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A descriptive study of the correlates of suicidal ideation in African American male teenagers

David Augustus Rose

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A DESCRIPTIVE STUDY OF THE CORRELATES OF SUICIDAL IDEATION IN AFRICAN AMERICAN MALE TEENAGERS

Advisor: Dr. Gale Horton
Thesis Dated: May, 1994

The overall objective of this study was to determine the social, psychological and emotional correlates of suicidal ideation in African American male adolescents. The author examined the following factors: First, the psychological correlates to suicidal ideation that were identified in the literature which included prior mental health treatment and family issues. Second, the social correlates to suicidal ideation that were identified in the literature which included deviance and the influence of the media on suicidal ideation.

The data was collected from case records of adolescent clients that reported suicidal ideation to the emergency room of a major metropolitan hospital. Fifty case records were reviewed, the data was tabulated and analyzed by use of a computer. Three hypothesis were tested concerning suicidal ideation in relation to social factors, psychological factors and emotional factors. The findings demonstrated seven common correlates of suicidal ideation in Black male adolescents. First, depression. Second, a poor self-image.
Third, a belief that life isn't worth living. Fourth, antisocial behavior. Fifth, verbal threats to commit suicide. Sixth, a sense of alienation and isolation from group life. Seventh, continual anger or rage.

The results of this study indicated that social workers must be aware of the seven common correlates of suicidal ideation in Black male adolescents in order to properly intervene in preventing a potential suicide from occurring.
A DESCRIPTIVE STUDY OF THE CORRELATES OF SUICIDAL IDEATION IN AFRICAN AMERICAN MALE TEENAGERS

A THESIS
SUBMITTED TO THE FACULTY OF CLARK ATLANTA UNIVERSITY
IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR
THE DEGREE OF MASTER OF SOCIAL WORK

BY
DAVID AUGUSTUS ROSE

SCHOOL OF SOCIAL WORK

ATLANTA, GEORGIA
MAY 1994
ACKNOWLEDGEMENTS

First and foremost the writer of this thesis would like to thank God for giving me the power within to complete this task. The writer is grateful to Dr. Gale Horton, thesis advisor, for his patience, his direction and for always being there when I sometimes became uncertain.

I would also like to thank Dr. Todd Estroff for providing me with information related to this study.
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CHAPTER ONE

INTRODUCTION

Suicide ranks eighth among the ten significant causes of death in most western countries.¹ In the United States, it is estimated that over 200,000 people attempt suicide every year and that over five million Americans have made a suicide attempt at some time in their lives. Official statistics demonstrate that some 20,000 successful suicides occur each year, indicating that approximately every twenty minutes someone in the United States commits suicide.² However, the problem may be much more serious than this statistic suggests since many self-inflicted injuries that result in a fatality are recorded and certified as being attributable to more respectable causes than suicide. Many experts agree that the number of actual suicides that occur on a yearly basis is at least twice - and possibly several times - as high as the number officially recorded.

However accurate, statistics cannot begin to convey the tragedy of suicide in human terms. The act of suicide affects not only the life of the victim, but also the lives of their families and associates and society as a whole. It can be assumed that the greater majority of persons that commit


suicide may be quite ambivalent about taking their own lives. Since the irreversible choice of suicide is made when they are alone, in a state of severe psychological stress and unable to view their problems objectively or develop an alternative course of action. However, the family and associates of the victim are generally surprised and unprepared for the profound actions of the suicide victim and often require extensive therapeutic intervention to cope with the devastating effects of a suicide.

In the United States, the peak ages for suicidal attempts are between 24 and 44 years of age. Men commit successfully completed suicides three times more often than women, but women are three times more likely to make a suicide attempt. Most suicide attempts occur within the context of interpersonal discord or other severe life stress. For females, the most commonly used method for a suicidal attempt is drug ingestion, usually barbiturates. However, males tend to use methods that are more likely to be lethal, such as the use of firearms, which is probably the reason that successful suicides are higher among men. In North America, white males older than 35 commit 75 percent of all suicides and depression is a contributing factor in 60 percent of all suicides.

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Another perplexing trend concerns the rates of completed suicides among teenagers and children which seem to be increasing at what many feel is an alarming rate. Every year, more than 5,000 teenagers within the United States successfully commit suicide and a half million attempt suicide. The statistics indicate that one in twelve U.S. high school students attempted suicide last year. Teenagers that attempted suicide reported more drug abuse, depression, sexual abuse, behavior problems, poorer peer friendships, problems with their self-image and poor communication skills. "It would seem that despair and hopelessness are not the exclusive province either of the down trodden or of those whose possibilities have narrowed with advancing age."

A change in a teenager's mood and behavior is a significant warning of potential suicide. Characteristically, the teenager becomes depressed and withdrawn, undergoes a marked decline in self-esteem and shows deterioration in

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habits of personal hygiene. This change in behavior is often accompanied by a loss of interest in academic study. Often, the potential teenage suicidal victim stops attending classes and stays home most of the day. Usually, the teenager will communicate their distress to at least one other person, most often in the form of a veiled warning of suicide. This distress is usually in the form of hopelessness or a felt sense that life is not worth living. If the warning signs are not recognized or ignored, the teenager may carry through on their threat and commit suicide.

