Person Factors Associated With Suicidal Behavior Among African American Women and Men

NADINE J. KASLOW
Emory University School of Medicine

ANN WEBB PRICE
Atlanta Catholic Charities

SARAH WYCKOFF
Northrop Grumman

MARNETTE BENDER GRALL
Georgia State University

ALISSA SHERRY
University of Texas at Austin

SHARON YOUNG
Ancora Psychiatric Hospital

This study was funded by a grant from the National Center for Injury Prevention and Control/Centers for Disease Control and Prevention, titled “Black Suicide Attempters: Risk Factors and Sex Differences.” We thank David Angelich, Gina Angelich, Brooke Bedell, Susan Ditter, Billie Jean Faust, Katie Greico, G. Lois Joseph, Lynne Millington, David Morgan, Alexandra Okun, Ruth Parker, Eena Redmond, Jasmin Tiro, Nancy Thompson, Heather Twomey, Emily Williams, and Gana Wood for their assistance with study implementation. We also thank the staffs of the Grady Health System’s Emergency Care Center, Psychiatric Emergency Service, Urgent Care Center, and Women’s Health Clinics, Atlanta, Georgia, for assistance with recruiting.

Correspondence concerning this article should be addressed to Nadine J. Kaslow, Department of Psychiatry and Behavioral Sciences, Emory University School of Medicine, Grady Health System, 80 Jesse Hill Drive, Atlanta, GA 30303. E-mail: nkaslow@emory.edu
This study compared person risk factors among the following groups of low-income, African American adults in an urban, public hospital: (a) suicide attempters and nonattempters, (b) male and female attempters, and (c) all four groups (50 female attempters, 50 female nonattempters, 50 male attempters, and 50 male nonattempters). Participants completed psychological distress, aggression, substance use, cognitive processes, religiosity/spirituality, and ethnic identity measures. Compared with nonattempters, attempters reported more psychological distress, aggression, substance use, and maladaptive coping strategies; less religiosity/spirituality; and lower levels of ethnic identity. Male attempters endorsed more substance use than female attempters. No person risk factors differentiated among the four groups. Assessment of person risk factors and implementation of commensurate culturally competent interventions are recommended.

Historically, suicide rates for European Americans have exceeded those of African Americans by a ratio of 2:1 (Maris, Berman, & Silverman, 2000). These low rates for African Americans are attributable to misclassification of suicides for African Americans, underreporting due to the heightened stigma associated with suicidal behavior in this population, and the presence of a number of protective factors (Gibbs, 1997; Maris et al., 2000; Nisbet, 1996; Phillips & Ruth, 1993). Further, the actual number of suicides among African Americans may be higher if the number of deaths misclassified as homicides or accidents was included (Poussaint & Alexander, 2000; Satcher, 1998). The rates of suicide in the African American community, particularly among younger men, are on the rise (Morbidity and Mortality Weekly Report, 1998).

Across racial and ethnic groups, men are four times more likely than women to commit suicide (www.cdc.gov/ncipc/osp/aboutmrt.htm). This sex difference may be even more pronounced within the African American community, with a 6:1 ratio (www.cdc.gov/ncipc/osp/aboutmrt.htm).

Suicide attempts are a leading risk factor for completions (Tejedor, Diaz, Castillon, & Pericay, 1999). A study of urban, African American young adults found lifetime, last-year, and 6-month prevalence rates for suicide attempts to be 5.3%, 1.2%, and 0.4%, respectively (Ialongo et al., 2002). Women across all racial, ethnic, and age groups are two to three times more likely than men to attempt suicide (Kahn, Kehle, Jenson, & Clark, 1990; Kessler, Borges, & Walters, 1999), a finding true for African American women as well (Juon & Ensminger, 1997).

**Psychosocial Factors and Suicide**

Only recently have investigators examined psychosocial factors associated with suicidal
behavior in African Americans. The person risk factors chosen for this study are based on data from African Americans and include psychological distress, aggression, substance use, and cognitive processes (Gibbs, 1997; Joe & Kaplan, 2001; Kaslow et al., 2000; Lester, 1998b; Poussaint & Alexander, 2000). To increase the cultural relevance of the research, religiosity, spirituality, and ethnic identity are examined (Gibbs, 1997; Poussaint & Alexander, 2000).

**Psychological Distress**

With regard to psychological distress, higher rates of psychiatric disorders and psychological symptoms have been reported among African American suicide attempters than nonattempters (Frierson & Lippmann, 1990). Two thirds of urban, African American young adults with a history of attempts report at least one lifetime psychiatric disorder (Ialongo et al., 2002). Compared with nonattempters, African American female attempters report more psychological distress, symptoms of posttraumatic stress disorder, and hopelessness (Kaslow et al., 2000; Kaslow et al., 1998; Kaslow et al., 2002; Thompson, Kaslow, Bradshaw, & Kingree, 2000; Thompson, Kaslow, & Kingree, 2002; Thompson et al., 1999). Among African American women abused by their intimate partners, high levels of psychological distress, depression, and hopelessness, and low levels of hopefulness, are associated with attempter status (Kaslow et al., 2002; Thompson et al., 2002). There is some evidence that African American men who attempt suicide are more likely to experience psychotic symptoms than are their female counterparts, whereas female attempters are more likely than male attempters to be depressed (Frierson & Lippmann, 1990). There are no current data on aggression or impulsivity in African American attempters.

**Substance Abuse**

Alcohol and drug abuse serve as risk factors for suicide attempts and completions (Frierson & Lippmann, 1990; Marzuk et al., 1992; Murphy, Wetzel, Robins, & McEvoy, 1992). African American female attempters are more likely than nonattempters to report drug, but not, alcohol abuse (Kaslow et al., 2000). However, among African American women abused by their partners, both alcohol and drug abuse are associated with attempter status (Kaslow et al., 2002; Thompson et al., 2002). African American male suicide attempters are more likely than female attempters to be intoxicated at the time of their attempt (Frierson & Lippmann, 1990).

**Coping Skills**

African American women attempters are more likely to evidence maladaptive coping skills than nonattempters (Kaslow et al., 2000; Kaslow et al., 1998). Abused African American women who have not attempted suicide are likely to evidence adaptive coping skills (Kaslow et al., 2002). The only article on the link between attributional styles and suicidal behavior with African Americans focused on African American and Caucasian adolescents’ perceived risk for suicide (Greening & Stoppelbein, 2002). An adaptive attributional style, as measured by the Children’s Attributional Styles Questionnaire (CASQ; Seligman, Peterson, Kaslow, Tanenbaum, & Abramson, 1984), was related to perceiving lower risks for suicide. No research has examined cognitive processes of African American male attempters.

