

## **Suicide and African Americans: An Overview**

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### **Abstract**

Suicide is increasingly becoming a major public health issue. Each year over one million people die by suicide worldwide. The World Health Organization estimates that suicide is the thirteenth leading cause of death worldwide (Gross 2006) and the National Safety Council rates death by suicide eleventh in the United States (Minino and Heron 2006). It is a leading cause of death among teenagers and adults under 35 (Nikola 2006). The rate of completed suicide is higher in men than in women (O'Connor and Noel 2000). It is estimated that workforce-related suicides cost businesses as much as \$13 billion annually (Research! America 2008) and for every suicide prevented, the United States could save an average of \$3,875 in medical expenses and \$1,178,684 in lost productivity (Research! America 2008). Caucasians are twice as likely as African Americans to complete suicide. The rate of suicide is growing faster among African American youth than among Caucasian youth (American Association of Suicidology 2006); it is the third leading cause of death for African Americans aged 15-24 (Centers for Disease Control and Prevention 2007). This is a descriptive study of various dimensions of suicide among African Americans in the past decade with a discussion of prevention and screening tools.

### **African American Attitudes towards Suicide and Mental Health Treatment**

Historically, suicidal behaviors among African Americans have received little attention. This may be attributed to the belief that very few African Americans believe in suicide or that religious beliefs prevent African Americans from committing suicide. There also is the belief that African Americans do not experience depression, which in its severe state often can lead to suicide. Abuse of medications, especially antidepressants, can be a factor in suicide completions. In a study conducted by TN Medicaid waiver managed-care program study (Ray Wayne et al. 2007), only 29 percent of reported African American suicides and possible suicides compared to 51 percent Caucasian suicides used prescribed anti-depressants in the year prior to committing suicide. Other studies also show a significant difference in prescribed anti-depressant treatment among African Americans compared to Caucasian Americans. Although African Americans are less likely to receive treatment for depression, they have similar to higher rates of depression than their Caucasian counterparts. Minority adults also are more likely to lack trust in their physicians. Cultural mistrust, especially in mental health services provided by European American clinicians, is believed to be behind the negative attitude towards psychiatric intervention.

Lack of doctors from patient's same race and ethnicity also plays an important role apart from the fact that culturally incompetent doctors are more likely to violate the

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patients' religious and cultural beliefs. This finding was based on the Tennessee Medicaid Waiver Managed Care Program study (Ray, Hall, and Meador 2007), which also mentioned lack of insurance coverage, linguistics and poor patient-doctor relationships as reasons for poor participation in seeking mental health treatment.

### **Misclassification of Suicide**

Actual studies of suicide among African Americans is compromised by the fact that African American suicides are more likely to be misclassified than any other ethnic group (Phillips and Ruth 1993; Warhauer and Monk 1978). Some researchers suggest that African American suicides may be "disguised" in the form of "victim-precipitated homicides" (Garrison et al. 1991), or as accidental deaths. This concept is especially relevant because victim-precipitated homicide occurs when an individual intentionally engages in behavior that thrusts another individual (e.g., police officer, gang member, etc.) to kill or harm him or her (Parent 199). Although it has been estimated that nearly 30 percent of urban homicides are victim-precipitated (Van Zandt 1993), these deaths are not formally recognized as a form of suicide. Labeling cause of death as *injury of undetermined intent* by investigators and medical examiners has been shown to lead to underestimation of suicide cases (O'Carroll 1989; Goldsmith et al. 2002; Croft, Lathrop, and Zumwalt 2006). Accurate accounts of African American suicides may not be known due to misclassifications of cause of death (O'Carroll 1989). African Americans are generally viewed as a psychologically unsophisticated race that is naturally high spirited and unburdened with a sense of responsibility (Prange and Vitols 1962). Often this perception of African Americans contributes to their misclassification of cause of death. Another noted distinction in African Americans who commit suicide is lack of suicide notes. According to data from the National Violent Reporting System from 2004-2006, only 18 percent of African-Americans leave behind suicide notes as compared to 21 percent in Hispanic suicide cases. Also, most African Americans are hesitant to report suicidal ideations due to self-stigma and public stigma. Other factors such as religious and cultural reasons, life insurance policy stipulations, and lack of psychological autopsies have been shown to influence the rate of suicide in African Americans (Litman 1989). African American males who attempted suicide were found to have more psychotic experiences than African American females documented with depressive symptoms. In a study using New York City medical examiner data, it was estimated that suicide was underestimated in 80 percent of African American deaths (Warhauer and Monk 1978). A more recent study on potential suicide misclassification in minorities estimated more than twice the number of African Americans to be prone to potential suicide misclassification as compared to Caucasians and Hispanics. Youths and lesser educated population groups also were more likely to be misclassified (Rockett 2010). Psychiatry comorbidity is present in nearly half of all suicide cases; yet less than 10 percent of these mental health disorders are actually reported on death certificates (Rockett 2010).

