Familial and Social Support as Protective Factors in African Americans at Risk for Suicide

by

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Abstract

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African Americans, who, despite suffering a multitude of life stressors associated with racism and discrimination, have historically had a lower rate of suicide. However, the recent increase in the rate of suicide among African Americans has yet to be explained. By examining suicide among young African American adults, a group experiencing the highest rate of suicide, this study seeks to highlight an under examined area in the research: the presence or absence of protective factors among African Americans that might decrease their risk of suicide. Family and the church have traditionally been protective factors for African Americans, regulating and modulating intense affective responses to adversity, thereby promoting a sense of wellbeing. This study hypothesizes that the recent rise in the rate of suicide may be attributable to the erosion of protective factors for African Americans. Ultimately, the erosion of these protective factors in the face of unchanging life stressors will place African Americans at increased risk for suicide. Participants (N = 60) were recruited from an introductory psychology class at a medium sized urban university. Subjects' age ranged from eighteen to thirty-four (M = 22.45, SD = 4.8). A comprehensive battery of self-report instruments

was chosen to assess the following variables: suicidality, family, social support and protective factors. Scales include the Harkavy Asnis Suicide Scale (HASS), College Reasons for Living Inventory for Adolescents (RFL-CS), Family Assessment Measure III (FAM-III), Young Adult Social Support Inventory (YA-SSI). Results: FAM-III Involvement (OR, 0.469; $p < .05$) and Spiritual Faith (OR, 0.34, $p < .05$) are significantly related to, and predictive of lifetime suicidal ideation. Moral Objection subscale (OR, 9.19; $p < .05$) is significantly related to, and predictive of suicide attempts. Similarly, Responsibility to Family and Friends subscale (OR, 8.06; $p < .05$) is predictive of current suicidal ideation. The addition of known cultural strengths to the assessment of protective factors is a worthy endeavor as it adds to the veracity of protective factors. Further the study of the impact of cultural characteristics on protective factors can improve the assessment of risk in African-American youth and serve as stepping stone to the development of prevention program for youth.

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Introduction

Throughout their history in the United States, from slavery to the civil rights movement, African Americans have withstood forced segregation, poverty, and violence. With sweeping social changes since the 1960's, some African Americans gained access to better schools, health care and a middle class lifestyle. However, according to the U.S. Surgeon General's report (2000), "African Americans are over-represented in high-need populations that are particularly at risk for mental illnesses:

- People who are homeless. While representing only 12% of the U.S. population, African Americans make up about 40% of the homeless population.
- People who are incarcerated. Nearly half of all prisoners in State and Federal jurisdictions and almost 40% of juveniles in legal custody are African Americans.
- Children in foster care and the child welfare system. African American children and youth constitute about 45% of children in public foster care and more than half of all children waiting to be adopted.
- People exposed to violence. African Americans of all ages are more likely to be victims of serious violent crime than are non-Hispanic whites." (Surgeon General's Report, 2000)

In this context, young Blacks are dying by suicide at an alarming rate. For Black youth age 15-24, suicide is the 3rd leading cause of death -- 17.60 per 100,000 ranking only behind homicide and accidental deaths (National Center for Health Statistics [NCHS], 1998). From 1980 through 1995, the suicide rate increased 114% for black youth (Morbidity and Mortality Weekly Report [MMWR], 1998). This recent increase in the rate of suicide among African Americans has begun to be addressed among suicide researchers. However, these researchers remain perplexed at the rise in suicide in African Americans, who, despite suffering a multitude of life stressors associated with racism and discrimination, have historically had a lower rate of suicide. The highest rate of suicide across the life span peaks in young adulthood (National Center for Health Statistics [NCHS], 1998).

By examining suicide among young African American adults, a group experiencing the highest rate of suicide, this study seeks to highlight an under examined area in the research: the presence or absence of protective factors among African Americans that might decrease their risk of suicide. A protective factor is a socio-culturally bounded buffer that serves to assuage impulses to self-harm. For instance, family and the church have traditionally been protective factors for African Americans, regulating and modulating intense affective responses to adversity, thereby promoting a sense of wellbeing. This study hypothesizes that the recent rise in the rate of suicide may be attributable to the erosion of protective factors for African Americans. Ultimately, the erosion of these protective factors in the face of unchanging life stressors will place African Americans at increased risk for suicide.

Literature Review

Scope of the Problem: Suicide in African American Young Adults

In the United States, the overall rate of suicide has dropped from the 8th in 1997 to the 11th leading causes of death in 1999 (10.6 per 100,000) across all age groups (National Center for Health Statistics [NCHS], 1997, 1999). Although the overall suicide rate has declined, for minority groups the rate of suicide remains among the ten leading causes of death for those below age 44 (NCHS, 1998). For all youth aged 15-24, the rate of suicide remains the third leading cause of death, 10.3 per 100,000 (NCHS, 1999) and consistently remains the third leading cause of death (NCHS, 1999, 1998, 1997, 1996, 1995). For all minority groups, suicide and suicidal behaviors has risen, especially among youth (Burr, Hartman & Matteson, 1999). For Black youth age 15-24, suicide is the 3rd leading cause of death -- 17.60 per 100,000 behind homicide and accidental deaths (NCHS, 1998).

The question emerges, what lies behind this high rate of Black youth suicide. Are Black youth depressed and engaging in self destructive behaviors? The Youth Risk Behavior Survey (Centers for Disease Control [CDC], 2000), a national survey of high school students, has provided interesting data on Black adolescents. For example, Black students were more likely than Hispanics and Whites to report a period of feeling hopeless and sad for at least two weeks and to report engaging in potentially self destructive behaviors, i.e. failing to wear protective head gear and set belts (CDC, 2000). From 1980 through 1995, the suicide rate increased 114% for black youth aged 10-19; the most dramatic increase occurred (233%) in those youth 10 to 14 years old and Black males aged 15 to 19 (223%) residing in the south (Morbidity and Mortality Weekly

Report [MMWR], 1998). At a time when the overall rate has dropped to the eleventh leading cause of death in 1999 (National Vital Statistic Report [NVSR], 2001), the interesting question becomes why the rate has begun to increase among Blacks.

Early research in the area of suicide has been successful in outlining the risk factors for youth. However, these studies have few Black participants; therefore researchers were unable hypothesize about identifying risks for Black youth. The relatively low rate of suicide among Blacks as compared to Whites has resulted in less attention paid to suicide risk factors for Black youth (Chance, Kaslow, Summerville & Wood, 1998). This lack of attention has bolstered the myth within the field of suicidology and the Black community that Blacks do not commit suicide. The recent rise in the number of suicides among black youth, however, has led to an increased focus on the risk factors for black youth.

Redefining suicide: the issues of myth and nomenclature for African Americans

There are a number of theoretical perspectives used to explain suicide, from the neurobiological to the psychodynamic to the sociocultural. Further complicating the issue is the plethora of definitions of the term suicide emerging from the different, perspectives, prompting some authors (O'Carroll, Berman, Maris, Moscicki, Tanny and Silverman, 1996) to attempt to clarify nomenclature. A suicide attempt is defined "as a potentially self-injurious behavior with a non-fatal outcome, for which there is evidence (either explicit or implicit) that the person intended at some (nonzero) level to kill himself/herself" (O'Carroll et al. (1996), p. 34). In turn, suicidal ideation refers to "any self reported thoughts of engaging in suicide-related behavior" (O'Carroll et al. (1996), p. 34). Stemming from work with children and adolescents, others have similarly defined

suicidal ideation as "thoughts or verbalizations of suicide intent" (Pfeffer, Plutchik, Mizruchi & Lipkins, 1986).

Pfeffer, Plutchik, Mizruchi et al. (1986) have elaborated on the definition of suicide to include the range of behaviors between ideation and completed suicide. For example, a suicide threat is defined as the "verbalization of an impending suicidal act that if fully carried out could lead to self-harm" (Pfeffer et al. 1986, p. 734) and a mild suicide attempt, an "actual self destructive act that realistically could have endangered life and did not require medical intervention" (Pfeffer et al.1986, p. 734): The final category is a serious suicide attempt, defined as "an actual self-destructive act that realistically could have lead to death and may have necessitated medical care" (Pfeffer et al. 1986, p. 735). Therefore, suicidal behaviors are defined as behaviors occurring along a continuum. Between these end points occurs a range of behaviors from suicidal ideation to expressed intent (Pfeffer, Klerman, Hurt et al., 1991).

Some researchers have posited that individuals who commit suicide and suicide attempters are from two similar populations with significant amounts of overlap. Other researchers suggest that both suicide attempters and completed suicides extend from a single population of individuals who engage in self-destructive behaviors, some of which lead to death (Brent et al., 1988; Beautrais, 2001). Verbalizations, gestures and attempts are included along a continuum of self-destructive behaviors. Any person engaged in a self-destructive behavior would be included within the population of all self-destructive behaviors. Therefore whether describing a gesture or an attempt all acts stem from a single population of destructive behaviors.

The broadening of this definition informs African American suicide by underscoring that self destruction can be expressed in a variety of forms. Self-hate and depression can be acted out on a societal level, where individuals will readily engage in behaviors that put themselves at risk. Turning to the research on African Americans, Poussaint and Alexander (2000) suggests that the study of suicide in African Americans should be expanded to include the spectrum of self-destructive acts. This broadening encompasses behaviors that place the individual in the path of danger, where bodily harm or death is an inevitable outcome. Examples would include deaths due to a lethal drug overdose or becoming physically threatening to law enforcement, deaths usually labeled as accidental or as homicide (Gibbs, 1988; Poussaint and Alexander, 2000). This idea is intriguing considering that accidental death and homicide are respectively the 1st and 2nd leading cause of death for Black youth aged 20-24 (CDC, 2000), suggesting that the suicide rate may be significantly higher if these deaths were to be reclassified and viewed through the lens of self destruction (Gibbs, 1988; Poussaint and Alexander, 2000). According to Poussaint and Alexander (2000), examining the impact of suicide on the Black community tells only part of the story. He argues that some Blacks engage self-destructive behaviors as a way of expressing internalized self-loathing and anger, stemming from their status as Blacks. By engaging in self-destructive acts, a Black youth gives voice to an underlying wish to die.

The questions over self destructive acts and its inclusion in the definition of suicide raise further questions about the degree to which standard models of suicide apply to African Americans. These models have attempted to explain suicidal behavior in the general population; however it is not clear how applicable they are to the subpopulation

of African Americans. While race is not a cause of suicide, it is a socio-cultural context that shapes a person's perceptions, values and beliefs. Suicidology, after all, focuses upon the universal nature of signs and symptoms of suicide negating the individual as emerging from a cultural context. To overlook the importance of culturally bound expressions of suicide risk is to reinforce the longstanding belief that Blacks do not commit suicide, and misses the potential to understand suicide more broadly by examining the particular issues for Blacks.