**Spirituality and Religion**

With regard to empirical examination of the link between religiosity and spirituality and suicidal behavior, abused African American women who endorse high levels of spiritual well-being are at reduced risk for attempting suicide (Kaslow et al., 2002). Among African Americans, institutional ties to religion lower prosuicide ideology (Stack & Wasserman, 1995). Religiosity corresponds with lower levels of suicide acceptability among African American women (Marion & Range, 2003b). One factor that contributes to lower rates of suicide among older African Ameri-
can women than European American women is a greater intrinsic religiosity (Bender, 2000). Consistent with this, African American adolescents with high levels of religious orthodoxy have a decreased perceived risk for suicide (Greening & Stoppelbein, 2002). A collaborative religious problem-solving style serves as a buffer against suicidal ideation among African American college students (Marion & Range, 2003a).

No data could be located on the association between ethnic identity and suicidal behavior. This study aims to (a) examine the differences between African American suicide attempters and nonattempters on the person variables outlined earlier; (b) examine the differences between African American women and African American men who attempt suicide on these person factors; and (c) examine the differences on the four groups of interest (female attempters, female nonattempters, male attempters, and male nonattempters) on the various person factors.

**Method**

**Sample**

Participants (N = 200) were recruited from a large, public urban university affiliated hospital in the southeastern United States that serves an indigent and minority population. The sample consisted of African American women and men, ages 18–64 years (M = 32.8, SD = 10.8) seeking medical or psychiatric care. There were four groups of participants: (a) women who presented after a nonfatal suicide attempt (female attempters, n = 50); (b) men who presented after a nonfatal suicide attempt (male attempters, n = 50); (c) women who presented for medical problems with no history of suicidal behavior (female controls, n = 50); and (d) men who presented for medical problems with no history of suicidal behavior (male controls, n = 50).

Of the 128 people referred for the attempter group, 28 (21%) were excluded: 20 (16%) refused to participate, 3 (2%) were unable to complete the protocol (acutely psychotic), 2 (1%) had significant cognitive impairment (i.e., low scores on theMini-Mental State Exam), and 3 (2%) were deemed unsuitable for participation because of nonspecific reasons. Of the 116 people approached to participate in the control group, 16 (15%) were excluded: 8 (7%) refused to participate, 6 (5%) reported a history of at least one prior suicide attempt, 1 (0.08%) had significant cognitive impairment, and 1 (0.08%) was deemed unsuitable for participation because of nonspecific reasons.

Among the 100 attempters, 65% had attempted suicide previously, with overdose being the most common method (64.6%). Risk-rescue ratings (Weissman & Worden, 1972) indicated low to moderate suicide attempt lethality. Scores on the Suicide Intent Scale (Beck, Schuyler, & Herman, 1974) indicated that overall the participants’ level of intent with regard to circumstances and lethality was low to medium.

**Procedure**

**Data Collection.** Research team members approached eligible participants, explained the study, and answered questions. After written informed consent was obtained, screening measures were administered to determine eligibility. Once eligibility was verified, the team member administered questionnaires verbally to prevent confounding by the low levels of functional literacy in this population. Data collection consisted of a 3-hr face-to-face interview. Participants were allowed to take breaks as needed and divide the session into more than 1 day if needed as well. Participants were first given a mental status exam to rule out the effects of any medication or acute cognitive dysfunction at the time of the interview. Participants were paid a $25 honorarium and provided with referrals to community agencies.

**Recruitment of Suicide Attempters.** The principal investigator (PI; Nadine J. Kaslow)
was available by pager at all times so that she could be notified immediately about all African Americans who presented after a suicide attempt. Upon receiving a referral, the PI determined if the behavior met criteria for a suicide attempt (self-injurious act that required medical attention or in which there was serious intent), and if so, a team member recruited the person once he or she was medically stable.

Recruitment of Control Participants. A team member approached people seeking care at the hospital’s clinics at various times of the day and days of the week. Upon approaching a potential participant, the team member explained study participation and determined eligibility.

Screening Measures

Screening Questionnaire. The Screening Questionnaire (SQ) identified people who met study criteria. Controls were asked if they had ever attempted suicide, and preliminary demographic data were collected.

Mini-Mental State Exam. The Mini-Mental State Exam (MMSE; Folstein, Folstein, & McHugh, 1975) is a 30-point measure divided into seven categories (orientation to place, orientation to time, registration, attention and concentration, recall, language, and visual construction) that assesses mental status at the time of the interview. MMSE scores < 24/30 if literate, or < 22/30 if functionally illiterate, indicate diffuse cognitive dysfunction. Reported internal consistency reliability estimates for the MMSE range from .82 to .95, whereas reported test–retest reliability estimates range from .75 to .94.

Rapid Estimate of Adult Literacy in Medicine. The Rapid Estimate of Adult Literacy in Medicine (REALM; Williams et al., 1995) consists of 66 medical terms, and pronunciation and the ability to read are assessed. Scores >19 were considered literate. The REALM correlates with other tests of achievement and literacy and mental status exam scores. It has excellent test–retest and interrater reliability.

Background Measures

Suicidal Behavior Measures

Risk/Rescue Ratio. The 10-item Risk/Rescue Ratio (Weissman & Worden, 1972) is used to determine the lethality of a suicide attempt by assessing the attempt method and the actual damage sustained (risk), as well as the observable circumstances and available resources present at the time of the attempt (rescue). Five risk (agent, impaired consciousness, lesions and toxicity, reversibility, and treatment required) and five rescue (location, person initiating rescue, probability of discovery by a rescuer, accessibility to rescue, and delay until discovery) variables are rated on a 3-point scale, then summed to form total risk and rescue scores, ranging from 5 to 15. Total risk and rescue scores then are transformed into a risk/rescue ratio ranging from 17 to 83; higher scores indicate more lethal attempts. The scale has good interrater reliability and discriminant validity, with reported interrater reliability estimates ranging from .78 to .95.

