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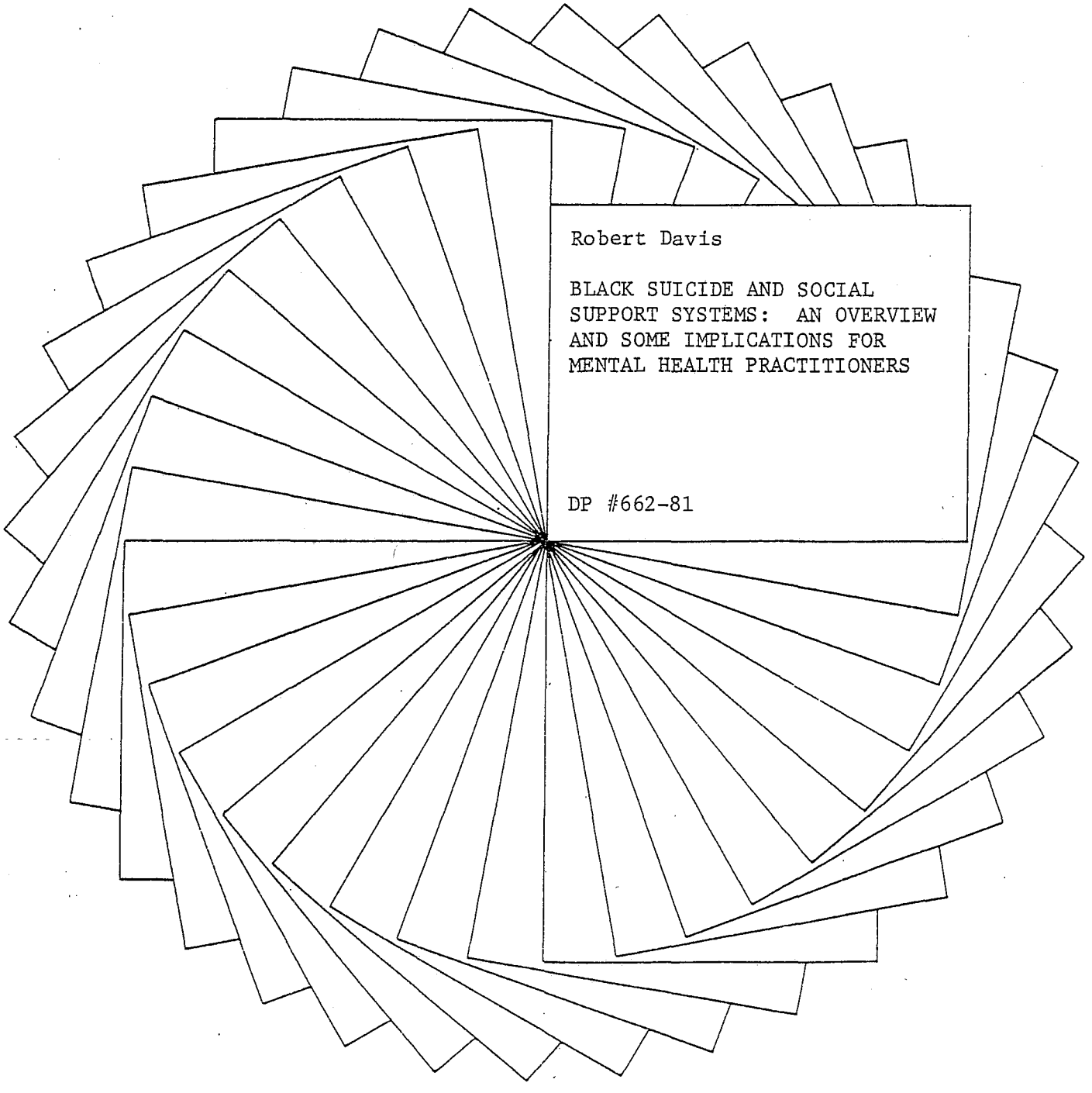

