“Let me Count the Ways:” Fostering Reasons for Living Among Low-Income, Suicidal, African American Women

LINDSEY M. WEST, PhD, TELSIE A. DAVIS, PhD, MARTIE P. THOMPSON, PhD, and NADINE J. KASLOW, PhD, ABPP

Protective factors for fostering reasons for living were examined among low-income, suicidal, African American women. Bivariate logistic regressions revealed that higher levels of optimism, spiritual well-being, and family social support predicted reasons for living. Multivariate logistic regressions indicated that spiritual well-being showed unique predictive value for reasons for living. Further, the multivariate model accurately predicted reasons for living 72% of the time. Partial support was found for a cumulative protective model hypothesizing a linear relationship between the number of protective factors endorsed and increased reasons for living. Implications for community-based preventive and recovery-oriented intervention efforts and future research are discussed.

The most recent national statistics compiled in 2007 and released in 2010 cite suicide as the eleventh leading cause of death in the United States. This reflects a pattern of relative stability in suicide rates since 2000 (Centers for Disease Control [CDC], http://www.cdc.gov/violenceprevention/suicide/statistics/trends01.html). However, suicide rates for women have gradually, yet steadily increased from 2000 to 2006 (CDC, http://www.cdc.gov/violenceprevention/suicide/statistics/trends01.html). In the African American community, as in all ethnic groups, women are less likely to commit but more likely to attempt suicide in comparison to men (Griffin-Fennell & Williams, 2006; Kaslow et al., 2005; Rowell, Green, Guidry, & Eddy, 2008). The 12-month prevalence rates for nonfatal suicide attempts in African American women is high relative to men and women of other racial/ethnic backgrounds (5%; Joe, Baser, Breeden, Neighbors, & Jackson, 2006); thus, research is warranted concerning how to prevent suicide attempts among this population.

The last decade has witnessed increased empirical attention to suicide prevention among African American women. Reviewers of this growing literature have identified the following variables as risk factors for suicidal behavior in this population: psychological distress, symptoms of depression and posttraumatic stress disorder, substance abuse, hopelessness, aggression, maladaptive coping strategies, low levels of religiosity and spirituality, low levels of...
ethnic identity, relationship discord, intimate partner violence, and limited social support (Kaslow et al., 1998, 2000, 2002, 2004, 2005). Though risk factors for suicide have garnered much of the focus, emergent literature has documented the following protective factors: reasons for living, hopefulness, self-efficacy, coping skills, spirituality, positive family relationships, social support, and an ability to obtain material resources (Compton, Thompson, & Kaslow, 2005; Kaslow et al., 2002; Meadows, Kaslow, Thompson, & Jurkovic, 2005).

Reasons for living have received robust empirical support as a protective factor for suicidal behavior (Linehan, Goodstein, Nielsen, & Chiles, 1983; Malone et al., 2000; Wang, Lightsey, Pietruszka, Uruk, & Wells, 2007). However, this construct has not been examined among African American women. Moreover, reasons for living typically have been explored as a predictor of suicidal behavior (Malone et al., 2000), with only a few investigations examining predictors of reasons for living (Wang et al., 2007), and none doing so with low-income, suicidal, African American women. As such, identifying predictors of reasons for living among the target population will address a gap in the literature.

Primary reasons for living include survival and coping beliefs, responsibility to family, child-related concerns, fear of suicide, fear of social disapproval, and moral objections (Linehan et al., 1983). Individuals differ on the degree to which they find each of these reasons salient. Optimism, spirituality, social support/family, coping, and effectiveness at obtaining resources are associated with these primary reasons for living (Ellis & Smith, 1991; Kaslow et al., 1998; Meadows et al., 2005; Range & Penton, 1994; Wang et al., 2007). These constructs are very salient to African American women.

Optimism and hope protect against suicidal behavior in the African American community (Meadows et al., 2005). Although the link between optimism/hope and reasons for living has not been studied among African Americans, higher levels of hope are associated with more reasons for living (Range & Penton, 1994). Optimism was one of three key predictors of subjective well-being in African Americans (Utsey, Hook, Fischer, & Belvet, 2008). Among African American single mothers, maternal optimism buffered against economic stressors, internalizing problems, and child behavioral issues (Taylor, Larsen-Rife, Conger, Widaman, & Cutrona, 2010).

