
A COMPARISON OF SUICIDAL THINKING AND REASONS FOR LIVING AMONG YOUNGER AND OLDER ADULTS

JILL S. MILLER, DANIEL L. SEGAL, and FREDERICK L. COOLIDGE

University of Colorado at Colorado Springs, Colorado, USA

A cross-sectional design was used to examine age-related differences in suicidal thinking and reasons for living among younger ($n = 82$; $M\ age = 21$) and older ($n = 82$; $M\ age = 68$) adults. Volunteers anonymously completed the Beck Scale for Suicide Ideation and the Reasons for Living Inventory. Findings indicated that older adults do not manifest suicidal ideation differently than younger adults. However, there does appear to be some age-related differences in reasons for not committing suicide. Compared to the younger group, the older group reported moral objections and child-related concerns as stronger reasons for not committing suicide. An implication is that the identification of specific reasons that deter individuals from committing suicide may be clinically useful and provide some assistance in suicide prevention efforts.

As a society, 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). In fact, suicide is a significant problem among the older adult population: older adults comprised about 13% of the U.S. population in 1992, yet accounted for 20% of the suicides. In contrast, young people (ages 15–24) comprised about 14% of the population and accounted for 15% of the suicides (Bharucha & Satlin, 1997; McIntosh, 1995).

Among older persons, there are between two to four suicide attempts for every completed attempt (Marcus, 1995), a ratio much lower than that of younger persons, suggesting more lethal attempts among older

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Address correspondence to Daniel L. Segal, Ph.D., Department of Psychology, University of Colorado at Colorado Springs, Colorado Springs, Colorado 80933. E-mail: dlsegal@mail.uccs.edu

persons. Demographic and epidemiological trends predict a steady increase in the number of suicides in the older population in the near future. McIntosh, Santos, Hubbard, & Overholser (1994) suggest that this increase reflects the growing population of older adults, as well as improved data collection and reporting. Research predicts that by the year 2030, older adults will comprise 20% of the United States population and, if the current trend persists, will account for a shuddering one-third of all U.S. suicides (McIntosh et al., 1994).

Older adults who attempt suicide die from the attempt more often than any other age group. This greater likelihood of fatality implies that taking suicidal thoughts and threats seriously may be even more crucial in the case of older adults (McIntosh et al., 1994). According to Seiden (1981, p. 265), older people "commit suicide the most while attempting it the least." They commit suicide "with a determination and single-mindedness of purpose not encountered among younger age groups." Suicidal thoughts and attempts by younger persons are often considered to be a call for help, an attempt to influence family or friends, or motivated by anger, revenge, guilt, and self-blame (Miller, 1979; McIntosh et al., 1994). In contrast, Atchley (1991) suggested that older adults may simply want the release from despair and emotional and physical exhaustion that death provides. Several researchers have agreed that older adults who attempt suicide genuinely want to die (Achte, 1988; Atchley, 1991; Lesnoff-Caravaglia, 1988). This authentic desire for death is apparent in the older adults' choice of more lethal methods than younger individuals. Use of firearms and hanging are common suicide methods (Achte, 1988; Lesnoff-Caravaglia, 1987). Compared to younger adults, the elderly tend to be less likely to seek relief from suicide prevention centers, crisis hotlines, or other types of mental health services. This could be attributed to older age cohorts' resistance to admit the need for any psychological help (Lesnoff-Caravaglia, 1987). Older adults also have relatively poor knowledge about suicide facts and myths (Segal, *in press*), suggesting that older persons are not receiving adequate educational efforts and open dialogue about suicide.