Suicide Intent Scale. The Suicide Intent Scale (SIS; Beck, Schuyler, & Herman, 1974) is a 20-item questionnaire that assesses the intensity of a suicide attempter’s wish to die at the time of the attempt. The SIS, scored on a 3-point Likert scale from 0 (least severe) to 2 (most severe), is divided into three sections, with only the first 15 items included in the total score. The first 9 items of the scale are related to the factual aspects of the attempt. Items 10–15 are related to the attempters’ thoughts and feelings at the time of the attempt. Items 16–20, which are not scored, assess the individual’s reaction to the attempt, conceptions of death, and
alcohol and drug use at the time of the attempt. Total scale scores range from 0 to 30, with higher scores being indicative of more serious intent. The SIS scale authors report good internal consistency (.82) and inter-rater reliability (.95).

**Psychological Distress**

**Symptom Checklist—Revised.** The Symptom Checklist—Revised (SCL–90–R; Derogatis, 1992) is a 90-item scale that assesses psychological symptoms and asks respondents to indicate how much discomfort each item caused them during the past week, including during the current day. Responses are scored using a 5-point Likert scale, with 0 = not at all and 4 = extremely. The global severity index (GSI) is a mean of all items across all nine subscales. Coefficient alphas for the subscales across samples range from .79 to .90; stability coefficients are good and range from .78 to .90 for 1 week and from .68 to .80 for 10 weeks. Studies have generally supported better convergent than divergent validity for the measure, and the scale has been found to have good diagnostic utility. The internal consistency alpha coefficient for the present sample was .98 for the GSI.

**Beck Depression Inventory—II.** The Beck Depression Inventory—II (BDI–II; Beck, Steer, & Brown, 1996) is a 21-item measure with a 2-week time frame. The measure is designed to measure depressive symptom severity and corresponds with criteria for diagnosing depressive disorder as listed in the Diagnostic and Statistical Manual of Mental Disorders (4th ed.; American Psychiatric Association, 1994). Scores can range from 0 to 63; higher scores indicate more depressive symptoms. For each item, the respondent chooses one of four responses that best describes the extent to which the depressive symptom is present. The total scale has good internal consistency reliability with reported alpha coefficients of .93 and .92 for college student and outpatient samples, respectively (Dozois, Dobson, & Ahnberg, 1998; Osman et al., 1997). The alpha coefficient for the present sample was .94.

**Beck Hopelessness Scale.** The Beck Hopelessness Scale (BHS; Beck, Weissman, Lester, & Trexler, 1974) contains 20 true-false questions that assess for negative expectations about the future. Each item is scored either 0 or 1, with total scores ranging from 0 to 20 and higher scores indicating more hopelessness. Internal consistency estimates from prior research range from .82 to .93. The scale has good convergent, criterion-related, and discriminant validity. The internal consistency alpha coefficient for the present sample was .95.

**Herth Hope Index.** The Herth Hope Index (HHI; Herth, 1992) is a 12-item scale designed to measure hope in adult clinical samples. The HHI measures three dimensions of hope: temporality and the future, positive readiness and expectancy, and interconnectedness. The temporality and the future dimension refers to the perception that a positive, desired outcome is realistic and probable for the near or distant future. The positive readiness and expectancy dimension represents a feeling of confidence coupled with the initiation of plans to affect the desired outcome. The interconnectedness dimension refers to the recognition that one is interdependent and interconnected both with spiritually and with others (Herth, 1992). Scale items are rated on a 4-point Likert scale (1 = strongly disagree to 4 = strongly agree), and totals for each of the three factors range from 4 to 16, with higher scores indicative of an increased sense of hope. Reported reliability estimates were high, indicating good internal consistency (Cronbach’s α = .97) and stability over time (test–retest reliability = .91; Herth, 1992). The internal consistency alpha coefficient for this sample was .91.

**Aggression**

**Aggression Questionnaire.** The Aggression Questionnaire (AQ; Buss & Perry, 1992) is a
29-item instrument that measures physical aggression (9 items), verbal aggression (5 items), anger (7 items), and hostility (8 items). Responses are based on a 5-point Likert scale, ranging from 1 = extremely uncharacteristic to 5 = extremely characteristic. The AQ has good internal consistency as reported by the scale authors and for the present sample, respectively: physical aggression (.85, .84), verbal aggression (.72, .71), anger (.83, .80), and hostility (.77, .82). The test–retest reliabilities for each of the subscales over a 9-week period range from .72 to .80. The AQ has good concurrent and construct validity.

**Barrett Impulsiveness Scale.** The 30-item Barrett Impulsiveness Scale (BIS–II; Barratt, 1994) assesses impulsivity as a trait independent of anxiety. Although it contains three subscales (impulsive nonplanning, motor impulsivity, and attentional impulsivity), the measure often is used as total scaled score of impulsivity. Respondents rate each item on a 4-point Likert scale ranging from 1 = rarely/never to 4 = almost always/always. Higher total scores are indicative of more impulsivity. Internal consistency reliability estimates across diverse samples range from .79 to .83. The internal consistency alpha coefficient for the present sample was .77.

**Substance Use**

**Brief Michigan Alcoholism Screening Test.** The Brief Michigan Alcoholism Screening Test (Brief MAST; Pokorny, Miller, & Kaplan, 1972) is a 10-question measure that uses a yes/no format to assess alcohol problems. Scores > 6 correctly identify true-positive individuals; misidentification occurs in 11% of cases. The internal consistency alpha coefficient for the present sample was .84.

**Brief Michigan Drug Abuse Screening Test.** The Brief Michigan Drug Abuse Screening Test (Brief DAST; Skinner, 1983) is a 20-question scale that uses a yes/no format to assess problems related to drugs. Each yes answer is scored 1, and each no answer is scored 0. The items are summed to provide a single overall score that represents that the individual has a clinically significant past or present drug problem. The bulk of the psychometric data available for the measure are for the 28-item version of the scale. However, the correlation between the Brief DAST and the 28-item version is .99. The measure has good internal consistency and concurrent validity. Specifically, measures of internal consistency from a study of people with substance abuse disorders who sought treatment and from a general psychiatric inpatient population were .92 and .94, respectively. The internal consistency alpha coefficient for the present sample was .93.