Spiritual well-being also buffers against suicide in African American women (Kaslow et al., 2004; Meadows et al., 2005). Writers of one study found a strong link between adaptive cognitive beliefs and reasoning with existential beliefs (Ellis & Smith, 1991). Although the association between spiritual well-being and reasons for living has not been explored with African American women, given what we know about spiritual well-being and suicidal behavior in African American women (Arnette, Mascaro, Santana, Davis, & Kaslow, 2007), and the strong link between spiritual well-being and quality of life (Utsey et al., 2007), the relationship between spiritual well-being and reasons for living deserve attention.

The role of social support, specifically within the family, is positively associated with a non-attempter status in low-income, suicidal, African American women exposed to intimate partner violence (Meadows et al., 2005). In this study, a multivariate model revealed that family social support was a unique predictor of non-attempter status, suggesting the ways in which family support plays a salient role for African American women threatening suicide. To that end, family social support may foster reasons for living in a similar sample.

Coping refers to the specific behavioral and psychological efforts individuals use to minimize stressful events (Folkman, 2010). Coping is positively correlated with reasons for living (Range & Stringer, 1996; Wang et al., 2007). As individuals engage in coping with problems, they may become more aware of reasons to stay alive (Wang et al., 2007). Given the positive correlation between coping and reasons for living, along with data showing that subsets of coping
have facilitated reasons for living (Molock, Puri, Matlin, & Barksdale, 2006; Wang et al., 2007), it is reasonable to propose that overall coping may be predictive of reasons for living. Social (Kaslow et al., 1998; Magne-Ingvar, Ojehagen, & Traskman-Bendz, 1992; Maris, 1997) and material (Ferrada-Noli & Asberg, 1997; Lester & Yang, 1997), resources protect against suicidal behavior. Abused African American women’s low self-perception of effectiveness at obtaining these resources is related to increased risk of suicidal behavior (Thompson, Kaslow, Short, & Wyckoff, 2002). A logical extension of these findings could be that high self-perception of effectiveness at obtaining resources is related to increased reasons for living; investigation of this relationship is warranted.

The current study aims to determine protective factors that predict reasons for living among low-income, African American women with a history of a suicide attempt in the prior year. We hypothesize that optimism, spirituality, social support/family, coping, and effectiveness at obtaining resources are positively associated with reasons for living. We also hypothesize a linear relationship between the number of factors women endorse and increased reasons for living. This work can assist in the development of interventions that can be tailored to facilitate reasons for living among suicidal, low-income, African American females.

**METHOD**

**Participants**

One-hundred fifty-six African American women (mean age 36 years) were recruited from a large public, university-affiliated hospital serving an indigent, urban population. Eligibility included a suicide attempt in the past year. Exclusion criteria included inability to complete the interview because of cognitive impairment, acute psychosis, or delirium. Compensation was $50 for the interview. Participants’ data for the current study is the first time point from a larger intervention study. Prior to its initiation, the study was approved by the university’s institutional review board and the hospital’s research oversight committee.

**Measures**

**Demographic Data Questionnaire.** This measure (Kaslow et al., 2010) asked respondents to provide basic demographic information (e.g., relationship status, religious affiliation, children), information about social class (e.g., homelessness status, number of people in the home, income, employment, health insurance), and psychiatric and legal history.