Suicide is an all-too-common alternative to intense psychological suffering. However, determining the psychological causes of late-life suicide is far from an exact science. The purpose of the present study was to identify age-related differences in levels of suicidal ideation and reasons for not committing suicide should the thought arise. Suicidal ideation, the thoughts one has about killing oneself, is considered an important risk

factor for more serious suicidal behavior (Reynolds, 1991). In reaction to the narrow research focus on youth suicide, we wanted to explore whether older adults manifest suicidal ideation differently than younger individuals. We were also interested in identifying older adults' reasons for refraining from committing suicide should the thought occur, and whether these reasons differ from younger adults. Due to different socialization, life experiences, and coping strategies between younger and older persons (Segal, Hook, & Coolidge, in press), we hypothesized that older adults will differ from younger adults on their responses to the Beck Scale for Suicide Ideation and the Reasons for Living Inventory.

Method

Participants and Procedure

Undergraduate students were recruited from psychology classes. They received extra credit for their participation or for the recruitment of older adults, usually family members or friends. Participants ($N = 164$) anonymously completed a questionnaire packet at home (all lived in the local community) and then returned it. Two groups were formed based on age: younger and older adults. All older adults were matched with younger adults on the basis of gender and ethnicity, and most were matched on the basis of religion (77%) and on self-ratings of physical health status (72%). The younger adult group ranged from 17 to 34 years of age ($n = 82$; M age = 21; 61% female; 90% Caucasian). Education ranged from 12 to 16 years ($M = 13$ years). The older adult group ranged from 60 to 95 years of age ($n = 82$; M age = 68; 61% female; 90% Caucasian). Education ranged from 8 to 26 years ($M = 14$ years).

Measures

Beck Scale for Suicide Ideation (BSS)

BSS (Beck, Steer, & Ranieri, 1988) is a 21-item self-report inventory that measures suicidal ideation. Respondents read 21 groups of statements and circle one out of three of the statements in each group that best describes how they have been feeling for the past week. The first 19 items are used to assess for suicidal ideation on a 3-point scale. The final two items are used to differentiate suicide attempters from

non-attempters and are not included in the score. Therefore, the total BSS score can range from 0 to 38 points. Endorsement of a 1 or 2 on any BSS item may reflect the presence of suicide intention. There are no clinical cutoffs. Factor analysis has yielded three distinct subscales: Active Suicidal Desire, Preparation, and Wish for Death (Steer, Rissmiller, Ranieri, & Beck, 1993). The BSS has strong reliability and validity (Beck et al., 1988; Steer et al., 1993).

Reasons for Living Inventory (RFL)

RFL (Linehan, Goodstein, Nielsen, & Chiles, 1983) is a 48-item self-report measure that assesses a range of beliefs and expectancies thought to be important in differentiating suicidal from non-suicidal individuals. Items assess potential reasons for *not* committing suicide should the thought occur. The RFL is based on a cognitive behavioral view of suicidal behavior which posits that cognitive patterns, whether they are beliefs, expectations, or capabilities, are significant mediators of suicidal behaviors (Linehan et al., 1983). A compelling advantage of the RFL is its positive wording. According to Range and Knott (1997), simply completing it may have a suicide-preventive impact. Respondents answer using a 6-point Likert scale, ranging from (1) *extremely unimportant* to (6) *extremely important*. Factor analysis has yielded six distinct subscales: Survival and Coping Beliefs, Responsibility to Family, Child Concerns, Fear of Suicide, Fear of Social Disapproval, and Moral Objections (Linehan et al., 1983; Osman et al., 1993). The number of items for each scale ranges from 3 to 24. Subscale and total scores are divided by the number of items, therefore scores range from 1 to 6. Ample evidence exists supporting validity of the RFL (Linehan et al., 1983; Osman et al., 1993).

Results

Both groups showed some evidence of suicidal thinking. For the younger group, scores on the BSS ranged from 0–24, and 63% indicated some suicidal thinking, as defined by a non-zero score (Beck et al., 1988). For the older group, scores ranged from 0–15, and 61% showed some suicidal thinking. Further, 11% of the younger persons and 5% of the older persons reported a moderate to strong desire to kill themselves (BSS item # 4), but these differences were not significant ($\chi^2(1, N = 163) = 2.16, p = .14$).

