die by suicide may cause a high stigmatizing attitude due to death related to suicide (Sorsdahl and Stein, 2010).

Family history of psychiatrists/psychological treatment is significant in this study in relation to depression, also students that do not have a family history of a psychiatrist

or psychological treatment have higher stigma and those with positive history have a higher level by mean of depression. According to another study, there was no significant relationship between family history and stigmatizing attitude in any way (Özturk &Akın, 2018).

Some other studies support the relationship between family history of a psychiatrist and psychological treatment as it relates to having an attitude or agreeing with depression as a factor causing suicide and even them attempting suicide (Rihmer et al, 2013; Sarchiapone et al, 2009; Skinner et al, 2017).

This study shows a significance between depression and having previous suicide ideation, that is either due to a bad experience, underlining mental illness or even family history, people who have a family history of suicide have high tendency for ideation or attempt while passing through minor life changes to major life challenges (Rihmer et al, 2013).

Stigma glorification and stigma are high in the people who have thought or have suicidal ideation in another study (Özturk& Akın, 2018). Stigma relating from the reaction they might have gotten from friends, seen peoples reaction on social media or even backsplash they got meanwhile glorification may be associated with the experience that leads to that thought and inability to perform or put plan through due to many factors such as seeking help, talking to relatives and so on. This suicidal thought is associated with many feelings, it is seen that university students might think of suicide when they cannot cope with school and family problems and that psychiatric symptoms (Engin et al, 2009).

## 6. CONCLUSIONS

### 6.1. Results

- Students have a high stigmatizing attitude towards people who commits suicide.
- There was a significant difference between the total scores of students' stigmatization attitudes towards a suicide based on nationality, knowing anyone with suicide acts and area of residence.
- There was a significant difference between depression subscale scores of the student's ages, education level, Nationality, Residence, family history of Psychiatrists/Psychological treatment, Suicide Ideation.
- There was a significant difference between the subscale dimension of stigma scores of students' stigmatization attitudes towards suicide and biological mother alive.
- There was a significant difference between the subscale dimension of glorification scores of students' stigmatization attitudes towards suicide: knowing anyone with suicide act, Nationality and education level.

### 6.2. Suggestions

Faculties need to plan educational programs for reducing stigmatizing attitudes toward people who commit suicide for students. It is recommended in order to raise awareness.

- In this study, be evaluated what affects students' attitudes. In other studies, it is recommended to look at its relation to other concepts that may be related to this topic.

- Students have a high stigmatizing attitude towards people who commits suicide. Therefore, it is recommended that there should be an early introduction of students to mental health nursing courses and more clinical exposure to reduce the level of stigma.

- Social activities for the students in the faculty of Nursing, that may include projects and drama presentations related to mental illness, suicide and suicide stigma is recommended.

- Future researchers may need to look more into the effect of education by comparing the difference between the attitude of the student before and after exposure to mental health-related courses, to ascertain or evaluate the change in perception or behaviour related to learning of these courses is recommended.

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**Appendix A**

**Evaluation of stigmatizing attitudes of Nursing student in Near East toward people who commit suicide.**

Dear Participant,
I am a master's Student in Faculty of Nursing at the Near East University. The aim of this study would be to evaluate stigmatizing attitudes of Nursing student in Near East toward people who commit suicide. Please note that your participation is totally voluntary, and if you choose to take part in this study, you will be answering questions via this questionnaire. The questionnaire consists of questions relating to some background information about you, and the Stigma of suicide. Scale short assessment form. All information received will remain strictly confidential, and no one will have access to them outside of the individuals involved. Your answers will remain anonymous and your name or student number is not required from you. By submitting your answers, you are consenting for your data to be used in my project, but you will not be individually identified, and your response will be used for statistical purpose only. Thank you for your time and participation.

Yours Faithfully,


Researcher
Bolutife Ajetomobi
Masters Student in Psychiatric
Department

Thesis Supervisor
Assist. Prof. Dr. MeltemMeriç
Psychiatric Nursing
Nursing Department


**DEMOGRAPHIC INFORMATION QUESTIONNAIRE**

1. Gender () Male () Female
2. Age

   ( ) 17 and bellow
   () 18 – 23
   () 24 – 29
   () 30 and above
3. Academic year

   ( ) 1st year ( ) 2nd year ( ) 3rd year ( ) 4th year
4. Mothers educational level

   ( ) Illiterate

   ( ) Primary School

   ( ) Secondary School

   ( ) Graduate\Postgraduate
5. Father's educational level

( ) Illiterate

( ) Primary School

( ) Secondary School

( ) Graduate\Postgraduate

6. Nationality: ……..
7. Place of Longest Residence
    a. Urban (city capitals or centre)
    b. Rural(district\town\village)

8. Specify the accommodation facility you live in

( ) I live with my parents
( ) I live in a flat or house alone
( ) I live in flat or house with my friends
( ) I stay in the dormitory