In the following study, representative of the research conducted with cross cultural participants, Shaffer, Gould, Fisher, Trautman, Moreau, Kleinman, and Flory (1996) sought to outline risk factors in a sample of adolescents as part of the EAC catchment area (Shaffer, Gould, Fisher et al. 1996). According to that study, the rate of reported suicide attempts by Black participants was very low especially when compared to white participants. Shaffer, Gould, Fisher et al. (1996) note that the relatively low number of Black participants in the study did not allow the findings to be indicative of the rate in the overall population, making any generalizability questionable. However, the low rate reported by Shaffer Gould, Fisher et al. (1996) reinforces the myth that African Americans do not commit suicide. As stated earlier, the possible expansion of the definition of suicide by looking at the particular forms of suicidal behavior in Blacks could yield interesting results (Gibbs, 1988; Poussaint and Alexander, 2000), just as the knowledge about risk and protective factors in Blacks will likely add to the field's understanding of these factors in the general population as well.

Lastly, the complexities of suicidal behavior in Blacks are further confounded by the use of Blacks verses African Americans in labeling persons of color in order to

discuss observed risk and assessment. Throughout the suicide literature, these terms are used interchangeably, leading to some confusion. For example, Black persons of color represent a variety of cultural heritages and countries of origin, from Caribbean to African. Further, researchers do not distinguish newly arrived immigrant Blacks verses first generation, second generation, etc.

This confusion of terms can be traced to the reporting of suicide data. The governing and reporting agencies that record the data on death by suicide, i.e. coroner's offices and Centers for Disease Control respectively used two categories of race (white, black) without reference to ethnicity. Until recently, Hispanic people were classified as other, a category shared with mixed race and Asians. Beginning in 1998, with more attention paid to suicide among people of color, Hispanic persons were assigned the category non-White (Hispanic origin). Correspondingly, the suicide rate of Hispanics was observed to rise, partially due to provision of this separate category for tracking. A similar pattern has occurred for African Americans, showing that as persons of color become "visible" to the agencies tracking suicide and suicidologists, the documented rate among these groups has risen. These are recent changes in the tracking of completed suicides. The field of suicide research is slow to change and the research literature has yet to reflect this trend. Much of the research available for this paper does not make distinctions regarding ethnicity and country of origin. Therefore, the terms Blacks verses African Americans will be used interchangeably in this paper, reflecting a systemic flaw in suicide research on persons of color.

Risk factors in all youth

Numerous studies have examined the epidemiology of suicide in adolescence and young adults and have outlined the associated risk factors for attempted and completed suicide. Psychopathology represents one major risk factor for suicide. Affective disorder alone or affective disorders in conjunction with substance abuse, conduct disorder, or antisocial behaviors all predict higher rates of suicide in youth (Shaffer, Gould, Fisher, Trautman, Moreau, Kleinman, Flory, 1996; Gould, Fisher, Parides, Flory, Shaffer, 1996).

Major depression is a common mental health disorder and suicides can occur in the context of a depressive disorder (Hirshfeld, 2001). According to the National Comorbidity Survey, the lifetime prevalence of major depression in the general population is 12.7% for men and 21.3% for women (Kessler, McGonagle, Zhao, Nelson, Hughes, Eshleman, Wittchen, Kendler, 1994). Several epidemiological studies have reported 8.3 percent of adolescents suffer from depression (Birmaher, Ryan, Williamson, Brent, Kaufman, Dahl, Perel, Nelson, 1996; Klerman & Weissman, 1989). With such a high prevalence rate, depression becomes a significant risk factor.

Aside from examining known risk factors like depression, research has refined assessment of suicide crisis and the identification of the suicide risk factors by comparing attempters to non-attempters (Brent, Bridge, Johnson, and Connolly, 1996). The risk of suicide increases for an adolescent given the diagnosis of depression and conduct disorder and impulsivity and aggression, associated with the diagnosis of conduct disorder was found to increase suicide risk (Askenazy, Sorci, Benoit, Lestideau, Myquel and Lecrubier, 2003; Feldman and Wilson, 1997; Shaffer, Gould, Fisher et al. 1996).

Several studies have shown that drug use, teen pregnancy, impulsive behaviors and sexual promiscuity are associated with higher teen suicide risk (Shaffer, Gould, Fisher et al. 1996; Gould, Fisher, Parides et al. 1998; Kosky, Silburn, Zubrick, 1990).

Inadequate coping skills or an inability to entertain alternative solutions to a stressful event have also been found in adolescents with a history of suicide attempts (Paykel, 1994; Paykel, 1976). These adolescents have often experienced an inordinately chaotic childhood and a history of loss, making them loss sensitive (Sulik & Garinkel, 1992). Families of adolescent suicide attempters tend to experience high levels of dysfunction, poor communication, low parental involvement and problematic affective expression (Brent, Bridge, Johnson et. al., 1996). Familial transmission of suicidality is associated with overt aggression and is directly related to completed and attempted suicides verses suicidal ideation. This suggests that adolescents with familial history of suicide have adopted similar aggressive styles of communicating versus the passive, isolative stance of suicide ideators (Brent, Bridge, Johnson et. al. 1996).

Pfeffer, Klerman, Hurt et al. (1991) found that adolescents who engaged in high-risk behaviors were likely to also have previously engaged in low risk suicide behaviors, pointing to the potential preventive value of early screening and detection. Indeed, there is a delay between research identifying a variety of teen risk factors, and effective community-based prevention programs, as the rate of suicide among youth is still high (Brent, Bridge, Johnson et. al. 1996).

Risk factors in African American Youth

Recent research has begun to examine suicidal behavior cross culturally, focusing on the prevalence of suicidal ideation, depression and attempts in adolescences and

young adulthood (Harris and Molock, 2000; Canino and Roberts, 2001). Suicide in African Americans is associated with feelings of hopelessness, recent loss or parental death in early childhood, concomitant anxiety or panic attacks, substance use disorders, lack of mental health treatment, past history of suicide attempts, childhood history of abuse (physical or sexual), negative life events (social, financial or family crisis), unemployment or financial problems, and social isolation and personality variables (aggression or hostility) (Summerville, Kaslow, Abbate, & Cronan, 1994; Brown, Ahmed, Gary & Milburn, 1995; Juon & Ensminger, 1997; Chance, Kaslow, Summerville & Wood, 1998; Kung & Juon, 1998; Kaslow, Thompson & Meadows et al. 2000).

Depression, Somatization & Hopelessness.

As stated earlier, depression is also found to be a significant clinical risk factor for suicide in the general population and in African Americans. According to the National Comorbidity Survey, the lifetime prevalence of any affective disorders among African American was significant (OR = 0.66; Confidence Interval = 0.46-.87) (Kessler, McGonagle, Zhao, Nelson, Hughes, Eshleman, Wittchen, Kendler, 1994). Juon and Ensminger (1997) found that for African American males and females, suicidal thoughts and attempts were associated with depressive symptomatology. One study found that major depression was related to young age (20 to 29 years old), stressful life events within the last year, having poor health and changing residences at least once within the last 5 years (Brown, Ahmed, Gary & Milburn, 1995). This finding suggests that young African American adults are at particular risk of depression due to the normative transitions occurring at this point in the life span such as leaving home, finding a career and setting up a home or family. Changing residences may be particularly meaningful, in

that uprooting and moving means separating one's self from family and support networks, furthering isolating the young adult from resources that can serve as protective factors against depression. For Blacks, their group identity and affiliations are a necessary source of self esteem.

Several researchers have studied depression in African Americans and found that African Americans tend to report an increase in somatic complaints when depressed (Iwata, Turner and Lloyd, 2002). Somatization is more common among African Americans (15%) than among whites (9%) (Surgeon General's Report, 2000). One study sought to compare depressive symptomatology across several ethnic groups of young adults (19-21 years old) and found that African Americans tended to over endorse somatic symptoms over affective/depressive symptomatology (Iwata, Turner and Lloyd, 2002).

Some researchers argue that African American children who experienced depression and depressive ideation early in childhood are more likely to adopt externalizing behaviors in order to adapt (Shaffer, Forehand, Kotchick et al., 2002). Reared in a high-risk environment, African American children may have adopted externalizing behaviors in order to survive, i.e. hyper-vigilance and anxious acting out over internalizing their distress by withdrawal or becoming isolative. As the teen moves into young adulthood, externalizing behaviors become increasingly unacceptable in social contexts such as school or work. Therefore, African Americans may somatasize their distress, rather than overtly expressing it (Shaffer, Forehand, Kotchick et al., 2002).

In addition to somatic symptoms common across racial groups, African Americans experience some culture-bound syndromes such as isolated "sleep paralysis,"

an inability to move while falling asleep or waking up, and "falling out," a sudden collapse sometimes preceded by dizziness (Surgeon General's Report, 2000; Baker and Bell, 1999). When an individual becomes somatic i.e. having a variety of bodily complaints, they are choosing to represent on their bodies the distress that cannot be tolerated consciously. If somatization is another form of acting out behavior, then the underlying depression is expressed through bodily distress. Modifying the standards of symptom presentation to take into account these socio-cultural differences may require a corresponding shift in the signs of suicide risk that manifest as distinct clustering of current risk factors for African Americans (Baker and Bell, 1999).

Hopelessness is a significant risk factor for depression and suicide in the general population and thus has been included in the Beck Depression Inventory and standard suicide assessment scales (Beck, Steer, Kovacs, Garrison, 1985). Therefore, it was surprising to find that, in a review of the literature on African American suicidal behaviors, high levels of hopelessness alone were found not to be predictive of suicidal behaviors in African American females (Chance, Kaslow, Summerville & Wood, 1998). However, in a later study, hopelessness was been found to be a more significant predictor of near-lethal suicide attempts among African Americans than among Caucasians (Kaslow, Thompson & Meadows et al., 2000). In a follow-up study examining suicidal behaviors in a sample of African American women with a history of intimate partner violence, Kaslow and colleagues (Kaslow, Thompson, Meadows, et al., 2000) found hopelessness was the most powerful risk factor for suicidal behavior among African American women, contradicting the earlier study. This finding suggests that

hopelessness is a powerful risk factor when coupled with relational discord and violence, where the women are the targets of aggression that is beyond their control.

Gender Disparity.

Recent research on suicide in African Americans centered on understanding the lower rate of completed suicide among women versus males (Joe & Kaplan, 2001), a trend that reflects a gender disparity in the overall population of completed suicides (Blumenthal & Kupfer, 1990). Brown, Ahmed, Gary & Milburn, (1995) examined major depression in Blacks and found that there was no difference in gender and reported depressive symptomatology. The study included near equal numbers of men (421) and women (444), suggesting that the study's inclusion of a high number of males may have been more representative of Black men. Further, the fact that Black males tend to underutilize healthcare services may explain insufficient representation in prior studies on depression. The authors indicated that this sample of men was taken near and around a military base. Many of the men had experienced recent combat or combat readiness, which may have skewed the results falsely reinforcing the idea that no gender disparity exists. Suggesting that gender disparity does not exist would mean that both sexes are relatively equal in their reporting of depressive symptomatology. However, the gender disparity seen in the rates of suicide may not stem from the lack of depressive symptoms but possibly from the lack of social support utilized by Black males versus Black females.

Others have suggested that early child rearing and socialization may be a cause of the gender disparity (Chance, Kaslow, Summerville & Wood, 1998). African American boys are expected to be tough and control their feelings in preparation for a lack of

supportive resources at school, in the community and the larger society. In contrast, African American women can expect to have greater access to community and economic resources (Chance, Kaslow, Summerville & Wood, 1998). Therefore, they are encouraged to make use of these supports, much as their grandmothers had to do to survive in the face of adversity. Women are encouraged and motivated to seek help at times of stress, making use of their social support network. This cultural tenet maybe a protective factor, insulating African American women from suicide and explains the lower rate among African American women.