Generally, when high school students attempt suicide, one of the first explanations for their behavior provided by those that know them, is that the student was doing poorly in school. However, in contrast to this belief, as a group, teenagers that attempt suicide are generally superior students. These students tend to expect a great deal from themselves in terms of academic achievement. For these students to exhibit scholastic anxieties over grades, academic competition and pressure over examinations are not generally regarded as significant precipitating stressors that might result in an attempt at suicide. While many of these students did lose interest in their studies prior to the onset of suicidal behavior and their grades went down, the loss of academic interest appears to be associated with depression and

withdrawal caused by other problems. Moreover, when academic behavior does appear to trigger suicidal behavior; a minority of cases; the actual cause of the behavior is generally considered to be a loss of self-esteem and failure to live up to parental expectations, rather than the academic failure itself.\textsuperscript{11}

For most suicidal teenagers, both male and female, the major precipitating stressor appears to be either the failure to establish, or the loss of, a close interpersonal relationship. Often the dissolution of a romance is the key precipitating factor leading to a suicidal attempt. It has also been noted that there are significantly more suicidal attempts and suicides by teenagers from families where there has been separation, divorce, or the death of a parent.\textsuperscript{12}

Although most high schools maintain contact with mental health facilities to assist distressed students, few suicidal teenagers seek professional help voluntarily. Thus, it is of vital importance for those around a suicidal teenager to notice the warning signs and try to obtain assistance for them.

Admittedly, as in the case of most complex issues, there does not seem to be any simple answer to the problem of


suicide or attempted suicide in teenagers. It seems the wiser course to encourage the establishment and support of new and existing suicide prevention programs and to foster research into suicidal behavior with the hope of reducing the toll in human life and misery that occurs each year through suicide and suicidal attempts by teenagers.

STATEMENT OF THE PROBLEM

Suicide is the second most common cause of death for teenagers. The adolescent or teenager that is contemplating suicide will exhibit a change in behavior such as depression, changes in sleep and appetite, making hints about suicide, making final arrangements by giving away prized possessions or unexplained cheerfulness after a long depression.13

"Teenagers are often reluctant to reveal the problems they are experiencing or their inner thoughts. Many teenagers also conceal their inner pains and fears so that even their parents and closest friends have no idea that they are suffering and considering suicide".14

Social workers, whether they practice in mental health agencies, medical facilities, or within schools, are in an ideal position to evaluate the mental state of teenagers and adolescents. If the social work practitioner fails to adequately identify, address, or treat the symptoms indicative of suicide or suicidal attempts by teenagers, the potential

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for risk of suicide may increase, the practitioner may be exposed to legal liability for incompetent practice, or the practitioner may develop higher levels of stress related to self-blame for failing to thwart a preventable suicide.

The social worker is also in an ideal position to provide system-linkages to support groups for suicidal teenagers, provide counseling and referral to appropriate treatment facilities for symptoms of depression evidenced by suicidal teenagers and provide educational and support counseling for families of teenagers that exhibit the high-risk behaviors that might lead to suicide.

SIGNIFICANCE AND PURPOSE OF THE STUDY

The author of this study became interested in the symptoms presented by suicidal teenagers after having been employed as a Crisis Counselor in an emergency room of a major metropolitan hospital. In this position, the author became concerned whether social workers could adequately and appropriately identify those behaviors and symptoms presented by teenagers that were indicative of potentially fatal suicidal attempts.

At this hospital, the author had the opportunity to speak with teenagers that were admitted to the emergency room with symptoms of suicidal ideation. In attempting to assess the patients level of dangerousness, the author noted a fairly high degree of ambivalence, heightened levels of depression, social factors associated with loss, bewildered parents and a
general failure by the parents and school authorities to recognize a potentially dangerous situation. The author became concerned that if the parent of a teenager could not recognize behavior or symptoms that could lead to suicide; when the parents lived with the child on a daily basis; would social workers be sufficiently competent or knowledgeable to recognize these same symptoms when presented with them in a brief interviewing or counseling session?

The failure of a social work practitioner to adequately identify or treat potentially dangerous symptoms presented by a teenager has serious consequences. The teenager may eventually kill themselves, the family of the victim will be disrupted, self-blaming and grief-stricken, the associates and classmates of the victim may suffer psychological problems and the social work practitioner may also experience a sense of grief or self-blame for failure to take appropriate action.

When confronted with a teenager that has exhibited changes in behavior, of any sort, a social worker must be willing to assertively, but compassionately, question whether the teenager is contemplating suicide, determine whether they have a plan to carry out a suicidal attempt, be careful not to dismiss the teenagers feelings as a consequence of youthful indiscretion, urge the teenager to discuss their problems and efficiently utilize any type of support system, including
immediate hospitalization, to help prevent a suicidal attempt.\(^1\)

Consequently, the major significance of this study is to provide the social work profession with the identification of symptoms and behaviors that a potentially suicidal patient may present during an interview or counseling session. By increasing the awareness of a social work practitioner to the possible social, personal, or behavioral factors involved in teenage suicide, the practitioner may be encouraged to take the appropriate steps or provide the appropriate intervention to prevent a suicide or suicidal attempt by the teenager.

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CHAPTER TWO

REVIEW OF THE LITERATURE

The literature on suicide prevention for young people is limited. Consequently, this literature review has been extended, where necessary, to include evaluations of preventive strategies directed mainly at adults. For the purpose of this review, the term "suicide" includes any behavior that relates to a conscious or declared wish to bring about one's death. This encompasses both suicide and suicidal attempts. Since, until after a suicidal event occurs, there is no sure way of distinguishing between the suicidal attempter who will go on to complete suicide and those who will never make another attempt at suicide.

Societal concern about teen suicide appears to have increased in recent years. This interest has been associated with a number of recent, highly publicized, outbreaks of suicide in teenagers and evidence that in contrast to the pattern found in other age groups, suicide among young males, 15 to 24 years old, has increased markedly since 1960. Adolescent suicide is uncommon. The suicide rate in 1984 for all 15 to 19 year old teenagers was nine deaths per 100,000 people in the population. This means that preventive efforts directed to the general population are likely to reach

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\[a\] Mortality Statistics Branch, Division of Vital Statistics, Center for Health Statistics, 1986.
relatively few teenagers that will eventually attempt or commit suicide.