**Cognitive Processes**

**WAYS OF COPING CHECKLIST (REVISED).** The Ways of Coping Checklist (Revised [WCCL–R]; Vitaliano, Russo, Catt, Maiuro, & Becker, 1985) is a 66-item checklist that assesses the thoughts and actions people use to deal with specific stressful encounters using a 4-point scale, ranging from 0 (not used) to 3 (used a great deal). Factor analysis revealed eight subscales. The internal consistency alpha coefficients for these subscales are noted in parentheses, first as reported by the scale’s author and then for the present sample: problem-focused coping (.70, .59), distancing (.61, .53), self-controlling coping (.70, .59), seeking emotional support (.76, .73), accepting responsibility (.66, .56), avoidant coping (.72, .67), planful problem-solving (.68, .72), and positive reappraisal (.79, .81).

**Attributional Style Questionnaire for African Americans.** The 24-item Attributional Style Questionnaire for African Americans (ASQAA), developed for this study, assesses causal attributions in low-income African Americans. The ASQAA was modeled after the CASQ (Seligman et al., 1984). For the 12 positive and 12 negative situations, people choose the response that best explains why the event occurred. Internality, stability, and
globality are assessed. A composite attributional style score (positive composite – negative composite) score is obtained; lower scores indicate more depressive styles. The internal consistency alpha coefficient for the present sample was .80. No other psychometric data are available for this measure at the present time.

Religiosity and Spirituality

**Multidimensional Measure of Religious Involvement.** The 12-item Multidimensional Measure of Religious Involvement (MMRI; Levin, Taylor, & Chatters, 1995) assesses organizational religiosity, nonorganizational religiosity, and subjective religiosity. Responses are measured on a 4-point scale. A measurement model found excellent overall fit, and all hypothesized factor loadings were strong and statistically significant (Levin et al., 1995). The internal consistency alpha coefficients for the present sample were .73 for organizational religious involvement, .73 for nonorganizational religious involvement, and .58 for subjective religiosity.

**Spiritual Well-Being Scale.** The 20-item Spiritual Well-Being Scale (SWBS; Ellison, 1983) asks people to rate on a 6-point scale (from strongly agree to strongly disagree) both their religious and existential (nonreligious) well-being. Ten items assess the degree to which an individual perceives the well-being of his or her spiritual life as it is expressed in relation to God, and 10 items measure the degree to which an individual is adjusted to self, community, and surroundings. All items are summed to form three scale scores: one score for religious well-being (RWB), one score for existential well-being (EWB), and one score for total spiritual well-being (SWB). RWB and EWB scores can range from 10 to 60. SWB scores can range from 20 to 120. Higher scores are indicative of greater well-being. The SWBS has excellent test–retest reliability, with reported reliability coefficients for each of the three scales as high as .99 and .93 for the total scale, .96 for RWB, and .86 for the EWB scale in the present sample. The internal consistency alpha coefficients for the present sample were .90 for both subscales, as compared with a range of .78 to .94 reported by the scale authors.

Ethnic Identity

**Multigroup Ethnic Identity Measure.** The 23-item Multigroup Ethnic Identity Measure (MEIM; Phinney, 1992) assesses feelings regarding one’s ethnicity, with higher scores representing a more positive ethnic identity. Twenty items are rated on a 4-point Likert scale (from strongly disagree to strongly agree). The scale consists of an overall ethnic identity score and four subscales measuring ethnic identity achievement, ethnic affirmation and belonging, ethnic behavior, and other group orientation. The other 3 items ask for personal and family ethnic identity. Prior coefficient alphas for the subscales ranged from .69 to .90. The internal consistency alpha coefficient for the present sample was .85 for the entire scale, .72 for ethnic identity achievement, .77 for affirmation and belonging, and .76 for other group orientation. No internal consistency coefficient could be conducted for the subscale ethnic behaviors because this subscale comprised only 2 items. There also are good data from prior studies supporting the construct validity of the measure.

Results

**Between-Groups Differences on Background Variables**

Sociodemographic differences between the four groups were examined using univariate analyses of variance (ANOVAs) for continuous variables and chi-square analyses for nominal variables. As seen in Table 1, attempters were more likely than nonattempters to be younger and homeless. These variables were used as covariates in subsequent analyses. There were no between-groups dif-
ferences on education, marital status, number of children, employment status, monthly household income, religious affiliation, or medical service utilization. Overall, including all 200 participants, this is a sample with limited education level; 49% did not complete high school and only 8.5% completed college or graduate school. With regard to marital status, 42% of the participants had never married; 8% were married; 25.5% were separated, divorced, or widowed; and 24.5% had a current partner to whom they were not married. Most participants had children (64.5%). The sample was relatively poor; 17.2% were homeless, 57.3% were unemployed, and 47.1% had household incomes less than $12,000. They had high rates of medical service utilization. With regard to religious affiliation, the sample was predominantly Baptist (51%). Almost half of the participants had been convicted of a crime (49%). Table 2 provides means and standard deviations for the four groups on all measures.

Differences Between Attempters and Nonattempters on Person Risk Factors

Multivariate analyses of covariance (MANCOVAs) were used to test the hypothesis that compared with nonattempters, attempters would evidence more psychological distress (SCL–90–R, BDI–II, BHS, and HHI), aggression (AQ and BIS–II), and substance use (Brief MAST and Brief DAST), more maladaptive cognitive processes (WCCL–R and ASQAA), lower levels of religiosity and spirituality (MMRI and SWBS), and lower levels of ethnic identity (MEIM).

In terms of psychological distress, the MANCOVA yielded a significant multivariate $F$, $F(4, 174) = 33.7$, $p < .01$. Separate ANOVAs using each psychological distress measure as dependent variables revealed that compared with nonattempters, African American attempters reported higher levels of global distress (SCL–90–R), $F(1, 177) = 87.0$, $p < .01$; more depressive symptoms (BDI–II), $F(1, 177) = 96.8$, $p < .01$; greater feelings of hopelessness (BHS), $F(1, 177) = 11$.

