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Suicidal Behavior Among Low-Income African American Women: A Comparison of First-Time and Repeat Suicide Attempters

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*This investigation ascertained dimensions of a suicide attempt and psychological and historical risk factors that differentiate low-income, female, African American suicide attempters as a function of having made a single, first-time attempt versus multiple attempts. Two groups were compared: first-time attempters (*n *= 135) and repeat attempters (*n *= 139). Participants were recruited from a large, urban hospital following a suicide attempt (i.e., index suicide attempt). Sociodemographic characteristics, details of the index attempt (i.e., the attempt that prompted entry into the study), psychological functioning, hopelessness, substance abuse, and trauma history were assessed. The two groups were largely similar across sociodemographic characteristics. Multivariate analyses of variance were used to test hypotheses. Relative to first-time attempters, the attempts of repeat attempters involved higher levels of intent, planning, and perceived lethality and were associated with more psychological distress, hopelessness, substance abuse, and childhood trauma. Research and clinical implications of the findings are discussed.*

Keywords: *African American; women; suicide attempters*

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Suicide is the fourth leading cause of death in the United States for 18- to 64-year-olds (www.cdc.gov/ncipc.wisqars). In 2002, 790,000 people in the United States attempted suicide. Attempters are 38 to 40 times more likely to complete suicide than are people with no history of attempts (Harris & Barraclough, 1997). Attempters are at risk for re-attempting (Johnsson-Fridell, Ojehagen, & Traskman-Bendz, 1996); 40% to 60% of patients presenting for medical care after an attempt are "repeaters" (van der Sande, Buskens, Allart, van der Graaf, & van Engeland, 1997). Longitudinal studies of attempters reveal that 14% to 18% re-attempted (Schmidtke et al., 1996; van der Sande et al., 1997). Even when covarying out myriad correlates of suicidal behavior, prior suicidality remains the most substantive risk factor for future attempts (Joiner et al., 2005).

Suicide is the 12th leading cause of death for African Americans aged 18 to 64. There is a 2.3% lifetime prevalence of attempted suicide among African Americans, and the risk of attempted suicide is lower in African American than in non-Black/non-Hispanic adults (Moscicki et al., 1988). Suicide is the 7th leading cause of death for women aged 18 to 64, and the 15th leading cause for African American women in this age group (www.cdc.gov/ncipc.wisqars). Women are 1.5 to 3 times more likely than men are to attempt suicide (Kessler, Borges, & Walters, 1999; M. M. Weissman et al., 1999), a finding true among African Americans (Chance, Kaslow, Summerville, & Wood, 1998; Juon & Ensminger, 1997).

There has been a recent burgeoning of attention on risk factors for suicide attempts among African Americans. Of relevance to this article is the research concerning psychiatric history; psychological distress and symptoms; hopelessness; substance abuse; aggression; maladaptive coping skills; a belief in the acceptability of suicide; low levels of religiosity, spirituality, and ethnic identity; being divorced or widowed; low levels of family adaptability and cohesion; relationship discord; family violence; poor interpersonal conflict resolution skills; social dysfunction; and low levels of social support and social embeddedness (Anglin, Gabriel, & Kaslow, 2005; Borrill et al., 2003; Compton, Thompson, & Kaslow, 2005; Cook, Pearson, Thompson, Black, & Rabins, 2002; Kaslow et al., 1998; Kaslow et al., 2002; Kaslow et al., 2004;

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Kaslow et al., 2005; Kaslow, Thompson, Brooks, & Twomey, 2000; Manetta, 1999; Ragin et al., 2002; Thompson, Kaslow, Short, & Wyckoff, 2002; Thompson, Kaslow, Bradshaw, & Kingree, 2000; Thompson, Kaslow, & Kingree, 2002; Thompson et al., 1999; Thompson, Kaslow, Kingree, et al., 2000; Willis, Coombs, Cockerham, & Frison, 2002; Willis, Coombs, Drentea, & Cockerham, 2003).