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BLACK SUICIDE AND SOCIAL SUPPORT SYSTEMS: AN OVERVIEW AND SOME IMPLICATIONS FOR MENTAL HEALTH PRACTITIONERS

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ABSTRACT

In this analysis, attention is focused on the role of support systems in black communities and their use by mental health practitioners as a means of minimizing suicidal behavior among young blacks. In the last decade, suicide became the third leading cause of death (after accidents and homicide) for young black males 18-29 years old. Examination of age-specific suicide rates by sex for blacks in metropolitan areas in the period 1970-1975 revealed a 7% increase among males and a 16% decrease among females. Significant increases occurred among young black males under 35, whereas metropolitan black females experienced declines in their suicide rates at all but the oldest age levels.

Existing explanations of suicide are reviewed: psychoanalytic theory, frustration-aggression hypotheses, status-integration theory, black family deficit theory. In addition, a sociocultural model that builds on the "external restraint theory" is offered. Finally, prevention and intervention strategies are discussed. The integration of social support systems with treatment plans by mental health practitioners is suggested as appropriate strategy when dealing with suicidal behavior within the black community.

Black Suicide and Social Support Systems: An Overview and Some Implications for Mental Health Practitioners

Previous research suggests that because of the insulating effect of poverty and low socioeconomic status, blacks should be least likely to commit suicide (Davis, 1978; Durkheim, 1951). By and large, this is true. But black men aged 18 to 29 do not conform to this expectation. Although suicide is not a leading cause of death among blacks, it is the third leading cause of death (after accidents and homicides) among black males in the 18 to 29 year age group. Young black men in this age group are three to four times as likely to commit suicide as young black women of the same age (Davis, 1979). Young adult black males accounted for 27% of the black suicides nationally between 1970 and 1975, while young adult black females accounted for only 8.3% (Davis, 1978).

The rate of suicide among young adult black men has risen over the past decade to the point of approximating and sometimes surpassing that of their white male cohorts, which is well above the national average. The rate of increase during the decade has been greatest among black males aged 20 to 24 (15%) and 25 to 29 (42%) (Davis, 1980). A striking increase in the incidence of black male suicide for all but the oldest age groups can be clearly discerned in Table 1, which presents rates at five-year intervals for the thirty-year period 1947-1977. Within the 20-24 year age group the rate increased dramatically (195%), from 7.3 to 21.5 per 100,000. In the peak suicide age range of 25-29, the rate increased nearly 250%, from 8.2 to 28.5 per 100,000 black male population. Equally as dramatic is the 137% increase experienced by black males aged 30 to 34 (9.5 to 22.5).

Table 1

Black Male Suicide Rates per 100,000 Population, 1947-1977

Years of Age	1947	1952	1956	1962	1967	1972[a]	1977	% Change, 1947-1977
20-24	7.3	6.4	7.9	11.8	14.3	26.0	21.5	194.5
25-29	8.2	11.0	11.0	10.4	18.1	23.1	28.5	247.5
30-34	9.5	9.1	13.9	14.0	16.9	18.4	22.5	136.8
35-39	10.3	9.5	10.1	13.5	14.0	18.5	15.8	53.4
40-44	11.9	7.5	10.3	11.1	15.6	13.1	13.6	14.3
45-49	8.5	8.0	12.2	11.6	11.7	14.6	12.9	51.8
50-54	9.9	11.4	10.5	12.6	11.5	11.6	10.2	3.0
55-59	13.6	12.7	10.6	10.6	15.7	11.0	13.0	-4.4
60-64	14.0	15.8	12.9	18.9	10.4	12.9	12.4	-11.4

Source: Vital statistics of the United States, Volume II, Mortality, Part A (published annually), Mortality Statistics Branch, Division of Vital Statistics, National Center for Health Statistics, Department of Health, Education, and Welfare.

[a]Rates for 1972 are based on a 50% sample of death certificates.

