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Moral Objections to Suicide and Suicidal Ideation among Mood Disordered Whites, Blacks, and Hispanics

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Abstract

Understanding the beliefs that protect individuals against suicide can help to enhance suicide prevention strategies. One measure of suicide non-acceptability is the Moral Objections to Suicide (MOS) subscale of the Reasons for Living Inventory (RFLI). This study examined the MOS and suicidal ideation of White, Black, and Hispanic individuals with mood disorders. We expected minority individuals to have stronger objections to suicide.

Method: 804 White (588), Black (122) and Hispanic (94) participants with DSM-IV diagnoses of MDD or Bipolar Disorder were administered the Scale for Suicide Ideation, the Reasons for Living Inventory and several measures of clinical distress.

Results: Higher suicidal ideation was modestly correlated with lower MOS scores overall ($r=0.15$, $p=.001$). Among Blacks however the relationship was inverted: despite having higher suicidal ideation than Whites or Hispanics, Blacks reported the least accepting attitudes toward suicide.

Conclusion: These results suggest that attitudes regarding the acceptability of suicide may be independent of suicidal ideation.

Keywords

suicide acceptability; risk factor; protective factor; reasons for living; ethnicity; moral objections to suicide

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Contributors

Dr. Richardson-Vejlgaard analysed the data and did most of the writing of the manuscript. Drs. Oquendo and J.J. Mann obtained the funding and oversaw the data collection. Dr. Sher consulted on the data analysis and contributed editorially to the manuscript. Drs. Oquendo and Lizardi revised drafts of the manuscript and offered editorial suggestions; Dr. Stanley was an Investigator on the studies from which data was used, mentored Dr. Richardson, provided editorial oversight, and revised drafts of the manuscript. All authors contributed to and have approved the final manuscript.

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Conflict of Interest

All authors declare that they have no conflicts of interest or relevant financial interests or personal affiliations that are related to the content of this paper.

1. INTRODUCTION

Ethnic minorities comprise 25% of the U.S. population and their numbers are expected to grow significantly over the next 50 years (Census, 2000). At the same time, trends in suicide rates among ethnic minorities have been changing, with younger minority males becoming increasingly susceptible to suicidal behavior ((CDC), 2007; Castle, Duberstein, Meldrum, Conner, & Conwell, 2004). The reasons people give for not engaging in suicidal behavior differ according to race/ethnic group due to factors such as cultural stigma about suicide, religious beliefs about responsibility for life, and coping styles informed by a history of overcoming adversity (Gibbs, 1997; Morrison & Downey, 2000; Oquendo et al., 2005). By understanding beliefs related to suicide, we may be able to enhance prevention systems to lower the incidence of suicidal behavior.

Having an accepting attitude toward suicide has been shown to predict the extent of planning of suicide attempts (Joe, Romer, & Jamieson, 2007), which in turn may increase the lethality of attempts (Baca-Garcia et al., 2001; Baca-Garcia et al., 2005; Brent, 1987; Mann & Malone, 1997). Yet it is only one factor that contributes to suicidal behavior, and may never result in suicidal behavior in the absence of other psychiatric or psychosocial risk factors. Acceptance of suicide as an option can be conceptually distinguished from the wish to die. An individual may have a wish to die, without believing that inflicting harm to the self is an option. Alternately, someone may reserve the hypothetical right to take his own life, without being depressed, or wanting to die. Regardless of one's circumstances however, a firm belief that suicide is not an acceptable option is likely to be an important protective factor.

This study examines the attitudes that mood disordered White, Black, and Hispanic individuals have regarding the non-acceptability of suicide, and the extent of their suicidal ideation. We use the term 'suicidal behavior' to refer to past suicide attempts, and 'suicidal ideation' to refer to thoughts about taking one's life. Our measure of suicide non-acceptability is the Moral Objections to Suicide Subscale of the Reasons for Living Inventory (RFLI). The RFLI was developed to elicit suicide potential indirectly, by asking respondents to identify which adaptive, life-sustaining beliefs would cause them to avoid suicidal behavior (Linehan, Goodstein, Nielsen, & Chiles, 1983). High scores on the scale indicate many reasons to avoid suicide. The Moral Objections to Suicide (MOS) subscale addresses the issue of acceptability/unacceptability of suicide most clearly. The MOS subscale contains four statements, three of which are of a religious nature (Only God has the right to end life; I am afraid of going to Hell; My religion forbids it) and one non-religious (*I consider it morally wrong*). This subscale has been reported to differentiate suicide ideators from non-ideators (Connell & Meyer, 1991; Linehan et al., 1983). Some research also indicates that responses on the MOS subscale may vary by race/ethnicity, with Blacks scoring higher than Whites (Morrison et al., 2000; Ellis & Range, 1991), and Latinos scoring higher than non-Latinos (Oquendo et al., 2005). As such, one would expect that ethnic minorities (Blacks and Hispanics) should score higher on the MOS subscale than Whites.