Table 1 Demographic Information

<table>
<thead>
<tr>
<th>Variable</th>
<th>Men</th>
<th>Women</th>
<th>Attempters</th>
<th>Nonattempters</th>
<th>Statistical test</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>34.4 (10.1)</td>
<td>31.3 (11.2)</td>
<td>30.9 (10.0)</td>
<td>34.8 (10.4)</td>
<td>$F(1, 195) = 6.7$, $p &lt; .01$ (group)</td>
</tr>
<tr>
<td>No. of children</td>
<td>2.4 (2.4)</td>
<td>2.5 (1.5)</td>
<td>2.5 (2.4)</td>
<td>2.3 (1.3)</td>
<td>$ns$</td>
</tr>
</tbody>
</table>

Frequency

<table>
<thead>
<tr>
<th></th>
<th>Men</th>
<th>Women</th>
<th>Attempters</th>
<th>Nonattempters</th>
<th>Statistical test</th>
</tr>
</thead>
<tbody>
<tr>
<td>Homeless</td>
<td>22</td>
<td>12</td>
<td>23</td>
<td>11</td>
<td>$\chi^2(1) = 4.8$, $p = .03$ (group)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$\chi^2(1) = 3.6$, $p = .06$ (sex)</td>
</tr>
<tr>
<td>No. having religious affiliation</td>
<td>89</td>
<td>89</td>
<td>80</td>
<td>98</td>
<td>$ns$</td>
</tr>
<tr>
<td>Income less than $1,000/month</td>
<td>70</td>
<td>78</td>
<td>74</td>
<td>74</td>
<td>$ns$</td>
</tr>
<tr>
<td>Unemployed</td>
<td>61</td>
<td>53</td>
<td>60</td>
<td>54</td>
<td>$ns$</td>
</tr>
<tr>
<td>Marital status</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$ns$</td>
</tr>
<tr>
<td>Single/never married</td>
<td>48</td>
<td>36</td>
<td>42</td>
<td>42</td>
<td>$ns$</td>
</tr>
<tr>
<td>Partnered</td>
<td>17</td>
<td>32</td>
<td>25</td>
<td>24</td>
<td>$ns$</td>
</tr>
<tr>
<td>Married</td>
<td>8</td>
<td>8</td>
<td>8</td>
<td>8</td>
<td>$ns$</td>
</tr>
<tr>
<td>Divorced, separated, widowed</td>
<td>27</td>
<td>24</td>
<td>25</td>
<td>26</td>
<td>$ns$</td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$ns$</td>
</tr>
<tr>
<td>Did not complete high school</td>
<td>52</td>
<td>45</td>
<td>55</td>
<td>42</td>
<td>$ns$</td>
</tr>
<tr>
<td>Completed high school only</td>
<td>20</td>
<td>25</td>
<td>20</td>
<td>25</td>
<td>$ns$</td>
</tr>
<tr>
<td>Some college/grad school</td>
<td>28</td>
<td>30</td>
<td>25</td>
<td>33</td>
<td>$ns$</td>
</tr>
</tbody>
</table>
The MANCOVA that included the two measures related to the construct of aggression (four subscales of the AQ: hostility, physical aggression, verbal aggression, and anger; total BIS–II score) also yielded significant between-groups differences, \( F(5, 186) = 14.6, p < .01 \). This was attributable to between-groups differences on three subscales of the AQ: hostility, \( F(1, 190) = 52.5, p < .01 \); physical aggression, \( F(1, 190) = 13.9, p < .01 \); and anger, \( F(1, 190) = 26.3, p < .01 \). An ANOVA also revealed between-groups differences on the measure of impulsivity (BIS–II), \( F(1, 190) = 40.2, p < .01 \). An examination of the mean scores revealed that attempters endorsed higher levels of aggression and impulsivity than nonattempters.

In terms of substance abuse, a MANCOVA revealed significant between-groups differences when both the MAST and the DAST

