Published in final edited form as:

Suicide Life Threat Behav. 2011 February ; 41(1): 12–20. doi:10.1111/j.1943-278X.2010.00008.x.

Effects of race and precipitating event on suicide versus non-suicide death classification in a college sample

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Abstract

The present study examined race group differences in suicide death classification in a sample of 109 Black and White university students. Participants were randomly assigned to read three vignettes for which the vignette subjects' race (only) varied. The vignettes each described a circumstance (terminal illness, academic failure, or relationship difficulties) that preceded the vignettes subject's ambiguously premature death. Participants were asked to describe "what happened". Black participants were significantly less likely than White participants to attribute a vignette target's death to suicide and also less likely to report that suicide is acceptable. Implications for future research and prevention efforts are discussed.

In the United States, suicide is the third leading cause of death among 15- to-24 year old youth and young adults and accounts for 12.9% of all deaths in this age group (Centers for Disease Control and Prevention [CDC], 2005). Additionally, there are an estimated eight to 25 non-fatal suicide attempts for each fatal attempt (Brickman & Mintz, 2003). Despite efforts to systematically address suicide and suicide attempts on college campuses (e.g., Furr, Westefeld, McConnell, & Jenkins, 2001; Schotte & Clum, 1982; Westefeld & Furr, 1987; Westefeld, Whitchard, & Range, 1990; Westefeld et al., 2005), studies reveal that many students may not receive clinical intervention even when depression is accompanied by thoughts of suicide (Garlow et al., 2008). Inarguably, better methods are called for to address suicide vulnerability for those who are not in clinical care.

One public health approach to suicide prevention on college campuses and elsewhere is to increase mental health literacy specifically associated with suicide and attendant risk factors. Jorm and colleagues (Jorm, Korten, Jacomb, et al., 1997a, 1997b; Jorm, 2000) coined the term "mental health literacy," as an indicator of lay persons' knowledge, recognition, help-seeking, and prevention for mental disorders. In the case of suicide, assessment, decision-making, and handling of relevant information is especially variable across ethnic groups. Persons who are members of underrepresented groups are more likely than European Americans to be "hidden ideators" who disclose suicidal thoughts less willingly (Morrison & Downey, 2000). Though there is little data associated with stigmatized beliefs about suicide (cf. Walker, Lester & Joe, 2006), there is some qualitative evidence that suicide might be considered a "white thing" by Black¹ Americans (Early & Akers, 1993). Such stereotyped beliefs may contribute to race group differences in disclosing suicide ideation and emerging plans including one's own ideation/plans and also those of others who may be vulnerable. Recognition, assessment, and appropriate responsiveness to suicide presentations require complex judgments that need not be further complicated by the addition of

Each of the three vignette subjects was assigned a gender neutral name (cf. Rousseau & Anton, 1991).

¹The ethnic label, "African American" and racial label, "Black," are used interchangeably in this text to retain the level of identification observed in the cited research. For the purposes of this discussion, both labels represent persons of African descent living in the U.S.

stereotypes. In the current study, we aim to test race group differences in suicide literacy by examining differences in how premature deaths are classified via vignette technique.

Previous research has indicated that individuals who identify with the Black community may be hesitant to disclose suicide vulnerability due to beliefs that suicide is a denial of Black culture and identity (Early & Akers, 1993). Early and Akers (1993) conducted one of the first studies to investigate lay suicide beliefs within the Black community. Following qualitative analysis, they described beliefs that exist within the Black community that because of the “Black struggle,” Black Americans are more resilient and, consequently, suicide is more of a White American problem. Racialized suicide attitudes and beliefs potentially undermine “universal” suicide prevention campaigns aimed at increasing public awareness and education.

To our knowledge, only one published study to date has investigated race group differences in suicide beliefs and attributions. Walker, Lester, and Joe (2006) examined perceptions of suicide in a sample of African American and European American university students. Findings revealed that African American participants were more likely than European Americans to report that God is responsible for life (versus the individual or government) and less likely to indicate that suicide could be attributed to interpersonal problems or conflict (Walker et al., 2006). Though the study was cross-sectional by design, it provided some insight to group differences in how suicide might be conceptualized. The authors speculated that the differences might account for the seeming irony associated with Black suicide whereby chronic stress persists but that is unmatched by suicide fatalities. Despite this seeming resilience, suicide remains a leading cause of death for young African Americans.