### **Gender Differences**

African American females are more likely to attempt suicide but African American males have more suicide completions. In 1998, African American deaths certified as suicide occurred at a rate of five per day (American Association of Suicidology 2006).

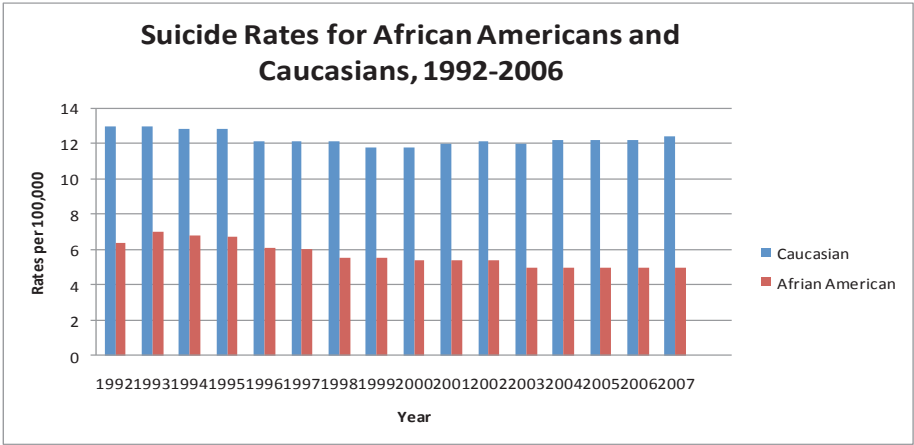
In 2002, 1,939 African Americans completed suicide in the United States. Of these, 1,633 (84 percent) were males (rate of 9.1 per 100,000); and 1.6 per 100,000 were females (American Association of Suicidology 2006).

African American males use lethal force (i.e., firearms) when attempting suicide more often than females do, and thus have more completion rates than females. Being a homosexual with an unsupportive family or in a hostile environment is also a major predisposing factor (Mathy 2009), but studies specific to African American homosexuals is lacking. Table 1 shows suicide rates by gender, ethnicity and age groups. Table 2 shows suicide rates for African Americans and Caucasians from 1992 – 2006.

Table 1: Suicide by Gender/Ethnicity/Age Groups

U.S. Suicide Statistics (2005) Breakdown by Gender / Ethnicity /Young, Old Age Groups						
All Ages Combined			Elderly (65+yrs)		Youth (15-24 yrs)	
Group	Number of Suicides	Rate of suicide	Elderly Suicides	Elderly Suicide Rate	Youth suicides	Youth Suicide Rate
White Men	23,478	19.7	4,361	32.1	2,945	17.3
White Women	6,049	5.0	779	4.2	595	3.7
Nonwhite Men	2,429	9.0	189	10.5	553	12.0
Nonwhite Women	681	2.3	75	2.7	119	2.7
Black Men	1,621	8.7	124	10.3	382	11.5
Black Women	371	1.8	28	1.4	55	1.7

Table 2: Suicide by Race



(American Association of Suicidology 2007)

According to the American Association of Suicidology, 2007

- In 2007, there were only 352 African American female suicides. The ratio of African American male to female suicide was 4.56 to 1.
- The suicide rate among African American females was the lowest of all racial/gender

