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Reasons for Living Across the Lifespan

Lesley P. Koven

Thesis submitted to the
College of Arts and Sciences
at West Virginia University
in partial fulfillment of the requirements
of the degree of

Master of Arts
in
Psychology

Barry Edelstein, Ph.D., Chair
Julie Hicks Patrick, Ph.D.
Stanley Cohen, Ph.D.

Department of Psychology

Morgantown, West Virginia
2001

Keywords: Reasons for Living, Suicide, Age Differences

ABSTRACT

Reasons for Living Across the Lifespan

Lesley P. Koven

This study examined gender and age-related differences in reasons for living, using a sample of 50 young adults ($M = 20.2$), 53 middle-aged adults ($M = 49.3$), and 55 older adults ($M = 78.5$). Participants completed a combined version of the Reasons for Living Inventory, the Reasons for Living Inventory for Younger Adults, and the Reasons for Living Inventory for Older Adults. Although no gender differences emerged in reasons for living, younger adults placed more importance on fear of social disapproval, moral objections, survival and coping skills, peer acceptance, survival and coping beliefs, fear of suicide, and future optimism than did middle-aged adults and more importance on future optimism, survival and coping beliefs, peer acceptance, and future optimism than older adults. Older adults rated fear of social disapproval, moral objections, and peer acceptance as more important than middle-aged adults. Implications of these findings in the areas of suicide prevention, assessment, and treatment are discussed.

Acknowledgements

I would like to thank several individuals and groups who made the completion of this project possible. First and foremost, I would like to extend a heartfelt thank you to my advisor, Barry Edelstein, Ph.D., whose endless input and guidance helped me reach this point. His support and encouragement will always be treasured! Thank you also to the other members of my committee, Stan Cohen, Ph.D. and Julie Hicks Patrick, Ph.D, whose time and effort into this project are deeply appreciated.

I am especially grateful to Amanda Charlton for her enthusiastic support and assistance in carrying out the data collection and data entry phases of this project. Thank you for your diligence and patience!

I would like to thank my parents for their never-ending support and encouragement (not to mention help with data collection). Thank you also to my friends at home and in the department for listening to me in my moments of frustration and anxiety. I am also appreciative of all of the individuals who used their connections to help me recruit participants.

This research was partially funded by the Department of Psychology Alumni Fund at West Virginia University. I am grateful to the benefactors who provided these funds and the individuals who put forth efforts to procure these funds.

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Reasons for Living Across the Lifespan

The frequency of suicidal behavior in the United States suggests that it is a phenomenon that continues to require attention. In 1997, suicide was the 8th leading cause of death in the United States; this translates to over 30,500 suicides a year (National Institute of Mental Health [NIMH], 1999). In contrast, it is estimated that approximately eight to 25 times this number, or from 240,000 to 750,000 persons, attempt suicide each year (NIMH). Suicide rates are especially high among older adults (age 65 and older). Older adults account for 20% of suicide deaths, but only 13% of the U.S. population (National Center for Injury Prevention and Control, 2000). Suicide rates tend to rise with age and are highest among white men age 65 and older. In fact, in 1997, the suicide rate for men over age 85 was over six times the rate of persons age 15-19 (65 per 100,000 compared to 9.5 per 100,000, NIMH). Among young people 20 to 24 years of age, the suicide rate in 1997 was 13.6 per 100,000. In all age groups, males commit suicide significantly more frequently than females, however, females and youth attempt suicide more frequently than males and older adults (NIMH).

Despite these statistics, suicide continues to have a very low base rate in the U.S.A., with an annual incidence of 10.6 suicides for every 100,000 persons, or .01% (NIMH, 1999). This low base rate hinders the development of accurate clinical instruments to identify individuals at risk of committing suicide (Jacobs, Brewer, & Klein-Benheim, 1999). Currently there is no psychological test, clinical technique, or biological marker with sufficient sensitivity or specificity to accurately predict the short-term risk of suicide in an individual (Jacobs et al.) Efforts to increase the sensitivity of suicide assessment measures tend to result in more false positives, that is, they identify individuals as at risk for suicide but who do not attempt suicide in the near future. In contrast, efforts to improve the specificity of risk-prediction measures tend to result in more false negatives, or the overlooking of some individuals who are actually at risk, which is clearly more hazardous than increased levels of false positives (Jacobs et al.). In fact, even if one uses an imaginary instrument with an idealistically low false-positive and false-negative rate of 1 percent, only 20 percent of the suicide predictions would be accurate (Jacobs et al.).

Despite the difficulties in assessing suicide risk, research in the area continues to flourish. In the past, the majority of research in the field of suicide assessment focused on the identification of characteristics of suicidal individuals to enhance prediction of suicidal behavior. Most of this research was directed at identifying maladaptive attributes of suicidal individuals, such as feelings of hopelessness or low self-worth and desires for revenge or escape of psychological pain (Linehan, Goodstein, Nielsen, & Chiles, 1983). Similarly, the most commonly used suicidal ideation instruments typically assessed suicidality, by measuring maladaptive levels of pessimism and hopelessness (e.g. the Hopelessness Scale; Beck, Weissman, Lester, & Trexler, 1974, the Suicide Probability Scale; Cull & Gill, 1982)

Linehan et al. (1983) argued that too little attention had been given to the question of whether suicidal individuals lack vital adaptive characteristics that may be characteristic of nonsuicidal individuals. They hypothesized that one of the factors distinguishing suicidal from nonsuicidal individuals is the content of their belief systems. Linehan et al. argued that nonsuicidal individuals hold a set of adaptive beliefs and expectancies not shared by individuals

who consider suicide or actually engage in suicidal behavior. To test this theory, Linehan et al. (1983) developed the Reasons for Living Inventory (RFL), an instrument measuring the degree of importance ascribed to a range of reasons for staying alive if suicide was contemplated. To develop the scale, they asked a group of diverse adults to list “(a) their reasons for not killing themselves at the point in their lives when they had most seriously considered killing themselves; (b) reasons why they would not now kill themselves; and (c) the reasons they believed kept other people from killing themselves” (Linehan et al., 1983, p. 277). Through content and factor analyses, the list of original items was reduced to 48 statements. Each item requires a rating of how important it would be for living if suicide was contemplated. Factor analyses indicated six categories of reasons for living: Survival and Coping Beliefs, Responsibility to Family, Child-Related Concerns, Fear of Suicide, Fear of Social Disapproval, and Moral Objections.

Linehan et al. (1983) found that the RFL differentiated suicidal from nonsuicidal individuals in a population of Seattle shoppers and psychiatric inpatients. Individuals who reported prior suicidal behavior reported fewer reasons for living than did individuals with no such suicidal history and valued these reasons to a smaller degree, $F(18, 532.2) = 3.76, p < .001$. Thus, these results strongly supported their theory. More recent research on the validity of the RFL (e.g. Cole, 1989; Osman et al., 1993; Osman et al., 1999) has offered further support for Linehan et al.’s theory. In diverse populations such as psychiatric inpatients, college students, and adolescent delinquents, the RFL consistently differentiates between suicidal and nonsuicidal individuals.

Additional research has been conducted with the RFL to determine what variables might influence one’s reasons for living. For example, several studies have indicated that mood can affect one’s reasons for living. For example, Ellis and Range (1989) found that, when individuals underwent a depression mood induction, they endorsed fewer survival and coping beliefs on the RFL. Further, when individuals underwent an elating mood induction by remembering elating childhood events, their beliefs about responsibility to their families were strengthened. Turzo and Range (1991) found similar results in that, compared to college students who did not undergo a mood induction procedure, students who underwent a depression mood induction reported more overall reasons for living, greater feelings of responsibility to family, and more moral objections to suicide. In contrast, elated students reported only more feelings of responsibility to family.

Linehan et al.’s (1983) RFL measure has been adapted to assess virtually every age group at risk of committing suicide. For example, using a similar methodology as Linehan et al., Osman and his colleagues developed the Reasons for Living Inventory for Adolescents (RFL-A; Osman et al., 1998) and the Reasons for Living Inventory for Young Adults (RFL-YA; Gutierrez et al., in press). Osman et al. found that the RFL-A differentiated between psychiatric inpatient suicidal, psychiatric inpatient nonsuicidal, and nonsuicidal high school students, and, nonsuicidal adolescents, $F(10, 408) = 16.31, p < .001$. Similarly, Gutierrez et al. found that the RFL-YA demonstrated good concurrent, convergent-discriminant, and predictive validity. Additional research by Westefeld, Cardin, and Deaton (1992) led to the development of the College Student Reasons for Living Inventory (CSRLI), which also was found to predict level of suicide risk among college students. Finally, Edelstein, McKee, and Martin (2000) developed the Reasons for Living Inventory for Older Adults (RFL-OA), which was found to have good internal consistency, but has not yet been validated.

The various adaptations of the RFL measure were all developed, in part, by questioning a relevant sample of individuals (those of the ages that the measure was being designed for) about their own reasons for living. In examining these instruments, it is apparent that each measure contains a different set of reasons for living statements. Although there are some similarities among measures, it is apparent upon visual inspection of the measures that different reasons for living are more salient at different ages. For example, each measure contains items related to coping beliefs and future optimism. However, the RFL and the RFL-OA have many items related to responsibilities to family and religious objections, whereas the RFL-YA has no such items. In contrast, the RFL-YA has numerous items related to peer acceptance and support whereas the RFL and RFL-OA have no such items.

To date, no research has empirically studied the differences in reasons for living that are apparent across the lifespan. However, these age differences apparent on the various RFL measures raise interesting developmental questions regarding why reasons for living are different at different points in the lifespan. There are a variety of potential explanations for the age-related differences in reasons for living that are apparent in the various adaptations of the RFL. Several life-span theories, specifically Erikson's (1966) theory of psychosocial development, Havighurst's (1972) developmental task theory, and Carstensen's (e.g. 1991, 1992, 1995) socioemotional selectivity theory, offer potential explanations for the differences in reasons for living that emerge at different ages. These three theories were selected because they are among the most well-accepted and empirically supported theories in the life-span literature that offer potential explanations for the age-related differences in reasons for living. Each of these theories suggests that there are certain tasks, values, and goals that serve to guide one's behaviors and activities at different ages. It is reasonable to assume that these developmental guides are drawn upon when one's reasons for living are challenged, that is, situations in which suicide might be considered.

The theoretical model of life-span development presented by Erikson (1966) offers one basis for explaining the differences in reasons for living that are apparent at different ages. Erikson's theory divides human development into eight stages. He proposed that people encounter a series of eight crises in their social relations with other people. The way that these conflicts are resolved determines the nature of development. If the conflict is resolved positively, the outcome is positive and healthy; if it is not resolved or is resolved negatively, the outcome is unhealthy and impairs development.

Erikson's final three psychosocial stages require resolution of different conflicts that may be related to reasons for living. The essential crisis for young adults is to resolve the conflict between intimacy and isolation – to develop the capacity to make full emotional, moral, and sexual commitments to other people. Young adults desire to incorporate other people into their identity and commit themselves to affiliations and partnerships with others, even if this necessitates sacrifices and compromises. Erikson argues that a failure to achieve this task will result in isolation and unhappiness. In midlife, adults face the conflict between generativity and stagnation. Individuals in their 30s and 40s move beyond a focus on themselves and their partners to broaden commitments to family, work, society, and future generations. Erikson theorizes that a failure to achieve this consideration for the future will result in selfishness and stagnation. Finally, in Erikson's last stage of late adulthood, older adults face the conflict of ego-

integrity and despair, which involves looking back on one's life without regrets and enjoying a sense of wholeness.

Munley (1975) offers empirical support for Erikson's (1966) psychosocial stage theory. Munley explored the relationship between psychosocial development, as described by Erikson, and vocational choice behavior and development. College students' resolution of Erikson's first six stages was explored as a variable influencing problems in vocational choice and vocational maturity. Munley found that students who had made adjusted vocational choices and developed mature career attitudes had also been successful in positively resolving the first six psychosocial stages.

Ryff and Migdal (1984) provided an empirical investigation of Erikson's theory for women, particularly the parts related to the transition from young adulthood's focus on intimacy to the concern for generativity in middle age. Besides comparing the responses of young adult and middle-aged women on the various measures of identity development, they also asked young adult women to indicate how they thought they would feel when they reached middle age. Similarly, they asked middle-aged women to recall their young adult years and complete the questionnaires in terms of their remembered feelings. As Erikson's theory would predict, intimacy was more important to young adult women than to middle-age women. Young women also anticipated that intimacy would be less important to them in middle age, while middle-aged women recalled that intimacy had been more important to them in young adulthood. In addition, generativity was more salient in the present than it was during young adult years for middle-aged women. However, the young adult women showed the reverse pattern: they saw generativity as being more salient at their current age than what they predicted during middle age. Thus, these findings support Erikson's theory of intimacy and provide partial support for his theory of generativity in women.

