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A descriptive study of suicidal intentions among African-American male college students

Mary Sue Singletary
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The intent of this study was to examine the suicidal intentions among a select group of African American male college students. The survey drew responses and information from these students within several major categories: (1) demographic and familial background, (2) personal and male modes of feeling, and (3) conditions surrounding suicidal intentions. Twelve of the students were unique in that these characteristics were outstanding compared to the expected responses of the population: more than expected (1) lived in a single room, (2) were only children, (3) were first born, (4) had self-destructiveness and loneliness in the family, (5) had a father as a suicidal model, (6) had prolonged pain when there was loss or separation, and (7) experienced spontaneous zaniness and risk taking. Therefore, further investigation might be warranted in the area of intervention on college campuses to address and process these special areas in African American males, as well as youth generally.
A DESCRIPTIVE STUDY OF SUICIDAL INTENTIONS AMONG AFRICAN AMERICAN MALE COLLEGE STUDENTS

A DISSERTATION
SUBMITTED TO THE FACULTY OF CLARK ATLANTA UNIVERSITY
IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR
THE DEGREE OF DOCTOR OF PHILOSOPHY

BY
MARY SUE SINGLETARY

DEPARTMENT OF COUNSELING AND HUMAN DEVELOPMENT

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CHAPTER I
INTRODUCTION

Current public health reports on suicide indicate that attempts of suicide and completed suicide among adolescents have risen dramatically at a stable increase per 100,000 over the last twenty to thirty years with a dramatic increase in suicide until the peak age of twenty-four. This increase has been threefold, for white males ages fifteen to twenty-four over the last twenty-five years.¹ Coupled with this increase in youth suicide have been statistics that show increase in African American male suicide in ages fifteen to twenty-four: 1960s, 4.1 percent; 1970s, 12.5 percent; 1980s, 12.3 percent; and 1990s, 12 percent.² The percentage increase over the last thirty years has tripled among African American males as well. These statistics are only of "completed suicides"; the range of suicide that includes destructive behavior would be calculated at a much


higher percentage if these statistics included accidents, drownings, drug and alcohol abuse, etc.

The history of gathering information regarding suicide is undergirded with bias of the data collectors due to an unconscious avoidance of material or information regarding death, much less the emotionally laden topic of suicide. In 1987, Westefeld and Patillo surveyed 178 university counseling center directors who constituted the Association of College and University Counseling Centers to find that of the 147 respondents, only 20 directors had a systematic procedure in place to keep records concerning suicide on campus. 3 "Dr. Herbert Hendin's famous black suicide study revealed statistics such that among blacks of both sexes between the ages of twenty and thirty-five, suicide was twice as frequent as it was among white men of the same age group."4

The history of research on suicide has brought an expansion of the range of behaviors delineating "completed suicides" to the range of self-destructive behaviors leading to suicide. This broader range of action which encompasses suicidal behavior can be communicated with the word


"intention." Since this particular communication opens the message that one may have a goal or purpose in mind, perhaps even unconscious or not clearly understood by the doer, the behaviors surrounding the suicidal attempt or act, subsequently, have relevance. This study will, therefore, survey the broader category of behaviors and purposes toward self-destructive suicidal intentions.

**Rationale**

There has been an increase in suicide among African American and white youth over the last ten years. Studies have been done which indicated an increase in the suicide rate from third to second among adolescents. Along with these studies on African American and white youth have been parallel reports of African American adult suicide which has increased to 114 percent in males ages fifteen to twenty-four and 33 percent in females fifteen to twenty-four.7


This study targets young African American males ages eighteen to twenty-one. The highest rate of suicides in African Americans occurs between the ages of twenty and thirty-four, with a 3:1 ratio of men to women. Preventive measures that can be duplicated within educational facilities, both public high schools and undergraduate college programs, are appropriate. The ages of eighteen to twenty-one encompass college undergraduates. Specifically, this study targets African American male college students, who may or may not have experienced forms of suicide intentions.

Some writers claim that the African-American population of the United States is a younger population with a broadly based population pyramid, the white population being older with a population that is more evenly distributed in all age groupings. Age adjustment is a method that corrects for these age differences in the population of each race.\(^8\) As a young culture, the African American culture often fought for identity. The Civil Rights Movement in 1954 and the Black Power Revolution later are examples. The power of these fights for identity can be associated with the assassination of Dr. Martin Luther King, Jr., in the late 1960s.

Other writers and educators believe that the African American culture is an older culture, beginning as soon as the slaves were transported and began their assimilation

\(^8\)Ibid., 191.
into the so-called white American culture. Later, this African culture began striving toward integrating into the culture of the middle and upper middle classes, which supposedly offered more opportunities. So some of the young men of the African American culture inherited the stresses of white racism and oppression: the economic, social, and psychological tensions.

Secondly, the extended family unit which transferred social and economic skills to their sons and daughters has been weakened by the trend toward a nuclear unit. "In the black population, 1,568,407 households were headed by a female without a husband present, with their own children under 18." Some researchers call this phenomenon a deficit, as Pinderhughes inferred in discussing the impact of poverty and racism on African American families.

Both the preceding arguments lead to the rationale for this study which emphasizes the use of educational institutions as additional socializing agents for the well-being of African American students. The nuclear family as a

9Carson Lee, professor at Clark Atlanta University, comments at doctoral committee meeting, 21 June 1993.


12Ibid., 201.
socializing agent may be overpowered by the weakening of the extended family. The educational system can serve as a surrogate extended family. In this way, the researcher suggests that educational institutions reach out to this population.

**Purpose of the Research Study**

The purpose of this research was to explore suicidal intentions among African American male college students. The study explores these intentions by surveying a population of young adult African American college males between the ages of eighteen and twenty-one who may present with feelings of anxiety and stress which could result in suicidal activity. The research data, once organized and compiled, will provide the groundwork for early prevention and other interventions helpful to educators and other health care practitioners.

**Research Question**

The major research question addressed in this study was:

1. How prevalent are suicidal intentions among African American male college students?

   Additional questions included:

   2. What is the demographic information surrounding these students?
3. What are the personal feelings of the students who report suicidal intentions?

4. What are the modes of feelings, as outlined by Robert Bly, that are demonstrated by these students?

5. If these students report suicidal intentions, what are the conditions surrounding these intentions?

6. What are the family characteristics of those who report suicidal intentions?

Significance of the Problem

The significance of the suicidal intentions among African American male college students is relevant in that it may reveal deeper and serious destructive thought patterns or structures underlying human suffering universally. When this research is completed, certain trends and/or patterns discovered will be revealed as to the specific needs of this population. In other words, research of this type will not only provide information as to intervention for those who are self-destructive, but will also provide information to those who want to live enriching lives.

Just as well, with the vast majority of pain left on the families and survivors of suicide, detailed information as to how suicide may be prevented in society is crucial to the survival of a total race that has just begun to stand with a sense of its own autonomy. Dr. Eugene Herrington, who did extensive research on the use of psychotherapy
with African American adolescents, made the conclusive comments:

The continuous decline in the well-being of Black male adolescents must be taken seriously . . . it may be useful to schedule seminars or groups that attempt to explore underlying Black male adolescent concerns.13

In summary, the author again restates the significance of this research as it relates to the African American male, as well as to youth generally. Particularly, this research lays the groundwork and first steps toward understanding suicide, as the following comments by Lester on an international level imply:

Twenty-three nations experienced an increase (with Norway experiencing the largest percentage increase) . . . and unlike general suicide rates, teenage suicide rates were not related to the quality of life in the nations surveyed.14

Research has proven that variables which correlate with the overall suicide rate of a country (such as the quality of life and the change in the suicide rate) are not significantly related to the youth suicide rate. This failure to find significant correlates of youth suicide suggests that different factors account for youth suicide internationally.15


15Ibid., 958.
Definition of Terms

The concept of suicide is very difficult to define, but this researcher will examine many levels of suicide and suicide intentions expressed in the following paragraphs:

Suicide is the end result of a process, not the process itself. In most behavior disorders we have at least part of the process at hand for examination.

In suicide, all we usually have is the end result, arrived at by a variety of paths. Unraveling the causes after the fact is well nigh impossible.

Since the completed suicides can be investigated only retrospectively, we are forced to utilize the unsuccessful suicides or suicide attempts for our source of data. But the unsuccessful suicides are no doubt quite different from the successful, and the former cannot be regarded as representatives of the latter.

However, there is some overlap between the unsuccessful and the successful, since some of the unsuccessful try again and succeed.

Thus the subset of suicide attempters who finally succeed provides us with the most valuable follow-up.16

Additional definitions of suicide include:

1. **Suicide**: Currently, in the Western world, suicide is a conscious act of self-induced annihilation, best understood as a multidimensional malaise in a needful individual who defines an issue for which the suicide is

---

perceived as the best solution. In that ideas and behaviors leading to suicide closure have a place in the definition of suicide, Dr. J. Zubin proposed the total complexity of suicide as seen figure 1.

![Diagram of the complexity of suicide]

Fig. 1. The complexity of suicide.

It may be safe to assume, for lack of better information, that the tendency towards suicide is distributed symmetrically, somewhat like intelligence in the general population, and that its distribution ranges from the extreme left, which represents the zero point of this suicidal tendency, to the extreme right, which represents successful suicide.

2. Suicide intention: To follow up Beck's 1986 research, which commented on the "subset of suicide

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attempters as being the most valuable information," he
developed a suicidal intent scale from which this researcher
drew for the partial development of the survey instrument.

Intent is defined as the seriousness or intensity
of the wish of a patient to terminate his life.
Intent is one component of overall suicidal risk
(or suicidal potential) that includes a conglomerate of other factors, such as access to lethal
methods, knowledge regarding the utilization of
these methods, absence of protective individuals in
the environment to intervene before or after the
suicidal act. To distinguish suicidal intent,
suicidal risk includes other indices that have been actuarially determined (such as age, social class,
sex, etc.). Suicidal intent, on the other hand, is
assessed simply by the behavior of the individuals
as reported by others and by self-reports.20

Definitions of suicide intentions include:

3. Suicidal intentions: Suicide itself "involves
a specific intention on the part of the victim to kill him-
self . . . he makes a plan, and he/she follows this plan and
dies."21 If the act of suicide is unsuccessful, then inten-
tion alone is not sufficient, since doubt may be placed on
the intention itself. By including the concept of inten-
tion, suicide as a concept, then, must involve the idea of
one destroying oneself knowingly. There is the intention to
to destroy oneself, as well as the act, and eventual

20Beck, Resnick, and Lettieri, The Prediction of
Suicide.

21N. Tabachnick, ed., Accident or Suicide? Destruc-
tion by Automobile (Springfield, IL: Charles Thomas Pub-
destruction of self for the total process to be defined suicidal.22

4. **Unconscious intentions:** Along with the understanding of suicide is the realization of "automobile accident," of which 20-30 percent of accidents have been researched and labeled "suicidal." In other words, certain individuals will drive an automobile into a wall, or off a cliff, rather than disgrace their family, and make it look like an accident. In this instance, "intention" toward self-destruction is characteristic of both suicide and accident.23

5. **Suicide ideation:** Suicide ideation includes behaviors that may be directly observed or inferred and that are concerned with or move in the direction of a possible threat to the individual's life, but in which the potentially lethal act has not actually been performed. Taking barbiturates out of a bottle and then returning them to the bottle could be classified as suicide ideation. However, swallowing several pills with the intent of committing suicide would be classified as suicide attempt.24

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23Tabachnick, Accident or Suicide?, 191.

6. **Suicide attempt**: Suicide attempt parallels a completed suicide; however, it does not result in death and it is characterized by the addition and implementation of other motivations besides the desire to die. Indeed, the attempter may have ambivalence as to whether he wishes to die.\(^\text{25}\) Fokorny also defined suicide attempt as including those situations in which a person has performed an actual or seeming life threatening behavior with the intent of jeopardizing his life or to give the appearance of such an intent, but which has not resulted in death. This category includes all nonlethal actions previously classified as incomplete suicides, unsuccessful suicides, suicidal gestures, histrionic suicidal attempts, abortive suicides, and ambivalent attempts. The information contained in these vague labels may be conveyed more precisely by rating the dimensions of intent, lethality, and mitigating circumstances to be discussed later.\(^\text{26}\)

7. **Self-destructive behavior**: Self-destructive behavior is behavior that results from forces or a combination of forces within the individual which leads to his damaging himself or losing his life, without knowledge or conscious understanding that these actions are damaging to life.\(^\text{27}\)

8. **Suicidal behavior**: Suicidal behavior is behavior that may be (cautiously) used to infer suicidal ideation without any verbal communication from the patient.

\(^{25}\)Tabachnick, *Accident or Suicide?*, 7.

\(^{26}\)Fokorny, "A Scheme for Classifying Suicidal Behavior," 36.

\(^{27}\)Tabachnick, *Accident or Suicide?*, 191.
CHAPTER II

SUICIDE: THE LANGUAGE OF DESPERATION

Suicide in History

According to Norman Cousins, "The great tragedy of life is not death, but what dies inside of us while we live."28 In past times, suicide was honored decently and has meant "the delivery from military defeat and escape from enslavement."29 In the last century, suicide captured the interest of mental health scientists, and the modern study of suicide got under way.30

Suicide is interesting to most researchers because on the other side of suicide is life, or the unique understanding of why life and not death is chosen. This beginning section of the literature review goes into depth regarding the history of suicide, its changes over the years, and how the factors of expectations and hope play in the phenomenon of increased suicide among youth.

28 Evans and Farberow, The Encyclopedia of Suicide.
30 Ibid.
Present Rate of Suicide and Changes Over the Last Ten Years

Suicide is very possible, even in industrialized countries. With the advent of changing mores, as especially seen in Future Shock, suicide and how the factors of future shock, as noted by Alvin Toffler, influence the rate and presence of suicide are poignant. Anita Taylor noted:

We are now well into a new age, call it what you will: the Electronic Age, the Information Age, the Post Industrial Age. And within 10 years, it will totally immerse us bringing immense changes in how we live. Toffler's thesis in Future Shock holds--for today and in the future. The pace of change in our lives is accelerating. Change begets change, and such changes bring turbulence.

Alvin Toffler noted that "there will be changes in our culture such that mores and values will need redefinition. Families will no longer be nuclear . . . they will expand and need extended recognition." If a child, adolescent, or adult is totally dependent on the values outside of self for definition he, or she, will be thrown into oblivion. Toffler wrote:

In 1965, in an article in Horizons I coined the term "future shock" . . . to describe the shattering stress and disorientation that we induce in individuals by subjecting them to too much change.


33Toffler, Future Shock, 243.
in too short a time . . . it first became clear that Future Shock is no longer a distantly potential danger . . . but a real sickness from which increasingly large numbers already suffer.\textsuperscript{34}

Toffler, as a futurist, has relevance for educators as well as those who are concerned for youth.

Today, in industrialized countries, where suicide statistics are available, suicide ranks among the ten most common causes of death. Such countries include: Finland, Austria, Denmark, Sweden, Hungary, and Japan. In the USA, suicide is the 10th leading cause of death.\textsuperscript{35}

Approximately thirty thousand people killed themselves in 1982. More than ten times that amount attempted suicide. Worldwide, more than one thousand people kill themselves every day. In the United States, seventy-three people kill themselves every day. Suicide has become the focus of scientific inquiry and public health attention in the most industrialized countries.\textsuperscript{36}

As mentioned earlier, suicide captured the interest of mental health scientists so that the modern study of suicidology got under way. What had been defended as an intellectual choice by enlightened thinkers came to be seen as, if not a sign of mental illness, a means of relief from psychic pain and sorrow.\textsuperscript{37} Researchers have learned

\textsuperscript{34}Ibid.
\textsuperscript{35}Moore, \textit{Useful Information on Suicide}, 1.
\textsuperscript{36}Ibid., 7-8.
\textsuperscript{37}Ibid., 7.
much about critical factors which contribute to suicidal behavior: "depression is generally the most important problem associated with suicide ... and it can be treated with psychotherapy and/or medication." $^{38}$

Reports of suicide among very young children are rare, but suicidal behavior is not. As many as twelve thousand children ages five to fourteen may be hospitalized in this country every year for deliberate self-destructive acts, such as stabbing, cutting, scalding, burning, overdosing, and jumping from high places. $^{39}$

Generally, adolescents and young adults are committing suicide to a greater extent than ever in history. The overwhelming majority of completed suicides are males who comprise approximately three-fourths of the total who commit suicide. Sharp increases in suicide among young African American males have in some urban areas outdistanced rates of white males in the same age groups.

This is a startling increase, since the overall suicide rate for African Americans traditionally is half of that of whites. Rates among African Americans, as well as other non-Anglo groups, peak in the early twenties, and these rates have been getting higher. $^{40}$

$^{38}$Ibid., 3.
$^{39}$Ibid., 10.
$^{40}$Ibid., 5.
Role of Identity

It is with this introduction that this researcher turns to the factors of expectations. The adolescent developmental stage is characterized by several predominant phenomena, each having significant impact on a young person and each having relevance to the adjustment of the person to the next stage of young adulthood. Changes in the physical, cognitive, and psychosocial domains of the individual can determine whether or not the person is able to establish his or her own identity as an adult.

With the implications of Future Shock that Anita Taylor pointed out, in which the values and mores of a culture are being totally challenged, it will be difficult for the young people of this generation to establish an identity. For example, if there is no father figure present, either emotionally or physically, how can the traditions of society be communicated?

There are reports that teenagers spend less than forty minutes a day alone with their mothers and less than five minutes a day with their fathers. If adolescents are to generate their own norms and rules outside of an established structure, however, this new generation is not possible. Rebellion cannot exist unless there is an institutional context from which they can counter an opposition.

Nothing can be created in the establishment of self in isolation from father and mother or the established structure.\textsuperscript{42}

Educators and parents are particularly concerned with how these expectations for youth development and transcendence from adolescence to young adulthood affect the normal stages of development and the "vision of hope" or simply the reason for living. "Whether or not suicide is intended, it is clear that a serious problem exists . . . and it is best to take such self-destructive behavior seriously."\textsuperscript{43}

\textbf{Communicating the Language of Suicide}

How young adults express suicidal ideation and attempt suicidal activity to communicate pain and desperation, as well as a loss of hope, is a new field of exploration. The fact that depression exists and that pain is hardly bearable is communicated by members in this population. If some relief does not happen before age 19, then the symptoms of suicidal ideation will be easily observed in the transition stage from adolescence to young adulthood. The explorers of how suicide stages communicate admit: "If

\begin{itemize}
\item \textsuperscript{42}M. Csikszentmihalyi and Jane McCormack, "The Influence of Teachers," \textit{Phi Delta Kappan} (February 1986): 417.
\item \textsuperscript{43}Moore, \textit{Useful Information on Suicide}, 7.
\end{itemize}
it (an attempt) is fatal, it is a final message; if it is not fatal, it is a part of dialogue."44

The first study which deals with suicide is on a university level. As written by Ralph Rickgarn:

Suicide is not a neutral word . . . it is not a neutral behavior. As a word, it evokes apprehension and creates a desire to avoid or detach oneself from a discussion. As a behavior, it evokes powerful emotional reactions regardless of the outcome.45

Suicide is a traumatic event for the individual and for all of those people who have some connection with it. As Henry David Thoreau announced, "The masses of men lead lives of quiet desperation."46 This statement is seconded by the first statement in Chapter II of this dissertation research review: "The great tragedy of life is not death, but what dies inside of us while we live."47 Beyond this, in regard to research on communication, counselors have the added burden of the fact that "Communication research dealing with suicide to health and social services may be very


45Ralph L. Rickgarn, The Issue Is Suicide (Minneapolis, MN: Minnesota University, 1983). 5.


47Norman Cousins, quoted in Evans and Farberow, The Encyclopedia of Suicide.
limited because it is emotionally demanding." While the emotional demands of such research are high, so are the potential insights to be gained. Consequently, a renewal on some of the various perspectives on suicide research is appropriate.

Psychologists commonly divide suicidal behavior into three categories: (1) suicide ideation, (2) attempted suicide, and (3) completed suicide. It has been estimated that 80 percent of all individuals will admit to having entertained suicidal thoughts. "Man may be the only species that questions the value of life, and with varying degrees of volitional and knowing intent assumes the right to terminate it prematurely."

Jacobs argued that suicidal ideation frequently serves a life-maintaining function by providing the comforting reassurance that if life becomes too unbearable one can always opt out. Attempted suicides communicate desperation, and completed suicides, nonetheless, constitute a


50 Ibid.

major health problem, as approximately 22,000 are recorded in the U.S. It is the second most common cause of death in college campuses, the leading cause of death among medical students, and the third leading cause of death among teenagers. Despite research and public health efforts, suicide rates show a relative consistency over time.\(^{52}\)

**The Role of Hope**

If youth enter this realm of development and find rejection as well as no support from their community, then there may be psychological destruction. In regard to the factor of hope,

recent studies tend to confirm earlier work showing that suicidal thoughts and behavior are more closely related to hopelessness rather than depression per se. Researchers studying the attitudes of some severely depressed people have concluded that they may think themselves into suicide. They misperceive the world and act accordingly. They are pessimistic, lack confidence in their ability to handle themselves, and set unattainable goals on which they pin whatever they have.\(^{53}\)

In her moving "State of the Dream" address recently, Coretta Scott King told the Ebenezer Baptist Church audience of over eight hundred that "hope is becoming an endangered

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\(^{53}\)Moore, *Useful Information on Suicide*, 9.
Mrs. King, President and Chief Executive Officer of the King Center for Nonviolent Social Change, blamed the "hopeless" condition of the poor on President Bush, stating that Bush should reorder his budget priorities to meet the most basic needs of the poor. These necessities include food, housing, education, and employment.