Though only one known study has examined race group differences in suicide beliefs, several previous studies have considered sex and gendered differences in suicide attributions (e.g., Dahlen & Canetto, 2002). In one study, male college students were found to be more likely to agree with suicide decisions than females (Dahlen & Canetto, 2002). For female students, morally acceptable “reasons” for suicide included loneliness, loss of a parent, insecurities about attractiveness, and a partner cheating or leaving rather than financial or academic problems, physical illness, depression, hopelessness, and feelings of failure (McAndrew & Garrison, 2007). Certain suicide methods (e.g., shooting, hanging, etc.) have also been characterized as more “masculine” relative to others (McAndrew & Garrison, 2007). Research on lay beliefs of suicide across sex groups has also been conducted for international populations. ahin, ahin, and Tumer (1994) found that Turkish study participants assigned more causes of suicide to vignettes containing female characters than those with males. In sum, these studies provide some insight to group differences in attitudes and beliefs associated with suicide. These disparate beliefs may account, at least in part, for differences in fatal and non-fatal attempts.

Present Study

The goal of the present study was to test race group differences in suicide death classification in a sample of university students. Underlying assumptions associated with suicide are noteworthy because they potentially impact reporting of fatal and non-fatal suicide attempts and also help-seeking for vulnerable persons. The vignette technique is particularly appropriate to elicit potential attitudes toward suicide, a stigmatized and sometimes threatening subject matter. Finch (1987) noted that seemingly ambiguous circumstances permit the respondent to define the situation. The use of vignettes in the current study directs the participant to consider premature death and hypothesize likely causes of death. The explicit hypotheses for the study are: (1) Participants will be more

likely to classify the vignette subject's death as suicide if the subject is White than if the subject is Black across three conditions (i.e., academic failure, relationship difficulty, terminal illness); (2) Black participants will be less likely than White participants to classify the vignette subject's death as suicide across three conditions; and (3) Participants' classification for cause of death will vary as a function of participant race and precipitating event.

Method

Participants

The participants in this study were 111 college students enrolled in a moderately-sized Midwestern university. Participants ranged in age from 18 to 51 years ($M = 19.49$, $SD = 3.49$) and received academic credit for their participation. The ethnic composition of the sample was 67.6 % Black ($N = 75$) and 30.6 % White ($N = 34$). Two participants (1.8%) did not report race group membership; their study data were not included in statistical analyses. Socioeconomic status was assessed using the Hollingshead Four-Factor Index of Social Status (Hollingshead, 1975). The four factors taken into account in producing this index are: education, occupation, sex, and marital status. Values on this scale range from 8 to 66, with higher numbers reflecting higher status. Hollingshead scores in the following sample ranged from 15 (*unskilled laborers, menial service workers*) to 63 (*major business and professional*) ($M = 50.2$, $SD = 12.82$).

Materials

Vignettes—To assess possible biases in suicide classification, participants were randomly assigned to read three short vignettes in which the vignette subject was Black or White. These vignettes were adapted from the Suicide Attitude Vignette Experience scale (SAVE; Stillion, McDowell, & Shamblin, 1984) which assessed the extent to which respondents sympathize and agree with suicidal actions. In the present study, SAVE situations were modified so that gender and cause of death would be presented ambiguously and also so to explicitly identify race. This modification was accomplished by using a gender neutral name (i.e., “Pat,” “Casey,” or “Terry”) as an identifier rather than personal pronouns (“he” or “she”) that might affect suicide attitudes; also, the last sentence of the SAVE situation (e.g., “She attempts suicide”) was replaced with a sentence at the beginning of the vignette stating that the subject “died in the last couple of days” (see Appendix). Each vignette describes a set of circumstances (terminal illness, academic failure, or relationship difficulties) that accompanies the vignette subject's death. After reading the vignettes, the participants were asked to respond to the open-ended question, “What do you think was [subject's] cause of death?”

Suicide Acceptability—Participants' beliefs about the acceptability of suicide were assessed using three previously adopted items (Neeleman, Wessely, & Lewis, 1998). The items prompted participants to indicate whether they believed suicide to be acceptable for women, for men, or for themselves. These items were scored on a 10-point Likert-type scale whereby a score of “1” was indicative that suicide is “never acceptable” and “10” is indicative that suicide is “always acceptable”. Several studies have demonstrated the reliability of this approach to assessing suicide acceptability in diverse samples that include African American/Black participants (e.g., Anglin, Gabriel, & Kaslow, 2005; Neeleman, Wessley, & Lewis, 1998; Stack, 1998).