**Reasons for Living Inventory (RFL; Linehan et al., 1983).** The RFL assesses the presence of specific buffers (reasons) against suicidal behavior to evaluate adaptive reasons for living even in the face of contemplating suicide (Linehan et al., 1983; Osman et al., 1993). This 48-item, 6-point Likert-type scale ranging from 1 (not important at all) to 6 (extremely important) asks participants to rate the importance of various reasons for not committing suicide, if they were to have the thought. Factor analytic research indicates that the RFL is comprised of six subscales: Survival and Coping Beliefs, Child-Related Concerns, Family Related Concerns, Fear of the Act of Suicide, Fear of Social Disgrace, and Moral Concerns. Subscale alphas range from .74 to .92, with a total score alpha of .89 (Osman et al., 1993). In the current sample, the internal consistency reliability for the total score was .96. The RFL has good validity with other self-report measures of suicide and general psychopathology (Osman et al., 1999). In this validation study, there was a 79% probability that a score ≥3.8 predicted adaptive reasons for living. Given this, the current study dichotomized the RFL at 3.8, with a score of 3.8 meaning high levels of reasons for living.

**Ways of Coping—Revised (WOC-R; Folkman & Lazarus, 1985).** The WOC-R is a 66-item, 4-point Likert-type (0 = does not apply and/or not used; 3 = used a great deal)
questionnaire containing a wide range of thoughts and acts that people use to deal with the internal and/or external demands of specific stressful encounters. Previous studies reported moderate alphas for the various subscales (Folkman, Lazarus, Dunkel-Schetter, DeLongis, & Gruen, 1986). For the purposes of this study, we were interested in the total score on this measure given the potential multicollinearity issues. The alpha for this measure was .89.

Social Support Behaviors Scale (SSB; Vaux, Riedel, & Stewart, 1987). The SSB, a multidimensional measure of social support, measures individuals’ perceptions of the social support they experience from family and friends; however, for this study only the 45 family items were used given the high intercorrelation between the subscales. The SSB taps five dimensions of social support and responses were measured on a 5-point Likert scale ranging from 1 (no one would do this) to 5 (most of them would certainly do this). The scale has good convergent, divergent, and concurrent validity (Vaux, Burda, & Stewart, 1986; Vaux & Harrison, 1985; Vaux et al., 1987). The coefficient alpha for the current sample was .99 for the family subscale.

Spiritual Well-Being Scale (SWBS; Paloutzian & Ellison, 1982). The 20-item SWBS assesses religious and existential well-being. Responses were made on a 6-point Likert scale ranging from 1 (strongly disagree) to 6 (strongly agree). The scale has good test–retest reliability and convergent validity. Coefficient alpha for the current sample was .90.

Effectiveness of Obtaining Resources (EOR; Sullivan, Tan, Basta, Rumptz, & Davidson, 1992). The 11-item EOR ascertains how successful a woman perceives she had been in obtaining resources in 11 domains: education, material goods, employment, resources for children, health care, legal resources, transportation, housing, finances, childcare, and social support. Items were measured on a 4-point Likert scale ranging from 1 (not very effective/successful) to 4 (very effective/successful). Coefficient alpha for the current sample was .86.

Life Orientation Test (LOT–R; Scheier, Carver, & Bridges, 1994). Optimism was assessed with the Optimism subscale from the LOT–R, which has three items and is scored on a 5-point scale ranging from 1 (strongly disagree) to 5 (strongly agree). Cronbach’s alpha was .65 for the Optimism subscale in this sample.

Procedure

The principal investigator was contacted via pager around the clock to ensure that all African American women who presented to the hospital emergency rooms or inpatient units after a suicide attempt were referred immediately to the study. Women also were referred if they potentially met inclusion criteria, even if they did not seek assistance for a suicide attempt. A suicide attempt was defined as a self-injurious act requiring medical attention and/or in which there was serious intent. After being contacted, a research team member (undergraduate and graduate students, post-doctoral fellows), trained in interviewing and supervised weekly, recruited women who met inclusion criterion once they were deemed medically stable. Women who agreed to participate provided written informed consent. Once consent was obtained, the women were screened for study eligibility. Face-to-face interviews for women who met inclusion and screening criterion lasted 2–3 hours and were conducted in private designated hospital areas. After completing the protocol, participants were compensated $50 and provided with referrals to groups associated with the program and to other community agencies. The current study is based on participants’ pre-intervention assessments.

RESULTS

Correlations among Protective Factors

Significant positive intercorrelations were found among the majority of possible
pairs of protective factors of reasons for living. See Table 1 for reported values.