**Table3: Percent of African American Suicides by Firearm**

Age	Both Gender	Male	Female
All ages	55	59	38
15-24	63	67	40
25-34	67	58	36
65 and older	74	79	38

(American Association of Suicidology 2002)

groups. As with all racial groups, African American females were more likely than males to attempt suicide and African American males were more likely to complete suicide

- From 1993 to 2002, the rate of suicide for African Americans (all ages) showed a small but steady decline (from 6.9 in 1993 to 5.2 in 2002). For Caucasians, the rate declined until 1999 (from 13.0 in 1993 to 11.5 in 1999), and then increased slightly since 2000.
- Suicide was the third leading cause of death among African American youth, after homicides and accidents. The suicide rate for young African American youth was 6.5 per 100,000 (n = 403).
- For African American individuals, the rate of male suicide (11.3 per 100,000) was 6.6 times higher than that of females (1.7 per 100,000).

**Method of Suicide**

Firearms are the predominant method of suicide completion among African American males. Nationally, firearms are involved in 74 percent of all suicides among African American teenagers aged 10-14; 61 percent of all suicides among 15-24 year olds; and 54 percent of all suicides among 25-34 year olds (Tennessee Suicide Prevention Network). See Table 3 for Suicides by Firearm and Gender.

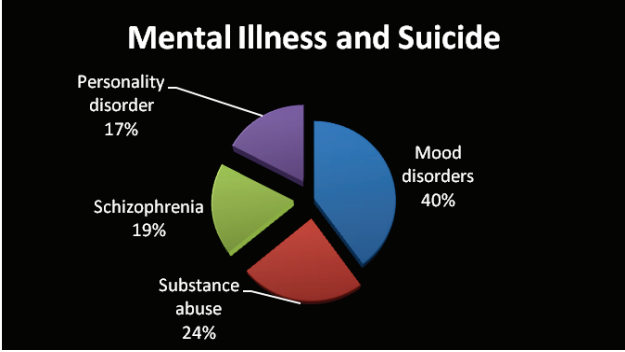
Other methods of suicide include drowning, which is among the least common method of suicide that typically accounts for less than 2 percent of all reported suicides in the United States (CDC-WISQARS 1998); drug overdose with analgesics (Brock and Griffiths 2003); poisoning especially with pesticide accounts for 30 percent worldwide (Griffiths 2007). Suicide by hanging is more prevalent in preindustrial societies (Maris et al. 2000); jumping from height (i.e., tall buildings, bridges) is least common and accounts for just 2 percent of the suicides in the United States (CDC-WISQARS 1998).

**Suicide Risk Factors**

Risk factors for suicide among African-Americans include being age 35 and under; residing in southern and northeastern states; substance abuse; having a firearm in the home; and threatening others with violence (Willis et al. 2003); and mental illness accounts for 87 percent-98 percent of suicide in the general population (Arsenault-Lapierre et al. 2004; Bertolote and Fleischmann 2000). Figure 1 illustrates risk factors related to suicide.

Other risk factors include having a prior suicide attempt (most significant risk factor); having an underlying psychiatric disorder such as depression or post-traumatic stress disorder; being intoxicated (a large percentage of suicides are committed under the influence of alcohol or drugs); behaving recklessly or impulsively; having a family history of mental disorders or substance abuse; having a family history of suicide or violence including physical or sexual abuse; recently undergoing a stressful life event such as the loss of a loved one or a breakup; having firearms in your home; having a signifi-

**Figure 1: Mental Illness and Suicide**



cant medical illness such as cancer or chronic pain; feeling socially isolated or lonely; having legal problems; having trouble in school; and social problems or disciplinary problems if you are a child or young adult.

**Socioeconomic Variables**

Status plays a significant role in the suicide rate among African Americans. According to a study on suicide behavior in low-income African American women, feelings of helplessness was the most important risk factor leading to suicide for this group. Other significant factors were psychological distress; drug use(cocaine most common); psychiatric disorders, especially depression and PTSD; primary relationship discord, specially women who were abused in any way; maladaptive coping skills; sense of hopelessness; and low level of social support systems, including less involvement with one’s own ethnic group. Alcohol abuse was found to be related to women suicide attempts with history of spousal abuse, but not otherwise. In men, both alcohol and drugs were associated with increase in suicide attempts. Childhood and adolescent trauma history also are risk factors for female suicide attempters as these are found to increase suicidal behavior (Kaslow et al. 2006). Kaslow (2002) reported that education and marriage were shown to have a protective role. She also hypothesized spiritualism to be a protective factor in low income African American populations.