Gold and Rogers (1995) found support for Erikson's theory of intimacy and isolation in entry-level counseling students. Hamachek (1990) operationalized the successful completion of the intimacy stage as requiring a sense of sacrifice and compromise on the part of the individual to transcend conflicts arising between individuals as a result of differences in values, roles, and experiences. This operationalization of the resolution of the intimacy stage is seen as consistent with definitions of empathic understanding and reflection, which have been identified as critical to successful counseling outcomes (Gold & Rogers). In fact, Gold and Rogers found a positive relationship between intimacy/isolation stage resolution and scores on the Hogan Empathy Scale, indicating that unresolved personal issues around intimacy may interfere with counselor trainee empathy.

Goebel and Boeck (1987) tested the hypothesis implicit in Erikson's theory, that ego integrity and fear of death are inversely related in older adults. Erikson postulated that, as a consequence of successful resolution of the ego integrity crisis, death loses its sting. Goebel and Boeck assessed level of resolution of the integrity versus despair crisis and fear of death in 51 older adults. As predicted, results supported Erikson's theory: older adults with higher ego integrity scores tended to report lower levels of fear of death than did older adults with low ego integrity scores.

Following Erikson's work on psychosocial stages, Havighurst (1972) developed a theory of lifespan developmental tasks, which also offers a potential explanation for the differences in reasons for living that are apparent across the lifespan. Havighurst defines a developmental task as:

a task which arises at or about a certain period in the life of the individual, successful achievement of which leads to his happiness and to success with later tasks, while failure leads to unhappiness in the individual, disapproval by the society, and difficulty with later tasks (p. 2).

Havighurst argues that some tasks, such as learning to behave acceptably with the opposite sex, arise primarily from physical maturation, whereas others, such as learning to participate as a socially responsible citizen, arise from the cultural pressure of society. Further, Havighurst states that some tasks emerge from the personal values and aspirations of the individual, such as choosing and preparing for an occupation and determining personal values and life philosophies. The social and biological components of Havighurst's theory distinguish it from Erikson's primarily psychosocially based developmental theory (Havighurst, 1972).

Havighurst (1972) argues that early adulthood, the period from eighteen to thirty, is the most individualistic period of life and the loneliest, in that individuals must tackle the most essential tasks of life with only minimum amounts of social attention and assistance. Havighurst argues that selecting a marriage partner, starting a family, rearing children, managing a home, starting an occupation, taking on civic responsibility, and forming new friendships are the developmental tasks of early adulthood.

The developmental tasks of middle age, from about age thirty to sixty, emerge from biological changes within the individual, from environmental pressures, and from demands or obligations resulting from the individual's values and aspirations. Havighurst (1972) argues that a primary developmental task of middle age is assisting adolescent children to become responsible and happy adults. Parents should provide a worthy pattern of behavior for the adolescent to follow, and provide their children with the freedom and guidance they need. Middle-aged adults should assume greater civic and social responsibility and attain optimal performance in their chosen career. Havighurst also acknowledges that the career task, for many people, involves achieving a flexible work role that is interesting, productive, and financially adequate. The final developmental tasks of middle age involve developing leisure-time activities, accepting and adjusting to the physiological changes of aging, and adjusting to aging parents.

Havighurst (1972) states that the developmental tasks of later maturity involve disengagement from many of the more active roles of middle age, and offer the opportunity for the individual to engage or to re-engage in other roles. The first three tasks involve adjusting to a form of loss, including decreasing physical strength and health, retirement, and the death of a spouse. Other developmental tasks of older adulthood include establishing an affiliation with, and becoming a constructive participant of, one's age group and adapting to new social roles. Havighurst argues that many older adults choose to develop and expand their family roles, develop new hobbies or leisure activities, or expand their community involvement. The final task that Havighurst argues as important for older adulthood is the establishment of comfortable and convenient living arrangements.

Merriam and Hyer (1984) examined the importance that women of varying ages place upon the marriage and family-related tasks that Havighurst theorized as important in young adulthood. The authors predicted age differences in the rated importance of these tasks, reflecting changing attitudes toward the traditional female role. As predicted, the importance of accomplishing various family-related tasks during young adulthood varied significantly by age group. Older women judged marriage, starting and raising a family, and managing a home as very important developmental tasks for young women to accomplish. Women in the middle age group judged these tasks as important, but less so than the older group. Younger women, however, assigned even less importance to traditional tasks than did either of the older groups. These findings suggest that, whereas Havighurst's developmental tasks of young adulthood continue to be important to women, the necessity of accomplishing these tasks during early adulthood is less pressing than what he originally theorized.

Socioemotional selectivity theory (Carstensen, 1991, 1992, 1995; Carstensen, Isaacowitz, & Charles, 1999), a life-span theory of social motivation, offers an alternate basis for different age-related reasons individuals choose for staying alive. According to socioemotional selectivity theory, time plays a vital role in the prioritization of social goals and selection of social partners. Age-related patterns in social motivation emerge because chronological age is negatively associated with amount of time left in life. However, these age patterns vary when individuals assume a time perspective different than which is predicted by their location in the life cycle (e.g. Carstensen & Fredrickson, 1998).

According to socioemotional selectivity theory, all social goals fall into two categories: those related to the achievement of knowledge, and those related to the regulation of emotion. Knowledge-related goals include behaviors geared toward learning about the social and physical world, whereas emotion motives involve attempts to avoid negative states, experience positive ones, find meaning in life, gain emotional intimacy, and establish feelings of social embeddedness.

Socioemotional selectivity theory posits that the assessment of remaining time plays a central role in selecting and performing behaviors geared toward accomplishing specific goals. Individuals with an expansive future tend to select behaviors aimed at the pursuit of knowledge-related goals. When knowledge-related goals compete with goals involving the regulation of emotion, future-oriented goals will be prioritized, even if they necessitate the delay of emotional rewards or emotional costs. However, when time is perceived as limited, a more present-oriented state is assumed. A present orientation involves the pursuit of emotional satisfaction and emotional meaning. Individuals focus their attention on experiences occurring in the moment, with less concern about the future. This often involves a high selectivity in choice of social partners in which individuals tend to prefer familiar social partners whose emotions are predictable and positive.

Age-related differences in the anticipated length of the future lead to developmental trends in the rated importance of knowledge-related and emotional goals. Knowledge strivings tend to be important from late adolescence to middle adulthood whereas goals related to acquiring positive emotions are more likely to be pursued later in life because they are experienced in the here and now.

Empirical research conducted by Carstensen and her colleagues provides extensive support for socioemotional selectivity theory. Older people, in comparison with younger people, were found to have smaller social networks that contain more emotionally close social partners (Lang, Staudinger, & Carstensen, 1998; Lang & Carstensen, 1994). Further, when directly asked about their preferences for social contacts, younger people preferred a wide range of familiar and unfamiliar partners, whereas older people preferred only familiar social partners (Frederickson & Carstensen, 1990). However, when younger people were asked to choose social partners under experimental conditions that limited time (e.g. when asked to imagine an impending geographical move), younger people also displayed this bias for familiar partners. Similarly, the familiarity bias in older adults disappeared under experimental conditions that expanded their time to live (e.g. when they were asked to imagine a medical breakthrough that would increase their longevity; as cited in Carstensen, Isaacowitz, & Charles, 1999). Older adults were found to remember emotionally laden material better than neutral material, suggesting that emotional material is processed more deeply (Carstensen & Turk-Charles, 1994). Finally, results from two studies indicated that increasing closeness to the end of life was also associated with increasing prominence of affect in the mental representations of social partners, both in older adults and in young men facing premature death from AIDS (Carstensen & Fredrickson, 1998).

Statement of the Problem

Research in the area of suicide assessment continues to require attention, as no measure or technique has been developed that can accurately predict short-term risk of suicide in an individual (Jacobs, Brewer, & Klein-Benheim, 1999). In the past, most suicide assessment research focused on the development of measures that evaluated individuals' level of suicidality (e.g. levels of pessimism or hopelessness). However, following Linehan et al.'s (1983) original work on the RFL Inventory, research has included the development of measures that assess individuals' adaptive beliefs and expectancies, in the form of reasons for living. A variety of Reasons for Living instruments have been developed, with foci ranging from adolescents to older adults. Upon examination of these various RFL instruments, it is apparent that each contains a somewhat different set of items, indicating that different reasons for living may be more salient at different ages. However, no research has empirically studied trends in reasons for living across the lifespan. That is, it remains unclear how types of reasons are different at different points in the lifespan and why certain types of reasons are particularly important for certain age groups. Further, it is unknown whether there are age-related differences in the number of reasons for living that individuals have, which individual reasons for living are the most important to each age group, and whether there are gender differences in reasons for living.

An understanding of the types of reasons for living that individuals of different ages value and why certain reasons are important for particular ages can greatly aid in assessing and treating suicidal ideation. For example, extensive research has examined factors that put individuals at risk for suicide (e.g. gender, age, psychiatric disorders, physical illness, economic status, education, etc.) in an attempt to aid clinicians in assessing and treating their clients. Along a similar vein, it is likely that knowledge of the reasons that individuals of different ages value for staying alive could also be helpful to clinicians dealing with suicidal or potentially suicidal clients. Specifically, clinicians may use information about age-related differences in reasons for living as a reference point for treatment options. For example, if middle-aged adults are found, in

general, to value items related to future optimism, clinicians may work to strengthen and reinforce middle-aged clients' future plans and goals. Finally, knowledge regarding age-related differences in reasons for living may assist in further development and refinement of RFL instruments.

The two primary purposes of the current study were to determine whether there are significant age and gender differences in the types of reasons for living that young, middle-aged, and older adults have and to determine which reasons are important to individuals of different ages. Erikson's (1966) theory of psychosocial development, Havighurst's (1972) developmental task theory, and Carstensen's (e.g. 1991, 1992, 1995) socioemotional selectivity theory offer bases upon which to form predictions about age-related differences in reasons for living.

Specifically, Erikson's (1966) theory would predict that young adults, in the intimacy versus isolation stage of psychosocial development, would tend to endorse reasons for living related to peer acceptance and support, and fear of social disapproval associated with suicide. Middle-aged adults, in contrast, who are in the generativity versus stagnation stage of development, would likely place importance on family-related reasons for living, including child-related responsibilities, as well as reasons related to optimism for the future. Finally, Erikson's theory would predict that older adults, in the ego integrity versus despair stage, would likely value reasons for living related to self-acceptance and adaptive coping beliefs.

Havighurst (1972) argues that the developmental tasks of both young adulthood and middle age relate to relationships with peers, marriage, family, and careers. Whereas in early adulthood these areas need to be established, in middle adulthood, they are molded and perfected. Therefore, according to Havighurst's theory, both of these age groups should place importance on reasons for living related to family, peer acceptance and support, and future optimism (e.g. optimistic career plans for the future). Havighurst argues that older adults place importance on establishing an affiliation with one's age group and developing and expanding family roles. Therefore, older adults also should value reasons for living related to peers and family.

Carstensen's (e.g. 1991, 1992, 1995) socioemotional selectivity theory states that young adults, who perceive themselves as having an expansive future, tend to value knowledge-related goals. However, older adults, who have a more present orientation, tend to pursue emotional satisfaction and emotional meaning. Thus, according to socioemotional selectivity theory, younger adults should endorse reasons for living related to optimism for the future, whereas older adults should endorse reasons for living related to peers and family alliance.

Erikson's (1966), Havighurst's (1972), and Carstensen's (e.g. 1991, 1992, 1995) theories all have extensive empirical support, however none of them has specifically addressed issues pertaining to reasons for living. Moreover, the predictions based upon these theories regarding the differences in reasons for living between age groups tend to be contradictory. Thus, there were no bases for presuming that any one of these theories would be supported in this context. Therefore, no specific hypotheses were tested regarding which reasons for living would be important to the different age groups.