Today, nearly one out of four American children under the age of six (6) is living in poverty. Babies born in 21 other countries have a better chance of surviving their first year of life than do American babies.

Some youth of today are born in a world of poverty that may be defined by absence of enough food or water, as many of the children in the slums experience; and poverty may also be expressed by the psychological absence of father and/or mother in an upper middle class family whose parents work to keep the $150,000 salary to pay for the home with the two-car garage, the Mercedes, and the pool.

Whatever the reason for poverty, physical or emotional, a significant rise in black youth committing suicide, much less killing each other, crosses cultures universally. When suicide occurred as a taboo for a culture whose security was dependent on the church and its teachings, the alarming increase in suicide among black youth is


55 Ibid.
significant for researchers in their understanding of the phenomenon in youth globally.

Perhaps the most important factor of youth is a long, healthy life. Defying the idea that suicide occurs by the gradual "death inside of self," hope brings "the fulfillment of energy." The role of educators is to discover the positive elements that make possible the energy of youth and thereby establish a medium of hope. If culture shock has presented a level of adaptation that is challenging for youth, an emphasis on this cultural acceptance with the medium of communication is a possible vignette of that energy and hope.

**Suicide Among Youth Eleven to Eighteen**

As the literature review has revealed so far, the factors of expectations, hope, and communication will weave in and out of this literature review. Therefore, the factors of communication and family are paramount.

Suicide among youth has increased astoundingly over the past twenty-five years and is now the third leading cause of death among young persons fifteen to twenty-four years of age and the second leading cause of death among

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56 Norman Cousins, quoted in Evans and Farberow, *The Encyclopedia of Suicide.*

college students. However, even more prevalent is the fact that in 1991 adolescent suicide became the second leading cause of death in the adolescent population. In 1989 four teenagers, ages eighteen and nineteen and two sisters ages sixteen and seventeen, brought national attention to the northern New Jersey community of Bergenfield when they committed suicide in a pact that had bound them in death as they had been in their short but troubled lives. A mother wrote after the death of her son:

I didn't blame counselors for David's death. And I don't mean to imply counselors are incompetent or are shirking their duties. I could also have written to the school officials who seemed more concerned with keeping "absolute order" than the emotional well being of their students . . . or the parents of some of David's friends who later made such comments as "Gee . . . I knew he was in trouble and wish I had said something." And you are trained to notice potential problems, particularly when parents alert you to problems at home that seem to be more than the children are able to handle.

This mother knew her son had told the counselors/psychologists that he was ready to kill himself.

I assumed that my son would get the best care. Only by accident, after he died, did I discover that David told the two of you, both professional

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58 Nelson et al., "Perception of Youth Suicide in California."

59 Siehl and Studer, "Mass Screening."


psychologists . . . that he had thought of killing himself, that there was a gun in the house, and that he wasn't coming back to see you, yet . . . you did nothing.  

With the introduction of youth suicide and its rapid progress, the researcher will begin to outline the major reasons for youth suicide. The initial reason for children or youth becoming suicidal is that they become the scapegoat for interrelationship problems. In reaction to the information that the researcher has in dealing with youth suicide, a parent that the researcher knows commented that her daughter gave signs of suicide when her relationship with her husband existed as only a passing hello-goodbye. The child responded to the death by displaying the symptomatic "suicidal" thought. Perhaps the child is the "projected" object of discontent in a system of relationships that do not work. The mother and father are projecting their dissatisfaction on the child and his/her life.

When society loses its most important perspective—communicating with one another—as evidenced by the breakdown of the family, rejection of each other, divorce, shared time with children as they are passed back and forth among families, it is no wonder that suicide is a symptom of breakdown of communication. The very system that created such a breakdown cannot quickly create a system to overcome that breakdown.

\[62\text{Ibid., 295.}\]
Shreve and Kunkel responded to the breakdown of the childhood-mother attachment in their article, "Self Psychology, Shame, and Adolescent Suicide: Theoretical and Practical Considerations." From their research this researcher understands that if the mother-son/daughter individuation is not healthy, in adulthood, difficulties can occur.

Using the psychoanalytic self-psychology of Henry Kohut as the theoretical foundation of this article, the authors discuss the role of shame in adolescent suicidal behavior. Shame is described as a "central component" of suicidal behavior, within the context of adolescence, a fundamental stage of development of the healthy self. Normal and pathological self-development are described as important issues pertaining to the development of the self during adolescence, and they are explored. A theoretical explanation of adolescent suicidal behavior from a self-psychology perspective is offered. Finally, suggestions for treatment of the suicidal adolescent and an illustrative vignette are presented.

Adolescence, as understood by Berger, includes: "We clothe ourselves with rainbows: and go as brave as the

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64 Ibid., 305.
zodiac. . . . Emerson described this as 'fate'. "And more vital is the understanding: "If they give you ruled paper, write the other way."66

Kathleen Berger, unfortunately, also reported that one of the most perplexing problems that may occur in adolescence is suicide. These comments accompanied Berger's graph (shown here as fig. 2):

The suicide rate for adolescents is half the rate for adults only because adolescents' attempts to kill themselves fail twice as often as those of adults. Unfortunately, the "success" rate for adolescents in the 1970s was double that of the 1960s. The two factors implicated in this increase were adolescent drug use, which increased during the 1970s, and divorces, which doubled between 1970 and 1975. A disproportionate number of suicidal adolescents are from divorced families, and drugs are a factor about half of the time.67

Strother commented:

There are geographical, racial, and seasonal variations in the suicide rate according to Dr. Barry Garfinkel. Suicides among the young tend more often to occur in late fall and early winter, for example.

Southern states with large black populations tend to have the lowest suicide rates . . . Meanwhile Native American young people have a suicide


67 Berger, The Developing Person, 363.
rate approximately 10 times higher than that of their Caucasian children.68

In another research paper dealing with understanding and preventing teenage suicide, Frymier and Garfinkel made these comments:

Frymier:

Clearly, these young people have trouble dealing with the difficulties of growing up. Are the stresses teenagers face today, both in the family and in school, greater than they were previously? Are we placing more demands on young people than ever before?

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68 Deborah Burnett Strother, "Practical Applications of Research: Suicide Among the Young," Phi Delta Kappan 67, no. 10 (June 1986): 756.
Garfinkel:

One of the things that we would like to achieve is for youngsters to be able to monitor themselves, to recognize when they are under stress or when they are beginning to feel depressed... Instead of letting the pressure build until they need massive amounts of help—possibly even hospitalization or medication—young people could then seek help sooner.69

Prevention and coping styles are pursued in the intervention section.

Suicide Among Youth Eighteen to Twenty-Four

The fact that adolescents commit suicide and that this option is chosen more frequently lately has been documented. This research review turns to the fact that youth who have been through public education, have been accepted into a college or university of choice, the pride of the family, and then decide to commit suicide is even more devastating to the concepts of expectations, communication, and hope as well as the attention of counselors.

A review of reasons for suicide on the college level is paramount. The following studies are limited to the university level. As mentioned before, "suicide is not a neutral word, it is not a neutral behavior. As a word it

evokes apprehension and creates a desire to avoid or detach oneself from a discussion."70

As most counselors know, death and the years preceding death have been dismissed in the past. The content of most textbooks has centered around youth. Helen Berger has changed that attention as she has developed Safe Adulthood, which contains four chapters on the years before death.71 Berger's decision to focus on these years in a university textbook reveals growth in researchers' and counselors' attitudes regarding death or "old age" as a significant developmental period in life.

Just as researchers and writers have avoided death as a topic easily confronted, so are the attitudes of researchers toward suicide. With this acknowledgement, this researcher attempts to educate readers as to issues that are factors in educators' and counselors' knowledge of suicide and the myths involved in knowledge of suicide as well. The information on suicide myths and facts which follows was taken from Depressive Disorders: Treatments Bring New Hope, by Marilyn Sargent.72

70 Rickgarn, The Issue Is Suicide, 5.
71 Berger, The Developing Person.
72 Marilyn Sargent, Depressive Disorders: Treatments Bring New Hope (Rockville, MD: National Institute of Mental Health, Division of Scientific and Public Information, 1986), 6-8.
The Issue is Suicide

Suicide is a highly personalized and individualized behavior in reaction to a perceived set of life stresses and situations. Statistics and demographics can show the probability of suicide and that may be important to know. However, regardless of the data, the question for an individual who becomes aware that another person is possibly contemplating suicide is "Is this person here with me right now wanting to commit suicide and what can I do about it?"

An encounter with a suicidal person is always a deeply emotional experience. There is a fear of not knowing what to do, or doing the wrong thing. But, the basic empathic "I care about you" indicates that there is hope and help, two key ingredients in the intervention process. Misinformation often prevents individuals from becoming involved for fear of making a situation worse. There are many myths about suicide which deter individuals from becoming involved. What are the myths and what are the facts?

Myth: People who talk about suicide rarely attempt or commit suicide.

Fact: Approximately 70-75% of the people who attempt or commit suicide have given some verbal or non-verbal clue to their intentions.

Myth: The tendency toward suicide is inherited.

Fact: Suicide has no characteristic genetic quality. Suicidal patterns in a family are a result of other factors and may result from a belief in the myth which facilitates suicidal actions.

Myth: The suicidal person wants to die.

Fact: Suicidal persons often reveal considerable ambivalence about living vs. dying and frequently call for help before and after a suicide attempt.

Myth: All suicidal persons are depressed.
Fact: Depression is often associated with suicidal feelings but not all persons who attempt or commit suicide are depressed. A number of other emotional factors may be involved.

Myth: Suicidal persons are mentally ill.

Fact: Many persons who have attempted or committed suicide would not have been diagnosed as mentally ill.

Myth: Once a person has attempted suicide, s/he will always be suicidal.

Fact: After a suicide attempt, a person may be able to manage his/her life appropriately and engage in no further suicidal action.

Myth: Asking "Are you thinking about committing suicide?" will lead the person to a suicide attempt.

Fact: Asking a direct, caring question will often minimize the anxiety and act as a deterrent to suicidal behavior.

Myth: Suicide is more common in lower socioeconomic groups.

Fact: Suicide crosses all socioeconomic group boundaries.

Myth: Suicidal persons rarely seek medical help.

Fact: Studies of persons who have committed suicide indicate that 50% have sought medical help within six months of their action.

Myth: Suicide happens without warning.

Fact: Persons who have attempted or committed suicide usually give some indication of their intended behavior.

Myth: "Good circumstances" prevent suicide.

Fact: Frequently the opposite is true. Physicians, dentists and psychiatrists have high suicide rates.
Myth: Suicide and attempted suicide are the same class of behavior.

Fact: Attempted suicide is a behavior with its own characteristics, not just a failed suicide. It signals a disturbed situation.

Myth: Motives or causes of suicide are readily established.

Fact: Suicide is usually a lengthy and complex pattern of behavior where precise motives are difficult to ascertain.

Myth: Suicide is related to weather phenomenon [sic].

Fact: From studies it appears that neither suicide nor attempted suicide is significantly related to weather phenomenon [sic].

Myth: Improvement in a suicidal person means the danger is over.

Fact: There is a significant danger within the first 90 days after a suicidal person is released from hospitalization.

Myth: Only a mental health professional can prevent suicide.

Fact: Suicide prevention by lay persons and centers has been an important, significant part of suicide prevention activities.

These myths and facts were synthesized from works by Blimling and Miltenberger (1981), Resnik (1968), Resnik and Hawthorne (1973) and Shneidman and Farberow (1961).

If researchers avoid the issue of death, they may also avoid research dealing with death. This avoidance may occur even though potential suicide attemptors are communicating signals: approximately 70-75 percent of the individuals who attempt or commit suicide do give some indicator
of their impending action. Indicators include factors toward self-destruction:

previous attempts, suicidal threats, chronic illness, feeling isolated, grief, financial stress, severe depression, domestic difficulties, alcoholism, chronic use of other chemicals, a family history of suicide, and living alone.73

Overall, there is no single pattern or causative factor in suicide. However, there is the feeling that things are out of control and there is a feeling of hopelessness. These two feelings, hopelessness and things being out of control, are the factors that are indicators for counselors and concerned others regarding suicide. "There is no such thing as an empty indicator— all indicators must be taken seriously."74 The factor of communication is there, if not in verbal form, then in action.

So, failure to keep accurate data makes it difficult for college suicide to be understood. In the study done by John Westefeld and Cynthia Pattillo,75 both of Auburn University, results indicated that only a small number of institutions compiled systematic records concerning suicide. As these authors communicated:

there are no studies dealing with the issue of college and university record keeping in the area

73 Rickgarn, The Issue Is Suicide, 8.
74 Ibid.
of student suicide. In many ways, however, research relating to this topic may be the first step in attempting to answer a larger question of how institutions can effectively respond to the problem.  

Studies have been concerned with student suicide, but most importantly, researchers have also been concerned about the accuracy of data received from colleges and universities... inaccuracy in sample data and uncertainty concerning the estimates of the true suicide rate for student populations emerge as two important areas of concern.  

The startling truth is

There are no studies dealing with the issue of college and university record keeping in the area of student suicide... in many ways, however, research relating to this topic may be the first step in attempting to answer the larger question of how institutions can respond to the problem.

The purpose of Westefeld and Pattillo's 1987 study was to determine whether record-keeping procedures exist in American colleges and universities and, if so, the nature of these procedures. Lack of information about record-keeping procedures at colleges and universities has raised questions concerning current data about suicide causes, demographics, and rates.

Respondents who indicated that their institutions did not keep any kind of systematic records were asked their

76Ibid., 34-35.
77Ibid., 34.
78Ibid.
opinions concerning why such records were not maintained. Responses to this question were summarized in a table, which indicated that concerns about the "difficulty of compiling accurate data" and "confidentiality issues" were the major reasons cited by the counseling center directors for not keeping records about death. 79

It is also significant that 5.5 persons checked the "other" category in responding to this question. When the responses in the "other" category were examined, Westefeld and Pattillo found that the respondents cited diverse reasons. 80 Three reasons, however, were frequently cited: (1) this is a politically controversial issue, (2) it is not necessary, and (3) no one has been asked to do it. The writer notes the feeling of avoidance in these responses.

Even though there are few records of suicide on college campuses, the need for suicide prevention programs on college campuses is well documented. In a recent study conducted at several colleges and universities, 81 percent of students surveyed reported experiencing depression since being at college, 32 percent had thought of suicide, and 1


80 Ibid., 119.
percent of college students had attempted suicide while at college. 81

Although the vast majority of suicidal thoughts do not result in attempts, nor do the majority of attempts result in deaths, there has been a significant increase in completed suicide among people from the ages of eighteen to twenty-four over the past few decades. 82 Research indicates that suicidal thoughts are not uncommon for college students under stress. In fact, these thoughts can be grouped with other self-destructive thoughts such as self-deprecation, unrealistic self-demands, perceived helplessness, "all or none" thinking, and doom predicting, all of which contribute to ineffective coping and pave the way for self-destructive behaviors.

Withdrawing from others, acting aggressively, abusing food, alcohol, or drugs, and attempting suicide are all self-destructive behaviors that students may employ in an ineffective attempt to deal with stress or to solve problems. 83

The issue that suicide research examines death in an abnormal population was challenged in a 1984 study by

81Ibid.


Campana et al. which looked at suicide in a normal population. A large population of college students filled out a questionnaire regarding suicidal thinking and behavior. Results showed that 39 percent of the subjects had seriously considered suicide, and 8 percent had made a suicide attempt. Females were significantly more likely to have thought about suicide during the previous year, but males were as likely as females to report using suicide as a threat or manipulation.

Although past research indicates that suicide projectors have higher rates of suicidal thinking, the fact that 62 percent of this sample were projectors raises questions about the validity of the projective method. However, more importantly, Campana's studies revealed a need for further research concerning the occurrence of suicidal thinking and suicide attempts among young adult nonpsychiatric populations.

Nonhealthy expectations, hopelessness, and loneliness, as well as poor communications, are significant. Westefeld, along with Whitchard and Range, later invested

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84Mary Campana, J. Gibson, Bruce Bailey, and Jerry Laskey, "Suicidal Risk Among College Students," Paper presented at the Annual Convention of the Texas Psychological Association as part of the Sixth Annual Undergraduate Student Merit Research Competition, 1984.

85Ibid.

86Ibid., 5.
his time into research on death and youth. In reasons for attempting suicide, Westefeld and Farr concluded that hopelessness and loneliness are the critical factors.87 Indeed, a number of other researchers have found that these two factors are very important in understanding the reasons for suicidal behavior.

Rosenkrantz concluded in a statistical analysis of suicide among middle to late adolescents (ages fifteen to twenty-four) that a perceived loss of love and intimacy is a critical factor in predicting suicidal risk.88 Cole developed a linear structural equation that revealed hopelessness is related to suicide attempts, even after controlling for depression and social desirability.89

Suicide is a growing and alarming concern in American society. Dixon, Heppner, and Anderson reported that approximately "28,500 people will commit suicide in 1991."90 In essence, these statistics reflect the inability

87Westefeld and Farr, "Suicide and Depression," 119-123.


to cope with the myriad of life demands, problems, and hassles. Moreover, issues relating to suicide are of consider- able interest to therapists, with regard not only to protecting clients but also to understanding the interpersonal and intrapersonal dynamics pertaining to suicide.

As mentioned before, the dynamics of taking one's life lend information to the seeds of holding onto life. As Dixon, Heppner, and Anderson discovered, suicidal individuals report four times as many negative life events preceding their suicide attempts as do nonsuicidal people, and 1.5 times as many negative life events. This increase in negative events reflects the number of such events reported by depressed people, as well, prior to the onset of depression. Furthermore, this relationship has been found to exist independently of age, sex, and social class variables.

Although there is an established relationship between stress and suicidal behavior, many of the people who are under stress do not make attempts on their lives. Thus, it seems likely that some variables exist which, in

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combination with high stress levels, make suicide more or less likely to occur.93

Again, the factor of hopelessness is apparent in suicide literature. The belief that high levels of stress, in combination with suicidal behavior, will lead to attempts on life has been researched as well. Other researchers have developed a diathesis-stress-hopelessness model of suicidal behavior.94 According to this model, problem-solving variables may moderate the effects of stress on hopelessness, which in turn lead to the occurrence of suicidal ideation.

Thus, when people who are deficient in problem-solving abilities are exposed to naturally occurring conditions of high negative life stress, they are cognitively unable to develop effective alternative solutions necessary for adaptive coping which in turn results in hopelessness. This hopelessness is then assumed to put the individual at an increased risk for suicidal behavior.95 Schothe and Clum tested this hypothesis by examining the relationship between problem-solving skills, negative life stress, hopelessness, and suicide ideation in a college population. Poor


problem solvers under high negative life stress were found to be significantly more hopeless and significantly higher in suicidal intent than any of the other groups.  

Schothe and Clum also evaluated problem-solving skills in suicidal hospital patients and nonsuicidal patients. Results indicated that "the suicidal group was significantly less able to generate alternative solutions to problems and to evaluate negative consequences of alternative solutions than were the nonsuicidal hospitalized patients." Thus, preliminary research supported Schothe and Clum's diathesis-stress-hopelessness model of suicidal behavior.

In an extended investigation of the research on Schothe and Clum's model, other problem-solving variables were examined. Within the coping and problem-solving literature, a variable that has received increased attention is the cognitive appraisal of one's ability to solve problems. Butler and Meichenbaum initially suggested that one's problem solving may be an important variable in the

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97 Ibid.


problem-solving appraisal, as measured by the Problem-Solving Inventory (PSI), that is associated with a wide range of cognitive, behavioral, and affective variables related to problem solving as well as with various indices of psychological adjustment (e.g., Heppner and Anderson).100

The results of these studies reveal that suicide can be conceptualized as an inability to adapt to life's demands. Results from these two studies indicate that high negative life stress and self-appraised ineffective problem solving are associated with higher levels of hopelessness and suicide ideation... More specifically, individuals under higher levels of stress reported significantly more hopelessness and suicidal thoughts than individuals under lower levels of stress. Likewise, self-appraised ineffective problem solvers reported significantly more hopelessness and more suicidal thoughts than self-appraised effective problem solvers.

Our results suggest that difficulty in adapting to life's demands, as reflected in hopelessness and suicide ideation, is not only a function of the demands or stressors (specifically, negative life events) but also a function of the perceived problem solving ability (i.e., a particular resource) that the individual brings to his or her responses to stressors.101

Thus, the diathesis-stress-hopelessness model, which found individuals deficient in problem-solving skills to be at an increased risk for suicidal behavior, is supported and lends


credence to the improvement of problem solving as intervention, as well as the possibility of stress-management strategy.\textsuperscript{102}

**College Suicide**

A unique revelation in this study which has significant implications for educational services and personnel on the college level is that students with suicidal thoughts were less likely than other students to have received training on how to deal with problems and emotions. This finding provides essential information that can be used to help colleges organize a built-in suicide prevention and life coping program. Student services can use these findings to develop an instrument for measuring the frequency of suicidal thoughts among incoming students.