### TABLE 2 Means (and Standard Deviations) for Study Scales

<table>
<thead>
<tr>
<th>Scale</th>
<th>Men</th>
<th>Women</th>
<th>Attempters</th>
<th>Nonattempters</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychological distress</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Global Severity Index (SCL–90–R)</td>
<td>11.2 (7.9)</td>
<td>11.9 (8.3)</td>
<td>16.6 (6.8)</td>
<td>7.2 (6.3)</td>
</tr>
<tr>
<td>Beck Depression Inventory–II</td>
<td>24.7 (15.7)</td>
<td>22.0 (15.6)</td>
<td>33.2 (12.6)</td>
<td>13.5 (11.7)</td>
</tr>
<tr>
<td>Beck Hopelessness Scale</td>
<td>6.9 (6.4)</td>
<td>6.3 (6.7)</td>
<td>10.7 (6.3)</td>
<td>2.6 (3.7)</td>
</tr>
<tr>
<td>Herth Hope Scale</td>
<td>35.9 (8.3)</td>
<td>36.5 (7.7)</td>
<td>31.6 (7.2)</td>
<td>40.8 (5.8)</td>
</tr>
<tr>
<td>Aggression</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hostility (AQ)</td>
<td>23.8 (8.1)</td>
<td>21.8 (7.6)</td>
<td>27.7 (6.9)</td>
<td>19.0 (6.9)</td>
</tr>
<tr>
<td>Anger (AQ)</td>
<td>19.9 (7.7)</td>
<td>18.4 (6.4)</td>
<td>21.7 (6.7)</td>
<td>16.6 (6.6)</td>
</tr>
<tr>
<td>Verbal Aggression (AQ)</td>
<td>15.2 (4.9)</td>
<td>14.2 (4.8)</td>
<td>15.4 (5.3)</td>
<td>14.0 (4.2)</td>
</tr>
<tr>
<td>Physical Aggression (AQ)</td>
<td>25.9 (8.9)</td>
<td>22.9 (8.6)</td>
<td>27.1 (9.4)</td>
<td>21.7 (7.5)</td>
</tr>
<tr>
<td>Barratt Impulsiveness Scale</td>
<td>73.3 (12.0)</td>
<td>70.3 (10.5)</td>
<td>77.0 (11.0)</td>
<td>66.7 (9.2)</td>
</tr>
<tr>
<td>Substance abuse</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brief MAST</td>
<td>8.1 (8.2)</td>
<td>2.9 (5.2)</td>
<td>6.4 (7.8)</td>
<td>4.6 (6.6)</td>
</tr>
<tr>
<td>Brief DAST</td>
<td>7.0 (5.8)</td>
<td>2.9 (4.3)</td>
<td>6.1 (5.7)</td>
<td>3.8 (5.1)</td>
</tr>
<tr>
<td>Cognitive processes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Positive reappraisal (WCCL–R)</td>
<td>10.0 (5.1)</td>
<td>10.3 (5.0)</td>
<td>8.8 (5.3)</td>
<td>11.5 (4.4)</td>
</tr>
<tr>
<td>Planful problem solving (WCCL–R)</td>
<td>7.7 (3.7)</td>
<td>8.4 (3.8)</td>
<td>7.2 (3.8)</td>
<td>8.9 (3.6)</td>
</tr>
<tr>
<td>Escape avoidance (WCCL–R)</td>
<td>1.3 (4.2)</td>
<td>11.1 (4.6)</td>
<td>125 (3.8)</td>
<td>9.8 (4.6)</td>
</tr>
<tr>
<td>Confrontive (WCCL–R)</td>
<td>7.4 (3.3)</td>
<td>7.6 (3.7)</td>
<td>7.9 (3.6)</td>
<td>7.1 (3.5)</td>
</tr>
<tr>
<td>Distancing (WCCL–R)</td>
<td>8.0 (3.2)</td>
<td>8.0 (3.5)</td>
<td>8.2 (3.4)</td>
<td>7.8 (3.3)</td>
</tr>
<tr>
<td>Self-controlling (WCCL–R)</td>
<td>10.3 (3.3)</td>
<td>10.6 (3.8)</td>
<td>10.8 (3.6)</td>
<td>10.1 (3.5)</td>
</tr>
<tr>
<td>Seeking social support (WCCL–R)</td>
<td>7.4 (3.8)</td>
<td>8.2 (3.9)</td>
<td>7.0 (3.7)</td>
<td>8.3 (3.9)</td>
</tr>
<tr>
<td>Accepting responsibility (WCCL–R)</td>
<td>5.2 (2.6)</td>
<td>5.0 (2.8)</td>
<td>5.6 (2.6)</td>
<td>4.0 (2.8)</td>
</tr>
<tr>
<td>Attributional style (ASQAA)</td>
<td>−2.8 (3.6)</td>
<td>−3.5 (3.8)</td>
<td>−2.2 (3.5)</td>
<td>−4.1 (3.7)</td>
</tr>
<tr>
<td>Religiosity and spirituality</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Subjective religiosity (MMRI)</td>
<td>10.0 (1.6)</td>
<td>10.0 (1.7)</td>
<td>9.8 (1.7)</td>
<td>10.2 (1.6)</td>
</tr>
<tr>
<td>Organizational religiosity (MMRI)</td>
<td>5.3 (2.8)</td>
<td>5.9 (2.9)</td>
<td>5.1 (2.8)</td>
<td>6.2 (2.8)</td>
</tr>
<tr>
<td>Nonorganizational religiosity (MMRI)</td>
<td>13.0 (4.0)</td>
<td>13.8 (4.0)</td>
<td>12.4 (4.2)</td>
<td>14.3 (3.6)</td>
</tr>
<tr>
<td>Religious well-being (SWBS)</td>
<td>21.4 (9.5)</td>
<td>20.5 (9.2)</td>
<td>25.3 (9.3)</td>
<td>16.8 (7.3)</td>
</tr>
<tr>
<td>Existential well-being (SWBS)</td>
<td>28.3 (10.5)</td>
<td>27.1 (10.8)</td>
<td>34.4 (9.0)</td>
<td>21.2 (7.7)</td>
</tr>
<tr>
<td>Ethnic identity</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ethnic behaviors (MEIM)</td>
<td>2.4 (.84)</td>
<td>2.4 (.99)</td>
<td>2.3 (.88)</td>
<td>2.5 (.93)</td>
</tr>
<tr>
<td>Ethnic identity achieve (MEIM)</td>
<td>3.0 (.57)</td>
<td>3.0 (.57)</td>
<td>2.8 (.58)</td>
<td>3.2 (.50)</td>
</tr>
<tr>
<td>Affirmation/belonging (MEIM)</td>
<td>3.4 (.58)</td>
<td>3.3 (.62)</td>
<td>3.6 (.44)</td>
<td>3.2 (.50)</td>
</tr>
<tr>
<td>Other group orientation (MEIM)</td>
<td>3.1 (.63)</td>
<td>3.3 (.54)</td>
<td>3.1 (6.1)</td>
<td>3.3 (.57)</td>
</tr>
</tbody>
</table>

Note. SCL–90–R = Symptom Checklist–Revised; AQ = Aggression Questionnaire; Brief MAST = Brief Michigan Alcoholism Screening Test; Brief DAST = Brief Michigan Drug Abuse Screening Test; WCCL–R = Ways of Coping Checklist–Revised; ASQAA = Attributional Style Questionnaire for African Americans; MMRI = Multidimensional Measure of Religious Involvement; SWBS = Spiritual Well-Being Scale; MEIM = Multigroup Ethnic Identity Measure.
were considered, \( F(2, 189) = 4.5, p < .05 \). Univariate tests indicated that attempters endorsed more drug use (DAST), \( F(1, 190) = 7.6, p < .01 \), and more alcohol use (MAST), \( F(1, 189) = 4.2, p < .05 \), than nonattempters.

The MANCOVA conducted on the measures of cognitive processes when all of the subscales from the WCCL–R plus the composite ASQAA were used revealed a significant multivariate \( F \), \( F(9, 172) = 6.4, p < .01 \). Separate ANOVAs on the WCCL–R revealed that compared with their nonattempter counterparts, attempters were more likely to use escape avoidance coping strategies, \( F(1, 180) = 16.1, p < .01 \). Additionally, attempters were less likely than nonattempters to use the following methods of coping: seeking social support, \( F(1, 180) = 8.9, p < .01 \); planful problem-solving, \( F(1, 180) = 11.1, p < .01 \); and positive reappraisal, \( F(1, 180) = 13.9, p < .01 \). Further, attempters evidenced a more depressive attributional style on the ASQAA than did their nonattempter counterparts, \( F(1, 180) = 11.9, p < .01 \). No group differences were found with regard to confronting, accepting responsibility, distancing, and self-controlling coping styles as assessed by the WCCL–R.

A multivariate analysis of variance (MANOVA), used to test between-groups differences with regard to spirituality and religiosity, included the two subscales from the SWBS and the three subscales of the MMRI and revealed a significant multivariate \( F \), \( F(5, 177) = 21.2, p < .01 \). The specific subscales that contributed to this finding were existential well-being, \( F(1, 181) = 102.2, p < .01 \), and religious well-being, \( F(1, 181) = 41.3, p < .01 \), as assessed by the SWBS; and organizational religious involvement, \( F(1, 181) = 7.3, p < .01 \), and nonorganizational religious involvement, \( F(1, 181) = 10.4, p < .01 \), as measured by the MMRI. Compared with nonattempters, attempters endorsed lower levels of both organizational and nonorganizational religious involvement, as well as lower levels of existential and religious well-being. However, there were no differences between the groups with regard to subjective religiosity.