Method

Participants

Participants consisted of 50 young adults (20 males, 30 females) between the ages of 19 and 25 ($M = 20.2$), 53 middle-aged adults (21 males, 32 females) between the ages of 39 and 58 ($M = 49.3$), and 55 older adults (25 males, 29 females, 1 unreported) between the ages of 69 and 88 ($M = 78.5$). No exclusion criteria were used. Demographic information and F values comparing the three age groups are summarized in Table 1. The young adults were recruited from undergraduate psychology courses at West Virginia University and were given course credit for participating. The middle-aged and older adults were recruited from various locations in the community, such as churches/synagogues, senior centers, university departments, and personal contacts. Sixty percent of the middle-aged adults and 11% of the older adults were recruited from a large mid-western Canadian city. A random drawing was held at the end of the study in which one middle-aged and one older adult each received a prize of \$50.

Measures

Items from the following RFL instruments were combined to form one large, multi-population version of the RFL that all participants completed. See the Procedure section for the method of combining measures.

The Reasons for Living (RFL) Inventory. Linehan et al.'s (1983) RFL Inventory is a 48-item self-report instrument in which participants are asked to rate "the importance to you of each for not killing yourself" on a 6-point scale from "Not at all important" to "Extremely important." Based on Linehan et al.'s (1983) factor analysis, the RFL Inventory has the following six subscales: (a) Survival and Coping Beliefs (e.g., "I believe I can find other solutions to my problems" and "I have the courage to face life"); (b) Responsibility to Family (e.g., "My family depends on me and needs me"); (c) Child-Related Concerns (e.g., "The effect on my children would be harmful"); (d) Fear of Suicide (e.g., "I am afraid of the 'act' of killing myself [the pain, the blood and violence]"); (e) Fear of Social Disapproval (e.g., "Other people would think I am weak and selfish"); (f) Moral Objections related to suicide (e.g., "My religious beliefs forbid it"). In addition to the 48 items of the RFL, 24 additional items, which had been removed from the RFL following a factor analysis during its development, were included in the current study to maximize content validity.

Several studies (e.g. Cole, 1989; Linehan et al., 1983; Osman et al., 1993; Osman et al., 1999) have demonstrated the discriminant validity of the RFL Inventory, in that it has consistently been found to differentiate between suicidal and nonsuicidal individuals in diverse populations (e.g. psychiatric inpatients, college students, delinquent adolescents, etc.). The RFL has also been found to have good internal consistency (Cronbach alpha = .93), concurrent validity, and predictive validity (Osman et al., 1999).

The Reasons for Living Inventory for Young Adults. The RFL-YA (Gutierrez et al., in press) is a 32-item measure adapted from Linehan et al.'s (1983) original RFL. Whereas the instructions, format, and rating scale are the same as the RFL, the item content and subscales are different. The RFL-YA contains five subscales: (a) Family Alliance (e.g., "I have a close relationship with my family"); (b) Coping Beliefs (e.g., "I would rather take responsibility for solving my problem than attempt suicide"); (c) Future Optimism (e.g., "I have many good things

Table 1
Demographic Characteristics, X^2 Values, and F Values for Age Groups

Variable	Young Adults ($n = 50$)	Middle-Aged Adults ($n = 53$)	Older Adults ($n = 55$)	X^2 or F^b
Age	$M=20.2$, $SD=1.4$	$M=49.3$, $SD=4.7$	$M=78.5$, $SD=4.9$	$F = 2673.67^{***}$
Gender	20 males, 30 females	21 males, 32 females	25 males, 29 females, 1 unreported	$X^2 = .61$
Ethnicity	86% C, 6% AA	98% C, 2% AA	96% C, 4% AA	$X^2 = 10.26$
Marital Status	98% S	91% M, 6% D, 2% S	47% M, 36% W, 11% D, 4% S	$X^2 = 182.18^{***}$
Education	$M = 12.72$, $SD = 1.26$	$M = 19.63$, $SD = 16.29$	$M = 17.27$, $SD = 16.46$	*
Work Status	100% student	89% employed, 8% homemaker, 2% retired	87% retired, 4% employed, 7% homemaker	$X^2 = 287.33^{***}$
Health Rating ^a	$M=3.76$, $SD=.82$	$M=4.01$, $SD=.86$	$M=3.04$, $SD=.91$	$F = 18.24^{***}$
Residence	100% U.S.	40% U.S. ($n = 21$), 60% Canada ($n = 32$)	89% U.S. ($n = 49$), 11% Canada ($n = 6$)	$X^2 = 59.32^{***}$
Questionnaire Return Method	98% in person, 2% SE	77% mail, 23% SE	95% mail, 5% SE	$X^2 = 162.89^{***}$

Note: C = Caucasian, AA = African American, S = single, M = married, D = divorced, W = widowed, SE = returned to investigator in a sealed envelope.

^a The 5-point scale used for self-reported health rating was reversed such that 1 = poor and 5 = excellent.

^b X^2 values rather than F values are presented for all demographic variables except age, education, and health status, which were measured as continuous variables.

* $p < .05$. *** $p < .001$.

to look forward to as I grow older”); (d) Peer Acceptance and Support (e.g. “I have close friends who really care a lot about me”); (e) Self-Acceptance (e.g., “I am happy to be the person I am”). In addition to the 32 items of the RFL-YA, 20 additional items, which had been removed from the RFL-YA following a factor analysis during its development, were included in the current study.

In an initial study examining the psychometrics of the RFL-YA, it was found to have excellent internal consistency (subscale alphas ranged from .89 to .94), and good convergent-discriminant, concurrent, and predictive validity (Gutierrez et al., in press). The RFL-YA was selected for the current study rather than the College Students Reasons for Living Inventory (CS-RFL) because the CS-RFL has several items specifically related to college concerns, which make it less appropriate for many middle-aged and older adults.

Reasons for Living Inventory for Older Adults (RFL-OA). The RFL-OA (Edelstein et al., 2000) is a 69-item instrument measuring reasons for living for older adults. The instructions, format, and rating scale of the RFL-OA are the same as the original RFL and the RFL-YA. The RFL-OA is a new measure, and thus little research has been done on its psychometrics or factor structure. In a preliminary study, the RFL-OA was found to have excellent internal consistency (total score alpha = .96).

Profile of Mood States (POMS). The POMS (McNair, Lorr, & Droppleman, 1981) is a widely-used measure of transient mood states. The measure consists of 65 adjectives assessing individuals’ recent mood reactions, including tension/anxiety, depression/dejection, anger/hostility, vigor/activity, fatigue/inertia, and confusion/bewilderment. A Total Mood Disturbance Score (TMDS) can be computed by summing the scores on the six primary subscales of the measure. A five-point scale is used for ratings of mood/feelings for the past week. Gibson (1997) found that the POMS had strong concurrent validity, as it was able to discriminate between healthy adults and patients with known mood disturbance. Further, it had excellent internal consistency (subscale alphas ranged from .82 to .9) and moderate test-retest reliability (subscale coefficients above .75). In a sample of 400 middle-aged adults and 170 older adults, POMS scores correlated highly with scores on other well-established measures of mood and anxiety, such as the STAI, the BDI, and the GDS (Nyenhuis, Yamamoto, Luchetta, Terrien, & Parmentier, 1999).

Because mood (specifically depression and elation) appears to affect reasons for living (Ellis & Range, 1989; Turzo & Range, 1991), in the current study, the POMS was included in order to statistically control for mood when isolating age differences in reasons for living. Although the POMS includes several mood scales in addition to the depression/dejection scale, there is no research to suggest that the other mood states are unrelated to reasons for living. Thus, the entire POMS measure was used in this study as an exploratory measure, and the Total Mood Disturbance Score was statistically controlled for to rule out the potential effect of different mood states on reasons for living.

Demographic variables. Demographic information was collected on age, gender, ethnicity, marital status, living situation, education, health status, and occupation to describe the participants. An additional exploratory question was added to the demographic questionnaire

asking “How many more years do you expect to live?” All responses were based on self-report (see Appendix A for a copy of the demographic questionnaire).

Procedure

The current study took place in two stages. In stage 1, the three RFL measures were combined into one large RFL instrument and q-sorted into subscales that were used for data analyses. In stage 2, data were collected from participants of the three age groups using the combined RFL items.

Stage 1. Five psychology graduate students and one psychology undergraduate student q-sorted all items from the RFL, the RFL-YA, and the RFL-OA into ten subscales. The ten subscales consisted of the six subscales from the RFL and the five subscales from the RFL-YA (one subscale from each were identical), which were determined via factor analysis during their development. Before the q-sort, the examiner removed any identically-worded items from the pool of items so they only appeared once in the q-sort. The sorters were instructed to sort each item into the subscale in which it fit best. Once the items were sorted into the proper categories, the sorters were asked to rate, on a scale from one to five, how well each item represented the subscale in which it was placed. The sorters were also instructed to remove any items that they felt were redundant with other items.

Following the six q-sorts, the examiner removed three items, as all six sorters agreed that they were redundant with other items. Thus, the final version of the combined RFL consisted of 162 items. Further, for each item, the sorters’ ratings were summed for each subscale that it was sorted into. For data analysis purposes, after sums were calculated, items were placed in the subscale in which they received the highest summed score. See Appendix B for a list of items, the subscales to which they were assigned, and the number of sorters (out of 6) who originally sorted items into the subscale that they were ultimately assigned to. Table 2 summarizes the number of items within each subscale with agreement by six, five, four, and three sorters, respectively.

Stage 2. Participants were asked to take part in a study examining reasons for living at different ages. Participants first completed the demographics questionnaire and then the large combined version of the three RFL measures (see Appendix B) and the POMS. The order of presentation of the combined RFL measure and POMS was alternated so that half of the participants completed the RFL measure first and the other half completed the POMS first. In addition, the middle-aged and older adult participants completed a form in which they indicated their phone number or address to allow the researcher to contact the two winners of the \$50 drawing (see Appendix C). Whereas all younger adult participants completed their questionnaires in the presence of the researcher or her assistant, many of the middle-aged and older adult participants mailed back the completed questionnaires because they did not have time to complete them while the researcher was present. Specifically, 77% of the middle-aged and 95% of the older adults returned their questionnaires via mail. Younger adults were tested just after the midterm period of the semester, to decrease the possibility that elevated stress levels would affect their reasons for living.

Table 2
 Number of Sorters Agreeing for Each Subscale^a

Subscale	Total No. Items	Number of Items per Subscale			
		6 sorters	5 sorters	4 sorters	3 sorters
FA	13	12	1	0	0
FS	12	7	2	2	1
SD	6	4	0	2	0
CR	5	2	1	1	1
MO	14	9	2	2	1
SC	55	17	17	9	12
SA	12	7	2	2	1
PA	14	10	1	3	0
FO	20	13	5	0	2
RF	11	5	5	1	0

Note: FA = Family Alliance, FS = Fear of Suicide, SD = Fear of Social Disapproval, CR = Child-Related Concerns, MO = Moral Objections, SC = Survival and Coping Beliefs, SA = Self Acceptance, PA = Peer Acceptance and Support, FO = Future Optimism, RF = Responsibility to Family.

^a Agreement = agreement that the item should be assigned to the subscale that it was ultimately assigned to for data analyses.

Results

Data Reduction and Statistical Analyses

To determine whether there were age and gender differences in the importance of different reasons for living, using the General Linear Model to control for unequal group sizes, a series of 3 (age: young adults vs. middle-aged adults vs. older adults) X 2 (gender: male vs. female) analysis of variance (ANOVA) tests were conducted for all subscales. An alpha rate of .05 was used to evaluate all statistical tests. Significant omnibus effects were followed by univariate Fisher's LSD post-hoc comparisons. Howell (1992) recommends using the LSD procedure in experiments with three means, as the familywise error rate "will stay at alpha, and you will gain the added power of using standard *t* tests" (p. 356).

Age and gender differences in numbers of reasons for living. To determine whether there were age differences in the number of reasons for living endorsed, each item was recoded into a new variable with 0 = not endorsed ("not an important reason at all", "quite an unimportant reason", and "somewhat an unimportant reason") and 1 = endorsed ("somewhat an important reason", "quite an important reason", and "an extremely important reason"). The total number of reasons for living endorsed for each participant within each subscale was summed, and a series of 3 (age: young adults vs. middle-aged adults vs. older adults) X 2 (gender: male vs. female) ANOVAs were conducted for all subscales.

Process for handling missing data. Because several participants had missing data, rather than calculating subscale totals, subscale means were calculated for the RFL and POMS. For each participant, if a subscale had at least 75% of its data intact, then the mean for that subscale was used for data analyses. However, if a participant had more than 25% missing data in a subscale, then that subscale mean was deleted and replaced with the "series mean" using the "replace missing values" procedure in SPSS Version 9.0 for Windows (SPSS, Inc., 1998).