Required seminars on coping and suicide could be given during freshman orientation. Sartore emphasized that the likelihood of suicide can be decreased by educating students about the causes, symptoms, and alternatives to suicide when they are faced with major problems.\textsuperscript{103}

Students entering college frequently have been accustomed to their parents making many of their decisions for them, and they are suddenly thrust into an environment

\textsuperscript{102}Ibid., 55.

in which they are expected to handle themselves. Mechanic stated clearly that if schools and other forms of preparation do not adequately help students cope with their problems, then personal failure and social disruption are inevitable.\textsuperscript{104}

College students are a targeted group for research in that they dwell in a "simplified environment." As Alan Lipschitz so poignantly expressed in his recent monograph:

> College students dwell in a privileged and sheltered world, and suicide is the most visible sign of their unhappiness. If we focus on college suicide as a target for intensive scrutiny, it is not to deny that any adolescent daunted by visions of a hostile world deserves to receive therapeutic attention for his or her miseries, whether they be fatal or not. On the contrary, we can hope that by identifying what provokes suicide in this simplified environment, we will better understand the psychic pain suffered by those who are not so protected by the demands of the world.\textsuperscript{105}

Because students are the most important resource on the college campus, an investment of time and money in research on these students has no need for justification.

Just as an interjection regarding thinking processes and problem-solving research, the author has done a great deal of research on creativity. In-depth study of E. Paul Torrance's "suprarational thinking process" addressed


\textsuperscript{105}Alan P. Lipschitz, \textit{College Suicide: A Review Monograph} (American Suicide Foundation, 1990), 2.
similar problems in the coping behavior and thinking processes of many students. Basically, most students are trained by teachers who have been taught to memorize and regurgitate material. With this type of learning, the teachers in schools tend to teach students this same two-way process. Low scores on GREs and SATs have driven educators to try to understand why.\textsuperscript{106} Specifically, between 1966 and 1986 verbal scores on SAT tests dropped 36 points, and math scores on SAT tests dropped 16 points.\textsuperscript{107}

Paul Torrance addressed "suprarational thinking" as process oriented rather than the rote memorization methods of linear thinking. Comprehension requires a different type of thinking than simple recall. It requires an understanding of the content of the material so that the reader has to think through the facts and come up with certain truths from this understanding. It requires that the learner use his or her mind to work through and interpret material.

In general, instructional methodologies have emphasized almost exclusively the rational processes, i.e. recalling and imagining, classifying and generalizing, comparing and evaluating, analyzing and synthesizing, deducing and inferring. Little or no attention has been given to the problem of setting in motion the incubation processes that seem to be necessary for seeing new connections, enlarging, enriching, and making more


accurate one's insights in solving immediate and future problems. 108

Basically, Torrance's suggestions regarding traditional thinking and learning processes reflect the thought patterns of students who break down when stress and high negative conditions in life are experienced. The author suggests that the group intervention sessions with "suicidal" students encompass problem-solving strategies that address more creative and less linear, tunnel-visioned nature. These thoughts have relevance for students on the college level.

African American Suicide

The idea that the African American man, as a species, is endangered has become a phrase that may be thrown around among professionals and researchers. The response of counseling and intervention strategies as mental health professionals to this "endangered species" has also been slow. As such, the current status of African American people (particularly men) is one of the "least recognized and effectively addressed issues in terms of counseling programs." 109


The literature on African American suicide follows certain basic divisions. Sections on themes describing African American men, trends of suicide, models of African American suicide, African American youth suicide, and family influence follow.

**Themes Describing African American Men**

Over the years, research on African American men has changed over time. Beginning research was focused on African American men as having low self-esteem, being sexual superstuds, being female dominated, and having the greatest potential as athletes. Conversely, other authors have seen them as having intact self-concepts, being strong role models, and being good husbands, providers, and fathers. However, the theme that a whole race of people is endangered by society and the world that man has developed is still prevalent. This is typified by the title of Parham and McDavis's article, "Black Men: An Endangered Species: Who's Really Pulling the Trigger?"

**Trends of African American Suicide**

This section of the literature review outlines the various developments of African American suicide, reporting from the time that African American youth may have become a

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110 Ibid., 24.

111 Ibid.
target population. Robert Davis addressed the increase in African American male suicide in his 1979 review of suicide and its implications to mental health professionals. He documented suicide as the third leading cause of death among African American males, after accidents and homicide, in the eighteen to twenty-nine age group. This statistic surpasses the traditional research of African American suicide which targeted African American females. African American males accounted for 27 percent of the African American suicides nationally between 1970 and 1975, while young African American females accounted for only 8.3 percent. The rate of suicide among young African American men has risen over the past decade to the point of approximating and sometimes surpassing that of their white male cohorts, which is also well above average. The rise has been greatest among African American males aged twenty to twenty-four (15 percent) and twenty-five to twenty-nine (42 percent).

The data in table 1 clearly indicate that the suicide rate among young African American males has been rising steadily since the early 1960s. As seen in the data for the

112 Robert Davis, "Black Suicide in the Seventies: Current Trends," Suicide and Life Threatening Behavior 9, no. 3 (Fall 1979): 131.
114 Ibid.
Table 1
Suicide Rates of Black Males per 100,000 Population, 1947-1977

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<td>12.9</td>
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*Rates for 1972 are based on a 50 percent sample of death certificates.

period 1947-1977, the highest suicide rate among African American males was recorded among the oldest age groups. Hendin reported a similar rise in African American male suicide as early as 1969: "Suicide is twice as frequent among Negro men between 20 and 35 as it is among white men." The data in table 1 indicate also that in the most recent decade suicide has become a growing menace to young adult African American males. This threat is particularly acute because in the African American community programmatic efforts in suicide prevention have been focused primarily on the female population. Although the trends shown in table 2 do not necessarily predict past or future years, they indicate that the suicide rate of African Americans increased slightly (2 percent over the six-year period). Among African American males the suicide rate increased by 7 percent, whereas the rate for African American females declined 16 percent. Indeed, significant declines occurred among metropolitan females at all but the oldest age levels.

Consistent with earlier findings, significant increases occurred among African American males in their twenties. Within the eighteen to twenty-five age group the suicide rate increased 13 percent (from 18 to 20 per


## Table 2

### Age-Specific Suicide Rates, by Sex, per 100,000 Metropolitan Black Population

<table>
<thead>
<tr>
<th>Age and Sex</th>
<th>1970</th>
<th>1975</th>
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<tr>
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<td>Males over 34</td>
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<tr>
<td>Young Females under 35</td>
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<td>Females over 34</td>
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</table>

**Source:** Robert Davis, "Black Suicide and Social Support Systems: An Overview and Some Implications for Mental Health Practitioners," *Phylon* 43, no. 4 (December 1982): 309.
10,000); the increase was 17 percent (from 23 to 27 per 100,000) in the peak range of twenty-five to twenty-nine. African American males under thirty-five experienced 13 percent increase in rate; the rate for those over thirty-four declined by 5 percent.

Clearly, this phenomenon, which may be read as symptomatic of deeply embedded social problems, has serious implications for the African American population. These suicide statistics represent not only a tragic loss to bereaved family and friends; they also represent an acute loss of human resources when the African American community is deprived of youthful manpower, the benefits of earned wages, procreative and nurturing sources, and a lot of other contributions that these individuals might have made to society.\footnote{117}{Davis, "Black Suicide and Social Support," 369.}

To accent these findings, the Department of Health and Human Services reported:

> Of two million American deaths per year, roughly twelve percent are Black. Between 1979 and 1981, an average of 227,000 Blacks died each year. Of these, 139,000 Blacks were under the age of 70 years. About 59,000 of these deaths among Blacks under age 70 would not have occurred had Blacks experienced the same age-sex death rates as Whites. These "excess deaths" represent 42.3 percent of all Blacks who died before the age of 70.\footnote{118}{Black and Minority Health: A Report of the Secretary's Task Force (Washington, DC: Department of Health and Human Services, 1985).}
A comparison of average annual age-adjusted death rates for males and females from all causes for the period 1979-1981 is shown in figure 3.

Separate from the basic excess in African American suicide, Spaights and Simpson noted special trends in African American suicide, as unique from white suicide.\footnote{Ernest Spaights and Gloria Simpson, "Some Unique Causes of Black Suicide," Psychology: A Quarterly Journal of Human Behavior 23, no. 1 (1986): 2-3.} Suicide among African Americans occurs predominantly in younger males, peaking between adolescence and young adulthood, whereas suicide among whites increases with chronological age. The battle to overcome discrimination has only made the African American population move upward on the economic ladder, which allows for more justice but, on the other hand, erodes African American cohesiveness. African Americans tend to blame themselves if they fail chances to move up this ladder. Without discrimination, the projection of failure and anger is turned inward; they blame themselves for failure, whether or not they should.

The effects of discrimination, which haven't been totally eliminated, still plague the young. The major emotional sets that predicated suicide are anger and low self-esteem. When the subject has various failures in family, friends, and other societal interactions, low self-esteem occurs. The hopelessness and powerlessness feelings
Fig. 3. Average annual age-adjusted death rates for all causes, 1979-1981.

Note: Death rates for Hispanics are not available. Death rates for Native Americans and Asian/Pacific Islanders are probably underestimated due to less frequent reporting of these races on certificates as compared with the Census.

of negative interactions lead the subject to the more powerful emotion of depression.  

Basically, Spaights and Simpson entitled their article "Some Unique Causes" because there are certain factors that exist in the African American culture that are separate from white culture. Along with changes in politics and guidelines governing the legality of discrimination, African Americans have legally been freed from discrimination. However, with this legal realization, attitudes and self-image do not immediately change. Besides this undercurrent of attitude is the responsibility of the "freed" African American to enter the assumptive powerful messages of the white culture, and these messages are not that healthy, either.

As the African American tries to keep up with the incessant and relentless demands of "upward mobility," the once strong fabric of the African American culture erodes. Family and race cohesiveness of the African American as "against white discrimination" can no longer band together. And, just as well, the expectations of the African American male are unique when compared to the white male.

Black males are expected to be tough, control their feelings, be "cool," be guarded, and respect

\[\text{120 Spaights and Simpson, "Some Unique Causes of Black Suicide," 2.}\]
their parents and black elders... all to a greater extent than is common in the white population.121

Because expectations of the African American male involve turning feelings inward, it can create an emotional makeup ripe for suicide.

As other African American male role models which exemplify virtues such as gentleness, sensitivity, and compassion, become available, old expectations may break down, helping to decrease African American suicide.122

Historical roots of obedience imposed by black culture are another factor to consider. Just as slave owners insisted on strict obedience from their slaves—blacks have internalized expectations of strict obedience in their relations with their own children.123

While teaching respect is not in itself a bad thing, the demand for respect sometimes involves harsh punishment. African American language conjures images born out of slavery: "She gonna beat you," "You wanta whippin?" This type of treatment is expressed in corporal punishment, which is often a standard practice in African American childrearing, passed from generation to generation. Its roots are planted in slavery, and it acts to repress a certain amount of the child's natural expression. These children find it

123 Grier and Cobbs, Black Rage.
difficult to rebel against parental demands for strict obedience, and this leads to a risk for suicide.

The trends seen so far are Davis's statistics which pinpoint, first, African American male suicide as the third leading cause of death among African American males, after accidents and homicide, in the eighteen to twenty-four age group. Secondly, Davis followed this study in 1979 with a study in 1981, which found the rate of suicide among young African American men had passed the rate of their white male cohorts, which is well above average. The rise has been greatest among African American males aged eighteen to twenty-four (15 percent) and 25-29 (42 percent).

These trends are shown in tables 1 and 2, previously presented. The data in table 1 indicated that in the most recent decade suicide has become a growing menace to young African American males. These results are highlighted because previously suicide was only related to African American females. Table 2 statistics showed a decline in female suicide but a rise in young African American male suicide. Statistics indicated the suicide rate of African Americans increased slightly (2 percent over the six-year period). Among African American males, the suicide rate increased by 7 percent, whereas the rate for African

124 Davis, "Black Suicide in the Seventies," 131.
American females declined 16 percent. The next section of this literature review turns to theories of African American suicide.

Theories of African American Suicide

Theories of suicide include general understandings of suicide to the powerful components that African American suicide theories convey. Emile Durkheim is probably the most famous philosopher on suicide. Durkheim's law states that suicide varies inversely with the degree of integration of the individual with the group. Proponents of this theory maintain that a disruption of social relations is the primary causal factor in suicide.

The precursor of theory on human behavior was, of course, Sigmund Freud. He believed that the act of suicide is directed against another person with whom the individual has identified. Alfred Adler, who disagreed that all behavior is sexual, gave credence to Durkheim's theory. Adler suggested that suicide results from a lack of social relations, which makes life purposeless. The author supports this need for social integration, including the targeted suicide victim and the family. The following theories are documented by Robert Davis.

127 Ibid.
128 Ibid., 310.
The following theories are unique to African American suicide:

1. According to Status-Integration Theory:

As blacks try to get rid of racism, they try to maintain an identity with middle and upper class people—they inherit the problems we have as whites: competitiveness and one-up-one stepping.\(^{129}\)

This inheritance makes the problems of adjustment and assimilation into the American mainstream more intense. A corroding sense of internal alienation results in self-destruction.\(^{130}\)

2. The Frustration-Aggression Hypothesis postulates that compounded urban stresses (or frustration aggression) associated with migration, poverty, unemployment, racism, poor housing, and poor education result in violence which often, though not always, takes the form of suicide.\(^{131}\)

3. The Black Family Deficit Theory portrays the African American family as being unable to meet the fundamental needs of its members for survival, socialization, and transmission of a viable cultural heritage.\(^{132}\)

4. The External Restraint Theory speaks more directly than any of the above theories to the concentration

\(^{129}\)Ibid.

\(^{130}\)Ibid.

\(^{131}\)Ibid.

\(^{132}\)Ibid.
of suicide among African Americans. This theory holds that suicides vary inversely with the restraining factors such as low social status and the insulation that strong communal and familial ties provide. This model postulates restraints which have previously tended to produce a solidarity among African Americans—for example, the stresses of overt racism and discrimination—have weakened for young African Americans.

Recently, there has been an increase in social opportunities (more prestige, better jobs, higher education, etc.) and social status among blacks. Generally, speaking, young black males and females have experienced an uplifting of goals, aspirations, and expectations as a result of the perceived changes toward greater opportunities within American society. Concurrently, this loosening of restraints has produced a false sense of freedom and security that has led to individualism and utilitarianism, which have tended to loosen or weaken the communal and family ties previously serving as a buffer against suicide.133

Youth Suicide

Within these aforementioned comments on African American suicide, the author turns to youth suicide. As noted by Gibbs, suicide among African Americans has become a youthful phenomenon.134 At a time when they should be developing an identity, exploring career options, or

133Ibid., 311.

beginning a family, too many young African Americans are destroying themselves. This study, by far, reveals limited conceptual approaches, few clinical investigations, and even fewer empirical studies of this group.

Family and communal ties tend to have their greatest influence on children and youth. In an age when the foundation of society, based on the institutions of the individual and society, has changed marriage relationships from permanent and lifelong status to unions existing for the pleasure of the two parties, the norm of the nuclear family has been changed.

Most children today have two or three sets of parents. There is no right or wrong in this issue; it is simply a reality. "With the acceleration of the divorce rate from the mid 1960s to the early 1990s, family structures other than the nuclear family type are rapidly proliferated." ¹³⁵

Of course, the traditional marriage is as popular as ever. Approximately 390,000 people marry each year, and this figure has held constant over the past thirty years.¹³⁶ On the basis of current practice, 79 percent of men and 84 percent of women are expected to marry at least once before


their fiftieth birthday, a gender discrepancy perhaps reflecting demographic trends where women of demographic age are beginning to outnumber men. Couples do not seem to be daunted by the fact that he can expect to live to age seventy-two and she to age seventy-seven.

The Factors of Family on Suicide

Family disorganization is a key factor in suicidal behavior. Most suicides among females occur in families where the father is either physically or emotionally absent on a continual basis. In general, lack of family support and the loss of a loved one are key relationships of the family to suicidal behavior. Isolation from either or both parents creates a situation which reflects the self-esteem of the children. It gives cause for anger and leads to depression.

In addition, the level of communication, particularly in the area of expression of feelings, is extremely important. An absent father increases the chance that the child will have no one who will listen.


The Family and the Culture of African American Males

The expectations of African American males by their culture are extremely tough and unique. They extend from family and cultural focus. African American males are expected to be tough, control their feelings, be "cool," be guarded, and respect both the parents and African American elders, all to a greater extent than is possible by the white population. As mentioned before, because expectations of the African American male involve turning feelings inward, an emotional makeup ripe for suicide is already put together. The demands of a minority are the same—to turn feelings inward.

To close this review on African American suicide, with a special focus on youth and the family, the author pulls in an all too familiar expert on adolescence and identity development, Erik Erikson. Erikson asserted that identity is a major issue of adolescence and young adulthood. This struggle makes a difficult time for those going through it and will have a large impact on self-esteem.

Ross noted:

Adolescence is also a period of transition between childhood and adulthood. To become an adult, the child must "put away childish things." He must give us his dependence and become an autonomously functioning individual; he must search for his identity and also for the path that will allow him to express that identity through relationships and career. These are the historical tasks for

141Grier and Cobbs, Black Rage.
adolescence, but today's teenagers must accomplish this while their world is shaken by social tremors which seriously strain their traditional support systems. The families of these teenagers are likely to be extended, not by grandparents or aunts and uncles, but by divorce and remarriage. Those who traditionally offered him support, guidance, and experience are likely—in these "reconstituted" families—to be distracted from his needs by the dilemmas arising from their own changing roles and relationships.142

For African American youth, the adolescent stage brings this need for identification, but it may be difficult to identify with their race if they have characteristics that their peers deem too "white."143 Instead, youth see gangs and drug abusers as peer identification models. Drug use provides the withdrawal and escape that are two symptoms of suicidal behavior,144 and gangs provide a crude system of support for their members145 but can create a tough social existence for those who are on the bottom rung of the hierarchy, as well as exerting a powerful influence on those who are not members. The opportunities for positive social interaction, especially in the ghetto, are therefore


144Getz, Myers, and Linder, Brief Counseling with Suicidal Persons.

145PBS, "Nova," 23 November 1992, 11:00-12:00 p.m.
limited. It is no wonder that suicide, symptoms of suicide, and communication of suicide should exist.

**Suicide Among International Youth**

The issue of African American suicide among adolescents and young adults is heavily poignant if it crosses intercultural and international lines and barriers. Several studies deal with this issue.

The first study points out suicide in youth from a cross-cultural perspective. David Lester found:

changes in the overall suicide rate from 1970 to 1980 were significantly related to the suicide rates in 1970 (r = .53, p = .001). Thus, countries with higher suicide rates experienced a greater absolute increase in their suicide rates from 1970 to 1980. The significant finding was that for youth suicide rates, the analogous association was not significant (r = .03). This lack of association was also found for both the male and female youth suicide rates.\(^{146}\)

The final comments of this study were:

A search for elements of the youth suicide rate revealed that variables which correlate with the overall suicide rate of a country (such as the quality of life and the change in the suicide rate) are not significantly related to the youth suicide rate.

The most important aspect of this study is that the failure to find significant correlates of the youth suicide rate suggests that different factors account for youth suicide internationally.\(^{147}\)


\(^{147}\)Ibid.
In the second study, A. A. Leenaars et al. discussed the myths or "fables" of suicide in Canada:

1. **Fable:** People who talk about suicide don't commit suicide.  
**Fact:** Of any 10 persons who kill themselves, 8 have given definite warnings of their suicidal intentions.

2. **Fable:** Suicide happens without warning.  
**Fact:** Studies reveal that the suicidal person gives many clues and warnings regarding his suicidal intentions.

3. **Fable:** Suicidal people are fully intent on dying.  
**Fact:** Most suicidal people are undecided about living or dying, and they "gamble with death," leaving it to others to save them. Almost no one commits suicide without letting others know how he is feeling.

4. **Fable:** Once a person is suicidal, he is suicidal forever.  
**Fact:** Individuals who wish to kill themselves are suicidal only for a limited period of time.

5. **Fable:** Improvement following a suicidal crisis means that the suicidal risk is over.  
**Fact:** Most suicides occur within about three months following the beginning of "improvement," when the individual has the energy to put his morbid thoughts and feelings into effect.

6. **Fable:** Suicide strikes much more often among the rich—or, conversely, it occurs most exclusively among the poor.  
**Fact:** Suicide is neither the rich man's disease nor the poor man's curse. Suicide is very "democratic" and is represented proportionately among all levels of society.

7. **Fable:** Suicide is inherited or "runs in the family."
Fact: Suicide does not run in families; it is individual in pattern.

8. Fable: All suicidal individuals are mentally ill, and suicide always is the act of a psychotic person.

Fact: Studies of hundreds of genuine suicide notes indicate that although the suicidal person is extremely unhappy, he is not necessarily mentally ill.\textsuperscript{148}

These authors described their research this way:

Based on the previous literature . . . , it is hypothesized that many Canadians believe the myths about suicide but that their knowledge is above chance level (i.e., 50\%). Three studies will be undertaken: first, the prevalence of specific myths and facts in a large sample—the largest sample reported in the literature to date—of Canadian university students; second, the difference in the prevalence of specific myths and facts in a number of different demographic samples such as student versus nonstudent, university student versus high school student, male versus female, and two different Canadian cities; and third, a follow-up study of subjects provided with correct information regarding facts and myths will be reported to evaluate memory for such information.\textsuperscript{149}

The results of their study revealed higher levels of understanding than previous suicidal behavior is accountable for.

