

ATTITUDES TOWARD SUICIDE AND SUICIDAL RISK
AMONG YOUNGER AND OLDER PERSONS

DANIEL L. SEGAL, MELISSA S. MINCIC, FREDERICK L. COOLIDGE,
AND ALISA O'RILEY

University of Colorado at Colorado Springs, Colorado, USA

Despite a burgeoning literature on some aspects of elder suicide, little is known about the specific attitudes that older people hold about suicide. The present study examined attitudes toward suicide and suicidal risk among 96 younger and 79 older adults. Participants completed the Suicide Opinion Questionnaire and the Suicide Risk Scale. Regarding suicidal risk, younger adults scored significantly higher than older adults. Regarding attitudes, older adults scored significantly higher than younger adults on 7 of 15 subscales, indicating that for older adults, suicide was more acceptable, more strongly related to a lack of religious conviction, more lethal, more normal, more irreversible or permanent, more strongly related to demographics, and more strongly related to individual aspects. An implication is that older adults hold both adaptive and maladaptive attitudes about suicide that may be useful in providing a social and cultural context to the study, prevention, and treatment of elder suicide.

It is a sad reality that suicide is a major public health problem for younger and older persons alike in the United States. In 2000, almost 30,000 people committed suicide, the death rate by suicide was 10.7 per 100,000 population, and suicide was ranked as the 11th leading cause of death (National Center for Health Statistics, 2000). Contrary to public perceptions, the facts indicate that older adults have the highest suicide rate of any age group (National Center for Health Statistics, 2000; also see review by Moscicki, 1995), although there is some variability across

Received 12 September 2003; accepted 11 January 2004.

Address correspondence to Daniel L. Segal, Department of Psychology, University of Colorado at Colorado Springs, P.O. Box 7150, Colorado Springs, CO 80933-7150. Email: dsegal@uccs.edu

geopolitical regions and between male/female populations. Notably, older males have a higher risk for suicide than any other age by gender group (National Center for Health Statistics, 2000).

Despite the magnitude of the problem of suicide among older persons, the existing knowledge base about the phenomenon is lacking in some areas. Duberstein and Conwell (2000), in their thorough review of elder suicide, indicated that estimates of the potency of various risk factors for elder suicide are not known and that specific treatments for suicidal behaviors among older persons have yet to be formally studied. Another potentially relevant topic concerns the types of attitudes that older adults hold about suicide—because attitudes are regarded as an important part of one's personality, they tend to be stable over time and are often predictive of one's behavior (Larsen & Buss, 2002). In a recent study, Segal (2000) reported that older adults hold a number of misconceptions about suicide that are likely to negatively affect their behavior, but that study focused exclusively on knowledge about suicide facts not attitudes about suicide. An enhanced understanding of such attitudes may be potentially important because it places the topic of elder suicide into a social context that can shape educational, intervention, and prevention efforts. We are unaware of any studies that specifically addressed these attitudes in the older adult community.

The purpose of the present study, therefore, was to examine attitudes toward suicide among younger and older adults. The study also investigated age differences in overall suicidal risk. Based on research showing that older adults have a generally poor knowledge base concerning suicide facts (Segal, 2000), different reasons for living when considering suicide (Miller, Segal, & Coolidge, 2001), and different socialization and coping strategies than younger persons (Segal, Hook, & Coolidge, 2001), we hypothesized that older adults will differ from younger adults regarding their attitudes about suicide. No hypotheses were made regarding age differences on suicidal risk factors because of conflict and uncertainty in the literature about this issue (Duberstein & Conwell, 2000).

Method

Participants and Procedure

Undergraduate students were recruited from psychology classes and given extra credit for their participation. Older adults were recruited

from local senior housing facilities. Participants ($N = 175$) anonymously completed the two questionnaires and a demographics questionnaire at home and then returned the packet. Two groups were formed based on age: younger and older adults.

The younger adult group ($n = 96$) ranged from 17 to 26 years of age ($M = 20.6$ years; 84.4% female). Education ranged from 12 to 16 years ($M = 13.4$) and the sample was 82.3% Caucasian, 5.2% African American, 4.2% Asian/Pacific Islander, and 4.2% Hispanic. Concerning marital status, 87.5% had never been married whereas 10.4% were married (5.2% had children). The older adult group ($n = 79$) ranged from 60 to 95 years of age ($M = 75.1$ years; 64.6% female). Education ranged from 9 to 25 years ($M = 15.4$) and the sample was almost exclusively Caucasian (97.4%). Concerning marital status, 44.3% were married (88.6% had children), 36.7% were widowed, and 17.7% were divorced.