Suicide Exposure—To assess the participants' past exposure to suicide, two supplementary “yes/no” items were included in the questionnaire packet. These questions

were (1) Have you or anyone that you know ever attempted suicide?" and (2) Has anyone that you know ever died by suicide?"

Demographic form—Each participant was asked to report age, sex, race, ethnicity, income, education, and employment status.

Procedure

The present study was granted institutional review board approval and conducted in groups of approximately 5-20 participants. Participants were informed that participation in the study could cease at any time and that referral to the university counseling center or psychology clinic for free services would be available if needed. Upon written consent, participants completed the initial study packet which included the demographics form and the three vignettes. Participants were randomly assigned to read vignettes for which the vignette subjects were either all White or the three vignette subjects were all Black. After returning the completed vignette packet to the study administrator, participants were administered the suicide acceptability items and suicide exposure items. None of the study participants discontinued participation, requested a referral for psychological services, or demonstrated imminent risk for danger.

All vignette classification responses for cause of death were transcribed to Microsoft Excel. Three independent undergraduate raters, blind to the vignettes and also to the overall nature of the study, developed a preliminary coding system for causes of death based on a sample of participant responses. In an iterative process led by the second author, the following final coding system was agreed upon in consensus: 1 = suicide, 2 = psychological distress or mental illness, 3 = murder or homicide, 4 = natural causes or physical illness, 5 = overdose², 6 = accident, 7 = "I don't know" and 8 = ambiguous³. Each of the vignette responses was assigned a code. In the event of coding discrepancies, the three raters and graduate assistant discussed the discrepancy toward reaching consensus. For analytical purposes, a binary code was developed such that "1" was indicative of suicide and "0" was indicative of all other responses.

Results

Preliminary results revealed that the sample of White and Black participants together was most likely to classify the vignette character's death as suicide in the event of academic failure (62%) or relationship difficulties (26%; see Table 2). However, in the condition for which "Terry" died, 39% of respondents classified the death as physical illness; fewer respondents (27%) attributed the death to suicide. Of the 109 participants, 55 (50.5%) read vignettes for Black characters and 54 (49.5%) read vignettes for White characters.

Is there an effect of either participant race or vignette subject race on suicide vs. non-suicide death classification?

Our hypotheses associated with race and suicide classification were partially supported. To test the hypothesis that participants would be more likely to classify the vignette subject's death as suicide as a function of the vignette subject's race across the sum of three conditions (academic failure, relationship difficulties, terminal illness), we used the Mann-Whitney *U* test for ordinal nonparametric data. The results revealed that there was no significant effect

²In cases for which the respondent indicated "accidental overdose," the coders agreed to declare the case as an "accident" rather than as an "overdose" given the respondents' choice of "accidental" as a qualifier.

³All responses that included multiple causes of death (e.g., "Pat's cause of death was probably *suicide* or *chronic health issues* that led from the *stress* of the end of such a long relationship") were coded as "ambiguous".

of vignette subject race for vignettes that included a White decedent compared to those that included a Black decedent ($z=-.578$, $p=.563$); see Figure 1 for distribution of deaths classified as suicide by vignette subject race. However, the Mann-Whitney U test revealed that Black participants were significantly less likely than White participants to attribute a vignette subject's death to suicide ($z=-2.888$, $p=.004$); see Figure 2 for percent of participants by race who classified vignette subject's death as suicide.

Is there an effect of race on suicide vs. non-suicide death classification per precipitating event?

Chi square analyses revealed that Black participants were significantly less likely to attribute the vignette subject's death to suicide when the nature of the precipitating event was terminal illness [Figure 3; $\chi^2(1, n = 108) = 16.00$, $p=.000$]. However, there were no participant race group differences in death classification when the specific precipitating event was relationship difficulties [$\chi^2(1, n = 108) = .84$, $p=.246$] or academic failure [$\chi^2(1, n = 108) = .22$, $p=.402$]. Consistent with previous analyses for vignette subject race effects, there were no differences in death classification as a function of vignette subject race and precipitating event.

