Attitudes to suicide amongst the West Midlands Police Service
Feedback report

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Executive Summary

- **There is a significant degree and a moderate-high regularity of work-related exposure to suicide among the West Midlands police staff.**

- **Exposure to suicide in a professional capacity is often accompanied by some degree of distress.**

- **Many police staff who have had professional encounters of suicide have also had personal experiences with suicide.**

- **There is a large perceived need for suicide specific training across all police ranks.**

- **Perceived competence to intervene following a suicide attempt is lower among Police constables and Sergeants than higher ranking officers.**

- **Attitudes towards suicide are largely tolerant, compassionate and informed although there are some enduring misconceptions surrounding suicide which may be addressed through tailored training programmes.**

Contents

1. Introduction

As the fifteenth leading cause of mortality globally, suicide remains a serious public health concern, with as many as 800,000 preventable deaths resulting from this form of intentional self-harm each year (World Health Organization (WHO), 2019). Someone dies by suicide every forty seconds worldwide (WHO, 2019). Within the UK, the equivalent figure stands at one death every two hours (Mental Health Foundation, 2018). Suicidality exists on a continuum ranging from thinking about suicide to "planning" to attempting suicide. For each suicide death**,** it is estimated that a further twenty suicide attempts are made (WHO, 2019). Combined, these events have significant emotional, economic and resource implications, culminating in a substantive ripple effect on families and the wider community. Research has since acknowledged the continuum of suicide exposure which concerns not only immediate family and friends, but more broadly impacts upon those such as first responders who are required to intervene or respond in the aftermath of such events (Cerel, McIntosh, Neimeyer, Maple, & Marshall, 2014).

Earlier reports from the WHO have highlighted shortcomings in police training stating that: "Although police officers and other first line responders must exercise discretion in identifying and managing people who are suicidal, they are rarely trained adequately for this role" (Health & Abuse, 2009). Moreover, despite the tangible personal cost of suicide exposure, both in terms of immediate distress and more enduring mental health outcomes (Cerel et al., 2016; Maple, Cerel, Sanford, Pearce, & Jordan, 2017; Stanley, Hom, & Joiner, 2016), the perspectives of first line police officers who often encounter suicide in a professional context, are frequently neglected. This is particularly concerning given that such individuals are tasked with scene management where suicidal behaviours have occurred and are oftentimes, the first point of contact with the family and friends of a person who has died by suicide (Health & Abuse, 2009). They are also regularly responsible for prompt interventions in situations where someone is experiencing a suicidal crisis (Spence & Millott, 2016), and in such times, effective and compassionate communication is essential.

Nonetheless, habituation to death or emotional numbing which can often accompany repeated suicide exposures, may not only shape their own suicide risk (Stanley, Hom, & Joiner, 2016), but may also be instrumental in moulding their attitudes towards others who are suicidal. Research shows that positive attitudes towards suicidal individuals or the treatment of suicidality can motivate people to engage in treatment and manage suicidal inclinations, whilst negative attitudes can compound the feelings of vulnerability and rejection for the individual (Norheim, Grimholt, & Ekeberg, 2013; Sartorius, 2007). Moreover, negative attitudes displayed towards family members following a suicide attempt or death by suicide can equally intensify the grieving process for the family. Since attitudes affect emotions, cognition and behaviour; a better understanding of police attitudes towards suicide and their current training needs may be an essential pre-requisite to future staff development.

Attitudes towards suicidality may be influenced by a multitude of factors including personal factors such as an individual's level of emotional intelligence (EI). EI is defined as an innate ability to acknowledge, comprehend and regulate one's own emotions as well as interpret emotional cues from others. This includes the ability to distinguish different emotions, and use that information to guide one's thoughts and behaviours (Mayer, Salovey, Caruso, & Sitarenios, 2001). Empirical research shows that emotionally intelligent people display better physical and mental health, increased well-being and life satisfaction, engage less in risky behaviours (substance abuse) and have better interpersonal and social relations in personal and professional contexts (Fernández, 2010). The relevance of this factor in the context of police attitudes towards suicide remains to be explored.

2. Research questions

The primary aim of this project was to examine police attitudes to various beliefs around suicide but also, to assess their levels of EI and how this may be associated with such attitudes. As such, we examined:

1) Police attitudes to suicide (in terms of acceptance, permissibility etc).
2) Levels of EI
3) The relationship between EI and attitudes to suicide.

3. Methodology

This project employed an online survey methodology. A URL link to the survey was distributed via a study advertisement posted in a regional police newsletter. Several demographic questions and validated measures were utilised:

3.1 Demographics

Demographic information included the gender and job role of the respondent as well as the number of years of service experience. Information regarding the personal/professional experience of suicide, and the perceived training needs of respondents was also requested.

3.2 Attitudes Towards Suicide (ATTS: Renberg & Jacobsson, 2003) is a 33-item instrument with a five-point Likert scale designed to capture attitudes to suicide across six areas, namely:

PERMISSIVENESS: the belief that people have the right to take their own life and acceptance of suicide in certain circumstances.

PREVENTABILITY: the belief that suicide can and must be prevented.

INCOMPREHENSABILITY: the belief that suicide cannot be justified or understood**.**

AVOIDANCE OF TALKING: the belief that talking about suicide can trigger suicidal thoughts.

UNPREDICTABILITY: the belief that suicide happens without any warning and that people who talk about suicide, do not usually go on to enact suicidal behaviours.

LONELINESS AND APPEAL: the belief that loneliness is a reason for suicide and a suicide attempt is predominately a cry for help.

Responses are ranked as follows 1 (strongly disagree) to 5 (strongly agree). A total score for each of the six subscales is calculated by summing the relevant items after reverse scoring negatively phrased questions. Reverse scoring involves converting the numerical scoring scale to the opposite direction i.e. 5 (strongly agree) is scored as a 1 (strongly disagree), 2 (somewhat agree) becomes 4 (somewhat agree) and so on. See appendix 1 for a breakdown of the questions which comprises each subscale (Reversed scored items are represented in italics). Higher scores on each individual question and the combined subscales indicate a greater level of agreement with that particular attitude.

3.3 The Assessing Emotions Scale

(AES: Schutte, Malouff, & Bhullar, 2009) is a 31-item self-report inventory generating a composite measure of EI. Respondents rate themselves on the items using a five-point Likert scale ranging from 1 (strongly disagree) to 5 (strongly agree). As with the ATTS, a total score is calculated by reverse scoring negatively phrased questions and summing the questions. See appendix 2 for breakdown of the questions and the reverse scored items in italics. Higher scores represent greater EI, i.e. a greater ability to acknowledge, comprehend and regulate one's own emotions as well as interpret emotional cues from others.

4. Results

This section contains sample characteristics of those who responded. Descriptive statistics, correlations and exploratory cross-tabulations are appropriate for analysing the relationship between two or more variables and provide a way of examining relationships between two or more points of data.

4.1 Sample characteristics

Two hundred and nine police officers responded to the questionnaire, however there was substantial missing data across multiple sections of the survey. Caution must be exercised in interpretation since missing data can present a slightly misleading depiction of the findings. Missing data is presented in most instances but where valid percent is referred to in the current report, this alludes to the percentage when missing data is excluded from the calculations. In the sample, there was a predominance of males (73.2%) and Police constables (Figure 1). Due to low prevalence of certain posts, several occupations were subsumed under the 'Other' category. There was an average of 15 years' service experience among those who responded to this question.

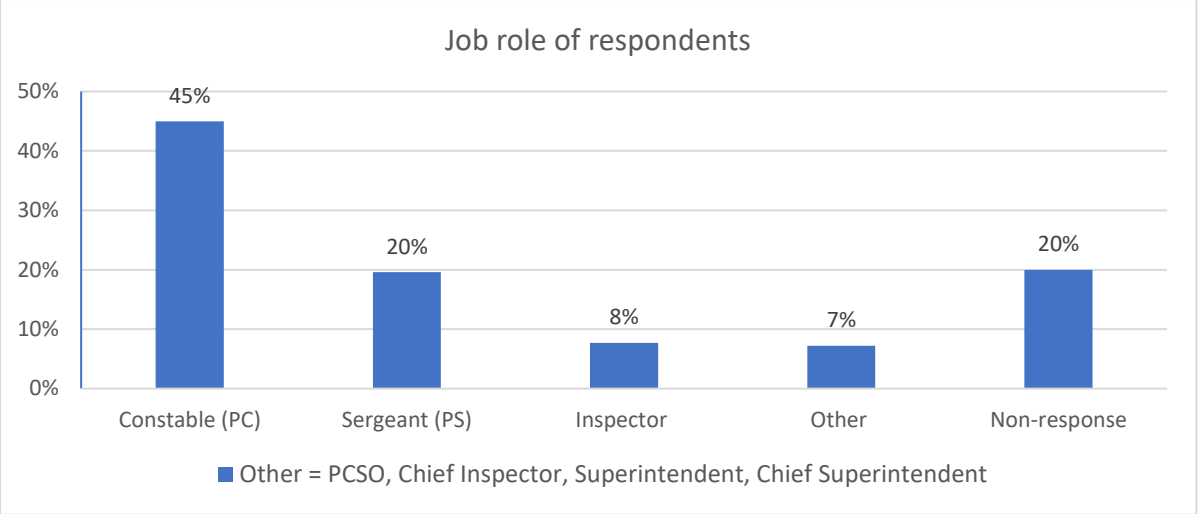


Figure 1: Job role of respondents

4.2 Suicide training

Respondents were asked several questions relating to their experiences of mental health and suicide prevention training. The results showed that whilst a proportion had received other relevant training and there was some awareness of the procedures for referral, there was an apparent a lack of suicide specific training (Figures 2-4). A supplementary open text question revealed that several respondents had received recent general mental health training.