Similarly, in African American males, Franklin (1998) suggests that anger in African American males is tied to their marginal societal status of being invisible, in effect having little control over their perception by the larger majority. The invisibility syndrome is borne out of subtle racial discrimination and 'mircoaggressions' a term used to describe racial slights that convey devaluations and a lack of regard of one's racial heritage. Their personal uniqueness is overshadowed by their race and the individual becomes invisible. The efforts used to manage these daily slights have an influence on the wellbeing and resiliency of African Americans.

Franklin and Boyd-Franklin (2000) suggest that as African American males struggle to fulfill their roles as the wage earners, they become are particularly susceptible to racism's impact due to their increased contact with the larger society. When considered in the context of the increasing suicide rate among African American males, it becomes interesting to consider whether the protective factors of family and church serve the same central and supportive role for men. Or, does the transition into mainstream society not allow for individuals' uniqueness and cultural distinctiveness to be supported?

Franklin and Boyd-Franklin (2000) states "...visibility for African Americans is frequently a day-to-day process of choice between societal assimilated identity based on an Anglo-European norm, and an identity incorporating the distinctiveness of being African American" (Franklin and Boyd-Franklin, 2000, p.35).

The transition from one's culture to the larger society may have differential effects on men versus women. African American women may be socialized to utilize support networks i.e., friends, extended kin networks, family and the church, especially during times of stress that may serve to protect and insulate them (Shaffer, Forehand, Kotchick et al., 2002). As opposed to African American males, who struggle to find adequate role models and support as they attempt to be a wage earner and bridge the barrier between two worlds (Blake and Darling, 1994). " Since the social support that bound previous generations to society and the community are no longer present, younger African American males are more at risk for unresolved psychological distress and therefore suicide due to the decline in institutions that guided behavior compounded by the absence of traditional male roles" (Willis, Coombs, Cockerman, and Frison, 2002 p. 915). Many of the social systems created to support Black families have removed men from the traditional role of economic provider. As the new generation of black males attempt to move beyond the bounds of the ghetto, face an increased absence of older male counterparts to emulate.

African Americans, Suicide & Aggression.

Early research into African American suicide was based upon a psychodynamic position that "black rage" manifested in suicide as anger turned against the self (Hendin, 1969). The rage stemmed from the realization that one's dreams and aspirations were

tempered by discrimination, poverty and a lack of opportunities. Unable to be sublimated, Rage erupted in periodic moments of violence or more likely, became rage turned against the self, manifesting as depression and ultimately suicide (Hendin, 1969).

Poussaint and Alexander (2000) build upon the psychoanalytic concept of depression, asserting that the core affect in depression is anger and hate, which resonates with the African-American experience. Suicide is the expression of this hate against the self. The aggressive act gives voice to the individual's self hate and loathing. For African Americans, self-hate is borne out of discrimination and difference. If the rage is allowed to run unchecked or regulated, the self hate and loathing spill over into aggressive acting out, erupting in self destructive acts i.e., drug use, violence or suicide (Franklin and Boyd-Franklin, 2000; Poussaint and Alexander, 2000).

Poussaint and Alexander (2000) further asserts, "Risky lifestyles are often ultimately lethal and are to some degree connected to internalized feelings of self-hatred and hopelessness" (Poussaint and Alexander, 2000, p.143). Still, to view suicide as aggression turned inward and violence is aggression directed toward others would be an over simplification. Contained within the expression of the aggressive act, suicide and violence, is the devaluation of self, life and one's race. Culturally bound protective factors, i.e., family, and the church, regulate anger, including sadness and aggression through the sharing of similar experiences and support. The institutions of church and family serve an important and necessary function, allowing the individual to cope with increased stress (Gibbs, 1997). Engaging in high-risk behaviors may be considered a declaration of the youth's wish to die or at least to be retaliated against.

Several researchers have highlighted the increase in the number of completed suicides and its relation to the high number of homicides for young African-American males, suggesting that there is a connection between the two phenomena (Poussaint, 2000). Homicide is the leading cause of death for Black youth age 15-24 and suicide is the 3rd leading cause of death for Black youth age 15-24 (National Center for Health Statistics [NCHS] 1998). The majority (89.1%) of these deaths were committed by using firearms (NCHS, 1998). The high percentage of firearm-related homicides suggests that the lifestyle of some African-American youth is often violent, aggressive and can lead to death. This violent and aggressive lifestyle is risky, reflecting an internal experience that is full of hate and self-loathing. African American youth may vacillate between the poles of self-loathing and oppositional/acting out. Additionally, Gibbs (1997) noted that Black males responding to the feelings of anger and alienation sometimes engage in violent confrontations with the police, family, and peers, resulting in victim precipitated homicide- arguably a form of extreme suicide. In either the case of suicide or homicide, it raises the question of how are these intense affective experiences regulated. Being forced to deal with daily microaggressions (racial slights) trigger intense feelings of anger, ranging from self hate to murderous rage in youth who developmentally are struggling with normative challenges of adolescence, would create a caldron of intense affect.

For African-American adolescents, regulating intense affective states, i.e., anger and sadness, may be particularly difficult. In a longitudinal study of suicide across the life span, Juon and Ensminger (1997) found a peak increase in suicide and violence among Black youth, suggesting that this may be a sign of underlying problem of affect

regulation and particularly anger. There may be a correlation of increased anger, violent acting out, externalization of anger for young Black youth. As stated earlier, according to adolescent suicide research, this age group has increased difficulty with problem solving. When a difficult situation presents itself, adolescents have trouble entertaining alternate solutions to their distress, suggesting that increased affective states cloud their judgment and suicide appears to be the only solution. In the grips of increased affective states African-American youth may have increased difficulty regulating their affect and be at risk for suicide by impulsively acting on their aggression. This was supported by Trautman, Rotheram-Borus, Dopkins, Lewin (1991), who reported a high rate of conduct disorder among African Americans and Hispanic adolescents when compared with European Americans, suggesting these minority populations can be at high risk for impulsively committing suicide. Chance, Kaslow, Summerville & Wood (1998) reviewed a number of studies on suicide attempts, suicidal ideation and aggressive behavior in African Americans and confirmed in their subjects a difficulty regulating their emotions, thus underscoring the psychoanalytic definition of suicide as aggression toward the self.

Then, for African Americans, an increase in aggressive acting out may be a risk factor for suicide; it may also be a sign of an underlying depression and suicidal ideation. Comparing African Americans with European American adolescents on aggressive behavior, Cairns, Peterson and Neckerman (1988) found that African Americans were less likely to attempt suicide, though judged equal in aggressive behavior with their European American cohorts. In an attempt to explain this finding, Chance, Kaslow, Summerville et al. (1998) hypothesized that African Americans youth may express their

distress by externalizing or acting out aggressively than the internalizing behavioral expression of suicide. Ultimately, these studies demonstrate that the examination of suicide in African Americans will need to be inclusive, expanding our understanding to include aggressive acting out rather than emphasizing suicide ideation and overt verbal statements of suicidal intent. Assessments may need to include a thorough history of aggressive and destructive acts, focusing on African American adolescent willingness to place him/her in harms way, knowing that death or injury would be the result of their behavior.

Unique clustering of risk factors in young African Americans.

The assessment of suicide risk begins with research addressing the rise in suicide and suicide-related behaviors among African Americans young adults. Gibbs (1997) has identified these risk factors: male sex, age, substance abuse, depression, family dysfunction, interpersonal discord or marital conflict, psychiatric disorders and psychological symptomatology. Further, Gibbs (1997) found distinct differences in the pattern of suicide among African Americans compared to whites. The trend toward suicide is low in adolescence, increases and peaks in young adulthood and decreases with age.

Attempting to understand the peak in the suicide rates among young African American adults, Molock, Kimbrough, Blanton-Lacy, McClure and Williams (1994) studied a sample of black college students attending a predominantly Black institution and measured the level of suicidal ideation and depression among this population. The researchers found that the rate of suicide attempts by Black college students were comparable to the rates of white college students as reported in the literature. The

authors highlight two important points: Black youth need to be viewed as their own distinct population and that research should focus on increasing the number of young Black participants, as the rate in this group is on the rise. The research investigation would be an effort to understand the factors that increase risk in this population.

When the focus is centered on young African Americans interesting within group differences emerge. For example, Molock, Kimbrough, Blanton-Lacy et al. (1994) found that alcohol use was not an associated risk factor for suicidal behaviors in their sample. The study found in their sample of African-American young adults relatively low alcohol use among the group who reported a history of suicidal ideation and attempts. Kaslow, Thompson & Meadows et al. (2000) confirmed this finding, determining that alcohol abuse was not significantly related to those who had a history of suicide attempts in a sample of African American females. The absence of alcohol abuse in young adult participants is contrary to the majority population's risk factors, outlined as the standard in suicide assessments.

Though alcohol use was not found to be a risk factor for Molock, Kimbrough, Blanton-Lacy et al. (1994) nor in Kaslow, Thompson & Meadows et al. (2000), others have found that drug use in the context of an affective state may be a possible risk factor for young African American adults. For example, Juon and Ensminger (1997) conducted a longitudinal study with community sample of African Americans, interviewed at regular intervals beginning in the first grade through adulthood. This study found that depression and drug use, i.e., marijuana and cocaine, were a significant risk factor among young adults. Juon and Ensminger (1997) emphasized that drug use in the context of a depressive disorder, thus becomes a significant risk factor. These factors independently

may not increase risk of suicide but in combination the potential for risk is significantly increased. This finding illustrates that the risk factors may be weighted differently for African Americans, presenting as a unique cluster of suicide risk.

Underutilization of Treatment.

Based on a review of the literature of research on suicide in African Americans, another interesting trend emerges---the problem of underutilization of mental health services within the Black community. This underutilization becomes a factor that places young African Americans at risk. Brown, Ahmed, Gary & Milburn (1995) found that the best predictor of depression was young age and poor health. African Americans who suffered poor physical health also suffered from depressive symptomatology, suggesting that these individuals were not presenting for treatment (Brown, Ahmed, Gary & Milburn, 1995). The poor health of African American young adults underscores a larger issue within the African American community; this population generally underutilizes healthcare due to financial constraints or misconceptions regarding physicians and mental health workers. Many African Americans in this age group chose to wait until the condition has deteriorated and emergency services were required. It is unclear whether the depressive symptomatology affected their health or poor health led to sad and depressive feelings. Either way, educating community and health care providers about symptoms of depression in African Americans might increase mental health care utilization among Blacks.

Fear of involuntary hospitalization and of the medical community adds further treatment obstacles for African Americans. Within the Black community, the stigma of mental illness is often quite powerful, keeping them from presenting to mental health

facilities when in distress and from remaining in treatment to prevent relapse (Summerville, Kaslow, Abbate, & Cronan, 1994; Gibbs, 1997; Chance, Kaslow, Summerville and Wood, 1998; Poussaint and Alexander, 2000). In addition, many Blacks believe that suicide does not affect them. This view along with the belief in their ability to triumph in the face of adversity directs African Americans away from directly expressing emotional distress and suicidal ideation (Poussaint and Alexander, 2000). Instead, distress is expressed as "physical acting out" or somatization (Gibbs, 1997). Others have suggested that African Americans may be "hidden ideators" who choose to not disclose their suicidal ideation in initial intake sessions (Morrison and Downey, 2000).