The facts about suicide are frequently not even heard, or even responded to before the act . . . previous research of primary caregivers and other rescuers indicated that there is a lack of sufficient knowledge in such individuals. It follows that the ultimate prevention of suicide is public and professional education.\textsuperscript{150}


\textsuperscript{149}Ibid., 197.

\textsuperscript{150}Ibid., 201.
The author chooses to include the following data regarding international suicide:

The use of log-linear models [e.g., Likert type items] for investigating differential item functioning (DIF) associated with examinee/respondent background characteristics were examined. The likert-type items used in this study were drawn from a 36-item self-report measure—the Suicide Probability Scale. Specifically, log-linear models were used to investigate whether contingency tables for ethnicity (55 African Americans, 186 Anglo Americans, and 189 Hispanic Americans) or gender (332 males and 627 females) by item response of mental health status suggested avoidance or an interaction between the background variable and item response.

Specifically, Dancer et al. found that "plots show that most of the interaction comes from respondents whose mental health status is diminished. In general, log-linear models were found useful for investigating DIF."151 In summary, overall, to be of color in this society will bring more interaction of Likert-type variables. The more ethnicity, the greater complexity of variables to cope with.

The author pulls on one final study which points out that there are multiple causes for suicide. The greater the diversity of societal expectations and reality, the greater is the risk of suicide.

Just as African American males (ages fourteen to twenty-four) show higher increases of suicide, so do older

white men. The issues seem to magnify the female archetype. Traditional means of self-esteem, such as being the breadwinner for the family, once experienced by African American males and older white males have rapidly changed. The feminine archetype, a universal change in the role of the family, has challenged this "role" of the male.

The same expectations of males are seen in whites. With these expectations changing, the ego of African American young males, as well as present older white males, is confronted. Both see roles of the male (African American or white) changing. Spaights and Simpson found:

First, black suicide peaks during adolescence and early adulthood. Second, in the peak age range of 20-34 years, suicide occurs primarily in males at a ratio of four to one over females . . . . In contrast, suicide within the white population increases with chronological age.

These researchers found suicide rates in young African American males and older white males rising if the change of role is too shocking for the ego. Perhaps a person only relates to his or her identity as a role, not understanding or having any knowledge of deeper identity.

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154Ibid.
Over the past several years, suicide among youths in the United States has received considerable attention. According to May, since the late 1950s, youth suicides have tripled, increasing from 4.5 per 100,000 in 1958 to 12.0 in 1985. The numerical increase in this period was from 1,000 to 5,000 deaths per year.

May studied the suicide rates among American Indians and Alaskan Natives as compared to the general U.S. population. He found suicide rates in these two groups to be more than double the rates in the general population among the age group 10-24 (see table 3). A vast majority of all Indians who attempt suicide are under age twenty-five, and almost half are under twenty years old. Those who attempt suicide appear to be quantitatively and qualitatively different from those who complete suicide.

Specifically, far more people attempt suicide (about thirteen to each suicide) than actually kill themselves. While most Indians who kill themselves are male, most of those who attempt suicide are female. The method most commonly used is an overdose of medication, while only about 2 percent of deaths occur by these means.

156Ibid., 52.
Table 3
Age Specific Suicide Rates per 100,000 Population of U.S. Indians and Alaskan Natives (1980-82) and the U.S. General Population (1981)

<table>
<thead>
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</tr>
<tr>
<td>20-24</td>
<td>35.4</td>
<td>15.6</td>
<td>2.3</td>
</tr>
<tr>
<td>All ages</td>
<td>19.4</td>
<td>11.5</td>
<td>1.7</td>
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An important factor to remember when working with Indians who have attempted suicide is the extenuating nature of the minority status and the less advantageous social conditions generally faced by the patient. An Indian youth and his or her family may have been subjected to greater levels of social stress and disruption, leaving fewer resources to draw upon in therapy.

Basically, international youth or, for that matter, intranational youth--young people who have moved to the USA to find pure expression of their identity--find discrimination as part of this society. American Indian youth find the same.
Intervention

General

The major concerns for suicide among counselors and educators stem from both self and client preservation: one's license might be revoked or a client's life taken. The issues of suicide tend to be avoided by the helping professional in that the question of death is apparent as well as the question of the failure of ability to "help" or be of "value" to someone else's life.

In that a weakness of "helpers" is to feel that they are "helpful," the defense to avoid or the coping mechanism to deny possible failure is very possible. When therapeutic work is only minimally successful and often frustrating, the chances of experiencing disillusionment are particularly high. When counselors work with depressed, homicidal, and suicidal clients, the stakes are particularly high for self-acceptance and validation. Any hint of suicide or depression immediately presents failure on that helper's part, and thereby the counselor may unconsciously avoid signals of depression or suicide. "Professional helpers need to see that what they do is worthwhile, yet the nature of their profession is such that they often don't see immediate or concrete results."157

This lack of reinforcement can have a debilitating effect as counselors begin to wonder whether anything they do makes a difference to anyone. The danger of burnout is all the greater if they practice in isolation and have little interchange with fellow professionals. So, first of all, the counselor, educator, or helper must deal with self. Harvard Medical School has produced an article, "Determining Suicide Risk." J. T. Maltsberger, M.D., found the following significant information:

Clinicians must decide whether to admit suicidal patients to a mental hospital or send them home. They also have to decide whether to discharge hospitalized patients or hold them, and whether to warn others or not. Many clinicians base these decisions almost entirely on the patient's current suicide state. In a long term study of suicide and suicide attempts, my colleagues and I have shown danger with that.158

Most mental health professionals know that some patients mask serious depression with smiles and false cheer. However, not all know that even in someone who is obviously severely depressed, improvement in mental state sometimes heightens the risk of suicide, because the patient is no longer paralyzed by misery. It is also easy to overlook the fact that many patients who commit suicide are not suffering from severe mood disorders.

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Among psychiatric inpatients, most suicides are schizophrenic; in general hospitals, some suicides are in a state of delirium from alcohol or other causes. Persecutory psychoses of all kinds culminate in suicide: some patients kill themselves to escape imaginary enemies and others in response to hallucinated commands. And even if the psychosis clears, it may be followed by suicidal despair.

In general, to give feedback to the author's original comments that counselors may fear encountering some clients considering death, Rickgarn wrote:

My work with suicidal individuals and reading on the subject have significantly contributed to my professional development—in a number of ways.

1. I have come to understand that suicide is indeed a very highly personalized act. Statistics and demographics provide patterns and information. It is the individual who has come to discuss his or her suicidal thoughts and behaviors, however, who is important, and that individual may or may not fit a pattern or statistic.

2. It has also become painfully clear that in spite of all my efforts, the individual may still choose to commit suicide . . . . I am responsible for doing what I can to deter that suicidal behavior . . . then, that individual's life is their responsibility, even as my life is my responsibility.

3. I have learned that suicide is very frightening to people. Often this fear not only precludes a discussion of suicide with an individual who is crying out for help . . . but it may well lead to a greater isolation of the suicidal individual and contribute to his or her suicidal actions.
4. I have chosen to become an educator in the field of suicide: Prevention, Intervention, and Postvention.\textsuperscript{159}

It is from these previous comments that the author secures certain elements for the counselor or helping professional who deals with clients who are considering death:

I hope that I can aid in dispelling mythologies that prevent positive intervention with suicidal persons. This work has brought me into contact with students in elementary, secondary, and college settings, as well as with adults in several arenas.\textsuperscript{160}

**Adolescent Suicide Intervention**

The section on adolescent suicide prevention adds to the section on adolescent suicide. Since each study's findings are unique, the researchers suggest intervention that is appropriate to that particular study's findings. The researcher summarizes with a section of her choice of possible intervention for this study.

In the first study, Phi Delta Kappa researchers found that young people seldom kill themselves without a previous psychiatric disorder.\textsuperscript{161} Precommunication elements include: (1) previous expressed suicidal ideas, (2) threats of suicide or previous attempts, (3) engagement in alcohol

\textsuperscript{159}Rickgarn, The Issue Is Suicide.


\textsuperscript{161}Strother, "Practical Applications," 756.
or drug abuse, and (4) histories of antisocial behavior. The parents of suicidal children themselves had parents who were "less nurturing and more prone to problems with drug abuse."

However, throughout all these symptoms, Dr. Cynthia Pfeiffer found that depression was the major symptom and was linked with severe suicidal behaviors for childhood and adolescent suicide. Berman found that depression was the most important signal of a child at risk.162

Prevention conclusions were made by Garfinkel, another Phi Delta Kappa researcher:

Garfinkel recommends that the topic of suicide not be directly addressed. He recommends instead discussions that develop communication skills, assertiveness, and coping techniques that counteract the tendency of suicidally depressed people to passively avoid problems.163

In a later study done by Franklin Nelson and his colleagues, whose paper was presented to the American Association of Suicidology/International Association for Suicide Prevention, the factors or reasons for suicide were found to be multiple: (1) vulnerability arising out of depression and other forms of psychopathology, (2) family dysfunction and conflict, (3) problems with interpersonal relationships,

162Ibid., 757.
163Ibid., 758.
(4) drug and alcohol abuse, and (5) peer-related pressures and conflicts.164

The interventions that were mentioned as potential solutions to the youth suicide problem were:

availability of social support from concerned persons and the availability of formal counseling and educational programs ... and it was the opinion that programs that tend to decrease vulnerabilities, decrease stresses, and increase support systems would be helpful in preventing suicide.165

Garfinkel, a medical doctor, was joined by Jack Frymier in 1988 in another study which Phi Delta Kappa conducted specifically dealing with understanding and prevention of teenage suicide. Frymier and Garfinkel found that the number of U.S. youngsters who kill themselves had jumped 300 percent.166 The three major reasons for suicide were: (1) family breakdown, (2) a youth's unemployment, and (3) decreasing religious observance among the young.

Garfinkel saw patterns of youngsters who commit suicide as youngsters who are isolated and who passively avoid issues and demands placed on them. Signs of this pattern may be: (1) deteriorating academic performance,


165 Ibid., 7.

166 Garfinkel, quoted in Frymier, "Understanding and Preventing Teen Suicide," 292.
(2) trouble complying with rules in school or at home, and
(3) avoidance of association with one's peer group.\textsuperscript{167}

Frymier and Garfinkel found that youngsters deal with problems with solutions that give them temporary relief, such as experimentation with drugs and engaging in thrill-seeking behavior. Garfinkel saw that these youngsters have difficulty with growing up. He commented:

One of the things that we would like to achieve is for youngsters to be able to monitor themselves . . . to recognize when they are under stress or when they are beginning to feel depressed. Instead of letting the pressure build until they need massive amounts of help . . . young people could then seek help sooner . . .

Yes, we'd like to see young people replace ineffective coping styles with coping mechanisms . . . to be able to adapt to stress and feelings of depression . . . or replace ineffective coping mechanisms with coping mechanisms.\textsuperscript{168}

Another important and effective method of coping is communication: "assertive, direct, and clear communication when one is troubled is a central goal of those of us who are trying to help troubled youth."\textsuperscript{169} If problems arise, we would like them to become logical problem solvers . . . so that when personal problems arise with their families or peer groups . . . they can sort them out logically and try to arrive at a rational solution.\textsuperscript{170}

\textsuperscript{167}\textsuperscript{Ibid.}
\textsuperscript{168}\textsuperscript{Ibid., 292.}
\textsuperscript{169}\textsuperscript{Ibid.}
\textsuperscript{170}\textsuperscript{Ibid.}
The final paper deals with "at risk youth . . . and a compilation of counseling technique papers." The most significant statement that this writer makes is this:

Adolescence is traditionally viewed to be a time of emotional turmoil . . . a period when abnormal moods and behavior are often considered normal. From the adolescent's perspective, this attitude can be a mixed blessing. It functions to give a greater leeway to the adolescent to act out his or her frustration . . . to give vent to rebellious inclination--in short to begin the transition from childhood to adulthood.

However, counselors, parents, and professionals view the adolescent as "naturally rebellious" during the phase of transition from adolescence to adulthood. The adolescent's real feelings may be dismissed as simply "adolescent rebellion." These feelings of adolescent suicide and rebellion may be overlooked.

Bowers found several treatment approaches for adolescents:

1. In Beck's cognitive view, treatment involves "first getting the client to identify his or her cognitive distortions and confronting them with the evidence of objective experience."

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172 Ibid., 2.

173 Ibid., 6.
2. Rehm's self-control model is a five-week training program that focuses on "self control manifestations and provides training in skills to overcome specific deficits."174

3. Stark, Reynolds, and Kaslow's behavior problem-solving program models problem-solving skills and the development of "strategies for increasing the occurrence of pleasant activities and decreasing the occurrence of unpleasant activities."175

A final approach to therapy is Maslow's social skills training approach. This approach focuses on children being trained in three types of target verbal responses (e.g., "giving compliments, giving help, and making appropriate requests").176

With this coverage of the research on adolescent suicide treatment, the researcher turns to a basic principle in adolescent development: Erikson's identity crisis. Significantly, adolescents rebel against parents and authority but look to peers for reinforcement. In this light, peer counseling or group treatment produces better success with adolescents.

174Ibid., 7.
175Ibid.
176Ibid., 8.
The first research article by Dee Robertson and Bernadette Mathews, "Preventing Adolescent Suicide with Group Counseling," gives guidelines in the use of group counseling for adolescents. C. H. Ross's work with suicide prevention in the schools is referred to again. He suggested that "peer" counseling is most appropriate because it allows an internal, as opposed to external, solution. With peers, young African American males can begin to identify and work through problems with each other. This finding has already been validated by Dr. Eugene Herrington, who suggested in his dissertation that group sessions would be an appropriate intervention when psychotherapy was not.

Young Adulthood Intervention

As young children, we look forward to the day we will be all grown up . . . imagining that when we become adult size we will automatically master the roles, privileges, and responsibilities of adulthood. As young teenagers, we likewise impatiently await our high school graduation, or 18th or 21st birthday—anticipating that independence, and the competence to cope with it, will be bestowed when we arrive at these "official" milestones. But


178 Ross, "Teaching Children the Facts of Life and Death."

young adults, who must make their own decisions about career goals, intimate relationships, social commitments, and moral conduct, usually find these aspects of independence exciting but far from easy to deal with.\footnote{Berger, The Developing Person, 388.}

This is especially true today because the array of lifestyle choices seems so vast and varied. And, no matter which of the roles of adulthood they choose to take on or how thoughtfully and eagerly they strive to play them, they are bound to be confronted with stresses, setbacks, and second thoughts.

Yet, for most young adults, it is problems faced and usually solved, and limitations accepted or overcome that make the decades from twenty to forty an exhilarating period when people often feel they are living to the fullest.\footnote{Ibid., 389.}

Basically, Berger has pinpointed the stress and rapid change of the era of "Future Shock"—when multiculturalism is a vast and forced adaptation for the young adult.

The next study magnifies the lack of records and statistics in college suicide, and therefore in intervention. In 1984, Mary Campana and her colleagues did a study on suicidal risk among college students. The findings of these studies reveal a need for further research concerning the occurrence of suicidal thinking and suicide attempts among young adult nonpsychiatric populations. Specifically,
there is a need to determine whether the probability of suicidal thinking has changed over time.182

The preceding studies are over a decade old, and suicide rates for young adults have come up over 40 percent during this intervening period.183 Also, there is a need to obtain more in-depth data regarding the circumstances and attitudes of young adults who are at risk in regard to suicidal thinking or suicide attempts.184 The overall findings of Campana and her colleagues imply a possible quantitative increase in suicidal thinking and attempts . . . this finding is consistent with the current rise in suicide in the young adult population . . . more in depth research of previous studies and more comprehensive future research must be conducted for validation of this finding.185

Following the theme of why college students commit suicide and the intervention approach as a natural reaction, Norma D. Carson and Rhoda Johnson186 published a study, "Suicidal Thoughts and Problem Solving Preparation Among

182Campana et al., "Suicidal Risk Among College Students," 5.


184Campana et al., "Suicidal Risk Among College Students," 5.

185Ibid., 12.

College Students." The research objectives of this study were (1) to determine the frequency of serious suicidal thoughts in a general student population, (2) to determine the differences between those with suicidal thoughts and those who had indicated that they did not have suicidal thoughts, and (3) to examine whether there was a relationship between suicidal thoughts and problem-solving preparation.187

Results of this study were significant. Their first table revealed that students with suicidal thoughts reported experiencing significantly more stress symptoms. Their second table revealed that students who had suicidal thoughts reported they were significantly less likely to have received information about how to deal with problems.188 To reinforce this information, students who had suicidal thoughts were significantly more likely to have low grade point averages.

In conclusion, Carson and Johnson made these final comments:

These findings indicate that the factors differentiating those who reported suicidal thoughts from those who did not were the number of stress symptoms recently experienced and whether the students had been instructed on how to deal with emotions and problems.189

187 Ibid.
188 Ibid.
189 Ibid.
In 1987, John S. Westefeld and Cynthia M. Pattillo did a study, "College Students' Suicide: The Case for a National Clearinghouse."\textsuperscript{190} The rate of suicide among college students has become a problem that has concerned many, not because of the rate, estimated to be 50 percent higher than for other Americans of comparable age, but because of the severe trauma that such an event may inflict on the entire college or university community. These researchers commented:

There are no studies dealing with the issue of college and university record keeping in the area of student suicide. . . . in many ways, however, research relating to this topic may be the first step in attempting to answer the larger question of how institutions can effectively respond to the problem.\textsuperscript{191}

Jamie R. Funderburk and James Archer (1989) invested a great deal of time and research on "This Campus Cares: A Suicide Prevention Project." Their research revealed that suicidal thoughts are not uncommon for college students under stress . . . in fact, these thoughts can be grouped with other self-destructive thoughts such as self-deprecation, unrealistic self demands, perceived helplessness, all or none thinking, and doom predicting--all of which contribute to ineffective coping and pave the way to self-destructive coping.\textsuperscript{192}

\textsuperscript{190}Westefeld and Pattillo, "College Students' Suicide," 38.
\textsuperscript{191}Funderburk and Archer, "This Campus Cares," 278.
\textsuperscript{192}Ibid.
The effective intervention strategy includes the goal of the university: primary prevention through the creation of a caring and an aware campus. This awareness and caring can be behaviorally effective. Emphasis focused on early intervention rather than focusing primarily on providing help for students who were already suicidal. The major emphasis was "to get the campus community to be more active in helping students cope with and confront problems before suicide became an option." This was effected by:

1. Distribution of a 20-page self-help booklet for students on coping with stress, including tips on how to help a friend titled "Maintaining the Balance," a newsletter for faculty and staff members on student distress warning signs, possible interventions and resources available.

2. An educational advertising campaign launched in the campus newspaper. For example, one ad asked "How supportive are you?" and stated "You are not alone," "There's still hope," "Help is available," and so on.

3. PSAs: two college women in their residence hall who were exhibiting suicidal warning signs (i.e., withdrawing, not eating, not having friends, missing class, giving away items).

4. A brochure to parents with case vignettes depicting common student problems: (a) academic struggles

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193 Ibid.
and career indecision, (b) potential substance abuse and eating disorders, and (c) sexual decision making, depression, loneliness, and identifying confusion. According to Funderburk and Archer, "each vignette is followed by suggestions of effective and ineffective intervention strategies for parents."194

5. Self-help psychology books for campus main libraries and residence hall reading rooms on such topics as "combatting depression, building self-esteem, coping with stress, etc."195

Westefeld, Whitchard, and Range's study summarized the prominent literature in college suicide until 1990.196 The major findings of their research regarding college suicide were:

1. It is very difficult to gather accurate data concerning attempted and completed suicides on college campuses, since there is no effective record-keeping system operational at most universities.

2. The data on suicide rates are inconsistent. Because of competition for students, some schools may be motivated to underreport or mislabel suicides. They

194 Ibid.


196 Westefeld, Whitchard, and Range, "College and University Student Suicide," 476.
nevertheless emphasized the need for colleges to extend and try to lower the suicide rate.

These reasons for attempting suicide were found:

1. Westefeld and Farr concluded that hopelessness and loneliness were critical factors.\textsuperscript{197}

2. Rosenkrantz researched suicide in middle to late adolescence (ages 15-24) and found that a felt loss of love and intimacy was a critical factor in suicidal risk.\textsuperscript{198}

In 1987, Bonner and Rich developed a predictive model for suicidal behavior: social-emotional alienation, cognitive distortions, and deficient adaptive resources serve as a predispositional base for suicidal behavior.\textsuperscript{199}

The stress vulnerability of the college student is exacerbated when stress is confronted, and the suicidal behaviors increase.

The author points out that Carson and Johnson found that lack of information on coping skills was a critical factor.\textsuperscript{200} Also, an important question that needs additional research is the question of whether or not there is something inherent in the college experience that

\begin{enumerate}
\item \textsuperscript{197}Westefeld and Farr, "Suicide and Depression," 119-123.
\item \textsuperscript{198}Rosenkrantz, "A Note on Adolescent Suicide," 214.
\item \textsuperscript{199}Bonner and McGhee, "Suicidal Communication," 16.
\item \textsuperscript{200}Carson and Johnson, "Suicidal Thoughts," 467-468.
\end{enumerate}
particularly creates an atmosphere of isolation for some students that may be different from the nonstudent.

