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Psychopathology, Family Functioning, and Cognitive Style in Urban Adolescents with Suicide Attempts

Mary B. Summerville,[1,3] Nadine J. Kaslow,[1] Maureen F. Abbate,[3] and Shade Cronan[2]

This study examined psychopathology, family functioning, and cognitive style in 121 African–American adolescents who attempted suicide. Group means suggested that these youths, when taken together, were not reporting significant psychological distress. However, after classifying the youths into three groups by level of depressive symptoms interesting findings emerged. Youth self-reports of depressive symptoms on the Children's Depression Inventory were associated with the presence of internalizing and externalizing disorders on the Youth Self-Report and Child Behavior Checklist, and with a maladaptive attributional style. Sixty-seven percent of participants classified their family types as maladaptive in terms of levels of cohesion and/or adaptability. In fact, the majority of adolescents and parents reported their families as disengaged. These findings are discussed from a culturally and developmentally sensitive framework which considers key demographic variables (race, socioeconomic status, age). Clinical implications are offered for individual and family interventions.

Adolescent suicide attempts are a significant public mental health problem. Suicide has become the second leading cause of death in adolescents (Alcohol, Drug Abuse, and Mental Health Administration, 1989). Adolescents who attempt suicide are at high risk for future attempts and completions. Some have identified a significantly lower rate of suicides among African–

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[1]Grady Memorial Hospital, Emory University, School of Medicine, Atlanta, Georgia 30335.
[2]Wesleyan University, Middletown, Connecticut.
[3]Address all correspondence, including reprint requests, to Mary B. Summerville, Grady Memorial Hospital, 80 Butler St., P. O. Box 26113, Infectious Disease Clinic, Georgia 30335.

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Americans than Caucasians (Group for the Advancement of Psychiatry, 1989); however, there is more comparability in suicide rates in the adolescent population across racial groups (Frederick, 1984). Between 1960 and 1987 the rate of completed suicides in African–American males, ages 15 to 24, tripled (Berman & Jobes, 1991).

Sociocultural factors have been offered as explanations for this increased suicide rate (Heacock, 1990). First, a rise in concern about the health of this population may have resulted in more accurate reporting. It is unclear whether the elevated rates of reported suicides reflect a true increase or an artifact of more careful data collection. Second, increased suicidal behavior in African–American adolescents may be indicative of recent changes in community and family structure (Smith & Carter, 1986): an increase in female-headed households, the disintegration of the extended family network, increased alienation from the larger society with a lessening of involvement in traditional African–American institutions (e.g., the church), and a lack of well-respected leaders. Finally, King (1982) asserted that suicide occurs in reaction to societal conditions, notably racism and oppression. As African–Americans face increased difficulties with assimilation associated with upward mobility and societal alienation, they may become more vulnerable to expressing their distress via suicidal behavior (Smith & Carter, 1986; Spaights & Simpson, 1986).

Despite the rise in suicide attempts among African–American adolescents, with few exceptions (e.g., King, Raskin, Gdowski, Butkus, & Opipari, 1990; Sumerville, Abbate, Siegel, Serravezza, & Kaslow, 1992; Trautman, Rotheram-Borus, Dopkins, & Lewin, 1991), researchers have neglected this population. Studies reveal that suicidal behavior in minority female adolescents is associates with a broad spectrum of psychiatric diagnoses (Trautman et al., 1991), and psychological problems (Sumerville et al., 1992). Nonattempters report a stronger support system and fewer negative life events than do attempters (King et al., 1990).

Family functioning and cognitive style are related to adolescent suicide attempts in Caucasian samples (Spirito, Brown, Overholser & Fritz, 1989). Family risk factors include parental psychopathology (e.g., substance abuse, depression), physical illness in a parent (Friedman et al., 1984), and family disruption, particularly loss (Aldridge, 1984). Suicidal adolescents and their families report less family cohesion and empathic communication, and more parental rejection (Wodarski & Harris, 1987) than their nonsuicidal counterparts (e.g., Asarnow, Carlson, & Guthrie, 1987). Suicidal adolescents often reside in families where difficulties with separation–individuation are prominent (Richman, 1986), and where inflexible family structures, dominated by hostile and controlling interactions, are charac-

teristic (Kaslow, Wamboldt, Wamboldt, Anderson, & Benjamin, 1989; Pfeffer, 1986).