Very few children under the age of twelve commit suicide, although many threaten and some make suicide attempts.\(^2\) Suicide becomes increasingly common after puberty and its incidence increases in each of the teen years, reaching a peak in young people at age twenty-three.\(^3\) It should be noted that the suicide rate in adolescence, although higher than the suicide rate in childhood, is less than the suicide rate of adults. The highest rates of suicide are experienced by elderly men.

**Influence Of Sex, Ethnicity And Geography In Suicide Rates.**

In the United States, nearly five times more teen boys commit suicide than girls. One study indicated that sexual differences in the suicide rates are considerably less noticeable among Hispanics and somewhat less among Blacks.\(^4\) Concerning ethnicity and suicide, within the United States, suicide rates in whites are higher than in Blacks of all age groups, including the teens. The difference between Black and White suicide rates are greatest in the South and least in the North Central States. The incidence of suicide widely varies among different Native American groups. Some of these groups

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\(^2\)Ibid.

\(^3\)P. Fisher. "The Epidemiology Of Suicide In Children And Young Adolescents". *Progress Report: National Institute Of Mental Health*, 1989, p. 84.

\(^4\)Ibid, p. 84.
have suicide rates more than twenty fold higher than the national average, whereas other groups have rates analogous for the nation as a whole. 

Concerning the effect of geography on suicide, youth rates when uncorrected for ethnicity are highest in the Western states and Alaska, and lowest in the Southern, North Central, and Northwestern States.

Precipitant And Methods Of Suicide In Teenagers

In the United States, adolescents of both sexes are most likely to commit suicide with a firearm. There is evidence that substance abuse is more common among those suicide victims that use a firearm to commit suicide. The next most common method of suicide for boys is by hanging, while for girls it is jumping from a height. Drug overdose, by far the most common method for adult suicide attempts, accounts for few completed suicides in teenagers.

Many teenagers commit suicide within the context of an acute disciplinary crisis or shortly after a rejection or humiliation. For example, a dispute with a girlfriend, an incident of being ridiculed or teased, or failing at some

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event, all with a brief stress-suicide interval. If these impressions are confirmed with subsequent research, it would insinuate a negative implication for suicide prevention programs for a number of reasons. For instance, since these are very common emotional stressors and unable to be avoided; often they are initiated by the type of psychopathology found in the victims of suicide; the short interval between the stressor and the act of suicide reduces the opportunity for effective preventive interventions.

Family History of Victims Of Suicide

A high proportion of the families of suicide victims had a first or second degree relative who had previously attempted or committed suicide. If suicide is an act of intra-familial imitation, a possible prevention strategy might be to stress the importance of minimizing exposure of vulnerable individuals to the patterns of suicidal behavior. For example, emphasizing to the suicidal mother of a young child the potential risk of talking about her suicidal ideas in the presence of her children, or if exposure of the child cannot be avoided, providing an intervention strategy to vulnerable offspring or siblings. On the other hand, if the high

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8 Ibid.
familial incidence of suicide has a genetic basis, there is the hope that reliable predictive measures will be developed through biological or chemical blood marking techniques.

Predicting who will commit suicide has been dismissed as a futile enterprise in the general class of predicting rare events from common ones.\textsuperscript{11} This year more than 5,000 American teenagers and young adults will take their own lives and perhaps 50 times that number will make serious but unsuccessful attempts to do so. Suicide now ranks as the third leading cause of death among those aged 15 to 24 years old, trailing only accidents and homicide.\textsuperscript{12} These figures are disturbing enough when viewed out of context. However, they become even more worrisome when one learns that the teenage suicide rate has tripled since the 1950's.\textsuperscript{13} Although there are indications that the growth curve for suicide may be flattening, the number of youth suicides remains far too high to permit any complacency on the part of suicide prevention experts.

Young people that commit suicide are not easily classified. Self inflicted deaths occur across or within all social, ethnic and economic classes. Adolescents who have all the "right" friends and are academically and athletically


\textsuperscript{12}\textit{Department Of Health And Human Services: National Center For Health Statistics}, 1991, p. 321.

\textsuperscript{13}\textit{Ibid}, p. 321.
successful kill themselves, as do youths that come from divided families, that have few friends and are failing in school-related activities.\textsuperscript{14}

However, certain generalities hold true for all age groups, including teenagers. For instance, women attempt suicide about three times as often as men. On the other hand, men complete suicide about three times as often as women.\textsuperscript{15} Approximately, about twenty percent of the individuals that attempt suicide, repeat the attempt, which tends to be a much more dangerous attempt than the preceding one.\textsuperscript{16}

The first question that arises when a teenager commits suicide is "why"? The fact that a person on the threshold of adulthood would choose to end his or her life is, and always has been, deeply troubling: not only to the deceased's immediate family, but also to friends, classmates and members of the community at large. In nearly every case of youth suicide there is no single identifiable cause, but rather a constellation of causes that interacted in various ways over time.\textsuperscript{17}

\begin{itemize}
\item \textsuperscript{14} Department of Health and Human Services: National Center For Health Statistics, 1991, p. 322.
\item \textsuperscript{16} T.C. Welu. "A Follow-Up Program For Suicide Attempters". Suicide Life Threatening Behaviors, No. 7, pp. 17-30.
\item \textsuperscript{17} L. Videka-Sherman. "Coping With The Death Of A Child". American Journal Of Orthopsychiatry, Vol. 52, 1982, pp. 688-698.
\end{itemize}
Some psychologists relate America's postwar baby boom to the increase in youth suicide. Children born between 1950 and 1955 passed through their teens and early twenties during the late 1970's, the period when the youth suicide rate was rising most quickly. Disappointment in love - the so-called "Romeo and Juliet" syndrome - is often cited as a factor, but many experts regard it as an unsatisfactory explanation for the upsurge in teen suicides in recent decades.

