Suicidality in African American Men: The Roles of Southern Residence, Religiosity, and Social Support

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The rise in suicide by African Americans in the United States is directly attributable to the dramatic, nearly three-fold increase in suicide rates of African American males. Gibbs (1997) hypothesized high social support, religiosity, and southern residence are protective factors against suicidality for Black people. This hypothesis was tested among 5,125 participants from the National Comorbidity Survey; 299 were African American males. In this study we hypothesized that there would be significantly lower suicidality in the South, and social support and religiosity would mediate this relationship. Our results indicate that Southern region is indeed a significant predictor of suicidal symptoms in African American men, such that suicidal symptoms were lower in the South, but religiosity and social support did not account for this effect. Other potential mediators were also examined.

Although suicide in the United States dropped from the ninth leading cause of death in 1996 to the eleventh leading cause of death in 2000, the rate of suicide among African Americans has steadily increased over the past decades, such that it is now the third leading cause of death in African Americans1 (Centers for Disease Control and Prevention, 2002). This rise in African American suicide in the United States is directly attributable to the dramatic increase in completed suicide rates of African American men (Centers for Disease Control and Prevention [CDC], 1998; Gibbs & Hines, 1989; Joe & Marcus, 2003; National Center for Injury Prevention and Control, 1995). Shaffer, Gould, and Hicks (1994) concluded that if Black suicide continues at the present rate, “suicide will be as common in Blacks as it is in Whites” (p. 1812).

Although Black male suicide rates have increased so dramatically, historically Black suicide rates on the whole have been relatively low compared to White suicide rates.2 Gibbs (1997) hypothesized that high social support,
religiosity, and southern residence each constitute protective factors against suicidality for Black people. These protective factors have been cited as explanations for the differences in Black versus White suicide rates.

**PROTECTIVE FACTORS**

**Social Support**

According to Gibbs (1997), social support, in combination with strong religious beliefs and cohesive ethnic neighborhoods, may indirectly help reduce the risk of suicide for African Americans. These conditions may buffer against the effects of aging and poverty, factors that are associated with greater risk of suicide (Hovey, 2000; Qin, Agerbo, & Mortensen, 2003). Consistent with the notion that social support plays a protective role, Nisbet (1996) found that having relatives across generations, neighbors, and friends helps with financial stressors and child rearing, and provides emotional support. Nisbet suggested that such support explained the lower rate of fatal suicide attempts by Black women. Additionally, research has shown that suicide rates among African Americans tend to be higher among those who live alone and are not involved with their families (Davis, 1980; Dunston, 1990; Gibbs & Martin, 1964). The protective effects of social support and living with others also have been hypothesized and demonstrated to be protective factors among groups of people from other ethnic backgrounds.

Social isolation has long been supported as a risk factor for suicide. Among the clearest findings in all the literature on suicide is the fact that people who die by suicide experience isolation and withdrawal previous to their deaths (Trout, 1980). Baumeister and Leary (1995) proposed that the need to belong to a social group is a fundamental human motive, and they provide many examples of empirical support for their model. In his interpersonal-psychological theory of suicide, Joiner (in press) suggests that the need to belong is so powerful that, when satisfied, it can prevent suicide; however, when the need for social connection is thwarted, risk for suicide is increased. Early and Akers (1993) suggested that social relationships provide support that counteracts the effects of negative situations that may lead to suicide. Additionally, they hypothesized that the normative climate or values and beliefs held by a culture may deter certain types of behaviors (e.g., suicide).

Related to social support, Lester (1988, 1990–91, 1998) investigated the importance of social integration and the strength of social networks by examining social indicators as predictors of suicide rates for Caucasians and African Americans in the United States. Results indicated that social disintegration was positively correlated with suicide rates for both African Americans and Caucasians. Additionally, in locations where African Americans represented a higher proportion of the population, suicide rates were found to be lower (Lester, 1988). According to this research, degree of social integration and the population density of African Americans in an area may partly account for regional ethnic differences in suicide rates.