Unfortunately, those African Americans who present for treatment due to a failed suicide attempt or somatic complaints often do not remain in treatment. For example, of those adolescent African American suicide attempters who presented at the emergency room for treatment, only 32 percent, 22 percent and 21 percent were participating in out patient therapy 3, 6 and 12 months (respectively) after the attempt (Summerville, Kaslow, Abbate, and Cronan, 1994). The reasons teens gave for not adhering to treatment were lack of transportation or money, refusal to attend, and parental beliefs that the treatment was not necessary (Summerville, Kaslow, Abbate, and Cronan, 1994; Chance, Kaslow, Summerville and Wood, 1998). As teens are still financially and emotionally dependent upon their parents, the high drop out rate may stem from a failure to engage the parents in the process of their treatment. The parents may have sabotaged the teens continuing in treatment by failing to endorse and support the teens need for treatment as well as provide the money necessary to attend regularly.

Rethinking Durkheim: Suicide in African Americans young adults

Several research studies have begun to address the rise in suicide and suicide-related behaviors among African Americans youth, many suggesting that the cause may be explained via social and cultural forces (Willis, Coombs Cocherham & Frison, 2002; Harris & Molock, 2000; Canino & Roberts, 2001; Hovey & King, 1996). The cultural and social forces, i.e., racial slights, discrimination and lower socio-economic status, can be considered stressful life events that precipitate a suicide attempt. Much of this recent research has suggested theoretical perspective that extends back to the work of Emil Durkheim.

Published in 1879, Durkheim's Suicide was an empirical and sociological examination of suicide. The work was written during the societal upheaval of the Industrial Revolution, during which the societal structure of Europe was shifting from feudalism to industrialism. Against this backdrop, Emil Durkheim undertook the study of suicide and addressed the issues with the rigors of empirical research. According to Durkheim's view, society serves as a system of organizations with clearly delineated rules, norms and laws. These strictures serve to give the individual boundaries within which he or she may operate with a sense of comfort and knowing. When the norms within a society break down, are confused or unclear, a state of anomie can occur, leading to deviant behavior. Important to his methodology are two underlying social forces or processes, social integration and moral regulation. Societal processes serve as guidelines for an individual to know his/her place in the societal structure and regulate his/her behavior. The failure of this societal process to assist the regulation of anxiety and emotions leads an individual to feel vulnerable and contemplate suicide.

According to Durkheim, there are four types of suicide: Egoistic, Altruistic, Anomic and Fatalistic, each is defined as a failure or excessiveness of the two underlying social forces or processes, social integration and moral regulation. For example, egoistic suicide occurs due to a person's lack of social integration into societal groups, organization or institutions. This individual would have few ties to the norms that govern someone in their age group, i.e., he or she is unmarried, unemployed and isolative. This phenomenon can be observed in the high rate of suicide among the elderly, many of whom become socially isolative due to lack of employment, spousal death or poor integration into the societal structure. Further, for all age groups, feelings of self-alienation and social withdrawal, which may also be secondary to depression, are a risk factor for imminent suicide.

Altruistic suicide, in turn, is the result of too much social integration. The hallmark of altruistic suicide is self-sacrifice to the point of the complete loss of individuality, where the individual turns the self over to the group's interests and is willing to sacrifice him or herself. The third type according to Durkheim is fatalistic suicide, the rarest of the four types. This type of suicide is typified by having a high state of regulation and confinement; an example would be individuals such as slaves. The final category of Durkheim's theory of suicide is anomic suicide, which he defined as a lack of regulation occurring on the opposite end of the regulation continuum. For this type of suicide the lack of regulation and its grounding in moral traditions promotes dissolution of societal norms, leading to a lack of cohesive societal identity and individual chaos (Frederick, 1989).

Building upon Durkheim's theory of suicide as stemming from social forces that impinge on the individual triggering the suicidal act, Willis, Coombs Cocherham and Frison (2002) add postmodern theories of decentralization, decline of the traditional family and lack of social cohesion as related factors in the rise of suicide rates. In the postmodern age, organizations as regulators or goal setting social bodies have declined in value, making the way for increased social freedoms and an erosion of social, self-regulating traditions. Willis, Coombs, Cocherham et al. (2002) suggest that an adolescent coming of age in the postmodern era may be unwittingly at the whim of these social forces and experience feelings of hopelessness, uncertainty and helplessness. Regarding African Americans, an adolescent from a lower socio-economic status may fall powerless, coupled with exposure to violence and the erosion of the black family and support networks, and may be at greater risk.

Gibbs (1988) suggests that several factors within the Black community have served to "immunize" their members from suicide. These protective factors include family, church, fraternal and social organizations, community schools and extended kinship networks. These protective factors provide social cohesion and social support to its members, among whom the values of the community are shared and reinforced. This system is based on traditional communal values, assuaging the stress of relating to the dominant mainstream culture. However, Gibbs (1988) cites the increase in sweeping social change, i.e., the rise of urbanization and the wearing away of traditional values and institutions as a factor in the increase in suicide risk for Blacks.

Converging with social integration issues for young African Americans are the developmental pressures unique to this stage of the life span. Kaplan and Worth (1993)

outline a suicide trajectory model incorporating key developmental issues. By reinterpreting Eriksonian theory, the model suggests that vertical movement from ego dystonic to ego syntonic within each stage supplements the linear age-based progression. Kaplan and Worth (1993) suggests that young adults in Erikson's Intimacy verse Isolation stage are initially faced with a state of increased anxiety as the demands of this stage call upon skills not yet acquired, creating increased stress. It is at this point that these individuals turn to familial and collegiate ties for possible role models. If the young adult is unable to negotiate the obstacles at this stage, they become at risk for depressive-isolative behaviors, and could possibly choose death as a solution (Kaplan & Worth, 1993).

Ultimately, then, it is interplay of developmental and social forces that places African American youth at risk. The notion of social integration and its impact on the individual has implications toward understanding the increase in suicide related behaviors among young African American adults. The process of social integration is an ongoing process over the course of the life span. However, for young adults, on their own for the first time or attending college, their place is yet to be determined and they are naïve as to the social force present in society. Further, the convergence of these multiple stressors may explain the higher rates of suicide for 20-24 year olds versus 15-19 year olds (NCHS, 1998).

Recent research has begun to examine the impact of social forces on suicide-related behaviors among African American youth (Stack, 2000; Willis, Coombs, Cockerman and Frison, 2002). For African Americans, it has been suggested that a possible risk factor for suicide is the impact of social integrative forces on this age group

(Willis, Coombs, Cockerman and Frison, 2002). At the same time, researchers have noted the erosion of cultural forces, i.e., the family and church that served to protect or buffer young adults from suicide (Nisbet, 1996; Gibbs, 1997; Harris and Molock, 2000). In a recent epidemiological report published by the Centers for Disease Control (CDC) documenting the increase in suicide among Black youth, offered the following explanation: "One possible factor may be the growth of the black middle class. Black youths in upwardly mobile families may experience stress associated with their new social environments. Alternatively, these youths may be adopting the coping a behavior of the larger society in which suicide is more commonly used in response to depression and hopelessness" (MMWR, 1998). A similar argument was put forth as a possible explanation of the higher suicide rate among African American males. "Ironically, African American male adolescents of higher socioeconomic status are more at risk now than ever before, because while they may be protected from some aspects, they become vulnerable in other areas. Due to their lack of reference group, they may feel as if they are trapped between two worlds, one 'White' the other 'Black' " (Willis, Coombs, Cockerman and Frison, 2002, p.915).

Chance, Kaslow, Summerville et al (1998) suggest that the recent rise in the rate of suicide may be attributable to an increase in societal stressors, i.e., poverty and discrimination. This finding supported by other researchers, who reported that urban adolescent suicide attempters (low SES) had a less supportive and cohesive social network (King, Schwab-Stone, Flisher, Greenwald, Kramer, Goodman, Lahey, Shaffer and Gould, 2001; Willis, Coombs, Cockerman et al. 2002). Poverty, crime and unemployment have increased at a time when the cohesive structures and regulating

processes, i.e., family and church have been on the decline, thus place African American youth at risk. For example, Juon and Ensminger (1997) examined a community sample of African Americans from first grade through 32 years old. This study found that, along with depression and cocaine use, the lack of social integration was a significant risk factor. The study further found that frequent moves from home to home early in life was related with suicidal thoughts in adolescence and adulthood, highlighting the protective nature of maintaining societal and familial bonds. Marriage is an example of a societal bond that promotes social integration. As further evidence supporting the importance of protective factors and the expression of suicide among African Americans, the same study found that lack of social integration, as evidenced by marital status in African American males was significantly related to suicidal behaviors (Juon & Ensminger, 1997).

Protective Factors for African Americans.

Shifting from the societal forces that either protects or places an individual at risk, suicide research has recently sought to understand the factors that protect an individual from suicide. Research into the area of protective factors or reasons for living has sought to provide insights into the between group differences of two disparate populations, individuals who think about suicide verses those who attempt or complete suicide (Linehan, 1986; Osman, Downs, Kopper, Barrios, Baker, Osman et al. 1998). In an effort to distinguish the boundary between these two groups, it has been suggested that individuals who think about suicide, have a 'factor' that prohibits them from acting on their thoughts of self-harm. Usually, suicide assessments include questions about the reasons a person may want to die. However, recent emphasis has been placed on the

reasons a person might have to live (Malone, Oquendo, Haas, Ellis, Li and Mann, 2000). In assessing a person for suicide risk, the goal would be to engage the person in a discussion of the reasons they have for living, i.e., the pain inflicted on a loved one by their death or religious prohibitions against suicide (Linehan, Goodstein, Nielsen, Chiles, 1983). Increased cross-cultural research on protective factors would seek to illuminate possible socio-cultural factors that may play a role in suicide expression or inhibition. Protective factor research on African Americans is scant and internal cultural factors may enliven the discourse.

Culture as a protective factor.

Within each culture, there are inherited strengths based upon a shared cognitive worldview, spiritual beliefs and coping skills. Reference group membership or cultural group provides the individual member with support, in the form of affect regulation, by reducing stress, anxiety, sadness or anger. This reduction in affect frees the individual to problem solve and entertain alternative solutions. In addition, the reference group has a prescribed method of handling stresses and it is communicated via informal or formal organizations, such as family, religious or social organizations. These organizations buffer the individual from daily stressors and hassles. Mere membership with one's cultural group provides the member with long-standing, inherited affect-regulating processes that serve as a buffer to the stresses of the dominant society. It is these inherited cultural strengths that have served as protective factors against the expression of suicide and mediate the risk of suicide. Examining protective factors within a cultural context could provide new insights into suicidal behaviors cross-culturally, thus explaining the between group differences (Chance, Kaslow, Summerville et al., 1998).

As noted earlier, African Americans were traditionally considered at low risk for suicide due to a variety of internal culturally derived protective mechanisms. Gibbs (1997) listed the protective factors as religiosity, residing in the South, old age and social support. Conversely, for the years 1980 through 1995, the suicide rate had increased 114% for black youth aged 10-19; The most dramatic increase occurred (233%) in those youth 10 to 14 years old and Black males aged 15 to 19 (233%) residing in the South (MMWR, 1998). Many studies have addressed the question of why the rate of suicide among African Americans has increased but none have examined this increase in relation to the culturally derived protective factors. Further, for those African American youth that do not make an attempt, what are the factors that effect their decision to not harm themselves?