Solutions to Campus Suicide

Solutions to campus suicide are addressed on individual and institutional levels. On the individual level:

1. An open response of discussing suicidal feelings is generally perceived as helpful.201

2. Campus seminars on suicide prevention or this topic as an aspect of a required course are preventive.

3. The development or encouragement of femininity or of androgeny (having both masculine and feminine characteristic) may help people develop adaptive characteristics that prevent suicide.

4. A brief positive mood induction such as remembering pleasant events in one's childhood can help people adapt.202

Institutional approaches, as mentioned before, include the need to keep more accurate records in the area as well as a national clearinghouse of these records, as


mentioned by Westefeld and Pattillo. Another relevant suggestion has been made by Gary Pavela in his monograph, "The Dismissal of Students with Mental Disorders: Legal Issues, Policy Considerations, and Alternative Responses." Pavela saw that students should not automatically be dismissed from college upon a suicide attempt. This dismissal should be avoided and, if no other option is possible, the officials should "refer the student to an appropriate facility for observation and evaluation."204

Butler and Meichenbaum presented the steps that administration and staff should take in the event of suicide: (1) notification of public safety office, (2) notification of residence hall director or commuter affairs specialist, (3) notification of chief student affairs officer, (4) notification of chaplain or campus minister, and (5) notification of family.205 These writers point out the need for having some kind of system in place in the event of a suicide and staff training that assures this system unfolds.

203 Westefeld and Pattillo, "College Students' Suicide," 38.


Webb presented a step-by-step procedure for suicide prevention. The major components of this procedure are:

1. All colleges have written policies to be used in the event of suicide.
2. Training is required for all staff who have contact with students.
3. "Postvention" services are offered, including the following guidelines: (a) establish a crisis counseling service, (b) initiate contact with victim's friends, (c) encourage catharsis throughout the college community, (d) encourage commemoration of the death, (e) avoid romanticizing the death, and (f) use outside consultants as appropriate.

Bernard and Bernard indicated that there are some situations in which the institutional response will have little benefit. Some suicidal situations simply will not be aided by institutional involvement.

And in conclusion, Westefeld and Farr's research was reemphasized from the standpoint of 962 college students.

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207 Ibid.

In their study, Westefeld and Farr's subjects cited the following solutions:

a) making people more aware of the problem
b) conducting seminars
c) having more understanding faculty
d) providing more individual counseling
e) providing more group counseling
f) sponsoring more interrelated activities that bring people together (not just for parties)
g) offering groups to help with stress, grades, and exams
h) educating people more about the signs of depression.209

In conclusion, Westefeld, Whitchard, and Range suggested that the subject of suicide for noncollege students between the age of eighteen and twenty-two needs further research, basically to see if the causes of suicide in college students are different from those of noncollege students.210 Also, the legal and ethical issues of college suicide need further research and insight in order that effective programming can be more educational to the community involved.

The final and latest study by Dixon, Heppner, and Anderson, already discussed in the section on college suicide, emphasizes the need for training in effective problem solving. "High negative life stress and self

209Westefeld and Farr, "Suicide and Depression," 123.

210Westefeld, Whitchard, and Range, "College and University Student Suicide," 476.
appraised ineffective problem solving are associated with higher levels of hopelessness and suicide ideation. The researcher emphasizes that more creative problem solving skills appear to be needed on both the adolescent and college level. The consistency of this finding among the African American population will add further validity to this finding.

**Intervention for African American Youth**

Existing explanations of the phenomenon of suicide are largely speculative, for few empirical studies of motives exist. Sociologists are only now beginning to tackle the topic of death in general, and suicide, with its painful implications of failure within family and social networks of support, presents formidable methodological problems.

Historically, African American suicide has never been a real and serious concern for the handful of sociologists and psychiatrists specializing in suicide research; only a few behavioral scientists have reached the lives of suicidal African American people. The explanations offered by these researchers are at best patronizing, depicting the weakness of the African American family, "a history of authority problems with the police," "retroflective anger,"

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and other distorted psychosocial patterns as central patterns in African American suicide.\textsuperscript{212}

The most comprehensive article regarding African American youth suicide that can be presented is the research of J. T. Gibbs, "Conceptual, Methodological, and Sociological Issues in Black Youth Suicide: Implications for Assessment and Early Intervention."\textsuperscript{213} Table 4 notes different patterns and rates for the sixteen to nineteen and twenty to twenty-four age groups. First, males and females in the twenty to twenty-four age group had higher rates than those in the sixteen to nineteen group. Second, the rates for African American males aged twenty to twenty-four accounted for most of the increase in the overall African American youth suicide rate, while the other three groups increased at a much slower rate. Third, the ratio of male to female rates was much higher in the twenty to twenty-four age group than in the sixteen to nineteen group.\textsuperscript{214}

Gibbs pointed out that concern for African American suicide was significant because:

\begin{quote}
 suicide is a significant problem for black youths not only because it is one of the leading causes for mortality of this age group, but because
\end{quote}

\textsuperscript{212}Davis, "Sociology of Black Americans," 221.

\textsuperscript{213}Gibbs, "Conceptual, Methodological, and Socio-Cultural Issues," 89.

Table 4
Black Youth Suicide Rates per 100,000 Residents by Subgroups

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<td>Blacks aged 15-19</td>
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<tr>
<td>Males</td>
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<td>5.1</td>
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it has a disproportionate impact on the black population, which is a youthful population with a median age of 25.8 years.215

Gibbs proceeded with four primary goals in this study which lead to appropriate intervention:

1) to examine methodological issues regarding black suicide among black youths

2) to evaluate three conceptual perspectives on black youth suicide

3) to delineate sociocultural factors that contribute to differential rates of suicide between black males and females

4) to propose implications for assessment and strategies for early intervention addressed to black youths who are high risk for suicidal behavior.216

Gibbs reviewed the three theories of African American suicide:

1. Sociological: Emile Durkheim (1897/1962) found that suicide is related to the lack of fit between the individual and society.

2. Psychological perspective: Freud (1917/1929) held the psychoanalytic perspective that suicide represents anger resulting from the loss of a loved object, turned against the self.

3. Ecological perspective: Holnger and Offer (1982) used correlational analysis to show that youth


216 Ibid., 76.
suicide rates increase as the proportion of the 15-24 age group increases in population.217

The author points out that the ecological perspective involves the factor of "stress," for, as Gibbs points out, African American youths still experience high rates of unemployment and other negative social indicators as well as "urban stress," or, as Gibbs described it, "high rates of unemployment, dysfunctional families, police brutality, racism, and chaotic environments."218 Gibbs concluded this research by accenting that:

For example, even though the unemployment rate for black youths aged 16-19 quadrupled between 1960 and 1983 (from 12.1% to 48.5%), the suicide rate for females in that age group was nearly the same, and the rate for males only slightly more than doubled in the same time period. However, the peak suicide rates for black youths in the past 20 years have occurred in 1967, 2 years after the passage of major civil rights legislation and urban riots; in 1971-1972, 2 years after the demise of the poverty program and the beginning of the Nixon administration; and in 1976-1977, at the end of the Nixon-Ford era. This suggests the concept of "relative deprivation" as a moderating factor in black youth suicide, that is, as the gap widens between their rising aspirations and their opportunities to achieve them, they become more angry and frustrated, internalizing their rage and directing it back to themselves.219

217Ibid., 80.
218Ibid.
219Ibid., 81.
Intervention strategies to deal with depression and self-destructive behaviors, especially as regards African American youth, were outlined by Gibbs:

1) Comprehensive clinics should be located in inner city high schools to provide improved access to health and mental health services for black youths.

2) Suicide prevention services should be located in inner city neighborhoods, and these services should develop aggressive community outreach programs, employ minority-group staff members, and operate 24-hour hotlines...

3) Black youths who are identified as at high risk for suicidal behavior should be referred for individual and family counseling and whatever social, emotional, economic, or medical services they may require.

4) Police and community relations should be improved to alleviate the tensions between black youths and the police...this would include having more black police officers, setting up police review boards, and providing strong sanctions against police brutality toward inner city blacks...

5) Young black males from fatherless homes need positive male role models to teach them appropriate "masculine" behaviors and values as alternatives to delinquency and violence...

organizations like Big Brothers and Sisters should recruit more black adults as volunteers for these programs.

6) Gun control legislation is badly needed to reduce the availability of lethal weapons.

7) Early intervention may increase the probability that some at-risk youths will be prevented from committing suicide, but it is not clear that it prevents the majority of suicide in this age group.\footnote{Ibid., 86-87.}
Conclusions from this research direct the reader to more research on the sometimes conflicting conceptual theories of African American youth suicide, especially in order to develop more important intervention programs designed to target this heterogeneous group.

And, the most important change would be a total change in American society so that the external stresses (poverty, dysfunctional families, discrimination) and the less identified but much more powerful internal stresses (feelings of alienation, frustration, anger, depression) impinging on African American youths that produce an intolerable stress. And as long as African American youths perceive the wide gap between the American dream of success and the barriers to the achievement of this goal, they will be extremely vulnerable to the twin tragedies of suicide (anger turned inward) and homicide (anger turned outward).

In the Secretary's Task Force on Youth Suicide, F. M. Baker also observed that suicide rates peaked between ages 25 and 34 for African American males.221 Baker's primary preventive strategy involved the focus upon conflict resolution in the family and clarification of expectations in various relationships:

Helping black adolescents and youth to understand the factors which are controlled by society may aid in clarifying the sources of frustration in the 1980s. As noted by Davis, high in-group stress may result from an individual's family relationships, friendships, and personal relationships. The extra-group stress can be modified by support from the extended family and community groups.222

To further accentuate Gibbs's third intervention involving family and community, as well as Baker's comments on family involvement, Durkheim's theory as well as its intervention seems appropriate:

Durkheim views primary intervention as being carried out by caring people, or significant others . . . parents, spouses, relatives, friends, etc. . . . who may note excessive perturbation, hostility or signs of lethality.223

The involvement of the community suggested by Durkheim is accented by Davis, and Spaights and Simpson's study points out the factor of family in suicide:

Family disorganization is a key factor in suicidal behavior. Most suicides occur in females where the father is either physically or emotionally absent on a continual basis. . . .

In general, lack of family support and the loss of a love one are key relationships of the family to suicidal behavior . . . . Isolation from either or both parents creates a situation which affects the self esteem of the child . . . gives cause for anger and leads to depression . . . . In addition, the level of communication, particularly in the area of expression of feelings, is extremely important (an absent father increases

222Ibid.

the chance that the child will have no one who
will listen). 224

Since there is no control absolutely of family
involvement, Dr. Eugene Herrington has made comments on his
research with African American adolescent youth. Basically,
he comments that traditional modes of psychotherapy are not
appropriate for African American youth. The researcher
comments on how universal the experience of the African
American male is to other members of society: "This study
provides us with findings that can be useful in terms of
guiding future investigations of empathy, trust, and power-
lessness, as well as feeling socially unequal in the thera-
peutic setting." 225 Herrington further reported that:

The suicide rate among Black males has received
little attention . . . . it is reported that the
suicide rate among Black males between the ages of
15 and 34 is higher than that of any other group.
. . . it is believed that the phenomenally high
rate of unemployment among Black males (officially
listed as over 40% for the at-risk group) is
linked to the high suicide rate. . . .

As a Black male therapist working with Black
families, I have experienced very positive results
while working with Black male adolescents in
"group psychotherapy." Black male adolescents
sharing their lived experiences with their peers
was highly therapeutic. . . . I watched and wit-
nessed as Black male adolescents listened in awe
as other adolescents told their problems, which
were the same problems they were experiencing. 226

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225 Herrington, "The Experience of the Black Male
Adolescent in Psychotherapy," 155.

226 Ibid., 155-156.
The author comments that a combination of group sessions as well as family and community involvement would be most appropriate for African American youth as an intervention strategy.

Suicidal Behavior in International Youth

In 1991, adolescent suicide became the second leading cause of death. Mass screening to aid competency-based program development became a method counselors could use to begin to identify "at risk" populations and to begin to create a competency based-counseling program.\textsuperscript{227}

In a recent study by Phi Delta Kappa's leaders of youth and suicide, Frymier and Garfinkel found that suicidal youngsters' behaviors were best profiled as being isolated and passively avoiding issues and demands placed on them.\textsuperscript{228} Signs of this pattern might be described by: (1) deteriorating academic performance, (2) trouble complying with rules in school and at home, (3) generally avoiding associations with one's peer group, (4) youngsters with chips on their shoulders, (5) tendency to exhibit aggressive behavior, and (6) youngsters using maladaptive patterns to deal with their problems.

\textsuperscript{227}Siehl and Studer, "Mass Screening," 12.

\textsuperscript{228}Frymier, "Understanding and Preventing Teen Suicide," 292.
But more important to our understanding of suicide in adolescents, college youth, African American, and white is this phenomenon outlined by Thomas K. Edwards:

The incidence of anxiety disorders among teenagers has been increasing dramatically. Over the past decade . . . and during the last two decades, teenage suicides have increased 300%. According to the National Center for Health Statistics, virtually all parts of the Northeastern U.S. have suffered waves of adolescent suicide. Moreover, the problem cuts across all socioeconomic lines: inner city, blue collar, and white collar communities have been affected.

Suicide is now the second leading cause of teenage deaths (topped only by vehicle fatalities). For every completed suicide among high school students, there are some 350 suicide attempts, and one study places the proportion of high school students who will attempt suicide at any given month at 3%.229

Edwards advises this: "How can school people help overcome adolescent alienation? They can provide young people with reasons for wanting to live by thoughtfully 'mentoring each youngster'—caring, nurturing, etc."230

In 1984, Toffler reviewed in Future Shock the reality that we are facing a culture that includes new cultures, some of them just gaining their own identity.231

The African American population of the United States is a younger population with a broader-based population pyramid.


230 Ibid.

231 Toffler, Future Shock.
The white population is older with a population pyramid that is more evenly distributed in all age groupings. Age adjustment is a method that corrects for these age differences in the population of each race.

Whether or not suicide occurs among adolescent youth in the U.S. only or extends across international lines, whether or not statistics show there is a trend, is irrelevant. According to David Lester's cross-cultural study results:

This study examined changes in the suicide rate of teenagers and young adults (aged 15-24 years) internationally from 1970 to 1980, using data published by the World Health Organization (1973, 1983). Twenty-three nations experienced an increase (with Norway experiencing the largest percentage increase), while six experienced a decrease. . . . Unlike general suicide rates, teenage suicide rates were not related to the quality of life in the nations surveyed. . . .

Intervention on the international level follows findings of intervention for African American youth. Francisco J. Vaz-Teal suggested a family therapist intervention called "metatherapy." Metatherapy involves two phases: (1) case evaluation, with the participation of the whole family group; and (2) case treatment, with exclusive


participation and active collaboration of the parental couple. Metatherapy emphasizes boundary delimitation and stresses the recuperation of parental executive capacity.

The only other study done noteworthy of mention was by the Thirty-Sixth International Psychoanalytical Congress. Roger Kennedy used clinical material from the analysis of a suicidal and self-mutilating seventeen-year-old male to illustrate a core breakdown in communication.234 Basically, the core pathology needs to be experienced in the transference of the adolescent in therapy for treatment to be effective.

In conclusion, the author makes some final comments in regard to suicide. Constance Holden made these comments in "A New Discipline Probes Suicide's Multiple Causes," noting David Kupfer's comments:

"We are dealing with a major disorder . . . officially there are 32,000 suicides in the U.S. but the real number is higher." Researchers are therefore heavily at work trying to nail down the factors that induce self destruction . . . . Families are not the key . . . previous work has shown that unstable families produce more than their share of pathology. . . . However, the majority of subjects in Brent's study came from reasonably stable families.

Findings such as his are suggesting that suicide itself—as opposed to attempts—is more closely linked with individual psychological factors than with family environment. What is

needed rather is an integrated effort that incorporates everything from cultural studies to biochemistry in studying the problem.

Other research suggests that people who actually commit suicide—rather than just attempt it—may have serotonin deficiencies even in the absence of violent histories. This work was reported by Pittsburgh neuroanatomist and receptor pharmacologist Victoria Arango. . . . Researchers warn that no single set of factors—much less a single neurotransmitter system—is adequate to explain suicide.235

**Research on Instrument to Be Used:**
**A Survey of Suicidal Intentions**

In any definition of suicide, or any scale rating the likelihood of suicide, the helping professional must learn to recognize and react to those behaviors which precede and, in many cases, predict subsequent suicide. So, before the actual new instrument is presented, some background material involving some of the leading researchers and authorities regarding suicide will be presented. This background is drawn from Beck, Resnik, and Lettieri's comprehensive survey of suicide, *The Prediction of Suicide*.236 Then, the justification for the selection of the various sections of the new instrument is given.

Dr. J. Zubin classified human behavior into scientific models of why suicide occurs. Such classic models

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are Durkheim's ecological model; as well as the developmental model, including Freud's biological, Hendin's child-rearing practices, and Rotter's locus of control; Henry and Short's freedom and constraint theories; the Teaming Theory model, including Ziegarnik's effect for the compulsive necessity for completion; Frederick and Resnik's alternative solutions model; and Beck's intentionality theory; Kallman's Genetic Model; and Glass et al.'s neurophysiological model. Finally, Zubin closed with a diagram of how the population of suicidal individuals compares to the normal curve, which has been displayed in figure 1 in Chapter I of this study.237

Dr. Alex D. Fokorny was able to divide suicide into completed suicide (CS), suicide attempt (SA), and suicidal idea (SI).238 The chart for this classification is shown in table 5.

The basic problem is to define the major aspect of the word "suicide" that makes it mean "suicidal." Acts of suicide attempt may have meanings other than suicide; suicidal behaviors such as overeating, abuse of alcohol and drugs, hazardous activities such as skydiving or bungee


238 Fokorny, "A Scheme for Classifying Suicidal Behavior," 29-44.
Table 5
Classification of Suicidal Behaviors

I. Completed Suicide (CS)
   A. Certainty of Rater (1-100%)
   B. Lethality (medical danger to life)
      (Zero, low, medium, high)
   C. Intent (to die)
      (Zero, low, medium, high)
   D. Mitigating Circumstances (confusion, intoxication, etc.)
      (Zero, low, medium, high)
   E. Method (not an ordinal scale)

II. Suicide Attempt (SA)
   A. Certainty (1-100%)
   B. Lethality (medical danger to life)
      (Zero, low, medium, high)
   C. Intent (to die)
      (Zero, low, medium, high)
   D. Mitigating Circumstances
      (Zero, low, medium, high)
   E. Method (not an ordinal scale)

III. Suicidal Ideas (SI)
   A. Certainty (1-100%)
   B. Lethality (medical danger to life)
      (Zero, low, medium, high)
      (Refers to the consequences if life-threatening plan were to be carried out)
   C. Intent (to die)
      (Zero, low, medium, high)
   D. Mitigating Circumstances
      (Zero, low, medium, high)
   E. Method
      (Multiple methods may be listed. In some cases method may be unknown. Not an ordinal scale.)

jumping, and psychosis are all manifestations of self-destructiveness—all behaviors that have been destructive have been thrown under the catch-all term "suicide."

Then there are the accident-like suicides—among all accidents, there is no scientific way to prove if they were accidental or intentional—which add confusion to the suicidal literature. The overall effort, however, is to come to some clearer perception of how to distinguish and predict those behaviors which predict subsequent suicide.

Dr. J. C. Diggory actually used the term "behaviors predicting suicide," but suggested more research using the power of multiple regression and opening minds to new facts, depending less on old theories. Dr. David Lester coined the term "suicidal risk." Basically, he advocated the evaluation of personal history, demographic information, information about suicidal history and current preoccupation, information about sociological state, and social resources of the patient.

J. A. Motto summarized the helping professional's concern:

A crucial consideration sometimes underemphasized is that we can only predict the risk of suicide, and not suicide as such. . . . There are difficulties of outcomes of "suicide" and "suicide behavior." Whatever, it is only the odds that can

240 Ibid., 75.
be estimated, necessitating serious attention to everyone who gives us reason to assess the chances of a suicidal act. 241

It is with this brief summary of authorities and how they have treated suicide and/or behaviors leading to suicide that the author presents the evolved scale for this study, A Survey of Suicidal Intentions. The first section of this survey is itemized for demographic information (Items 1-11). The second section of the survey is organized for feelings (Items 12-14). Dr. Eugene Herrington, who researched African American adolescents in psychotherapy, endorses this scale that was developed from Robert Bly's 1986 research on the feelings of males and females in the male movement.