A MANCOVA using the four MEIM subscales yielded a significant overall \( F \), \( F(4, 187) = 4.0, p = .01 \). Attempters had lower scores than nonattempters on affirmation and belonging, \( F(1, 190) = 10.3, p < .01 \); ethnic identity achievement, \( f(1, 190) = 13.7, p < .01 \); and other group orientation, \( F(1, 190) = 5.5, p < .05 \). There were no group differences on the ethnic behavior subscale. Compared with nonattempters, attempters felt less affirmation by individuals in their ethnic group, had less well-developed ethnic identity development, and experienced less connection toward members of other ethnic groups.

**Differences Between Women and Men on Key Risk Factors**

MANCOVAs also were used to test the hypothesis that female and male suicide attempters would differ in terms of their levels of psychological distress aggression, substance abuse, cognitive processes, religiosity and spirituality, and ethnic identity. The only variable in which there were differences was substance abuse. This MANCOVA revealed significant sex differences when both the MAST and the DAST were considered, \( F(2, 93) = 11.2, p < .01 \). Separate ANOVAs indicated that compared with female attempters, male attempters scored higher on both the MAST, \( F(1, 94) = 11.8, p < .01 \), and the DAST, \( F(1, 94) = 22.3, p < .01 \), indicating a higher incidence of substance abuse by male as compared with female attempters.

**Interaction Effects Between the Four Groups on Key Risk Factors**

MANCOVAs were used to test our hypothesis that there would be a significant Group \( \times \) Sex interaction on psychological distress, aggression, substance use, cognitive processes, religiosity and spirituality, and ethnic identity. No statistically significant interaction effects on any of the six variables
emerged, indicating that the differences noted between groups are accounted for by attempter status, as seen in the first set of analyses, rather than by sex or the interaction between attempter status and sex.

Discussion

Comparing Attempters and Nonattempters

Consistent with prior literature, strong group differences were found between attempters and nonattempters on all person variables studied: psychological distress, aggression and impulsivity, substance abuse, cognitive processes, spirituality and religiosity, and ethnic identity.

Psychological Distress. Compared with nonattempters, African American suicide attempters reported higher levels of global psychological distress, depressive symptoms, and hopelessness, and lower levels of hopefulness. These data highlight similarities and differences between low-income, African American suicide attempters and other groups. Findings indicating that low-income, African American suicide attempters have higher levels of global psychological distress, depressive symptoms, hopelessness, aggression, and impulsivity than nonattempters are similar to findings with more middle-class and nonminority samples (Harris & Molock, 2000; Langhinrichsen-Rohling, Monson, Meyer, Caster, & Sanders, 1998; Lester, 1998a; Mann, Waternaux, Haas, & Malone, 1999; Tondo et al., 1999). Despite the evidence that hopelessness is a robust predictor of suicidal behavior, our findings are among the first to demonstrate that a lack of hopefulness is also associated with suicide attempt status. Hopefulness taps into the sense of self-efficacy of one’s experiences.

Aggression and Impulsivity. Compared with nonattempters, African American suicide attempters reported higher levels of physical aggression, anger, hostility, and impulsivity. This is an important finding considering that presently there are no published studies investigating aggression or impulsivity in African American suicide attempters. These findings are not surprising given that suicidal behavior often is an impulsive act, and inadequate control of aggressive impulses is a greater indicator of risk for impulsive suicide attempts than depression (Simon et al., 2001).

Substance Abuse. Compared with nonattempters, African American suicide attempters reported higher levels of substance use. In addition, this was the only person risk factor identified that differentiated between male and female attempters; men reported higher levels of alcohol and drug abuse than women. The finding of elevated rates of substance use in attempters as compared with nonattempters is consistent with prior work (Hufford, 2001; Mann et al., 1999). There are a number of potential mechanisms to explain the link between substance abuse and suicidal behavior. The use of substances reduces a person’s judgment and level of impulse control and as a result may render the individual more vulnerable to self-harm. The suicidal behavior may be related to the context or situation in which the substance use occurs. Or both acts may reflect maladaptive efforts to cope with stress and painful affects.

Cognitive Processes. Compared with nonattempters, African American suicide attempters were more likely to use maladaptive coping strategies such as escape avoidance and a depressive attributional style, and less likely to use adaptive strategies such as seeking social support, planful problem-solving, and positive reappraisal. Consistently, research has revealed that suicidal people are more rigid and inflexible and less able to change their problem-solving strategies than nonattempters and have more difficulty generating alternative solutions to problems because of their cognitive rigidity. As a result, they may turn to suicidal behavior as the only solution when
faced with an emotional problem (Pollock & Williams, 2001).

**Spirituality and Religiosity.** Compared with nonattempters, African American suicide attempters endorsed lower levels of religious involvement and spiritual well-being. Given the salience of church involvement and spirituality in the African American community and prior research on the link between religiosity and suicidal behavior within the African American community (Early, 1992; Neeleman, Wessley, & Lewis, 1998), the protective role of both religious involvement and spiritual well-being is not surprising. This study offers the most rigorous test of the link between both religious involvement and spiritual well-being and suicidal behavior in the African American community.

**Ethnic Identity.** Compared with nonattempters, African American suicide attempters felt less connected and affirmed by their own ethnic group as well as more distant from other ethnic groups. The findings that African Americans who attempt suicide have lower rates of affirmation and belonging, ethnic achievement, and other group orientation offer a new aspect of our understanding of suicidal behavior in this group.