Suicide in African American youth: the erosion of family and social supports.

The extended family network has long been a source of social support within the African American community. A sense of communalism ties the African American community together around shared experiences which then serve as a support mechanism. Within the context of shared experiences, an African American individual receives support in the form of being listened to, having their perspective validated and a reduction in affective discomfort (Johnson, 1995; Patterson, 2002). Support networks have historically been important to African-American sense of wellbeing.

For African American families, there is a long tradition of elderly family members residing in the home providing additional support to the household and taking on care taking roles with the children or doing cooking and cleaning (Range, Leach, McIntyre, et al., 1999). This is especially true for African American women, for whom

having additional support networks within the home and the community was found to be a protective factor of psychiatric illness and suicide (Nisbet, 1996). One study found a higher incidence of depression among African American youth who had moved residences, suggesting that the disruption of the individual's social support networks have a deleterious effect on African Americans (Brown, Ahmed, Gary & Milburn, 1995).

Juon and Ensminger (1997) examined the importance of social integration as a protective factor against suicide across the lifespan and found that societal bond i.e. the institution of marriage, may insulate African Americans from suicide. One study found that married persons had a lower rate of depression than did unmarried people, especially for African American males (Brown, Ahmed, Gary & Milburn, 1995). It is interesting to note that African American females have a lower rate of completed suicide than men, who typically do not utilize additional support mechanisms. However, marriage serves as a significant protective factor, suggesting that social support is as important to African American females, but African American males do not avail themselves of the support provided with in the community. Or it may be that African American males' perception of the support might be inadequate.

In a study examining perceived social support, familial support of adolescents with a history of attempts compared with those adolescents who did not make an attempt, loss and low family support were found to be the best predictors of serious suicide attempts. The value of family support is as a buffer against serious vulnerability to suicide. Lower levels of family support have been associated with suicidal ideation in a normal school population (Dubow and Tisak, 1989). According to one study, adolescents with a history of suicide attempts perceived their family as dysfunctional, and inflexible,

choosing to isolate themselves for the family. For those adolescents without suicide history, viewed their families as more flexible and cohesive (Miller, King, Shain & Naylor, 1992).

Family is a buffer against the increase stress of negotiating one's relationship with the dominant society. Family, as an institution, provides a holding environment for the developing young adult as they negotiate the obstacle of this developmental period. Frederick (GAP Report, 1989), seeking to place the act of suicide within a socio-cultural context, reviewed a study completed by Davis (1975), highlighting the importance of communal ties with family and other social relationships for Blacks and its directed impact on suicide risk. Davis (1975) found a statistically significant relationship between rate of suicide and poor social relationships, defined as the "alienation from established communal and family ties." (Frederick, 1989; p. 34) Frederick (1984) reviewed the early research on suicide in Blacks, and found that lack of familial and communal ties were significantly related to suicide among blacks.

In a study examining the role of family cohesion, family support and communalism in suicidal ideation in African-Americans, Harris & Molock (2001) found that lower levels of suicidal ideation and depression were associated with higher levels of family cohesion and family support. It was suggested that family support and cohesion serves as a buffer to the stress associated suicidal ideation and depression. Therefore, the quality of the youths' interpersonal relationships becomes an important factor in the assessment of suicidal risk. This idea would have implications for other groups as well. If an individual has difficulty in mastering the skill necessary to succeed in mainstream

culture, then this would lead to increased stress and feelings of frustration and self-loathing.

Summerville, Kaslow, Abbate and Cronan (1994) found that among African American adolescent suicide attempters (67%) reported that their families were dysfunctional, specifically in the areas of cohesion and adaptability. Juon and Ensminger (1997) found that family mobility early in life, living in a mother alone or mother absent family was associated with later suicidal behavior and thoughts, thus suggesting the importance of familial stability in freeing up the child so that he/she may develop skills in and out side the home that may serve to assist the child's development. According to Juon and Ensminger (1997), a maternal presence in the home seems to provide the child with important interpersonal skills, i.e., connecting to others, regulating affect and self-soothing. For African American families, it is the "availability of extended family, role and resource sharing and flexibility, and a legacy of courage and strength of overcoming obstacles" (Chance, Kaslow, Summerville et al., 1998). The African American family as an institution places emphasis upon education, moral and religious values, and thus indirectly raises feelings of self-esteem and ultimately impacting lower rates of depression and ultimately suicide.

Additional protective factors: Religiosity & Social Support.

Religiosity and family are known factors that serve to buffer African Americans from the added stress of racism. Molock, Kimbrough, Blanton-Lacy et al. (1994) suggests that intragroup cohesion and connections with family, church and social organizations serve as possible protective factors explaining the relatively lower rate of suicide when compared to whites. A recent study examining attitudes toward suicide and

religiosity among Blacks has suggested that the emphasis on religion as a protective factor may have been overstated, especially among youth (Stack, 1998). Religiosity may be a lifespan issue and may not become an important factor of well being in Blacks until old age. However, another study examining major depression in a community sample of African Americans, found that those individuals with a religious affiliation had a lower one-year prevalence of depression (Brown, Ahmed, Gary & Milburn, 1995). This result was not statistically significant. However, this may suggest spirituality may be a subtle protective factor and when in combination with other protective factors can become highly robust.

House (2002; Dissertation) examined protective factors such as family closeness, religiosity and neighborhood relationships and compared it with depressive and antisocial behaviors among African American adolescents. House (2002; Dissertation) found a significant inverse relationship between family closeness and depressive and antisocial behaviors. This finding suggests that family closeness served as a buffer to the stressors experienced by the adolescents and as such they were less depressed and engaged in antisocial behaviors. The study further established a significant inverse relationship between religiosity and depression among African American adolescents. Therefore the more spiritual the adolescent the less likely he or she was to be depressed. These findings suggest an important relationship between protective factors and African American adolescent mental health. Interesting, no significant relationship was noted between neighborhood relationships and depressive /antisocial behaviors, suggesting the central import of the church and family within the community (House, 2002; Dissertation).

Statement of Problem

Given the recent rise in the rate of suicide among Black youth, any information leading to a better understanding of this recent trend is paramount. Of particular interest is the function of family and social support networks in this recent rise in suicide. Research into culturally derived protective factors would further our clinical understanding of suicide as it presents in an ethnically diverse population. Family and social support have served as protective factors for African Americans, regulating and modulating intense affective responses to adversity, thereby promoting a sense of wellbeing. The research has suggested that the recent rise in the rate of suicide may be attributable to the erosion of family and social supports as well as religiosity for African Americans. African-American youth are particularly vulnerable as evidenced by the rise in the rate of suicide. The erosion of culturally derived protective factors in the face of unchanging life stressors has left African American youth increasingly vulnerable to suicide. Therefore, the overall research question to be examined is the following: Are familial and social supports protecting African American youth from suicide risk?

Much of the research in suicidology emphasizes the reasons including cognitions and emotions, precipitating factors, and life events that precede an attempt or trigger thoughts for self-harm. Recently research in the area of suicidality has undertaken the study of protective factors and termed this area of research "reasons for living." Delving into this area of study, researchers have suggested that non-suicidal individuals differ from suicidal individuals in their life affirming beliefs and values (Osman, Kopper, Barrios, Osman, Besett and Linehan, 1996; Westefeld, Cardin, & Deaton, 1992; Linehan, Goodstein, Nielsen and Chiles, 1983). The development of assessment scales to capture

the reasons an individual has for living has sought to understand the boundary that separates these two populations. The current study will examine the extent of reasons for living construct, a standard suicide assessment, is associated with suicide risk in African American youth.

A comprehensive battery of self-report instruments was chosen to assess the following variables: suicidality and protective factors. The Harkavy Asnis Suicide Scale (HASS) will capture suicidality in this sample. The College Student Reasons for Living Inventory (RFL-CS) will assess the protective factors variable along with the Family Assessment Measure III (FAM-III) and Young Adult Social Support Inventory (YA-SSI). A brief demographic questionnaire will capture additional information about the subjects' current living situation.

Based on a review of the literature, the following hypotheses are proposed:

H1: Subjects who endorsed on the HASS current suicidal ideation, history of suicidal ideation and suicide attempts will be found associated with higher family dysfunction as measured by Task Accomplishment, Involvement, Affective Expression, Control and Communication subscales of the FAM-III.

H2: Subjects who endorsed on the HASS current suicidal ideation, history of suicidal ideation and suicide attempts will be found associated with lower social support scores as measured by Parent/Sibling, Spiritual Faith, Other Relatives and College Friends subscales of the YA-SSI.

H3: Subjects who endorsed on the HASS current suicidal ideation, history of suicidal ideation and suicide attempts will be found associated with Survival and Coping, Moral Objection and Responsibility to Family and Friends subscales of the RFL-CS.

H4: Subjects who endorsed on the HASS current suicidal ideation, history of suicidal ideation and suicide attempts will be found associated with higher family dysfunction (FAM-III), fewer social supports (YA-SSI) and fewer reasons for living (RFL-CS).

Method

Sample

Participants (N = 60) were recruited from an introductory psychology class at a medium sized urban university and were offered course credit for filling out the questionnaire. The demographic information describing the sample is in Table 1. The age of the subjects ranged from eighteen to thirty-four (M = 22.45, SD = 4.8). There were nineteen men (32%) and forty-one female participants (68%). Twelve subjects (20%) reported that they were Catholic and another ten subjects (17%) were Baptist. However the largest number of subjects (37%) chose the other religion category. Subjects' ethnicity ranged from African American (55%), Caribbean (28%), African (10%) and Hispanic (7%). Of the sixty subjects, thirty four subjects (57%) were born in the United States and the remaining twenty six subjects (43%) were born abroad.

Instruments

A comprehensive battery of self-report instruments was chosen to assess the following variables: suicidality, family, social support and protective factors. Scales include the Harkavy Asnis Suicide Scale (HASS), College Reasons for Living Inventory for Adolescents (RFL-CS), Family Assessment Measure III (FAM-III), Young Adult Social Support Inventory (YA-SSI) and a brief demographic questionnaire.

Suicidality.

The Harkavy Asnis Suicide Scale (HASS) was designed "as an information-gathering tool" to directly assess current and past suicidal behavior (Harkavy-Freidman and Asnis, 1989). The scale has three sections. The first section (HASS-DEMO) is used for collecting demographic information (including factors found in the past to be related

to suicidal behavior), and current suicidal ideation and plans, suicide attempts and exposure to suicidal behavior. The second section (HASS-I) has 21 questions for assessing the frequency of suicide-related and substance abuse behaviors in the past two weeks. The third section (HASS-II) references lifetime suicide-related behaviors.

For the purpose of this study, subjects completed the first (HASS-DEMO) and second section (HASS-I) of the Harkavy Asnis Suicide Scale, capturing current suicidal ideation (current and lifetime) and the frequency of suicide-related, and substance abuse behaviors in the last two weeks. The items on HASS-I fall along three factors: passive suicidal ideation, active suicidal ideation and substance use. Regarding internal consistency, the coefficient alpha was obtained from clinical and non-clinical samples ranging from 0.897 to 0.915 (Harkavy-Freidman and Asnis, 1989).

