# Perception of Consequences of Suicide Among Educated Adults in Ondo Metropolis, Nigeria

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**Abstract**
This study investigated perception of consequences of suicide among educated adults. Descriptive survey research design was adopted in the study. The population comprised all educated adults in Ondo metropolis. Random sampling technique was used to select two hundred (200) educated adults as sample for the study. Structured questionnaire titled "Questionnaire on Suicide" (QS) was used as instrument to collect data for the study. Reliability of the instrument was ascertained using Cronbach's Alpha statistics which yielded a coefficient of 0.91. Data collected was analysed using mean, ranking, t-test and Analysis of Variance. The results showed consequences of suicide as emotional suffering of the families, wastage of resources in terms of medical care, lost productivity and emotional suffering of the communities in descending order. It was also found that gender has a significant influence on perception of consequences of suicide while marital status and religion do not. It was therefore recommended that family should be closely knit and consider mental health of members very paramount. Families should monitor members with mental illness for social and psychological support. All avenues should be used to sensitize communities to prevent suicide. Mostly affected sex should be identified for intensive prevention move. All religions should work collaboratively for the prevention of suicide.

## 1. Introduction

Suicide is the act of intentionally causing one's own death. Suicide is often carried out as a result of despair, the cause of which is frequently attributed to a mental disorder such as depression, bipolar disorder, schizophrenia, borderline personality disorder, alcoholism, or drug abuse, as well as stress factors such as financial difficulty, troubles with interpersonal relationships and bullying.

Among the most common causes of suicide is that of mental illness. Most people end up trying a variety of psychiatric drugs and/or talk therapies. After years of trying various medications, going through medication withdrawals, and experimenting with therapies, some people are stuck in a constant state of mental pain and despair.

According to Onofa (2019), about 10-20% cases of depression die by suicide. Over 90% of people who die by suicide have depression. Multiple factors leading to depression – suicide include shame of recurrent failure/frustration, marital difficulties, unemployment, financial difficulties/non-payment of salaries, major disappointment/major recent loss, stagnation of work/ denial of promotion, chronic mental illness, use of alcohol and psychoactive substances.

Every year, almost one million people die by suicide around the world, Suicide remains a significant social and public health problem. In 1998, suicide constituted 1.8% of the total disease burden; this is to rise to 2.4% by 2020 worldwide, suicide is one of the three leading causes of death among those in the most economically productive age group (15 – 44 years), and the second leading cause of death in the 15 – 19 years age group. At the other end of the age spectrum, the elderly are also at high risk in many countries (Public Health Action for the Prevention of Suicide, 2012).

Onofa (2019) pointed out that in Nigeria, the real suicide rate is not known but there is increase in the wave of suicide in recent time and many cases are not reported because of stigma. World Health Organisation estimated that 877,000 deaths were due to suicide in the year 2002, the majority of which (85%) occurred in low and middle-income countries (WHO, 2003). According to United States National Action Alliance for Suicide

Prevention (2012), suicide is a serious public health problem that causes immeasurable pain, suffering and loss to individual, families, communities nationwide.

Behera, Balabantray and Nayak (2005) found that male sex are very prone to take extreme decision (2.7 times more than female sex) and suicide is more prevalent during 20 to 40 years of age. Married people are found to take this decision more frequently than unmarried ones with psycho social factor like family dispute playing a great role compared to mental or physical illness. Disharmony existing between family members trigger to take the fatal decision.

Religion is the strongest element in man and exerts probably the greatest influence in man. It is regarded as a most important part of the life of human beings. Almost all societies have religious beliefs or practices. In almost every human community, people have prayed or worshipped. In very many communities, people have thought religion to be very important, and some have thought it more important than any other part of life. Religion has very strong influence on human perception about almost everything in life.

Like in many developing countries, suicide in Nigeria is grossly under-reported and under documented due to the non-existence of a vital statistics system and the sensitive nature of the subject (Alabi, Alabi & Ayinde et al., 2014; Panyayong, Tantirangsee & Bogolan, et al., 2018). The dearth of data is also shrouded in stigma, and cultural and religious sentiments associated with suicide in Nigeria. Deaths by suicide are perceived as sinful, a taboo and caused by evil forces, so the family are often times stigmatized and denied social opportunities. People prefer to hide the mode of death, declaring suicides as accidental deaths or as homicides. Many of the reported cases rely on police and hospital records, neither of which are comprehensive and might have been influenced by the bereaved (Ohayi, 2019; Islam & Islam, 2003).