**Bivariate Logistic Regression Models**

Logistic regressions were used for the bivariate and multivariate analyses to explore the associations between the protective factors and reasons for living. The protective factors were dichotomized to obtain odds ratios that would indicate the magnitudes of their associations with the outcome measure. There were no published cut points for the protective factors; thus, we dichotomized them such that women whose responses were in the top quartile were classified as having the protective factor. Our rationale for this approach was that it is more likely to “catch” higher levels (i.e., a good “dose”) of each factor than another approach such as median splits.

We conducted bivariate logistic regression analyses to determine the association of each of the five protective factors with the RFL. Results are shown in Table 2 and indicate that three of the five protective factors were significantly associated with higher scores on the RFL.

Women with high levels of optimism were almost four times (COR [crude odds ratio] = 3.90; 95% Confidence Interval [CI] = 1.40, 11.01) more likely to report reasons for living compared to women with lower levels of optimism. Similarly, women with high levels of spiritual well-being were thirteen times (COR = 13.25; CI = 3.77, 46.60) more likely to report reasons for living than their counterparts with lower levels of spiritual well-being. Women with high levels of social support from family were three times (COR = 3.14; CI = 1.40, 7.02) more likely than their counterparts with lower levels of social support to report reasons for living. However, there were no significant differences on reasons for living between women with high levels of coping and high levels of EOR compared to their respective counterparts.

**Multivariate Logistic Regression Model**

A multivariate logistic regression analysis was conducted to determine the unique contribution of each protective factor in predicting reasons for living (see Table 3). Only one of the five protective factors, spiritual well-being, remained uniquely associated with reasons for living after controlling for all other protective factors. Women who endorsed high levels of spiritual well-being were almost seventeen times (AOR [adjusted odds ratio]; 95% CI = 2.84, 101.75) more likely than their counterparts with lower levels of spiritual well-being to report reasons for living. The multivariate logistic regression model had

<table>
<thead>
<tr>
<th>TABLE 1</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Raw Score Means, Standard Deviations, and Correlations among Variables of Interest</strong></td>
</tr>
<tr>
<td>Variables</td>
</tr>
<tr>
<td>---</td>
</tr>
<tr>
<td>1. Coping</td>
</tr>
<tr>
<td>2. Social support</td>
</tr>
<tr>
<td>3. Optimism</td>
</tr>
<tr>
<td>4. Spirituality</td>
</tr>
<tr>
<td>5. EOR</td>
</tr>
<tr>
<td>6. RFL</td>
</tr>
</tbody>
</table>

Coping, the total score on the Ways of Coping-Revised; Social support, the total family score on the Social Support Behaviors scale; Optimism, total score on the Life Orientation Test-Revised; Spirituality, the total score on the Spiritual Well-Being scale; EOR, the total score on the Effectiveness of Obtaining Resources scale; RFL, the total score on the Reasons for Living scale.

*p < .05, **p < .01.
good predictive value; suicide attempt status was predicted accurately 72% of the time assuming knowledge of scores on the five measured protective factors.

### Cumulative Protection Model

To test the cumulative protective factor model, we formed three groups based on the number of protective factors a woman endorsed: (1) 0–1 protective factors, \( n = 25 \); (2) 2–3 protective factors, \( n = 61 \); and (3) 4–5 protective factors, \( n = 55 \). The group with 0–1 protective factors served as the reference category to which the other two groups were compared. Dummy variables were used to compare the groups and were simultaneously entered into a logistic regression model predicting reasons for living. Women who had 2–3 protective factors were at least five times more likely to report reasons for living than women with just 0–1 protective factors (AOR = 5.61; 95% CI = 1.95, 16.14). Women with 4–5 protective factors were eleven times more likely to report reasons of living than women with just 0–1 protective factors (AOR = 11.35; CI = 3.71, 34.74), suggesting that as the number of protective factors increased, so too did a woman’s likelihood of reporting high levels for reasons for living.