TABLE 1 Comparison between younger ($n = 82$) and older ($n = 82$) adults on the Beck Scale for Suicide Ideation

BSS	Older	Younger	<i>t</i> -value	<i>df</i>	<i>p</i>	Cohen's <i>d</i>
	<i>M</i> (<i>SD</i>)	<i>M</i> (<i>SD</i>)				
Active Suicidal Desire	.13 (.47)	.29 (.94)	1.37	118.70	.172	.22
Wish for Death	.44 (1.03)	.83 (1.54)	1.91	141.61	.058	.30
Preparation	.99 (1.58)	1.34 (2.10)	1.20	156	.231	.19
Total BSS Score	2.43 (3.20)	3.63 (4.94)	1.86	138.78	.066	.29

Note. Bonferroni adjusted $p = .013$.

Next, age differences were examined for the BSS total score of suicidal ideation and three subscales. Four independent *t* tests were performed. A Bonferroni adjustment, by dividing alpha (.05) by 4, was used to control for family-wise error rate. No significant differences were found between the two groups (see Table 1). Due to non-normal distributions, non-parametric tests (Mann-Whitney U) were also conducted and the same pattern of results was found. Effect sizes (Cohen's *d*) were small (range = .19 to .30). Therefore, age had little impact on the types and levels of suicidal ideation.

Finally, age differences were examined using the RFL (Linehan et al., 1983). Six independent *t* tests were performed with the Bonferroni adjustment ($p = .008$). The analysis revealed two significant group differences: older adults scored higher than younger adults on the Moral Objections subscale and the Child-Related Concerns subscale (see Table 2), and both had moderate effect sizes (.43, .49, respectively).

TABLE 2 Comparison between younger ($n = 82$) and older ($n = 82$) adults on the Reasons for Living Inventory

RFL	Older	Younger	<i>t</i> -value	<i>df</i>	<i>p</i>	Cohen's <i>d</i>
	<i>M</i> (<i>SD</i>)	<i>M</i> (<i>SD</i>)				
Survival and Coping Beliefs	4.98 (.97)	4.76 (.80)	1.52	159	.129	.25
Child-Related Concerns	4.95 (1.27)	4.19 (1.79)	3.07	140.4	.003*	.49
Responsibility to Family	4.94 (1.04)	4.53 (1.20)	2.33	159	.021	.37
Moral Objections	4.26 (1.40)	3.63 (1.54)	2.70	159	.008*	.43
Fear of Social Disapproval	3.14 (1.55)	3.11 (1.37)	.15	158	.878	.02
Fear of Suicide	2.58 (1.24)	2.81 (1.18)	1.19	159	.234	.19

Note. Bonferroni adjusted $p = .008$. *significant at adjusted level.

Discussion

The purpose of the current study was to identify age-related differences in suicidal ideation and reasons for living. Results from our study provide mixed evidence for the existence of such differences. Our findings indicate that older adults do not necessarily manifest suicidal ideation differently than younger individuals. However, there does appear to be some age-related differences in reasons for not committing suicide should the thought arise, with older adults higher on two RFL subscales. Notably, the mean scores on the RFL subscales in our study were similar to means from another sample of older persons ($N = 78$) recruited from churches, retirement groups, and relatives of students (Range & Stringer, 1996). Interestingly, Range and Stringer also reported that dispositional coping was related to reasons for living among older persons, and that women were higher than men in total reasons for living but not in coping. Age differences were not examined in their study, so direct comparisons cannot be made regarding age effects.

The fact that there were no differences on suicidal ideation among younger and older adults raises some interesting questions. Perhaps younger adults do indeed think about suicide at the same level as older adults, despite the higher suicide completion rate among older adults. Alternatively, perhaps older adults do indeed think about suicide more than younger adults, but are less inclined to communicate their suicidal ideation and intentions. This second possibility raises the issue of a potential cohort effect. According to Lesnoff-Caravaglia (1987), the elderly are often more resistant than younger age groups to admit the need for any psychological help and tend to be more reluctant to communicate their intent to commit suicide. Despite the fact that the suicide completion rate of the elderly is 50% higher than the population as a whole (McIntosh et al., 1994), age apparently did not have a strong influence on the type or level of suicidal ideation reported. Perhaps older adults are indeed less inclined to reveal their suicidal intentions, but more inclined than younger age groups to actually commit suicide when suicidal thoughts do arise. This makes the assessment of suicidal intentions among older clients an important but potentially difficult task. Indeed, a full evaluation of suicidal risk has been strongly recommended as part of any standard testing battery or assessment session with older clients (Segal, Coolidge, & Hersen, 1998).