Beyond counting the numbers of suicide and suicide attempts, is the often unexplored psychological burden from feelings of guilt, sorrow and anguish, which is often experienced by the family members and close associates of individuals who commit suicide. Every act of suicide affects averagely six other people, at the minimum (WHO, 2000). Considering the fact that suicide is a significant social and public health problem, there is a need to come up with empirical data on its consequences, in order to stir up all individuals towards its prevention.

The World Health Organisation (WHO) defined suicide as the act of killing oneself, deliberately initiated and performed by the person concerned in the full knowledge or expectation of its fatal outcome (Patton, Coffey Sawyer et. al, 2009). Suicide is the third leading cause of death among young people aged 15 to 44 years, and ranks second for adolescent between ages 15 and 19 years old (WHO, 1998). It is estimated that globally, about one million deaths occur from suicide every year, which roughly translates to one suicide death every forty seconds. The incidence of attempted suicide is twenty five times more common than completed suicide. It is also the most important cause of violent death worldwide, accounting for 49% of all cases. Other major contributors to violent deaths worldwide include homicide (32%), with conflicts and wars making up the remaining 19% (WHO, 2000).

## 1.1. Objectives of the Study
The study is designed to:

a.  Investigate the consequences of suicide as perceived by educated adults.

b.  Find out whether gender influences the perception of consequences of suicide among educated adults.

c.  Examine whether marital status influences the perception of consequences of suicide among educated adults.

d.  Determine whether religion influences the perception of consequences of suicide among educated adults.

## 1.2. Research Question
What are the consequences of suicide as perceived by educated adults?

## 1.3. Research Hypotheses
a.  There is no significant influence of gender on the perception of consequences of suicide among educated adults.

b.  There is no significant influence of marital status on the perception of consequences of suicide among educated adults.

c. There is no significant influence of religion on the perception of consequences of suicide among educated adults.

## 2. Method

Descriptive survey research design was adopted for the study. The population comprised all educated adults in Ondo metropolis. Random sampling technique was used to select two hundred (200) educated adults as sample for the study. Structured questionnaire titled "Questionnaire on Suicide (QS)" was used as instrument for the study. The questionnaire was divided into two sections (A & B). Section A contains personal data of the respondents (such as gender, marital status and religion)while Section B consists of items on consequences of suicide on a four Likert type scale of Strongly Agree, (SA), Agree (A), Disagreed (D) and Strongly Disagree (SD). Reliability of the instrument was ascertained using Cronbach's Alpha statistics which yielded a coefficient of 0.91. Data collected was analysed using t-test and Analysis of Variance (ANOVA).

## 3. Results and Discussion

### 3.1. Research Question: What are the Consequences of suicide as Perceived by Educated Adults

To answer this question, the responses of the sample selected for the study were analysed using mean and ranking as presented in Table 1.

**Table 1. Mean and rank order Table of the Consequences of Suicide**

| S/N | Consequences of suicide | $\bar{X}$ | Rank |
|---|---|---|---|
| 1 | Emotional suffering of the families. | 3.16 | 1st |
| 2 | Emotional suffering of the communities | 2.77 | 4th |
| 3 | Wastage of resources in terms of medical care | 3.08 | 2nd |
| 4 | Lost productivity | 2.86 | 3rd |

Table 1 shows that emotional suffering of the families ranked 1st with mean value of 3.16, wastage of resources in terms of medical care ranked 2nd with mean value of 3.08, lost productivity ranked 3rd with mean value of 2.86 while emotional suffering of the communities ranked 4th and last with mean value of 2.77. This implies that suicide has consequences on families and communities at large.

### 3.2. Testing of Hypotheses

### 3.2.1. Hypothesis One: There is no Significant Influence of Gender on the Perception of Consequences of Suicide Among Educated Adults

In testing this hypothesis, the respondents were classified into two groups based on their gender (i.e. male and female) and scores on consequences of suicide were analysed using t-test. The results are presented in Table 2.

**Table 2. Independent t-test Summary Showing the Difference in the Perception of Consequences of Suicide Based on GENDER**

| Variable | Gender | N | $\bar{X}$ | St.D | Df | t | Sig | P | $\eta^2$ |
|---|---|---|---|---|---|---|---|---|---|
| Perception on the consequences of suicide | Male | 91 | 6.48 | .882 | 198 | 1.613 | .000 | <.05 | 0.013 |
| | Female | 109 | 4.11 | 4.710 | | | | | |

Table 2 shows that male subjects have a mean score of 6.48 and a standard deviation of 0.882 while the female counterparts have a mean score of 4.11 and a standard deviation of 4.710. A t-test analysis of these values yielded a t-value of 1.613 which is significant at 0.05 level. This implies that there is a significant difference in the perception of consequences of suicide based on gender. Size of effect ($\eta^2$ = 0.013) reveals that gender has low effect (according to Cohhen, 1988 and Field, 2000 rule of thumb for size of effect) on the perception of consequences of suicide; that is, gender accounted for 1.3% change in the perception of respondents towards consequences of suicide.