2. METHOD

2.1 Participants

Data from four studies conducted in the Suicide Intervention Center and Conte Center for the Neurobiology of Mental Disorders were aggregated and analyzed for this study. Eight hundred and four (804) participants who met the DSM-IV criteria for lifetime or current MDD or Bipolar Disorder were included. Participants were recruited from newspaper and internet advertisements and clinician referrals. A written informed consent, approved by the

Institutional Review Board, was obtained from each participant after a complete description of the study.

2.2 Materials

An extensive personal, social, psychiatric, and family history was obtained from participants. The Structured Clinical Interview for DSM-IV, Axis I (SCID; (First, Spitzer, Gibbon, & Williams, 1996) was administered to assess Axis I diagnoses. A lifetime history of suicide attempts was obtained from the Columbia Suicide History Interview, including dates, method, and environmental trigger. A suicide attempt was defined as a deliberate self-injurious act performed with at least some intent to die (Mocicki et al., 1988). Medical lethality was measured using the Lethality Rating Scale (Beck, Beck, & Kovacs, 1975). Suicidal ideation was measured using the Scale for Suicide Ideation, which assesses the extent of an individual's wish to die, and the degree of planning associated with that wish (Beck, Kovacs, & Weissman, 1975). The Brown Goodwin Aggression History (Brown & Goodwin, 1986) was used to rate lifetime aggressive behaviors. The Barratt Impulsivity Scale (Patton, Stanford, & Barratt, 1995), a 30-item self-report, assessed the dimension of impulsivity. Objective levels of depression were assessed with the Hamilton Depression Rating Scale (Hamilton, 1960).

The Reasons for Living Inventory (RFLI) was administered to assess beliefs about the acceptability/unacceptability of suicide. Responses on this 48-item scale load onto six main factors that include: survival and coping beliefs (e.g., I believe I can learn to adjust or cope with my problems), responsibility to family (e.g., I have a responsibility and commitment to my family), child related concerns (I want to watch my children as they grow), fear of suicide (e.g., I am afraid of the unknown), fear of social disapproval (e.g., I am concerned about what others would think of me), and moral objections to suicide (e.g., I believe only God has the right to end a life). The RFLI has been found to be a valid and reliable predictor of suicidal ideation, despite the fact that it does not directly ask about the wish to die (Connell et al., 1991; Linehan et al., 1983). It has been shown to discriminate suicide attempters from non-attempters (Malone et al., 2000), and has been found useful in identifying "latent ideators" or individuals who are unwilling to disclose suicidal ideation on screening forms, but then report suicidal wishes during the clinical assessment (Morrison et al., 2000). Internal consistency for the RFLI subscales are reported to vary between 0.72 and 0.89 (Linehan et al., 1983).

2.3 Data Analysis

All analyses were conducted using SPSS (15) statistical software. For tests comparing the three ethnic groups on continuous dependent measures Bonferroni post-hoc tests were used to make pairwise comparisons. Group differences on categorical dependent variables were analyzed using Kruskal Wallis Chi Square tests. Alpha levels were adjusted for multiple comparisons, and appear at the foot of each table. Several demographic variables had significant effects on the RFLI and suicidal ideation, including age, marital status, years of education, and sex. The association between MOS and suicidal ideation was determined by partial correlation, controlling for these demographic variables. These variables were also included as covariates in multivariate analyses of covariance examining the effects of ethnic group on the five RFLI subscales, and on depression, hopelessness, aggression and impulsivity. Separate ANCOVA analyses were conducted to evaluate group differences on MOS and suicidal ideation.

Because the proportion of Whites in this sample was substantially greater than the numbers of Blacks and Hispanics we evaluated the skewness and kurtosis for each dependent variable by race/ethnicity. These were found to be within normal limits. To further ensure that the

differences in sample sizes did not adversely affect our interpretations of the data, we selected 100 cases from the sample of White participants using the random selection feature of SPSS, and re-ran all of our analyses. This had no effect on either the strength, or direction of our key findings.