Many experts see the breakdown in the nuclear family, manifested by high rates of divorce and remarriage, more children living in single-parent families, multiple changes of residence and school and child abuse which may lead to emotional isolation, as a key factor in youth suicide. Many young people that commit suicide are drug or alcohol abusers. Although their drug abuse may not have been the chief cause of their deaths, the same inner anguish that led the youngsters to drugs or alcohol probably influenced their decisions to kill themselves. In this way, excessive drug or alcohol use may function as a suicide trigger.


Although a teenager's suicide always comes as a great shock, the victim typically provides numerous clues to friends and family before committing the fatal act. For example, expressing feelings of hopelessness, helplessness, or worthlessness. The potential victim may drop hints about suicide or have a preoccupation with death.\textsuperscript{21} The trouble being that family members and friends often fail to detect these telltale signs, or if they do, they disregard them. This is often a tragic oversight, according to mental health professionals, since experience shows that most young people are ambivalent about taking their lives; it is believed that few really want to die; they simply want to put an end to their emotional pain.

The determination of suicide is in fact a decision regarding the mode or manner of death.\textsuperscript{22} The mode of death may be determined to be a homicide if the cause of death was externally inflicted injury and was brought about through the intentional actions of another. The manner of death may be attributed to suicide if the cause of death was externally inflicted and was self-induced with the intent of causing death. A death will generally be considered accidental if the cause of death was externally inflicted, but not intentionally.


brought about and considered natural if the cause of death was not externally inflicted.23

OVERVIEW OF MAJOR THEORETICAL ORIENTATIONS

For purposes of this study, two different theoretical orientations will be utilized to discuss the findings from this study. The first theory was developed by Emile Durkheim, a French sociologist in order to explain the phenomenon of suicide. The second theory, the Psychosocial Management Model, is commonly used by social workers as a case management model.

Durkheim identified three types of suicide. The first, Altruistic Suicide, occurs when an individual accepts the values and norms of a group as his own. The individual does not distinguish between his personal interests and those of the group, nor is he likely to think of himself as a unique individual with a life separate and apart from the group. If the individual fails to meet group goals, death may be preferable to life. This form of suicide is evidenced in the World War Two phenomenon of Japanese Kamikaze pilots that willingly sacrificed their lives for their country.24

The second type of suicide identified by Durkheim, Egoistic Suicide, occurs when the individual is only weakly attached to the social order. This individual lacks emotional attachments and emotional supports that deep immersion in


group life can provide. This type of suicide is self-centered, in that it occurs because the individual is uninvolved and detached from groups and group standards.29

The third type of suicide identified by Durkheim is known as Anomic Suicide. According to Durkheim, a society that lacks clear-cut norms to govern people’s aspirations and moral conduct is characterized by anomie. This term, in the manner utilized by Durkheim, means a lack of rules or normlessness. This type of suicide occurs when society fails to provide the victim with controlling standards of behavior, life may be unbearable to the anomic suicide because of inadequate self-discipline.26 These three types of suicide relate to the individuals relationship to groups, group norms and human relatedness and the personal disorientation that can occur when people lack a sense of belonging to a secure moral order.

The Psychosocial Management Model is commonly used by social workers as a theory utilized in case management. As stated by Beaver and Miller:

"This model points out the twofold nature of social work intervention. The worker is the coordinator of the interdisciplinary care provisions for the patient. At the same time, the social worker is the primary case manager who is doing direct intervention including the following: one-to-one counseling with the patient and their family,


26Ibid, p. 258."
linking the client to group involvements for educational and emotional support, linking the family to a variety of concrete services, and conducting family therapy where necessary."\(^2\)\(^7\)

The use of these two theories will provide a theoretical framework for the discussion of the findings of this study.

**STATEMENT OF THE NULL HYPOTHESES**

1. There will be no significant relationship between the norms and values of American society and suicidal ideation in African American male teenagers.

2. There will be no significant relationship between social-emotional affinity and suicidal ideation in African American male teenagers.

3. There will be no significant relationship between accepted standards of behavior and suicidal ideation in African American male teenagers.

**VARIABLES**

The independent variables in this study are the social or psychological factors experienced by adolescents and teenagers in American society.

The dependent variables in this study are suicidal ideation or a suicidal attempt by an adolescent or teenager.

CHAPTER THREE

METHODOLOGY

The research design employed in this study is known as the Descriptive or Explanatory research design. This research design is utilized for the development of social technology or in the formation, selection, evaluation and assembly of relevant basic information for purposes of technological innovation.¹

The population for this study consisted of adolescents and teenagers from the ages of 13 to 19 years old that have exhibited some form of suicidal ideation. The sample for this study consisted of fifty case records of patients within this age range that were interviewed in the emergency room of the Southern Regional Medical Center; which is located in Atlanta, Georgia; between the years of 1988 to 1993. The sampling design was the purposive or judgmental sampling design. This sampling design is a nonprobability sampling design predicated on the assumption that the researcher has sufficient knowledge related to the research problem to allow the selection of "typical" persons for inclusion in the sample.² The purposive research design is a sampling design based on available, appropriate sampling units. The sample for this study was selected based on three criteria. First, the case


²Ibid, p. 87.
record had to concern an adolescent or teenager between the ages of 13 to 19 years old. Second, the case record had to indicate that the patient had exhibited some form of suicidal ideation. Third, the case record had to be available for selection and review by the author.

**Instrument Design**

The data compilation sheet utilized in this study is an original form developed by the author (See Appendix A). This form has ninety-three different correlates of suicidal ideation that was identified in the literature. The data compilation sheet has a listing of indicators of suicidal ideation related to social, emotional, psychological, behavioral and familial factors related to suicide and suicidal attempts.

The ninety-three items on the data compilation sheet were designed to collect data from case records on the social, emotional, psychological, behavioral and familial factors related to suicidal ideation in adolescents and teenagers that presented themselves to the emergency room of a major metropolitan hospital.