The older group reported Moral Objections as a stronger reason for not committing suicide than the younger group. Because the strengthening of religious beliefs is a common coping strategy used by many elderly people, and because older persons' religious values often prohibit suicide (Koenig, George, & Siegler, 1988), it is understandable that they would report moral objections to be a compelling reason not to commit suicide. Our results also showed that Child-Related Concerns was a stronger reason for living for the older group compared to the younger group. The fact that only 13% of the younger participants reported having children, whereas 90% of the older participants reported having children may partially explain this finding. Because older adults likely have raised, cared for, and nurtured their children for more years than younger adults, the longer and stronger attachment to their children among older persons is likely to be a compelling reason not to end their lives.

A strength of the present study was that we assessed several dimensions of suicidal ideation including active suicidal desire (frequent, persistent, and compelling thoughts about killing oneself), preparation (behaviors that range from deciding upon a method for actually committing suicide to specifying what arrangements will be made after one is dead), and wish for death (passively longing for death). We also examined potential reasons for refraining from committing suicide should the thought occur (e.g., survival and coping beliefs). In this particular examination, adaptive life-sustaining characteristics that might be lacking in suicidal individuals were identified, rather than maladaptive characteristics that might be present. We also examined negative expectancies held by individuals about what may transpire as a result of suicide (e.g., fear of social disapproval). Despite some positives to our study, several limitations should be noted. First and foremost, the study employed a non-clinical population, which limits potential generalizability to actual suicidal people. There was, however, evidence of some suicidal ideation in both age groups. Levels of suicidal ideation and reasons for living were also measured exclusively by self-report, which is inherently biased. This bias is likely to exist particularly for ratings of suicidal ideation. Mental health problems carry such a negative stigma that many people are unwilling to admit they have experienced suicidal thoughts. Therefore, social desirability and reactivity to the measures may have influenced our findings. Finally, the sample sizes were modest and there was little ethnic diversity, thus limiting generalizability of the results.

Despite limitations of the present study, our findings point to the need for further research on age-related differences in suicidal thinking, especially with clinical samples (e.g., psychiatric inpatients or outpatients) in order to assess generalizability of our findings. Replication with larger and more diverse samples is also recommended. It is likely that more accurate and thorough information would be gathered if structured interviews were employed in prospective studies. Investigators might also extend the study to other age groups such as middle-aged adults, and distinguish between the “young-old” (aged 65–84) and the “old-old” (aged 85 and over). Gender should also be examined to replicate potentially important differences among men and women regarding reasons for living (Range & Stringer, 1996).

Our findings point to the value of identifying age-related differences in reasons for not committing suicide. Rather than merely trying to identify why it is that individuals commit suicide, as some past research has attempted, identifying the reasons that deter individuals from committing suicide may be clinically useful and provide some assistance in suicide prevention efforts. Further exploration is needed to clarify the association between reasons for living and levels of suicidal ideation and attempts. Why is it that older adults report more reasons for living than younger adults, but have a 50% higher suicide rate than the general population? What is really stopping individuals from committing suicide if the thought were to arise? Is it positive life-sustaining characteristics, such as responsibility to family and survival and coping beliefs, or is it fears of suicide, social disapproval, and moral rights and wrongs? Future studies might also add to the burgeoning literature regarding the relationships among suicidal ideation and various forms of psychopathology, including clinical disorders and personality disorders (e.g., Duberstein et al., 2000).

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