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# SUICIDE ACCEPTABILITY AND RELIGIOUS WELL-BEING: A COMPARATIVE ANALYSIS IN AFRICAN AMERICAN SUICIDE ATTEMPTERS AND NON-ATTEMPTERS

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This study was designed to examine the relationship between suicide acceptability and religious well-being, and to investigate the differences that may exist between African American suicide attempters and non-attempters on these two concepts. Two hundred low-income, African Americans were administered self-report questionnaires measuring suicide acceptability and religious well-being. Findings indicated that suicide acceptability was negatively related to religious well-being for both suicide attempters and non-attempters. There was also a significant difference between these two groups on suicide acceptability and religious well-being. Results were consistent with previous research that suggests that African Americans who attempt suicide endorse higher levels of suicide acceptability and lower levels of religious well-being than do their nonattempter counterparts. These findings have important implications for culturally-competent community programming and community mental health programs that serve low-income ethnic minority populations.

Suicide is a serious problem facing many different types of people in the United States. Although it is difficult for research to demonstrate exact national attempted suicide rates, research has estimated that to every completed suicide, there are 8-25 suicide attempts (see <http://www.nimh.nih.gov/research/suifact>). The Surgeon General made recommendations in the Suicide Prevention Call to Action in 1999, which we attempted to address in the present study. Two of the recommendations proposed in this report were to advance the science of suicide prevention by researching risk and protective factors related to suicidal behavior, and to address culture-specific issues related to suicidal behavior (U.S. Department of Health and Human Services, 2001). The purpose of the present study was to further examine the effects of potential risk factors (i.e., suicide acceptability) and protective factors (i.e., religious well-being) on suicidal behavior in African Americans.

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## SUICIDE IN AFRICAN AMERICANS

Suicide within the African American community has not been assessed as much as it has been examined among Caucasians. This may be because despite significant economic and social stressors facing the African American community (e.g., racial discrimination and economic strains), African Americans are consistently reported to have lower suicide rates than European Americans (Lester, 1998; Maris, Berman, & Silverman, 2000; Poussaint & Alexander, 2000). The literature suggests that these lower rates may be partly attributable to culturally relevant protective factors (Gibbs, 1997; Satcher, 1998), such as the important role of religion and the importance of supportive extended family networks within the African American community (Range et al., 1999). However, research also suggests that the lower rates of suicide among African Americans may be partly attributed to underreporting because of an increased sense of stigma for suicide and because of misclassification of suicides as homicides or accidents (Phillips & Ruth, 1993). Thus, it is probable that these rates may actually be higher among African Americans than the statistics portray. In addition, recent statistics have demonstrated that the suicide rates of young African American teenagers between the ages of 15 and 19 are increasing comparatively faster than the rates for Caucasian teenagers (Morbidity and Mortality Weekly Report [MMWR], 1998). Given the possibility of underreporting and this increasing suicide rate among young African Americans, an examination of both risk and protective factors for suicidal behavior is warranted in this vulnerable group within the African American community.

### *Suicide Acceptability*

Gibbs (1997) identified several suicide risk factors in the African American community, including substance abuse, psychiatric disorder, and family and marital/relationship discord. Another important risk factor that has received less attention in the literature is suicide acceptability. This construct refers to the extent to which individuals believe suicide is an appropriate solution to life's major problems. Research suggests that people who approve of suicide score higher on suicide risk scales, and are at greater risk of suicide attempts and completed suicide (Agnew, 1998). Investigations focusing on suicide acceptability suggest that suicide is considered most acceptable when the victim is male and when it

is in response to a terminal or chronic physical illness. Suicide is considered least acceptable in response to a serious or persistent psychiatric illness. In addition, men tend to view suicide as more acceptable than women, and people who are married view suicide as less acceptable than those who are not married (Dahlen & Canetto, 2002; R. Deluty, 1988-1989; R. H. Deluty, 1998-1989; Lo Presto, Sherman, & Dicarlo, 1994-1995; Stack, 1998a).