**The Sample**

The sample consisted of fifty case records of adolescent and teenage patients that were interviewed in the emergency room of a major metropolitan hospital with symptoms and complaints related to suicidal ideation, or after an attempt at suicide.
The author reviewed the case records, known as the "Crisis Intervention Contact Sheet - Emergency Room" which lists the chief complaint, the history of the present illness, the patient's social history, their past psychiatric history, a mental status exam, the clinical impression, the voluntary or involuntary admission of the patient and various notifications of authorities. The author selected those case records that fit the sample characteristics and tabulated the occurrence of factors on the data compilation form related to suicidal ideation as indicated in the literature.

Method Of Analysis

The methods of analysis that comprised this study consisted of descriptive statistics. The descriptive statistics in this study consisted of frequency distributions and percentages. The data obtained in this study was coded into a computer and analyzed by the use of the statistical computer program Statistical Package For The Social Sciences.³

CHAPTER FOUR  
FINDINGS  
FREQUENCY DISTRIBUTIONS  

Frequency Distributions were utilized to demonstrate percentages of responses. See Table I and II.

TABLE I  
DEMOGRAPHIC DATA OF AFRICAN AMERICAN ADOLESCENT MALES THAT DEMONSTRATED SUICIDAL IDEATION.

1. Age of Respondent.  
   25%: 15 years old.  
   14%: 16 years old.  
   35%: 17 years old.  
   23%: 18 years old.  
   3%: 19 years old.

2. Race of Respondent.  
   100%: African American.

   100%: Male
**TABLE II**

**Frequency Of The Social, Psychological and Environmental Correlates Of Suicidal Ideation.**

1. Evidence of Depression.  
   **100%**: Yes.

2. Loss or loneliness.  
   **42%**: Yes.

3. Family Troubles.  
   **76%**: Yes.

4. Pressure.  
   **18%**: Yes.

5. Underlying Chronic Problem.  
   **12%**: Yes.

6. Prior Mental Problem.  
   **36%**: Yes.

7. Stressing Event.  
   **38%**: Yes.

   **30%**: Yes.

9. Sense of Inferiority.  
   **2%**: Yes.

10. Sense of Persecution.  
    **50%**: Yes.

11. Sense of Injustice.  
    **2%**: Yes.

    **48%**: Yes.

13. Irritability.  
    **46%**: Yes.

    **6%**: Yes.

15. Increased Risk Taking.  
    **8%**: Yes.
<p>| Frequency Of The Social, Psychological and Environmental Correlates Of Suicidal Ideation. |
|---|---|
| 16. Extremely Shy. | 2%: Yes. |
| 17. Poor Peer Relationships. | 6%: Yes. |
| 18. Poor Self Image. | 68%: Yes. |
| 19. Poor Communication Skills. | 22%: Yes. |
| 20. Belief That Life Isn't Worth Living. | 56%: Yes. |
| 21. Recently Playing With Weapons. | 44%: Yes. |
| 22. Recent News About Suicide. | 6%: Yes. |
| 23. Recently Read A Book About Suicide. | 50%: Yes. |
| 24. Recently Seen A Movie About Suicide. | 50%: Yes. |
| 25. Received Prior Treatment For Suicidal Ideation. | 10%: Yes. |
| 26. Prior Treatment At Mental Health Center. | 36%: Yes. |
| 27. Parents Have Psychiatric Problems. | 12%: Yes. |
| 29. Parents Used Alcohol During Pregnancy. | 100%: Missing Data. |
| 30. Parents Attempted Suicide. | 4%: Yes. |
| 31. Parent Committed Suicide. | 100%: Missing Data. |</p>
<table>
<thead>
<tr>
<th>No.</th>
<th>Factor</th>
<th>Percentage</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>32.</td>
<td>Diagnosis of Borderline Personality Disorder</td>
<td>2%</td>
<td>Yes</td>
</tr>
<tr>
<td>33.</td>
<td>Diagnosis of Aggressive Personality Disorder</td>
<td>28%</td>
<td>Yes</td>
</tr>
<tr>
<td>34.</td>
<td>Diagnosis of Major Mood Disorder</td>
<td>42%</td>
<td>Yes</td>
</tr>
<tr>
<td>35.</td>
<td>Antisocial Behavior</td>
<td>56%</td>
<td>Yes</td>
</tr>
<tr>
<td>36.</td>
<td>Extreme Fear</td>
<td>6%</td>
<td>Yes</td>
</tr>
<tr>
<td>37.</td>
<td>Rage</td>
<td>42%</td>
<td>Yes</td>
</tr>
<tr>
<td>38.</td>
<td>High Levels of Anxiety</td>
<td>46%</td>
<td>Yes</td>
</tr>
<tr>
<td>39.</td>
<td>Illegal Activity</td>
<td>42%</td>
<td>Yes</td>
</tr>
<tr>
<td>40.</td>
<td>Acute Disciplinary Crisis</td>
<td>54%</td>
<td>Yes</td>
</tr>
<tr>
<td>41.</td>
<td>Felt Sense of Rejection</td>
<td>8%</td>
<td>Yes</td>
</tr>
<tr>
<td>42.</td>
<td>Felt Sense of Humiliation</td>
<td>4%</td>
<td>Yes</td>
</tr>
<tr>
<td>43.</td>
<td>Recently ridiculed</td>
<td>4%</td>
<td>Yes</td>
</tr>
<tr>
<td>44.</td>
<td>Recently teased</td>
<td>4%</td>
<td>Yes</td>
</tr>
<tr>
<td>45.</td>
<td>Failing At Some Event</td>
<td>2%</td>
<td>Yes</td>
</tr>
<tr>
<td>46.</td>
<td>Learning Disorder</td>
<td>10%</td>
<td>Yes</td>
</tr>
<tr>
<td>47.</td>
<td>Perfectionism</td>
<td>100%</td>
<td>Missing Data</td>
</tr>
</tbody>
</table>
### TABLE II, Continued