Low-income African American women who are less likely to improve their economic standing and educational attainment show increase in suicide attempts, especially when raising a child is involved and they have no support systems in place, or recovering substance abusers, and or have a dual diagnosis. Importantly, these risk factors when identified should lead to proper psychosocial interventions such as education, behavior therapy (Najavitis 2002) and group therapy (Foy et al. 2001).

**Religiosity and Suicide**

Religious beliefs generally provide a protective effect against suicide in the African American community as suicide is seen as an unforgivable sin (Early and Akers 1993). Durkheim (1984) posited that religion acts as a deterrent against suicide because it enhances social integration and normalizes submission or adherence to regulation. Several researchers have noted that ties to religious institutions in general serve as a

protective barrier against suicidal behaviors because religious organizations are easily accessible, provide an important source of positive effect, emphasize social ties, and enhance group cohesiveness (Pescosolido and Georgianna 1989). Religiosity also has been found to be a protective factor for suicide ideation, suicide attempts, and suicide completion among adolescents from various ethnic backgrounds (Donahue and Peter 1995; Stack, Wasserman, and Kposowa 1994; Zhang and Jin 1996). However, few studies to date have empirically validated this phenomenon among African American adolescents in spite of the centrality of religion and spirituality in the African American culture (Lincoln 1990; Wilmore 1998). In a recent study of African American and Caucasian adolescents, religious orthodoxy, or commitment to a few cores, religious beliefs were found to buffer perceived suicide risk (Greening and Stoppelbein 2002). In multiple national samples that examined different aspects of African American life, African Americans consistently engaged in more public and private religious devotion than other racial/ethnic groups. Eight out of 10 African American respondents reported that religious beliefs are very important and 56 percent attend church two or more times a month. Nearly 39 percent read religious material and 36 percent listen to religious broadcasts at least once per week (Chatters et al. 1999). Even African Americans who do not attend church regularly engage in more private devotional activities than other racial/ethnic groups (Taylor 1988).

In spite of these positives, religiosity also has been found to discourage mental health help-seeking behaviors (Blank et al. 2002; Lesniak 2006) and colleagues recently found that different dimensions and aspects of religion, such as intrinsic religiosity, are uniquely related to various mental health outcomes (Lesniak et al. 2006). Traditionally, research that examined the relationship between religion and mental health focused on public or organizationally based religious behaviors (e.g., church membership, church attendance, involvement in church activities). Although this aspect of religiosity is an important component, public religious participation may not fully capture the effect of religion on psychological well-being which was validated by Taylor and his colleagues.

## **Pathophysiology**

Suicide behavior has been shown to have a genetic link within families and this familial transmission cannot solely be explained by the transmission of psychiatric disorders alone. The highest suicide rates are not observed in the biological relatives of patients with affective disorders, who by themselves have a strong genetically driven vulnerability (Brent 2005). Twin studies have shown that monozygotic twins have a significantly higher concordance rate for completed and attempted suicide than dizygotic twins (Roy 1983) do. This finding was replicated in a large Australian twin study in which the risk of a serious suicide attempt by a monozygotic twin was 17-fold increased if the co-twin made a serious suicide attempt (Statham et al. 1998). The heritability of suicide and suicidal behavior seems to be determined through at least two components: the heritable liability to psychiatric disorders and the heritable liability to impulsive aggression or other personality traits. Hence, the concordance of both liability factors results in the highest risk for suicidal behavior (Brent 2005). Based on neurobiological findings, genetic studies have been conducted for over a decade in order to elucidate the genetic contribution to the vulnerability of suicidal behavior. As there is convincing

evidence that a serotonergic dysfunction is involved in the biological susceptibility to suicide, especially in high-lethality suicide, the majority of the studies were performed with candidate genes of the serotonin pathway.