**Religiosity**

Religion has long been viewed as a protective factor against medical and mental illnesses and, particularly, against suicidality. Durkheim’s (1951/1997) theory of social integration is often cited as the framework within which to conceptualize this phenomenon. Specifically, there appears to be a negative link between religiosity and suicide, which may be due, in part, to increased levels of social integration associated with religious participation (Neeleman, Wessely, & Lewis, 1998). Literature provides support for the contention that religiosity (i.e., active participation, spirituality, subjective affiliation, etc.) is a distinct protective factor against suicide risk. One study found that active participation in religious activities had a protective ef-
fect against suicide, over and beyond that provided by social contact (Nisbet, Duberstein, Conwell, & Seiditz, 2000). Based on data from the 1998 National Health Center Statistics, and death records of 100 people (50 of whom died by suicide and 50 of whom died of natural causes), Nisbet and his colleagues found that the odds of dying by suicide were greater for those people who had relatively low religious participation. Religious participation was not associated with death from natural causes. Moreover, the two groups did not significantly differ in terms of frequency of social contact.

Ellison, Burr, and McCall (1997) theorized that religious homogeneity would enhance social integration, and would interact with ethnic or regional culture to produce greater protection against suicidality. In this study, the authors compared 1980 Census data with the statistical and demographic data obtained from religious denomination headquarters, and collapsed this information into standard metropolitan statistical areas (SMSAs), which were consistent in terms of sociological and economic integration. Results indicated that overall religious homogeneity was inversely related to suicide.

Although the literature supports the protective effects of religion in general, many studies focus on the effects of religion within the African American community to explain the comparatively low suicide rate among African Americans in the United States (Gibbs, 1997; Lester, 1988). This research focus is sensible, given the relatively high religiosity among African Americans compared to Caucasians (Neighbors, Musick, & Williams, 1998), and the protective characteristics of religiosity against suicide risk.

Hunt and Hunt (2001) conducted a comparison of African American and White religious involvement and the impact of geographic region. They found that African Americans had a higher level of religious participation (church attendance), a stronger subjective identification with their church affiliation, and were more likely to belong to a church-related group. Geographic region too was an important variable in the distinction between African Americans and Caucasians. Specifically, in the rural South, African Americans and Caucasians were essentially similar in terms of religious involvement. In the urban North, however, there was a significant difference between the two groups; African Americans evidenced greater disengagement than Caucasians from religious institutions. Neither the rural south pattern, nor the urban north pattern is unexpected, given migration and social integration theories. The African American community has documented trends of northern migration and urbanization. These patterns of geographic dispersal among otherwise socially contiguous groups and individuals may serve to elevate suicide rates by removing the protective element of cultural homogeneity irrespective of social support. The more provocative finding, one that is not so easily explained in terms of these theories, is the difference between African Americans and Caucasians in the urban South, where African Americans were significantly more involved in religious activities than Caucasians.

**Southern Residence**

Overall, suicide rates differ in various regions of the United States. Southern residence in the United States is often identified as a protective factor that reduces suicide risk among African Americans. Suicide rates in White people tend to be higher than in Black people at all ages, with greater differences identified in southern states (Shaffer, 1988). In their regional analysis of suicide in teens, Shaffer et al. (1994) found that suicide rates among Black people were lowest and the differences between rates among Black people

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4. South represents all states that were coded in the National Comorbidy Study data as “southern region.” The South, as referred to in our study, is composed of the following states: Delaware, Maryland, Washington DC, Virginia, West Virginia, North Carolina, South Carolina, Georgia, Florida, Arkansas, Louisiana, Oklahoma, Texas, Kentucky, Tennessee, Alabama, and Mississippi.
and White people were greatest in the southeast central region. In a regional analysis of African American suicides, Lester (1990–91) found that rates were higher in the northern states in general and in states with higher rates of unemployment. Additionally, Willis, Coombs, Drentea, and Cockerham (2003) stated that research has consistently found that African Americans in southern states are at less risk than in western and northern states. Interestingly, the results of their study suggested that when compared to the West, African American suicides were more likely to occur in the Midwest, Southeast, and Northeast.