**Sex Differences**

While the between-groups findings for African American attempters and nonattempters are consistent with previous research (Anderson, Tiro, Price, Bender, & Kaslow, 2002; Frierson & Lippmann, 1990; Kaslow et al., 2000; Kaslow et al., 1998; Marzuk et al., 1992; Murphy et al., 1992; Stack & Wasserman, 1995; Thompson et al., 2000), what was not supported was the hypothesis that there would be attempter sex differences among the person variables. It was hoped that this study would expand our understanding of sex differences beyond epidemiological factors to person risk factors to begin to inform gender-specific treatments for suicidal individuals. No prior research addressed the specific experiences of African American male suicide attempters on variables such as hopelessness and hopefulness, and cognitive processes, and thus this study adds significantly to our knowledge base about suicidal behavior among African American men. Research has only recently begun to address person variables that serve as risk and protective factors for African American women (Kaslow et al., 2000; Kaslow et al., 1998; Kaslow et al., 2002). Not only does this indicate that sex differences research is in its infancy and findings of no effect add to the literature by narrowing variables for further study, but it also highlights the importance of learning more about risk and protective factors associated with suicidal behavior among both men and women in the African American community.

**Theoretical and Methodological Considerations**

Social cognitive theory posits that a person’s behavior is determined by person and environment factors (Bandura, 2000). Feminist and multicultural theories stress the presence of gender-specific behaviors based on gender expectations of society and culture (Chodorow, 1995; Espin & Gawelek, 1992; K. Malone et al., 2000). Thus, there may be sex differences on such person variables as social role expectations, attachment, self-efficacy, experiences of racism, gender identity, and empowerment. Regarding the person factors researched in this study, the most powerful are differences based on attempter status. For these variables, male and female attempters experience similar levels of dysfunction. However, that does not necessarily mean that gender-specific treatment approaches are unwarranted, as there may be gender-specific ways in which they make meaning of these symptoms or gender-specific paths in which these symptoms developed to which these measures are not sensitive (Edwards & Holden, 2001).

There are several strengths to this study. The present research focuses on an often neglected group of people in the empirical literature, namely a low-income, African
American sample. Recently, the American Psychological Association adopted the Resolution on Poverty and Socioeconomic Status (www.apa.org/pi/urban/povres), indicating a commitment by the profession to research, develop public policy, educate, and train in a manner that addresses the needs of low-income people. There also has been increased calls to focus our research on specific ethnic groups, such as African Americans (Atkinson, Morten, & Sue, 1997; Ponterotto, 1997). For culturally competent conceptualizations of psychological outcomes, such as suicidal behavior to be developed, it is imperative that research target specific groups (Burless & De Leo, 2002). It is important to realize both similarities and differences in culture and class when working with low-income, African American suicide attempters, to minimize cognitive and behavioral distancing (Lott, 2002) and formulate culturally competent and effective treatments (Heron, Twomey, Jacobs, & Kaslow, 1997).

Second, the present research begins to examine sex differences in suicide attempts for African Americans. Few published studies have examined sex differences for suicide attempters, even though feminist and multicultural theories address how the different sexes make meaning of their worlds (Brown, 1990; Chodorow, 1995; Espin & Gawelek, 1992; J. L. Malone, 2000). Sex differences research is potentially valuable because it may prove useful in designing clinical interventions to reduce suicide attempts.

This study has methodological strengths as well. First, the attempters were interviewed within 24 hr of becoming medically stable. Immediate data collection enhances the accuracy of the participants’ reports of the events leading up to the attempt, as well as their psychological state at the time of the attempt. Further, participants are less likely to use denial immediately following the attempt than after time has elapsed. Second, because the study was hospital based, all of the attempters required medical attention. Third, to capture all suicide attempters who received treatment at the hospital, the researchers were on call 24 hr per day, 365 days per year. Additionally, several of the hospital’s services were involved in this project. Thus, the sample is a representative sample of suicide attempters. Finally, the controlled nature of the design, as well as the breadth of risk factors investigated, added to the study’s validity. The results need to be considered in light of the study limitations. Although the sample is representative of suicide attempters, these were only those attempters that came to the attention of medical professionals. The sample does not include those whose injuries were not recognized as suicide attempts or those who did not seek medical attention. The data are based on retrospective self-reports, which may be biased. The information was not corroborated by other sources. Because the participants had to be read the questionnaires, this may have increased the social desirability of their responses. No formal diagnostic information was obtained. The variables were measured at one point in time, precluding the determination of causality. Although the majority of the measures have good psychometric properties, one measure was developed specifically for this study (ASQAA), and thus limited psychometric data are available on the scale. In addition, many of the measures were not normed or evaluated with low-income African Americans. Despite this, the internal consistency reliabilities for the present sample for all measures were good. Different recruitment strategies were used for attempters and controls. Although efforts were made to ensure the accuracy of responses, it is possible that the interview procedure was not able to rule out those individuals who were too fatigued or too medicated to participate. Further, there may have been factors related to the hospital environment in which the interviews were conducted that might have influenced responding. Finally, these results may not generalize to populations other than low-income African Americans.

Future research should incorporate data from multiple methodologies and sources.
It would be useful to compare suicidal and nonsuicidal depressives, possibly using sex and race as moderators. It would also be helpful to assess and control for Axis I and Axis II disorders using a structured diagnostic interview. Owing to the high incidence of suicide attempts among individuals with Axis II disorders, the use of a structured interview may provide additional information about the factors that lead to suicide attempts within the diagnostic criteria of either Axis I disorders or Axis II disorders. Future investigators should address environmental factors in addition to homelessness, as well as the interaction between person and environmental risk factors. Research currently being conducted (Kasl et al., 2003) has indicated that a number of environmental factors, such as the number and type of racist events one experiences, as well as the access to resources and health care, can contribute to an increased risk of suicide attempts. Such environmental factors should also be examined in the context of person risk factors. A broader array of person constructs should be studied before drawing conclusions regarding the lack of sex differences. Longitudinal designs will help establish causality of person factors implicated in suicide attempts. It is important to study African Americans across the socioeconomic continuum and in comparison with other ethnic groups.

Finally, the results gleaned have a number of clinical implications. When assessing African Americans, one should query those with elevated levels of psychological distress, aggression, and substance use; maladaptive cognitive processes; and low levels of religiosity, spirituality, and ethnic identity regarding their suicidal ideations and history of suicidal behavior. Preventative interventions for suicidal African Americans and those at risk for suicidal behavior should target reducing psychological symptoms, increasing feelings of hopefulness, and reducing substance use via the teaching of effective strategies for the management of aggression and impulsivity and skills training related to adaptive cognitive processes. Highlighting the value of church involvement and affiliation and religious coping is also recommended. Finally, helping people feel more positively about their ethnic background and more connected with members of their own ethnic group will foster a greater sense of affirmation and belonging.

References


Person Factors Associated With Suicidal Behavior