## **Prevention of Suicide**

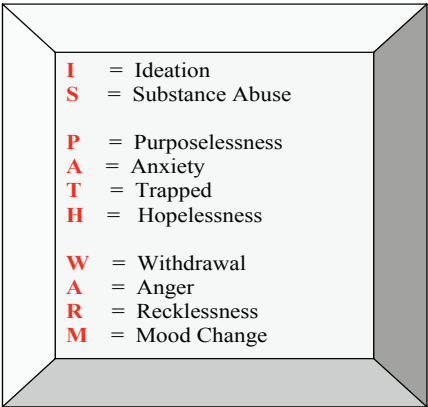
Successful prevention efforts seek to minimize risk factors and maximize protective factors (i.e., effective clinical care for mental, physical and substance abuse disorders; family and community support; and promoting skills in problem solving, conflict resolution and nonviolent handling of disputes). Addressing the overall health of those at risk has demonstrated success. Providing effective, targeted and community-based mental health services for children and adolescents who are identified to be at risk for suicide is the primary suicide prevention tactic. Research shows that early intervention strategies that target risk factors for depression, substance abuse and aggressive behaviors and building resiliency may have promise in preventing youth suicide. Ensuring that youth have adequate access to mental health services through mental health parity legislation is another prevention tactic. “You can have all the prevention programs in the world, but if people don’t have access to care, it’s meaningless,” says Jerry Reed, the Executive Director of the Suicide Prevention Action Network. Approximately 25 states have laws for full mental health parity that require insurers to cover mental illness to the same extent as physical illness. Reed points out that suicide has been “stigmatized for so long” that reliable data on prevalence and on effective prevention strategies are just beginning to become available. Surveillance data is “critically important” to understanding those at risk and how to direct suicide prevention resources (National Conference of State Legislatures 2005). Also of equal importance is appreciation of early warning signs because people with suicidal behavior usually present with warning signs. A proper understanding of these symptoms is very vital in the prevention of suicidal attempts or completion. Some of these signs include previous suicide attempts; giving away prized possessions; making final arrangements; loss of interest in usual activities; recent loss of a loved one; loss of job; and increase in substance abuse. The American Association of Suicidology provides a Mnemonics for early suicide warning signs: “IS PATH WARM”.

## **Suicide Screening Tools**

The use of early screening tools has shown to be very effective in identifying people at risk and in need of treatment and monitoring. One such tool is the Columbia Suicide Screen (CSS) developed by researchers at Columbia University that is able to identify more accurately patients with suicide-related behaviors than other similar instruments. Earlier screening tools such as the Beck Depression Inventory (BDI) have been faulted for their lack of precision. By administering the CSS to 1,729 high school students, researchers from Columbia University and similar universities intended to provide a more accurate test of suicide-related behavior. The CSS more correctly identified teens with suicide-related behaviors that were at risk of committing suicide. The tool also identified which teens did not exhibit suicide-related behaviors and who therefore had little or no risk of committing suicide (Shaffer et al. 2004). Based on this research, a TeenScreen public health initiative was developed and has been implemented at different capacities in 43 states and the District of Columbia. In these States, the TeenScreen



**Figure 2: IS PATH WARM: A Suicide Prevention Mnemonic**



staff provides consultation, training, screening tools and technical assistance to independently- and locally-operated screening programs, educate local providers about the youths’ needs, and link mental health services by connecting mental health providers and community resources, particularly schools (National Conference of State Legislatures 2005).

Other preventive measures includes Cognitive Behavioral Therapy by psychiatrists with emphasis on helping patients learn new coping skills instead of just talking to the clinician about their suicidal ideations has proven to be very effective in suicide prevention (Lizardi et al. 2011). Good patient follow-up practice by psychiatrists has shown decreased patient and youth dropout rates, especially with low socioeconomic background individuals and thus, reducing suicide rates.

Finally, discussions on prevention would be incomplete if the issue of method of suicide is not addressed. Gun control with respect to mentally ill patients has correctly been discussed, and this topic has continued to generate a lot of passionate debate. Reducing the easy availability of lethal weapons and other similar means commonly used to commit suicide is an issue the government has to review.

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