Cognitive factors related to suicidality in primarily Caucasian samples of adolescents include problem-solving deficits and cognitive distortions (Spirito et al., 1989). Maladaptive attributional patterns are characteristic of depressed adolescent suicide attempters (Rotheram-Borus, Trautman, Dopkins, & Shrout, 1990). The strength of these findings is questionable due to equivocal results (Spirito, Overholser, & Hart, 1991).

The present study examined psychopathology, perceived family functioning, and attributional patterns in urban African–American adolescent suicide attempters. This sample is of interest given the increasing rates of suicide among African–American youth and the elevated risk for suicide in lower socioeconomic status (SES) youth (Lewis, Johnson, Cohen, Garcia, & Velez, 1988).

METHOD

Subjects

The sample consisted of 121 African–American youths presenting to the psychiatric emergency room of a public teaching hospital following a suicide attempt. Participants were 12 years, 3 months, to 18 years, 0 months (mean age = 15 years, 6 months). There were 93 females (77%) and 28 males (23%). Six (5%) used firearms, 101 (83%) ingested foreign substances, three (2%) attempted to hang themselves, and eleven (9%) used other methods. The mean Hollingshead score is 21.7 (SD = 9.9; range = 8 to 56; n = 79), representing the lower end of the SES spectrum. Despite this SES range, the lack of sufficient numbers of adolescents in the middle and upper SES categories limited the potential for addressing possible SES differences.

Procedure

Upon presentation to the psychiatric emergency room, each youth and his/her primary caretaker were invited to participate. Informed consent was obtained from 97% of the adolescents approached. Adolescents who consented to participate were interviewed by a mental health professional utilizing a semistructured interview (Sumerville et al., 1992). Information to determine the Hollingshead Social Status Index (Hollingshead, 1975) was obtained. Due to interinformant discrepancies between youths and par-

ents, which are pronounced amongst suicide attempters (Walker, Moreau & Weissman, 1990), questionnaire data were completed by the youths and the primary caretakers.

Measures

Children's Depression Inventory (CDI; Kovacs & Beck, 1977). The adolescent completed the CDI, a 27-item self-report scale of depressive symptoms. The scale has adequate psychometric properties (e.g., Cary, Faulstich, Gresham, Ruggiero, & Enyart, 1987; Nelson, Politano, Finch, Wendel, & Mayhall, 1987; Saylor, Finch, Spirito, & Bennett, 1984). A factor-analytic study revealed differences between African-American and Caucasian youths, including less suicidal ideation and dysphoric affect and more oppositionality in the African–American youths (Politano, Nelson, Evans, Sorenson, & Zeman, 1986).

Youth Self-Report (YSR; Achenbach & Edelbrock, 1987). Adolescents completed the Behavior Problem Scale items of the YSR, which has adequate reliability and validity and has been normed on a representative sample of youths based on SES, ethnicity, and gender. The YSR contains narrow-band scales with a *T*-score ≥70 indicating a clinically significant elevation. The YSR also includes two broad-band scales assessing internalizing and externalizing behavior; a T-score ≥63 suggests a clinically significant elevation.

Child Behavior Checklist (CBCL; Achenbach & Edelbrock, 1983). The primary caretaker completed the CBCL, which has good psychometric properties and has been normed on a representative sample of youths based on SES, ethnicity, and gender. Scores ≥70 on the narrow-band scales and scores ≥63 on the broad-band scales (internalizing and externalizing) are clinically significant.

Family Adaptability and Cohesion Evaluation Scales—III (FACES-III; Olson, Portner, & Lavee, 1985). FACES-III, a 20-item scale of family relations, useful in differentiating functional and dysfunctional families across racial groups, was completed by each adolescent and his/her parent. The measure has good reliability and validity (Olson, 1986; Rodick, Hengeller, & Hanson, 1986). Families can be categorized as balanced, midrange, or extreme based upon their scores on the adaptability and cohesion dimensions. Moderate values on both dimensions place families within the balanced range. These families are considered to be the most adaptive. Midrange families receive moderate scores on one dimension and extreme scores on the other dimension. Families are classified extreme (i.e., dysfunctional) when they receive extreme scores on both dimensions.

Children's Attributional Style Questionnaire (CASQ; Seligman et al., 1984). The CASQ was developed based upon the attribution model of learned helplessness (Abramson, Seligman, & Teasdale, 1978). Depressed children evidence more internal–stable–global attributions for negative events and more external–unstable–specific attributions for positive events than their nondepressed peers (Seligman et al., 1984; Kaslow, Rehm, & Siegel, 1984).