**Frequency Of The Social, Psychological and Environmental Correlates Of Suicidal Ideation.**

<table>
<thead>
<tr>
<th>No.</th>
<th>Description</th>
<th>Percentage</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>48</td>
<td>Recent Change In Circumstances.</td>
<td>4%</td>
<td>Yes</td>
</tr>
<tr>
<td>49</td>
<td>Recent Dislocation.</td>
<td>100%</td>
<td>Missing Data</td>
</tr>
<tr>
<td>50</td>
<td>Diagnosis of Manic Depressive Disorder.</td>
<td>100%</td>
<td>Missing Data</td>
</tr>
<tr>
<td>51</td>
<td>Diagnosis of Schizophrenia.</td>
<td>4%</td>
<td>Yes</td>
</tr>
<tr>
<td>52</td>
<td>Preoccupation With Death.</td>
<td>14%</td>
<td>Yes</td>
</tr>
<tr>
<td>53</td>
<td>Overt Sadness.</td>
<td>30%</td>
<td>Yes</td>
</tr>
<tr>
<td>54</td>
<td>Sense of Feeling Hopelessness.</td>
<td>26%</td>
<td>Yes</td>
</tr>
<tr>
<td>55</td>
<td>Sense of Feeling Helpless.</td>
<td>19%</td>
<td>Yes</td>
</tr>
<tr>
<td>56</td>
<td>Sense of Feeling Worthless.</td>
<td>62%</td>
<td>Yes</td>
</tr>
<tr>
<td>57</td>
<td>Unable To Feel Good About Themselves.</td>
<td>72%</td>
<td>Yes</td>
</tr>
<tr>
<td>58</td>
<td>Evidence of Poor Relationships With Others.</td>
<td>12%</td>
<td>Yes</td>
</tr>
<tr>
<td>59</td>
<td>Sexual Identity Problems.</td>
<td>4%</td>
<td>Yes</td>
</tr>
<tr>
<td>60</td>
<td>Inability To Make Career Choices.</td>
<td>8%</td>
<td>Yes</td>
</tr>
<tr>
<td>61</td>
<td>Illegal Drug Use.</td>
<td>18%</td>
<td>Yes</td>
</tr>
<tr>
<td>62</td>
<td>Use of Alcohol.</td>
<td>20%</td>
<td>Yes</td>
</tr>
<tr>
<td>63</td>
<td>Feeling Like A Failure.</td>
<td>36%</td>
<td>Yes</td>
</tr>
</tbody>
</table>
TABLE II, Continued

Frequency Of The Social, Psychological and Environmental Correlates Of Suicidal Ideation.

64. A Change In Usual Behavior.  
   2%: Yes.

65. Recently Viewed Media Account About Violence.  
   6%: Yes.

66. Loss Of Interest In School.  
   28%: Yes.

67. Loss Of Interest In Hobby.  
   12%: Yes.

68. Loss Of Interest In Physical Appearance.  
   12%: Yes.

69. Loss Of Interest In Friends.  
   12%: Yes.

70. Insomnia.  
   20%: Yes.

71. Nonstop Sleeping.  
   40%: Yes.

72. Recent Weight Loss.  
   12%: Yes.

73. Recent Weight Gain.  
   12%: Yes.

74. Making Verbal Threats About Suicide.  
   88%: Yes.

75. Talking About A Plan For Suicide.  
   60%: Yes.

76. Having Identified Specific Ways To Commit Suicide.  
   54%: Yes.

77. Giving Away Of Possessions.  
   2%: Yes.

78. Recently Making A Will.  
   100%: Missing Data.

79. Making Ambiguous References To Their Future.  
   100%: Missing Data.
<table>
<thead>
<tr>
<th></th>
<th>Description</th>
<th>Frequency</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>80</td>
<td>Experiencing Pressure To Succeed</td>
<td>2%</td>
<td>Yes</td>
</tr>
<tr>
<td>81</td>
<td>Recent Family Upsets</td>
<td>38%</td>
<td>Yes</td>
</tr>
<tr>
<td>82</td>
<td>Residential Mobility</td>
<td>20%</td>
<td>Yes</td>
</tr>
<tr>
<td>83</td>
<td>Changing Value Systems</td>
<td>2%</td>
<td>Yes</td>
</tr>
<tr>
<td>84</td>
<td>Failing Grades</td>
<td>38%</td>
<td>Yes</td>
</tr>
<tr>
<td>85</td>
<td>Recent Family Problems</td>
<td>36%</td>
<td>Yes</td>
</tr>
<tr>
<td>86</td>
<td>Unexplained Cheerfulness</td>
<td>2%</td>
<td>Yes</td>
</tr>
<tr>
<td>87</td>
<td>Extreme Sadness</td>
<td>28%</td>
<td>Yes</td>
</tr>
<tr>
<td>88</td>
<td>Extreme Anger</td>
<td>46%</td>
<td>Yes</td>
</tr>
<tr>
<td>89</td>
<td>Extreme Guilt</td>
<td>18%</td>
<td>Yes</td>
</tr>
<tr>
<td>90</td>
<td>Immigrant</td>
<td>100%</td>
<td>Missing Data</td>
</tr>
<tr>
<td>91</td>
<td>Sexual Abuse</td>
<td>100%</td>
<td>Missing Data</td>
</tr>
<tr>
<td>92</td>
<td>Physical Child Abuse</td>
<td>100%</td>
<td>Missing Data</td>
</tr>
<tr>
<td>93</td>
<td>Latchkey Child</td>
<td>100%</td>
<td>Missing Data</td>
</tr>
</tbody>
</table>
FREQUENCY DISTRIBUTION FINDINGS

Data was compiled from fifty case records of adolescent, male, African Americans that had demonstrated or exhibited suicidal ideation. Of the fifty units under study, twenty-five percent were fifteen years old, fourteen percent were sixteen years old, thirty-five percent were seventeen years old, twenty-three percent were eighteen years old and three percent were nineteen years old.