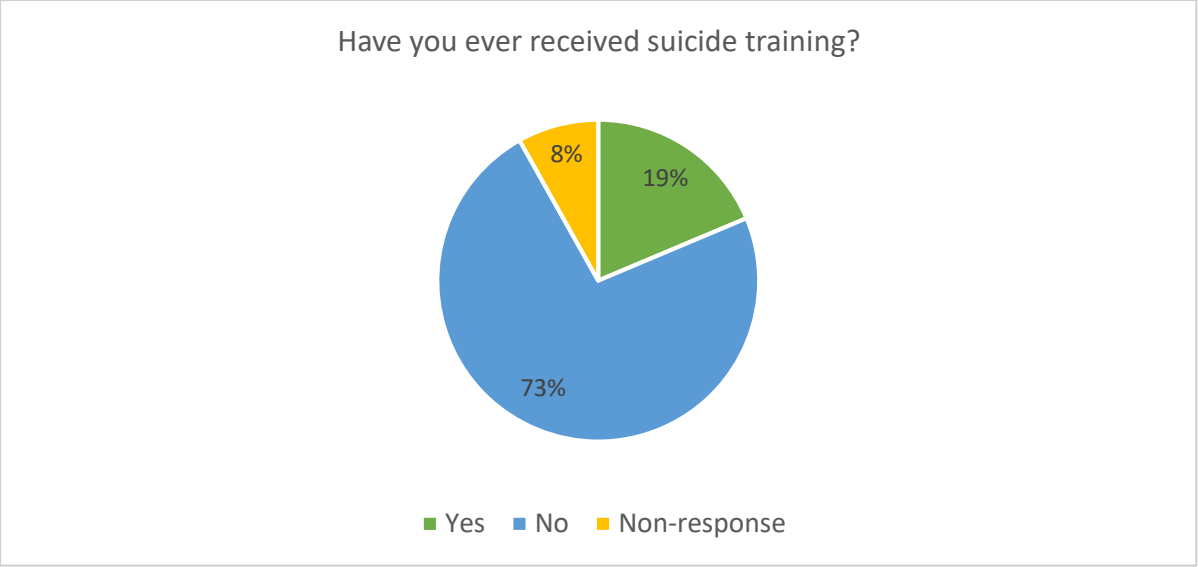


Figure 2: Receipt of suicide training

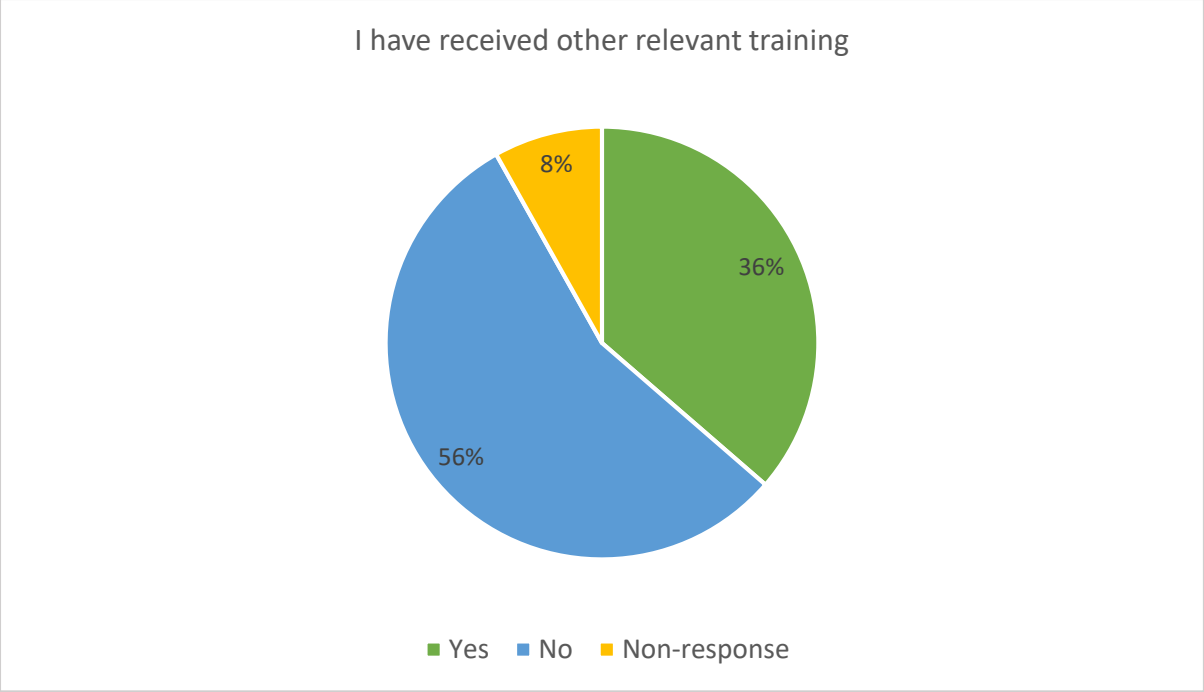


Figure 3: Receipt of other relevant training

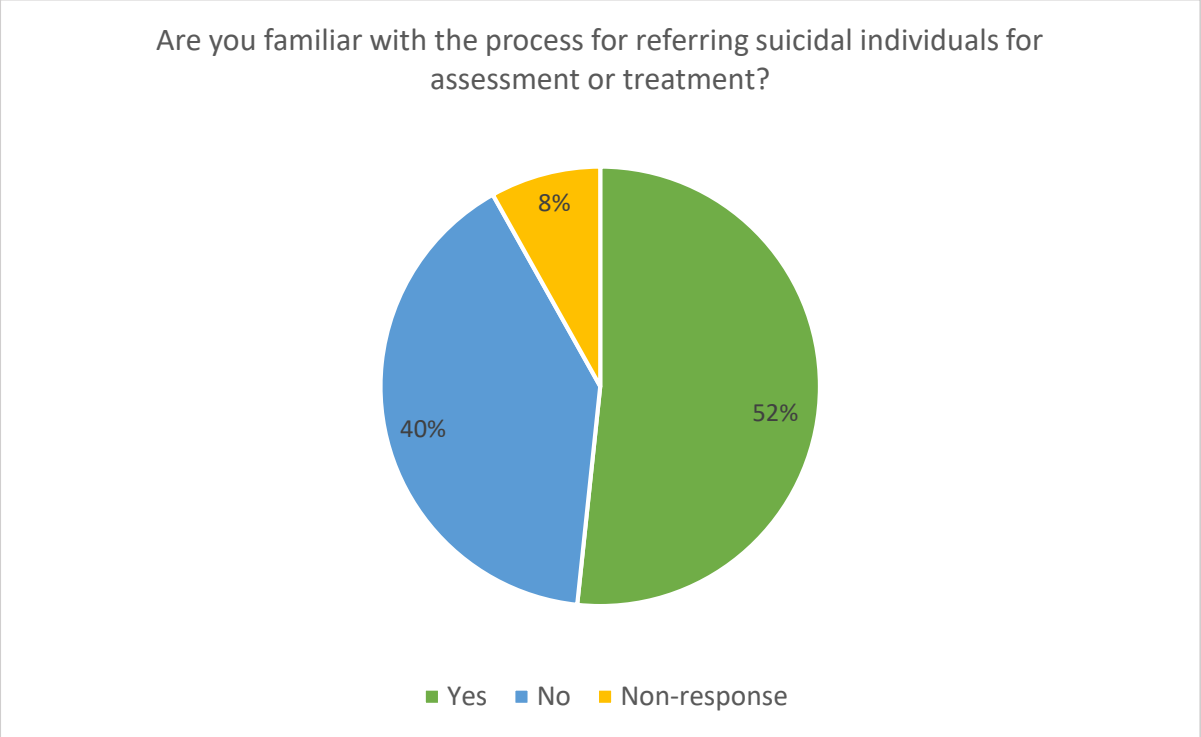


Figure 4: Familiarity with the referral process

4.3 Exposure to suicide

Respondents were then asked two questions relating to their personal and professional exposure to suicide. Results revealed widespread exposure to suicide in a professional context and whilst slightly less prevalent, a significant proportion had personal encounters with suicide or attempted suicide (Figures 5 & 6). Cross tabulations revealed that among those who had professional encounters of suicide, 44.8% also reported personal experiences. Only 17% of the sample had neither professional nor personal suicide encounters.