Control of potential confounding variables. Current mood state (specifically depression and elation) has been found to influence reasons for living (Ellis & Range, 1989; Turzo & Range, 1991). Further, significant age differences were found on the five of the six subscales and the Total Mood Disturbance Score (TMDS) of the POMS (see discussion of POMS results below). Thus, if the original age X gender ANOVA was significant, an analysis of covariance (ANCOVA) was performed with the same dependent variables, controlling for TMDS on the POMS. If the ANCOVA yielded the same results as the ANOVA, the ANCOVA results are not discussed.

If significant age differences were found on any RFL subscales, follow-up statistical tests were performed to determine if these differences could be explained by the significant differences between the groups in education level or method of returning the questionnaire (see Table 1 for *F* values). Specifically, to rule out the effects of education, an ANCOVA was performed, using number of years of education as the covariate. To rule out the effects of the method of questionnaire return, only individuals who mailed back the questionnaire were compared. Because all of the younger adults completed the questionnaire in the presence of the investigator and none of the middle-aged or older adults did so, there was no way to equate the groups on this variable. Thus, only the middle-aged and older adults were compared with this

follow-up test ($n = 41$ middle-aged adults and 52 older adults). The results of the follow-up statistical tests on education and method of questionnaire return are reported only when they yield different results than the original age X gender ANOVA. Although the age groups differed significantly on other demographic variables, such as marital status, work status, and self-reported health status, these variables were not examined in follow-up statistical tests. Young adults, middle-aged adults, and older adults necessarily differ on these variables by virtue of their chronological age; therefore no attempt was made to eliminate the effects of these variables on reasons for living.

Age Differences in POMS Scores

Significant age differences emerged on five of the six POMS subscales. Means, standard deviations, F , and η^2 values for POMS subscales and TMDS are summarized in Table 3. Specifically, younger adults had higher scores on the tension/anxiety, anger/hostility, fatigue/inertia, and confusion/bewilderment subscales than did middle-aged adults and older adults (all p values $< .05$). Further, younger adults had higher TMDS scores than did middle-aged adults ($p < .01$). Although the groups differed statistically on these subscales, mean values were quite low, suggesting that none of the groups were in the clinically significant range on this measure.

Age and Gender Differences in Importance Ratings by Subscale

Means and standard deviations on the 10 RFL subscales by age group and gender are presented in Table 4. A series of 3 X 2 ANOVAS indicated that there were no interaction effects between age and gender on any of the RFL subscales. Further, there were no main effects for gender on any of the RFL subscales. However, there were significant main effects for age on six of the ten subscales, including Fear of Social Disapproval, Child-Related Concerns, Moral Objections, Survival and Coping Beliefs, Peer Acceptance and Support, and Future Optimism. There were no significant age differences on the Family Alliance, Self-Acceptance, Fear of Suicide, or Responsibility to Family subscales.

Results for each subscale with significant main effects for age will now be discussed. If follow-up tests that were conducted to rule out the effects of the POMS TMDS score, education level, and method of returning questionnaire yielded the same results as the original ANOVA, the results from the follow-up tests are not reported.

Fear of Social Disapproval. Significant age differences existed on the Fear of Social Disapproval subscale [$F(2, 151) = 11.11$, $p < .001$, $\eta^2 = .12$]. Younger adults ($p < .01$) and older adults ($p < .001$) placed more importance on fear of social disapproval than did middle-aged adults.

Child-Related Concerns. There were significant age differences on the Child-Related Concerns subscale [$F(2, 151) = 4.01$, $p < .05$, $\eta^2 = .04$]. Post-hoc tests indicated that younger adults and older adults rated child-related concerns as more important than did middle-aged adults ($p < .05$ for each comparison). When education was entered as a covariate [$F(2, 153) = 2.91$, $p = .06$], no significant age differences emerged.

Table 3
Means, Standard Deviations, F, and η^2 values for POMS Subscales and TMDS

Subscale	Young Adults (A) (n = 50)	Middle-Aged (B) (n = 53)	Older Adults (C) (n = 55)	F Value (df = 2,155)	η^2	Significant Post-Hoc Differences
Tension/Anxiety	1.40 (.86)	.93 (.68)	.97 (.84)	5.64**	.07	A > B, C
Depression/Dejection	.72 (.83)	.40 (.74)	.55 (.76)	2.23	.03	
Anger/Hostility	1.00 (.78)	.43 (.60)	.40 (.56)	13.64***	.15	A > B, C
Vigor/Activity	2.00 (.76)	1.62 (.84)	1.85 (.83)	2.86	.06	
Fatigue/Inertia	1.76 (.89)	1.30 (.93)	1.12 (.90)	6.77**	.08	A > B, C
Confusion/Bewilderment	1.48 (.84)	.70 (.73)	.96 (.72)	14.01***	.15	A > B, C
TMDS	1.38 (.53)	1.11 (.38)	1.21 (.53)	3.94*	.05	A > B

Note. Standard deviations are in parentheses. TMDS = Total Mood Disturbance Score

* $p < .05$. ** $p < .01$. *** $p < .001$.

Table 4
Means and Standard Deviations for RFL Subscales by Age Group

Subscale	Young Adults (A) (<u>n</u> = 50)	Middle-Aged Adults (B) (<u>n</u> = 53)	Older Adults (C) (<u>n</u> = 54)	Significant Post-Hoc Differences
SD	3.18 (1.21)	2.51 (1.01)	3.58 (1.31)	A, C > B
CR	4.76 (1.25)	4.25 (1.14)	4.79 (1.16)	A, C > B ^a
MO	4.18 (1.45)	2.85 (1.58)	4.47 (1.39)	A, C > B
SC	4.54 (.68)	4.06 (.79)	4.52 (.96)	A, C > B
PA	5.00 (.93)	4.13 (.94)	4.77 (.91)	A, C > B
FO	5.02 (.74)	4.53 (.99)	4.71 (.97)	A > B ^b
FA	5.08 (1.10)	4.96 (.99)	5.27 (.91)	
FS	4.22 (.93)	4.13 (.86)	4.30 (1.05)	
SA	4.90 (1.04)	4.75 (1.05)	5.12 (.85)	
RF	4.22 (.93)	4.13 (.86)	4.30 (1.05)	

Note. Standard deviations are in parentheses. FA = Family Alliance, FS = Fear of Suicide, SD = Fear of Social Disapproval, CR = Child-Related Concerns, MO = Moral Objections, SC = Survival and Coping Beliefs, SA = Self Acceptance, PA = Peer Acceptance and Support, FO = Future Optimism, RF = Responsibility to Family.

^a This result was not significant when education was entered as a covariate.

^b This result was not significant when POMS TMDS score was entered as a covariate.

Moral Objections. Significant age differences emerged in the Moral Objections subscale [$F(2,151) = 18.45, p < .001, \eta^2 = .19$]. Specifically, younger adults and older adults both rated moral objections as more important than did middle-aged adults ($p < .001$ for both comparisons).

Survival and Coping Beliefs. Results indicated that there were significant age differences on the Survival and Coping Beliefs subscale [$F(2,151) = 5.85, p < .01, \eta^2 = .07$]. Post-hoc tests revealed that younger adults and older adults rated survival and coping beliefs more highly than did middle-aged adults ($p < .01$ for both comparisons).

Peer Acceptance and Support. Significant age differences emerged in the value placed on peer acceptance and support [$F(2,151) = 12.73, p < .001, \eta^2 = .14$]. Specifically, younger adults and older adults rated peer acceptance and support as more important than did middle-aged adults ($p < .001$ for both comparisons).

Future Optimism. Significant differences between age groups existed on the Future Optimism subscale [$F(2,151) = 3.59, p < .05, \eta^2 = .05$]. Post-hoc tests revealed that younger adults rated future optimism as more important than did the middle-aged adults ($p < .01$). When the POMS TMDS was used as a covariate [$F(2,150) = 6.04, p < .01$], the original difference between the younger adults and middle-aged adults was upheld ($p < .01$), and younger adults were also found to rate future optimism as more important than older adults ($p < .05$).

Age Differences in Numbers of Reasons for Living by Subscale

Means and standard deviations for numbers of reasons for living endorsed as at least “somewhat important” on the 10 RFL subscales by age group and gender are presented in Table 5. A series of 3 X 2 ANOVAS indicated that there were no interaction effects between age and gender for numbers of reasons for living on any of the subscales. Further, there were no main effects for gender on any of the RFL subscales. However, there were significant main effects for age on numbers of reasons for living on seven of the ten subscales, including Fear of Social Disapproval, Moral Objections, Survival and Coping Beliefs, Peer Acceptance and Support, Future Optimism, Responsibility to Family, and Fear of Suicide. There were no significant age differences for numbers of reasons for living on the Family Alliance, Self-Acceptance, or Child-Related Concerns subscales. Results for each subscale with significant main effects for age will now be discussed. If follow-up tests that were conducted to rule out the effects of the POMS TMDS score, education level, and method of returning questionnaire yielded the same results as the original ANOVA, the results from the follow-up tests are not reported.

Fear of Social Disapproval. There were significant age differences in numbers of reasons for living endorsed in the Fear of Social Disapproval subscale [$F(2,151) = 7.15, p < .01, \eta^2 = .09$]. Post-hoc tests revealed that younger adults ($p < .01$) and older adults ($p < .001$) both endorsed more Fear of Social Disapproval items than did middle-aged adults.

Moral Objections. When numbers of reasons for living were compared across age groups on the Moral Objections subscale, significant differences emerged [$F(2,151) = 10.99, p < .001, \eta^2 = .13$]. Specifically, younger adults and older adults both endorsed more moral objections items than did middle-aged adults ($p < .001$ for both comparisons).

Table 5
Means and Standard Deviations for Number of Items Endorsed in RFL Subscales by Age Group

Subscale	Younger Adults (A) (<u>n</u> = 50)	Middle-Aged Adults (B) (<u>n</u> = 53)	Older Adults (C) (<u>n</u> = 54)	Significant Post-Hoc Differences
SD (n=6)	2.42 (1.74)	1.45 (1.48)	2.70 (2.04)	A, C > B
MO (n=14)	10.00 (4.97)	5.62 (4.93)	9.57 (5.36)	A, C > B
SC (n=55)	42.20 (7.24)	36.62 (9.84)	36.80 (16.12)	A > B, C
PA (n=14)	12.48 (2.61)	9.87 (4.14)	10.07 (4.81)	A > B, C
FO (n=20)	17.22 (2.39)	14.28 (4.72)	13.17 (6.47)	A > B, C
RF (n=11)	7.48 (2.05)	6.98 (2.13)	6.02 (3.21)	A > C, B > C ^a
FS (n=12)	4.88 (3.51)	3.09 (2.86)	3.78 (3.81)	A > B
FA (n=13)	11.60 (2.77)	11.21 (2.98)	10.17 (4.55)	
CR (n=5)	4.56 (1.59)	3.75 (1.44)	3.96 (2.17)	
SA (n=12)	10.22 (2.39)	9.83 (3.12)	9.54 (4.08)	

Note. Standard deviations are in parentheses. FA = Family Alliance, FS = Fear of Suicide, SD = Fear of Social Disapproval, CR = Child-Related Concerns, MO = Moral Objections, SC = Survival and Coping Beliefs, SA = Self Acceptance, PA = Peer Acceptance and Support, FO = Future Optimism, RF = Responsibility to Family.

^aThis result was not significant when POMS TMDS score was entered as a covariate.

Survival and Coping Beliefs. Significant differences emerged across age groups in the number of reasons for living endorsed in the Survival and Coping Beliefs subscale [$F(2,151) = 3.13$, $p < .05$, $\eta^2 = .05$]. Post-hoc tests indicated that younger adults endorsed more survival and coping beliefs than did middle-aged adults or older adults ($p < .05$ for both comparisons).

Peer Acceptance and Support. There were significant differences in numbers of reasons for living endorsed in the Peer Acceptance and Support subscale [$F(2,151) = 6.17$, $p < .01$, $\eta^2 = .08$]. Post-hoc tests revealed that younger adults endorsed more peer acceptance and support items than did middle-aged or older adults ($p < .01$ for both comparisons).

Future Optimism. Significant age differences emerged in the numbers of Future Optimism items endorsed [$F(2,151) = 8.33$, $p < .001$, $\eta^2 = .11$]. Specifically, younger adults endorsed significantly more future optimism items than did middle-aged adults ($p < .01$) or older adults ($p < .001$).