Although rates of suicide are relatively low in the South, the recent increase in Black male suicide has made an impact in the South. According to the CDC (1998), during 1980–1995, trends in suicide rates for Black youths differed by region; the largest increase in suicide rates occurred for Black people aged 15–19 years in the South (214%). By sex, the largest increase in suicides occurred among Black males aged 15–19 years in the South (223%).

The overall pattern of fewer Black suicides in the South has been explained in relation to population density, integration, and urban migration. The Group for the Advancement of Psychiatry (GAP, 1989) agreed that the lower rates of suicide are partly a function of the high population density of Black people in this region. GAP also reported that there is an inverse relationship between the proportion of the population residing in a region and its suicide rate: Black suicide is higher in urban areas where Black people are more dispersed than in rural areas where the population density of Black people is higher.

Gibbs’ (1997) description of the South as a protective factor emphasizes low racial integration as a possible buffer against suicidality (Hickman, 1984; Lester, 1990–91; Shaffer 1994). Low racial integration is the separation of different racial groups and cohesion among individuals within each racial group (e.g., White and Black people are segregated, but White people form a close group with each other and Black people form a close group with each other). Durkheim’s classic theory of suicide (1951/1997) also highlights the importance of social integration and the strength of the individual’s social network. In communities where Black people are less integrated in the White society, they may experience greater social cohesion within the Black community, particularly in cities where the Black community is often geographically and socially segregated (Lester, 1990–91; Shaffer et al., 1994 cited by Gibbs, 1997). These theories of social integration are thought to partially account for the findings of lower Black suicide rates in the South, and higher Black suicide rates in areas with smaller proportions of Black people.

In another effort to describe lower suicide rates in the South, Gibbs (1997) stated that in the absence of social agencies to provide essential services for disadvantaged Black people in the South, the extended family, kin networks, and the African American church fulfilled those needs. In recent years, this family form has diminished among Black people as they have migrated from the rural South to the urban North and West, and have generally become more affluent, leaving the inner-city disadvantaged families behind in deteriorating communities (Wilson, 1987).

The purpose of the current study was to examine the relationship between African American suicidality and region of the United States in which African Americans reside. Due to the recent dramatic increase in suicide among African American men, coupled with an exceptional increase specifically in the South, the focus of this investigation is on African American men. We predicted that among African American men in our sample, the region of the country in which they reside would serve as a predictor of suicidality. We hypothesized further that religiosity and social support would account for the influence of southern region on the rates of suicidality.

METHOD

Samples and Field Procedures

Data were derived from The National Comorbidity Survey (NCS), which is based
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Preliminary analyses are focused on the total sample \( n = 5,125 \) to confirm that African American men in the South experienced fewer suicidal symptoms than other groups.

**Diagnostic Assessment**

The psychiatric diagnoses obtained via the NCS are based on DSM-III-R criteria (APA, 1987). The diagnostic interview used to generate the diagnoses was a modified version of the Composite International Diagnostic Interview (CIDI) and was designed to be used by trained lay interviewers (Robins, Wing, Wittchen, & Helzer, 1988). The CIDI has demonstrated good interrater reliability, test-retest reliability, and validity on almost all diagnoses, with the exception of acute psychotic disorder. For this reason, an adapted version of the Structured Clinical Interview for DSM-III-R (Spitzer, Williams, Gibbon, & First, 1992), an instrument with demonstrated reliability in the diagnosis of schizophrenia, was also administered to those respondents who reported any evidence of psychotic symptoms. Extensive demographic information was also collected including the following variables that are of specific interest in this study: sex, race, and geographic region.