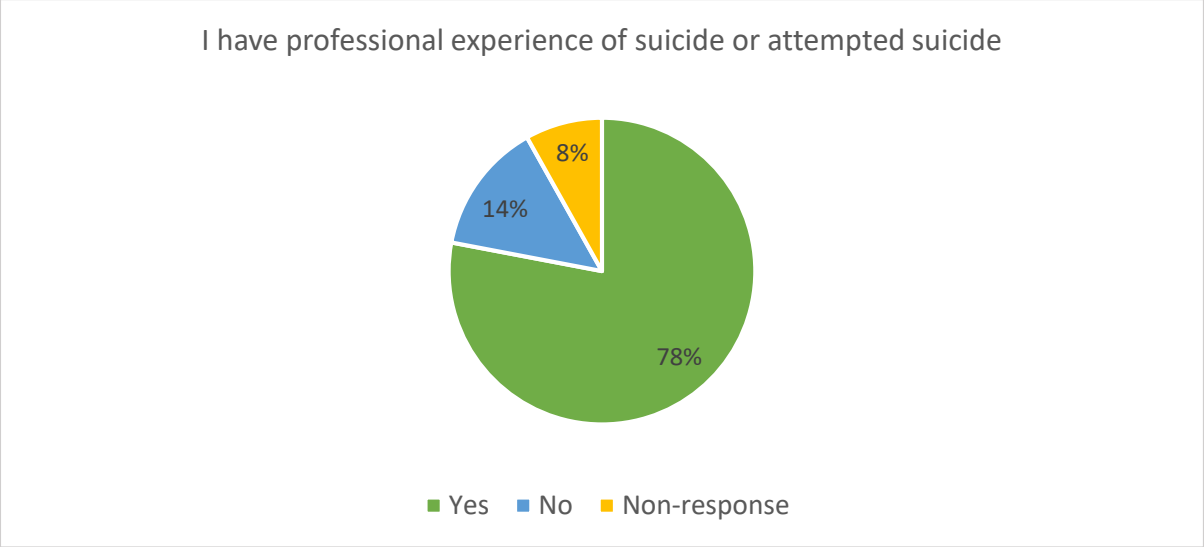


Figure 5: Professional experiences of suicide or attempted suicide

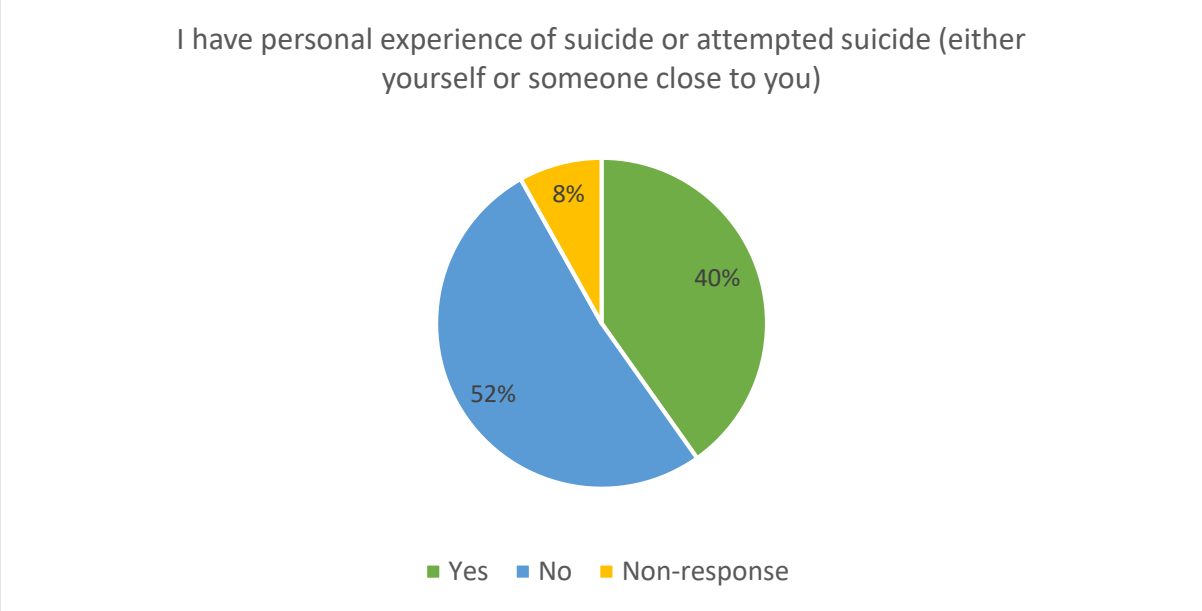


Figure 6: Personal experience of suicide or attempted suicide

4.4 Frequency of exposure to suicide

Respondents were asked how frequently they were exposed to suicide at work, and how distressing they found those experiences. Overall, respondents reported relatively frequent exposure and most reported at least some distress associated with such events (Figures 7 & 8). Cross tabulations (not shown) of `job role` with `frequency of suicide exposure within a professional capacity` revealed that while a higher proportion of Police constables reported 'very frequent' exposure than other ranking officers, although 'frequent' exposure was relatively comparable across all policing occupations.

Respondents were then asked how competent they felt in a situation where there was an attempted suicide, with a large proportion of the sample (40%) reporting feeling fairly well equipped to care for individuals who had attempted suicide (Figure 9).

Respondents were further asked if they felt they required more training in suicide prevention, with the majority reporting that they would benefit from further suicide specific training (Figure 10).

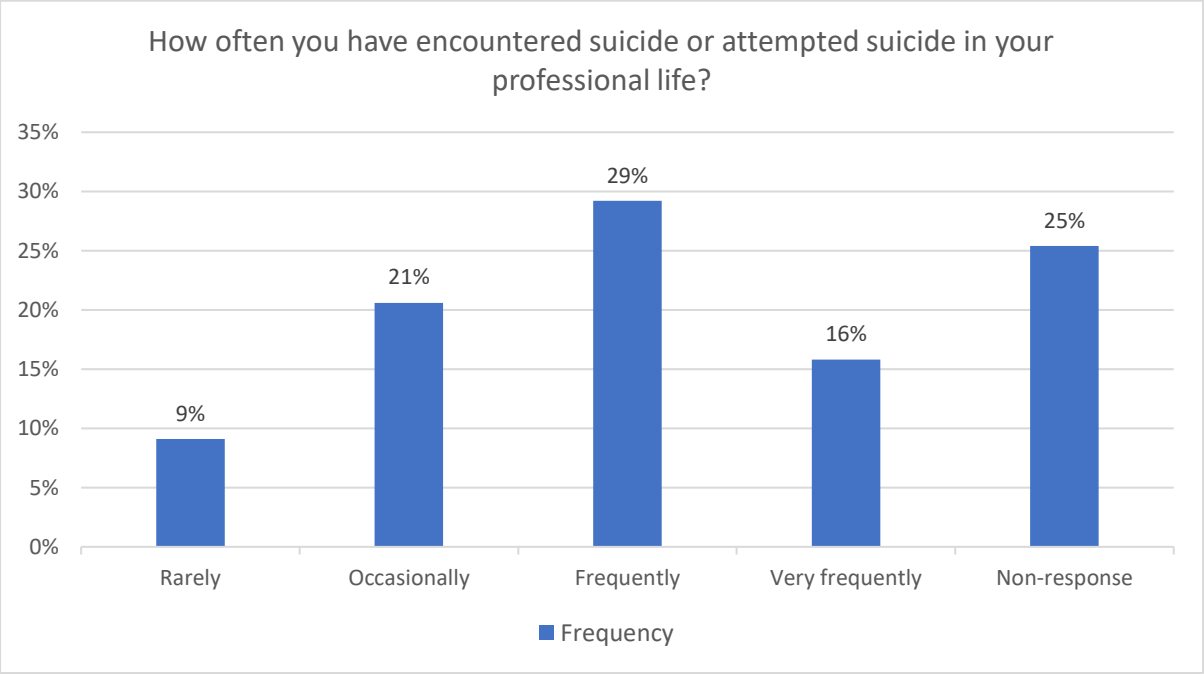


Figure 7: Frequency of professional suicide exposures

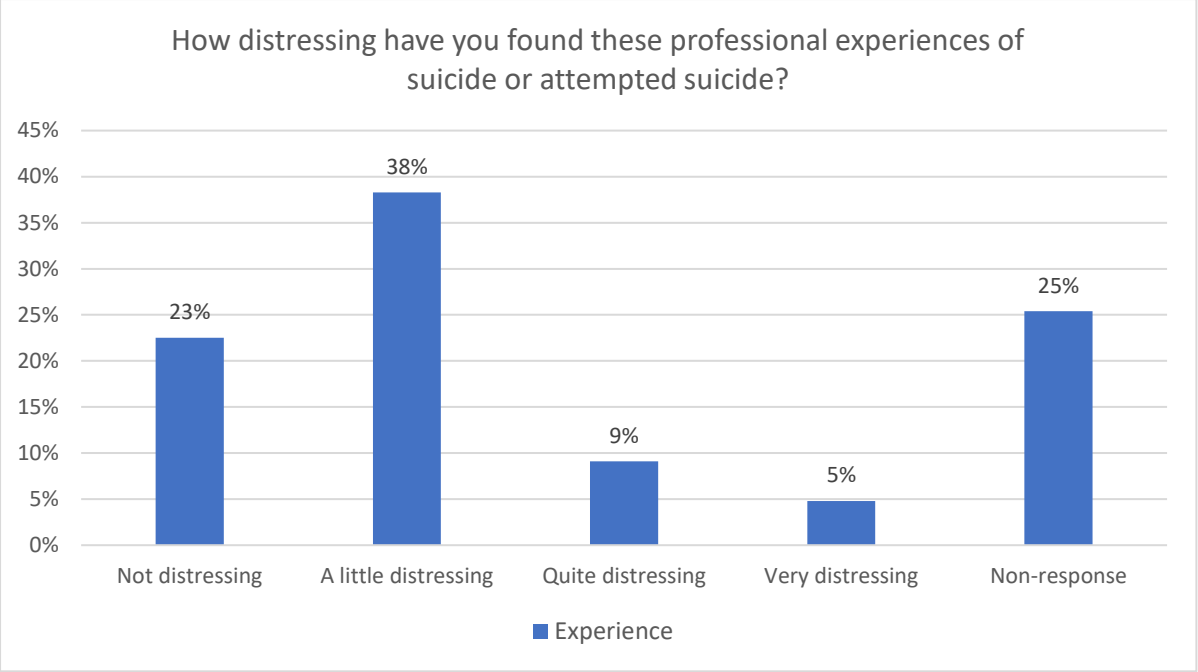


Figure 8: Perceived distress associated with professional suicide exposures

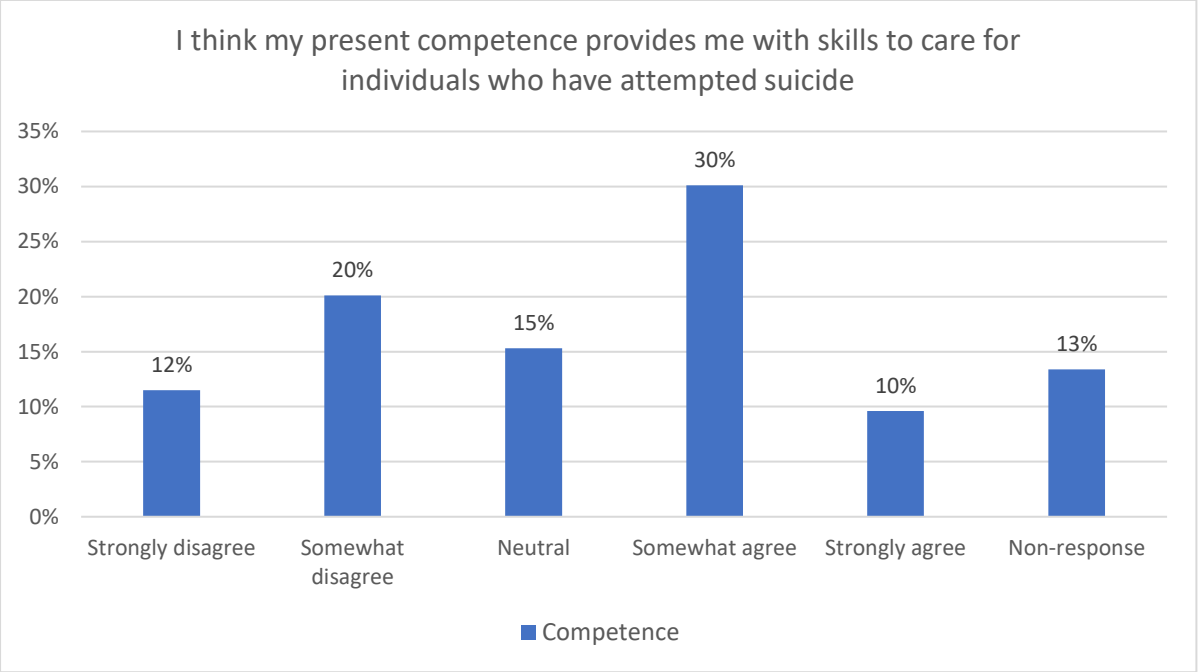


Figure 9: Perceived skills and competence in responding following a suicide incident