Responsibility to Family. There were significant age differences in the numbers of Responsibility to Family items endorsed [$F(2,151) = 3.87$, $p < .05$, $\eta^2 = .06$]. Post-hoc tests revealed that younger adults ($p < .01$) and middle-aged adults ($p < .05$) both endorsed more items related to responsibility to family than did older adults. When the POMS TMDS score was used as a covariate [$F(2,154) = 6.02$, $p < .01$], the difference between the younger adults and older adults remained significant ($p < .001$), however the difference between the middle-aged and older adults was no longer significant. Similarly, when individuals who mailed back their questionnaires were compared, the difference between the middle-aged and older adults was no longer significant.

Fear of Suicide. Significant age differences emerged in the numbers of reasons for living endorsed in the Fear of Suicide subscale [$F(2,151) = 3.17$, $p < .05$, $\eta^2 = .04$]. Post-hoc tests revealed that younger adults endorsed more items related to fear of suicide than did middle-aged adults ($p < .01$).

Top RFL Items by Age Group

To determine which RFL items were most important to each age group, means and standard deviations were calculated for each item. Appendix D lists the mostly highly rated items for each age group by subscale and across the entire measure. The top third of items from each subscale and the top ten items of the overall measure are presented by age group. Although the original plan was to only include items that everyone within the age group endorsed as “somewhat important” or higher, there were only several items across the entire measure that fit this description. Thus, items with the highest means are presented here, whether or not every member of an age group endorsed them as “somewhat important”.

The age groups differed substantially in terms of their most important reasons for living. For example, seven of the top ten reasons for younger adults related to Future Optimism, whereas eight of the top ten reasons for older adults related to Survival and Coping Beliefs. Middle-aged adults’ top ten was comprised of four Survival and Coping beliefs items, four Family Alliance items, and two Child-Related Concerns items. When examining the most highly

rated items within subscales, however, there was a lot of similarity among the age groups. For several of the subscales, the most highly rated items were identical among age groups. Thus, whereas the age groups differed substantially regarding their overall most important reasons for living, there was some agreement between individuals of different ages regarding the most important items within subscales.

Discussion

This study examined gender and age-related differences in types, importance, and numbers of reasons for living. Although no gender differences emerged in importance ratings or numbers of reasons for living, significant age differences were found in both areas. The main findings of the study will be discussed followed by a discussion of possible theoretical explanations for the findings.

Younger adults rated Fear of Social Disapproval, Child-Related Concerns, Moral Objections, Survival and Coping Beliefs, Peer Acceptance, and Future Optimism as more important than middle-aged adults. Similarly, older adults rated Fear of Social Disapproval, Child-Related Concerns, Moral Objections, and Peer Acceptance as more important than middle-aged adults. When the POMS TMDS score was added as a covariate, younger adults also rated Future Optimism as more important than did older adults. Further, when education was entered as a covariate, the age differences in Child-Related Concerns were no longer significant.

Younger adults endorsed more Fear of Social Disapproval, Moral Objections, Survival and Coping Beliefs, Peer Acceptance, Future Optimism, and Fear of Suicide items than did middle-aged adults and more Survival and Coping Beliefs, Peer Acceptance, Future Optimism, and Responsibility to Family items than did older adults. Middle-aged adults endorsed more Responsibility to Family items than did older adults. Finally, older adults endorsed more Fear of Social Disapproval and Moral Objections items than did middle-aged adults. When the POMS TMDS was entered as a covariate or when only individuals who mailed back their questionnaires were examined, middle-aged adults no longer differed significantly from older adults in the numbers of Responsibility to Family items endorsed.

A discussion of the significant results of the study by subscales follows, with reference to major life-span theories of development. Results related to importance ratings and numbers of reasons for living will be discussed concurrently by subscale.

Peer Acceptance and Fear of Social Disapproval

Younger adults placed greater importance on peer acceptance than did middle-aged adults (based on mean importance ratings and numbers of items endorsed) and older adults (based on numbers of items endorsed). Further, older adults valued peer acceptance more than middle-aged adults. These findings are consistent with Erikson's lifespan psychosocial theory and Carstensen's socioemotional selectivity theory, although Erikson and Carstensen disagreed as to the time in life at which intimacy and emotional connectedness with peers is important. Erikson theorized that intimacy with peers and loved ones is more important in young adulthood than older adulthood, whereas Carstensen argues that older adults place more value on emotional closeness with others than do younger adults. Thus, the finding that younger adults placed

greater importance on peer acceptance than did middle-aged adults and older adults is consistent with Erikson's theory, whereas the finding that older adults placed greater importance on peer acceptance than middle-aged adults is consistent with Carstensen's theory. Further, placing increased importance on peer relationships and intimacy likely translates into fear of disapproval from people within an individual's social network. Thus, the finding that younger adults and older adults feared social disapproval more than middle-aged adults, reflected both in mean ratings and number of items endorsed, is also consistent with Erikson and Carstensen's theories.

Future Optimism

The finding that younger adults placed more importance on reasons for living related to future optimism than middle-aged adults (reflected in mean ratings and number of items endorsed) and older adults (reflected in number of items endorsed) is consistent with Carstensen's socioemotional selectivity theory. Carstensen theorizes that younger adults with an expansive future hold a "future orientation", whereas adults who perceive time as limited have more of a "present orientation". She argues that older adults focus attention on experiences occurring in the moment, with less concern about the future. Thus, based on this theory, younger adults should value reasons for living related to future optimism more than middle-aged or older adults.

In the current study, when the POMS TMDS score was statistically controlled, in addition to younger adults rating future optimism as more important than middle-aged adults, younger adults also rated future optimism as more important than did older adults. It is possible that, given younger adults' self-reported negative mood state at the time of the study, their future did not appear very hopeful to them. By eliminating the contribution of mood state, it is possible that their level of future optimism rose, such that it became significantly different from that of older adults.

Moral Objections

Younger adults and older adults placed greater importance on moral objections than did middle-aged adults. Although Erikson, Havighurst, and Carstensen's theories do not offer predictions related to moral objections, Kohlberg's theory of moral development (1968; Kohlberg & Kramer, 1969) may explain the high levels of moral objections found in younger adults. Kohlberg argues that, as individuals mature in their moral development, they focus less on following laws and rules, and more on subscribing to internal ethical and moral principles. It is possible that, in contrast to the middle-aged adults, the younger adults in this study had not progressed past the conventional stage of morality. This would be reflected in the endorsement of external rules that had been taught to them at a young age, such as "I believe only God has the right to end a life," "My religious beliefs forbid it," and "I consider it morally wrong," thereby increasing their scores on the Moral Objections subscale.

Another potential explanation for the age differences found in Moral Objections relates to geographical differences between the age groups. The majority of older adults in the current study lived in West Virginia, whereas the majority of middle-aged adults lived in Canada. West Virginia has a significantly higher level of fundamental religions than does Canada. For example, 29% of West Virginia residents belong to the Baptist church, which traditionally has strong views against suicide (Kosmin & Lackman, 1993). In contrast, Canada has a very small

proportion of Baptists (Baptist World Alliance, 1998). Unfortunately, the current study did not examine participants' religious orientation. However, in line with geographical religion trends, it is possible that the older adults had stronger religious beliefs related to suicide than did the middle-aged adults.

Fear of Suicide

Younger adults endorsed more Fear of Suicide items than did middle-aged adults. Although none of the life-span theories discussed offers any basis for explaining this finding, there are several potential explanations. First of all, research indicates that younger adults have a high prevalence of suicide ideation, with 21% of 18-year-olds reporting a history of suicidal ideation (Lewinsohn, Rohde, & Seeley, 1996). The rates of suicidal ideation found in younger adults are higher than those found in middle-aged adults (Lewinsohn, Rohde, & Seeley). Thus, it is not surprising that the age group with the highest likelihood of suicidal thoughts would be the most fearful of suicide. Further, younger adults likely have had less experience with death than middle-aged adults, which may have added to their fear of suicide and death.

Survival and Coping Beliefs

Younger adults and older adults were found to endorse more survival and coping beliefs than middle-aged. None of the life-span theories include components that offer an explanation for this result. However, the younger adults in this study scored significantly higher than the middle-aged adults on various POMS subscales, reflecting high levels of tension, anger, fatigue, and confusion and low levels of energy and vigor. These results are consistent with Muntaner and Barnett's (2000) study of depressive symptomatology in West Virginia residents. They found that the highest rates of depressive symptoms across the lifespan were among adolescents and young adults, and that these rates were two-three times higher than rates across the U.S.A. It is possible that the younger adults had encountered high levels of stress and multiple challenging situations prior to participating in the study, which would explain their negative mood states. These stressful situations may have made survival and coping beliefs more salient to them than the middle-aged adults. Older adults may have had more opportunities over the course of their life to build strong survival and coping beliefs than the middle-aged adults, which would be reflected in high importance ratings on these items.

Responsibility to Family

Younger adults endorsed more Responsibility to Family items than did older adults. Whereas several of the Responsibility to Family items are related to concerns about providing care for one's family, many of the subscale items are related to desire to prevent one's family from being hurt and disappointed. Younger adults may have felt that, by virtue of their young age, suicide would devastate their family more than middle-aged or older adults.

Implications of Findings

Results of the current study can greatly aid in assessing and treating suicidal ideation. Clinicians may use the information gained in this study about age-related differences in reasons for living as a reference point for assessment and treatment options. For example, when clinicians are assessing suicidal young adults, they would benefit from asking questions about reasons for living related to fear of social disapproval, moral objections, peer acceptance, and future optimism, as these areas were found to be of importance to younger adults. Further, when

treating suicidal younger adults, clinicians may work to strengthen and reinforce their clients' religious beliefs, future plans and goals, and peer relationships.

Knowledge about age-related differences in reasons for living can supplement information currently conveyed in suicide prevention programs. Many suicide prevention programs include components that address coping skills and helping a suicidal peer (Ploeg et al., 1996). Information about reasons for living can be included in this discussion. For example, when teaching participants how to help an acutely suicidal peer, participants could be encouraged to discuss potential reasons for living with the peer before professional help arrives. Most suicide prevention programs focus on informing participants about individuals who are most at risk of committing suicide (Rihmer, 1996). Information about age-related reasons for living could supplement this discussion; individuals with few reasons for living that have been found to be important to their particular age group may be more at risk of committing suicide (Linehan, 1983).

Limitations

Several limitations in this study warrant caution when interpreting or generalizing the results. First of all, a statistical factor analysis would have been beneficial for establishing the RFL subscales. However, due to the large sample size required for a factor analysis, a q-sort was conducted instead. Although there was substantial agreement between the sorters for the majority of the items, for several of the items, only 50% of the sorters agreed on the subscale to which they should be assigned. A second limitation in the current study involved the significant differences between the age groups on several variables other than age, such as education level, marital status, work status, health status, country of residence, and method of returning questionnaire; this made it difficult to isolate the effects of age on reasons for living. For example, although statistical controls were used to rule out the effects of education and method of returning the questionnaire, conclusions and interpretations would have been clearer if the groups had been matched on these variables. Further, the majority of the participants in the current study were Caucasian. Therefore, the age differences reported here may not apply to other ethnic groups. In spite of the foregoing, the results of this study suggest several directions for future research.

Directions for Future Research

Results of this study suggest that further development and refinement of the Reasons for Living instruments may be important. Young adults and older adults were found to place importance on reasons for living that aren't currently included on the RFL measures designed for those age groups. For example, in the current study, younger adults were found to value reasons for living related to moral objections and child-related concerns more than middle-aged adults, however, no items related to these areas are included on the RFL-YA. Similarly, older adults were found to value reasons for living related to fear of social disapproval more than middle-aged adults, however, only one item from this subscale is currently listed on the RFL-OA.

Several of the items that were removed from the original RFL and RFL-YA following factor analyses were in the top third items for several subscales in this study. For example, the item "It would be painful and frightening to take my own life," which was removed from the RFL-YA during factor analysis, was the most highly rated item within the Fear of Suicide

subscale for each age group. The RFL scales were developed to assess individual's overall reasons for living. Thus, although particular items may not load well on the measures' factors, the purpose of the measures warrants their inclusion, as they appear to be important to many people. The content validity of the RFL and RFL-YA may be sacrificed by excluding these items.

Future studies may examine differences in reasons for living between other groups of people. For example, high-school students or younger adults from the general community may be studied to further clarify age-related differences in reasons for living. The relationship between various demographic variables, such as education and marital status, and reasons for living may be studied in the future. By matching groups on age and breaking them into "high" education and "low" education, or "single" and "married", one can isolate the effects of these variables on reasons for living.