**Measures**

**Religiosity.** For the purpose of the current study, scales were constructed from participants' responses in order to measure constructs of interest. The religiosity scale was created from four items: (1) In general, how important are religious or spiritual beliefs in your daily life? (very, somewhat, not very, not at all important); (2) How often do you attend religious services? (more than once a week, about once a week, 1 to 3 times a month, less than once a month, never); (3) When you have problems or difficulties in your family, work, or personal life, how often do you seek spiritual comfort? (almost always, often, sometimes, rarely, never); (4) When you have decisions to make in your daily life, how often do you ask yourself what God would want you
to do? (almost always, often, sometimes, rarely, never). Participants’ responses were coded as integers and then treated as interval-level data. Responses to each item were scored so that higher scores represented more religiosity. Scores were then standardized into z-scores to compensate for the different numbers of response options for the different items. The scale was formed by summing the z-scores of the responses for each item. Internal consistency of this religiosity scale was $\alpha = 0.87$.

Social Support. The social support scale was created from 12 items. Six of the questions inquired about social support received from non-spouse relatives: (1) How much do your relatives really care about you? (2) How much do they understand the way you feel about things? (3) How much do they appreciate you? (4) How much can you rely on them for help if you have a serious problem? (5) How much can you open up to them if you need to talk about your worries? (6) How much can you relax and be yourself around them? The response options for the social support scale were: a lot, some, a little, or not at all. The remaining six questions consisted of the same items with respect to support from friends. The ordered responses were coded as integers and then treated as interval-level data. The scale score was calculated by summing responses to the 12 items. Possible scores ranged from 12 to 48, with higher scores indicating more social support. Internal consistency was $\alpha = 0.86$.

Suicidality. A suicidality scale was created from participants’ responses to four items: (1) Has there ever been a period of 2 weeks or more when you thought a lot about death—either your own, someone else’s, or death in general? (2) Has there ever been a period of 2 weeks or more when you felt like you wanted to die? (3) Have you ever felt so low you thought about committing suicide? (4) Have you ever attempted suicide? The response options for these items were dichotomous: yes or no. The ordered responses were coded as integers and then treated as interval-level data. The scale score was computed by summing responses to the four items. Possible scores ranged from 0 to 4, with higher scores indicating more suicidal symptoms. Internal consistency was moderate at $\alpha = 0.66$. However, given that the four items composing the suicidality scale address a wide range of severity of suicidal behavior, it is not expected that people answer similarly across these items. For this reason, we did not anticipate an especially high level of internal consistency.

Of the total sample, 2,896 Caucasians and 130 African American men were asked the suicide questions. The survey was conducted such that questions regarding suicidality were only asked of those individuals who first endorsed having experienced a number of symptoms of depression or dysthymia. This is appropriate as the large majority of people who attempt or commit suicide currently have, or have a history of, a mood disorder (Conwell, Duberstein, Cox, & Herrmann, 1996; Ialongo et al., 2002). Participants were questioned about the presence of current or past symptoms of both depression and suicidality. Participants who were not interviewed about past or current suicidal symptoms due to no reported history of mood disturbance were assigned a score of zero on the suicidality scale.

RESULTS

Preliminary Analyses

Preliminary data screening indicated that the mean reported score on the suicidality scale for our combined Caucasian and African American sample ($N = 5,125$) was 0.62 ($SD = 1.02$). While the majority of participants obtained a score of zero on this measure, skewness was found to be within acceptable limits for analysis ($S = 1.76$).

The primary hypotheses of this study rest on the underlying premise that there is an interaction among sex, race, and region in the prediction of suicidal symptoms. Our focus was specifically on African American men. Based on past work (e.g., Gibbs, 1997), we expected that African American men in
the South experienced fewer suicidal symptoms than other groups. Before conducting the primary analyses, it was imperative to confirm the existence of such an interaction. A 2 (gender) × 2 (region, South vs. other) × 2 (race, Caucasian vs. African American) factorial analysis of variance (ANOVA) was conducted, with participants’ scores on the suicide scale as the dependent variable. Results did indicate a significant three-way interaction between these variables, \( F(1, 4742) = 5.71, p = .02 \). An investigation of the means indicated that African American men in the South reported the lowest scores on the suicide scale of any group (see Figure 1). This finding supported the underlying premise; accordingly, we pursued our planned investigation of potential mediators of this effect of region on suicidality in African American men. 5

**Primary Analyses**

For the primary analysis zero order correlations were then computed between region and suicidality for African American males. Following this, a hierarchical regression analysis was conducted with social support and religiosity as independent values in the first step, region as the independent value in the second step, and suicidality as the dependent value. The partial correlation from the regression analysis was then inspected to determine whether region remained a significant predictor of suicidality after controlling for social support and religiosity.