Few studies have examined suicide acceptability among African Americans, and of those that have, most have studied African American college samples (Ellis & Range, 1991; Marion & Range, 2003a). For example, Marion and Range (2003a) found that among African American college students, three things accounted for 17% of the variance in less suicidal ideation: a view that suicide was unacceptable, family support, and a collaborative religious coping style. These results suggest that suicide acceptability is an important risk factor for suicidal ideation among African American college students. However, no study to date has examined suicide acceptability in a vulnerable (i.e., low-income and lack of education) clinical African American sample.

## THE PROTECTIVE ROLE OF RELIGION

Research has sought to understand what cultural factors contribute to lower suicide rates in African Americans. Living in ethnically similar neighborhoods, having strong ties to the community, social support, and family and religious social networks have been identified as protective factors against suicide among African Americans (Chance, Kaslow, Summerville, & Wood, 1998; Gibbs, 1997). The protective role of religion has received attention in the literature and was specifically identified in the Surgeon General's 1999 report (U.S. Public Health Service, 1999). For African Americans, religion may serve as a protective factor through the Black church, because suicide is strongly condemned by church leaders (Stack, 1998b) and because of the powerful role of social networks within the church community (Stack & Wasserman, 1992).

Examination of the protective role of religion in suicide dates as far back as 1966 with the work of Durkheim. He proposed that the more an individual is religiously integrated, the lower his or her risk of suicide. He defined religious integration as the extent to which people have a collective sense of common religious beliefs and practices, and sense of

devotion to their religious community above the needs of the individual self (Durkheim, 1996). More recently, Stack and Wasserman (1992) proposed that it is not religion or religious affiliation per se that decreases suicidal behavior, rather it is the social networks obtained from religious involvement (e.g., in church) that lead to decreased suicide rates among African Americans. Early (1992) assessed this proposal by conducting a qualitative study of African American pastors and members of their congregation. He found that the African American church played a significant role in low suicide acceptability among African Americans through its condemnation of suicide. He suggested that African American church members, compared with Caucasian church members, were more integrated into their churches socially and formed social networks that permeated outside of the church walls. Early found that African American congregation members tended to view suicide under any circumstances as almost antithetical of what it means to be African American. The members viewed suicide as an unforgivable sin and some members saw suicide as a "White thing" (Early & Akers, 1993).

Although a number of studies have found that religious participation often reduces the risk of suicide (De Leo, 2002; Larson & Larson, 2003), only recently have researchers begun to systematically focus on the role of religiosity and spirituality as protective factors against suicidal behavior within the African American community (Gibbs, 1997). For example, Cook and colleagues found that low religiosity was one factor associated with both active and passive suicidality in older African Americans (Cook, Pearson, Thompson, Black, & Rabins, 2002).

### *Research on Suicide Acceptability and Religiosity*

Some researchers have begun to examine the link between suicide acceptability and religiosity (Lo Presto et al., 1994-1995). Neeleman, Wessely, and Lewis (1998) compared the role of religion and suicide acceptability between African Americans and Caucasians. In general, they found a strong negative association between personal religious commitment and suicide acceptability. Specifically, they noted that suicide acceptability was lower for African Americans than Caucasians, and that this difference was most attributed to high levels of personal devotion and orthodox religious beliefs by the African

Americans in the sample. This difference between groups was not just attributed to church attendance and religious affiliation. However, this study was limited by the use of a single item measure of suicide acceptability.

Stack (1998b) also studied the relationship between suicide acceptability and religiosity in African Americans and Caucasians. Using a national sample, he found that contrary to the results of Neeleman and colleagues (1998), church attendance was negatively correlated with suicide acceptability for African Americans, but specific religious beliefs (like the belief in an afterlife) were not. Furthermore, Stack reported that other variables were stronger predictors of suicide acceptability than church attendance. For example, education was twice as related to suicide acceptability than church attendance for African American women, and being married was just as powerful a predictor. Thus, Stack suggested that religion, as it has been measured in much of the research (i.e., beliefs and church attendance), may have been overestimated in explaining low levels of suicide acceptability among African Americans. He further purported that religiosity as it has been assessed in the research may be the most important correlate of suicide acceptability for Caucasian Americans, but not necessarily for African Americans.