The current study raises questions about the nature of reasons for living. Future studies may examine whether reasons for living are enduring beliefs, or whether they vary across time and situation. Studies examining the process by which individuals consider reasons for living, whether individuals weigh reasons for living and reasons for dying, and the relative weight of reasons for living versus reasons for dying, would be helpful in advancing our knowledge of the suicide contemplation process.

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Appendix A

Demographics Questionnaire

1. What is your date of birth? _____(Month/Day/Year)
2. Are you:
 - 1) Male, or
 - 2) Female?
3. What is your marital status, are you:
 - 1) Single,
 - 2) Married,
 - 3) Divorced,
 - 4) Widowed, or
 - 5) Other? _____ (please specify)
4. Do you currently live:
 - 1) Alone,
 - 2) With a spouse,
 - 3) With a friend/non-relative,
 - 4) With relatives, or _____(please specify)
 - 5) Other? _____(please specify)
5. To which racial group do you belong:
 - 1) African American/Black,
 - 2) Caucasian/White,
 - 3) Latino American,
 - 4) Asian American, or
 - 5) Other? _____(please specify)
6. What is (was) your primary occupation? _____
7. What is your primary work status? Are you:
 - 1) Employed (full or part-time),
 - 2) Student,
 - 3) Retired,
 - 4) Unemployed,
 - 5) Homemaker, or
 - 6) Other? _____(please specify)
8. What is the highest grade or level of education you've completed? _____

9. How would you rate your overall health at the present time?

- 1) Excellent,
- 2) Good,
- 3) Fair, or
- 4) Poor?

10. How many more years do you expect to live? _____

Appendix B

Subscales Formed from the Q-Sort

Family Alliance

- 16. I love and enjoy my family too much. (5)
- 79. I have a close relationship with my family. (6)
- 81. I enjoy being with my family. (6)
- 84. My family takes the time to listen to my experiences at school, work, or home. (6)
- 85. My family gives me the love I need. (6)
- 92. When I have a problem, I can turn to my family for support or advice. (6)
- 95. My family understands the way I feel. (6)
- 97. I am satisfied with my relationships with members of my family. (6)
- 105. My family gives me support or encouragement when I need it. (6)
- 117. My family cares about me even when I am in trouble. (6)
- 119. For the most part, I feel loved at home. (6)
- 120. I would miss the love and affection I get from my family. (6)
- 159. I have a loving family who supports me through bad times. (6)

Fear of Suicide

- 6. I am afraid of death. (6)
- 15. I am afraid of the unknown. (6)
- 18. I am afraid that my method of killing myself would fail. (5)
- 26. I am a coward and do not have the guts to do it. (6)
- 33. I could not decide where, when, and how to do it. (4)
- 38. I am afraid of the actual "act" of killing myself (the pain, blood, violence). (6)
- 46. I am so inept that my method would not work. (5)
- 61. I am afraid that my death would not matter to anyone. (3)
- 62. The finality of the act would stop me. (6)
- 106. It would be painful and frightening to take my own life. (6)
- 118. In general, I worry about those things (weapons, drugs, alcohol) that could kill me. (6)
- 134. I fear the hereafter. (4)

Responsibility to Family

- 1. I have a responsibility and commitment to my family. (6)
- 7. My family might believe that I did not love them. (5)
- 9. My family depends upon me and needs me. (6)
- 30. It would hurt my family too much and I would not want them to suffer. (5)
- 47. I would not want my family to feel guilty afterwards. (5)
- 63. It would be too much of an embarrassment to my family. (4)
- 115. I would not want my family to feel like I let them down. (5)
- 141. I do not want to abandon my spouse. (6)
- 143. My life insurance policy would not be valid if I committed suicide. (5)
- 149. My spouse requires care. (6)
- 152. I have a responsibility to my pet. (6)

Fear of Social Disapproval

- 31. I am concerned about what others would think of me. (6)
- 41. Other people would think I am weak and selfish. (6)
- 43. I would not want people to think I did not have control over my life. (6)
- 48. I would not want my family to think I was selfish or a coward. (4)
- 57. Society disapproves of killing myself. (6)
- 139. Suicide is a sign of defeat. (4)

Child-Related Concerns

- 11. I want to watch my children as they grow. (5)
- 21. It would not be fair to leave the children for others to take care of. (6)
- 28. The effect on my children could be harmful. (6)
- 133. I enjoy my grandchildren and/or great grandchildren. (4)
- 154. I want to see my grandchildren grow up. (3)

Moral Objections

- 5. I believe only God has the right to end a life. (6)
- 23. I am afraid of going to hell. (3)
- 27. My religious beliefs forbid it. (6)
- 34. I consider it morally wrong. (6)
- 126. I want to show others God's way. (6)
- 127. I have faith in God. (6)
- 142. Everyone has a time to die. (4)
- 144. My religion gives me the strength and peace to carry on. (5)
- 146. I put my life in God's hands. (6)
- 150. I want the opportunity for fellowship or worship with my church family. (5)
- 151. I want to travel to see the beauty of God's work. (4)
- 156. Through prayer, God will give me the will to live. (6)
- 157. God's spirit would prevent me from even considering committing suicide. (6)
- 160. God knows how much I can bear and will not over burden me. (6)

Survival and Coping Beliefs

- 2. I believe I can learn to adjust or cope with my problems. (6)
- 3. I believe I have control over my life and destiny. (4)
- 4. I have a desire to live. (5)
- 8. I do not believe things get miserable or hopeless enough that I would rather be dead. (6)
- 10. I do not want to die. (4)
- 12. Life is all we have and is better than nothing. (3)
- 14. No matter how badly I feel, I know that it will not last. (5)
- 20. Life is too beautiful and precious to end it. (3)
- 22. I believe I can find other solutions to my problems. (6)
- 24. I have a love of life. (3)
- 32. I believe everything has a way of working out for the best. (3)
- 36. I have the courage to face life. (5)
- 39. I believe killing myself would not really accomplish or solve anything. (6)
- 42. I have an inner drive to survive. (5)

- 44. I believe I can find a purpose in life, a reason to live. (3)
- 45. I see no reason to hurry death along. (5)
- 49. I would not be able to see the effect of my death on others. (5)
- 51. I can find meaning in suffering. (5)
- 54. Rational people do not kill themselves. (4)
- 55. If I were depressed enough to want to die, I would be too depressed to kill myself. (6)
- 56. I make a contribution to society. (4)
- 59. I see no reason to die and let someone else enjoy the things I worked for. (4)
- 60. It is a sign of weakness and I don't want to be a quitter. (3)
- 65. There are obligations I feel I should keep. (3)
- 66. I would think of others worse off than myself. (5)
- 67. I have a job in which I am involved and where I am needed. (3)
- 69. I would know I probably was not serious and it was just a passing thought. (5)
- 70. Experiencing unhappiness is an important part of life. (5)
- 71. I would stop feeling sorry for myself. (6)
- 72. The thought of suicide is totally incompatible to me. (5)
- 74. I believe that suicide is not the way to deal with any of my problems. (6)
- 78. I believe that I can make good decisions without considering suicide. (5)
- 83. I believe I can deal with most of the losses (e.g., divorce or separation of parents, death of a loved one) in life without attempting suicide. (6)
- 93. After an argument, I prefer to focus on dealing with the situation rather than attempt to kill myself. (6)
- 98. When faced with a problem, I work hard to understand and avoid similar problem situations. (6)
- 99. I would rather take responsibility for solving my problem than attempt suicide. (6)
- 103. I believe that every problem has a potential positive solution. (4)
- 108. I usually think of some way to deal with my problem rather than consider committing suicide. (6)
- 109. When I am in trouble, I take the time to think of good alternate solutions. (6)
- 110. I have learned to deal with most of the hassles in my life. (6)
- 113. If I initially fail to find a solution to my problem, I prefer to think about other alternatives. (6)
- 114. I believe that I can cope or deal with most of my problems. (6)
- 121. I have the courage to face my problems. (5)
- 122. If I killed myself, I will not get what I want in life. (4)
- 123. I feel confident in my ability to handle my problems. (3)
- 124. I have learned to laugh at my troubles and not take life too seriously. (5)
- 128. I am in good health. (4)
- 129. My financial affairs are good. (3)
- 135. I am still able to contribute to others. (3)
- 136. Life is a gift. (4)
- 137. I can always think of someone who is worse off than I am. (5)
- 138. I don't want to leave my earthly possessions. (5)
- 147. I have an excellent job. (3)
- 155. Committing suicide would be stupid or foolish. (5)
- 162. I have coped before and I can do it again. (6)

Self Acceptance

- 19. I care enough about myself to live. (5)
- 25. I am too stable to kill myself. (4)
- 37. I am happy and content with my life. (6)
- 53. I have too much pride in myself. (6)
- 76. Most of the time I feel good about myself. (6)
- 89. I am satisfied that things are going well for me these days. (5)
- 90. I am happy to be the person I am. (6)
- 91. I have a great deal of respect for myself. (6)
- 94. I am happy with myself. (6)
- 104. I feel like I do have many good qualities. (6)
- 111. I feel that my life is important. (4)
- 130. I am still capable of doing many things. (3)

Peer Acceptance

- 50. Close friends depend on me and need me. (6)
- 52. There are friends I enjoy and love too much to leave. (6)
- 58. I have people who love me and would listen to and understand me. (4)
- 64. I would hurt close friends too much. (5)
- 68. I have a responsibility and commitment to my friends. (6)
- 77. My friends stand by me whenever I have a problem. (6)
- 82. I have close friends who really care a lot about me. (6)
- 86. I believe that my friends treat me fairly. (6)
- 88. I believe that my friends appreciate me when I am with them. (6)
- 101. I have close friends who are willing to help in times of need. (6)
- 112. My friends look up to me and depend on me. (6)
- 116. I would not want to hurt my close friend(s) emotionally. (6)
- 131. I feel needed by others. (4)
- 148. I want to spend time with friends and loved ones. (4)

Future Optimism

- 13. I have future plans I am looking forward to carrying out. (6)
- 17. I want to experience all that life has to offer and there are many experiences I haven't had yet which I want to have. (6)
- 29. I am curious about what will happen in the future. (6)
- 35. I still have many things left to do. (5)
- 40. I have hope that things will improve and the future will be happier. (6)
- 73. I have many good things to look forward to as I grow older. (6)
- 75. When I think about my future, I feel good inside. (6)
- 80. I have many plans I am looking forward to carrying out in the future. (6)
- 87. I am hopeful about my plans or goals for the future. (6)
- 96. My future looks quite hopeful and promising. (6)
- 100. I would like to see my plans (have a job, career, or family) for the future come true. (6)
- 102. I look forward to many fun things in the future. (6)
- 107. I still look forward to having fun with my friends. (3)

- 125. I'm looking forward to developing new personal relationships. (3)
- 132. The future may hold new cures for my illness. (6)
- 140. Some parts of my life are getting better as I age. (5)
- 145. I am just beginning to experience the benefits of what I have worked for. (5)
- 153. Tomorrow I may feel better. (5)
- 158. I want to experience all life has to offer. (6)
- 161. I want to enjoy my life's accomplishments. (5)

Note: Numbers in parentheses indicate number of sorters (out of 6) who placed item into that category.

RFL = items 1-72

RFL-YA = items 73-124

RFL-OA = items 124-162.