Measures

Suicide Opinion Questionnaire (SOQ)

The SOQ (Domino, Moore, Westlake, & Gibson, 1982) includes 100 self-report questions designed to assess attitudes toward suicide. The SOQ provides scores on 15 distinct factors. Participants responded to each item on a 5-point response scale ranging from *strongly agree*, *agree*, *undecided*, *disagree*, and *strongly disagree*. The measure is scored so that higher scores reflect a stronger relationship of each factor with suicide (i.e., a higher score on the Mental and Moral Illness Factor would mean that a participant sees suicide as more reflective of mental and moral illness). Factor analysis revealed that the 15 factors accounted for 77% of the total variance. The SOQ possesses good psychometric properties (Domino et al., 1982).

Suicide Risk Scale (SR Scale)

The SR Scale (Plutchik, van Praag, Conte, & Picard, 1989) is a 15-item self-report measure with “Yes” or “No” responses designed to describe the degree to which an individual reveals characteristics similar to those of a suicide prototype. A total score is tallied to assess an individual’s suicidal risk. Scores range from 0 to 15 with higher scores indicating higher suicidal risk. The measure has good evidence of reliability and validity and can be used with psychiatric and non-psychiatric groups (Plutchik et al., 1989).

Results

First, age differences concerning attitudes about suicide (based on the SOQ) were examined. The 15 factors were analyzed using independent samples *t* tests (see Table 1). Overall, older adults scored significantly higher ($p < .05$) on seven SOQ Factors: Acceptability and Normality, Religion, Lethality, Normality, Irreversibility, Demographic Aspects, and Individual Aspects. Using the Bonferroni correction (corrected $p < .003$), three scales retained their significance: Normality, Irreversibility, and Demographic Aspects, and the latter two had medium to large effect sizes (.61 and .63, respectively). There were small to medium effect sizes (Cohen's *d* range = .32 to .48) for the Acceptability and Normality, Religion, Lethality, Normality, and Individual Aspects factors. Interestingly, younger adults were not higher than older adults on any scale.

TABLE 1 Mean Scores (SD) for Younger and Older Adults on the Suicide Risk Scale Total Score and the Fifteen Factor Scores of the Suicide Opinion Questionnaire

Scales and scale factors ^a	Younger adults	Older adults	<i>t</i> value	<i>p</i>	Cohen's <i>d</i> effect size
Suicide Risk Scale total score (15)	3.2 (2.6)	2.4 (2.3)	2.04	.04	.315
Suicide Opinion Questionnaire factors					
Acceptability and normality (16)	38.5 (10.3)	42.2 (12.7)	-2.05	.04	-.320
Mental and moral illness (13)	36.9 (5.9)	36.8 (7.7)	.06	.95	.015
Suicide as semi-serious (7)	15.0 (3.1)	15.9 (3.5)	-1.79	.08	-.272
Religion (5)	12.6 (3.7)	14.2 (4.0)	-2.80	.01	-.415
Risk (4)	12.1 (2.3)	11.7 (2.0)	1.02	.31	.045
Lethality (4)	8.8 (2.2)	9.6 (2.1)	-2.57	.01	-.372
Normality (6)	12.7 (2.5)	13.8 (2.1)	-2.96	.01	-.476
Irreversibility (4)	9.1 (1.8)	10.2 (1.8)	-3.78	.00	-.611
Demographic aspects (3)	7.8 (1.6)	8.8 (1.6)	-4.20	.00	-.625
Aging (3)	6.7 (1.6)	6.7 (2.0)	-.11	.91	0.00
Motivation (5)	18.3 (2.2)	18.0 (2.3)	.71	.48	.133
Impulsivity (3)	8.5 (1.8)	8.5 (2.2)	.24	.81	0.00
Getting Even (3)	8.8 (2.1)	8.8 (2.3)	-.11	.92	0.00
Individual aspects (3)	8.1 (1.6)	8.8 (1.7)	-2.60	.01	-.424
Sensation-seeking (3)	7.7 (1.6)	8.2 (1.9)	-1.61	.11	-.285

^aThe values in parentheses in this column indicate the number of items composing each SOQ factor.