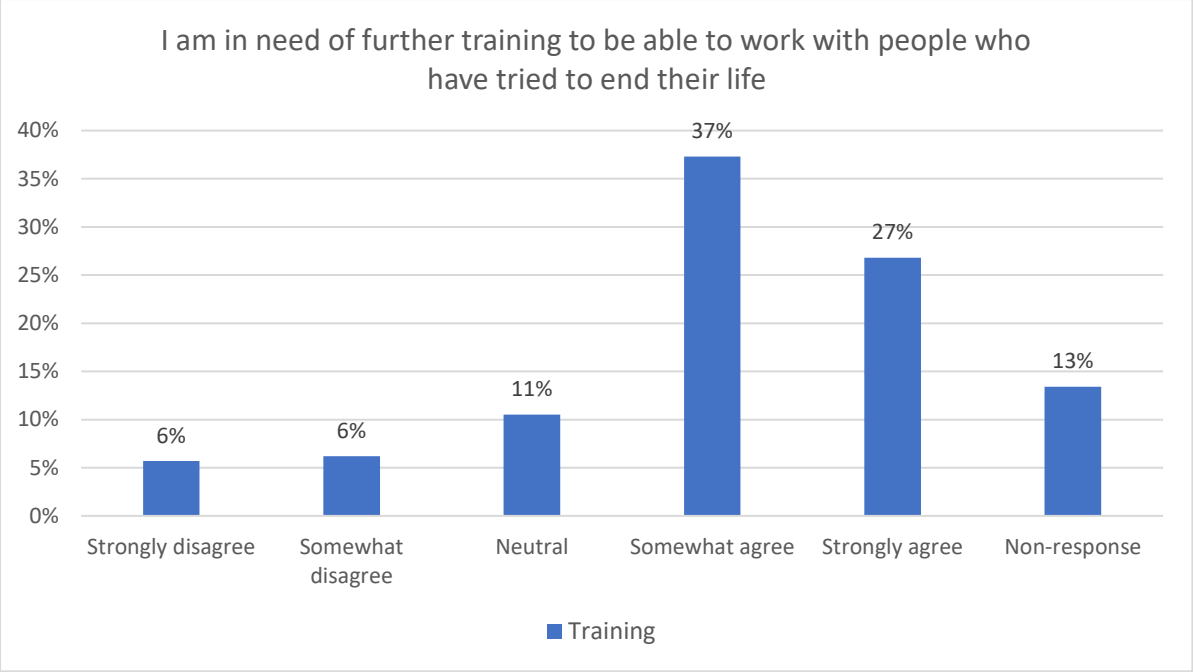
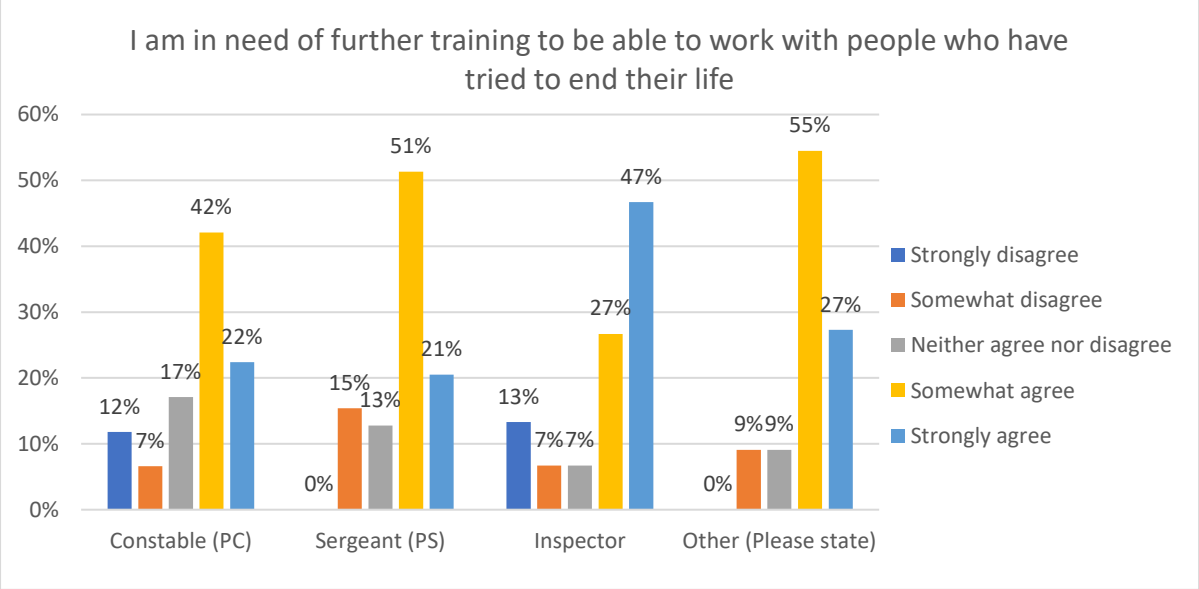


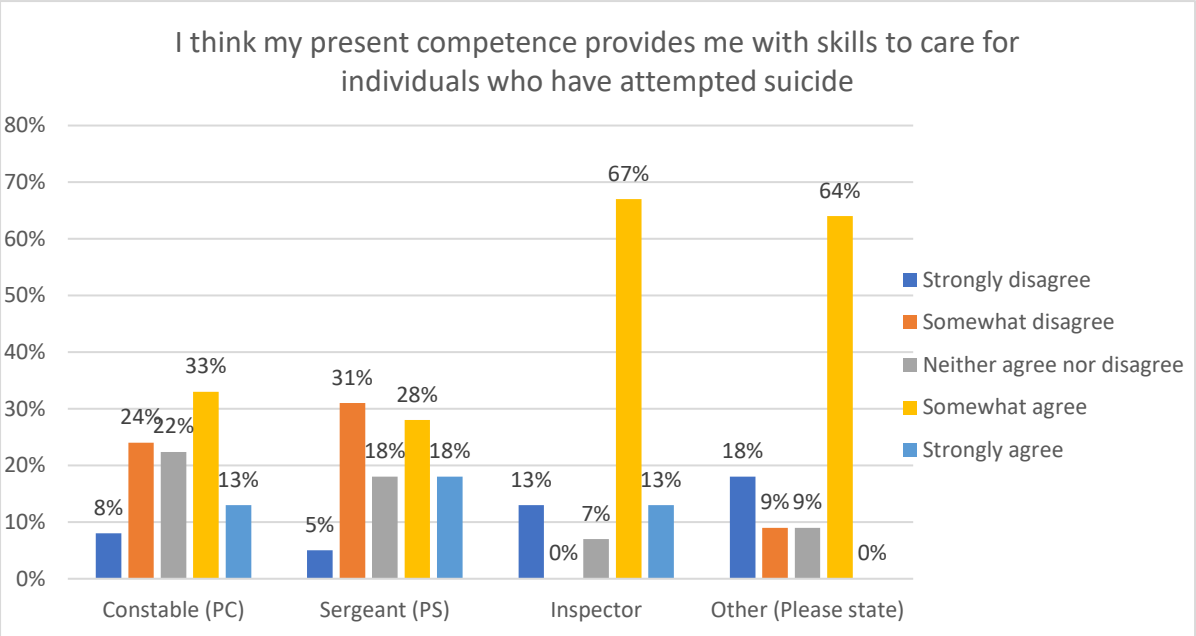
Figure 10: Perceived need for further suicide specific training

Cross-tabulations were conducted examining the perceived training needs and competency in dealing with suicide attempts within job roles. The majority of respondents across all job roles felt that they require further training to deal with suicide situations (Figure 11), whilst the perceived competence in dealing with suicide incident was much higher among higher ranked roles (Figure 12).



Other: PCSO, Chief Inspector, Superintendent, Chief Superintendent

Figure 11: Perceived training needs disaggregated by job role



Other: PCSO, Chief Inspector, Superintendent, Chief Superintendent

Figure 12: Perceived competence in responding to a suicide incident disaggregated by job role

4.5 Police attitudes to suicide

Respondents were asked a series of 33 questions about their attitudes to suicide. Questions covered six main themes.

1. Permissiveness
2. Preventability
3. Incomprehensibility
4. Avoidance of talking
5. Unpredictability
6. Loneliness and appeal (for help)

1. Permissiveness

Permissiveness relates the person's level of acceptance of suicide (particularly in the case of incurable illness) and the belief that suicide is a human right. This scale was comprised of eight

questions. Responses to an example item are shown in figure 13 (valid % reported) (See appendix 1 for full questionnaire). Example items include “People should have the right to take their own lives” and “Suicide can sometimes be a relief for the ones involved.” In general, police attitudes were supportive of an individual’s right to die. Moreover, attitudes towards suicide were largely tolerant with a significant proportion of the sample reporting that they believed that suicide can be a relief for the person involved, they could understand why some people choose to end their lives by suicide (e.g. in the case of a severe, incurable illness) and that they themselves might consider suicide or would endorse suicide under such circumstances. However, it is unclear whether respondents believed that enduring mental health disorders constituted a severe, incurable illness or whether responses reflect attitudes towards physical ailments solely. The strength of conviction in the perceived permissibility of suicide was weaker for the items “There are situations where the only rational solution is suicide” and “Suicide should be accepted as a solution to end an incurable suffering,” where the apparent justification for suicide was less discernible.