### 3.2.2. Hypothesis Two: There is no Significant Influence of Marital Status on the Perception of Consequences of Suicide Among Educated Adults

In testing this hypothesis, the subjects were classified into two groups based on their marital status (i.e. single or married) and scores on consequences of suicide were analysed using t-test. The results are presented in Table 3.

**Table 3. Independent t-test Summary Showing the Difference in the Perception of Consequences of Suicide Based on Marital Status**

| Variable | Marital status | N | $\bar{X}$ | St.D | df | t | Sig | P |
|---|---|---|---|---|---|---|---|---|
| Perception on the consequences of suicide | Single | 124 | 8.13 | .880 | 198 | 4.703 | .116 | >0.05 |
| | Married | 76 | 7.82 | .735 | | | | |

As shown in Table 3, single subjects have a mean score of 8.13 and a standard deviation of 0.880 while married subjects have a mean score of 7.82 and s standard seviation of 0.735. A t-test analysis of these values yielded a t-value of 4.703 which is not significant at 0.05 level. This implies that marital status of the respondents does not have significant influence on their perception of consequences of suicide.

### 3.2.3. Hypothesis Three: There is no Significant Influence of Religion on the Perception of Consequences of Suicide Among Educated Adults

In testing this hypothesis, the subjects were classified into three groups based on their religion (i..e. Christianity, Islam or African Traditional Religion) and scores on consequences of suicide were analysed using Analysis of Variance (ANOVA). The results are presented in Table 4.

**Table 4. One-way Analysis of Variance Showing the Difference in the Perception of Consequence of Suicide Based on Religion**

| | Sum of Squares | df | Mean Square | F | Sig |
|---|---|---|---|---|---|
| Between Groups | 1556.045 | 2 | 778.023 | 7.324 | .099 |
| Within Groups | 20926.500 | 197 | 106.226 | | |
| Total | 22482.545 | 199 | | | |

From Table 4, the mean squares between groups and within groups are 1556.045 and 20926.500 respectively. These yielded the F-value of 7.324 which is not significant at 0.05 level. This implies that religion has no significant influence on consequences of suicide as perceived by educated adults.

## 3.3. Discussions

This study showed consequences of suicide as emotional suffering of the families, wastage of resources in terms of medical care, lost productivity and emotional suffering of the communities in descending order. This is an indication that family of the victim is most affected as members are the closest before spreading the brunt to the community and society at large. This can be attributed to close family i.e. in Africa culture, especially Nigeria, where family is responsible for the upbringing and up keep of children; unlike in the western world where the government is responsible for almost everything about a child. If anything happens to any member of the family, the whole family will suffer for it because all the responsibilities will be passed on to everybody. This is corroborated by Alutu and Joseph (2020) who found parents as the most preferred source of assistance by in-school adolescents having depression symptoms. In the same vein, United States National Action Alliance for Suicide Prevention (2012) identified suicide as a serious public health problem that causes immeasurable pain, suffering and loss to individuals, families, communities nationwide. Beyond counting the numbers of suicide and suicide attempts is the often unexplored psychological burden from feelings of guilt, sorrow and anguish, which is often experienced by the family members and close associates of individuals who commit suicide. Every act of suicide affects averagely six other people at the minimum WHO, 2000).

It was found that there is a significant difference in the perception of consequences of suicide based on gender. This is related to the study of Rohde, Lewinsohn, Klein, Seeley and Gau (2014) who found boys to have more depressive symptoms than girls. Wirback (2018) reported that girls had an increased risk of both self-reported depressive symptoms and diagnosed depression compared to boys. Granrud, Myhrene and Behera et. al. (2005) equally reported that male sex are very prone to take extreme decision of suicide (2.7 times more than female sex). On the other hand, Alutu and Joseph (2020) found no significant difference between male and female on depression symptoms. Tamounojki, Chinawa, Aniwada, Manyike, Ndu and Nduagba (2017) found that gender was not significantly associated with depression.

The study revealed that marital status does not significantly influence perception of consequences of suicide. This is in contrast to the study by Behera et. al. (2005), who found that married people take the decision

of suicide more frequently than unmarried ones in that psychosocial factor like family dispute plays a great role as compared to mental or physical illness. This shows that disharmony existing between family members trigger to take the fatal decision. Despite this contrast, the results could be based on the fact that both married and single acknowledged the grievous consequences of suicide on individuals, families and the communities at large.