The Harkavy Asnis Suicide Scale (HASS) has been used for a non-clinical high school sample and as a screening tool for referral to an outpatient clinic for Hispanic and African-American adolescents (Wetzler, Asnis, Hyman, Virtue, Zimmerman and Rathus, 1996). In a primarily African American and Hispanic outpatient population, adolescents with a history of suicide attempts and ideation reported an increased number of suicide-related events, as detected on the HASS, than non-suicidal adolescents on other measures of suicide (Recent Passive Suicidal Ideation, Lifetime Suicidal Plans and Action, Lifetime Suicidal Ideation, and Lifetime Thoughts of Death) (Wetzler, Asnis, Hyman, Virtue, Zimmerman & Rathus (1996).

Protective Factors.

When examining an at-risk population, it is important to understand not only the pressures that impinge upon Black youth, but also to highlight the adaptive behaviors that

have allow some Black youths in the system to flourish. For this study, several scales were selected to measure protective factors in Black youth. These include: College Student-Reasons for Living Scale, Family Assessment Measure III (FAM-III) and Young Adult Social Support Inventory (YA-SSI).

College Student-Reasons for Living scale (RFL-CS).

Turning to the suicide research on protective factors, termed Reasons for Living, several measures have been developed from the original Reasons for Living (Linehan, 1983) in order to capture specific age-related variables (Osman, Kopper, Barrios, Osman, Besett and Linehan, 1996). The College Student-Reasons for Living scale (RFL-CS) was created in order to capture the reasons a college student may have for choosing life over suicide (Westefeld, Cardin, & Deaton, 1992). The RFL-CS was developed from the Brief Reasons for Living Inventory for Adolescents (B-RFLA).

The College Student Reasons for Living Inventory (RFL-CS) is similar to the Brief Reasons for Living Inventory for Adolescents (B-RFLA). Four of its factors are identical in theme to those of the B-RFLA. However, in order for the RFL-CS to capture additional age-related concerns, two new factors, Responsibility to Family and Friends including peer relationships and College/Future Concerns were added. The internal consistency of the scale is robust at .91 (Range and Knott, 1997; Westefeld, Cardin, & Deaton, 1992). For each of the subscales, the reliability data (Cronbach alpha) are as follows: Survival and Coping Beliefs = 0.88; College and Future related Concerns = 0.88; Moral Objections = 0.86; Responsibility to Friends and Family = 0.80; Fear of Suicide = 0.71; Fear of Social Disapproval = 0.69 (Westefeld, Badura, Kiel and Scheel, 1996). A study that compared European American and African American college students found

that African American students scored higher on the Moral Objection and Survival and Coping Beliefs subscales of the Reasons for Living scale (Morrison and Downey, 2000). Current research utilizing the College Student Reasons for Living Inventory in this population has yet to be conducted.

Family Assessment Measure III (FAM-III).

As noted in the suicide literature, suicidal young adults tend to perceive their families as dysfunctional, correlating with levels of depression and self esteem (Adams, Overholser and Lehnert, 1994). For instance as indicated on the FAM-III (described below) adolescents were found to be less likely to endorse suicidal thinking when their families were affectively involved and spent time together (Rubinstein, Halton, Kasten Rubin and Stechler, 1998).

The Family Assessment Measure III (FAM-III) is a 134-item self-report measure, assessing the individual's perception of family functioning. FAM-III is composed of three scales: general scale (50 items), dyadic relationship scale (42 items) and an individual rating scale (42 items) (Skinner, Steinhauer, & Santa-Barbara, 1995). The scale has been used with children from at least 10 years old through adulthood (Skinner, Steinhauer, & Sitarenios, 2000). The general scale of the FAM-III takes approximately 20 minutes to complete.

For the purpose of this study, the FAM-III general subscale (50 items) was used to assess overall family functioning. The dimensions are as follows: task accomplishment, role performance, communication, values and norms, affective involvement, and control (Steinhauer, Skinner & Santa-Barbara, 1984). For the general scale, there are two additional dimensions, denial-defensiveness and social desirability,

indicating the level of subject's minimization of family's current functioning relative to their scores on the other six dimensions (Steinhauer, 1984).

Regarding internal consistency, the normative data on the FAM-III was based on a sample of 247 normal adults and 65 normal adolescents. The coefficient alpha for the general scale was .93 for adults and .94 for teens (Skinner, Steinhauer, & Sitarenios, 2000).

Young Adult Social Support Inventory (YA-SSI).

The Young Adult Social Support Inventory (YA-SSI) was selected to assess social support. The YA-SSI was developed from the original scale, the Social Support Inventory, to assess the stressors and support for new parents, individuals in the process of child rearing and other individuals across a variety of contexts. Conceptually, social support was defined as consisting of five types of support: emotional, esteem, network, appraisal and altruistic. Support can be garnered from a variety of sources i.e., family, friends, church groups or social organizations and it can vary based on the amount received. The YA-SSI measure contains 11 subscales or factors. For each of the subscales, the reliability data (Cronbach alpha) are as follows: Parent & Sibling = .95, Spiritual Faith = 91, College Friends = 91, Special Groups I Belong to = .89, Co-Workers = .86, Church/Synagogue Groups =.90, College Faculty/Counselors/ Administrators = .78, Reading Books/Watching TV/Listening to Music = .86, High School Friends = .85, Other Professionals/Other service providers = .82 and Other Relative items =.84. The internal reliability is 0.89 and test-retest was 0.90 (McCubbin and Thompson, 1989).

Procedure

The paper and pencil measures were administered anonymously to students in groups in a classroom setting. Subjects were not required to provide any personal or identifying information and the measures were labeled with a code number for purpose of the statistical analyses. Anonymity was assured in order to increase subjects' willingness to participate and share personal details. Accordingly, subjects were not required to sign a consent form, as completion of the survey was voluntary. The cover page of the questionnaire outlined the goals of the study, assuring the student regarding the anonymous nature of the questionnaire and provided a list of counseling resources. Subjects were encouraged to take the cover page, containing a list of mental health resources, if needed. The following statement was added to the informational cover page, as requested by the university's institutional review board, ensuring subjects' clear understanding of the benefits and risks of the study: "This study is NOT designed to identify individuals at risk of suicide and help them. Therefore, the study staff cannot (because the questionnaires are anonymous) contact you after you have handed in the materials. If you have suicidal thoughts or plans you should seek help from physicians, therapists, or religious counselors." The investigator's name and phone number as well as her advisor's contact information were included on the informational sheet. During the data collection, neither was contacted by a student in distress.

Statistical Analysis

Analysis was performed with SPSS version 11.5 and SAS, using descriptive statistics, [chi]2 tests, and logistic regression to investigate relationships between the predictor (independent) variables and to estimate the probability of an outcome i.e. suicidal behaviors. Logistic regression is a statistical model that is used to describe the

relationship of several predictor variables to a dichotomous dependent variable. For this study, the logistic regression analyses were performed using the family, social support and reasons for living variables to predict history of suicidal ideation, current suicidal ideation and attempted suicides. The logistic model describes the likelihood of an event occurring, (i.e., suicidal behaviors) based upon the predictor variables. The odds ratio is the only measure of association estimated from the logistic model. The independent contribution of each risk factor was determined by an odds ratio. For example, as the score on a given predictor variable approaches one standard deviation above the mean, the likelihood of the event occurring is calculated as the odds of that event occurring. Based on the odds ratio, probability values were also calculated. Additional inferential statistics were calculated examining all subscales of the predictor variables and the normative data on these measures.

Results

Descriptive analyses, as shown in Table 2, were conducted on the Harkavy Asnis Suicide Scale (HASS). Nineteen subjects (32%) reported having thought about suicide in the past. Of the nineteen subjects who reported having a history of suicidal ideation, five (26%) were male and the remaining fourteen subjects (74%) were female. Five subjects (8%) in the sample reported having made a past attempt, and the number of attempts were two or greater. Of the five subjects who made an attempt, four subjects (80%) were female. Regarding current suicidal ideation, only four subjects (7%) reported current suicidal ideation within the last two weeks. Twenty subjects (40%) reported having alcohol between once or twice a week. Substance use was low; six subjects (10%) reported having smoked marijuana once and four subjects (7%) reported using drugs other than prescription.

In this sample, subjects scored comparably with previous data on college students for each of the predictor variable measures with the exception of the Family Assessment Measure-III (FAM-III). The FAM-III means from the normative data set of college students from Bloomquist & Harris (1984) were compared with the sample means on all subscales of the FAM-III. The t-test yielded a significant difference as shown in Table 3, suggesting that this sample is different from the normative sample of college students. The average scores on each of the subscales from the current study are significantly higher than the scores reported by Bloomquist & Harris (1984) with relatively low variability.

The mean scores on the RFL-CS for this sample were compared with mean scores from a similar sample of college students, collected as part of the normative data on the

scale (Westefeld, Bandura, Keil et al. 1996). The overall mean score on the RFL-CS for this sample is 4.47 compared with 4.31 from the normative data (Westefeld, Bandura, Keil et al. 1996). As shown in Table 4, both samples are highly correlated ($r = .933$, $p < .05$) and there was no significant difference in the means (t (5) = .897, p = .411, NS). Similarly the YA-SSI sample data was compared to the normative data (see Table 5) on young adults (McCubbin and Thompson, 1989). Analyses found that both samples are highly correlated ($r = .795$, $p < .01$) and there was no significant difference in the means (t (10) = 1.484, p = .17, NS).

Hypothesis 1.

The subscales of the Family Assessment Measure III (FAM-III), Task Accomplishment, Involvement, Affective Expression, Control and Communication subscales were analyzed in relationship to scores for lifetime thoughts about suicide, current ideation and attempts. The logistic regression between the FAM-III scores and history of suicidal ideation yielded a weak relationship, only accounting for 19% of the variation in history of suicidal ideation ($R^2 = 0.1857$). As shown in Table 6, family functioning, as measured by the subscales of the FAM-III were also not significantly related to lifetime history of suicidal ideation ($X^2_{(5, N = 60)} = 8.52$, $p<.13$, NS). However, when each of the five predictor variables were compared to the outcome variable while holding the others constant, FAM-III Involvement subscale was significantly related to, and predictive of lifetime suicidal ideation (OR, 0.469; $p < .05$). Therefore, an increase in Family Involvement above the mean is associated with a reduction (.47) in the odds of having a history of suicidal ideation (see Table 7).

Further analysis found that there was no significant relationship between the Task Accomplishment, Affective Expression, Control, Involvement and Communication subscales and current suicidal ideation ($X^2_{(5, N = 60)} = 7.82$, $p = .17$, NS) or attempts ($X^2_{(5, N = 60)} = 4.01$, $p = .55$, NS). Further analysis of the adjusted odds ratio also yielded non-significant results.

Hypothesis 2.