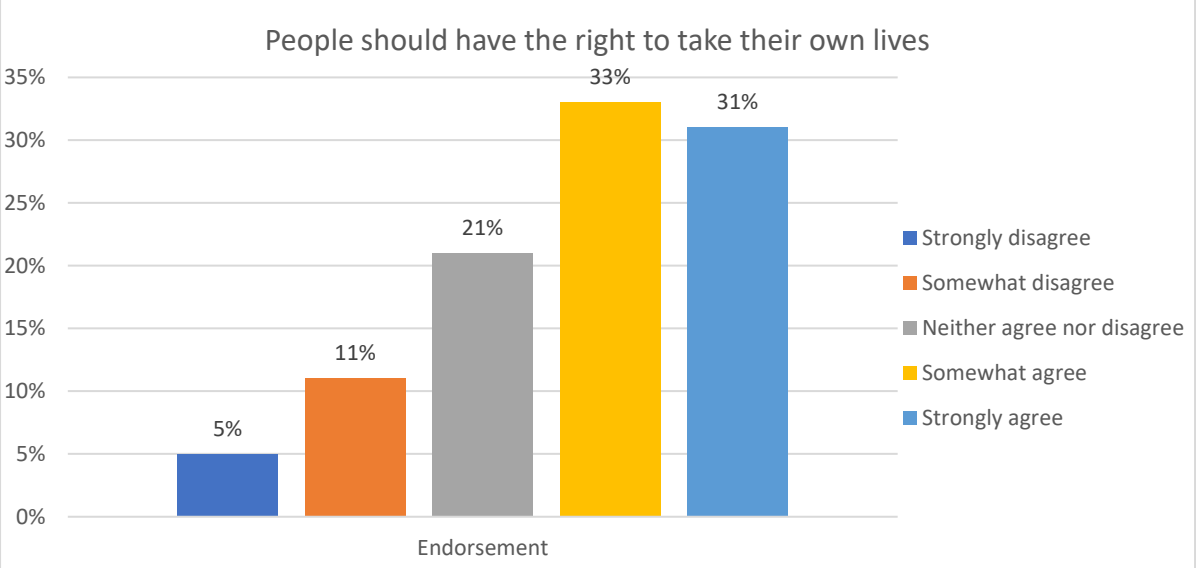


Figure 13: Sample permissiveness item

2. Preventability

Preventability is the belief that suicide can and must be prevented. This scale is measured by six items. Responses to an example item (figure 14) are shown below. Example items include “Suicide is preventable” and “I am prepared to help a person in a suicidal crisis by making contact”. Overall, results were positive and showed a general trend whereby respondents not only felt that suicide

was preventable but also that they a sense of personal responsibility and willingness to play an active role in the prevention of suicide. The only item where there was significant divergence of opinion was in relation to the belief that "You can always help a person with suicidal thoughts."

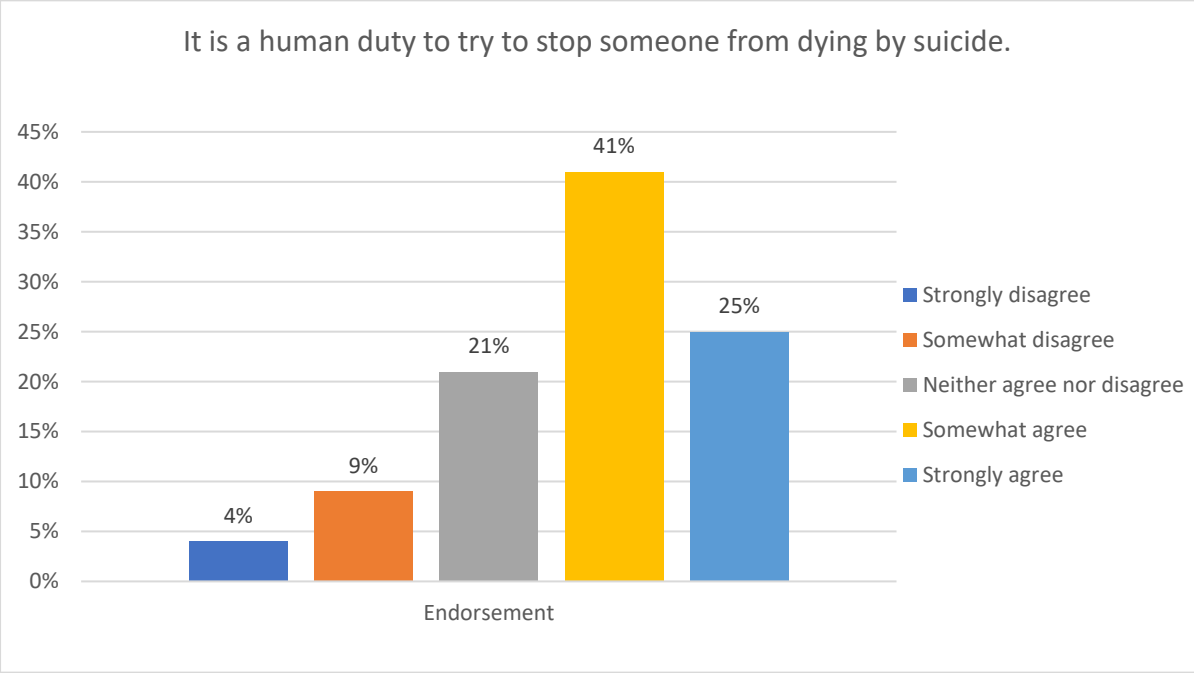


Figure 14: Sample preventability item

3. Incomprehensibility

Incomprehensibility is the belief suicide cannot be justified or understood. This scale was measured by five items with example questions such as "Suicide can never be justified" and "On the whole, I do not understand how people can take their lives." Example items are presented in figure 15 and 16 below. Responses to items in this subscale were mixed. In line with responses to the permissiveness subscale, there was support for the justification for suicide in certain instances. Many believed that suicide was understandable under certain extenuating circumstances and may be accounted for largely by mental illness. However, there was also support for the belief that "Suicide is among the worst things to do to one's relatives."

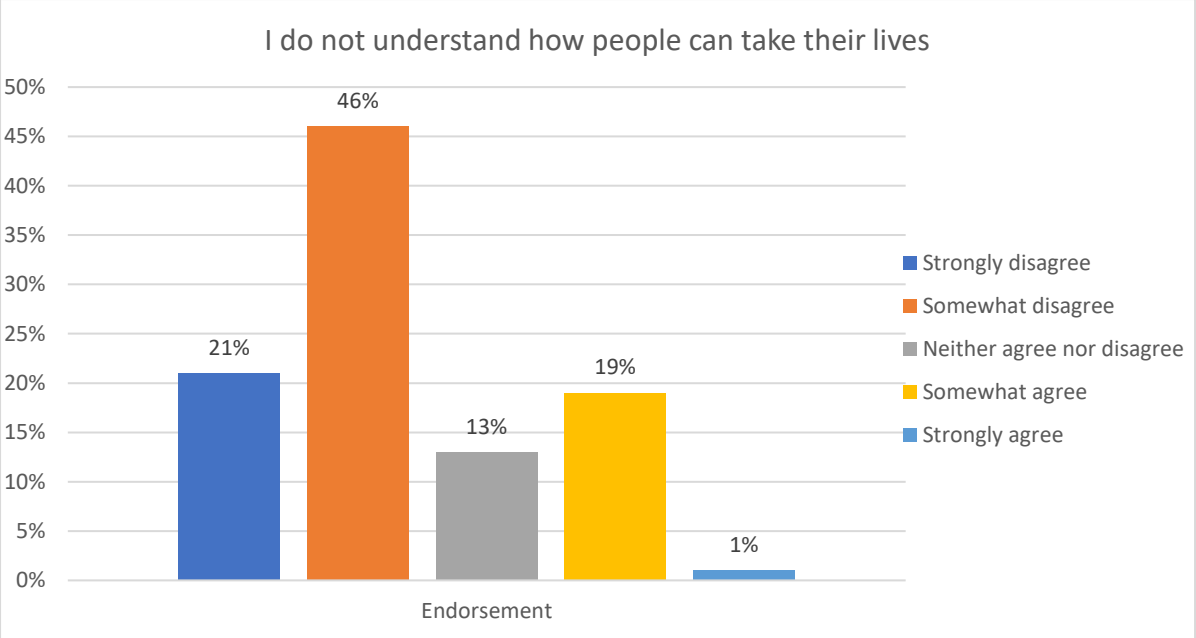


Figure 15: Sample incomprehensibility item

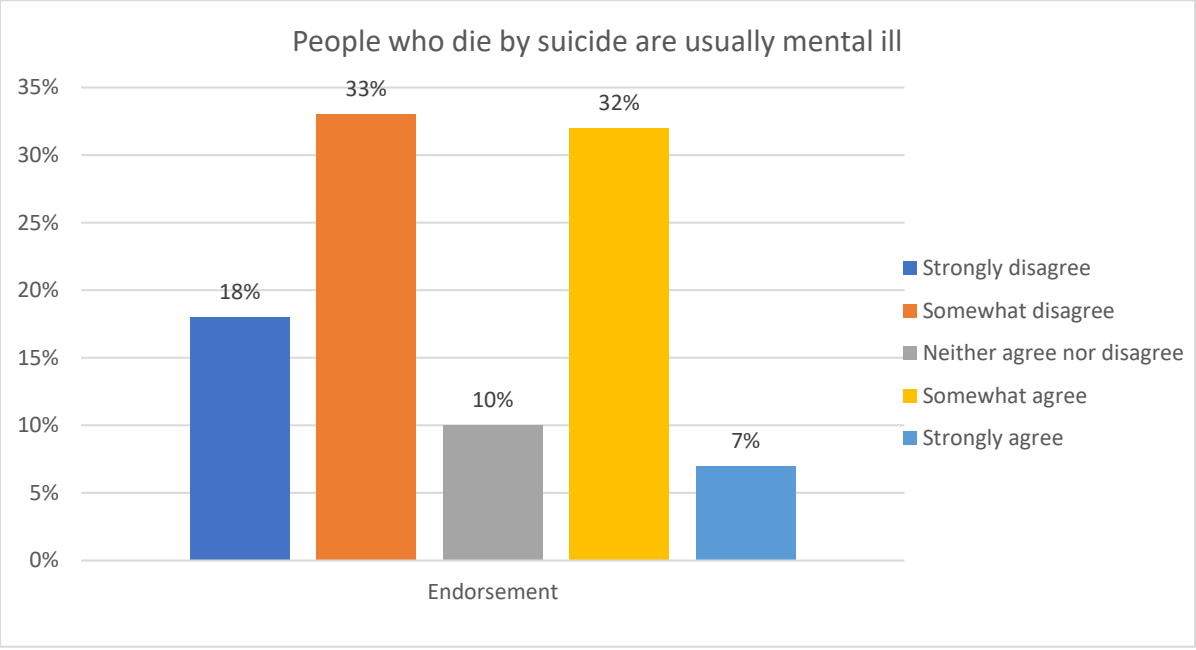


Figure 16: Sample incomprehensibility item

4. Avoidance of talking

Avoidance of talking is the belief that discussion of suicide may influence or invoke feelings of suicide in those at risk. This scale is indexed by four items, with example questions “There is a risk to evoke suicidal thoughts in a person’s mind if you ask about it” and “Suicide is a subject that one should not talk about”. While the results showed a general trend towards favourable attitudes, there are still some who believed (Somewhat + Strongly agree) that discussing suicide should be avoided and may lead to suicidal thoughts.