Post-hoc analysis of suicide acceptability

Given previous reports that suicide has been characterized as an anomaly in Black culture, we examined responses to the acceptability of suicide in the current sample. Post-hoc chi-square analyses supported previous claims that Black people may not find suicide to be acceptable. That is, White respondents in this sample were significantly [$F(1, 103)=9.27$, $p=.003$] more likely to respond positively to the statement "suicide is acceptable for me" ($M=1.42$, $SD=1.30$) relative to Black respondents ($M=1.07$, $SD=.64$). Interestingly, Black and White respondents did not differ in response to acceptability of suicide for men [$F(1, 103)=1.29$, $p=.259$] with mean acceptability scores of 1.90 ($SD=2.06$) and 1.85 ($SD=1.48$), respectively. However, a non-significant trend was found for race group differences in suicide acceptability for women [$F(1, 103)=3.17$, $p=.078$] whereby Black respondents [$M=1.88$, $SD=1.99$] found suicide to be more acceptable for women than did White respondents [$M=1.70$, $SD=1.16$]. This pattern of results may be indicative of race group differences in actual suicide beliefs.

Discussion

Several studies and conceptual reports have indicated that Black Americans' suicide beliefs and attitudes differ from those of White Americans. In the present study, we attempted to experimentally test race group differences in classification (suicide vs. non-suicide) of premature death via vignette analysis. We reasoned that (1) vignette subjects that were Black would be less likely classified as having had a suicide death than White vignette subjects; (2) Black respondents would be less likely than White respondents to classify a death as suicide; and that (3) within each precipitating event condition (academic failure, relationship difficulty, terminal illness), race group differences would affect how the death was classified. Our hypotheses were partially supported as suicide death classifications differed as a function of respondent race and also as a function of precipitating circumstance though not as a function of the vignette subject's race. The finding that Black and White participants offered different assessments for identical stimuli is consistent with reports of racial differences in suicide-related phenomena. When the precipitating event was a terminal illness, there seemed to be far less ambiguity for Black participants who overwhelmingly indicated that the death was due to the illness (and not suicide). When the events preceding the death of a young adult is more dubious and there is no medical condition, young Black Americans may be as likely as young White adults to classify a death as suicide.

It is notable that more White than Black participants in the current study also reported having known someone who died by or attempted suicide. No known epidemiological reports to date have provided estimates of suicide “exposure” and how such exposure might affect subsequent suicide literacy. This exposure may have rendered White participants more sensitized to the possibility of a suicide-related death and thus more likely to have classified a death as suicide (regardless of terminal illness). On the other hand, if stereotypic beliefs affect reporting of suicidality in the Black population, the sample of participants in the current study may have been affected by “underexposure” to suicide. Analysis of 1999-2002 data from the CDC revealed that African American suicide deaths are significantly more likely to be misclassified by medical examiners as accidents relative to European American suicide deaths (Rockett, Samora, & Coben, 2006). While such mislabeling may not directly affect long-held stereotypes associated with who dies by suicide, racialized underreporting for this significant cause of life lost warrants future study.

The overall findings could have important implications for prevention planning. Since universal models of suicide prevention presume to implement widespread public education campaigns and school-based suicide awareness programming, internalized beliefs that differentially affect consumer receptivity and suicide literacy should be considered and evaluated. Since Black participants in this study were significantly less likely than their White counterparts to indicate that suicide is acceptable, we posit that this objection to suicide may have underscored classification of the suicide death. In all, the accumulation of possible factors (e.g., acceptability, racial bias, etc.) associated with death classification is cause for future investigation. Future studies should also test whether the current findings hold up in community samples and across groups that are more socioeconomically diverse.

Racial and cultural context is important for evaluating suicide literacy in that cultural patterns often influence the causes, method, prevalence and reporting of suicide in a society. In Latin America and in Islamic nations, the problem of hidden and “non-confirmed” suicide has been systematically scrutinized in order to better suicide prevention efforts (Pritchard & Amanullah, 2007; Pritchard & Hean, 2008). In the U.S., suicide attitudes and subsequent stigma in the Black community may contribute to underreporting of suicide, but are grossly understudied. It has been suggested that population-wide efforts may be necessary to meaningfully reduce suicide rates (Knox et al., 2004). This study highlights the need for more research that investigates factors that could undermine such efforts.

These results have important implications for prevention if adults, young adults, and youth are less likely to seek help and less likely to intervene on behalf of a vulnerable other in the face of stressful events that invoke suicidal thoughts. Suicide must be addressed as a public health challenge that is complicated by race group differences. Suicide attitudes and beliefs undermine general knowledge and awareness across communities but may have especially deleterious effects in the Black community. Though some at-risk adolescents and adults will receive the attention of a mental health professional, persons from underrepresented groups in the U.S. are pervasively underserved.