The CASQ, a 24-item measure, yields separate scores for positive and negative events, and a composite score. This measure has adequate reliability and validity (Seligman et al., 1984). Rotheram (1985), utilizing this instrument with minority adolescents, found adequate internal consistency, test–retest reliability, and construct validity on the 48-item version of this scale.

Parent CASQ. This 24-item scale is a parallel measure to the CASQ. Parents complete this scale, indicating the attributions they make for events in their children's lives.

RESULTS

The mean CDI score for the sample was 13.0. As a group, the youths reported mild levels of depressive symptoms. Based upon the large variance on the CDI within this sample, youths were classified into three groups, according to guidelines recommended by Kovacs (personal communication, September 13, 1991). Future analyses used this classification scheme. Group 1, nondepressed subgroup, included youths with CDI scores ≤10 (n = 52). Group 2 consisted of adolescents reporting mild depressive symptoms, CDI scores 11 to 18 (n = 41). Group 3 included youths reporting significant levels of depressive symptoms, CDI scores ≥19 (n = 28). Table I reports means and standard deviations for the entire sample and for the three groups separately on all dependent measures.

Discriminant function analyses were conducted to validate the utility of the CDI classification schema. The internalizing and externalizing broadband factors from the CBCL and YSR were used as predictor variables. This analysis was statistically significant, Wilks's lambda (8) = .43, $p <$ .001, with d scores of –.92 for CBCL internalizing, 1.2 for CBCL externalizing, 1.1 for YSR internalizing, and –.09 for YSR externalizing, with 65% of the youths correctly classified.

Chi-square analyses on nominal data and analyses of variance (ANOVAs) on interval data conducted on demographic factors (gender, age, SES) as independent variables and the child's CDI classification as the dependent variable, revealed no significant between-group differences. Thus, the entire sample was considered in further analyses. One-way ANOVAs were conducted with CDI classification as the index variable.

Table I. Means and Standard Deviations on Dependent Variables[a]

	Total sample (N = 121)		Group 1 (N = 52)		Group 2 (N = 41)		Group 3 (N = 28)	
	Mean	(*SD*)	Mean	(*SD*)	Mean	(*SD*)	Mean	(*SD*)
Children's Depression Inventory								
	13.0	(8.7)	5.5	(3.3)	14.0	(2.6)	25.5	(6.0)
Child Behavior Checklist								
Internalizing	61.5	(11.1)	57.3	(9.2)	63.6	(10.9)	65.2	(13.0)
Externalizing	60.4	(11.2)	55.3	(6.8)	61.9	(11.2)	66.7	(14.2)
Youth Self-Report								
Internalizing	56.9	(12.1)	49.0	(8.9)	59.1	(10.6)	70.4	(5.1)
Externalizing	52.4	(11.2)	45.3	(9.7)	54.1	(9.7)	62.8	(7.5)
FACES-III—Adolescent								
Cohesion	28.7	(9.0)	32.4	(8.4)	27.5	(8.6)	23.4	(8.9)
Adaptability	24.5	(6.4)	25.1	(4.0)	24.9	(8.3)	22.2	(6.2)
FACES-III—Parent								
Cohesion	32.9	(6.9)	35.1	(6.3)	33.0	(7.6)	28.2	(6.1)
Adaptability	24.5	(6.4)	25.1	(4.0)	24.9	(8.3)	22.2	(6.2)
CASQ—Adolescent								
Positive	6.8	(2.2)	8.0	(1.8)	5.7	(1.6)	5.8	(2.4)
Negative	3.0	(2.1)	1.9	(1.5)	2.9	(1.9)	4.9	(1.9)
Composite	3.8	(3.4)	6.1	(2.8)	2.8	(2.3)	0.9	(2.5)
CASQ—Parent								
Positive	7.4	(2.3)	8.2	(2.1)	6.8	(2.9)	6.7	(0.6)
Negative	4.2	(2.2)	3.3	(0.8)	4.2	(2.9)	6.3	(2.1)
Composite	3.8	(3.0)	4.8	(1.7)	4.2	(3.7)	0.3	(1.5)

[a]FACES-III = Family Adaptability and Cohesion Evaluation Scales—III; CASQ = Children's Attributional Style Questionnaire.