Comparing the history of suicidal ideation and the subscales of the Young Adult Social Support Inventory (YA-SSI) subscales, Parent/Sibling, Spiritual Faith, Other Relatives and College Friend, the logistic regression yielded a moderate relationship, accounting for 23% of the variation in lifetime history of suicidal ideation. Social support, as measured by Parent/Sibling, Spiritual Faith, Other Relatives and College Friend subscales, taken collectively were significantly related to lifetime history of suicidal ideation ($X^2_{(4, N = 60)} = 9.92$, $p < .05$). Of the four YA-SSI subscales, Spiritual Faith and College Friends produced significant odds ratios indicating the likelihood a youth would have a history of suicidal ideation. Further, the likelihood that a person scoring above the mean on Spiritual Faith would have a history of suicidal ideation is decreased by 30% (OR, 0.34, $p < .05$). Therefore, a youth who endorses a commitment to spiritual beliefs is less likely to think about suicide. Conversely, an individual scoring above the mean on College Friends increases the likelihood of a history suicidal ideation and has over twice the odds of a history of suicidal ideation (OR, 2.18, $p < .05$). In other words, a youth who reports an increase of social support stemming from their college friends will increase the likelihood of having thought about suicide.

The YA-SSI predictor variables were taken as a set and compared to the dependent variable current ideation; the logistic regression yielded a moderate relationship, accounting for 26% of the variation in current ideation ($R^2 = 0.26$). Therefore, the logistic regression has detected a moderate relationship between the YA-SSI predictor variables and current ideation. However, by testing the global null hypothesis to further to assess the significance of this relationship is given as a Chi-Square statistic. Social support, as measured by Parent/Sibling, Spiritual Faith, Other Relatives and College Friend subscales, were also not significantly related to current ideation ($X^2_{(4, N = 60)} = 6.14$, $p = .18$). However, when each of the four predictor variables were compared to the outcome variable while holding the others constant, YA-SSI Other Relatives (OR, 10.45; $p < .05$) and College Friends (OR, 0.29; $p < .05$) subscales were significantly related to, and predictive of current ideation. Therefore, as the scores on the subscale Other Relatives go above the mean the odds increase of having current suicidal ideation. The probability of current ideation increasing for subjects who score above the mean is .334 (see Table 8). The YA-SSI subscales were compared to suicide attempts and were found not significant.

Hypothesis 3.

The survival and coping, moral objection and responsibility to family subscales of the College Student Reasons for Living Inventory (RFL-CS) were selected and compared with history of suicidal ideation, current ideation and attempts. There was no significant relationship found between history of suicidal ideation and the predictor variables, Survival and Coping, Moral Objection and Responsibility to Family and Friends subscales ($X^2_{(3, N = 60)} = 0.77$, $p = .86$, NS).

Suicide attempts ($X^2_{(3, N = 60)} = 6.92$, $p = .07$, NS) and current suicidal ideation ($X^2_{(3, N = 60)} = 4.24$, $p = .24$) were also found not significantly related to Survival and Coping, Moral Objection and Responsibility to Family and Friends subscales. However, when each of the three predictor variables were compared with suicide attempts, odds ratio found that the Moral Objection subscale (OR, 9.19; $p < .05$) was significantly related to, and predictive of suicide attempts. Similarly, Responsibility to Family and Friends subscale (OR, 8.06; $p < .05$) was predictive of current suicidal ideation. As both Responsibility to Family and Friends and Moral Objection subscales increase above the mean, the likelihood of suicidal ideation and attempts increase.

Hypothesis 4.

The total scores on three predictor variables, College Student Reasons for Living Inventory (RFL-CS), Young Adult Social Support Inventory (YA-SSI) and Family Assessment Measure III (FAM-III) were compared to each of the measures of suicidality, lifetime thoughts about suicide, current ideation and attempts. There was no significant relationship found between the total scores of the predictor variables, and the outcome variables, current suicidal ideation, suicide attempts and history of suicidal ideation.

Discussion

Assessment of protective factors is essential to understanding African-American youth at risk for suicide. Within the African-American culture, there are inherited strengths based upon shared worldview, spiritual beliefs and coping skills. The cultural group or reference group provides African-American youth with support, in the form of affect regulation, by reducing stress, anxiety, sadness and anger. In addition, the cultural group has a prescribed method of handling stresses and this is communicated via informal or formal organizations, such as family, religious or social organizations. The inherited cultural strengths serve as protective factors against the expression of suicide. Examining protective factors within a cultural context provide new insights into suicidal behaviors cross-culturally (Chance, Kaslow, Summerville et al., 1998). Other researchers have begun to address cultural issues as a means of understanding suicide in African-American youth (Harris & Molock, 2000; Poussaint & Alexander, 2000). This study sought to address the extent the Reasons for Living construct is related to the assessment of risk in African Americans and whether protective factors need to be expanded to include well-known inherited cultural strengths.

To address the issue of protective factors in African-American youth, the College Student Reasons for Living (RFL-CS) was selected along with two measures of social support (FAM-III and YA-SSI). Taken as a whole, YA-SSI, FAM-III, and RFL-CS did not distinguished themselves as predictors of risk in a non-clinical sample of African-American youth. However, several subscales on each of the measures were found predictive of suicide risk and are linked to research in the field of suicidology.

The current study found that an increase in family involvement reduces the likelihood of a history of suicidal ideation. The importance of family is a well-known African-American cultural strength. For African-American youth, the involvement and relatedness to family provide increased support and serve as a buffer from depression and suicidal thoughts. The value of family support serves as a buffer against vulnerability toward suicide. Lower levels of family support have been associated with suicidal ideation in a normal school population (Dubow and Tisak, 1989). Harris & Molock (2001) found that lower levels of suicidal ideation and depression were associated with higher levels of family cohesion and family support. This study further suggested that family support and cohesion serves as a buffer to the stress associated suicidal ideation and depression. The current study confirms the social integration hypothesis put forth by some researchers. For African-American youth, the more they feel integrated and supported the less they are at risk for suicide (Dubow & Tisak, 1989; Brown, Ahmed, Gary & Milburn, 1995; Nisbet, 1996; Willis, Coombs, Cockerman et al. 2002).

Family involvement was significantly related to suicidal behaviors over all other subscales, i.e., Task Accomplishment, Affective Expression, Control and Communication subscales, confirming the importance of collectivism and family cohesion (Harris & Molock, 2000). Within the context of shared experiences, African Americans receive support in the form of being listened to, having their perspective validated and a reduction in affective discomfort (Johnson, 1995; Patterson, 2002). Support networks have historically been important to African-American sense of wellbeing. Family involvement subscale captures the family's ability to meet the individual's emotional needs while supporting the individual's autonomy of self (Steinhauer, 1984). This

suggests that the combined emotional and ego supporting function measured by the family involvement subscale captures an important quality of African American experience.

The extended family network has long been a source of social support within the African American community. A sense of communalism ties the African American community together around shared experiences, which serve as a support mechanism. However, the Other Relatives subscale on the social support measure (YA-SSI) was found to increase the likelihood of current ideation. This finding seems to contradict the current understanding of kinship networks and the support they provide. This suggests that the support provided by Other Relatives is poor. A large number of subjects in this sample (43%) were born abroad, suggesting that they may be separated from parents and siblings and possibly residing with relatives other than close family. Most immigrant families move in stages, where new arrivals to this country reside with distant relatives. While their parents remain in the home country in order to send money. Further, these subjects may be at different levels of acculturating, a known risk factor. When examined in the context of the suicide literature, several studies have cited that African-American youth, who experienced increase in the number of separations and geographical moves, were at higher risk of suicide. However, only 7% of the sample reported current suicidal ideation, making any inferences as to this significance of Other Relatives finding questionable.

Turning to social support, taken collectively Parent/Sibling, Spiritual Faith, Other Relatives and College Friend subscales, was significantly related to history of suicidal ideation. When compared to RFL-CS, a relationship was detected between the subscales

measuring social support and a history of suicidal ideation. Social support may tell us more about African-American youth who think about suicide than the Reasons for Living construct. This finding may be useful with non-clinical youth samples where prevention programs can target sub-clinical populations for outreach programs. The social support measure (YA-SSI) also captured the quality of the social support given by a variety of sources. With regard to African-American youth, researchers have reported that the quality of the support is more important than having support from multiple sources (Brown, Ahmed, Gary & Milburn, 1995). Therefore, it may be the perceived quality of available support that may be a protective factor for African-American youth.

The four subscales of the YA-SSI, Parent/Sibling, Spiritual Faith, Other Relatives and College Friend, were selected based on the existing cultural strengths in the African-American community. The most notable of the social support subscales was Spiritual Faith, where an increase in Spiritual Faith is related to a 30% reduction in suicidal ideation. Spirituality and religiosity are regarded as important cultural strengths for African Americans and some have argued that it may not hold true for today's youth and is a phenomenon among older African Americans (Stack, 1998). However, these results confirm the importance of spiritual faith for African-American youth and it has a protective influence on youth, by insulating them against suicide (Gibbs, 1997).

Turning to the social integration theory, Stack (1998) further argues that it is not the religious prohibitions toward suicide that may protect African-Americans, but the emotional and other supports provided by religious institutions that are protective, reflecting the regulatory process in positive social integration. Researchers on suicide in African Americans have cited social integration as an important protective factor in the

expression of suicide. Here, the cultural ties to the institution or organization serve to regulate intense emotion through connectedness and sharing.

The College Student Reasons for Living RFL-CS scale was found not related to history of suicidal ideation. Confirmed by research in the field of suicidology, the Reasons for Living construct was developed as part of suicide risk assessment and therefore would not be related to past ideation. The relationship between the RFL and current suicide risk is inversely related, where the suicidal person would report fewer reasons for living than a non-suicidal person. As the person endorses more reasons for living the perceived risk is reduced. However, in this sample, as the score on the Moral Objections subscale increased, the probability of current ideation also increased by 26%. Similarly as the score on the Responsibility to Family and Friends scale increases, the probability of suicide risk also increased. This finding contradicts the theoretical basis of the RFL construct. However, it is interesting that the Moral Objections and Responsibility to Family and Friends scales were found related to current risk and past attempts. Family and spirituality are cultural strengths with in the African-American community and contribute to African Americans' resiliency. The language and the tone of the questions may have evoked a defensive reaction from the participants, as they are asking for reasons one has for not killing themselves. For example, many of the items on the CS-RFL scale are written as a statement affirming living verses dying, i.e. "I enjoy life", "I am happy" "I want to live to see what potential I have." Subjects are asked for how important these statements are to them. Given the myths regarding suicide within the African-American community, these items may evoke fear and anxiety. Conversely, the social support measure asks about a person's coping style, i.e. "When I feel upset, I

get support from my ... (parents, siblings, spiritual faith, college friends, other relatives)." The social support measure may access youth's coping strategies, a known African-American cultural strength. Again, only four subjects reported current suicidal ideation and five reported past suicide attempts, making the generalizability of this finding questionable.

There were interesting and additional unpredicted findings from the current sample. Though there was a moderate relationship between current ideation and the collective FAM-III subscales; except for family involvement, the other family subscales were not found related to suicide. As family is an important cultural mainstay in the African-American community, it is surprising that Affective Expression and Communication was not found related to any of the outcome variables. The Black family as an institution regulates emotions and is based on shared experiences through oral traditions, yet these subscales were not found to reduce risk. This could be due to the unique nature of this sample. As referenced in the Results section, this sample was found significantly different from normative data on the Family Assessment Measure. This difference could be related to the lack of significant findings.