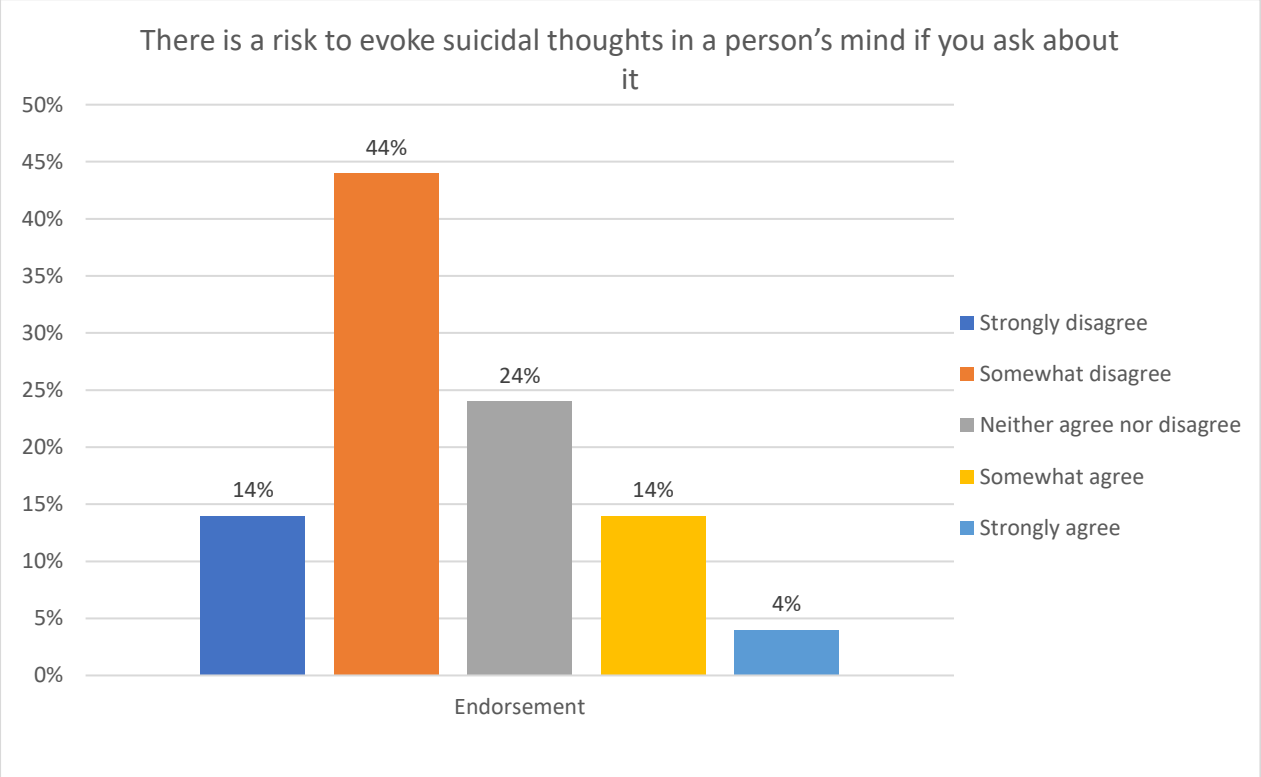


Figure 17: Sample avoidance of talking item

5. Unpredictability

Unpredictability is the belief that suicide happens without any warning and people who talk about suicide do not usually progress to behavioural enaction. There are five questions in this scale, examples include “Suicide happens without (previous) warning”, and “People who make suicidal threats seldom complete suicide.” Responses to items varied both in relation to beliefs surrounding the continuum of suicide thoughts and behaviours as well as the perceived unpredictability of suicide.

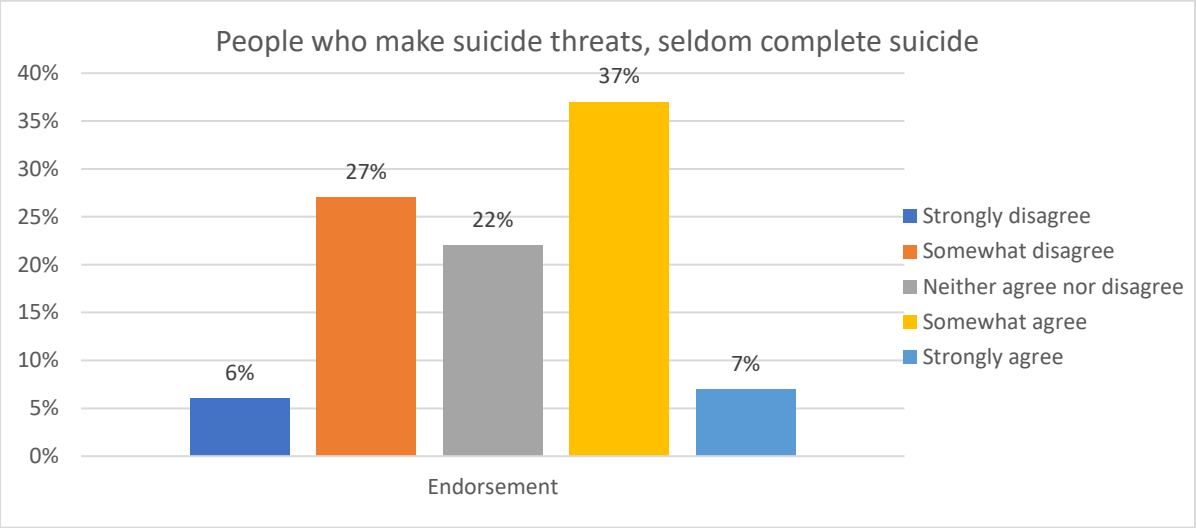


Figure 18: Sample unpredictability item

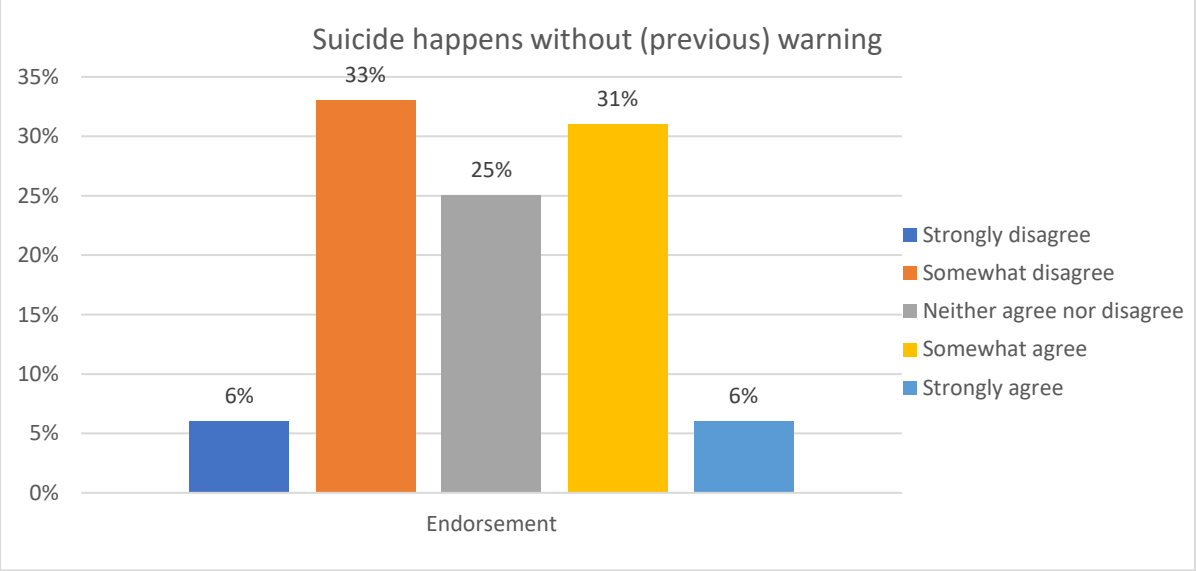


Figure 19: Sample unpredictability item

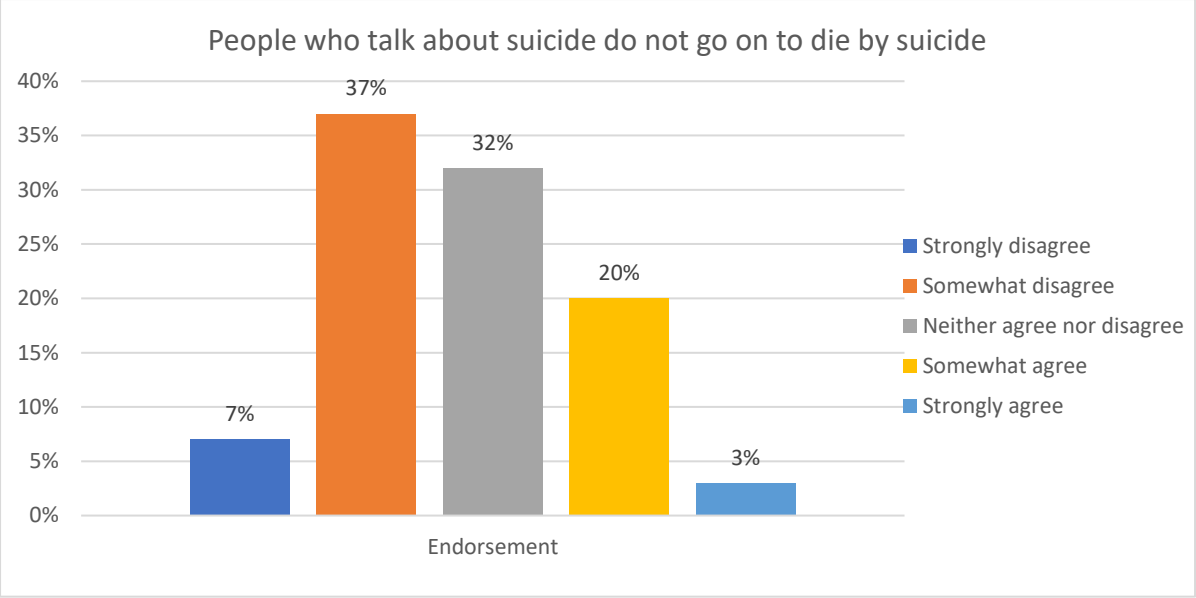


Figure 20: Sample unpredictability item

6. Loneliness and appeal (for help)

This subscale is indexed by three items that reflect the belief that loneliness could be one reason why some choose suicide. Example items include "It is mainly loneliness that drives people to take their own life" and "A suicide attempt is essentially a cry for help". Results suggested that in general, loneliness was not considered a sufficient or an overriding motivation for suicide but there was a strong belief amongst many that suicide was an appeal for help.