Though this study provides interesting preliminary insights to race group differences in premature death classification, the results should be interpreted with some caution. The vignette-supported findings offered both advantages and disadvantages. The available findings demonstrated race group differences that could not otherwise be manipulated. However, the elicited beliefs do not confer actions or predict behavior. Individuals’ responses to a fictional story are not indicative of one’s own suicidal behavior or the likelihood that one would intervene should a suicide crisis evolve. Another limitation is associated with the intentions of the respondents and is an inherent artifact of suicide research. That is, some participants may have been unwilling to specify the death as a

suicide per se though they considered “overdose” a means of suicide. However, only clear suicide classifications were designated as suicide for the purposes of this study.

In sum, we question whether actual responses to a suicidal person are consistent across racial and ethnic groups. Suicide awareness curricula and peer gatekeeping strategies potentially add to suicide prevention efforts when youth and young adults can be expected to identify at-risk peers and follow the necessary course of action. Some research has indicated that African Americans are chronically underserved by mental health systems due, at least in part, to youth's challenges in recognizing depression and anxiety among their peers and also ambivalence towards accepting mental health professionals as appropriate helpers (Molock et al., 2007). The current study provides some preliminary evidence for how group differences in suicide assessment and decision-making might be integrated in future research.

Appendix

“Pat died in the last couple of days. Pat was a 22 year old [White/Black] student who had been in a relationship for the past three years. The couple was in their senior year of college and had planned to be married after graduation. For the past six months they had been arguing frequently. A week before graduation, Pat broke off the relationship.”

“Casey died in the last couple of days. Casey, a 24 year old [White/Black] student wanted to be a lawyer for four years. Casey's grades had been failing during the last six months. Last week Casey got back a major exam that had a failing score. Casey would probably not be admitted to law school because of the low test score and failing grades.”

“Terry died in the last couple of days. Terry was a 26 year old [White/Black] student who had been healthy and physically active. Six months ago, however, Terry was diagnosed with an incurable but nonfatal painful physical illness. Last week the pain increased to the point where the medication was no longer controlling it effectively.”

References

- Anglin DM, Gabriel KOS, Kaslow NJ. Suicide acceptability and religious well-being: A comparative analysis of African American suicide attempters and non-attempters. *Journal of Psychology and Theology*. 2005; 33:140–150.
- Brickman AL, Mintz DC. Datapoints: U.S. rates of self-inflicted injuries and suicide, 1992-1999. *Psychiatric Services*. 2003; 54:168. [PubMed: 12556595]
- Centers for Disease Control and Prevention (CDC). Web-based Injury Statistics Query and Reporting System (WISQARS) [Online]. National Center for Injury Prevention and Control, CDC (producer).; 2005. Available from URL: www.cdc.gov/ncipc/wisqars/default.htm
- Dahlen ER, Canetto SS. The role of gender and suicide precipitation in attitudes toward nonfatal suicidal behavior. *Death Studies*. 2002; 26:99–116. [PubMed: 11871460]
- Early KE, Akers RL. “It's a white thing”: An exploration of beliefs about suicide in the African American community. *Deviant Behavior*. 1993; 14:277–296.
- Finch J. The vignette technique in survey research. *Sociology*. 1987; 21:105–114.
- Furr SR, Westfield JS, McConnell, Jenkins JM. Suicide and depression among college students: A decade later. *Professional Psychology*. 2001; 32:97–100.
- Garlow SJ, Rosenberg J, Moore JD, Haas AP, Koestner B, Hendin H, et al. Depression, desperation, and suicidal ideation in college students: Results from the American Foundation for Suicide Prevention college screening project at Emory University. *Depression & Anxiety*. 2008; 25:482–488. [PubMed: 17559087]
- Hollingshead AB. Four factor index of social status. 1975 Unpublished manuscript.