The discrepancy of findings across studies may be in large part due to the limited measures of suicide acceptability and one-item measures of religiosity (i.e., church attendance, religious affiliation, or specific religious beliefs). Hoelter (1979) measured suicide acceptability with several different items including, "If I were suffering from a terminal illness, I might kill myself." He found that religiosity, as measured by childhood church attendance, self-perceived religiosity, and belief in a supreme being, was related to less suicide acceptability. Similarly, Marion and Range (2003b), who used an 11 item measure of suicide acceptability, found that among both African American and Caucasian female college students, religiosity was significantly related to suicide acceptability (Marion & Range, 2003b).

### *Religious Well-Being*

Most of the religious measures employed in the reviewed research used scales specific to religious doctrine. Religious well-being is a more inclusive aspect of religion that describes an individual's purpose and life satisfaction in terms of their relationship with God

(Ellison, 1983). This construct is less dependent on specific aspects of religious beliefs and allows for a broader view of religiosity as an aspect of overall well-being (Ellison & Smith, 1991). The concept of religious well-being also seems to capture how religion can be used as a coping mechanism for life's challenges. This concept has been assessed within African Americans samples. Kaslow et al. (2002) found that African American women who endorsed high levels of religious well-being were at reduced risk for attempting suicide. Further investigation with this broader aspect of religious well-being in relation to suicide acceptability is warranted in an African American sample.

The purpose of the present study was to further examine the link between suicide acceptability, religious well-being, and suicidal behavior in African Americans. The first question examined was whether or not there is an association between suicide acceptability and religious well-being. We expected a negative relationship between suicide acceptability and religious well-being. Second, we addressed whether there were differences between African American suicide attempters and nonattempters with regards to the extent with which they believe suicide is acceptable, and their levels of religious well-being. We predicted suicide acceptability to be higher, and religious well-being to be lower, in suicide attempters than non-attempters. Third, we focused on the extent to which suicide attempt status can be predicted by religious well-being, and if that prediction is mediated by less suicide acceptability. It was anticipated that religious well-being would negatively predict suicide attempt status, and that this would be mediated by believing suicide is less acceptable.

## METHOD

### *Participants*

Participants were recruited from a large, public university affiliated hospital that serves a primarily indigent and urban population (92% African American). They were either: (1) women and men who recently made a nonfatal suicide attempt receiving psychiatric services (attempters) ( $n = 100$ ;  $n = 50$  for each gender), or (2) women and men who have no history of suicidal behavior receiving medical services (controls) ( $n = 100$ ;  $n = 50$  for each gender). Of the 244 people referred to or approached for the study, 44 (18%) were excluded: 28 (11%) refused to

participate, 6 (2%) reported a lifetime history of at least one prior suicide attempt (control group), 3 (1%) were unable to complete the protocol (acutely psychotic), 1 (.4%) had significant cognitive impairment, and 4 (1.6%) were determined unsuitable for participation due to other reasons.

### *Procedures*

To obtain control participants, research team members recruited in various clinics in the hospital at various times of the day during the week. They approached eligible participants (i.e., never made a suicide attempt), explained the study, and answered questions. The researchers were on-call 24 hours per day all year, and personnel from several hospital services were involved in this project. To obtain participants who had made a recent suicide attempt, the principal investigator (PI) was available by pager to be notified immediately about all African Americans who presented to the hospital after a suicide attempt. The attempters were interviewed within 24 hours of becoming medically stable. Upon receiving a referral, the PI determined criteria (i.e., did a self-injurious act that required medical attention or in which there was serious intent), and if eligible, a research team member recruited the person once he or she was medically stable. After informed consent was obtained, screening measures were administered to determine eligibility. For example, participants were screened using a mini mental status exam to rule out the effects of any medication or acute cognitive dysfunction at the time of the interview. Once eligibility was verified, the research team member conducted a 3 hour face-to-face interview. The comprehensive battery of measures was administered verbally to prevent confounding by the low levels of functional literacy in this population. Only a subset of the measures administered was included in this study. Remuneration for study participation was \$25.

### *Measures*

*Demographic Data Questionnaire.* The Demographic Data Questionnaire was created by the research team. This questionnaire assessed gender, age, educational level, marital status, number of children, employment status, monthly household income, religious affiliation, medical and psychiatric history, and gun access.