Finally, a scale of items was selected from Beck et al.'s comprehensive survey of how to predict suicide: the Suicide Intent Scale. Since many facets of suicide include behavior, attempts, false positives, false negatives, etc., the selection of an "intent" scale emphasizes the conscious desire to end one's life, or "the seriousness or intensity of the wish of a patient to terminate his life."242

Since demographic and feeling data are collected by the previously described sections of the survey, the final section (intent scale) allows the researcher to assess

241Ibid., 85.
242Ibid., 45.
simply the constructs which give information as to this intent. Intent consists of several major elements: "first, the balance between the intensity of the wish to die vs. life-protective wishes; secondly, the patient's subjective probability estimate that his suicidal plan or wish will result in death."\textsuperscript{243}

In this survey, the intent scale accurately details the degree of intent of those who admit a suicidal activity. An intent scale might normally be administered after the first attempt and includes items relevant to the circumstances surrounding the suicidal act: evidence of premeditation such as planning (later explicable in terms of making suicidal preparations); location of attempt (isolation, concealment, deception); timing of suicidal act so as to invite or forestall intervention; attempt to communicate suicidal intent; degree of lethality; and conditions surrounding intent, such as drug or alcohol use.\textsuperscript{244}

The intent scale is the final section of this survey and provided information to the researcher, as well as implications regarding the seriousness of communication of such data. All data were collected and analyzed for relevance to suicidal activity of African American college males.

\textsuperscript{243}Ibid.

\textsuperscript{244}Ibid.
CHAPTER III

METHODOLOGY

The survey technique was utilized in this study. Robert E. Slavin commented on this technique as follows:

Sometimes we simply want to find out how many people agree with certain statements, intend to vote in a particular way, or have certain characteristics . . . for example, we might want to know what proportion of teachers in the Los Angeles Certified School District support busing, or what portion of tenth grade students in the Des Moines Public Schools own hand calculators. . . . however, the most important value of survey research is that the measures being used are reliable and valid, as well as to be sure that the individuals from whom we receive surveys are representative of all individuals to whom we wish the results to apply.245

Research began the week of March 22-26, 1993, and terminated when appropriate research had been completed. Basically, research terminated after the researcher had surveyed and collected appropriate information. The termination date was between May 1 and May 17, 1993.

Site and Setting

The site was the southeastern United States. The setting included several predominantly African American colleges in the southeastern United States.

Subject Pool

The subject pool consisted of African American male students of several predominantly African American universities in the southeastern United States.

Sample

The sample consisted of approximately 130 to 150 members of the subject pool who were targeted by administration to participate in the survey.

Instrument

The screening instrument was A Survey of Suicidal Intentions (see appendix). This instrument was developed in collaboration with the researcher's doctoral committee. This instrument has three sections. It contains twenty items which are all closed-ended items. Sections and items are described below.

Section A: Demographic Characteristics

The purpose of this section is to gather information regarding the demographic characteristics of the students surveyed.

Item 1: This item was closed ended. It was designed for the student to record whether the person responding was male or female. (This was a blindly designed item.)
**Item 2:** This item was closed ended. It was designed for the student to record his age. (This was a blindly designed item.)

**Item 3:** This item was closed ended. It was designed for the student to record at what level he was in college. (This was a blindly designed item.)

**Item 4:** This item was closed ended. It was designed for the student to record what race or ethnic group he was a member of. (This was a blindly designed item.)

**Item 5:** This item was closed ended and was designed for the student to record what area he had lived in the longest.

**Item 6:** This item was closed ended and was designed to record the living environment of the student.

**Item 7:** This item was closed ended and was designed to record the yearly income of the student's parents.

**Item 8:** This item was closed ended and was designed to record the student's number of siblings.

**Item 9:** This item was closed ended and was designed to record the student's birth order.

**Item 10:** This item was open ended and was designed to record the student's religious preference.

**Item 11:** This item was closed and open ended to record frequency of attendance at religious services.
Section B: Personal Feelings

Items 12a and 12b: These items were designed in a closed-ended fashion to record whether or not the student had received support for his feelings, as well as the source and type of support.

Item 13: This item was designed to record the student's suggestions for support.

Items 14a through 14g: These items were designed around Robert Bly's model of male feelings. Introduced as male and female feelings, the items record whether the student's feelings are male (first choice) or female (second choice) oriented as found in research. Each item is clear and self-explanatory.

Section C: Intentions

Item 15: This item was specifically designed in a Yes/No response format to record if the student has thought of hurting himself.

Item 16: This item was designed to record further information if the student had answered Yes to Item 15: was the attitude thought, gesture, or attempt?

Item 17: If the answer to Item 15 was Yes, this item was designed to record the characteristics of planning around these intentions. Subquestions addressed: (a) whether the student was alone or with others, (b) whether timing was involved, (c) the types of precautions taken for
discovery, (d) the types of actions taken to gain help or intervention, (e) whether there was a suicide note, (f) whether there was communication of the intent before the attempt, (g) the degree of lethality, (h) the degree of destructiveness as elicited by involvement of addictions, and (i) the degree of damage done to oneself and the type of damage.

**Item 18:** This item recorded whether this was a first, second, or third attempt.

**Item 19:** This item recorded the history of self-destructiveness in the family, the member of the family involved, and whether this destructiveness was thought, gesture, or attempt.

**Item 20:** This item recorded whether loneliness or depression was in the history of the family.

**Procedures**

Procedures for this study included three segments. These segments included the Preresearch Period (implementation period), the Research Period, and the Postresearch Period (termination period). These periods and the accompanying procedures are discussed below.

**Preresearch Period**

**Procedure 1:** A letter or telephone call requesting permission to conduct the survey was sent or delivered to
the appropriate personnel of participating predominantly African American universities, designated University A, B, and C by the principal investigator (this researcher).

Procedure 2: Surveys and instructions for their administration were delivered to the accepting southeastern universities.

Research Period

Procedure 3: Surveys were administered to targeted groups of students by the appropriate personnel of the participating universities.

Postresearch Period

Procedure 4: The principal investigator collected all data, and the study was terminated.

Data Collection

All data were collected by the principal investigator and organized according to outstanding trends, regularities, and/or irregularities.

Data Analysis

The data from the completed surveys were analyzed according to the survey technique. In addition, Pearson chi-square was used to test the independence of a number of variables across suicidal intentions.
Consent and Release Form

All students who volunteered to participate in the survey signed a Consent and Release Form (human services contract) that adhered to the three principles of ethics as outlined by Corey and Corey in *Issues and Ethics of Counseling*: (1) informed consent; (2) confidentiality, privileged communication, and privacy; and (3) duty to warn and protect.246

246Corey and Corey, *Issues and Ethics in the Helping Profession*. 
CHAPTER IV

RESULTS

The purpose of the results chapter was to explain the findings based upon research questions raised earlier in Chapter I. The research questions are listed below. The overall findings review the information gathered about suicidal intentions.

1. How prevalent are suicidal intentions among African American male college students?

2. What is the demographic information surrounding these students?

3. What are the personal feelings of the students who report suicidal intentions?

4. What are the modes of feeling (as outlined by Robert Bly) that are demonstrated by these students?

5. If these students report suicidal intentions, what are the conditions surrounding these intentions?

6. What are the family characteristics of those who report suicidal intentions?

Demographic Information

This section of the survey of suicidal intentions consists of eleven closed-ended questions. The purpose of
the demographic section was to obtain a profile of the typical survey respondent based on a number of responses. These responses are contained in the following major categories and are explicated further in this chapter: general information, family characteristics, and religious factors.

Within the general information section were six variables. These variables were sex, age, college level classification, ethnicity, geographic region where subject has lived the longest, and living arrangements. The variables of sex, classification, and ethnicity are implicated in the title of the study but were "blind" to the subject, so as not to single out and bias the responses of African American male college students. The computer selected from the overall population only those subjects who were African American, male, and college students, so the descriptive data that follow only describe those variables.

General Information: Institution, Age, Region, and Living Arrangements

Table 6 displays data on the variable of institution. As shown in table 6, of 79 subjects, 33 (41.8 percent) came from Institution A, a large, coed urban college; 36 (45.6 percent) came from Institution B, a large coed rural college; and 10 (12.7 percent) came from Institution C, located along the southeastern coast of the United States.
Table 6
General Characteristic of Institution

<table>
<thead>
<tr>
<th>Institution</th>
<th>Number</th>
<th>Percent*</th>
</tr>
</thead>
<tbody>
<tr>
<td>A (large coed urban college)</td>
<td>33</td>
<td>41.8</td>
</tr>
<tr>
<td>B (large coed rural college)</td>
<td>36</td>
<td>45.6</td>
</tr>
<tr>
<td>C (located along SE coast of US)</td>
<td>10</td>
<td>12.7</td>
</tr>
</tbody>
</table>

*Due to rounding, percentages may not total exactly 100%.

Regarding the variable of age, of 79 subjects, 1 (13 percent) was age seventeen; 29 (36.7%) were age eighteen, 30 (38 percent) were age nineteen, and 19 (24.1 percent) were age twenty or over. Table 7 shows this information.

Table 7
General Characteristic of Age

<table>
<thead>
<tr>
<th>Age</th>
<th>Number</th>
<th>Percent*</th>
</tr>
</thead>
<tbody>
<tr>
<td>17</td>
<td>1</td>
<td>13.0</td>
</tr>
<tr>
<td>18</td>
<td>29</td>
<td>36.7</td>
</tr>
<tr>
<td>19</td>
<td>30</td>
<td>38.0</td>
</tr>
<tr>
<td>20+</td>
<td>19</td>
<td>24.1</td>
</tr>
</tbody>
</table>

*Due to rounding, percentages may not total exactly 100%.

As revealed in table 8, of the 79 subjects, 35 (44.3 percent) came from the Southeast, 9 (11.4 percent) came from the Southwest, 17 (21.5 percent) came from the Northeast, 8 (10.1 percent) came from the Northwest, 2 (2.5 percent) came
Table 8
General Characteristic of Region

<table>
<thead>
<tr>
<th>Region Where Lived Longest</th>
<th>Number</th>
<th>Percent*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Southeast</td>
<td>35</td>
<td>44.3</td>
</tr>
<tr>
<td>Southwest</td>
<td>9</td>
<td>11.4</td>
</tr>
<tr>
<td>Northeast</td>
<td>17</td>
<td>21.5</td>
</tr>
<tr>
<td>Northwest</td>
<td>8</td>
<td>10.1</td>
</tr>
<tr>
<td>New England</td>
<td>2</td>
<td>2.5</td>
</tr>
<tr>
<td>Midwest</td>
<td>5</td>
<td>6.3</td>
</tr>
<tr>
<td>Other areas outside the U.S.</td>
<td>3</td>
<td>3.8</td>
</tr>
</tbody>
</table>

*Due to rounding, percentages may not total exactly 100%.

from New England, 5 (6.3 percent) came from the Midwest, and 3 (3.8 percent) came from countries outside the United States.

Finally, as shown in table 9, of the 79 subjects, 19 (24.1 percent) lived in a single dorm room, 46 (58.2 percent) lived in a larger dorm room, and 14 (17.7 percent) had other living arrangements.

Table 9
General Characteristic of Living Arrangements

<table>
<thead>
<tr>
<th>Living Arrangements</th>
<th>Number</th>
<th>Percent*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single dorm room</td>
<td>19</td>
<td>24.1</td>
</tr>
<tr>
<td>Larger dorm</td>
<td>46</td>
<td>58.2</td>
</tr>
<tr>
<td>Other arrangements than dorm</td>
<td>14</td>
<td>17.1</td>
</tr>
</tbody>
</table>

*Due to rounding, percentages may not total exactly 100%.
Family Characteristics: Income, Number of Siblings, Birth Order

As shown in table 10, only 1 of the 79 subjects had parents with no income. Three (3.8 percent) had parents with income under $5,000; 14 (17.7 percent) had parental income under $15,000; 10 (12.7 percent) had parental income under $25,000; 11 (13.9 percent) had income under $35,000; and 32 (40.5 percent) had parental income over $35,000. Finally, eight (10.1 percent) gave no response to this item.

Table 10

<table>
<thead>
<tr>
<th>Parental Income</th>
<th>Number</th>
<th>Percent*</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>1</td>
<td>1.3</td>
</tr>
<tr>
<td>Under $5,000</td>
<td>3</td>
<td>3.8</td>
</tr>
<tr>
<td>$5,000-$15,000</td>
<td>14</td>
<td>17.7</td>
</tr>
<tr>
<td>$15,001-$25,000</td>
<td>10</td>
<td>12.7</td>
</tr>
<tr>
<td>$25,001-$35,000</td>
<td>11</td>
<td>13.9</td>
</tr>
<tr>
<td>Over $35,000</td>
<td>32</td>
<td>40.5</td>
</tr>
<tr>
<td>No response</td>
<td>8</td>
<td>10.1</td>
</tr>
</tbody>
</table>

*Due to rounding, percentages may not total exactly 100%.

As revealed in table 11, 20 (25.3 percent) of the 79 respondents were only children, 17 (21.5 percent) had one sibling, 19 (24.1 percent) had two siblings, 14 (17.7 percent) had three siblings, 7 (8.9 percent) had four or more siblings, and 2 (2.5 percent) gave no response to this item.
Table 11

Family Characteristic of Number of Siblings

<table>
<thead>
<tr>
<th>Number of Siblings</th>
<th>Number</th>
<th>Percent*</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>20</td>
<td>25.3</td>
</tr>
<tr>
<td>1</td>
<td>17</td>
<td>21.5</td>
</tr>
<tr>
<td>2</td>
<td>19</td>
<td>24.1</td>
</tr>
<tr>
<td>3</td>
<td>14</td>
<td>17.7</td>
</tr>
<tr>
<td>4+</td>
<td>7</td>
<td>8.9</td>
</tr>
<tr>
<td>No response</td>
<td>2</td>
<td>2.5</td>
</tr>
</tbody>
</table>

*Due to rounding, percentages may not total exactly 100%.

Finally, as shown in table 12, 47 (59.5 percent) of the 79 subjects were first born, 14 (17.7 percent) of the subjects were second born, 12 (15.2 percent) were third born, 2 (2.5 percent) were fourth born, 1 (1.3 percent) was seventh born, 1 (1.3 percent was over tenth in order, and 2 (2.5 percent) gave no response.

Table 12

Family Characteristics of Birth Order

<table>
<thead>
<tr>
<th>Birth Order</th>
<th>Number</th>
<th>Percent*</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>47</td>
<td>59.5</td>
</tr>
<tr>
<td>2</td>
<td>14</td>
<td>17.7</td>
</tr>
<tr>
<td>3</td>
<td>12</td>
<td>15.2</td>
</tr>
<tr>
<td>4</td>
<td>2</td>
<td>2.5</td>
</tr>
<tr>
<td>7</td>
<td>1</td>
<td>1.3</td>
</tr>
<tr>
<td>Over 10th in order</td>
<td>1</td>
<td>1.3</td>
</tr>
<tr>
<td>No response</td>
<td>2</td>
<td>2.5</td>
</tr>
</tbody>
</table>

*Due to rounding, percentages may not total exactly 100%.
Religious Characteristics

Data on the final section of the demographic portion are presented in this section. As shown in table 13, of the 79 subjects, 54 (68.4 percent) were Protestant (Baptist, Methodist, and A.M.E. were collapsed into this division); 5 (6.3 percent) were Catholic, 6 (7.6 percent) were Muslim, and 14 (17.7 percent) claimed no religious affiliation.

Table 13

Religious Characteristic of Religious Preference

<table>
<thead>
<tr>
<th>Religious Preference</th>
<th>Number</th>
<th>Percent*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Protestant</td>
<td>54</td>
<td>68.4</td>
</tr>
<tr>
<td>Catholic</td>
<td>5</td>
<td>6.3</td>
</tr>
<tr>
<td>Muslim</td>
<td>6</td>
<td>7.6</td>
</tr>
<tr>
<td>None</td>
<td>14</td>
<td>17.1</td>
</tr>
</tbody>
</table>

*Due to rounding, percentages may not total exactly 100%.

With regard to attendance at religious services, of the 79 subjects, 26 (32.9 percent) attended services weekly, 6 (7.6 percent) attended services biweekly, 19 (24.1 percent) attended services monthly, and 27 (34.2 percent) checked "Other" as the frequency of religious service attendance (see table 14). One person (1.3 percent) gave no response to this item.
Table 14

Religious Characteristic of Frequency of Attending Services

<table>
<thead>
<tr>
<th>Frequency of Attending Services</th>
<th>Number</th>
<th>Percent*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weekly</td>
<td>26</td>
<td>32.9</td>
</tr>
<tr>
<td>Biweekly</td>
<td>6</td>
<td>7.6</td>
</tr>
<tr>
<td>Monthly</td>
<td>19</td>
<td>24.1</td>
</tr>
<tr>
<td>Other</td>
<td>27</td>
<td>34.2</td>
</tr>
<tr>
<td>No response</td>
<td>1</td>
<td>1.3</td>
</tr>
</tbody>
</table>

*Due to rounding, percentages may not total exactly 100%.

Personal Feelings: Support and Robert Bly Research

This section on suicidal intention consists of three closed items. The first portion of the Personal Feelings section sought information from subjects regarding support for feelings, and the second portion capitalizes on Robert Bly's research on male and female feelings. Robert Bly is a mythological poet and major writer in the so-called "man's movement." The first choice of each of these items pulls on the typical male response, and the second choice pulls on the female response. This was blind, of course, to the subject.

The first section, which is divided into two questions, pulls information from the subjects regarding support for their feelings. As shown in table 15, 67 (84.8 percent) reported receiving support. The kinds of services that
Table 15
Sources of Support for Feelings

<table>
<thead>
<tr>
<th>Sources of Support for Feelings</th>
<th>Number</th>
<th>Percent*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Formal counseling</td>
<td>2</td>
<td>3.0</td>
</tr>
<tr>
<td>Informal counseling</td>
<td>4</td>
<td>6.0</td>
</tr>
<tr>
<td>Family</td>
<td>53</td>
<td>79.1</td>
</tr>
<tr>
<td>Peers</td>
<td>35</td>
<td>52.2</td>
</tr>
<tr>
<td>Self-help</td>
<td>21</td>
<td>31.1</td>
</tr>
</tbody>
</table>

67 (84.8%) reported receiving support from these sources:

*Because subjects could select more than one response, the percentages do not total 100%.

these subjects reported as being sources for this support were: formal counseling, 2 (3 percent); informal counseling, 4 (6 percent); family, 53 (79.1 percent); peers, 35 (52.2 percent); and self-help, 21 (31.3 percent). It should be noted that subjects could select more than one response on this item.

The second section pulls information from subjects regarding where they felt they should receive support if they did not. Eleven subjects responded to this item: 2 (18.2 percent) implicated formal counseling; 3 (27.3 percent) suggested informal counseling; and 3 (27.3 percent) suggested family, including father (4 or 36.4 percent), mother (3 or 27.3 percent), and siblings (1 or 9.1 percent). Two subjects (18.2 percent) suggested peers, and 5 (45.5 percent).
percent) suggested self-help. Again, subjects could select more than one response on this item. These responses are shown in Table 16.

Table 16
Suggested Sources of Support for Feelings

<table>
<thead>
<tr>
<th>Sources of Support for Feelings</th>
<th>Number</th>
<th>Percent*</th>
</tr>
</thead>
<tbody>
<tr>
<td>11 (13.9%) reported receiving no support but suggested these sources:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Formal counseling</td>
<td>2</td>
<td>18.2</td>
</tr>
<tr>
<td>Informal counseling</td>
<td>3</td>
<td>27.3</td>
</tr>
<tr>
<td>Family</td>
<td>3</td>
<td>27.3</td>
</tr>
<tr>
<td>Father</td>
<td>4</td>
<td>36.4</td>
</tr>
<tr>
<td>Mother</td>
<td>3</td>
<td>27.3</td>
</tr>
<tr>
<td>Siblings</td>
<td>1</td>
<td>9.1</td>
</tr>
<tr>
<td>Peers</td>
<td>2</td>
<td>18.2</td>
</tr>
<tr>
<td>Self-help</td>
<td>5</td>
<td>45.5</td>
</tr>
</tbody>
</table>

*Because subjects could select more than one response, the percentages do not total 100%.

The second part of the Personal Feelings section deals with Robert Bly's theory of the feelings of males, distinct and separate from the feelings of females. Table 17 reveals how the African American male college subjects responded to the feelings listed.

As shown in table 17, 49 (67.1 percent) of the 79 African American male college students reported feeling grief, whereas 24 (32.9 percent) reported feeling pain. Of the 79 subjects studied, 62 (82.7 percent) reported feeling
Table 17

How Males Experience Feelings

<table>
<thead>
<tr>
<th>How Males Experience Feelings</th>
<th>Number</th>
<th>Percent*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grief</td>
<td>49</td>
<td>67.1</td>
</tr>
<tr>
<td>Pain</td>
<td>24</td>
<td>32.9</td>
</tr>
<tr>
<td>Short-term</td>
<td>62</td>
<td>82.7</td>
</tr>
<tr>
<td>Prolonged</td>
<td>13</td>
<td>17.3</td>
</tr>
<tr>
<td>Inwardly</td>
<td>63</td>
<td>81.8</td>
</tr>
<tr>
<td>Outwardly</td>
<td>14</td>
<td>18.2</td>
</tr>
<tr>
<td>Short-term merging</td>
<td>48</td>
<td>66.7</td>
</tr>
<tr>
<td>Long-term merging</td>
<td>24</td>
<td>33.3</td>
</tr>
<tr>
<td>Spontaneous reaction</td>
<td>58</td>
<td>79.5</td>
</tr>
<tr>
<td>Organization in reaction</td>
<td>15</td>
<td>20.5</td>
</tr>
<tr>
<td>Blind risk taking</td>
<td>16</td>
<td>20.8</td>
</tr>
<tr>
<td>Organization of risk taking</td>
<td>61</td>
<td>79.2</td>
</tr>
<tr>
<td>Great deal of guilt</td>
<td>32</td>
<td>42.1</td>
</tr>
<tr>
<td>Short-term guilt</td>
<td>44</td>
<td>57.9</td>
</tr>
</tbody>
</table>

*Not all of the 79 subjects responded to each item; percentages total 100% of the subjects responding.

short-term pain, rather than the prolonged pain reported by 13 (17.3 percent). Of the 79 African Americans studied, 63 (81.8 percent) of the subjects reported inward pain, whereas 14 (18.2 percent) reported outward pain. Of the 79 studied, 48 (66.7 percent) reported short-term merging rather than long-term merging (knowledge of one's boundaries and personal space); 24 (33.3 percent) reported long-term merging. Of the 79 subjects studied, 58 (79.5 percent) reported
spontaneous reaction, compared with 15 (20.5 percent) who reported more organization. Of the 79 studied, 16 (20.8 percent) reported blind risk taking, whereas 61 (79.2 percent) reported more organization and awareness. Finally, 32 (42.1 percent) of the 79 subjects reported a great deal of guilt, whereas 44 (57.9 percent) reported short-term guilt. It should be noted that not all of the 79 subjects responded to each item; percentages cited total 100 percent of the number of subjects responding.