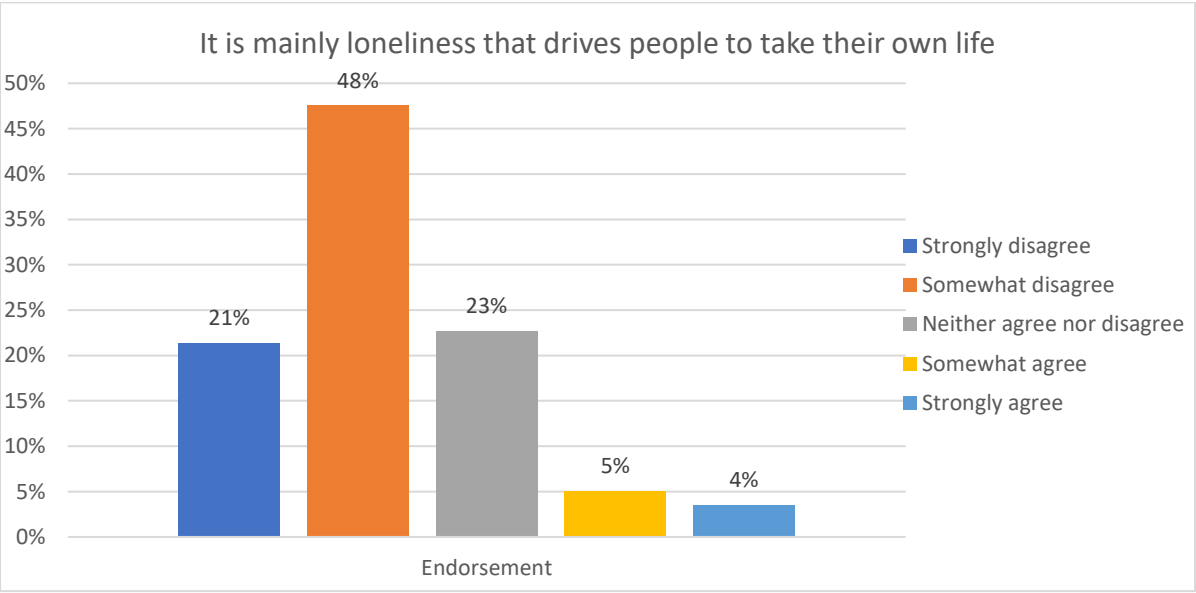


Figure 21: Sample loneliness item

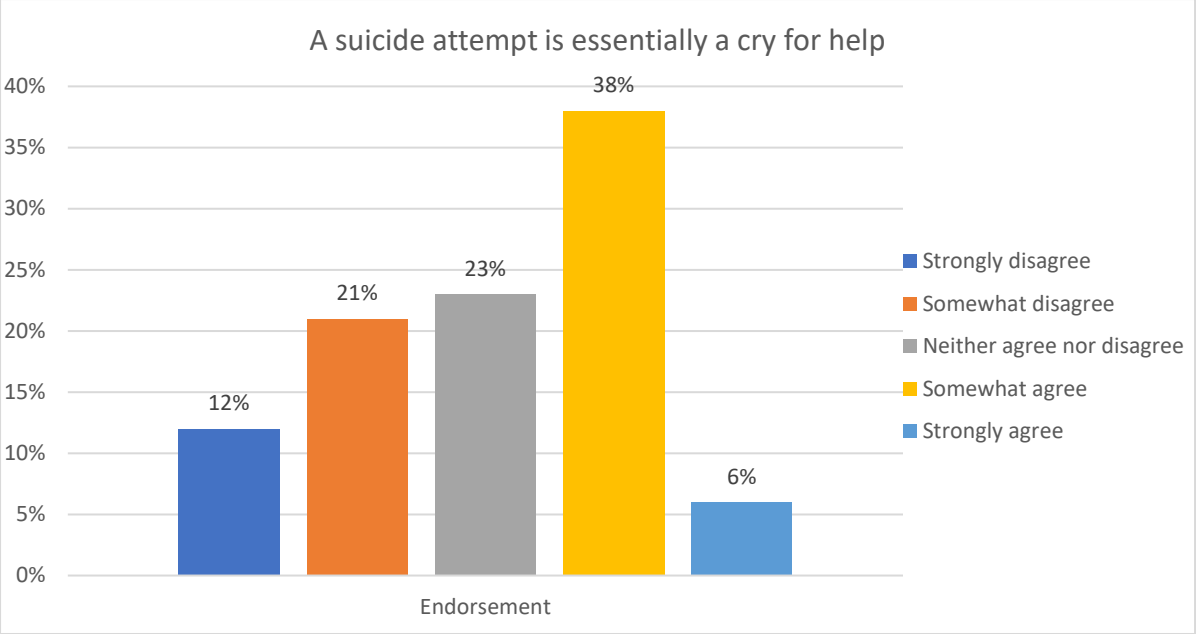


Figure 22: Sample appeal item

A correlation analysis was conducted for the six total subscales. Correlation analysis is used to explore the strength and direction of the relationship between variables. A significant correlation was found between permissiveness, incomprehensibility, unpredictability and loneliness/appeal. Individuals who believed that suicide was permissible tended to score higher on beliefs surrounding loneliness and appeal (i.e. that loneliness was a possible explanation or motivation for suicide and that suicide was often a cry for help) and scored lower on incomprehensibility (i.e. that suicide is beyond your understanding).

Interpretation of the correlations mean; higher scores on permissiveness, preventability and loneliness/appeal are more positive as they show more compassionate attitudes towards suicide, greater commitment to intervention/ prevention and a better awareness of the social and contextual risk factors for suicide. On the other hand, higher scores on incomprehensibility, unpredictability and avoidance of talking are more negative as they can promote stigmatising attitudes and suggest a lack of understanding of suicide, its risk factors and the continuum of suicidal thoughts to behaviours.

4.6 Comparison of attitudes to suicide among police job roles and experience

A one-way between groups analysis of variance (ANOVA) was conducted to explore differences of job role on the six components of Attitudes to Suicide Scale (ATT). Respondent groups were:

(1) Constable (PC)

(2) Sergeant (PS)

(3) Inspector

(4) 'Others' (comprised of PCSO, Chief Inspector, Superintendent, Chief Superintendent.

When all six subscales were analysed, analyses showed only significant mean differences in police job roles and their attitudes to suicide on the subscale Unpredictability. Unpredictability is the belief that suicide happens without any warning and people who talk about suicide do not usually enact the behaviour.

The difference in mean scores on Unpredictability between the different job role was large with an effect size of 0.14, calculated using eta squared. Post-hoc comparisons using the Turkey HSD test indicated that the mean score for Constables (PC) M=16.50, SD2.97) was statistically significant from those in the 'Other' category (12.33, SD=3.67). The mean scores of Inspectors (M=15.62, SD=2.89) was also significantly different from the 'Other' category as well (M=12.33, SD=3.67). Finally, the mean scores of Sergeants (PS) (M=15.62, SD=2.89) was significantly different from 'Others' (M=12.33, SD=3.67). This suggests that Constables, Inspectors and Sergeants all endorsed higher beliefs about the unpredictability of suicide compared to the collapsed `Other` category (encompassing PCSO, Chief Inspector, Superintendent, Chief Superintendent). There were no significant differences in mean scores on the other five other subscales indicating that beliefs among job roles were fairly similar.

4.7 Emotional intelligence

Scores on emotional intelligence (EI) were assessed using the Assessing emotions scale**.** There were 33 items and the variables were summed to create a total score. Scores can range from 33 to 165 with higher scores indicative of greater EI. The sample showed a median score of 121 which sits at the 50th quartile and can be interpreted as the middle level of emotional intelligence for the sample. The average for the sample was 119, which is slightly lower than reported elsewhere in a variety of other countries and samples (AES: Schutte et al., 2009).

Correlation analysis was used to explore the strength and direction of the relationship between emotional intelligence (EI) and attitudes to suicide. Results revealed significant correlations between levels of EI and the preventability, avoidance of talking and loneliness/appeal ATTS subscales. Higher scores on EI (i.e. greater EI) was associated with stronger beliefs around the preventability of suicide and weaker endorsement of the belief that we should avoid talking about suicide. The relationship between EI and the remaining suicide subscales was non-significant.

5. Discussion

Police officers are among the first emergency services called upon crisis and this includes an incident when a person is at risk of suicide (Spence & Millott, 2016). In such circumstances, they must often adopt the role of mental health support worker. The ability to conduct this role as well as the quality and effectiveness of their responses depends largely on their attitudes towards suicide, personal experiences, knowledge, training and levels of emotional intelligence (Fry, O'riordan, & Geanellos, 2002; Omoaregba, James, Igbinowanhia, & Akhiwu, 2015).

There is limited investigation of UK police force attitudes towards working with suicidal individuals, yet some studies highlight a high discrepancy between perceived and actual responsibilities in relation to working with individuals with mental health problems. Police staff often believe that dealing with individuals with mental health crisis is not their duty and feel frustrated with the lack of appropriate mental health services (Dew & Badger, 1999; Fry et al., 2002; Psarra et al., 2008; Trovato, 2001).

Conversely, in the United States of America, police officers understand that working with individuals with mental health problems is an integral part of their duties, which suggests cultural differences in attitudes towards suicidal behaviour (Cooper, Mclearen, & Zapf, 2004). However, in the US study, positive attitudes was found to be correlated with level of education, suggesting that more training may help to improve attitudes, raise awareness, encourage police officers in their ability to manage suicidal behaviour and as a secondary outcome, reduce the negative effects such as stigma, and risks related to exposure to suicidal behaviour (LaGrange, 2003; Marzano, Smith, Long, Kisby, & Hawton, 2016). In sum, there remains a need for more research and training for police officers in order to increase their competence and confidence in situations of crisis.

6. Recommendations

The police force are important gatekeepers within the community given their exposure to some of the most vulnerable in society. The results of this survey suggest that they not only frequently encounter suicide professionally, but that these encounters often coincide with personal experiences of suicide and are regularly accompanied by a level of distress (Figures 5-8). Since research suggests that the consequences of repeated suicide exposures may also influence police staffs' own suicide risk (Stanley, Hom, & Joiner, 2016), ongoing reviews of the institutional support and internal debrief procedures to assist police staff following suicide incidents, if not already in place, may be worthwhile.