Of the fifty units under study, one-hundred percent of them were diagnosed as being depressed, seventy-six percent had family troubles, and eighty-eight percent had made verbal threats concerning suicide. Sixty-eight percent indicated that they had a poor self-image, fifty-six percent held the belief that life isn't worth living and they exhibited antisocial behavior. Fifty-four percent experienced an acute disciplinary crisis, sixty-two percent expressed a sense of feeling worthless, seventy-two percent expressed an inability to feel good about themselves and sixty percent had spoken about a plan to commit suicide.

The case records indicated that forty-two percent of the units under study had reported feeling loss or loneliness. Thirty-six percent had evidence of prior mental problems, thirty-eight percent had experienced a stressful event, thirty percent indicated they felt inadequate and fifty percent felt a sense of persecution. Forty-eight percent of the records indicated the units of study felt continual anger, forty-six
percent of them felt irritable and twenty-two percent had poor communication skills.

Forty-four percent of the case records indicated the units under study had recently played with weapons, fifty percent of them had recently read a book about suicide, thirty-six percent had received prior treatment at a mental health center and forty-two percent of them had a prior diagnosis of a major mood disorder. The case records further indicated that forty-two percent of the units under study felt rage, forty-six percent felt high levels of anxiety and were involved in illegal activity.

The records indicated that thirty percent of the cases felt a sense of overt sadness, twenty-six percent felt hopeless and thirty-six percent felt like a failure. The records further indicated that twenty-eight percent of the cases had lost an interest in school, forty percent of them had been sleeping nonstop, thirty-eight percent had some recent family upset and had experienced failing grades.

Thirty-six percent of the cases had recent family problems, twenty-eight percent felt extreme sadness and forty-six percent felt extreme anger. Eighteen percent of the cases reported experiencing pressure and prior illegal drug use. Twelve percent reported underlying chronic problems, a recent weight loss or weight gain, that their parents had psychiatric problems, they exhibited evidence of poor relationships with others, they had lost interest in a hobby, their friends and
their personal appearance.

Two percent of the cases reported having a felt sense of inferiority, being extremely shy, having a prior diagnosis of Borderline Personality Disorder, failing at some event, feeling a sense of injustice and giving away their possessions. Six percent of the cases reported complaints of boredom, poor peer relationships, having received recent news about a suicide, feeling extreme fear and having recently viewed a media account which contained violence.

Eight percent of the cases reported increased risk taking, a felt sense of rejection, and the inability to make career choices. Four percent of the records indicated that the units under study felt humiliated, ridiculed, teased and that their parents had attempted suicide at some time in the past. Twelve percent of the cases reported their parents as having psychiatric problems and that they had some form of learning disorder. Fourteen percent of the cases reported a preoccupation with death and twenty percent of them reported insomnia and residential mobility. Eighteen percent of the cases reported having extreme guilt and none of the cases indicated whether their parents had smoked or used alcohol during pregnancy and whether their parents had committed suicide.

The records did not demonstrate that the units under study felt a sense of perfectionism, a diagnosis of manic depressive illness, a sense of feeling helpless, the making of
a will, or their making ambiguous references to their future. Furthermore, the records did not indicate the cases were immigrants, that they had experienced either sexual or physical abuse or that of being a latchkey child.
CHAPTER FIVE
DISCUSSION OF THE FINDINGS

The purpose of this study was to determine the correlates of suicidal ideation in adolescent, male, African Americans. The phenomena of suicide is an expanding problem within the United States today, ranking eighth among the ten significant causes of death in most western countries.¹ Social workers, regardless of the nature of their practice or the populations that they practice with, must be aware of the psychological, social and emotional indicators of a potential suicide. This study was an attempt to determine the common correlates that teenage, male, African Americans exhibit or verbally express that might indicate their predisposition toward suicide.

This study had three hypotheses. The first null hypotheses indicated that no significant relationship would be observed between the norms and values of American society and the occurrence of suicidal ideation in African American male teenagers. The second null hypotheses indicated that no significant relationship would be observed between social-emotional affinity and suicidal ideation in African American male teenagers. The third null hypotheses indicated that no significant relationship would be observed between accepted standards of behavior and suicidal ideation in African American male teenagers.

The data compilation form on which the data was collected, had forty-one items to test the first hypothesis, forty-five items to test the second hypothesis and five items to test the third hypothesis. The findings of this study demonstrated that depression, family troubles, verbal threats concerning suicide, a poor self-image, the belief that life isn't worth living, antisocial behavior, experiencing an acute disciplinary crisis, a sense of feeling worthless, the inability to feel good about themselves and a plan to commit suicide are the most common correlates of suicidal ideation in teenage Black males.

The findings also demonstrated that suicidal ideation is often reported among this population when they feel a sense of loss or loneliness, after they experience a stressful event, when they are feeling inadequate, continual anger, rage, or a sense of persecution. The findings of this study also demonstrated that less often reported correlates of suicidal ideation in this population include their having played recently with weapons or their being influenced toward suicide by the media, whether books, movies, or news reports.

According to the findings of this study, family problems, family upsets, or parental psychiatric problems were only moderately reported in the case records. This finding might conform to the common occurrence of family members being unaware of their teenager's disposition toward suicide. It could reasonably be expected that a teenager would express a
desire to die during a family argument. However, since family members frequently state that they were unaware of the risk that their son might attempt or commit suicide they took no steps to counteract it.