**Suicidal Intentions**

The final section of the survey examined how the subjects responded to Question 15, which elicited a "Yes" or "No" response to the question "Have you ever actively considered hurting yourself?" As shown in table 18, of the 79 subjects who filled out the survey, 12 responded with the affirmative choice.

Of the 12 who responded "Yes," as shown in table 18, 9 (75 percent) checked this intention as thought only, 2 (16.7 percent) selected this intention as gesture, and 1 (8.3 percent) selected this activity with multiple responses (thought and gesture). No subjects checked this activity as an actual attempt.

Furthermore, of the 12 who responded affirmatively to suicidal intention, 8 (66.7 percent) expressed that there was a well thought out plan, 3 (25 percent) responded that
Table 18
Suicidal Intentions

<table>
<thead>
<tr>
<th>Suicidal Intentions</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you considered hurting yourself?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>12</td>
<td>15.1</td>
</tr>
<tr>
<td>No</td>
<td>57</td>
<td>84.9</td>
</tr>
<tr>
<td>For those who reported suicidal intentions, type of intention:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thought</td>
<td>9</td>
<td>75.0</td>
</tr>
<tr>
<td>Gesture</td>
<td>2</td>
<td>16.7</td>
</tr>
<tr>
<td>Multiple response</td>
<td>1</td>
<td>8.3</td>
</tr>
</tbody>
</table>

there was no planning, and 1 (8.3 percent) gave no response. Table 19 shows this information.

Table 19
Existence of Suicidal Planning

<table>
<thead>
<tr>
<th>Was there a well thought out plan?</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>8</td>
<td>66.7</td>
</tr>
<tr>
<td>No</td>
<td>3</td>
<td>25.0</td>
</tr>
<tr>
<td>No response</td>
<td>1</td>
<td>8.3</td>
</tr>
</tbody>
</table>

For the eight subjects who admitted that suicidal intentions were well planned, table 20 provides detailed
Table 20
Details of Suicidal Planning

<table>
<thead>
<tr>
<th>Details of Suicidal Planning</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Isolation</td>
<td>6</td>
<td>75.0</td>
</tr>
<tr>
<td>Others involved</td>
<td>2</td>
<td>25.0</td>
</tr>
<tr>
<td>Timing so that intervention was</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Probable or likely</td>
<td>4</td>
<td>50.0</td>
</tr>
<tr>
<td>Not likely</td>
<td>4</td>
<td>50.0</td>
</tr>
<tr>
<td>Precautions against discovery</td>
<td>3</td>
<td>37.5</td>
</tr>
<tr>
<td>Passive precautions</td>
<td>3</td>
<td>37.5</td>
</tr>
<tr>
<td>Actions to gain help during attempt</td>
<td>3</td>
<td>37.5</td>
</tr>
<tr>
<td>No actions to prevent intervention</td>
<td>5</td>
<td>62.5</td>
</tr>
<tr>
<td>A suicide note</td>
<td>3</td>
<td>37.5</td>
</tr>
<tr>
<td>No suicide note</td>
<td>5</td>
<td>62.5</td>
</tr>
<tr>
<td>Overt communication</td>
<td>5</td>
<td>62.5</td>
</tr>
<tr>
<td>No overt communication</td>
<td>3</td>
<td>37.5</td>
</tr>
</tbody>
</table>

information as to characteristics of this planning. As shown, 6 (75 percent) admitted that this planning was in isolation, whereas 2 (25 percent) involved others; 4 (50 percent) timed their suicidal activity so that intervention was possible or likely, whereas the other 4 (50 percent) planned the activity so that intervention was not likely; 3 (37.5 percent) took precautions against discovery, and 3 took passive precautions; 3 (37.5 percent) took actions to gain help during or after their suicidal activity, and the remaining 5 (62.5 percent) took no action to gain help.
during or after the activity; 3 (37.5 percent) wrote a suicide note, whereas 5 (62.5 percent) wrote no suicide note; 5 (62.5 percent) overtly communicated intent of suicide before the attempt, and 3 (37.5 percent) communicated nothing before the attempt.

As shown in table 21, of the 8 who admitted planning, 4 (50 percent) communicated that the activity was so lethal that hospitalization was involved, and 1 (12.5 percent) admitted that the suicidal activity was lethal enough to involve a doctor's care; 1 (12.5 percent) checked that drugs were involved, 2 (25 percent) involved alcohol in the activity, 2 (25 percent) included other addictions, and 3 (37.5 percent) gave no response to addiction involvement. Five respondents (62.5 percent) expressed that the degree of damage to self was accidental, whereas 1 (12.5 percent) indicated the damage was intentional, and 2 (25 percent) gave no response to the degree of damage; 4 (50 percent) checked that the damage was to a human being, whereas 2 (25 percent) checked that the damage was to property and 2 (25 percent) gave no response. Table 21 concludes with 3 (37.5 percent) communicating that this was a first attempt, whereas 3 (37.5 percent) communicated that these action were a second attempt; 2 (25 percent) gave no response to what attempt this was.

The final two questions of the Intention section pulled information regarding self-destructiveness in the
Table 21
Additional Details of Suicidal Planning

<table>
<thead>
<tr>
<th>Details of Suicidal Planning</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Degree of lethality</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospitalization</td>
<td>4</td>
<td>50.0</td>
</tr>
<tr>
<td>Doctor's care</td>
<td>1</td>
<td>12.5</td>
</tr>
<tr>
<td>No response</td>
<td>3</td>
<td>37.5</td>
</tr>
<tr>
<td>Degree of destructiveness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drugs</td>
<td>1</td>
<td>12.5</td>
</tr>
<tr>
<td>Alcohol</td>
<td>2</td>
<td>25.0</td>
</tr>
<tr>
<td>Other addictions (work, etc.)</td>
<td>2</td>
<td>25.0</td>
</tr>
<tr>
<td>No response</td>
<td>3</td>
<td>37.5</td>
</tr>
<tr>
<td>Degree of damage to self by</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accident</td>
<td>5</td>
<td>62.5</td>
</tr>
<tr>
<td>Intention</td>
<td>1</td>
<td>12.5</td>
</tr>
<tr>
<td>No response</td>
<td>2</td>
<td>25.0</td>
</tr>
<tr>
<td>This damage was to</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Human</td>
<td>4</td>
<td>50.0</td>
</tr>
<tr>
<td>Property</td>
<td>2</td>
<td>25.0</td>
</tr>
<tr>
<td>No response</td>
<td>2</td>
<td>25.0</td>
</tr>
<tr>
<td>This action was</td>
<td></td>
<td></td>
</tr>
<tr>
<td>First attempt</td>
<td>3</td>
<td>37.5</td>
</tr>
<tr>
<td>Second attempt</td>
<td>3</td>
<td>37.5</td>
</tr>
<tr>
<td>Third attempt</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>No response</td>
<td>2</td>
<td>25.0</td>
</tr>
</tbody>
</table>

Table 22 shows how these 12 students responded to these queries. As shown in table 22, 3 (25 percent) of the 12 reported a history of self-destructiveness. The table further shows that the mother was not checked as being self-destructive, whereas 2 (16.7 percent) of the 12 checked the father. Neither sister nor brother was checked as being self-destructive.
Table 22

History of Self-Destructive Behavior

<table>
<thead>
<tr>
<th>History of Self-Destructiveness</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is there a history of self-destructive behavior in the family?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>3</td>
<td>25.0</td>
</tr>
<tr>
<td>No</td>
<td>9</td>
<td>75.0</td>
</tr>
<tr>
<td>Family members who had self-destructiveness:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not checked</td>
<td>3</td>
<td>25.0</td>
</tr>
<tr>
<td>Filtered</td>
<td>9</td>
<td>75.0</td>
</tr>
<tr>
<td>Father</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not checked</td>
<td>1</td>
<td>8.3</td>
</tr>
<tr>
<td>Checked</td>
<td>2</td>
<td>16.7</td>
</tr>
<tr>
<td>Filtered</td>
<td>9</td>
<td>75.0</td>
</tr>
<tr>
<td>Sister</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not checked</td>
<td>3</td>
<td>25.0</td>
</tr>
<tr>
<td>Filtered</td>
<td>9</td>
<td>75.0</td>
</tr>
<tr>
<td>Brother</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not checked</td>
<td>3</td>
<td>25.0</td>
</tr>
<tr>
<td>Filtered</td>
<td>9</td>
<td>75.0</td>
</tr>
</tbody>
</table>

Table 23 communicates that 2 (16.7 percent) of the 12 checked that this suicidal history was expressed by thought; 1 (8.3 percent) of the 12 expressed that it was by gesture. Also, 4 (33.3 percent) of the 12 communicated that there was loneliness in the history of the family; 1 (8.3 percent) checked that there was depression in the rest of
### Table 23
Additional History of Self-Destructive Behavior

<table>
<thead>
<tr>
<th>Self-Destructive Behavior</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>How this was shown:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thought</td>
<td>2</td>
<td>16.7</td>
</tr>
<tr>
<td>Gesture</td>
<td>1</td>
<td>8.3</td>
</tr>
<tr>
<td>Filtered</td>
<td>9</td>
<td>75.0</td>
</tr>
<tr>
<td>Other history:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Loneliness</td>
<td>4</td>
<td>33.3</td>
</tr>
<tr>
<td>Depression</td>
<td>1</td>
<td>8.3</td>
</tr>
<tr>
<td>Multiple response</td>
<td>2</td>
<td>16.7</td>
</tr>
<tr>
<td>No response</td>
<td>5</td>
<td>41.7</td>
</tr>
</tbody>
</table>

the family; 2 (16.7 percent) checked that there was loneliness and depression; and 5 (41.7 percent) checked nothing.

Finally, the researcher had a chi-square analysis done on the 12 subjects who checked they had serious suicidal activity. That is, the researcher sought to determine if any information pulled from the survey regarding the distinct characteristics of these 12 respondents differed from the expectations of the population. As shown in table 24, of the 79 respondents surveyed, only those items on the scale which pulled information from the 12 students tested that differed from the expected number of cases are included.
Table 24
Cases Observed of Twelve Students with Suicidal Intentions

<table>
<thead>
<tr>
<th></th>
<th>Cases Observed</th>
<th>Cases Expected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Living arrangements:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single dorm room</td>
<td>5</td>
<td>3.21</td>
</tr>
<tr>
<td>Not single room</td>
<td>6</td>
<td>7.79</td>
</tr>
<tr>
<td>Geographic region where lived longest:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Southeast</td>
<td>8</td>
<td>5.53</td>
</tr>
<tr>
<td>Rest of the country</td>
<td>4</td>
<td>6.47</td>
</tr>
<tr>
<td>Number of siblings:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Only child</td>
<td>5</td>
<td>3.12</td>
</tr>
<tr>
<td>Not only child</td>
<td>7</td>
<td>8.88</td>
</tr>
<tr>
<td>Mode of feeling upon loss, separation:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grief</td>
<td>5</td>
<td>8.05</td>
</tr>
<tr>
<td>Pain</td>
<td>7</td>
<td>3.95</td>
</tr>
<tr>
<td>Coping with emotions/feelings:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Short-term</td>
<td>7</td>
<td>9.92</td>
</tr>
<tr>
<td>Prolonged</td>
<td>5</td>
<td>2.08</td>
</tr>
<tr>
<td>Zaniness:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spontaneously</td>
<td>11</td>
<td>9.54</td>
</tr>
<tr>
<td>Planning, organization</td>
<td>1</td>
<td>2.46</td>
</tr>
<tr>
<td>Take risks:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blindly</td>
<td>6</td>
<td>2.50</td>
</tr>
<tr>
<td>Organization, awareness</td>
<td>6</td>
<td>9.50</td>
</tr>
<tr>
<td>History of self-destructiveness:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>3</td>
<td>1.06</td>
</tr>
<tr>
<td>No</td>
<td>9</td>
<td>10.94</td>
</tr>
<tr>
<td>History of self-destructiveness in family:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Father</td>
<td>2</td>
<td>1.00</td>
</tr>
<tr>
<td>History of loneliness/depression:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Loneliness</td>
<td>4</td>
<td>2.34</td>
</tr>
<tr>
<td>Depression</td>
<td>1</td>
<td>2.88</td>
</tr>
</tbody>
</table>
As shown in table 24, in regard to living arrangements, 5 of the 12 students checked that they lived in a single room, when the expected number was 3.21. Six students lived in other than a single room, when the expected was 7.79.

Eight of the 12 students checked that they lived longest in the Southeastern region, when the expected was 5.53. Four of the 12 checked that they had lived elsewhere in the rest of the country, when the expected was 6.47.

In regard to the number of siblings, 5 of the 12 checked that they were only children; the expected was 3.12. Seven checked that they were not only children; the expected was 8.88 (see table 24).

In regard to how African American male college students cope with loss, separation, or an ending, 5 of the 12 students checked the item dealing with grief, when the expected was 8.05. Seven checked "pain," when the expected was 7.79.

In dealing with emotions/feelings, 7 of the 12 had short-term shame, when the expected was 9.92. Five had prolonged shame, when the expected was 2.08.

Zaniness was experienced spontaneously in 11 of the students when the expected was 9.54. One student included planning and organization in zaniness, when the expected was 2.46.
As shown in table 24, 6 of the 12 students took risks blindly, when the expected population was 2.50. Six of the 12 students were organized and aware when taking risks, when the expected was 9.50.

In regard to background of the family, 3 of the 12 students reported a history of self-destructiveness in the family, when the expected was 1.06. Nine of the 12 reported no self-destructiveness, when the expected was 10.94. Also, 2 of the 12 reported that the father was the member of the family who was self-destructive, when the expected was 1.00.

Four of the 12 reported that there was a history of loneliness, when the expected was 2.34. One of the 12 reported that there was a history of depression, when the expected was 2.88.

In summary of the observations of the above results, there is a 2-4 digit span difference in the "suicidal" students as to how they deal with emotions from the expected population of the 79. In the data on self-destructiveness, 3 of the 12 students answered positively to a history of self-destructiveness in the family, when the expected was 1.06. Two of those 12 communicated that the person who was self-destructive was the father, when the expected was 1.00.

Obviously, the background and data collected on the population of male African American college students who reported suicidal intentions holds interest and statistical relevance for further focus by researchers. Chapter V
follows and not only provides discussion of the data of this study but also profiles each suicidal student for specific, individualized insight.
CHAPTER V

DISCUSSION

The primary purpose of this study was to survey a selected population of African American male college students to gather information regarding their attitudes and/or intentions toward suicide. The predominant information collected from this survey was reported in the results chapter for the three sections: demographic, feeling orientation, and suicidal intentions.

To bring out the conclusions, the researcher first presents a profile of each of the twelve students who checked that they had seriously considered suicide. The researcher then expands these findings by comparing and contrasting the characteristics within these twelve students, and then comparing and contrasting the characteristics of these students to the other sixty-seven who did not reveal suicidal intent. Results are then pulled together regarding education and theory on suicide.

After these major findings are reviewed regarding the twelve profiled students, summary and conclusions, limitations, implications for counselors, and directions for further research are presented.
Individual Profiles of the Twelve Students Who Expressed Suicidal Intentions

All of the twelve students who expressed suicidal intentions shared some common characteristics: they were all African American male college students attending a predominantly African American institution in the southeastern region of the United States.

Student 207. Other than the fact that this student is age eighteen and a freshman in college and the fact that he has no religious preference and his family has an income between $15,000 and $25,000, there are other qualities which the researcher focused on. For instance, regarding personal feelings, he reported that he had not received any help from family or peers and had to seek formal counseling. He claimed that he moves toward his pain, which is unusual for a male (who usually experiences loss with grief only) and lives this pain on a short-term basis. Also, this student moves toward merging on a long-term rather than a short-term basis, which is also unusual for a male. Regarding this pain, he accepts it and moves toward it, when most males try to ignore pain and move away from pain with long-term merging rather than short-term merging, an unusual characteristic of males. Usually males experience pain with short-term boundaries.

Also, this male experiences zaniness (being fantastically or absurdly ridiculous) spontaneously, and this
male takes risks blindly with no planning. Unfortunately, if there is failure he internalizes his guilt.

As far as suicide is concerned, this person checked his suicidal activities as "gesture," but he also had a well thought out plan. This plan involved isolation, timing, passive precautions such as avoiding others, actions taken to contact or prevent intervention, and no suicide note. This student reported that there was a degree of lethality involved, including (a) hospitalization, (b) use of drugs, and (c) accident to self (human), and that this attempt was the second one.

With regard to family, there was a history of self-destructive behavior in the family in his sister, who attempted suicide out of loneliness. And finally, this person is a student at a small "rural" college in the South-eastern United States.

**Student 208.** Student 208 is eighteen, is a freshman who comes from the Southeast, and has one roommate. His parents have a yearly income in the range of $5,000 to $15,000. He is an "only child," having no siblings, and attends religious services only rarely.

This student receives support for his thoughts and feelings from family and self. He experiences pain with short-term grief, inwardly and spontaneously. He wants to take risks with more organization and awareness, and he
feels guilt on a short-term basis. He has actively considered hurting himself, but there was no well thought out plan for this behavior or attitude.

**Student 209.** This student is age 20 or older, a college junior from the Southwest, and has a single roommate. His parents had a yearly income in the range of $25,001 to $35,000. He stated he is an only child and is second in birth order, so he must have lost a sibling by death. He chose Christianity as his religious preference and attends services weekly.

He revealed that he received support for his feelings from family, peers, and self. He suggested that more help from his father was needed.

In terms of feelings as related to Robert Bly's research on the male movement, this student moves toward pain, not grief. This pain is prolonged, not short-term, and is experienced inwardly. When zaniness is experienced it is spontaneous, but this student takes risks with organization and planning. However, this student experiences guilt on a short-term basis.

This student had actively considered hurting himself, and planning involved others, timing was likely, and actions for help were considered after the attempt. There was no suicide note and no overt communication of intent before the suicidal attempt. He reported that there had
been no self-destructive behavior in his family, but there had been a history of loneliness.

Student 212. This eighteen-year-old freshman from the Southwest has a single roommate and parental income in the range of $25,001 to $35,000. He has four siblings and is last in birth order rank, attending Christian religious services monthly. He receives support from family and peers for his personal feelings.

He moves toward pain, not grief, and this pain is short-term, not prolonged. He experiences this pain inwardly and with long-term merging. Also, zaniness is spontaneous, not planned or organized, and this student only takes risks with organization and awareness. His guilt is experienced in short spurts.

This student has actively considered hurting himself through thought, gesture, and attempt. There was a well thought out plan associated with these behaviors, and this plan was in isolation. Timing existed so that intervention was not likely. Precautions included avoiding others but doing nothing to prevent their intervention.

Actions involved gaining help during and after this attempt. There was no suicide note, and there was overt communication of the intent before the suicidal attempt. This student reported no self-destructive behavior in the family.
Student 219. This student is nineteen years old, is a freshman from the Midwest, and has a single roommate. His parents have an income in the range of $15,001 to $25,000, and he has no brothers or sisters. He is a Christian and attends religious services weekly. He feels he receives support for thoughts and feelings from family and peers.

When experiencing feelings, he moves toward pain, which is prolonged and inward. Rather than long-term, this student experiences pain on a short-term basis of merging. Craziness or zaniness is experienced spontaneously, and this student takes risks blindly. When he experiences shame, it is with a great deal of guilt.

This student has actively considered hurting himself and the appropriate intention is thought only. He has developed a well thought out plan with this behavior. This planning involved isolation, timing so that intervention was likely, precautions that were "other," and actions to gain help during or after the attempt. There was no suicide note, but there was overt communication of intent before the attempt. This student reported no history of self-destructive behavior within the family.

Student 235. This student is an eighteen-year-old freshman from the Southwest. He lives in a single room, has parental income above $35,000, and has one sibling. He is second in birth order and is a Baptist, attending services regularly.
He has received support for his thoughts and feelings from family, peers, and others. These feelings are grief oriented and are experienced inwardly on a short-term basis. When this subject takes risks, he does it with organization and awareness. When guilt is felt, it is intense.

