Levels of Knowledge About Suicide Facts and Myths Among Younger and Older Adults

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ABSTRACT. Despite the fact that older adults have the highest suicide rate of any age group, little is known about the kind of information older adults possess about suicide facts. Purpose of study was to investigate the prevalence of a number of misconceptions about suicide in younger (N = 116; age range = 17-52 years; *M* age = 26.2 years) and older (N = 62; age range = 55-79 years; *M* age = 62.4 years) adults and to assess for differences in levels of knowledge between younger and older persons. Volunteer participants completed anonymously a 47-item suicide knowledge quiz, with items derived from the Revised Facts on Suicide Quiz (Hubbard & McIntosh, 1992) and several abnormal psychology texts. Responses to the items were analyzed for percentage of endorsement and differential endorsement as related to age. Using 70% correct per item as the criterion for adequate knowledge, results for older adults indicated that level of knowledge was good for 16 items (34%) but poor for 31 items (66%). Younger adults showed good knowledge on 19 items (40%). Chi-square revealed that older adults had poorer knowledge on 3 items and better knowledge on 3 items compared to younger adults. This study suggests that misconceptions about suicide are prevalent among younger and older persons. Education efforts aimed at decreasing myths about suicide may serve to heighten awareness of the problem and increase adaptive behaviors in some individuals. *[Article copies available for a fee from The Haworth Document Delivery Service: 1-800-342-9678. E-mail address: <getinfo@haworthpressinc.com> Website: <http://www.HaworthPress.com> © 2000 by The Haworth Press, Inc. All rights reserved.]*

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Suicide is a significant public health problem for younger and older persons alike in the United States. In fact, recent mortality figures from the National Center for Health Statistics indicate that suicide is ranked as the ninth leading cause of death among adults in general, accounting for over 30,000 deaths annually (Kochanek & Hudson, 1995). As a society, however, we tend to view suicides of young adults as far more prevalent than those of older adults. This may be due to the fact that youth suicides attract considerably more media attention than late-life suicides (Glass & Reed, 1993). Contrary to public perceptions, the disturbing reality is that older adults have the highest suicide rates of any age group (Bharucha & Satlin, 1997). Specifically, suicide rates generally increase with age, with the highest rates among persons over age 65 (Moscicki, 1995), although there is variability across countries and between male/female populations.

As documented by extensive research, suicide is an all-too-common alternative to intense psychological suffering among older adults. However, determining the psychological causes of late-life suicide is far from being an exact science. Besides age, other risk factors of elderly suicide include male gender, depression, hopelessness, substance abuse, previous suicide attempt, widowhood, and physical illness. Older adults may also hold a number of misconceptions about suicide which can potentially affect behavior in a negative way. Indeed, prevention and early intervention efforts for other physical health (e.g., AIDS, heart attack) and mental health (e.g., depression, substance abuse) problems often focus on educational efforts about the nature of the problem and on dispelling myths about the illness. Unfortunately, little is currently known about the actual levels of factual knowledge about suicide among younger and older persons. The purpose of the present study, therefore, was to investigate the prevalence of a number of misconceptions about suicide in younger and older adults and to assess for differences in levels of knowledge between younger and older persons.

METHOD

Participants and Procedure

Participants were community-dwelling adults (N = 178) who were divided into two groups, younger and older adults. The younger adults

(*n* = 116; age range = 17-52; *M* age = 26.2; 62% female; 80% white) were students in psychology classes at a southwestern university. The older adults (N = 62; age range = 55-79; *M* age = 62.4; 58% female; 95% white) were family members or friends of students. Informed consent was obtained from participants who then anonymously completed the Suicide Knowledge Quiz.

Measures

The Suicide Knowledge Quiz (47 items) was created for this study, with 35 items derived from the ''Revised Facts on Suicide Quiz'' (Hubbard & McIntosh, 1992) and 12 items culled from several abnormal psychology textbooks that had a specific section on suicide myths. Table 1 presents the original source for all items.