Appendix C

The Top Ten Items Overall and the Top Third
Most Highly Rated Items of Each Subscale for Each Age Group

Top Ten

Younger Adults

158. I want to experience all life has to offer. (M = 5.66, SD = .59)
100. I would like to see my plans (have a job, career, or family) for the future come true. (M = 5.58, SD = .78)
161. I want to enjoy my life's accomplishments. (M = 5.45, SD = .61)
73. I have many good things to look forward to as I grow older. (M = 5.40, SD = .76)
17. I want to experience all that life has to offer and there are many experiences I haven't had yet which I want to have. (M = 5.38, SD = .92)
1. I have a responsibility and commitment to my family. (M = 5.36, SD = 1.03)
80. I have many plans I am looking forward to carrying out in the future. (M = 5.34, SD = .98)
4. I have a desire to live. (M = 5.34, SD = 1.15)
87. I am hopeful about my plans or goals for the future. (M = 5.32, SD = .79)
85. My family gives me the love I need. (M = 5.32, SD = 1.06)

Middle-Aged Adults

4. I have a desire to live. (M = 5.47, SD = 1.07)
11. I want to watch my children as they grow. (M = 5.44, SD = 1.11)
81. I enjoy being with my family. (M = 5.38, SD = .88)
79. I have a close relationship with my family. (M = 5.36, SD = .81)
10. I do not want to die. (M = 5.36, SD = 1.30)
16. I love and enjoy my family too much. (M = 5.28, SD = 1.06)
108. I usually think of some way to deal with my problem rather than consider committing suicide. (M = 5.14, SD = .89)
119. For the most part, I feel loved at home. (M = 5.08, SD = 1.27)
28. The effect on my children could be harmful. (M = 5.08, SD = 1.33)
99. I would rather take responsibility for solving my problem than attempt suicide. (M = 5.06, SD = 1.04)

Older Adults

99. I would rather take responsibility for solving my problem than attempt suicide. (M = 5.52, SD = .63)
81. I enjoy being with my family. (M = 5.51, SD = .80)
162. I have coped before and I can do it again. (M = 5.40, SD = .80)
85. My family gives me the love I need. (M = 5.40, SD = .92)
78. I believe that I can make good decisions without considering suicide. (M = 5.39, SD = .93)
136. Life is a gift. (M = 5.38, SD = .84)
74. I believe that suicide is not the way to deal with any of my problems. (M = 5.38, SD = .85)
83. I believe I can deal with most of the losses (e.g., divorce or separation of parents, death of a loved one) in life without attempting suicide. (M = 5.38, SD = .87)

93. After an argument, I prefer to focus on dealing with the situation rather than attempt to kill myself. (M = 5.38, SD = .92)

24. I have a love of life. (M = 5.36, SD = .85)

Family Alliance

Younger Adults

85. My family gives me the love I need. (M = 5.32, SD = 1.06)

79. I have a close relationship with my family. (M = 5.22, SD = 1.23)

16. I love and enjoy my family too much. (M = 5.18, SD = .96)

81. I enjoy being with my family. (M = 5.12, SD = 1.30)

Middle-Aged Adults

81. I enjoy being with my family. (M = 5.38, SD = .88)

79. I have a close relationship with my family. (M = 5.36, SD = .81)

16. I love and enjoy my family too much. (M = 5.28, SD = 1.06)

119. For the most part, I feel loved at home. (M = 5.08, SD = 1.27)

Older Adults

81. I enjoy being with my family. (M = 5.51, SD = .80)

85. My family gives me the love I need. (M = 5.40, SD = .92)

159. I have a loving family who supports me through bad times. (M = 5.32, SD = 1.04)

79. I have a close relationship with my family. (M = 5.32, SD = 1.00)

Fear of Suicide

Younger Adults

106. It would be painful and frightening to take my own life. (M = 3.76, SD = 1.91)

62. The finality of the act would stop me. (M = 3.62, SD = 1.67)

6. I am afraid of death. (M = 3.56, SD = 1.83)

38. I am afraid of the actual "act" of killing myself (the pain, blood, violence). (M = 3.32, SD = 1.89)

Middle-Aged Adults

106. It would be painful and frightening to take my own life. (M = 3.27, SD = 1.93)

6. I am afraid of death. (M = 3.21, SD = 1.83)

62. The finality of the act would stop me. (M = 3.02, SD = 1.83)

38. I am afraid of the actual "act" of killing myself (the pain, blood, violence). (M = 2.81, SD = 1.79)

Older Adults

106. It would be painful and frightening to take my own life. (M = 4.36, SD = 1.85)

62. The finality of the act would stop me. (M = 4.02, SD = 1.78)

18. I am afraid that my method of killing myself would fail. (M = 3.04, SD = 2.10)

38. I am afraid of the actual "act" of killing myself (the pain, blood, violence). (M = 3.02, SD = 2.06)

Responsibility to FamilyYounger Adults

1. I have a responsibility and commitment to my family. (M = 5.36, SD = 1.03)
 30. It would hurt my family too much and I would not want them to suffer. (M = 5.12, SD = 1.24)
 47. I would not want my family to feel guilty afterwards. (M = 4.73, SD = 1.43)
 9. My family depends upon me and needs me. (M = 4.60, SD = 1.40)

Middle-Aged Adults

1. I have a responsibility and commitment to my family. (M = 5.64, SD = .86)
 30. It would hurt my family too much and I would not want them to suffer. (M = 5.36, SD = .92)
 9. My family depends upon me and needs me. (M = 5.09, SD = 1.21)
 141. I do not want to abandon my spouse. (M = 5.02, SD = 1.42)

Older Adults

1. I have a responsibility and commitment to my family. (M = 5.29, SD = 1.25)
 30. It would hurt my family too much and I would not want them to suffer. (M = 5.28, SD = 1.21)
 115. I would not want my family to feel like I let them down. (M = 5.00, SD = 1.11)
 47. I would not want my family to feel guilty afterwards. (M = 4.64, SD = 1.65)

Fear of Social DisapprovalYounger Adults

139. Suicide is a sign of defeat. (M = 4.02, SD = 1.70)
 48. I would not want my family to think I was selfish or a coward. (M = 2.96, SD = 1.63)

Middle-Aged adults

48. I would not want my family to think I was selfish or a coward. (M = 3.47, SD = 1.59)
 139. Suicide is a sign of defeat. (M = 2.52, SD = 1.75)

Older Adults

48. I would not want my family to think I was selfish or a coward. (M = 4.38, SD = 1.54)
 139. Suicide is a sign of defeat. (M = 4.02, SD = 1.79)

Child-Related ConcernsYounger Adults

11. I want to watch my children as they grow. (M = 5.18, SD = 1.24)
 154. I want to see my grandchildren grow up. (M = 5.12, SD = 1.33)

Middle-Aged Adults

11. I want to watch my children as they grow. (M = 5.44, SD = 1.11)
 28. The effect on my children could be harmful. (M = 5.08, SD = 1.33)

Older Adults

133. I enjoy my grandchildren and/or great grandchildren. (M = 5.32, SD = 1.20)
 154. I want to see my grandchildren grow up. (M = 5.11, SD = 1.33)

Moral ObjectionsYounger Adults

23. I am afraid of going to hell. (M = 4.60, SD = 1.74)
 127. I have faith in God. (M = 4.60, SD = 1.78)
 5. I believe only God has the right to end a life. (M = 4.45, SD = 1.78)
 160. God knows how much I can bear and will not over burden me. (M = 4.36, SD = 1.66)
 151. I want to travel to see the beauty of God's work. (M = 4.28, SD = 1.68)

Middle-Aged Adults

127. I have faith in God. (M = 3.66, SD = 1.79)
 5. I believe only God has the right to end a life. (M = 3.26, SD = 2.15)
 142. Everyone has a time to die. (M = 3.23, SD = 1.83)
 144. My religion gives me the strength and peace to carry on. (M = 3.14, SD = 1.91)
 151. I want to travel to see the beauty of God's work. (M = 3.06, SD = 1.92)

Older Adults

127. I have faith in God. (M = 5.13, SD = 1.44)
 5. I believe only God has the right to end a life. (M = 4.94, SD = 1.50)
 146. I put my life in God's hands. (M = 4.87, SD = 1.81)
 160. God knows how much I can bear and will not over burden me. (M = 4.80, SD = 1.70)
 144. My religion gives me the strength and peace to carry on. (M = 4.79, SD = 1.65)

Survival and Coping BeliefsYounger Adults

4. I have a desire to live. (M = 5.34, SD = 1.15)
 162. I have coped before and I can do it again. (M = 5.29, SD = .89)
 93. After an argument, I prefer to focus on dealing with the situation rather than attempt to kill myself. (M = 5.24, SD = 5.08)
 108. I usually think of some way to deal with my problem rather than consider committing suicide. (M = 5.16, SD = 1.00)
 83. I believe I can deal with most of the losses (e.g., divorce or separation of parents, death of a loved one) in life without attempting suicide. (M = 5.10, SD = .91)
 78. I believe that I can make good decisions without considering suicide. (M = 5.10, SD = 1.05)
 136. Life is a gift. (M = 5.10, SD = 1.30)
 99. I would rather take responsibility for solving my problem than attempt suicide. (M = 5.08, SD = 1.12)
 121. I have the courage to face my problems. (M = 5.04, SD = .88)
 3. I believe I have control over my life and destiny. (M = 5.00, SD = 1.16)
 74. I believe that suicide is not the way to deal with any of my problems. (M = 4.98, SD = 1.39)
 114. I believe that I can cope or deal with most of my problems. (M = 4.96, SD = .99)
 103. I believe that every problem has a potential positive solution. (M = 4.96, SD = 1.11)
 155. Committing suicide would be stupid or foolish. (M = 4.96, SD = 1.44)
 2. I believe I can learn to adjust or cope with my problems. (M = 4.94, SD = .87)
 110. I have learned to deal with most of the hassles in my life. (M = 4.94, SD = .98)
 44. I believe I can find a purpose in life, a reason to live. (M = 4.94, SD = 1.09)

10. I do not want to die. (M = 4.92, SD = 1.45)

Middle-Aged Adults

4. I have a desire to live. (M = 5.47, SD = 1.07)

10. I do not want to die. (M = 5.36, SD = 1.30)

108. I usually think of some way to deal with my problem rather than consider committing suicide. (M = 5.14, SD = .89)

99. I would rather take responsibility for solving my problem than attempt suicide. (M = 5.06, SD = 1.04)

93. After an argument, I prefer to focus on dealing with the situation rather than attempt to kill myself. (M = 5.02, SD = 1.32)

83. I believe I can deal with most of the losses (e.g., divorce or separation of parents, death of a loved one) in life without attempting suicide. (M = 5.00, SD = 1.02)

78. I believe that I can make good decisions without considering suicide. (M = 4.98, SD = 1.23)

114. I believe that I can cope or deal with most of my problems. (M = 4.96, SD = .86)

162. I have coped before and I can do it again. (M = 4.96, SD = 1.07)

20. Life is too beautiful and precious to end it. (M = 4.96, SD = 1.47)

121. I have the courage to face my problems. (M = 4.88, SD = 1.06)

24. I have a love of life. (M = 4.87, SD = 1.35)

44. I believe I can find a purpose in life, a reason to live. (M = 4.83, SD = 1.16)

123. I feel confident in my ability to handle my problems. (M = 4.81, SD = .99)

42. I have an inner drive to survive. (M = 4.81, SD = 1.32)

109. When I am in trouble, I take the time to think of good alternate solutions. (M = 4.80, SD = .98)

113. If I initially fail to find a solution to my problem, I prefer to think about other alternatives. (M = 4.79, SD = 1.04)

110. I have learned to deal with most of the hassles in my life. (M = 4.79, SD = 1.05)

Older Adults

99. I would rather take responsibility for solving my problem than attempt suicide. (M = 5.52, SD = .63)

162. I have coped before and I can do it again. (M = 5.40, SD = .80)

136. Life is a gift. (M = 5.38, SD = .84)

83. I believe I can deal with most of the losses (e.g., divorce or separation of parents, death of a loved one) in life without attempting suicide. (M = 5.38, SD = .87)

93. After an argument, I prefer to focus on dealing with the situation rather than attempt to kill myself. (M = 5.38, SD = .92)

78. I believe that I can make good decisions without considering suicide. (M = 5.39, SD = .93)

74. I believe that suicide is not the way to deal with any of my problems. (M = 5.38, SD = .85)

24. I have a love of life. (M = 5.36, SD = .85)

4. I have a desire to live. (M = 5.29, SD = 1.26)

114. I believe that I can cope or deal with most of my problems. (M = 5.28, SD = .88)

110. I have learned to deal with most of the hassles in my life. (M = 5.21, SD = .90)

113. If I initially fail to find a solution to my problem, I prefer to think about other alternatives. (M = 5.17, SD = .85)

121. I have the courage to face my problems. (M = 5.16, SD = 1.00)

36. I have the courage to face life. (M = 5.15, SD = .94)
 137. I can always think of someone who is worse off than I am. (M = 5.15, SD = 1.15)
 109. When I am in trouble, I take the time to think of good alternate solutions. (M = 5.10, SD = .77)
 20. Life is too beautiful and precious to end it. (M = 5.10, SD = 1.19)
 98. When faced with a problem, I work hard to understand and avoid similar problem situations. (M = 5.09, SD = .98)

Self-Acceptance

Younger Adults

91. I have a great deal of respect for myself. (M = 5.22, SD = 1.15)
 90. I am happy to be the person I am. (M = 5.14, SD = 1.13)
 94. I am happy with myself. (M = 5.08, SD = 1.12)
 76. Most of the time I feel good about myself. (M = 4.98, SD = 1.24)