Tukey *post hoc* comparisons were conducted to ascertain which between-group differences accounted for each significant overall ANOVA. Table II provides data on ANOVAs and *post hoc* comparisons.

Child Behavior Checklist

Table III presents means and standard deviations for CBCL broad and narrow-band factor scores. For the entire sample, CBCL narrow- and broad-band scores were within the normal range. This was true for all mean scores for children in group 1. Adolescents in Group 2 had mean CBCL narrow-band factor scores within the normal range; however the group mean for the internalizing broad-band factor was in the low end of the pathological range. Adolescents in Group 3 had parents who reported them to evidence clinically significant behavioral symptoms on the CBCL internalizing and externalizing broad-band factors, and on several narrow-band factors; somatic, depressed, delinquent, and cruel.

Table II. Analysis of Variance and *Post Hoc* Effects

Measures[a]	*F*	Tukey[b]
Child Behavior Checklist		
Internalizing	n.s.	
Externalizing	4.8[d]	Gp1 < Gp3
Anxious–obsessive	3.9[c]	None
Somatic complaints	n.s.	
Schizoid	n.s.	
Depression–withdrawal	n.s.	
Hyperactive	n.s.	
Delinquent	7.0[d]	Gp1 < Gp3
Aggressive	4.9[d]	Gp1 < Gp3
Cruel	7.4[d]	Gp1 < Gp3
Youth Self-Report		
Internalizing	47.4[e]	Gp1 < Gp2; Gp1 < Gp3; Gp2 < Gp3
Externalizing	25.8[e]	Gp1 < Gp2; Gp1 < Gp3; Gp2 < Gp3
Somatic	12.5[e]	Gp1 < Gp2; Gp1 < Gp3
Depressed	68.7[e]	Gp1 < Gp2; Gp1 < Gp3; Gp2 < Gp3
Unpopular	18.1[e]	Gp1 < Gp2; Gp1 < Gp3; Gp2 < Gp3
Thought disorder	23.3[e]	Gp1 < Gp2; Gp1 < Gp3; Gp2 < Gp3
Aggressive	9.1[e]	Gp1 < Gp3; Gp2 < Gp3
Delinquent	26.0[e]	Gp1 < Gp2; Gp1 < Gp3; Gp2 < Gp3
FACES-III—Adolescent		
Cohesion	3.8[c]	Gp1 < Gp3
Adaptability	n.s.	
FACES-III—Parent		
Cohesion	n.s.	
Adaptability	n.s.	
K CASQ—Adolescent		
Positive	6.1[d]	Gp1 < Gp2; Gp1 < Gp3
Negative	8.6[e]	Gp1 < Gp3; Gp2 < Gp3
Composite	12.5[e]	Gp1 < Gp2; Gp1 < Gp3
K CASQ—Parent		
Positive	n.s.	
Negative	n.s.	
Composite	n.s.	

[a]FACES-III = Family Adaptability and Cohesion Evaluation Scales—III; CASQ = Children's Attributional Style Questionnaire; Gp1 = Group 1; Gp2 = Group 2; Gp3 = Group 3.
[b]All Tukey *post hoc* comparisons significant at $P < .05$.
[c]$p < .05$.
[d]$p < .01$.
[e]$p < .001$.

Separate one-way ANOVAs, with CDI classification as the index variable and CBCL factor scores as the dependent variables, yielded the following significant between-group differences. Parents of children with higher CDI scores reported that their children evidenced more externalizing behaviors than those reported by parents of youths with lower CDI scores [$F(2, 50) = 4.8$, $p < .01$]; however, no between-group differences

Table III. Means and Standard Deviations on the Child Behavior Checklist and Youth Self-Report Broad- and Narrow-Band Factor Scores