The data in Table 1 clearly indicate that the young black male suicide rate has been rising steadily since the early 1960s. Until then, the rate fluctuated with no clear discernible pattern. In the period 1947-1956, the highest black male suicide rate was recorded among the oldest age groups. Generally the data in Table 1 indicate that in the most recent decade suicide has become a growing menace to young adult black males. The threat is seen as particularly acute because in the black community programmatic efforts in the area of suicide prevention have been focused primarily upon the female population.

Table 2 presents age-specific suicide rates by sex for blacks residing in Standard Metropolitan Statistical Areas (SMSAs) for the period 1970-1975. An SMSA consists of a county or group of counties containing a city of 50,000 or more and forming an integrated economic and social unit which is metropolitan in character. Although the trends shown in Table 2 do not necessarily predict past or future years, they indicate that the black suicide rate increased slightly (2%) over the six-year period. Among black males the suicide rate increased by 7%, whereas the rate for black females declined 16%. Indeed, significant declines occurred among metropolitan black females at all but the oldest age levels. Consistent with our earlier finding, significant increases occurred among young black males in their twenties. Within the 18-25 year age group the suicide rate increased 13% (from 18 to 20 per 100,000); the increase was 17% (from 23 to 27 per 100,000) in the peak age range 25-29. Black males under 35 experienced a 13% increase in their rate; the rate for those over 34 declined by 5%.

Clearly this phenomenon, which may be read as symptomatic of deeply embedded social problems, has serious implications for the black popula-

Table 2

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

(125 SMSAs, 1970s)

Age and Sex	1970	1975	Change
Male and Female	9.9	9.7	2.1
All Males	16.7	15.6	7.1
18-24	19.8	17.6	12.5
25-29	27.0	23.0	17.4
30-34	20.8	21.6	-3.7
35-39	16.0	15.4	3.9
40-44	12.6	11.9	5.9
45-49	11.9	18.2	-34.6
50-54	9.3	12.9	-27.9
55-59	8.3	10.7	-22.4
60-64	11.4	9.4	21.3
65+	8.9	8.9	0.0
Young Males under 35	22.4	19.8	13.2
Males over 34	12.0	12.6	-4.8
All Females	4.2	5.0	-16.0
18-24	4.2	6.8	-38.2
25-29	7.2	7.4	-2.7
30-34	4.8	7.2	-33.3
35-39	4.3	5.0	-14.0
40-44	3.5	4.8	-27.1
45-59	2.9	4.4	-34.1
50-54	6.1	3.9	56.4
55-59	2.8	1.3	115.4
60-64	3.3	2.8	17.9
65+	2.9	3.2	-9.4
Young Females under 35	5.1	6.8	-25.0
Females over 34	3.6	3.7	-2.7

Source: Computations by author from 1970 and 1975 Mortality Tapes and 1970 County Group Public Use Sample and 1976 Survey of Income and Education

tion. These suicide statistics not only represent a tragic loss to bereaved family and friends; they also mean an acute loss of human resources when the black community is deprived of youthful manpower, the benefits of earned wages, procreative and nurturing sources, and a host of other contributions that these individuals might have made to society.

ETIOLOGICAL FACTORS AND PREVENTIVE MODELS

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

Historically, black 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' careers have touched the lives of suicidal black people. The explanations offered by these researchers are at best patronizing, depicting the "weakness of the black family," "a history of authority problems with the police," "retroflexive anger," and other distorted psychosocial patterns as the central factors in black suicide.

In his classic treatise, Suicide, Emile Durkheim proposed that the suicide tendency is the result of collective forces acting upon the individual. Durkheim's law states that suicide varies inversely with the degree of integration of the individual into the group (see Durkheim, 1951). Modern proponents of this theory maintain that a disruption of social relations is the primary causal factor in suicide.