- Jorm AF. Public knowledge and beliefs about mental disorders. *British Journal of Psychiatry*. 2000; 177:396–401. [PubMed: 11059991]
- Jorm AF, Korten AE, Jacomb PA, Christensen H, Rodgers B, Pollitt P. “Mental health literacy”: A survey of the public's ability to recognize mental disorders and their beliefs about the effectiveness of treatment. *The Medical Journal of Australia*. 1997a; 166:182–186. [PubMed: 9066546]
- Jorm AF, Korten AE, Rodgers B, Pollitt P, Jacomb PA, Christensen H, et al. Beliefs systems of the general public concerning the appropriate treatments for mental illness. *Social Psychiatry Psychiatric Epidemiology*. 1997b; 32:468–473. [PubMed: 9409162]
- Knox KL, Yeates C, Caine ED. If suicide is a public health problem, what are we doing to prevent it? *American Journal of Public Health*. 2004; 94:37–45. [PubMed: 14713694]
- McAndrew FT, Garrison AJ. Beliefs about gender differences in methods and causes of suicide. *Achieves of Suicide Research*. 2007; 11:1–9.
- Molock SD, Barksdale C, Matlin S, Puri R, Cammack N, Spann M. Qualitative study of suicidality and help-seeking behaviors in African American adolescents. *American Journal of Community of Psychology*. 2007; 40:52–63.
- Morrison LL, Downey DL. Racial differences in self-disclosure of suicidal ideation and reasons for living: Implications for training. *Cultural Diversity and Ethnic Minority Psychology*. 2000; 6(4): 374–386. [PubMed: 11089313]
- Neeleman J, Simon W, Lewis G. Suicide acceptability in African- and White Americans : The role of religion. *Journal of Nervous and Mental Disease*. 1998; 186:12–16. [PubMed: 9457142]
- Pritchard C, Hean S. Suicide undetermined deaths among youths and young adults in Latin America. *Crisis*. 2008; 29:1–9. [PubMed: 18389639]
- Pritchard C, Amanullah S. An analysis of suicide and undetermined deaths in 17 predominantly Islamic countries contrasted with the UK. *Psychological Medicine*. 2007; 37:421–430. [PubMed: 17176500]
- Rockett RH, Samora JB, Coben JH. The black-white suicide paradox: Possible effects of misclassification. *Social Science & Medicine*. 2006; 63:2165–2175. [PubMed: 16844274]
- ahin N, ahin NH, Tümer S. Stereotypes of suicide causes for three age/gender cohorts. *International Journal of Psychology*. 1994; 29:213–232.
- Schotte D, Clum G. Suicide ideation in a college population: A test of a model. *Journal of Consulting & Clinical Psychology*. 1982; 50:690–696. [PubMed: 7142542]
- Stack S. The relationship between culture and suicide: An analysis of African Americans. *Transcultural Psychiatry*. 1998; 35:253–269.
- Stillion JM, McDowell EE, Shamblin JB. The suicide attitude vignette experience: A method for measuring adolescent attitudes toward suicide. *Death Education*. 1984; 8:65–79.
- Walker RL, Lester D, Joe S. Lay theories of suicide: An examination of culturally relevant suicide beliefs and attributions among African Americans and European Americans. *Journal of Black Psychology*. 2006; 32:320–334. [PubMed: 19672479]
- Westefeld JS, Furr SR. Suicide and depression among college students. *Professional Psychology: Research & Practice*. 1987; 18:119–123.
- Westefeld JS, Homaifar B, Spotts J, Furr S, Range L, Werth JL. Perceptions concerning college student suicide: Data from four universities. *Suicide and Life-Threatening Behavior*. 2005; 35:640–644. [PubMed: 16552979]
- Westefeld JS, Whitchard KA, Range LM. College and university student suicide: Trends and implications. *Counseling Psychologist*. 1990; 3:464–476.

Figure 1. Percent of Black and White vignette targets' deaths classified as suicide across zero, one, two, and three conditions.

Figure 2. Percent of Black and White participants who classified one, two, three or no condition as suicide.

Figure 3.
Suicide classification as a function of participant race per each precipitating event.

Table 1

Demographic Variables by Participant Race

Demographic Variable	Black	White
Mean Age (SD)	19.24 (3.99)	20.06 (2.09)
Percent Female	64%	47.1%
Exposure to Suicide Attempt (self/other)	50.7%	73.5%
Exposure to Suicide Death	22.7%	61.8%

Table 2

Death Classification by Precipitating Event and Vignette Character

Classification	Academic Failure "Casey"	Relationship "Pat"	Terminal illness "Terry"
Suicide	69 (62.2%)	29 (26.1%)	30 (27.0%)
Psychological Distress/Mental Illness	17 (15.3%)	16 (14.4%)	5 (4.5%)
Murder	0 (0%)	20 (18.0%)	0 (0%)
Physical Illness	2 (1.8%)	8 (7.2%)	43 (38.7%)
Overdose	7 (6.3%)	2 (1.8%)	14 (12.6%)
Accident	3 (2.7%)	9 (8.1%)	5 (4.5%)
"I don't know"	2 (1.8%)	7 (6.3%)	1 (0.9%)
Ambiguous	11 (9.9%)	20 (18.0%)	13 (11.7%)