	Total sample		Group 1		Group 2		Group 3	
	Mean	(*SD*)	Mean	(*SD*)	Mean	(*SD*)	Mean	(*SD*)
Child Behavior Checklist								
Broad-band factors								
Internalizing	61.5	(11.1)	57.3	(9.2)	63.6	(10.9)	65.2	(13.0)
Externalizing	60.4	(11.2)	55.3	(6.8)	61.9	(11.2)	66.7	(14.2)
Narrow-band factors								
Anxious–obsessive	62.8	(8.7)	57.8	(4.2)	65.1	(9.0)	66.5	(10.3)
Somatic	66.3	(12.8)	62.7	(15.1)	66.7	(10.6)	72.2	(10.0)
Schizoid	62.7	(8.8)	59.9	(7.7)	62.7	(7.9)	67.5	(10.7)
Depressed	63.8	(10.9)	59.5	(8.0)	62.7	(7.0)	70.9	(14.8)
Hyperactive	64.0	(9.8)	60.2	(6.7)	65.3	(11.7)	68.4	(9.0)
Delinquent	65.8	(10.1)	61.1	(5.6)	66.6	(10.0)	73.0	(12.4)
Aggressive	63.1	(10.4)	57.7	(4.9)	65.4	(10.0)	68.6	(14.0)
Cruel	64.5	(9.1)	59.3	(4.2)	64.8	(8.3)	71.3	(10.7)
Youth Self-Report								
Broad-band factors								
Internalizing	56.9	(12.1)	49.0	(8.9)	59.1	(10.6)	70.4	(5.1)
Externalizing	52.4	(11.2)	46.3	(9.7)	54.1	(9.7)	62.8	(7.5)
Narrow-band factors								
Somatic	60.8	(7.8)	57.5	(5.2)	61.8	(7.8)	66.2	(9.0)
Depressed	60.5	(7.0)	56.0	(2.5)	60.7	(6.0)	70.0	(5.8)
Unpopular	59.3	(6.1)	56.4	(3.8)	59.8	(6.6)	64.5	(6.1)
Thought disorder	62.0	(8.4)	57.5	(4.5)	63.4	(8.2)	69.3	(9.4)
Aggressive	57.5	(4.5)	56.1	(2.9)	57.6	(3.9)	60.6	(6.7)
Delinquent	59.0	(6.1)	55.9	(2.3)	59.2	(5.2)	65.0	(8.1)

were found on the internalizing factor. Between-group differences were found on the following CBCL narrow-band factor scores, accounted for primarily by differences between Groups 1 and 3: anxious–obsessive [$F(2, 36) = 3.9, p < .03$], delinquent [$F(2, 46) = 7.0, p < .002$], aggressive [$F(2, 46) = 4.9, p < .01$], and cruel [$F(2, 46) = 7.4, p < .01$].

Youth Self-Report

Table III presents means and standard deviations for YSR broad- and narrow-band scores. When YSR data for the entire sample were taken together, mean narrow- and broad-band factor scores fell within the normal range. This was true for youths in Groups 1 and 2 and for Group 3 youths on all scales except the internalizing broad-band factor and the depression narrow-band scale. Group 3 youth reported significant internalizing problems and depression.

One-way ANOVAs, with CDI classification as the index variable and YSR scores as the dependent variables, led to the following results. Youths with higher CDI scores self-reported more internalizing [$F(2, 107) = 47.4$, $p < .001$) and externalizing [$F(2, 107) = 25.8, p < .001$) behavior problems. Significant between-group differences were found on all narrow-band factor scores: somatic [$F(2, 107) = 12.5, p < .001$], depressed [$F(2, 107) = 68.7$, $p < .001$], unpopular [$F(2, 107) = 18.1, p < .001$], thought disorder [$F(2, 107) = 23.3, p < .001$], aggressive [$F(2, 107) = 9.1, p < .001$], and delinquent [$F(2, 107) = 26.0, p < .001$]. Tukey *post hoc* comparisons, presented in Table II, revealed that between-group differences were accounted for by differences between Groups 1 and 2, 2 and 3, and 1 and 3, with the exception of the somatic and aggressive narrow-band factor scores. Group 3 adolescents reported more symptoms than Group 1 or Group 2 youths, with Group 2 youths endorsing more behavior problems than Group 1 youths.

FACES-III

One-way ANOVAs with CDI classification as the index variable were conducted with FACES-III cohesion and adaptability scores for adolescents and parents separately as the dependent variables. The only significant difference that emerged was on the cohesion subscale of the FACES-III by the adolescents' reports [$F(2, 47) = 3.8, p < .03$]. Youths who reported more depressive symptoms indicated lower levels of cohesion (more disengaged) within the family.