Concerning deviant behavior and suicidal ideation, the findings of this study demonstrate that while antisocial behavior was a common correlate, the use of illegal substances and alcohol were not often reported in the case records. This finding may be related to a fear of the respondent to openly discuss drug or alcohol involvement.

The findings of this study conform to the theory of Emile Durkheim who discussed suicide in relation to the level of emotional attachment the individual has to the social order. The findings demonstrated that the cases reviewed were depressed, they had a poor self-image, they were lonely, they didn't believe that life was worth living and they didn't feel good about themselves. They also felt continual anger, rage and a sense of injustice as to how they had been treated. All of these elements point to a felt sense of emotional alienation and isolation from general society. These findings demonstrate that these cases felt a lack of emotional support from group life and a lack of involvement from group standards as described by Durkheim in his discussion of the Egoistic Suicide.

IMPLICATIONS FOR SOCIAL WORK PRACTICE

The findings of this study have implications for the
profession of social work and for those social workers that interview, counsel or conduct therapy with adolescent, black males. The findings of this study enable a social worker to identify the presenting symptoms, the social factors and behavioral indicators of potential suicide by a member of this population. The failure of a social worker to identify and adequately address this issue could lead to serious consequences for the client, their family and potential legal liability for the social worker.

This study has demonstrated that a social worker should evaluate the potential of a client committing suicide based on the following factors: First, is the client depressed. Second, does the client have a poor self-image and a sense of feeling worthless. Third, does the client believe that life isn't worth living. Fourth, have they exhibited some form of antisocial behavior. Fifth, has the client made verbal threats concerning suicide and developed or thought about a plan as to how they would commit suicide. Six, does the client feel estranged, alienated or isolated from group or social life. Seventh, does the client express a sense of continual anger or rage. According to the findings of this study, these seven elements were common to the verbal expression or exhibition of suicidal ideation in Black, adolescent males.

By utilizing the seven criteria above in evaluating risk of suicide, a social worker may prevent a young male from attempting or committing suicide. Consequently, the findings
of this study may save lives, it may reduce, or prevent, the trauma that is experienced by families of suicide victims and it may reduce the legal and moral liability of the social worker having to cope with the problems related to a client that committed suicide.

LIMITATIONS OF THE STUDY

The findings of this study is limited to the fifty case records studied. Consequently, the findings of this study cannot be generalized to the larger population. However, this study establishes the groundwork for future research on the social, emotional, and psychological correlates for suicidal ideation in African Americans.

SUMMARY

This study demonstrated that seven common correlates exist for suicidal ideation in African American, male, adolescents. These seven correlates are: depression, a poor self-image, a sense of feeling worthless, a belief that life isn't worth living, antisocial behavior, verbal threats to commit suicide, the making of a suicide plan, estrangement from group life and continual anger or rage. Social workers that evaluate or treat male adolescents must recognize these indicators that predispose the client to suicide and take appropriate steps to prevent it.
APPENDIX A

Case No. _____
Client Age: _______  Client Sex: _______
Client Race ______

CHECKLIST FOR DETERMINING RISK OF SUICIDE

1. ______ depression
2. ______ loss or loneliness
3. ______ family troubles
4. ______ pressure
5. ______ underlying chronic problem
6. ______ prior mental problem
7. ______ specific stressing event (traumatic experience)
8. ______ feeling inadequate
9. ______ inferiority
10. ______ persecution
11. ______ injustice
12. ______ continual anger
13. ______ irritability
14. ______ frequent complaints of boredom
15. ______ increased risk taking
16. ______ extremely shy
17. ______ poor peer relationships
18. ______ poor self image
19. ______ poor communication skills
20. ______ life isn't worth living
21. ______ playing with weapons (guns, knives, poisons)
22. ______ recent exposure to news about suicide
23. ______ recently read book about suicide
24. ______ recently seen movie about suicide (copycat)
25. ______ prior treatment for suicidal ideation
26. ______ prior treatment at mental health center
27. ______ parents have psychiatric problems
28. ______ parents smoked during pregnancy
29. ______ parents drank alcohol during pregnancy
30. ______ parent(s) attempted suicide
31. ______ parent committed suicide
32. ______ borderline personality type
33. ______ aggressive personality type
34. ______ major mood disorder
35. ______ antisocial behavior
36. ______ extreme fear
37. ______ rage
38. ______ high levels of anxiety
39. ______ illegal activity (behavior)
40. ______ acute disciplinary crisis
41. ______ rejection
42. __humiliation
43. __incident of being ridiculed
44. __incident of being teased
45. __failing at some event
46. __learning disorder
47. __perfectionism
48. __change in circumstances
49. __dislocation
50. __manic depressive
51. __schizophrenic
52. __preoccupation with death
53. __overt sadness
54. __feeling hopeless
55. __feeling helpless
56. __feeling worthless
57. __unable to feel good about self
58. __unsatisfied with relationships with others
59. __sexual identity problems
60. __inability to make career choices (college)
61. __drug use
62. __alcohol use
63. __feel like failure
64. __change in usual behavior
65. __messages about violence in media (movies, songs, news)
66. __loss of interest in school
67. __loss of interest in hobbies
68. __loss of interest in physical appearance
69. __loss of interest in friends
70. __insomnia
71. __nonstop sleeping
72. __weight loss
73. __weight gain
74. __making threats about suicide
75. __talking about a plan
76. __identification of specific ways to commit suicide
77. __giving away prized possessions
78. __making a will
79. __ambiguous references to the future
80. __pressure to succeed
81. __family upsets
82. __residential mobility
83. __changing value systems
84. __failing grades
85. __family problems
86. __unexplained cheerfullness after long depression
87. __extreme sadness
88. __extreme anger
89. __extreme guilt
90. __immigrant
91. __sexual abuse
92. __child abuse (physical)
93. __latchkey child
BIBLIOGRAPHY