*Suicide Acceptability Scale.* The Suicide Acceptability Scale (SAS) is an 8-item measure of suicide

acceptability. There are 5 dichotomous items and 3 continuous items. The dichotomous items in the scale are based on the suicide acceptability items taken from the US General Social Surveys, 1972-1994 used by Stack (1998b). The 3 continuous items are based on the measure of suicide acceptability used by Neeleman, Wessley and Lewis (1998). The original items taken from Stack (1998b) and Neeleman et al. (1998) are presented in Appendix A. Both sets of items were modified by the PI and the research team to be more relevant and applicable to the clinical African American sample in the present study. As in Stack's study, the present scale contains yes/no items pertaining to whether a person has a right to take his or her life if certain circumstances existed. The 5 circumstances used in the present study were having a terminal illness, serious financial problems, been disgraced by family, been a burden to family, and been tired of living. The original items were summed by Stack into an index of suicide acceptability, and the internal consistency reliability was .81.

The remaining three continuous items asked about the acceptability of suicide for men, women, and the respondent using a 10-point Likert scale with a range of 1 = never acceptable to 10 = always acceptable. Neeleman et al. (1998) asked only one question using the 10-point Likert scale related to suicide acceptability in general (see Appendix A). Our modification was the use of three items targeting the acceptability of suicide for men, women, and oneself. We recoded the 3 items on the 10-point Likert scale into 3 dichotomous items with values 1-5 = 0 (not acceptable), and 6-10 = 1 (acceptable). All 8 suicide acceptability items were averaged to create one index of suicide acceptability. The score ranges from 0 to 1. The internal consistency reliability of our modified suicide acceptability scale was .90.

**Spiritual Well-Being Scale.** The Spiritual Well-Being Scale (SWBS; Ellison, 1983; Paloutzian & Ellison, 1982) is a 20-item scale used to assess one's perception of his or her quality of life and spiritual well-being, which contains both a religious and social psychological component. Respondents indicate their level of agreement to statements using a 6-point Likert scale with 6 = strongly agree, 5 = moderately agree, 4 = agree, 3 = disagree, 2 = moderately disagree, and 1 = strongly disagree. Composite scores on all items from this scale range from 20 to 120. The higher score represents more spiritual well-being. The SWBS has two subscales with 10 items each: Religious Well-Being (RWB) and Exis-

tential Well-Being (EWB). The RWB subscale assesses a respondent's spiritual life through his or her relationship with God (Ellison, 1983). The EWB subscale assesses one's sense of purpose and satisfaction in life. Items summed from each subscale create a score that ranges from 10 to 60. Based on the data from several studies, the internal consistency reliability coefficients for the total scale, RWB and EWB subscales ranged from .89 to .94, .82 to .94, and .78 to .86 respectively (Boivin, Kirby, Underwood, & Silva, 1999). Paloutzian and Ellison (1982) reported excellent test-retest reliability coefficients for the total scale (.93), the RWB (.96) and EWB (.86) subscales. Validity was determined based on the correlation between the SWBS and Allport and Ross's Intrinsic Religious Orientation Measure,  $r(175) = .79$  ( $p < .001$ ; Ellison, 1983). For this study, only the RWB subscale is used. The internal consistency reliability obtained for the RWB for the present study was .89.

## RESULTS

The sample consisted of 200 African American women ( $n = 100$ ) and men ( $n = 100$ ), ages 18-64 ( $M = 32.8$ ,  $SD = 10.8$ ) seeking medical or psychiatric care. The majority of the participants had at least a high school diploma (52%), were unemployed (57%), were not homeless (82%), had a monthly household income between \$500 and \$1999 (56.5%), and were Baptist (50.5%) (see Table 1). The mean of children for the sample was 2.4 ( $SD = 1.9$ ).

Sociodemographic differences between suicide attempters and nonattempters were examined using univariate analyses of variance (ANOVA) for continuous variables and chi-square analyses for nominal variables (see Table 1). The only sociodemographic variables on which there were between group differences were age, homeless status, and religious affiliation. Specifically, suicide attempters were significantly younger than nonattempters ( $F(1, 195) = 6.7$ ,  $p < .01$ ) and were more likely to be homeless ( $\chi^2 = 4.8$ ,  $p < .03$ ). In addition, suicide attempters were more likely to identify with no religious affiliation than nonattempters ( $\chi^2 = 16.6$ ,  $p < .0001$ ). These three variables (i.e., age, homeless status, religious status) were used as covariates in subsequent analyses. There were no significant mean differences between attempters and nonattempters on education, marital status, number of children, employment status, and monthly household income.