Adolescent and parent scores were graphed on the circumplex model, which differentiates balanced, midrange, and extreme families. As seen in Figure 1, the majority of families fall within the midrange and extreme groups. Chi-square analyses, elucidating these visual impressions, revealed significant results for the adolescent data only [χ^2 (2, $N = 48$) = 24.2, $p < .001$], with 26% reporting their families as balanced, 42% reporting midrange family functioning, and 32% reporting extreme family functioning. To examine the specific family types, scores were divided into five groupings: balanced, flexibly separated, flexibly connected, structurally separated, and structurally connected. Significant chi squares were obtained on the adolescent [χ^2 (4, $N = 46$) = 49.4, $p < .001$] and parent (χ^2 (4, $N = 29$) = 13.5, $p < .01$] data. Youths and parents categorized their families as either flexibly separated or structurally separated. Thus, parents and youths perceived their families as disengaged (cohesion dimension) in either a chaotic or rigid (adaptability dimension) fashion.

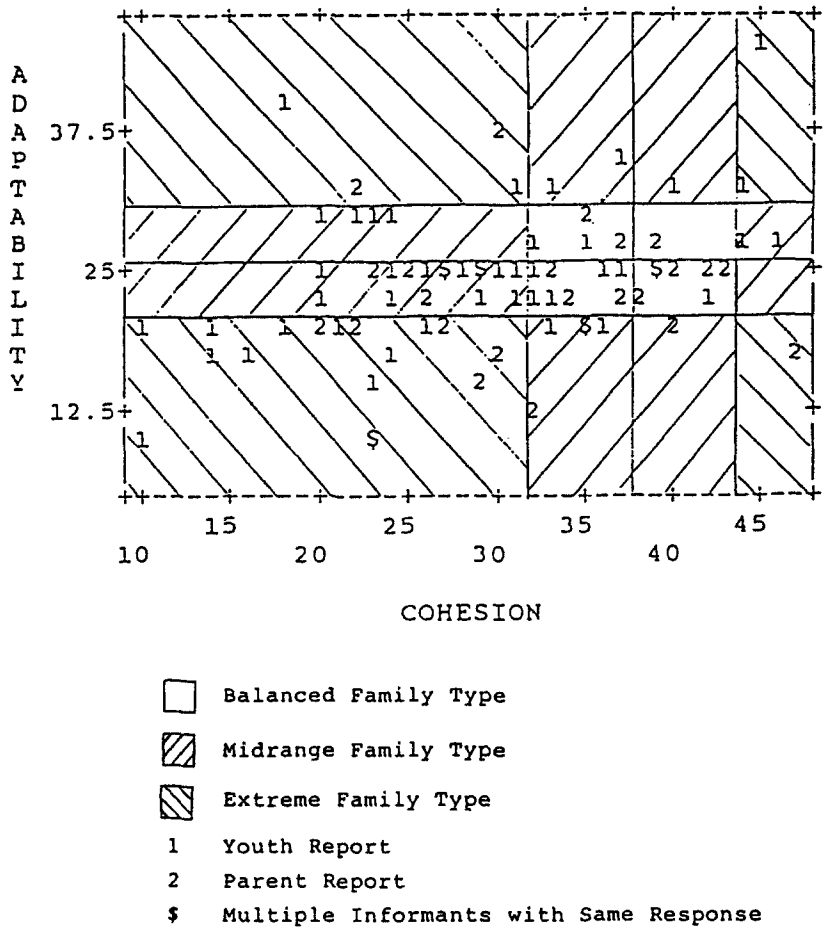

Fig. 1. Family functioning in African–American adolescent suicide attempters by youth and parent reports: The relationship between adaptability and cohesion.

CASQ

ANOVAs revealed significant between-group differences on the positive [$F(2, 33) = 6.1, p < .01$], negative [$F(2, 33) = 8.6, p < .01$], and composite score [$F(2, 33) = 12.5, p < .001$] of the CASQ. Adolescent suicide attempters who reported depressive symptoms on the CDI revealed a depressive style in attributing causality for positive and negative events. No between-group differences were found for parents' attributions regarding the causes of events in their children's lives.

DISCUSSION

The sample as a whole did not report clinically significant levels of psychopathology. These findings appear contradictory to research suggesting that adolescent suicide attempters evidence internalizing and externalizing problems (Husain & Vandiver, 1984; Pfeffer, 1986). However, consistent with earlier findings (Summerville et al., 1992), three groups of youths emerged: those reporting minimal, moderate, and severe psychiatric symptomatology. Similarly, although the sample as a whole did not evidence a maladaptive attributional style, youths who endorsed depressive symptoms possessed the attributional style characteristic of depressed youth (e.g., Kaslow et al., 1984). These findings are akin to other research (Rotheram–Borus et al., 1990; Spirito et al., 1989) that depressive symptoms, not suicidality, are associated with a maladaptive attributional style.