RESULTS

Responses to the 47 items were analyzed for percentage of endorsement and differential endorsement as related to age. Complete results are displayed in Table 2. To determine whether younger and older adults had ''good'' or ''poor'' knowledge for each item, 70% correct was selected as the arbitrary criterion or cutoff for adequate knowledge. Results for the older adults indicated that level of knowledge was good for 16 items (34%) but poor for 31 items (66%). Younger

TABLE 1. Original Sources of Items for Suicide Knowledge Quiz

Items 1-18, 30-47: Hubbard, R. W., & McIntosh, J. L. (1992). Integrating suicidology into abnormal psychology classes: The Revised Facts on Suicide Quiz. *Teaching of Psychology*, *3*, 163-165.

Items 19-22: Moursund, J. (1993). *The process of counseling and therapy* (3rd ed., pp. 126). New Jersey: Prentice-Hall.

Items 23 and 24: Alloy, L. B., Accocella, J., & Bootzin, R. R. (1996). *Abnormal psychology: Current perspectives* (7th ed., pp. 243-244). New York: McGraw Hill.

Items 25 and 26: Nevid, F. S., Rathus, S. A., & Greene, B. (1997). *Abnormal psychology: In a changing world* (3rd ed., pp. 299-300). New Jersey: Prentice-Hall.

Items 27-30: Holmes, D. S. (1994). *Abnormal psychology* (2nd ed., pp. 224). New York: Harper Collins.

TABLE 2. Percent Correct on Suicide Knowledge Quiz for Younger (*n* = 116) and Older (*n* = 62) Adults

	Young Adults	Older Adults	X^2	p
1. People who talk about suicide rarely commit suicide. (F)	72.4	62.9	1.71	.19
2. The tendency toward suicide is not genetically (i.e., biologically) inherited and passed on from one generation to another. (T)	54.3	62.9	1.22	.27
3. The suicidal person neither wants to die nor is fully intent on dying. (T)	37.9	43.5	0.53	.47
4. If assessed by a psychiatrist, everyone who commits suicide would be diagnosed as depressed. (F)	63.5	45.9	5.04	.02
5. If you asked someone directly "Do you feel like killing yourself?" it will likely lead that person to make a suicide attempt. (F)	96.6	100	2.19	.14
6. A suicidal person will always be suicidal and entertain thoughts of suicide. (F)	75.9	72.6	0.23	.63
7. Suicide rarely happens without warning. (T)	51.3	74.2	8.75	.00
8. A person who commits suicide is mentally ill. (F)	80.2	61.3	7.41	.01
9. A time of high suicide risk in depression is at the time when the person begins to improve. (T)	35.3	29.5	0.61	.43
10. Nothing can be done to stop people from making the attempt once they have made up their minds to kill themselves. (F)	93.1	90.3	0.43	.51
11. Motives and causes of suicide are readily established. (F)	65.5	82.3	5.54	.02
12. A person who has made a past suicide attempt is more likely to attempt suicide again than someone who has never attempted. (T)	81.9	87.1	0.80	.37
13. Suicide is among the top 10 causes of death in the U.S. (T)	71.3	74.2	0.17	.68
14. Most people who attempt suicide fail to kill themselves. (T)	74.8	72.6	0.10	.75