Means, standard deviations, and bivariate correlations between all variables of interest among African American men are presented in Table 1. Data screening indicated that in this reduced sample, scores on the suicidality scale were significantly positively skewed, as a sizable majority of Black male participants obtained a score of zero on this measure. Accordingly, a square root transformation was performed on the suicidality scale. This transformation reduced the skewness of this scale to within acceptable limits for analysis (\( S = 1.93 \)). The distributions of participants’ scores on the religiosity and social support scales were both acceptably normal.

Notably, a significant positive correlation was noted between region (coded South = 1; Other = 0) and religiosity (\( r = .23, p < .01 \)), indicating that Southern region predicted higher self-reported religiosity, consistent with our expectations. In addition, a significant negative correlation was noted between region and suicidality (\( r = -.17, p < .01 \)), consistent with our results reported above indicating that among African American men, Southern region predicted lower scores on suicidality. Region was not found to correlate significantly with social support; however, a significant positive correlation was noted between participants’ social support and religiosity (\( r = .16, p < .01 \)), suggesting that those participants who were more religious reported having more social support, consistent with expectation. Social support was also observed to correlate negatively with suicidality (\( r = -.18, p < .01 \)), also consistent with expectation. No significant correlation was observed between religiosity and suicidality.

To more thoroughly examine the unique effects of region, religiosity, and social support on suicide in African American men, a hierarchical multiple regression was conducted with transformed suicide scores as the dependent variable. Religiosity scores and scores on the social support measure were entered

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5. Other findings from the preliminary analysis are consistent with expected findings. Results indicated significant main effects for gender, \( F(1, 4742) = 21.46, p < .001 \); and for race, \( F(1, 4742) = 24.82, p < .001 \). Consistent with well established prevalence rates of suicidality, females in this sample reported significantly more suicidal symptoms (\( M = 0.63, SD = 0.03 \)) than males (\( M = 0.42, SD = 0.03 \)). It has been well established that females report significantly more suicidal symptoms as well as suicide attempts than males, which is consistent with our results. This is distinct from the well established finding that males consistently complete suicide more often than females. Caucasians reported significantly more suicidal symptoms (\( M = 0.63, SD = 0.02 \)) than African Americans (\( M = 0.41, SD = 0.04 \)). No main effect of region (South vs. other) was noted in the overall sample of Caucasians and African Americans (but see below).
Figure 1. The three-way interaction among gender, race, and region in the prediction of suicidal symptoms.
TABLE 1
Means, Standard Deviations, and Bivariate Correlations for Variables of Interest in African American Men

<table>
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<tr>
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<th>(1)</th>
<th>(2)</th>
<th>(3)</th>
<th>(4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Region (South v. Other)</td>
<td>1.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(2) Social Support</td>
<td>0.07</td>
<td>1.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(3) Religiosity</td>
<td>0.23**</td>
<td>0.16**</td>
<td>1.00</td>
<td></td>
</tr>
<tr>
<td>(4) Suicidality Score (transformed)</td>
<td>−0.17**</td>
<td>−0.20**</td>
<td>0.11</td>
<td>1.00</td>
</tr>
<tr>
<td>N</td>
<td>299</td>
<td>295</td>
<td>299</td>
<td>299</td>
</tr>
<tr>
<td>M</td>
<td>N/A</td>
<td>19.55</td>
<td>0.71</td>
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<td>SD</td>
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<td>5.38</td>
<td>3.13</td>
<td>0.47</td>
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**Significant at the 0.01 level (2-tailed).