There are many psychoanalytic theories of suicide; relevant here are the psychological and social psychological schools of thought. In its simplest form, the former stresses the aggressive nature of suicide. The urge for self-preservation is so strong, Freud maintained, that the act is directed against another person with whom the individual has identified. Adler, too, emphasized interpersonal factors--the effect of suicide on others--but proposed that suicide results from a lack of social relations that makes life purposeless.

Some explanations directly address black suicide. Most frequently cited is the urban stress (or "frustration aggression") hypothesis. It postulates that compounded urban stresses associated with migration, poverty, unemployment, racism, poor housing, and poor education result in violence which often, though not always, takes the form of suicide.

Proponents of "the status-integration theory" believe that as blacks work their way into the middle and upper-middle classes they inherit the economic, social, and psychological tensions of their white counterparts. The more upwardly mobile that blacks are, the more intense are the problems of adjustment and assimilation into the American mainstream. A corroding sense of internal alienation may ultimately result in self-destruction.

The "black family deficit theory" portrays the black family as being unable to meet the fundamental needs of its members for survival, socialization, and transmission of a viable cultural heritage.

On the other side, there are some who argue that the increase in rate of black suicde has been overestimated. It is, they claim, an artifact of statistical reporting: coroners are investigating ambiguous black deaths much more thoroughly today than in the past.

A DIFFERENT MODEL

A model that speaks more directly than any of the above theories to the concentration of suicide among young blacks builds on the "external restraint theory," which holds that suicides vary inversely with such restraining factors as low social status and the insulation that strong communal and familial ties provide. The model postulates that restraints which have previously tended to produce a solidarity among blacks--for example, the stresses of overt racism and discrimination--have become weakened among young blacks:

> Recently . . . there has been an increase in social opportunities (more prestige, better jobs, higher education, etc.) and social status for some blacks. Generally speaking, young black males and females have experienced an uplifting of goals, aspirations, and expectations as a result of the perceived change 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 (Davis, 1978, pp. 6-7).

Those concerned with suicide prevention in the black community should be aware not only of the many stresses blacks are exposed to that may lead to suicide but also of the sources of help. Preventive models must be long-range and societal as well as immediate and personal.

Durkheim noted that prevention, intervention, and postvention corresponds with primary, secondary, and tertiary prevention. He agrees with others who have studied suicide that its prevention must be carried

out by caring people or significant others--parents, spouses, relatives, friends, etc.--who may note excessive perturbation, hostility or signs or lethality. The need for significant others to intervene in immediate suicide threats is especially evident for blacks because they do not seem to turn to such places as crisis intervention centers as often as do other groups. In a survey of CI centers by Dennis and Kirk (1976), it was estimated by personnel at some of the centers that there was proportionately low utilization by blacks, not only in relation to their numbers in the community where the center was located, but also in relation to the multiplicity of their problems. This survey also revealed that many of the crises faced by blacks stemmed from financial or other economic conditions. This suggests that immediate prevention or intervention may depend upon one's ability to relieve an economic crisis.

Local hospitals, church groups, and other agencies should supplement the work of the prevention centers and provide information about services available to help those who feel the impulse to take their own lives. Because a great many black suicide attempts are unplanned and impulsive, prevention programs should recognize self-help groups and community networks as readily available support structures. Blacks who feel trapped by oppressive authorities can be helped a great deal by agencies that can provide legal aid, financial support, and the skills to deal with indifferent and bureaucratic government and business agencies. Poussaint (1975) observed that the feeling that "there's no place to turn increases one's sense of fatalism and can lead to the desire to escape through suicide." It is his view that until the general quality of life improves in America, the best deterrent to suicide among blacks is the development

of strong bonds of kinship within the family and a sense of belonging to a group within the community.

A specific conceptual framework for viewing and intervening in suicide among blacks has been proposed by Bush (1976). It is designed to give mental health practitioners and mental health planners a framework for developing and carrying out strategies for intervention and prevention of self-destructive behavior among blacks.