### DISCUSSION

Commentators of this study represent the first attempt to examine predictors of reasons for living among suicidal, low-income African American women. Results revealed strong interrelationships among the protective factors. Further, three of the five proposed protective factors (optimism, spiritual well-being, and social support from family members) were associated with higher levels of reasons for living in this sample. When taking other protective factors into account, one variable, spiritual well-being, distinguished African American women with high versus low levels of reasons for living. Although only one variable was associated uniquely with more reasons for living in the multivariate model, the model had very good predictive value such that it predicted reasons for living 72% of the time. In addition, the data revealed a powerful association
between the number of protective factors endorsed and the reasons for living reported. Specifically, women who endorsed two to three protective factors and those who endorsed four or more protective factors were at least five times and eleven times, respectively, more likely to acknowledge reasons for living than those women who only endorsed zero to one protective factors.

The high, positive correlations between pairs of protective factors are consistent with theoretical and empirical literature that shows overlap in the conceptualization and measurement of these factors. Results of the bivariate regressions are consistent with previous research suggesting that optimism, spiritual well-being, and social support from family members increase aspects of well-being (Utsey et al., 2007) and quality of life (Utsey et al., 2008), and buffer against suicide (Kaslow et al., 2004; Meadows et al., 2005). The unique predictive value of spiritual well-being is consistent with our understanding of the role spirituality plays in African American women’s lives. One reason for the strong association between spiritual well-being and reasons for living relates to the culturally specific role spirituality plays in the African American community, and particularly, the southern African American community (Parks, 2003). Historically, African Americans have relied on their spirituality to cope with hardships and adversity (Boyd-Franklin, 2010), and spirituality is an important cultural value in the African American female community (Mattis, 2002). Findings from the cumulative protective factor model support the idea that the number of protective factors experienced by low-income, suicidal, African American women may be as significant as the specific protective factors experienced. Researchers of this study are the first to find such a link.

Despite the strength of the findings, they need to be considered in light of study limitations. African American experiences in the world are complicated by their position at the intersection of racial and gender oppression, which is termed gendered racism (Thomas, Witherspoon, & Speight, 2008). Studies have shown that experiences of sexism (Moradi & Subich, 2003), sexual harassment (Buchanan & Fitzgerald, 2008), and classism (Neal-Barnett & Crowther, 2006) likely affect African American women’s well-being differently from European American women and African American men. As a result, future studies should examine the role of these “isms” on African American women to better understand the role this triple burden may play in the relationships among coping, social support, and reasons for living.

The study is also limited by a small sample and the demographics of the sample, which impacts and may limit the generalizability of findings. Researchers of future studies should examine the links between the various protective factors and reasons for living in different samples with regard to gender, race/ethnicity, and class, to shed light on the generalizability of the results. In addition, culturally relevant protective factors, such as spiritual well-being in African Americans, should be included in these investigations. Further, inasmuch as the data from this sample are correlational and cross-sectional, causal explanations cannot be asserted with confidence among the variables of interest. Future research in this area would benefit from experimental and longitudinal paradigms so that the temporal, conditional, and contextual natures of these variables can be assessed more fully.

There are a number of clinical implications of the findings. Clinicians working with suicidal individuals should discuss with them their individualized reasons for living (Miller, Segal, & Coolidge, 2001). However, depending on their current functioning, they may struggle to find ways to articulate their beliefs. Given the results of the current study, one potential avenue clinicians can take is to help suicidal women understand their level of spiritual well-being, optimism, and social support from family members as related to their reasons for living. Such assessments should also assess the numbers of protective factors women are able to endorse. Interventions with
suicidal persons should target bolstering optimism and social support from significant others (Linehan, 2008). For interventions with suicidal African American women to be optimally effective and culturally competent, they should target strengthening the women’s sense of spiritual well-being. Moreover, strength-based strategies that are designed to increase systematically the number of protective factors that individuals possess should be designed and implemented as they may both reduce suicidal people’s risk for future suicidal behavior by helping them feel that life is more worth living and prevent at-risk groups from becoming suicidal.

REFERENCES


Manuscript Received: April 11, 2011
Revision Accepted: April 17, 2011