	Young Adults	Older Adults	X^2	p
15. Those who attempt suicide do so only to manipulate others and attract attention to themselves. (F)	74.1	62.9	2.40	.12
16. Oppressive weather (e.g., rain) has been found to be very closely related to suicidal behavior. (F)	35.3	22.6	3.08	.08
17. There is a strong correlation between alcoholism and suicide. (T)	81.9	79.0	0.21	.64
18. Suicide seems unrelated to moon phases. (T)	54.3	48.4	0.57	.45
19. The suicidal person wants to die and feels there is no turning back. (F)	30.2	25.8	0.38	.54
20. Everyone who commits suicide is depressed. (F)	69.0	67.7	0.03	.87
21. Suicide is more common among the lower socioeconomic groups than elsewhere in our society. (F)	82.8	78.7	0.44	.51
22. Suicidal persons rarely seek medical help. (F)	30.2	33.9	0.26	.61
23. People who threaten to kill themselves will not carry out the threat. Only the "silent type" will pull it off. (F)	79.3	69.4	2.19	.14
24. People who attempt suicide and fail are not serious about ending their lives, they are just looking for sympathy. (F)	78.4	74.2	0.41	.52
25. Suicide is a sign of insanity. (F)	88.8	85.5	0.41	.52
26. Most people who commit suicide tell others of their intentions or leave clues beforehand. (T)	78.3	69.4	1.71	.19
27. Suicides and attempted suicides are in the same class of behavior. (F)	44.0	42.6	0.03	.86
28. Protestants are more likely to commit suicide than Catholics. (F)	75.9	82.3	0.97	.33
29.Suicide rates are higher in rainy months than sunny months. (F)	31.9	22.6	1.72	.19
30. What percentage of suicides leaves a suicide note? (A) A. 15-25 %, B. 40-50 %, C. 65-75 %	40.0	45.9	0.57	.45

TABLE 2 (continued)

	Young Adults	Older Adults	X^2	p
31. Suicide rates for the U.S. as a whole are _____ for the young. (C) A. lower than B. higher than C. the same as	16.5	14.5	0.12	.73
32. With respects to sex differences in suicide attempts (B) A. males and females attempt at similar levels. B. females attempt more often than males. C. males attempt more often than females.	41.4	33.9	0.96	.33
33. Suicide rates among the young are _______ those for the old. (A) A. lower than B. higher than C. the same as	10.3	09.7	0.02	.89
34. Men kill themselves in numbers _______ those for women. (B) A. similar to B. higher than C. lower than	51.7	53.2	0.04	.85
35. Suicide rates for the young since the 1950s have (A) A. increased B. decreased C. changed little	93.1	100	4.40	.04
36. The most common method employed to successfully kill oneself in the U.S. is: (B) A. hanging B. firearms C. drugs and poison	56.9	48.4	1.18	.28
37. The season of highest suicide risk is: (C) A. Winter B. Fall C. Spring	12.1	6.5	1.40	.24
38. The day of the week on which most suicides occur is: (A) A. Monday B. Wednesday C. Saturday	47.4	59.7	2.43	.12
39. Suicide rates for non–whites are ______ those for whites. (C) A. higher than B. similar to C. lower than	33.6	18.0	4.79	.03
40. Which marital status category has the lowest rates of suicide? (A) A. Married B. Widowed C. single, never married	60.0	67.7	1.03	.31
41. The ethnic/racial group with the highest suicide rate is: (C) A. Whites B. Blacks C. Native Americans	24.1	24.6	0.00	.95
42. The risk of death by suicide for a person who has attempted suicide in the past is ______ that for someone who has never attempted. (C) A. lower than B. similar to C. higher than	77.6	79.0	.05	.82

	Young Adults	Older Adults	X^2	p
43. Compared to other Western nations, the U.S. suicide rate is: (B) A. among the highest B. moderate C. among the lowest	23.3	26.2	0.19	.66
44. The most common method in **attempted suicide** is: (B) A. firearms B. drugs and poison C. cutting one's wrists	52.6	46.8	0.55	.46
45. On the average, when young people make suicide attempts, they are _____ to die compared to elderly persons. (A) A. less likely B. just as likely C. more likely	45.7	32.3	3.01	.08
46. As a cause of death, suicide ranks ______ for the young when compared to the nation as a whole. (B) A. the same B. higher C. lower	77.4	82.3	0.58	.45
47. The region of the United States with the highest suicide rate is: (C) A. East B. Midwest C. West	20.9	32.3	2.80	.09

Note. Correct response for each item is indicated in parentheses after the item.

adults showed good knowledge on 19 items (40%). Chi-square revealed that older adults had poorer knowledge on 3 items (# 4, #8, #39) and better knowledge on 3 items (# 7, #11, #35) compared to younger adults ($p < .05$ for each item).