Finally, the results of the study showed that religion has no significant influence on the perception of consequences of suicide. This is an indication that the three religions (Christianity, Islam and African Traditional Religion) have the same perspective about consequences of suicide. All religions have much in common especially the acknowledgement of God and moral values. No religion would ever support taking one's life. That implies that all religions can work collaboratively to combat suicide.

## 3.4. Recommendations

Based on the findings of this study, the following recommendations are made:

a. Families should be closely knit and consider mental health of members very paramount.

b. Families should monitor members with mental illness for social and psychological support.

c. All avenues should be used to sensitize communities on importance of family relationship to prevent suicide.

d. Mostly affected sex should be identified for intensive prevention move.

e. All religions should work collaboratively for the prevention of suicide.

f. Consequences of suicide should be the driving force for all hands to be deck in its prevention.

# 4. Conclusion

Consequences of suicide are found to be emotional suffering of the families, wastage of resources in terms of medical care, lost productivity and emotional suffering of the communities. Gender has significant influence on the perception of consequences of suicide while marital status and religion do not.

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## Declaration on AI Use

The authors declare that no artificial intelligence (AI) or AI-assisted tools were used in the preparation of this manuscript. AI were used only to improve readability and language under strict human oversight; no content, ideas, analyses, or conclusions were generated by AI.

## References

Alabi, O., Alabi, H., & Ayinde, et al. (2014). Suicide and suicidal behavior in Nigeria: A review. *Psychiatry Journal*, *37*, 1–6.

Alutu, A. N., & Joseph, C. H. (2020). Depression symptoms and preferred sources of assistance among in-school adolescents in Edo State: Implications for mental health counselling. *Journal of Professional Counselling*, *3*(1), 37–46.

Behera, A., Balahantruy, J. K., & Nayuk, S. R. (2005). Review of suicide cases: A retrospective study. *JIAFM*, *27*(2), 100–102.

Granrud, M. D., Myhrene, S., & Theander, K. (2017). Gender differences in symptoms of depression among adolescents in Eastern Norway: Results from a cross-sectional study. *Scandinavian Journal of Public Health*, *47*(28), 140–149.

Islam, M. N., & Islam, M. N. (2003). Pattern of unnatural death in a city mortuary: a 10-year retrospective study. *Legal medicine*, *5*, S354-S356.

Ohayi, S. R. (2019). Doctor, please don't say he died by suicide: Exploring the burden of suicide survivorship in a developing country. *Egyptian Journal of Forensic Sciences*, *9*, 3–9.

Onofa, L. C. (2019). *Promoting mental health awareness for a productive and healthy lifestyle*. Mental health talk presented to academic staff of Adeyemi College of Education, Ondo, Nigeria, April 25, 2019.

Panyayong, B., Tantirangsee, N., Bogolan, B. R. D., et al. (2018). Psychiatric disorders associated with intimate partner violence and sexual violence in Thai women: Results from the Thai national mental health survey. *General Psychiatry*, *31*, e000008.

Patton, G. C., Colley, C. J., Sawyer, S. M., et al. (2009). Global patterns of mortality in young people: A systematic analysis of population health data. *The Lancet*, *374*, 881–892.

Public Health Action for the Prevention of Suicide. (2012). *National suicide prevention strategy: A framework*. U.S. Department of Health and Human Services.

Rohde, P., Lewinsohn, P. M., Klein, D. N., Seeley, J. R., & Gau, M. (2014). Key characteristics of major depressive disorder occurring in childhood, adolescence, and adulthood. *Clinical Psychological Science*, *1*(1), 41–53.

Tamounoski, C. A., Chinawa, J. M., Aniwada, E. C., Manyike, P. C., Ndu, I., & Nduagba, O. C. (2017). Determinants of depression among medical students in two medical schools from South East Nigeria: A screening test. *Annals of Nigerian Medicine*, *11*, 27–31.

United States National Action Alliance for Suicide Prevention. (2012). *National strategy for suicide prevention: Goals and objectives for action*. U.S. Department of Health and Human Services.

Wirback, T. (2018). *Depression among adolescents and young adults: Social and gender differences* (Doctoral thesis). Department of Public Health Sciences, Karolinska Institute, Stockholm, Sweden.

World Health Organisation. (1998). *Primary prevention of mental, neurological and psychosocial disorders*. Geneva: Author.

World Health Organisation. (2000). *Preventing suicide: A resource for physicians*. Geneva.

World Health Organisation. (2003). *The world health report: Shaping the future*. Geneva.