3. RESULTS

3.1 Sample Characteristics

Overall, participants were between the ages of 17 and 85 years, with an average age of 38.7 years. The amount of formal education ranged from 3 to 24 years, with an average of 14.6 years. Women in the sample (69%) outnumbered men, and this was most true among Blacks. Whites were by far the largest racial/ethnic group in the sample, followed by Blacks, then Hispanics. Whites had the highest educational level of any of the racial/ethnic groups. Marital status was not different between the three groups, however, Blacks had the most children of any racial/ethnic group. A complete description of the sample composition is presented in Table 1.

3.2 Clinical Characteristics

All participants had a psychiatric diagnosis of mood disorder; 73% had Major Depressive Disorder, and 27% had Bipolar Disorder, and were currently suffering from a Major Depressive Episode. There were no significant race/ethnic differences in the percentages of participants with Depression vs. Bipolar disorder. A one-way analysis of variance found no effects of diagnostic category on suicidal ideation, number of suicide attempts, or RFLI scores in our sample.

Clinician ratings of depression, hopelessness and impulsivity were similar for all three groups, however there were clear differences between groups on the dimension of aggression, with Blacks being significantly more aggressive than Whites and Hispanics, and Whites being significantly more aggressive than Hispanics.

3.3 Ethnicity and suicide acceptance

There was a modest association between MOS and suicidal ideation overall (partial $r=0.15$, $p=.001$). A MANCOVA revealed that Blacks reported having moral objections to suicide at a significantly higher rate than Whites or Hispanics. Clear distinctions emerged between Blacks and Whites on other RFLI subscales, including survival coping beliefs, child-related concerns, and total reasons for living. The Hispanic sample was not distinct from Whites or Blacks on any of the RFLI subscales, and their mean scores were often similar to Whites. The pattern of endorsing reasons for living among Blacks was distinct from Whites or Hispanics. Whereas Whites and Hispanics were likely to cite family responsibility as the single most important reason for not engaging in suicidal behavior, Blacks also rated coping beliefs related to survival and child-related concerns to a similarly high degree (see Table 3).

In terms of suicidal behavior, Blacks were most likely to have made a suicide attempt in the past, although the average number of prior attempts was no different from other ethnic groups, and the lethality of their most serious attempt was significantly lower than Whites. Blacks reported the highest level of suicide ideation of the three groups.

4. DISCUSSION

These results suggest that differences in race and ethnicity may have an effect on the reasons people give for not accepting suicide as an option. Our finding that Blacks endorsed a distinct pattern of responses from Whites is consistent with Morrison and Downey (2000)

who found that Black college students endorsed higher moral objections to suicide and survival coping beliefs than Whites. Similarly Ellis and Range (1991) found that Black college students rated higher than Whites on the moral objections subscale. The fact that our clinical sample responded in a similar way to two college student samples indicates that racial/ethnic differences on the RFLI are robust, and suggests that this scale may be used in further explorations of ethnic differences in suicide acceptability.

Given the religious themes of the MOS items, it is possible that ethnic differences on this subscale may be related to differences in religious affiliation across ethnic groups. Dervic et al. (2004) reported that individuals with religious affiliations perceived more reasons for living—particularly moral objections to suicide—than those without religious affiliations. Similarly, Lizardi et al (2007) reported that those with low MOS were more often without religious affiliation as compared to those with high MOS. Kaslow et al (2005) have also noted that religiosity is associated with lower suicidality among African Americans.

Two-thirds of the Blacks in our sample had made a prior suicide attempt, albeit of a lower average level of lethality than Whites. The majority of these individuals were female (83% of Black attempters, and 56% of total Black sample), suggesting that the frequency of low-lethality suicide attempts in the Black sample may be related to the disproportionate number of women in this sample. This is consistent with other research showing that women make suicide attempts far more frequently than men, but their attempts tend to be much less lethal (Hawton, 2000; Moscicki et al., 1988). This finding, as well as the evidence of heightened symptom severity among Black participants (including high levels of aggression, greater incidence of prior suicide attempts, and higher suicidal ideation) also suggests a possible a selection bias, in that the Black volunteers who presented for these clinical studies may have been more in need of treatment. Some research shows that Blacks in the U.S. are less willing to seek clinical care at the early stages of illness due to mistrust of White providers (Nickerson, et al, 1994) and negative attitudes toward help-seeking (Mouton et al, 1997). However, recent research using a representative sample from the National Comorbidity Survey has found that Blacks had more positive attitudes toward help-seeking than Whites (Diala et al., 2001). In either case, given the difference in suicidal behavior between the Blacks in our sample and those in epidemiological samples (e.g. Joe et al, (2006)) our sample cannot be assumed to be representative of the wider population.