Other findings that were contrary to the research are that the College Friends subscale (YA-SSI) increases the likelihood of having a history of suicidal ideation by 50%. In the African-American community, social connections and groups are a source of support, where members can discuss ways of coping with daily stressors. College friends may be a risk factor if the quality of support provided is poor. The notion of social integration and its impact on young African American adults has implications toward understanding the increase in suicide related behaviors. Lack of social integration

was found to be a risk and may provide an explanation of college support may not be adequate (Willis & Combs, 2000). Young adults, on their own for the first time and attending college, are attempting to make the transition to new surroundings, which may add to the stress of finding a new reference group on campus. The convergence of these multiple stressors may explain the higher rates of suicide for 20-24 year olds versus 15-19 year olds (NCHS, 1998). Further, youth at this age are becoming reflective about themselves as they develop into adults and may be more thoughtful about themselves and their life. This new self-reflective ability, having been shared with other college friends, may have facilitated a consciousness about suicide, getting them to examine their own mortality. It is possible that those students with more of a social network might spend more time in intimate conversations, in which one topic might be struggles with emotional difficulties, including whether they've ever considered suicide. These conversations may make memories of past thoughts of suicide more accessible and/or acceptable to report.

Gender disparity remains an interesting question. As African American men are expected to be tough and control their feelings in preparation for a lack of supportive resources in the larger society, African American women can expect to have greater access to community and economic resources (Chance, Kaslow, Summerville & Wood, 1998). Therefore, women are encouraged and motivated to seek help at times of stress, making use of their social support network. However, in this study African American women were overrepresented in the group who attempted suicide and who thought about suicide within the past two weeks. Nisbet (1996) found that Black women who had thoughts about death were significantly related to higher education attainment. As

African-American women move into mainstream society, they may be forced to leave behind their cultural roots and ways of relating in favor of the dominant society's rule of conduct. It is possible that for these women, the quality of the support provided by their college friends is not adequate, as in this sample, college students were found to increase suicidal behaviors.

The limitations of this study centered on statistical power and small sample, namely, this study endeavored to examine a relatively rare phenomenon occurring in a small sample size. In this current sample, five subjects made an attempt, four subjects were currently thinking about suicide and nineteen subjects have thought about suicide at some point in the past. In 2001, the Centers for Disease Control reported 433 suicides in Black youth ages 15 to 24 years old out of a population of 6,066,822 young adults (NCHS, 2001). This rare phenomenon was found in relatively low numbers in each level of the dependent variable, make inferences and statements about significance and its ability to be generalized to the larger population of African-American youth highly questionable.

The addition of known cultural strengths to the assessment of protective factors is a worthy endeavor as it enlivens the debate as to the veracity of protective factors. Further, the study of the impact of cultural characteristics on protective factors can only serve to enhance the assessment of risk in African-American youth and serve as stepping stone to the development of prevention program for youth.

Appendix

Table 1. Demographic Data		
Age		
Mean	22.45	
Standard Deviation	4.82	
Range	18-34 years	
	n	Percent
Sex		
Male	19	32%
Female	41	68%
Ethnicity	Frequency	Percent
African American	33	55%
Caribbean	17	28%
African	6	10%
Hispanic*	4	7%
Place of Birth	Frequency	Percent
U.S. Mainland	34	57%
Other	26	43%
Religion	Frequency	Percent
Catholic	12	20%
Baptist	10	17%
Protestant	8	13%
Other	22	37%
Not Applicable	7	12%
Marital Status	Frequency	Percent
Single	50	83%
Married	8	13%
Other	2	3%
Current Living Situation	Frequency	Percent
Immediate Family	38	63%
Other Relatives	8	13%
Alone	6	10%
Spouse/Partner	2	3%
Non Relatives	1	2%
Other	3	5%
Seen a Mental Health Professional		
Yes	8	13%
No	52	87%

* Includes Dominican, Puerto Rican & Central American

Table 2. Harkavy Asnis Suicide Scale (HASS)	Frequency	Percent
Suicide Data		
Suicidal Ideation (Past)	19	32%
Current Ideation (last two weeks)	4	7%
Suicide Attempts	5	8%
Substance Use		
Smoked Marijuana		
Never	53	88%
Once	6	10%
Drinking Alcohol (once/twice a week)		
Never	33	55%
Once	17	28.30%
1-2 times per week	7	11.70%
3-4 times per week	3	5%
Drugs other than Prescription and Marijuana		
Never	56	93%
Once	2	3%
3-4 times per week	2	3%

Table 3. Raw Scores Means on FAM-III as Compared with Normative Data*

	Mean	Standard Deviation
FAM-III Task Accomplishment	8.60 (6.0)	1.49 (2.5)
FAM-III Role Performanace	8.95 (6.4)	2.28 (5.3)
FAM-III Communication	7.27 (5.7)	1.92 (4.5)
FAM-III Affective Expression	6.72 (5.5)	1.59 (2.7)
FAM-III Involvement	7.22 (4.5)	1.85 (6.4)
FAM-III Control	6.78 (6.0)	2.41 (7.4)
FAM-III Values and Norms	6.73 (5.3)	1.69 (2.3)
Comparision of Means		
$r^2 = 0.559$, $p = 0.193$, NS		
$t = 6.275$, 6 *df*, $p < 0.001$		

* Bloomquist & Harris (1984) mean raw scores and standard diviation are in brackets.

Table 4. Raw Score Means on College Student Reasons for Living (RFL-CS) as Compared to Normative Data*	Mean*‡	Standard Deviation
RFL-CS Factor 1: Survival & Coping	4.83 (4.94)	1.02
RFL-CS Factor 2: College & Future-Related Concerns	4.73 (4.47)	1.11
RFL-CS Factor 3: Moral Objection	4.56 (4.26)	1.22
RFL-CS Factor 4: Responsibility to Friends & Family	4.62 (4.90)	1.17
RFL-CS Factor 5: Fear of Suicide	3.39 (3.23)	1.26
RFL-CS Total	4.47 (4.31)	0.92
Comparision of Means		
$r^2 = 0.933$, 5 *df*, $p < 0.05$		
$t = 0.897$, 5 *df*, $p = 0.411$, NS		

* Mean scores obtained from Westefeld, Bandura, Keil et al. (1996) are in brackets.

‡ Scores range from 1=Not at All Important to 6=Extremely Important

Table 5. Raw Score Means on YA-SSI as Compared with Normative Data*	Mean‡	Std. Deviation	Mean*	Std. Deviation*
YA-SSI Factor 1: Parents and Siblings†	2.40	0.55	2.51	0.36
YA-SSI Factor 2: Spiritual Faith†	2.18	0.65	1.75	0.38
YA-SSI Factor 3: College Friends†	2.11	0.46	1.94	0.38
YA-SSI Factor 4: Special Groups I Belong To	1.67	0.61	1.66	0.32
YA-SSI Factor 5: Co-Workers	1.70	0.54	1.83	0.37
YA-SSI Factor 6: Church/Synagogue Groups	1.96	0.70	1.83	0.39
YA-SSI Factor 7: College Faculty, Counselors	1.72	0.50	1.30	0.33
YA-SSI Factor 8: Reading Books, Watching TV & Listening to Music	1.64	0.54	1.82	0.29
YA-SSI Factor 9: High School Friends	2.18	0.54	2.15	0.37
YA-SSI Factor 10: Other Professionals or Service Providers	1.69	0.51	1.54	0.29
YA-SSI Factor 11: Other Relatives†	2.26	0.53	2.19	0.36
Comparision of Means				
$r^2 = 0.795$, $p < 0.01$				
$t = 1.484$, 10 *df*, $p = 0.17$, NS				

* McCubbin and Thompson, (1989)

† Scales used in calculation of R^2.

‡ Scores range from 1=No, 2=Yes or 3=Yes a lot.

Table 6. Logistic Regression & Chi Square Results for Each Predictor and Outcome Variables			
	Lifetime Suicidal Ideation	Current Ideation	Suicide Attempts
n (N)	19 (60)	4 (60)	5 (60)
Family Assessment Measure-III*	$R^2 = 0.185$	$R^2 = 0.317$	$R^2 = 0.148$
	$X^2_{(5, N = 60)} = 8.52$, $p<.13$, NS	$X^2_{(5, N = 60)} = 7.827$, $p<.17$, NS	$X^2_{(5, N = 60)} = 4.009$, $p = 0.55$, NS.
Young Adult Social Support Inventory (YA-SSI)**	$R^2 = 0.227$	$R^2 = 0.262$	$R^2 = 0.072$
	$X^2_{(4, N = 60)} = 9.92$, $p < 0.05$	$X^2_{(4, N = 60)} = 6.149$, $p = 0.18$ NS	$X^2_{(4, N = 60)} = 1.847$, $p = 0.76$, NS
College Student Reasons for Living (RFL-CS)***	$R^2 = 0.018$	$R^2 = 0.178$	$R^2 = 0.251$
	$X^2_{(3, N = 60)} = 0767$, $p = 0.85$, NS	$X^2_{(3, N = 60)} = 4.238$, $p = 0.23$, NS	$X^2_{(3, N = 60)} = 6.920$, $p = 0.07$, NS
Total Score from RFL-CS, YA-SSI & FAM-III	$X^2_{(3, N = 60)} = 0.854$, NS	$X^2_{(3, N = 60)} = 0.817$, NS	$X^2_{(3, N = 60)} = 3.150$, NS

* Only based on five subscales of FAM-III

** Only based on four subscales of YA-SSI

*** Only based on three subscales of RFL-CS

Table 7. Significant Odds Ratios for Predictor Variables*‡			
	Lifetime Suicidal Ideation (X_1)	Current Ideation (X_2)	Suicide Attempts (X_3)
n (N)	19 (60)	4 (60)	5 (60)
Involvement (FAM-III)	OR, 0.469, $p < .05$.	NS	NS
Spiritual Faith (YA-SSI)	OR, 0.344, $p < .05$	NS	NS
College Friends (YA-SSI)	OR, 2.183, $p < .05$†	OR, 0.289, $p < .05$	NS
Other Relatives (YA-SSI)	NS	OR, 10.454, $p < .05$†	NS
Moral Objection (RFL-CS)	NS	NS	OR, 9.198, $p < .05$†
Responsibility to Family & Friends (RFL-CS)	NS	OR, 8.064, $p < .05$	NS

*Significance is based on one standard deviation above the mean and its predictive effect on X1, X2 and X3.

† Increase in the likelihood the event (X_x) will occur.

‡ 95% Confedence Interval

Table 8. Significant Probabilities for Predictor Variables*‡

	Lifetime Suicidal Ideation (X_1)	Current Ideation (X_2)	Suicide Attempts (X_3)
n (N)	19 (60)	4 (60)	5 (60)
Involvement (FAM-III)	$p = .156$	NS	NS
Spiritual Faith (YA-SSI)	$p = .136$	NS	NS
College Friends (YA-SSI)	$p = .50$	$p = .021$	NS
Other Relatives (YA-SSI)	NS	$p = .334$†	NS
Moral Objection (RFL-CS)	NS	NS	$p = .264$†
Responsibility to Family & Friends (RFL-CS)	NS	$p = .234$†	NS

*Significance is based on one standard deviation above the mean and its predictive effect on X1, X2 and X3.

† Increase in the probability the event (X_x) will occur.

‡ 95% Confedence Interval

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