Post Hoc Analyses on Other Possible Mechanisms

Because the hypothesized mediation effects of religion and social support on the relationship between Southern region and suicidal symptoms in African American men were not supported, we wished to determine whether we could identify any other potential mediators of this relationship. Candidates considered included employment status, income, hours worked per week, level of education, and urbanicity, all of which were assessed in the National Comorbidity Survey. These factors were selected because they are general factors that indicate possible inefficac-

6. Of note, controlling for age did not significantly affect the results of these analyses.
years, 13–15 years, or 16 or more years of education. Finally, urbanicity was coded dichotomously, with participants identified as residing in metro/urban counties, or non-urban (fewer than 20,000 residents) counties.

In order to briefly examine whether these variables might play a role in mediating the observed relationship between region and suicidal symptoms in African American men, a second hierarchical multiple regression equation was constructed (see Table 3). In the first block of the equation, religion, social support, and the five post hoc variables outlined above were entered. Region (South vs. Other) was entered into the second block of the equation. As Table 3 illustrates, the first block of the equation was significant, \( F(7, 211) = 3.26, p < .01 \). However, the second block of the equation, in which region was entered, was also significant, \( F(8, 210) = 3.45, p < .01 \). Controlling for the hypothesized mediating variables of religion and social sup-

**TABLE 2**
Hierarchical Multiple Regression Equation Predicting Suicidal Symptoms in African American Men

<table>
<thead>
<tr>
<th>Block</th>
<th>Predictors Entered in Set</th>
<th>( F ) for set</th>
<th>( t ) for Predictors in Set</th>
<th>( df )</th>
<th>Partial Correlation ( (pr) )</th>
</tr>
</thead>
<tbody>
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<td>9.59***</td>
<td>2.59**</td>
<td>.15</td>
<td>-.22***</td>
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<tr>
<td></td>
<td>Religiosity</td>
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<td></td>
<td>.15</td>
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<tr>
<td></td>
<td>Social Support</td>
<td>-3.91**</td>
<td></td>
<td></td>
<td>-.22</td>
</tr>
<tr>
<td>2</td>
<td>Region (South vs. Other)</td>
<td>10.83***</td>
<td>-3.54***</td>
<td>-.20</td>
<td></td>
</tr>
</tbody>
</table>

**Significant at the .01 level.
***Significant at the .001 level.

**TABLE 3**
Post hoc Hierarchical Multiple Regression Equation Predicting Suicidal Symptoms in African American Men

<table>
<thead>
<tr>
<th>Block</th>
<th>Predictors Entered in Set</th>
<th>( F ) for set</th>
<th>( t ) for Predictors in Set</th>
<th>( df )</th>
<th>Partial Correlation ( (pr) )</th>
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<td>1</td>
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<td>2.15*</td>
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<td>-3.18**</td>
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<td></td>
<td>Income Category</td>
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<tr>
<td></td>
<td>Hours Worked</td>
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<td>-.14</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Education</td>
<td>0.56</td>
<td></td>
<td>-.04</td>
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<tr>
<td></td>
<td>Urbanicity</td>
<td>1.19</td>
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<td>.08</td>
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</tr>
<tr>
<td>2</td>
<td>Region (South vs. Other)</td>
<td>3.45**</td>
<td>-2.11*</td>
<td>-.14</td>
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</tr>
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</table>

*Significant at the .05 level.
**Significant at the .01 level.
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port and for the five post hoc variables of employment, income, hours worked, education, and urbanicity, region still constituted a significant unique predictor of suicidal symptoms in African American men. However, the F-value obtained for this second block of this post hoc equation \( F = 3.07 \) was substantially lower than the F-value obtained when the post hoc variables were not included \( F = 10.83 \), see Table 2). This finding suggests the possibility that one or more of those variables entered in block one of the post hoc equation partially mediated the relationship between region and suicidality in African American men.