**Table 1**  
*Demographic Characteristics*

Variable	Attempters ( <i>n</i> = 100)	Non-attempters ( <i>n</i> = 100)	Statistical test by group
Education			<i>ns</i>
<12 <sup>th</sup> grade	55	42	
High school grad/GED	2	25	
Post high school Graduage	25	33	
Employment status			<i>ns</i>
Employed	40	45	
Unemployed	60	54	
Homeless status			$\chi^2 = 4.8^*$
Homeless	23	11	
Not homeless	77	87	
Monthly household income			<i>ns</i>
Less than \$999	49	41	
Over \$1000	46	55	
Religious affiliation			$\chi^2 = 16.6^{***}$
Affiliation	81	98	
None	19	2	
Mean ( <i>SD</i> ) No. of children	2.5 (2.4)	2.3 (1.3)	<i>ns</i>
Mean ( <i>SD</i> ) Age	30.9 (10.9)	34.8 (10.4)	$F(1,198) = 6.5^*$

Note. *N* = 200. \**p* < .05, \*\*\**p* < .0001

Means and standard deviations for the Suicide Acceptability Scale and the RWB Subscale are presented in Table 2. A significant negative correlation was found between religious well-being and reported suicide acceptability ( $r(200) = -.47, p < .0001$ ). Thus, finding suicide acceptable was correlated with lower levels of religious well-being. Univariate analyses of covariance (ANCOVAs) were conducted to compare suicide attempters and nonattempters on the Suicide Acceptability Scale and the RWB subscale (see Table 2). Age, homeless status, and religious status were entered as covariates. The results indicated suicide attempters scored higher than nonattempters on suicide acceptability ( $F[4, 196] = 15.64, p < .0001$ ). There was also a significant difference between these two groups on religious well-being ( $F[4, 196] = 14.18, p < .0001$ ). African American suicide nonattempters scored higher on the RWB subscale, which indicates higher levels of religious well being, than attempters.

Logistic regression models were used to examine whether religious well-being strongly predicted suicide attempt status, and if that prediction is mediated by suicide acceptability. Age, homeless status, and religious status were entered first as covariates in the models. In the first model, religious well being was entered as a predictor and suicide attempt status was entered as the dependent variable. In the second model, suicide acceptability was added as a predictor. The results of the model are presented in Table 3. Religious well-being was a significant negative predictor of group status ( $OR = .90, .87 - .94, p < .00001$ ). In the second model, suicide acceptability was a significant positive predictor of suicide attempt status ( $OR = 13.98, 3.35 - 58.32, p < .001$ ). Religious well-being remained a significant negative predictor of suicide attempt status in the second model and the effect did not decrease

**Table 2**

*Means, Standard Deviations, and Analysis of Covariance of Suicide Acceptability and Religious Well-Being by Suicide Attempt Status*

Variable	Attempters	Non-attempters	<i>F</i> (4, 196)
	( <i>n</i> = 100)	( <i>n</i> = 100)	
	Mean ( <i>SD</i> )		
Age	30.94 (9.97)	34.77 (11.23)	
Homeless status	.23 (.42)	.11 (.32)	
Religious Status	.80 (.40)	.98 (.14)	
Suicide acceptability	.39 (.36)	.11 (.20)	15.64***
Religious well-being	42.71 (10.04)	51.77 (7.82)	14.18***

Note. *N* = 200, \**p* ≤ .001, \*\*\**p* < .0001

**Table 3**

*Summary of Logistic Regression Analysis for Variables of Suicide Acceptability Predicting Suicide Attempt Status*