9. Is your biological mother alive?

( ) Live
( ) Died

10. Is your biological father alive?

( ) Live
( ) Died

11. A family story of psychiatric/ psychological treatment

    ( ) Yes ( ) No

12. Have you ever applied to a psychiatrist or psychologist?

    ( ) Yes ( ) No

13. Have you ever thought of committing/ Attempting suicide (suicidal ideation)

    ( ) Yes ( ) No

14. Do you know of anyone who died from committing suicide

    ( ) Yes ( ) No

15. If yes was his he or she to you?

    ( ) family ( ) friend ( ) neighbor ( ) stranger or distance person

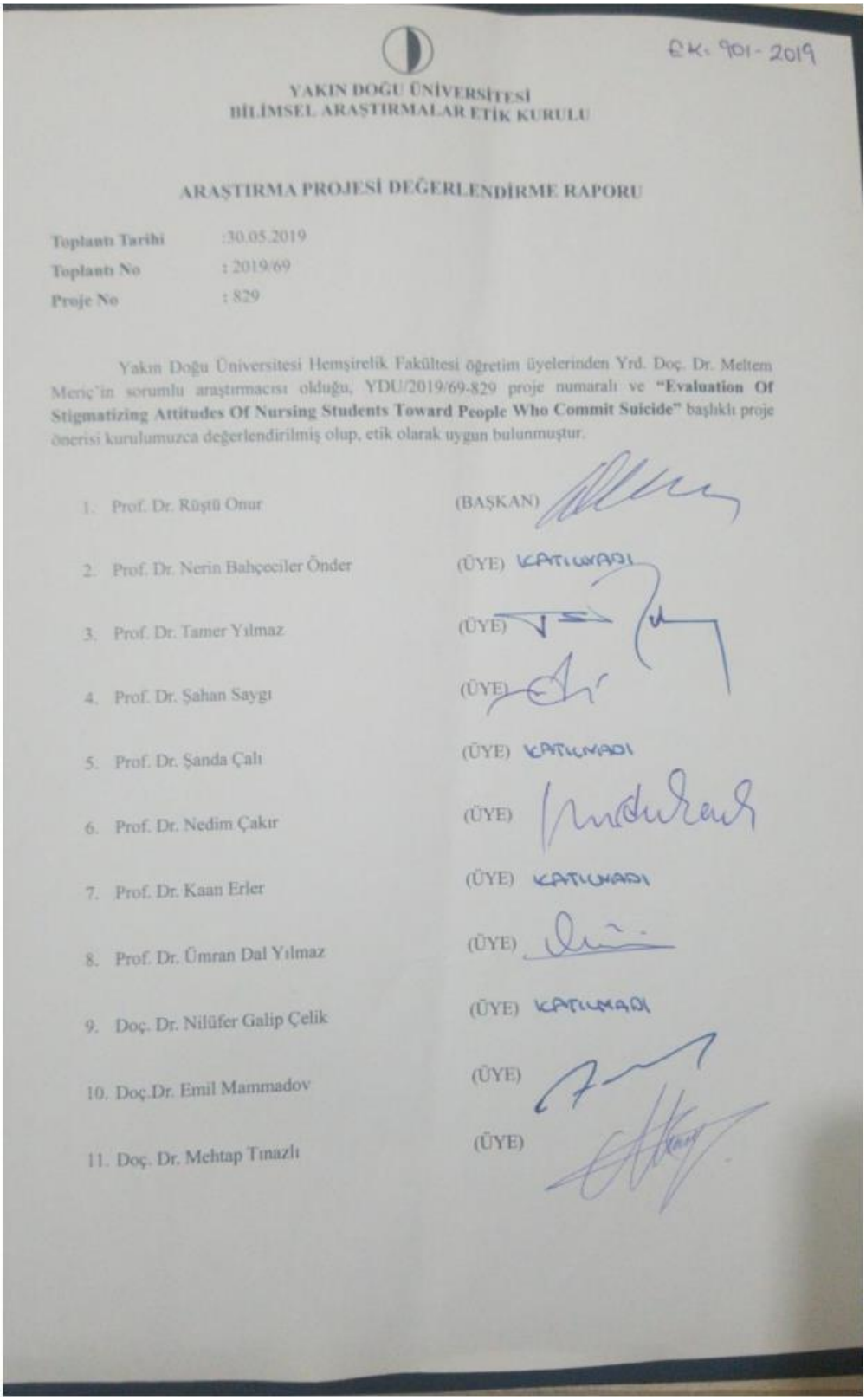
**Appendix B**

**STIGMA OF SUICIDE SCALE**

Using the scale below, please rate by ticking how much you agree with the word used in descriptions of people who take their own lives (die by suicide). In general, people who die by suicide are: ✓

| S/N | Describing Words | Strongly Disagree | Disagree | Neutral | Agree | Strongly Agree |
|---|---|---|---|---|---|---|
| 1. | Brave | | | | | |
| 2. | Cowardly | | | | | |
| 3. | Dedicated | | | | | |
| 4. | Disconnected | | | | | |
| 5. | An Embarrassment | | | | | |
| 6. | İmmoral | | | | | |
| 7. | İrresponsible | | | | | |
| 8. | Isolated | | | | | |
| 9. | Lonely | | | | | |
| 10. | Lost | | | | | |
| 11. | Noble | | | | | |
| 12. | Pathetic | | | | | |
| 13. | Shallow | | | | | |
| 14. | Strong | | | | | |
| 15. | Stupid | | | | | |
| 16. | Vengeful | | | | | |