In addition to the above information, this student has actively considered hurting himself but has no well thought out plan or history of self-destructiveness in the family. There is a history of loneliness in the family, however.

Student 139. This student is nineteen years old, a freshman from the American Northwest, and lives in a single room. His parents have an income in the range of $5,001 to $15,000, and he has two siblings. He is first in birth order rank and has no religious preference outside of African American awareness. He does not frequent religious services. He says he has received support for thoughts and feelings from family and suggests formal counseling and self-help if the above sources do not come through.

Regarding Bly's male mode of feelings, this student moves toward grief, not pain, in a short-term inward manner. This student experiences zaniness spontaneously, and when he takes risks he does so with organization and awareness. Guilt is experienced on a short-term basis.
This student has actively considered hurting himself and had a well thought out plan. This plan involved others and was timed so that intervention was likely. Precautions against discovery and/or intervention, such as a locked door, were taken. There was no action taken to contact others or prevent their intervention.

There was a suicide note but no overt communication of intent before the suicidal activity. He reported that there was a degree of lethality (hospitalization), destructiveness (alcohol), a degree of damage to self (intention), and damage to property. This action was a first attempt.

There was a history of self-destructiveness in the student's family, and this self-destructiveness was in his father. His family has a history of depression.

**Student 138.** This student is age twenty or above, a freshman, and from the southeastern region of the United States. He lives in a single room, his parents have an income above $35,000, and he has three siblings. He is second in birth order and is Baptist in religious preference. He attends services weekly. He reports that he has received support for thoughts and feelings from family and self.

As related to Bly's male mode of feeling, he moves toward pain, not grief. This pain is prolonged, not short-term, and is directed inward, not outward. This pain involves short-term merging. Zaniness (or ridiculousness)
is experienced with planning and organization, and this male college freshman takes risks blindly, with short-term guilt.

This student has actively considered hurting himself through gesture. There was no well thought out plan, and what planning there was involved isolation and no timing. Precautions against discovery were taken, but no actions were taken to prevent intervention. There was no suicide note or overt communication of intent to commit suicide.

This student indicated a degree of lethality in that a doctor's care was involved, destructiveness involved alcohol, the degree of damage was intentional, and there was damage to property. This was a second attempt at suicide.

There was a history of self-destructiveness in this student's family. His father had thought of suicide, and the family had a history of depression.

**Student 136.** This student is age eighteen and a freshman from the southeastern region of the United States. This student has only one roommate and no siblings. He attends a Baptist church regularly. He feels he has received support for his feelings from family, peers, and self-help.

In the area of personal feelings, when there is loss or separation this student moves toward grief. When there is an experience that exposes him internally, he has prolonged pain. This student experiences pain outwardly and moves toward it. He merges with space and boundaries on a
short-term basis, experiences zaniness spontaneously, takes risks blindly, and internalizes a great deal of guilt.

This student checked that he had actively considered hurting himself, and there was a well thought out plan in regard to suicide. This plan included isolation and was devised so that intervention was not likely. He took passive precautions so that intervention was possible. He left a suicide note and did not communicate that he was considering suicide.

The degree of lethality regarding suicide was evident in that it resulted in a doctor's care and included destructiveness by alcohol and a degree of damage to himself accidentally. This suicidal attempt was the second one. There is a history of self-destructiveness in this student's family, as exemplified by the father, who had a history of loneliness and depression.

Student 127. This nineteen-year-old student comes from the southeastern area of the United States. He lives in a single room and has parents who make between $25,001 and $35,000 per year. This student is an only child and attends Muslim religious services weekly. He receives support for his thoughts and feelings from his family.

In the male mode of feeling, when there was a situation of loss this student experienced grief on a short-term basis and expressed these feelings inwardly. As far as boundaries, this student experiences them on a short-term
level only. When zaniness is experienced, it is done spontaneously. When this student takes risks, he takes them with organization and awareness. Guilt is expressed on a short-term basis.

This student actively considered hurting himself, and the plan for hurting himself was well thought out and involved others but was timed so that intervention was not likely. Actions were taken to gain help during and after the suicidal attempt. There was no suicide note, and there was communication that this student intended to commit suicide before the attempt.

The degree of lethality associated with this student's suicidal attempt involved hospitalization, other addictions, and a degree of damage done to self. This was this student's second attempt at suicide. There has been no self-destructive behavior in his family.

**Student 124.** This student is nineteen, a freshman, and from the southeastern part of the country. His parents have a yearly income of over $35,000, and he lives off campus. He has one sibling, and he is first in birth order. He attends religious services weekly. He has received support for his feelings from family.

When there is a situation that is associated with loss, this student experiences and moves toward prolonged pain. This experience is an inward one, and movement is
toward that pain. When there is an issue that indicates merging, it is short-term. When zaniness is experienced, it is done spontaneously. When this student takes risks, he takes them with organization and awareness. When guilt (awareness of right and wrong) occurs, this student has a great deal of guilt.

This student has actively considered hurting himself but did not report an attempt. There has been no history of self-destructive behavior in the family.

**Student 117.** This freshman student is twenty years of age or older and comes from the southeastern region of the United States. He has one roommate, and he reported parental income between $5,001 and $15,000. He is first born in birth order and is Baptist. He does not feel he has received support for his feelings but suggests that the help of his mother and father might be positive.

This student moves toward pain, which might be prolonged and inward. When boundaries are questioned, he responds spontaneously, and when risks are taken they are done blindly. He experiences guilt heavily.

This student has actively considered hurting himself and had a well thought out plan including isolation, timing so that intervention was not likely, precaution against discovery and/or intervention, such as a locked door, and no action taken to prevent intervention. There was a suicide
note as well as overt communication of intent before the attempt.

As far as the seriousness of this student's suicidal activity is concerned, he claims no hospitalization, no destructiveness, a degree of damage done to self, and a degree of damage done to property. This suicidal action was the first attempt. There is a history of self-destructive behavior in the family, as well as a history of loneliness and depression in the family.

Student 108. This freshman, age nineteen, is from the southeastern region of the country and has one roommate. His parents have two incomes: he listed his father's income as $5,001 to $15,000 and his mother's income as $35,000 or more. He has four siblings and is third in birth order. He is Baptist in religious preference and attends services occasionally. He feels he has received support for his thoughts and feelings from peers and self.

He moves toward pain, and it is short-term. He expresses that pain inwardly, in a short-term manner. Zaniness is expressed spontaneously, and he takes risks blindly. Guilt is only experienced on a short-term basis.

This student has actively considered hurting himself with a well thought out plan. Planning involved isolation but was timed so that intervention was likely. There was no suicide note, and overt communication of intent was not made by this student.
Student 138. This freshman from the Southeast is twenty years of age or older. He lives in a single room, and his parents have a yearly income above $35,000. He has three siblings and is second in birth order. He prefers Baptist services and attends weekly. He admits that he has received support for thoughts and feelings from his family.

Even though he should experience these feelings with grief only, he has moved toward pain with prolonged emotion. He experiences boundaries on an inward level, with short-term merging as well as planning and organization. When he takes risks, they are taken blindly with only a short-term level of guilt.

He has actively considered hurting himself. There was no well thought out plan associated with this behavior. He noted such a plan would include isolation, timing so that intervention was not likely, precautions against discovery and/or intervention, no action to contact or prevent intervention, no suicide note, and no overt communication of his intentions.

Trends Within the Twelve Students Who Had Seriously Considered Suicide

Certain characteristics tend to occur in the twelve students who had actively considered suicide as a coping mechanism. Educators and researchers begin to form certain hypotheses to take the next logical step after a survey—
intervention. This section outlines these characteristics and/or trends.

In the first section of the survey, from which demographic information was pulled, six of the twelve students checked that they were only children, and one of the twelve was the youngest, or baby, of the family. This is a high figure—50 percent of these students feel the responsibilities that an only child tends to bear. Perhaps by being the only child and pampered at home, college life may be more stressful in that he does not receive the attention he is accustomed to at home.

In addition, six of the twelve students are first in birth order. First-born children undergo tremendous pressure to maintain this position, especially since they are dethroned by the second child. Perhaps being first born also relays the message that he must set the example and live up to the family's expectations. If any type of failure occurs, the first born may feel more guilt and be more depressed.

From the demographic information, five of the twelve students (nearly 50 percent) attend religious services rarely, and six of the twelve attend religious services weekly. Perhaps attending religious services has no real influence on these students' thoughts regarding life, or perhaps other stresses supercede these students' lives as
compared to the impact of traditional religion in their lives.

As far as economics are concerned, four of the twelve students have parents whose income exceeds $35,000, and four have parents whose income is below $15,000. The remaining four students have parents with income somewhere between $15,000 and $35,000. So the suggestion is that income has no relevance to a student's suicidal thinking; it occurs across the board. Factors other than income are creating the problems that these students are dealing with.

One other factor the researcher would like to point out is this: seven of the suicidal students come from an urban university, and five come from a rural university. Since these numbers both approach an even division of six, whether the environment is rural or urban does not seem to have an impact, except that a rural environment might be slightly better than an urban one.

The final observation regarding demographics is that close to 50 percent (five) of these students live alone, without a roommate. Perhaps living alone is conducive to depression. Also, seven of the twelve live with others, so having others around does not mean that depression will not exist.

The second major section of this survey dealt with personal feelings. The first observation the researcher makes concerns where these students tend to get support:
nine of the twelve students (75 percent) get support for their feelings from their family. The researcher suggests that the problem of depression and/or suicide may be entwined with the family and the systems that these students' families communicate. Further investigation might include research on how these systems have created suicidal thinking in regard to these students. The family has definitely had an impact on these students. The other three students have received support from formal counseling, peers, and self-help, and one student wishes he had more family support.

Research might focus on how families can be enriched to give support to students moving into educational environments. Changes in the family system, such as the roles played by mother and father, might be explored, especially regarding how these roles change and put more pressure on the parents to adjust to new areas of individual exploration and discovery outside of role playing. One of the toughest problems is attending to children and youth as they grow up; perhaps parents are too busy with other tasks.

The next major section on feeling surrounds Robert Bly's movement on male feelings. Eight of the twelve students expressed that they move toward pain, not grief. Normally, the male moves toward grief; to have eight of the twelve, or 66 percent of the suicidal population, move
toward the "female" aspect of experiencing pain is remarkable. The researcher draws from past experience with Carl Jung's discoveries on the unconscious element of man's evolution. The feminine archetype is expressed in many ways. For the researcher to observe that eight of the twelve suicidal students are moving toward pain, not repressing it, is relevant. Perhaps men are allowing feeling to occur, and not repressing it. However, if moving toward this pain also brings suicidal thought, perhaps intervention could be structured so that pain is dealt with and support is provided as soon as possible.

As far as pain is involved, six of the twelve students experienced pain in a "prolonged" or feminine manner, whereas in the traditional male this pain should be short-termed. Again, the researcher points out the strength of the feminine archetype, the unconscious element of men who do not totally understand the forces in control evolutionarily. At the same time, six students of the twelve expressed short-term pain, and six students expressed prolonged pain.

Unfortunately, six of the twelve students expressed themselves inwardly—traditionally, males tend to repress their real feelings—and merging is only on a short-term basis for nine of the twelve. Males do not allow themselves to merge with others, or feelings, on a long-term basis.
Zaniness, or being fantastically ridiculous, is brightly expressed by eleven of the twelve students. This group of students allows fantastic craziness to occur.

As far as risks are concerned, six of the twelve students take them spontaneously, whereas the remaining six take them with organization and awareness. As far as risk taking is involved, six of the twelve students admitted that they had taken these risks blindly, and six selected organization and awareness. When guilt is experienced, it is with a great deal of expression.

Finally, the researcher includes data from the intention section. The information selected regards several aspects. These intentions are important; they involve: (1) isolation, (2) timing that makes intervention probable or likely, (3) precautions that make intervention not likely, and (4) action to gain help during or after an attempt at suicide. All of these students admitted an intention to commit suicide. In comparing and contrasting within the twelve suicidal students, there tends to be a trend of self-destructiveness in the families of African American males.

Conclusions

Now the researcher compares and contrasts the twelve students expressing suicidal intentions with the remaining sixty-seven students surveyed. The real issues appear when
the twelve students who checked having had serious suicidal considerations are compared to the rest of the population in regard to the information surveyed. For instance, perhaps living in a single dorm room or alone, being an only child, and living predominantly in the Southeast are factors that could be researched further as possible conditions that are conducive for suicidal consideration. If an African American male college student has experienced self-destructiveness or depression in his family history, further research might examine if suicidal coping behavior is "inherited."

The most informative information was conveyed in the section dealing with Robert Bly's scale on how males deal with emotions. Suicidal African American males show some differentiation from the expected population in how they deal with grief: only five of the twelve checked grief, and the other seven checked pain. Perhaps loss and separation is not felt like most males experience but as the expected female would approach it—with pain.

Also, this population experiences prolonged shame, not short-term shame. These males tend to feel guilt with greater depth level some people do. As far as zaniness and risk-taking are concerned, these students scored high in spontaneously experiencing zaniness, and fewer students than the expected included planning in their zaniness. African American males tend to be zany without planning. Also, risk
taking was more predominant in this population, without planning and organization, than in the expected population.

In conclusion, the chi-square information shows that the distributions are slightly skewed, indicating that the suicide sample is not exactly like the rest of the surveyed population. Also, based on the issues of Robert Bly's scale on male-female feelings, the twelve students who checked suicidal consideration show certain trends that are supported by the survey.

**Limitations**

This descriptive study was limited in that the population from which the suicidal sample was chosen may not have been large enough. The study was also limited in that the instrument designed for screening may not have been developed highly enough for the African American male college population under study to detect distress and thereby treat such distress.

**Implications for Counselors**

The fact that twelve students out of a small population of seventy-nine checked items dealing with suicidal intentions is strong enough in terms of research to justify the importance of further study in this unique population. The relevance of a growing incidence of suicide in a population of people who previously had virtually no suicides bears impact to suicide in youth universally.
The therapeutic relationship of counselor to client can be fragile. The demands on the client (adolescent, Japanese, African American, divorced, etc.) that have been thrown into oblivion by "future shock" have far-reaching implications for counselors and others in the helping profession. The expanded knowledge and search for understanding of these dynamics is implied. The young African American adult symbolizes far-reaching demands on the rest of the members of the dynamically changing clientele of counselors. The sensitivity of these varied dynamics universally can be understated and yet possibly addressed by this study. The advent of psychological needs and methods beyond the traditional Eurocentric philosophies are not only surveyed by the African American counselors and psychologists but, as such, demanded by counselors who are committed to meeting the demands of their profession ethically, to allow change and growth in personal self continually.

As to further research, data collected from this survey should uncover the information that would lead to treatment of suicide in general and with African American male college students in particular. Treatment would follow significant information entailed as data have been gathered in each section of the survey.
Summary

Society is experiencing major changes in family and social support systems. Suicide as an alternative for children, adolescents, and young adults has increased. "Everyone knows that we are going into a wrong direction . . . but we do not know how to stop it."248

On the other side of the coin, the preventive and life-giving measures that might interrupt the process of desperation amid one population that educators and counselors serve is an option. This study lays the groundwork of data needed for the next level--intervention--in which sharing these thoughts and confronting one another's pains and struggles and thereby gaining strength from sources readily available can serve as alternatives. A joining of members in the educational and social community to serve as an "extended family" can begin to be the new fabric and context for applying these evolving interventions.

248PBS, "Nova," 23 November 1992, 11:00-12:00 p.m.
APPENDIX

A SURVEY OF SUICIDAL INTENTIONS
Instructions for a Survey of Suicidal Intentions

Proctors, teachers, and other personnel, please read the following aloud to your group:

We are assisting a doctoral student who is doing research on college students. We would appreciate it if you would complete this checklist. The information received from this checklist will be used to assist students with stresses relative to college life. If you prefer to keep your participation confidential, please fill in the last four digits of your Social Security Number in place of your name.

We want to assure students that they will not be identified in any part of publication and/or exposure to the public. Privately, if anyone needs help, counseling will be provided by the school counselors whose names are listed below:

[Listed here were names and telephone numbers of the institution's counselors]

Consent and Release Form

Please read and sign before filling out the survey:

I release [name of institution], administrators, counselors, faculty, and researchers from liability in regard to this research. If I need further assistance, I will contact the appropriate counselor or the researcher. This institution complies with the Public Law as well as with Title 45 of the Code of Federal Regulations in regard to reviewing activities and projects involving human subjects. I give out this confidential information with the understanding (consent) that information gleaned from such research will aid in the enrichment of future college students' lives.

Your Name (or last 4 digits of your SSN) Date Time
A SURVEY OF SUICIDAL INTENTIONS

Indicate the choice that best describes your feeling or condition. Answer each item.

Demographic Information

1. Sex:
   ____ Male
   ____ Female

2. Age:
   ____ 17
   ____ 18
   ____ 19
   ____ 20+

3. Classification:
   ____ Freshman
   ____ Sophomore
   ____ Junior
   ____ Senior
   ____ 1st Semester
   ____ 2nd Semester

4. Ethnicity:
   ____ African American
   ____ Caucasian
   ____ Hispanic
   ____ Other:

5. Geographic region where you have lived the longest:
   ____ Southeast
   ____ Southwest
   ____ Northeast
   ____ Northwest
   ____ New England Area
   ____ Midwest

6. Dormitory living arrangements:
   ____ Single room
   ____ Not single room; number of roommates:

7. Parent(s) yearly income:
   ____ None
   ____ Under $5,000
   ____ $5,001 to $15,000
   ____ $15,001 to $25,000
   ____ $25,001 to $35,000
   ____ Above $35,000
8. Number of siblings:
   ___ None
   ___ 1
   ___ 2
   ___ 3
   ___ 4+

9. Birth order rank:______ (example: 1st, 2nd, 3rd, etc.)

10. What is your religious preference?_____________________

11. How frequently do you attend religious services?
   ___ Weekly
   ___ Biweekly
   ___ Monthly
   ___ Other (specify):_____________________

Personal Feelings:

12. a. Do you feel that you have received support for your thoughts and feelings?
   ___ Yes
   ___ No

   b. If you have received support for your thoughts and feelings, please check the source:
      a. ___ Formal counseling
      b. ___ Informal counseling
      c. ___ Family
      d. ___ Peers
      e. ___ Self-help

13. If you have not received support, what source would you suggest?
   a. ___ Formal counseling
   b. ___ Informal counseling
   c. ___ Family:
      ___(1) Father
      ___(2) Mother
      ___(3) Siblings
   d. ___ Peers
   e. ___ Self-help
14. Robert Bly (1986) suggests a model of the male mode of feeling. Listed below are mixed modes of male and female feelings. Please check only one appropriate choice.

a. When there is a situation that is associated with loss, separation, or an ending, which mode of feeling would you express?
   ___grief
   ___pain

b. When there is an experience that tends to expose you internally or externally, as in shame, how do you cope with this emotion?
   ___short-term
   ___prolonged

c. When there is an expression of internal hurt, pain is expressed inwardly, by accepting the pain and trying to ignore it, or outwardly, by movement toward that pain. When I have feelings of pain, I express myself
   ___inwardly
   ___outwardly

d. When there is an issue that indicates merging (knowledge of one's boundaries and personal space), I indicate
   ___short-term merging
   ___long-term merging

e. When zaniness (being fantastically ridiculous or absurdly ridiculous) is felt, I indicate it
   ___spontaneously
   ___with planning and organization

f. When I take risks, I take them
   ___blindly
   ___with more organization and awareness

g. When guilt (awareness of right and wrong) is felt, I internalize
   ___a great deal of guilt
   ___short-term guilt
Intentions:

15. Have you ever actively considered hurting yourself?
   ___Yes
   ___No

16. Check the appropriate attitude related to the above question if you have answered Yes:
   a. ___thought
   b. ___gesture
   c. ___attempt

17. Was there a well-thought-out plan associated with any of the above behaviors?
   ___Yes
   ___No

If yes, did the planning involve:

a. Isolation
   ___(1) Isolation
   ___(2) Other(s) involved

b. Timing so that intervention was
   ___(1) Probable or likely
   ___(2) Not likely

c. Precautions
   ___(1) Precautions against discovery and/or intervention such as a locked door
   ___(2) Passive precautions such as avoiding others but doing nothing to prevent their intervention
   ___(3) Other

d. Actions
   ___(1) Actions to gain help during/after attempt
   ___(2) No actions to contact or prevent their intervention

e. A suicide note
   ___Yes
   ___No

f. Overt communication of intent before attempt
   ___Yes
   ___No
From the above questions, was there a degree of:

g. Lethality
   ____ (1) hospitalization
   ____ (2) doctor's care

h. Destructiveness
   ____ (1) drugs
   ____ (2) alcohol
   ____ (3) other addictions (work, etc.):

i. Degree of damage done to self by
   ___ (1) accident(s)
   ___ (2) intention

   This damage was
   ___ Human
   ___ Property

18. This action was
   a. ____ First attempt
   b. ____ Second attempt
   c. ____ Third attempt

19. Has there been a history of self-destructive behavior in your family?
   ____ Yes
   ____ No

   a. If yes, what member?
      ____ Mother
      ____ Father
      ____ Sister
      ____ Brother

   b. Was this by
      ____ thought
      ____ gesture
      ____ attempt

20. Has a member of the family had a history of
    ____ Loneliness
    ____ Depression
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