Variable	~ <i>R</i> <sup>2</sup>	<i>b</i> ( <i>s.e.</i> )	OR ( <i>C.I.</i> )
Model 1	.36***		
Age		-.03 (.02)	.97 (.94 - .99)*
Homeless Status		-.89 (.45)	.41 (.17 - .99)*
Religious Status		1.87 (.80)	6.51 (1.37 - 30.97)*
Religious Well-Being		-.10 (.02)	.90 (.87 - .94)***
Model 2	.44***		
Age		-.04 (.02)	.96 (.93 - .99)*
Homeless Status		-.56 (.50)	.57 (21 - 1.53)
Religious Status		1.89 (.81)	6.61 (1.34 - 32.52)*
Religious Well-Being		-.08 (.02)	.92 (.89 - .96)***
Suicide Acceptability		2.64 (.73)	13.98 (3.35 - 58.32)***
<i>N</i>	197		

Note. *N* = 197, \**p* < .05, \*\**p* < .01, \*\*\**p* < .001, \*\*\*\**p* < .00001

appreciably (*OR* = .92, .89 - .96, *p* < .001). Suicide acceptability did not mediate the effect of religious well-being on suicide attempt status. The resulting Nagelkerke estimation for *R*<sup>2</sup> for the overall model was .44, which suggests that religious well-being and suicide acceptability explain 44.0% of the variance in suicide attempt status after accounting for the effects of age, homeless status, and religious status.

## DISCUSSION

### *Religious Well-Being and Suicide Acceptability*

The results of the present investigation suggest that as hypothesized, religious well-being was negatively related to suicide acceptability. Those African Americans who tended to view suicide as an acceptable option in different situations tended to also report less religious well-being. This suggests that it is maladaptive to view suicide as an acceptable option

for oneself and others, as people who do so report less well-being. The level at which African Americans report a sense of satisfaction in their relationship with God affects whether they see suicide as a viable option for dealing with life's problems (e.g., terminal illness, financial problems, burden to family).

### *Suicide Attempters and Non-Attempters*

The results of the present investigation also suggest that, as hypothesized, African American suicide attempters tended to endorse more suicide acceptability than non-attempters. Given similar background characteristics, believing suicide is acceptable was more common among the African Americans who had a history of a recent suicide attempt. This is consistent with the research that suggests suicide acceptability is an important risk factor for attempting suicide (Agnew, 1998). Being more accepting of suicide could increase the chances of a vulnerable individual making a suicide attempt. However, it is also possible that individuals who have made a suicide attempt need to view suicide as acceptable in order to rationalize their past behavior. It may be too overwhelming to think of suicide as unacceptable if one has already attempted suicide in the past.

As hypothesized, there was a significant difference between African American suicide attempters and nonattempters on religious well-being. African American attempters endorsed significantly less religious well-being than those who have never attempted suicide. Suicide attempters were also more likely to have no religious affiliation, to be homeless, and to be younger, than non-attempters. However, even after controlling for these types of difficult life circumstances (e.g., homelessness), less religious well-being had an independent effect on being a suicide attempter. This suggests that in this vulnerable African American population, suicide attempters are not finding or seeking comforts and support through religion. They may have difficulty accessing spiritual wellness in themselves through God. In addition, the likelihood of being a suicide attempter decreased the more an individual endorsed religious well-being. It seems that as Kaslow et al. (2002) hypothesized and found, aspects of spiritual well-being serve as a protective factor against suicide attempts in low-income African American populations.

### *Logistic Regression Analyses*

It was hypothesized that believing suicide is unacceptable was the mechanism through which religious

well-being protected against attempting suicide. Overall the results from this study suggest that suicide acceptability is a unique risk factor for attempting suicide, and religious well-being is a unique protective factor against attempting suicide. The logistical regression analyses employed in this study suggest that believing suicide is unacceptable is not the way by which religious well-being protects against attempting suicide among vulnerable African Americans. Feeling a sense of personal and spiritual purpose decreases one's likelihood of attempting suicide, and this is regardless of whether they view suicide as a viable option for difficult circumstances. When one believes that their relationship with God contributes to their well-being, this in itself can be a coping mechanism for dealing with life's struggles.

These results also highlight the relevance of suicide acceptability among some African Americans. It strongly and uniquely predicted suicide attempt status. The issue of suicide cannot simply be seen as a "white thing" as suggested by participants in Early's (1992) study. Among some of the most vulnerable African Americans (i.e., no or low income, disrupted family systems, intermittently homeless) in the population, suicide acceptability is a major risk factor for suicide attempts.