## Appendix C



EK: 901-2019

YAKIN DOĞU ÜNİVERSİTESİ
BİLİMSEL ARAŞTIRMALAR ETİK KURULU

ARAŞTIRMA PROJESİ DEĞERLENDİRME RAPORU

**Toplantı Tarihi** :30.05.2019
**Toplantı No** : 2019/69
**Proje No** : 829

Yakın Doğu Üniversitesi Hemşirelik Fakültesi öğretim üyelerinden Yrd. Doç. Dr. Meltem Meriç'in sorumlu araştırmacısı olduğu, YDU/2019/69-829 proje numaralı ve **"Evaluation Of Stigmatizing Attitudes Of Nursing Students Toward People Who Commit Suicide"** başlıklı proje önerisi kurulumuzca değerlendirilmiş olup, etik olarak uygun bulunmuştur.

1. Prof. Dr. Rüştü Onur (BAŞKAN)
2. Prof. Dr. Nerin Bahçeciler Önder (ÜYE) KATILMADI
3. Prof. Dr. Tamer Yılmaz (ÜYE)
4. Prof. Dr. Şahan Saygı (ÜYE)
5. Prof. Dr. Şanda Çalı (ÜYE) KATILMADI
6. Prof. Dr. Nedim Çakır (ÜYE)
7. Prof. Dr. Kaan Erler (ÜYE) KATILMADI
8. Prof. Dr. Ümran Dal Yılmaz (ÜYE)
9. Doç. Dr. Nilüfer Galip Çelik (ÜYE) KATILMADI
10. Doç.Dr. Emil Mammadov (ÜYE)
11. Doç. Dr. Mehtap Tınazlı (ÜYE)

**Appendix D**

---------- Forwarded message ---------
From: **Philip Batterham** <Philip.Batterham@anu.edu.au>
Date: Tue, 23 Apr 2019 at 08:24
Subject: RE: Permission letter from Bolutife Ajetomobi
To: Ajetomobi Oluwadamilola <damilolar14@gmail.com>

Dear Bolutife,

Thanks for your email. Happy for you to use the SOSS. I have attached the scale for your reference, along with a related scale on literacy (knowledge) of suicide.

The SOSS (long or short form) is scored by calculating three separate scores, one for each subscale (stigma, isolation/depression, normalisation/glorification), based on the mean (average) of all items within the subscale. A response of strongly disagree is scored 1, up to strongly agree is 5. The mean scores will consequently range from 1-5, with higher scores indicating higher stigma, greater attribution to isolation/depression or greater normalisation/glorification. Most studies have used the short form of the SOSS (16 items). The LOSS is scored as the number of correctly answered items (most studies also use the short form, range 0-12; "don't know" is scored as incorrect).

Please let me know if you need any of the papers related to the scale, and please let me know if I can be of further assistance. Best wishes with your research.

Kind regards,

Assoc Prof Phil Batterham
Deputy Head
Centre for Mental Health Research
Research School of Population Health
The Australian National University
63 Eggleston Road
Acton ACT 2601 Australia

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**From:** Ajetomobi Oluwadamilola <damilolar14@gmail.com>
**Sent:** Friday, April 19, 2019 6:11:59 PM
**To:** Philip Batterham
**Subject:** Permission letter from Bolutife Ajetomobi

Dear Assoc. Prof.Dr. Batterham,

I want to use your "The stigma of suicide scale(SOSS)"for research if you permit us to use your scale. I am sending my permission letter to relating to the subject in the attachment.

turnitin_Ajetomobi

ORIJINALLIK RAPORU

| %13 | %6 | %6 | %10 |
|---|---|---|---|
| BENZERLIK ENDEKSI | İNTERNET KAYNAKLARI | YAYINLAR | ÖĞRENCI ÖDEVLERI |

BIRINCIL KAYNAKLAR

| | | |
|---|---|---|
| 1 | Submitted to Yakın Doğu Üniversitesi<br>Öğrenci Ödevi | %4 |
| 2 | José Pinto-Gouveia, Teresa Carvalho, Marina Cunha, Joana Duarte, Robyn D. Walser. "Psychometric properties of the Portuguese version of the Acceptance and Action Questionnaire–Trauma Specific (AAQ-TS): A study with Portuguese Colonial War Veterans", Journal of Affective Disorders, 2015<br>Yayın | %3 |
| 3 | nimhr.anu.edu.au<br>İnternet Kaynağı | %1 |
| 4 | www.dovepress.com<br>İnternet Kaynağı | <%1 |
| 5 | dradamvolungis.files.wordpress.com<br>İnternet Kaynağı | <%1 |
| 6 | phdergi.org<br>İnternet Kaynağı | <%1 |