Next, an independent samples *t* test was used to assess an age difference regarding suicidal risk. As shown in Table 1, younger persons scored significantly higher on the total risk score than older persons but the effect size was small (.32). Both groups also showed relatively low risk scores, which was expected given the nature of the sample (community-dwelling and not selected to have any specific form of psychopathology).

Discussion

The results of this study show that younger adults and older adults hold many different attitudes about the topic of suicide. Some attitudes of the older group may be viewed as positive. For example, they saw suicide as reflective of an absence of religious faith (Religion factor). Because the use of religion and spirituality as coping strategies tends to increase with age (Koenig, George, & Siegler, 1988), this type of attitude may be a protective factor for the group. Indeed, in our related study of reasons for living among younger and older adults, we found that older adults reported moral objections as a stronger reason for not committing suicide than younger adults (Miller et al., 2001). Another potentially positive attitude is that most suicide attempts result in death (Irreversibility factor). We view this perception as potentially adaptive because it highlights the seriousness of suicide attempts and may dissuade some older people from acting dangerously solely as a cry for help.

Other attitudes may be viewed in a negative light for the older adult group. Most illustrative are their heightened views (compared with younger adults) that suicidal behaviors are normal in some situations (Acceptability and Normality factor) and that the suicidal person is generally not depressed or lonely (Normality factor). In contrast to such attitudes, the data are clear that most older adults who commit suicide were in some form of psychological distress and that major depression is the specific form of psychopathology most linked to elder suicide (Duberstein & Conwell, 2000). Another potentially hazardous attitude endorsed at greater frequency among the older adult group concerns the Lethality factor, reflecting beliefs that suicidal behaviors are not a cry for help, nor can a suicide attempter be dissuaded by a concerned listener. Such attitudes may reflect the seriousness and hopelessness many older adults perceive about suicide, and, unfortunately, the hopelessness

component may prevent some suicidal elders from requesting (and receiving) appropriate lay and professional help and support.

Regarding suicidal risk, the younger adults were found to have a greater risk than older adults, although the average risk for both groups was low. Several explanations may account for the age difference. It is possible that the finding is veridical although this is at odds with the higher suicide completion rates among older persons. In our opinion, a better hypothesis is that the finding reflects the well-researched notion that, as a cohort, older adults are less likely to *report* suicidal thinking compared with younger adults (Duberstein et al., 1999; Gallo, Anthony, & Muthen, 1994) despite having actual greater risks. Harwood, Hawton, Hope, and Jacoby (2000) reported that older adults with high suicidal risks often consulted their general practitioners within the month before their deaths, but the majority of these contacts were to report physical complaints rather than symptoms of psychological distress. Our findings add to this literature and suggest the possibility that older adults may under-report other suicidal risk factors as well. It is also possible that risk factors are different for younger and older adults, and that the SR Scale is not sensitive to unique risk factors among older adults. More research should be done to clarify common and unique risk factors among diverse age, gender, socioeconomic, and ethnic groups. Lastly, mortality effects may have played a role: The most impaired and ill people are not likely to live to old age.

A strength of the present study was that we assessed multiple dimensions of attitudes about suicide among older adults, not merely global attitudes such as a positive or negative opinion about suicide. Despite this positive, several limitations of our study should be highlighted. First, the study relied solely on self-report measures of the constructs of interest. Self-report data may be biased, especially regarding the SR Scale because older adults in the present cohort tend to be uncomfortable answering very personal questions associated with psychological issues due to the tremendous stigma they associate with mental health problems (Segal, Coolidge, & Hersen, 1998). Another limitation was that the study used a community-dwelling (non-clinical) older population, which limits potential generalizability to actual suicidal older people. Finally, the sample sizes were modest and there was little ethnic diversity, which further limits generalizability. Future studies with larger and more diverse samples of older people might be fruitful to examine the extent to which attitudes about suicide are influenced by or related to social support, psychosocial stressors,

suicidal behaviors, and various forms of psychopathology. Finally, researchers may want to examine suicide attitudes and associated behaviors among the “young-old” (aged 65–84) and the “old-old” (aged 85 and over).

In conclusion, our preliminary findings highlight potentially important age differences in attitudes about suicide. The present study suggests that older adults appear to hold both adaptive and maladaptive attitudes about suicide, suggesting that continued education and discussion about elder suicide is necessary. Preventive efforts may target specific negative attitudes (e.g., that the suicidal person cannot be dissuaded from making an attempt) as part of a larger program. Assessment of attitudes about suicide may also prove useful in the clinical setting to more accurately assess a given older person’s suicidal potential.

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