In spite of the negative predictors of depressive illness, high incidence of prior suicide attempts, high levels of aggression, and high suicidal ideation, Blacks in this sample endorsed the strongest objections to suicide. This schism serves to illustrate the distinction between suicidal thoughts, and attitudes about the acceptability of suicide, and may be important in the clinician's understanding of suicidal ideation in members of this ethnic group. It has been noted elsewhere that the low incidence of completed suicide found among Black Americans despite the aggregation of negative predictors (such as poverty, joblessness, and exposure to violence) may be partly attributable to the strong moral opposition to acting on suicidal wishes (Garlow, Purselle, & Heninger, 2005; Kaslow et al., 2004). A prevention or treatment approach that harnesses this opposition to suicide while providing practical support may be especially effective for members of this group. Recall that this subsample also rated coping beliefs and concerns about family very highly. This is consistent with Compton's (2005) view that family networks and social support occupy a prime position in the lives of Black Americans. The results of this study suggests that there is perhaps an uncomfortable balance in the lives of depressed Blacks that involves a daily compromise between reasons to live, and reasons to die. In such a scenario, a strong moral objection to suicide may be the single most important protector against self-destructive action.

Our finding that Hispanics were not distinct from Blacks or Whites stands in contrast to Oquendo et al (2005) who found that Latinos had higher scores than non-Latinos on survival and coping beliefs, responsibility to family, and moral objections to suicide. Many of the participants included in this study were also included in Oquendo's sample. However, whereas this sample was restricted to individuals with mood disorders, Oquendo's sample also included participants with schizophrenia spectrum disorders, and this may have added more variability to their assessment of reasons for living. The discrepancy between the two studies may also highlight the difficulty in separating individuals into the broad categories of Black, White and Hispanic. In each group there are important subgroups and distinctions that are glossed over by the more general categorization.

4.1 Limitations

This sample was taken from urban populations in diverse northeastern cities. Our demographic data did not capture national origin, nor degree of acculturation, so it is impossible to evaluate what effects these factors may have on our dependent measures. Each of these populations have widely diverging attitudes regarding the acceptability of suicide (2005). Generalization of these findings to specific groups of individuals in the United States or abroad should be cautiously undertaken. Also, this was an entirely clinical sample of mood disordered participants who presented to participate in research studies. Although our findings converge with other research with college student populations, some caution should be taken when applying these findings to individuals without primary mood disorder diagnoses.

This sample was comprised mainly of women (69%), reflecting on the one hand the greater frequency of depression in females, but also the increased tendency for women to present for mood disorder treatment. Some caution is therefore needed in applying these findings to populations of men, as the suicidal behavior of women is substantially different from men. Women make suicide attempts more frequently than men, but are less likely to complete suicide (Joe, Baser, Breeden, Neighbors, & Jackson, 2006).

The use of broad racial/ethnic categories is potentially problematic, as the lines of differentiation between these groups are imprecise, and do not encompass homogeneous racial or cultural entities (Hawton, 2000; Oquendo et al., 2001). Within each group there are multiple subgroups of varying degrees of distinctiveness in terms of language, degree of acculturation, experience of discrimination, economic advantage, and other factors (Duster, 2005). Nonetheless, there may be some benefit in investigating the reliability and validity of increasingly distinctive ethnically-related score profiles in future research with community samples, as they can offer new, more nuanced insights into the factors that protect individuals from suicidal behavior.

4.2 Conclusion

Suicide is a complex and multiply determined phenomenon. Although it is clear that membership in an ethnic/racial category has an impact on suicidal behavior, it is not well understood whether this impact is also manifested in people's attitudes regarding the acceptability of suicide. In clinical settings, suicidal ideation is assessed for the purpose of determining whether a patient is an imminent risk to him or herself. An in-the-moment assessment may fail to identify whether someone holds deeply engrained ideas about the value of life, and the acceptability of suicide. An individual who believes that suicide is acceptable may not endorse current suicidal ideation, but become determinedly suicidal following a subsequent crisis. Some research shows that individuals who believe suicide is acceptable are more likely to develop a plan (Joe et al., 2007). This study showed that depressed Blacks simultaneously report high levels of suicidal ideation, while believing that

suicide is unacceptable. Further research is needed to determine whether the lethality of an attempt may be more serious, and the determination to die may be greater in someone who has contemplated suicide as an acceptable option.