### *Methodological Strengths and Limitations*

This study has much methodological strength and some limitations. In terms of strengths, first, the immediate data collection procedure 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. Second, to capture all suicide attempters who received treatment at the hospital, the researchers were on call 24 hours per day all year. This increases the likelihood that the sample is representative of suicide attempters in this setting. Lastly, the experimental control design used in the study adds to the validity of the results. Non-attempters and attempters were obtained from the same hospital environment. Thus, it is likely that both groups came from the same joint source population.

Despite these methodological strengths, the results from the present study need to be interpreted in light of the limitations. First, 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. Second, the data are based on retrospective self-reports and thus recall bias may have influenced the significant findings. Suicide acceptability and religious well-being were measured at one point in time, precluding the determination of causality. In addition, because the participants had to be read the questionnaires, this may have increased the social desirability of their responses. Despite this, the internal consistency reliabilities for the present sample for both measures were good, suggesting both groups were responding to the items with similar consistency. Finally, these results may not generalize to populations other than low-income African Americans.

### *Implications and Directions for Future Research*

The results from the present study suggest that it is essential that spirituality and religion are recognized and included in suicide prevention efforts (Larson & Larson, 2003) within the African American community. Focusing on religious well-being will help make such prevention efforts more culturally competent and relevant: it has been identified as a significant protective predictor of suicide attempt status. Thus, in a related vein, it is imperative that providers of low-income African Americans in community mental health centers include questions specific to religious well-being in the evaluative intake process. This may aid in the identification of those most at risk for suicide.

Leaders from the faith community need to be more aware of the significant role religion can play in reducing the risk of suicide attempts (Larson & Larson, 2003). Because these findings reveal that those who report less religious well-being are at a greater risk for attempting suicide, more effort may need to be put forth from leaders in the faith community toward outreach outside of churches and into the lay community. Outreach efforts from the faith community may be needed to help this susceptible group of African Americans connect with their spiritual selves. In addition, given the higher levels of suicide acceptability among those who have made a suicide attempt, more attention should be put towards decreasing the acceptance of suicide among those who have a history of suicidal behavior.

In future research, it would be useful to gather a more comprehensive assessment of religious well-being, which includes specific measures of religious involvement, religious coping, and religious behaviors. There may be other specific mediating path-

ways not addressed in the present study through which religious well-being protects against suicide attempts. In addition, given the rising incidence of suicide among African American adolescents, it would be useful to include a sample that is representative of this at risk sub-population. Greening and Stoppelbein (2002) found that African American adolescents who scored high on depressive symptoms and lower on religious orthodoxy reported higher perceived risks for suicidal behavior. Future research should focus on whether religious well-being and suicide acceptability also significantly predict suicidal behavior among African American adolescents. In addition, research in this area could be advanced by developing a comprehensive and psychometrically sound measure of suicide acceptability that is used consistently across studies. Further, the generalizability of the findings gleaned from this study needs to be ascertained with individuals from other ethnic and social class backgrounds.

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**APPENDIX****Suicide Acceptability Scale – Original and Final Modified Items**

Original suicide acceptability items taken from Stack (1998b)

Do you think that it is right for a person to end his or her own life if this person ...

1) has an incurable disease?	1 = disapproved	2 = approved
2) has gone bankrupt	1 = disapproved	2 = approved
3) has dishonored his or her family?	1 = disapproved	2 = approved
4) is tired of living and ready to die:	1 = disapproved	2 = approved

Original suicide acceptability item taken from Neeleman, Wessley, and Lewis (1998)

On a scale from 1 to 10 (1 = never acceptable to 10 = always acceptable)

How acceptable is suicide?

Final Scale

Do you think a person has the right to take his/ or her life if:

1) he/or she suffers from a terminal illness?	Yes	No
2) he/or she has serious financial problems: <i>(no place to live, not enough food to eat, being evicted, cannot pay bills)</i>	Yes	No
3) he/or she has disgraced their family?	Yes	No
4) he/or she is a burden to their family?	Yes	No
5) he /or she is tired of living and is ready to die?	Yes,	No

On a scale from 1 to 10 (1 = never acceptable to 10 = always acceptable)

How acceptable is suicide for women? \_\_\_\_\_

How acceptable is suicide for men? \_\_\_\_\_

How acceptable is suicide for you? \_\_\_\_\_

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