The most striking findings emerged from the reports of family functioning. Thirty-three percent of the participants reported a balanced family structure, characterized by moderate levels of adaptability and cohesiveness. Thus, only one-third felt that their families had appropriate levels of affect and warmth (cohesion) balanced with the ability to respond to stress in a developmentally sensitive fashion (adaptability). Not only did the bulk of participants rate their families as moderately to significantly dysfunctional, but the majority reported the most dysfunction on the cohesion dimension. Families were reported to be disengaged; however, the nature of this disengaged presentation ranged across the adaptability spectrum (chaotic, flexible, structured, rigid).

These findings questioned the cultural sensitivity of the FACES-III for low-SES African–American families, as they appear contrary to the typical presentation of African–American families, in which strong kinship bonds are evident (Boyd-Franklin, 1989). However, the scale's validity appears adequate given that previous research found that low-SES African–American families without identifiable psychopathology in the youths generally fall into the balanced range (Rodick et al., 1986). The specificity of the findings to suicide attempters is suggested given that families of juvenile offenders (externalizers) appear chaotically enmeshed on the FACES (Rodick et al., 1986). Thus, there appears to be a unique family presentation in a sample of primarily lower-SES African–Americans in which the identified patients are adolescent suicide attempters (primarily internalizers). The generalizability of these findings to other ethnic, racial, and socioeconomic groups, and to nonsuicidal adolescents with internalizing problems, are questions which warrant further investigation.

A number of clinical implications emerge from these results. First, the variability in symptom presentation necessitates tailoring interventions

to consider whether or not a youth denies symptoms, or reports moderate to severe levels of psychopathology (Summerville et al., 1992). Second, inpatient or outpatient individual treatment is recommended based upon the severity of the clinical presentation, and the acknowledged need for intervention. Individual work must be offered in a culturally sensitive fashion (Comer & Hill, 1985), with particular emphasis placed on cognitive therapy interventions (e.g., attribution retraining), particularly for depressed youths. Third, a recommendation for family therapy is warranted. Emphasis should be placed upon improving family attachments, by helping the family develop a nurturing environment in which adaptive communication predominates. Given our followup study findings that less than 15% of these youths attended recommended outpatient treatment, outpatient referrals must be preceded by an educational intervention in the emergency room. This intervention should provide evaluation feedback, explain psychotherapy, and develop a therapeutic alliance. Appropriate referrals for outpatient therapy may include individual or family therapy, group therapy, or a support group. Treatment in a group context may be particularly beneficial for the adolescent suicide attempters who are socially isolated. Further, as many African–Americans have strong religious affiliations, church-based counseling may be a more acceptable resource and/or clergy may be an important support for the psychological intervention.

There are a number of limitations of this study. No appropriate comparison groups were included. Future studies should include a nonpsychiatric control group of similar demographics to ascertain whether or not the findings obtained are specific to African–American suicidal youths. Adolescent suicide attempters with different demographics need to be compared to this sample on similar variables. The incorporation of matched comparison groups may yield important information enabling clinical researchers to develop more culturally appropriate therapy models. The lack of inclusion of a standard psychiatric interview that yields DSM-III-R-compatible diagnoses hinders our understanding of the psychiatric picture of these youths. The appropriateness of the measures to a low-SES African–American population remains questionable until more relevant psychometric data has been collected. Further, the lack of SES diversity in the sample does not allow for appropriate statistical analyses to understand the effects of SES on psychopathology and cognitive and family functioning in suicidal adolescents. Finally, the present data set cannot address the effects of social desirability on the participants' reports of psychopathology.

The strength of the current study lies in its focus on an underresearched population. Given the high rates of violence and death among African–American adolescents and the connection between violence and suicide, it is imperative that examinations of African–American suicide

ideaters, attempters, and completers be conducted (Hendin, 1991). Given the diverse gender roles, comparisons between adolescent suicidal behavior in males and females is deserving of attention. Future research will be strengthened by a closer examination of the role of parental pathology, more careful diagnostic assessments of psychiatric and substance abuse, observational data regarding family functioning, and ethnographic examinations of the three separate groups of youths. With increased understanding of the socioecological, economic, historical, and cultural context in which suicidal behavior among African–American youths occurs, our clinical awareness, research designs and interpretations will be enhanced (Earls & Jemison, 1986).

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