Some particularly interesting items for which knowledge was poor for older adults included: #8. A person who commits suicide is mentally ill (False, 61% correct); #16. Oppressive weather (e.g., rain) has been found to be very closely related to suicidal behavior (False, 23% correct); #18. Suicide seems unrelated to moon phases (True, 48% correct); #22. Suicidal persons rarely seek medical help (False, 34% correct); #33. Suicide rates among the young are *lower than* those for the old (10% correct from multiple choice); and # 45. On the average, when young people make suicide attempts, they are *less likely* to die compared to elderly persons (32% correct from multiple choice).

DISCUSSION

This preliminary study suggests that misconceptions about suicide are prevalent among older persons. Notably, older adults showed a poor understanding of suicide facts on the majority of items on the Suicide Knowledge Quiz. Younger adults also showed poor knowledge on the majority of items but had a slightly better overall knowledge rate. Our results highlight the need for education efforts aimed at decreasing myths about suicide. Such strategies may serve to heighten awareness of the problem and might actually increase healthy behaviors in some individuals. For example, if one becomes aware that not all suicidal people are depressed, one might better identify a suicidal potential in a person who is in an emotional crisis state but who is not currently depressed. Another example might involve increasing knowledge that most suicidal people are ambivalent about dying and usually experience a conflict between a wish to die and a wish to live. Armed with this information, it is possible that some people may be more proactive in seeking mental health help for someone who expresses suicidal wishes. These are just two examples of the way that increasing knowledge about suicide facts could have significant benefits. This research suggests that increased public education and open discussion about suicide is needed as one possible mechanism to reduce suicides. Since some older adults likely would feel uncomfortable talking directly about suicidal feelings, it is possible that a discussion about suicide facts might be less threatening and can open the door to future discussions about suicidal tendencies.

In the clinical setting with older adults, it is indeed good clinical practice to include a full evaluation of suicidal risk as part of a standard clinical interview. The reason for this is two-fold: (1) protection of the client during a crisis point when the person may be irrational, psychotic, or severely depressed and may want to escape from emotional turmoil by ending his/her life; and (2) protection of the clinician who can be held legally liable if a thorough suicide risk assessment was not performed or if the clinician failed to take proper steps to prevent the client from self-harm and the client committed suicide (Segal, Coolidge, & Hersen, 1998).

During assessment of suicide potential with older persons, clinicians are advised to begin with general queries about suicidal ideation which are then followed up with probes about specific plans and intent (Segal et al., 1998). If the assessment reveals that the client is currently at risk for self-harm, the clinician must act to protect the client. One

implication of this study is that a discussion of the older person's attitudes and beliefs about suicide could be included as part of a more thorough assessment of suicide risk. Several formal assessment measures of suicidal potential exist, including the Scale for Suicidal Ideation (SSI; Beck, Kovacs, & Weissman, 1979) and the Geriatric Hopelessness Scale (GHS; Fry, 1986), but these do not address specifically one's attitudes about suicide.

Several limitations of the present study should be noted. Most notably, we focused exclusively on the prevalence of misconceptions about suicide facts. This study did not measure actual suicidal behavior among the respondents. Another limitation was the sampling of younger adults who were all college students from a psychology class. The sample size was also relatively small, and participants were predominately white which limits potential generalization of these findings. As such, replication of this study using a broader and more diverse sample of younger and older adults should be conducted. Nonetheless, this is one of the few studies looking at levels of knowledge about suicide among younger and older samples. One unexplored area of inquiry is that of the potential relationship between misconceptions about suicide and actual suicidal behavior among older persons.

In conclusion, this research suggests that several popular misconceptions about suicide still exist, and are in fact prevalent. Older adults may not be adequately educated about the topic of suicide, possibly due to the discomfort felt by the current cohort of older persons concerning mental health topics and the shame and stigmatization associated with psychiatric problems among the elderly (Lazarus, Sadavoy, & Langsley, 1991). Future efforts to dispel myths about suicide should be undertaken, and such efforts would likely be a useful part of a program to address this serious problem. Because of the devastating consequences of suicide for the attempter and those who are left behind, prevention and intervention efforts are paramount. Continued education and open discussion about suicide is sorely needed to reduce suicides.

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