In a practical sense therapists and mental health planners must understand the context in which blacks may attempt to commit suicide. That framework will assist therapists in understanding suicide attempts by blacks and will provide the basis for strategies for intervention. For example, high "intragroup" stress may stem from an individual's family relations, friendships, and personal relations; the accompanying symptoms may be depression, feelings of persecution, and substance (drug) abuse. High "extragroup" stress may stem from work, relations with other people, and financial difficulties; the accompanying symptoms may be immobilization of activity and somatic features.

On a larger scale, mental health planners who recognize the rapid rise in suicide among young blacks may find this perspective of social context useful in designing mental health policies and programs to reinforce and contribute to the well-being of predominantly black communities. The mental health planner will be aware of the intragroup indicators of social interactions, such as church attendance and social club activities; of social indicators of family life, such as parent-child relations; and of social indicators of "community," such as recreation and creative activities. The mental health planner will also seek to understand the extragroup indicators relating to employment and

income. These social indicators, plus the negative ones related to ill health, mental illness, and substance abuse, will reflect the degree of social functioning or dysfunctioning of members of a predominantly black community.

Kirk (1976) reports the results of a study investigating the role of sociopsychological factors as potential precursors to suicidal behavior among urban black males. In the context of this study, suicide attempts are conceptualized as the outgrowth of a two-factor process, related not only to what the attempter feels--i.e., greater alienation--but also to what he does not feel--a sense of positive identity that is tied to his experience of himself as a black person. Kirk contends that black suicidal behavior needs to be viewed as the outgrowth of social forces involving normlessness (rootlessness) as well as of a greater sense on the part of the suicidal individual of his own estrangement, emptiness, and psychological isolation.

Kirk's findings suggest that the social ties of attempters are equal to or greater than those of nonattempters, but that the personal integration of those ties into a coherent sense of black identity has been less successful. Kirk's findings also revealed that those blacks with a greater sense of black consciousness and, hence, a more positive self-concept were less likely to attempt suicide than were those with a lesser sense of black consciousness and, hence, a more negative self-concept.

CONCLUSION AND RECOMMENDATIONS

Except for the general concern of selected individuals, there is no organized interest group or research structure that can disseminate

current information on the nature and pattern of black suicide and its implications for mental health practitioners. Similarly, there is no evidence that black professional organizations (e.g., National Association of Black Social Workers, Association of Black Sociologists, Association of Black Psychologists, etc.) have assigned this problem a particularly high priority. Hence, there has been no apparent surge of public opinion designating suicide as a problem within the black community.

It was due to these shortcomings that a national Committee on Black Suicide[1] was organized and structured, bringing together mental health service providers, practitioners, private interests, and public officials to pursue the following objectives:

- To examine alienation from family and community support structures.
- To define and analyze the key issues for viewing and intervening in black suicide.
- To examine existing preventive systems.
- To stimulate both public and private sources to work together toward providing well-developed, community-based supportive networks.
- To examine various strategies for minimizing suicidal behavior as an acceptable model for young blacks.

In terms of preventive strategies, the committee has suggested that increased attention to the role of support systems in helping to solve many of the social and psychological difficulties confronting black people may well be the appropriate strategy for mental health prac-

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[1]The Committee on Black Suicide was organized in Chicago in 1979 by this author and several other interested persons. Since then, the committee has presented two symposia on black suicide.

titioners and behavioral and social scientists disturbed by the rapidly rising suicide rate among young blacks. As one observer noted:

> Many Black people with personal problems customarily turn to informal organizations in their environment rather than to professionals. These informal groups and voluntary associations such as bars, barbershops, peer groups, gangs, and storefront churches make up the social network of the Black community . . . . Little research has been conducted to determine the significance of social networks in the Black community and most mental health workers do not integrate the social support system with treatment plans when working with Black clients (Gary, 1978, pp. 39-40).

That quotation sets the thematic framework for this paper. In other words, prevention programs must begin to focus upon support systems in black communities and their relationships to black suicide.

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