To ascertain whether one or more of the variables entered might indeed have a mediating effect on the relationship between region and suicidality in African American men, a final series of five hierarchical multiple regression equations was performed, with transformed suicide scores as the dependent variable. In each equation, social support and religion were entered into the first block, one of the five post hoc variables was entered into the second block, and region (South v. Other) was entered into the third block. The F-values for each of the three blocks of each equation are presented in Table 4. As the table illustrates, results indicated that of the five potential mediators considered, only the number of hours worked per week demonstrated a significant unique predictive relationship to suicidal symptoms in African American men. Including this variable in the regression equation decreased the F-value of the final block from 10.83 (see Table 2) to 6.70 (see Table 4), suggesting that number of hours worked per week serves as a partial mediator of the relationship between region and suicidality in African American men. Region was found to have a significant positive correlation with hours worked per week among African American men \( (r = .29, p < .01) \) such that southern region predicted more hours of work per week, thus providing further support for a potential meditational effect of hours worked.

### DISCUSSION

Many studies have attempted to identify protective factors for suicide risk that may explain dissimilar prevalence rates among differing age and racial groups. The rates of suicide among African American men have tripled over the last 30 years (Gibbs & Hines, 1989), making them a group of particular interest. Accordingly, this study was conducted in an attempt to examine factors related to suicidality among African American men in the United States.

We predicted that the relationship between relatively lower suicidal symptoms in African American men and southern region would be largely mediated by religiosity and

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<th>TABLE 4 Post hoc Regression Analyses with Potential Mediator Variables Considered Individually</th>
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<td>Post hoc Mediator</td>
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*Significant at the 0.05 level.
**Significant at the 0.01 level.
***Significant at the 0.001 level.
social support. Our results did not support this hypothesis. Southern region was a significant predictor of suicidal symptoms in African American men even when controlling for religiosity and social support, and accounting for these variables did not significantly impact the strength of the relationship between region and suicidality. Consistent with the hypothesis, however, residence in the southern region significantly predicted higher self-reported religiosity in our sample, and higher social support predicted fewer reported suicidal symptoms.

Research has proposed that religiosity is a distinct protective factor for suicide risk, above and beyond the potential protective effects of social support (Nisbet et al., 2000). This relation may be especially important in African American individuals, given that they report higher religiosity than Caucasians in the United States (Neighbors et al., 1998); although there is evidence to suggest that African Americans and Caucasians report similar religious involvement in the rural south, African Americans have higher religious involvement than Caucasians in the urban south (Hunt & Hunt, 2001). Studies examining the protective effects of particular religious denominations for suicide have revealed inconsistent results. While some studies have found that involvement in certain religious denominations serves as a protective factor for suicide, others have found that involvement in these groups can aggravate the risk for suicidal behavior (Pescosolido & Georgianna, 1989). In the current study, there was no association between religiosity and suicidality among African American men in general.

Ellison et al. (1997) suggest that the strongest protective effects of religion for suicide will exist in areas where the religious affiliation overlaps with broader ethnic or regional cultures. They found that religious homogeneity (i.e., the extent to which community residents adhere to a single religion) was more predictive of suicide than other indices related to religion. In the South, these authors found that when homogeneity was conceptualized using specific denominations as the predictive factor rather than overall shared belief systems, religiosity exerted a mild aggravating effect on suicide. Taken together, these results suggest that the relation between religiosity and suicide is complex.

Because recent evidence has corroborated the broad protective power of social support (Nisbet, 1996), we included this variable in a mediational analysis of southern region as a primary protective factor against suicidality among African Americans. Consistent with expectations, we found a significant negative relationship between measures of social support and suicidality in this population. In the context of the recent and dramatic increase in suicide rates among African American men in the South, our findings might possibly be explained in terms of migration theories. Recent social trends of northern migration and urbanization have been characteristic of the African American community over the past several decades (Davis, 1980; Gibbs, 1997). Although urbanity and northern residence are not specifically linked to variations in suicide rates per se, these and other patterns of geographic dispersal among otherwise socially contiguous groups and individuals may serve to elevate suicide rates by removing the protective element of cultural homogeneity irrespective of social support. Simply living among those who share a similar set of norms, values, and customs may reduce loneliness and sociological distress (the consequence of which Durkheim [1951/1997] believed to be anomic suicide; i.e., suicide caused by the erosion of norms, including those which discourage suicide). This phenomenon may occur in the presence or absence of formal social support, and is consistent with our findings that southern region (which is associated with high African American population density and therefore higher cultural homogeneity) is a uniquely predictive variable. Although the literature has not yet borne out the specific process behind this phenomenon, this is a valuable and challenging question awaiting further study.