Moreover, whilst the results of this study show largely compassionate, tolerant and informed attitudes to suicide, there are some areas which could be improved, both in terms of attitude change and training requirements. Just as police staff reported receipt of routine generic mental health training, so too might there may be scope to include suicide specific training (Figure 2 & 10), particularly among constables who reported feeling less equipped to deal with suicide incidents (Figure 12) and who reported 'very frequent' exposure to suicide. Ostensibly, it may not only be officers with suicide negotiation responsibilities who may benefit from such specialised training (Figure 11), but instead there may be utility in cascading the training across the organisation with the view to upskilling the entirety of the workforce.

Specialised suicide training can assist in challenging some of the persistent myths surrounding suicide and contribute to the reframing of misconceptions such as the belief among a minority of individuals that talking openly about suicide can promote suicidal thoughts (Figure 17), something which is not supported by the research evidence (Blades, Stritzke, Page, & Brown, 2018; Dazzi, Gribble, Wessely, & Fear, 2014). Other common fallacies include beliefs surrounding the inevitability of suicide, the lack of continuity in suicidal thoughts and behaviours as well as a lack of awareness of suicide risk factors including the minimisation of contextual and/or social factors (such as loneliness) relative to mental health. Whilst there may be truth underpinning these beliefs, research informed training can help to shed light on the true nature of the relationships. For instance, the phrasing of the loneliness questions may help to explain the poor endorsement (i.e. it is mainly loneliness that drives people to take their own life – Figure 21), however the importance of loneliness in suicide should not be underestimated since thwarted belongingness (e.g. *alienation, social loneliness etc.*) which is central to contemporary theories of suicide (Joiner, 2007; Van Orden et al., 2010; Van Orden, Witte, Gordon, Bender, & Joiner Jr, 2008) is posited as one of the key motivators for suicide

(O'Connor & Kirtley, 2018). That said, suicide arises from a complex interplay of factors and loneliness alone is likely to be insufficient to result in suicidal thoughts, let alone behaviour (O'Connor & Kirtley, 2018; O'Connor & Nock, 2014).

High endorsement of the belief that suicide is among the "worst thing to do to one's family" and the belief among some that "suicide is a subject that one should not talk about" is likely to perpetuate the stigma surrounding suicide. Similarly, the belief that "people who talk about suicide do not go on to die by suicide" (Figure 20) may be equally stigmatising and could have the potential to prevent future disclosures if met with scepticism in the first instance. Although suicide ideation is relatively common and largely transient, it should be acknowledged as an important risk factor for the enactment of suicidal behaviours. Moreover, whilst suicide remains difficult to forecast (Franklin et al., 2016, 2017) and in this sense is understandably viewed as unpredictable, there are a number of known risk indicators which police staff should be familiar with including communication of suicide intent or pronouncements of feelings of loneliness or social alienation (Van Orden et al., 2010). Whilst the presence of these does not inevitably necessitate an intervention or signposting to secondary services, being attuned to potential risk markers may help police staff to feel more confident to fulfil their safeguarding duties.

In the current sample, there was mixed responses to the item "People who die by suicide are usually mental ill." In reality, mental health diagnoses are common among individuals who are suicidal, yet it remains a contradiction that the majority of people with a mental health disorders do not end their lives by suicide. Although mental ill health, drugs, and alcohol do increase the risk of suicide, incorrectly assuming that this sole driver of suicide can minimise the role of important social factors and contextual factors and ultimately compound the stigma.

Another myth is that "Once a person has made up their mind about dying by suicide, no-one can stop him/her" or that they will do it sooner or later. Being suicidal is not an enduring condition but death is. In fact, though a history of suicidal behaviour is one of the strongest predictors of subsequent suicidality (Ribeiro et al., 2016; Van Orden et al., 2010), it remains the case that many individuals who attempt, never go on to re-attempt (Ribeiro et al., 2016) and therefore suicide may be, for the most part, preventable. Importantly, the findings of this report suggest that police staff not only embrace a sense of personal accountability for suicide intervention and prevention but that they also recognise the importance of talking openly about suicidal inclinations, espouse tolerant and compassionate attitudes towards suicide and are eager to develop their knowledge in this

domain. Subsequent training should thus build upon current strengths observed, equipped to recognise and strengthening positive responses to suicidal behaviour.

Consequently, we recommend a tailored awareness programme which seeks to consolidate literature around suicide stigma, and suicide with the view to better educating police staff on contemporary suicide literature. Such training may also integrate elements of the mitigation framework so that police staff would not only have the confidence to respond any potential suicidality among members of the public, but, if the situation arises, may also provide support to colleagues which is likely to have a positive knock on effect within the police force (Arensman et al., 2016). Since greater EI was found to be associated with more positive attitudes in terms of preventability, avoidance of talking and unpredictability, this might also be explored as an avenue for attitudinal change, although the practicalities of this may need to be investigated further.

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8. Appendices

1. The Attitudes Towards Suicide Scale (ATTS).
2. Assessing Emotions Scale (AES).

Appendix 1

The Attitudes Towards Suicide Scale

Each of the following items asks you about your attitudes towards suicide. Please indicate, on a 5-point scale, to what extent do you agree/disagree with each statement.

1 = strongly disagree

2 = disagree

3 = cannot decide

4 = agree

5 = strongly agree

Permissiveness	
1. Suicide should be accepted as a solution to end an incurable suffering.	1 2 3 4 5
2. There are situations where the only rational solution is suicide.	1 2 3 4 5
3. Suicide can sometimes be a relief for the ones involved.	1 2 3 4 5
4. I would consider the possibility of taking my own life if I were to suffer from a severe, incurable disease.	1 2 3 4 5
5. A person suffering from a severe, incurable disease expressing wishes to die, should get that help.	1 2 3 4 5
6. I can understand that people suffering from severe, incurable disease choose to end their lives by suicide.	1 2 3 4 5
7. People should have the right to take their own lives.	1 2 3 4 5
8. I would like to get help to end my own life if I suffered from severe, incurable disease.	1 2 3 4 5
Preventability	
9. You can always help a person with suicidal thoughts.	1 2 3 4 5

10. Once a person has made up their mind about dying by suicide, no-one can stop him/her.	1 2 3 4 5
11. It is a human duty to try to stop someone from dying by suicide.	1 2 3 4 5
12. If somebody wants to take his/her life, it is their own business and others should not interfere.	1 2 3 4 5
13. I am prepared to help a person in a suicidal crisis by making contact.	1 2 3 4 5
14. Suicide can be prevented.	1 2 3 4 5
Incomprehensibility	
15. Suicide can never be justified.	1 2 3 4 5
16. Suicide is among the worst things to do to one's relatives.	1 2 3 4 5
17. People who die by suicide are usually mentally ill.	1 2 3 4 5
18. Suicide among younger people is incomprehensible since they should have so much to live for.	1 2 3 4 5
19. On the whole, I do not understand how people can take their lives.	1 2 3 4 5
Avoidance of talking	
20. There is a risk to evoke suicidal thoughts in a person's mind if you ask about it.	1 2 3 4 5
21. Suicide is a subject that one should not talk about.	1 2 3 4 5
22. A person, once having suicidal thoughts, will never let them go.	1 2 3 4 5
23. Most people avoid talking about suicide.	1 2 3 4 5
Unpredictability	
24. When a person dies by suicide, it is sometimes that he/she has considered it for a long time.	1 2 3 4 5
25. People who make suicidal threats seldom complete suicide.	1 2 3 4 5
26. Suicide happens without (previous) warning.	1 2 3 4 5
27. Relatives have usually no idea about what is going on when a person is thinking about suicide.	1 2 3 4 5
28. People who talk about suicide do not go on to die by suicide.	1 2 3 4 5
Loneliness and Appeal	
29. Loneliness could for me be a reason to take my life.	1 2 3 4 5
30. It is mainly loneliness that drives people to take their own life.	1 2 3 4 5

31. A suicide attempt is essentially a cry for help.	1 2 3 4 5

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Appendix 2

The Assessing Emotions Scale

Each of the following items asks you about your emotions and reactions associated with emotions. After deciding whether a statement is generally true for you, use the 5-point scale to indicate to what extent you agree/disagree with each statement.

1 = strongly disagree

2 = somewhat disagree

3 = neither agree or disagree

4 = somewhat agree

5 = strongly agree

1. I know when to speak about personal problems to others.	1 2 3 4 5
2. When I am faced with obstacles, I remember times I faced similar obstacles and overcame them.	1 2 3 4 5
3. I expect that I will do well on most things I try.	1 2 3 4 5
4. Other people find it easy to confide in me.	1 2 3 4 5
5. I find it hard to understand the nonverbal messages of other people.	1 2 3 4 5
6. Some of the major events of my life have led me to re-evaluate what is important and not important.	1 2 3 4 5
7. When my mood changes. I see new possibilities.	1 2 3 4 5
8. Emotions are one of the things that make my life worth living.	1 2 3 4 5
9. I am aware of my emotions as I experience them.	1 2 3 4 5
10. I expect good things to happen.	1 2 3 4 5
11. I like to share my emotions with others.	1 2 3 4 5
12. When I experience a positive emotion, I know how to make it last.	1 2 3 4 5
13. I arrange events others enjoy.	1 2 3 4 5

14. I seek out activities that make me happy.	1 2 3 4 5
15. I am aware of the non-verbal messages I send to others.	1 2 3 4 5
16. I present myself in a way that makes a good impression on others.	1 2 3 4 5
17. When I am in a positive mood, solving problems is easy for me.	1 2 3 4 5
18. By looking at their facial expressions, I recognise the emotions people are experiencing.	1 2 3 4 5
19. I know why my emotions change.	1 2 3 4 5
20. When I am in a positive mood, I am able to come up with new ideas.	1 2 3 4 5
21. I have control over my emotions.	1 2 3 4 5
22. I easily recognise my emotions as I experience them.	1 2 3 4 5
23. I motivate myself by imagining a good outcome to a task I take on.	1 2 3 4 5
24. I compliment others when they have done something well.	1 2 3 4 5
25. I am aware of the non-verbal messages other people send.	1 2 3 4 5
26. When another person tells me about an important event in his or her life, I almost feel as though I experienced this event myself.	1 2 3 4 5
27. When I feel a change in emotions, I tend to come up with new ideas.	1 2 3 4 5
28. When I am faced with a challenge, I give up because I believe I will fail.	1 2 3 4 5
29. I know what other people are feeling just by looking at them.	1 2 3 4 5
30. I help other people feel better when they are down.	1 2 3 4 5
31. I use good moods to help myself keep trying in the face of obstacles.	1 2 3 4 5
32. I can tell how people are feeling by listening to the tone of their voice.	1 2 3 4 5
33. It is difficult for me to understand why people feel the way they do.	1 2 3 4 5

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