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Table 1

Sample Characteristics

		<u>Stat</u>	<u>Ethnicity</u>			<u>Test</u>	<u>P value</u>	<u>Contrast</u>
			<u>White</u>	<u>Black</u>	<u>Hispanic</u>			
Sex	Male	N (%)	202 (34)	22 (18)	28 (30)			
						KW X^2 (df=2) =16.6	0.002 *	
	Female	N (%)	386 (66)	100 (82)	66 (70)			B>W,H
Age		Mean±SD	39 ±13	38 ± 11	36 ± 11	F (2,800)=3.7	0.026	
Education	Years	Mean±SD	15 ±3	14 ± 2	13 ± 4	F (2,780)=17.2	0.000 *	W>B,H
Marital Status	Single	N (%)	237 (40)	53 (43)	42 (45)			
	Married	N (%)	192 (33)	26 (21)	24 (26)			
	Separated	N (%)	38 (7)	12 (10)	9 (10)	KW X^2 (df=2) =0.3	0.846	
	Divorced	N (%)	99 (17)	28 (23)	17 (18)			
	Widowed	N (%)	20 (3)	3 (3)	2 (2)			
No. of Children		Mean±SD	1.2 ± 1.5	1.9 ± 1.5	1.4 ± 1.5	F(2,773) =25.2	0.000 *	B>W,H

* Bonferroni adjusted alpha level for statistical significance is $p<0.01$

Table 2

Clinical Features

		Ethnicity						Contrast
		Stat	White	Black	Hispanic	Test	P value	
Diagnosis	Bipolar	N (%)	152 (26)	32 (26)	33 (35)	KW χ^2 (df=2) =3.5	0.169	
	MDD	N (%)	436 (75)	90 (15)	61 (10)			
Prior attempt?	Yes	N (%)	258 (46)	78 (67)	37 (44)	KW χ^2 (df=2)=17.3	0.000*	B>W,H
	No	N (%)	295 (53)	38 (32)	47 (56)			
No. of attempts		Mean±SD	2.5±2.0	2.3±1.6	1.8±1.0	F(2,340) =0.87	0.419	
Highest Lethality		EMM±SE ^a	3.3±0.1	2.4±0.2	2.2±0.3	F(2,322)=10.7	0.000*	W>B,H
Depression		EMM±SE ^a	15.6±0.5	16.2±1.0	17.4±0.9	F(2,580) =1.73	0.178	
Aggression		EMM±SE ^a	19.3±0.3	20.7±0.6	16.9±0.7	F(2,580) =8.85	0.000*	B>W>H
Impulsivity		EMM±SE ^a	55.6±.9	55.4±1.8	55.5±2.0	F(2,580) =0.003	0.997	
Hopelessness		EMM±SE ^a	11.5±0.4	10.2±.8	10.8±1.1	F(2,580) =1.78	0.170	

* Bonferroni adjusted alpha level for statistical significance is $p < 0.006$.

^a Covariates appearing in the model are evaluated at the following values: Age = 38.31, Sex = 0.30, Marital Status = 2.13, Number of Children = 1.38, Years of education = 14.75.

Table 3

Reasons for Living and Suicidal Ideation

	Ethnicity						Contrast
	Stat	White	Black	Hispanic	Test	P value	
Reasons for Living Inv.	EMM±SE ^{†a}	19.0 ± 0.3	19.9 ± 0.7	19.2 ± 0.7	F(2,478)=0.83	0.435	
Survival Coping Beliefs	EMM±SE ^a	3.5 ± 0.1	3.8 ± 0.1	3.5 ± 0.2	F(2,478)=2.22	0.109	
Responsibility to Family	EMM±SE ^a	4.1 ± 0.1	3.9 ± 0.2	4.1 ± 0.2	F(2,478)=0.58	0.558	
Child-related Concerns	EMM±SE ^a	3.4 ± 0.9	3.7 ± 0.2	3.5 ± 0.2	F(2,478)=1.28	0.279	
Fear of Suicide	EMM±SE ^a	2.8 ± 0.1	2.8 ± 0.1	2.7 ± 0.1	F(2,478)=0.23	0.798	
Fear of Social Disapproval	EMM±SE ^a	2.6 ± 0.1	2.5 ± 0.2	2.5 ± 0.2	F(2,478)=0.14	0.868	
Moral Objections to Suicide	EMM±SE ^a	2.6 ± 0.1	3.2 ± 0.2	2.8 ± 0.2	F(2,478) = 3.54	0.030*	B>W,H
Suicidal Ideation	EMM±SE ^a	6.0 ± 7.9	8.1 ± 9.5	5.1 ± 6.7	F(2,685)=3.61	0.027*	B>W,H

[†] Estimated marginal means ± standard error.

^a Covariates appearing in the model are evaluated at the following values: Age = 37.47, Sex = 0.30, Marital Status = 2.04, Number of Children = 1.13, Years of education = 14.85.