While the mediational variables underlying the protective power of southern residence are not entirely clear, the outcome of
the present study provides reasonable evidence for the existence of some sociocultural variables related to the relatively low incidence of suicide among African American men in this region of the country (such as hours worked per week). However, it should be mentioned that the limitations inherent in the present methodology make it difficult to infer the specific mediational pathways. Because of the cross-sectional design of the study we are unable to make causal inferences as we cannot establish a timeline with independent variables occurring before the measurement of suicidality. The relatively modest internal consistency of the suicidality index may have also decreased our ability to identify subtle mediational effects.

Another possible limitation of our study is that only participants who endorsed symptoms of depression were asked questions about suicidality. As mentioned earlier, a large majority of those people who have attempted suicide either were suffering from, or have a history of, a mood disorder. Additionally, suicidal ideation is a criterion for a major depressive episode according to the Diagnostic and Statistical Manual of Mental Disorders. Because of the above reasons, it is sensible that only participants who endorsed symptoms of depression were questioned further about suicide; however, people who are not depressed and those with other mental disorders do in fact ideate about and attempt suicide. These results may only be generalizable to those people who endorse suicide symptoms related to the presence of mood disorders. Because suicidality was not assessed in all participants, it is possible that we may have underestimated the amount of suicidality in our study. Nevertheless, as suicidality in this study is significantly associated with religiosity, Southern region, and social support, it is likely that if suicidality were further endorsed, it would continue to display a significant relationship with the variables.

Given that southern residence appears to be a robust protective factor for African American men, future investigations of this trend will need to address a wide variety of basic, but as yet unanswered questions. The unique sociological and cultural experiences of African Americans living in the South must be established. An in-depth analysis of population density, religious homogeneity, urbanization patterns, and social integration and their association with subsequent suicide is an essential step in understanding this phenomenon. The relationship between differential identification with mainstream culture, social support, and suicide needs to be established. Although results are generally consistent regarding southern region as a protective factor (i.e., this study, Shaffer et al., 1994; Lester, 1990–91), these in-depth analyses may inform inconsistent findings (i.e., Willis et al., 2003). Finally, the difficult issue of religiosity demands additional study, given that some authors have found a mild aggravating effect on suicidality (Pescosolido & Georgianna, 1989).

The number of hours spent working and its relation to suicide is another area that deserves further empirical investigation. Our results suggest that the number of hours worked per week partially mediates the relation between southern region and suicidality. Indeed of the seven potential mediators examined, hours worked was the only one that displayed relatively clear mediational involvement. We speculate that number of hours worked per week mediated the relation between southern region and suicidality for three inter-related reasons. First, more hours worked may be an indication of more financial stability. More financial stability acts as a buffer against poverty, a significant risk factor for suicide (Hovey, 2000; Ialongo et al., 2002; Qin et al., 2003). Number of hours worked could be an indication of effectiveness in obtaining material resources, a protective factor (Kaslow et al., 2002). A second possible explanation for the mediational effect is that more time spent working could mean less social isolation, and likely more social support. Third, more hours worked likely translates into a more socially rhythmic lifestyle as many jobs have consistent established hours and duties. Those who work more often than others are less likely to have variable schedules and activities. Social Rhythms Therapy
(which focuses on regularity and consistency in sleep and dietary patterns and in social life) has been found to be useful in the treatment of mood disorder symptoms (Frank, Swartz, & Kupfer, 2000); more hours worked may be a natural device to entrain social rhythms.

The current study found that religiosity and social support did not mediate the relation between decreased suicidality and southern region. Though suicide rates in the United States have decreased somewhat over the last decade, suicide remains a leading cause of death in African American men. As such, continued research focused on dismantling the complex relations between the host of variables related to suicide is essential to aid in the understanding, treatment, and prevention of death by suicide.

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