Middle-Aged Adults

111. I feel that my life is important. (M = 5.04, SD = 1.30)
 130. I am still capable of doing many things. (M = 4.96, SD = 1.10)
 90. I am happy to be the person I am. (M = 4.96, SD = 1.27)
 19. I care enough about myself to live. (M = 4.83, SD = 1.46)

Older Adults

90. I am happy to be the person I am. (M = 5.33, SD = .91)
 91. I have a great deal of respect for myself. (M = 5.21, SD = .87)
 111. I feel that my life is important. (M = 5.16, SD = 1.31)
 19. I care enough about myself to live. (M = 5.13, SD = 1.18)

Peer Acceptance and Support

Younger Adults

82. I have close friends who really care a lot about me. (M = 5.36, SD = 1.01)
 58. I have people who love me and would listen to and understand me. (M = 5.34, SD = .82)
 148. I want to spend time with friends and loved ones. (M = 5.30, SD = .89)
 52. There are friends I enjoy and love too much to leave. (M = 5.06, SD = 1.21)
 88. I believe that my friends appreciate me when I am with them. (M = 5.02, SD = 1.06)

Middle-Aged Adults

58. I have people who love me and would listen to and understand me. (M = 4.85, SD = 1.13)
 148. I want to spend time with friends and loved ones. (M = 4.79, SD = 1.35)
 131. I feel needed by others. (M = 4.65, SD = 1.43)
 82. I have close friends who really care a lot about me. (M = 4.32, SD = 1.40)
 88. I believe that my friends appreciate me when I am with them. (M = 4.31, SD = 1.23)

Older Adults

50. Close friends depend on me and need me. (M = 5.15, SD = 1.04)
 82. I have close friends who really care a lot about me. (M = 5.07, SD = 1.04)
 148. I want to spend time with friends and loved ones. (M = 5.04, SD = 1.01)

101. I have close friends who are willing to help in times of need. (M = 4.96, SD = 1.28)
 86. I believe that my friends treat me fairly. (M = 4.94, SD = 1.05)

Future Optimism

Younger Adults

158. I want to experience all life has to offer. (M = 5.66, SD = .59)
 100. I would like to see my plans (have a job, career, or family) for the future come true. (M = 5.58, SD = .78)
 161. I want to enjoy my life's accomplishments. (M = 5.45, SD = .61)
 73. I have many good things to look forward to as I grow older. (M = 5.40, SD = .76)
 17. I want to experience all that life has to offer and there are many experiences I haven't had yet which I want to have. (M = 5.38, SD = .92)
 80. I have many plans I am looking forward to carrying out in the future. (M = 5.34, SD = .98)
 87. I am hopeful about my plans or goals for the future. (M = 5.32, SD = .79)

Middle-Aged Adults

80. I have many plans I am looking forward to carrying out in the future. (M = 5.83, SD = 1.44)
 17. I want to experience all that life has to offer and there are many experiences I haven't had yet which I want to have. (M = 5.00, SD = 1.30)
 73. I have many good things to look forward to as I grow older. (M = 4.91, SD = 1.34)
 100. I would like to see my plans (have a job, career, or family) for the future come true. (M = 4.90, SD = 1.29)
 87. I am hopeful about my plans or goals for the future. (M = 4.85, SD = 1.29)
 40. I have hope that things will improve and the future will be happier. (M = 4.81, SD = 1.14)
 75. When I think about my future, I feel good inside. (M = 4.77, SD = 1.20)

Older Adults

107. I still look forward to having fun with my friends. (M = 5.19, SD = 1.10)
 102. I look forward to many fun things in the future. (M = 5.02, SD = 1.18)
 158. I want to experience all life has to offer. (M = 5.00, SD = 1.27)
 161. I want to enjoy my life's accomplishments. (M = 4.84, SD = 1.24)
 73. I have many good things to look forward to as I grow older. (M = 4.83, SD = 1.27)
 35. I still have many things left to do. (M = 4.64, SD = 1.54)
 29. I am curious about what will happen in the future. (M = 4.64, SD = 1.55)

CURRICULUM VITAE

LESLEY PAULA KOVEN

F8-1325 Stewartstown Road, Morgantown, WV 26505
(304) 599-5487 or (304) 293-2001 ext 802
Email: lkoven2@wvu.edu

EDUCATION

Doctoral Institution: West Virginia University - Degree Expected 2004
Program: Clinical Adult Psychology
Specialty Interest: Geropsychology

M.A.: West Virginia University (2001)
Major: Clinical Adult Psychology
Advisor: Barry Edelstein, Ph.D.

Thesis: Reasons for Living Across the Lifespan

B.A. (Hons): University of Manitoba (1998)
Major: Psychology
With Multidisciplinary Option in Aging

Honours Thesis: Behavioral Assessment of Dependent and Independent Self-Care Behaviors in Elderly Residents of a Personal Care Home

HONORS

Received Alumni Fund money to complete Master's thesis research, Fall, 2000
West Virginia University Graduate Assistantship, 1999, 2000 & HERF Fellowship, 1999
University of Manitoba Graduate Fellowship, 1999 (declined)
Ontario Graduate Scholarship, 1999 (declined)
University of Manitoba Students' Union Scholarship, 1997
University of Manitoba Entrance Scholarship, 1994
Seven Oaks School Board Scholarship, 1994

CLINICAL EXPERIENCE

Psychology Practicum Student, Department of Behavioral Medicine & Psychiatry
Morgantown, WV August 2001-present
Supervisor: Eric Rankin, Ph.D.

Provide psychological services to the outpatient clinic of Chestnut Ridge Hospital, including conducting weekly intakes and providing therapy for outpatient clients. Conduct initial and

follow-up visits with family caregivers of memory disorder clinic patients, assessing burden, depressive symptoms, coping skills, and family support.

Volunteer Camp Counselor at Pediatric Burn Camp

(Sponsored: The Western Pennsylvania Hospital)

Camp Kon-O-Kwee, PA May 2001

Supervisor: Christina Adams, Ph.D.

Supervised children, ages 6-17 years, in typical camp activities. Assisted in the implementation of a positive behavior support program. Administered questionnaires for a study assessing short- and long-term effects of camp on children's attitudes and behaviors surrounding their burns. Led small-group discussion sections on coping strategies used in difficult social situations.

Psychology Practicum Student, Hopemont Hospital

Terra Alta, WV August 2000- July 2001

Supervisor: Barry Edelstein, Ph.D.

Conducted complete psychological evaluations on Hopemont residents, provided psychological consultation to nursing staff at weekly care plan meetings, developed and assisted with implementation of behavior management programs, planned and delivered six in-services to hospital staff on preventing burnout, treating burnout, and dementia.

Quin Curtis Center for Psychological Services Vertical Team

West Virginia University, Morgantown, WV August 2000-August 2001

Supervisor: Lindsey Cohen, Ph.D.

Provided psychological services to clients at the Department's training clinic, with a focus on pediatric psychology issues.

Quin Curtis Center for Psychological Services Vertical Team

West Virginia University, Morgantown, WV August 1999- May 2000

Supervisor: Jeannie Sperry, Ph.D.

Provided psychological services to clients at the Department's training clinic, with a focus on behavioral medicine issues. Planned psychoeducational group to be offered to newly diagnosed Diabetes patients at the WVU Family Medicine Center.

Crisis Counselor, Klinik Community Health Centre

Winnipeg, Manitoba 1997- 1999

Klinik provides health and counseling services as well as community development and education to the City of Winnipeg. As a volunteer crisis counselor, I received approximately 70 hours of crisis intervention training in the areas of suicide, domestic abuse, sexual assault, child abuse, grief counseling, and mental health. I worked a weekly night shift on the crisis lines.

Critical Incident Stress Debriefing Team Member, Klinik Community Health Centre

Winnipeg, Manitoba, May 1998-July 1999

Participated in a 16-hour training session to learn how to debrief individuals who have experienced traumatic life events. Volunteered on a team that debriefed families and community groups after they experienced critical incidents such as homicides and suicides.

RESEARCH EXPERIENCE

Research in Progress

Circadian Rhythms: Implications for Cognitive Assessment of Older Adults

West Virginia University, 2000-present

Parenting Stress and Child Adaptation in Childhood Immunodeficiency Syndrome

West Virginia University, 2001-present

Use of the CES-D with Older Adults: Appropriate Versions and Relationship to the GDS

West Virginia University, 2000-present

Past Projects:

Research Assistantship, Comparison of self-other reports of egocentrism

University of Manitoba, Winnipeg, Manitoba 1998-1999

Honours Thesis

University of Manitoba, Winnipeg, Manitoba 1997-1998

Topic: Behavioral Assessment of Dependent and Independent Self-Care Behaviors in Elderly Residents of a Personal Care Home

Research Assistant, Behavior Analysis Laboratory

University of Manitoba, 1996-1997.

Topic: Comparisons of computerized shaping and chaining to modify limb movement
Assisted with calibration of limb-movement detection equipment and participated in practice sessions to test equipment, testing sessions with participants, and data analysis.

Clinical Interviewer, Independent Research in Psychology Course

University of Manitoba, January-April 1997.

Topic: Identity and decision making

Participated in training in communication and listening skills; administered questionnaires to, and conducted semi-structured interviews with, Junior High School, High School, and University students; coded the interviews obtained by other interviewers for level of identity achievement.

TEACHING EXPERIENCE

Introduction to Clinical Psychology, Teaching Assistant

West Virginia University, August 2001-present

Supervisor: Barry Edelstein, Ph.D.

This course is required for all clinical psychology graduate students. I met weekly with different pairs of first year clinical graduate students to assist them in developing clinical interviewing skills. Played the role of the client while students played the role of therapist. Reviewed videotapes of client-therapist role plays and provided feedback to students on interviewing. Met weekly with faculty supervisor and graduate instructors to discuss student progress.

Behavioral Assessment II Teaching Assistant

West Virginia University, January 2001-May 2001

Supervisor: Christina Adams, Ph.D.

This course is required for all clinical psychology graduate students. I evaluated student performance of psychological testing by viewing videotapes of their test administrations (WAIS, WMS, WIAT, etc.) I also devised mock test protocols and assisted graduate students in attaining mastery criteria for each test administration.

Introduction to Psychology Instructor

West Virginia University, August 1999-May 2000

Supervisor: Christina Adams, Ph.D.

Taught two 60-student sections of Introductory Psychology for Fall and Spring semesters.

PROFESSIONAL ACTIVITIES

Committee Memberships

Adult Clinical Faculty Search Committee

West Virginia University, August 2001-present

Adult Clinical Training Committee

West Virginia University, August 2000-May 2001

Elected to serve as student representative to this committee. Responsibilities included representing student interests at bi-weekly adult clinical training committee meetings, organizing the department's interview weekend for graduate admissions, and voting on program area issues and admissions decisions.

Diversity Issues Committee

West Virginia University, August 1999- May 2000

Presentations

Koven, L. (2001, October). A demonstration of the science of psychology. Presentation delivered to 8th grade science classrooms for Exploring Behavior Week. Westwood Middle School, Morgantown, WV.

PUBLICATIONS

Bonner, K., Koven, L. P., & Patrick, J. H. (in press) Effects of religiosity and spirituality on affect and prosocial behaviors. Journal of Religious Gerontology

Edelstein, B. A., Martin, R. R., & Koven, L. P. (in press) Assessment in Gerontology Settings. In J. R. Graham & J. A. Naglieri (Eds.) Handbook of assessment psychology. Wiley & Sons.

PRESENTATIONS

Koven, L. P., & Edelstein, B. A. (2001, November). Reasons for Living Across the Lifespan. Poster presented at the meeting of Gerontological Society of America, Chicago, IL.

Spira, A. S., Koven, L. P., & Edelstein, B. A. (2001, November). Using Differential Reinforcement to Decrease Compulsive Stealing in a Nursing Home Resident. Poster presented at the meeting of Gerontological Society of America, Chicago, IL.

Bonner, K., Koven, L. P., Patrick, J. H. (October, 2001). Daily Religious Experiences and Depressive Symptoms. Paper presented at West Virginia Conference on Rural Aging, Morgantown, WV.

Koven, L. P., Holborn, S.W., & Piotrowski, A. (1998, May). Behavioral Assessment of Dependent and Independent Self-Care Behaviors in Elderly Residents of a Personal Care Home. Poster presented at the meeting of the Association for Behavior Analysis, Orlando, FL.

Koven, L. P., & Holborn, S. W. (1998, May). Behavioral Assessment of Dependent and Independent Self-Care Behaviors in Elderly Residents of a Personal Care Home. Paper presented at the 17th Annual Prairie Undergraduate Psychology Conference, University of Winnipeg, Manitoba.