A small literature has emerged comparing repeat and first-time attempters. With regards to demographics, repeat attempters are more likely to be unemployed, divorced, and less educated than first-time attempters (Bille-Brahe & Jessen, 1994; Forman, Berk, Henriques, Brown, & Beck, 2004; Osvath, Kelemen, Erdos, Voros, & Fekete, 2003). In terms of their clinical and diagnostic presentations, compared to first-time attempters, repeat attempters display more severe and persistent psychopathology and suicidality, are more accepting of their attempts, express a greater desire to repeat their suicidal behavior, and are also at elevated risk for subsequent attempts and completion (De Leo et al., 2002; Forman et al., 2004; Hawton, Houston, Haw, Townsend, & Harris, 2003; Moscicki, 1995; Osvath et al., 2003). They have higher rates of social phobia, panic disorder, posttraumatic stress disorder, and personality disorders (Oquendo et al., 2005; Osvath et al., 2003; Rudd, Joiner, & Rajab, 1996). They show higher rates of comorbidity with respect to number of current and lifetime Axis I and Axis II diagnoses (Hawton et al., 2003; Rudd et al., 1996).

Compared to their non-repeat-attempter counterparts, repeaters have more severe interpersonal dysfunction (Forman et al., 2004), cognitive rigidity (Patsiokas, Clum, & Luscomb, 1979), and problem-solving difficulties (Reynolds & Eaton, 1986). With regards to background characteristics, compared to first-time attempters, repeat attempters self-report more childhood maltreatment (Forman et al., 2004; Ystgaard, Hestetun, Loeb, & Mehlum, 2004), family history of mental illness or suicide (Forman et al., 2004; Jeglic, Sharp, Chapman, Brown, & Beck, 2005), and early parental loss (De Leo et al., 2002).

Although extant research suggests that repeat and first-time attempters differ in many respects, no study has focused solely on African Americans. This study is the first to examine differences between first-time and repeat suicide attempters among a sample of African American women on the following characteristics: aspects of the most recent suicide attempt (lethality, severity of intent, degree of planning), psychological distress and symptomatology, and traumatic life events. It was expected that the repeat attempters would be significantly higher on all variables of interest than the first-time attempters.

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METHOD

PARTICIPANTS

Participants were recruited from a large, university-affiliated public hospital serving a low-income, urban population that is 82% African American. The sample was drawn from those of two larger studies (Kaslow et al., 1998; Kaslow et al., 2002) of women aged 18 to 64 years presenting for emergency service following a nonfatal suicide attempt and those presenting to a walk-in medical clinic for nonemergency medical problems. The unique issues associated with a geriatric population contributed to the decision to exclude individuals older than 64 years of age from the study. Only the attempters and the African American participants from these studies were included in this sample, resulting in a sample of 274 women categorized according to their attempt status (first-time attempters, n = 135; and repeat attempters, n = 139). Demographic data for the total sample and the two subgroups are provided in Table 1.

PROCEDURE

The research team was notified by hospital staff about all women who presented to either the medical or psychiatric emergency services following a suicide attempt. If a woman met these entry criteria, her participation was solicited once she was medically stable. After written informed consent was obtained, a brief screening was conducted to further determine eligibility. Women were excluded if they had a life-threatening medical condition, significant cognitive impairment, or acute psychosis. Measures were administered verbally. Participants were paid $25 and given referrals.

MEASURES

Suicide Attempt Measures

Suicide history. The following aspects of the index attempt were assessed via interview: risk factors, method used, and precipitants. Each of these variables was scored on a nominal scale of measurement. Repeat attempters were asked about number of lifetime attempts and methods involved in the three attempts preceding the index attempt.

Suicide attempt lethality. Lethality of the index attempt was measured via the Risk-Rescue Ratio (R-RR; A. D. Weissman & Worden, 1972), a 10-item, interviewer-rated scale. The first five questions focus on the level of

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TABLE 1
Descriptive Statistics of Sociodemographic Characteristics for First-Time and Repeat Attempters

	First-Time Attempters	*Repeat Attempters*
	(n = *135)*	(n = *139)*
Variable	M *(*SD*)*	M *(*SD*)*
Age (in years)	30.33 (9.32)	31.37 (8.89)
Number of children	2.18 (1.57)	2.31 (1.67)
Other Variables	*%*	*%*
Marital status		
Single/never married	69.6	62.6
Married	15.6	7.9
Divorced	6.7	10.8
Separated	6.7	13.7
Widowed	1.5	5.0
Education Level		
8th grade or less	3.0	7.2
9th to 11th grade	34.3	43.2
12th grade/high school graduate	33.6	28.1
Some college/technical school	27.6	20.9
College degree and/or graduate school	1.5	0.7
Homelessness		
Yes	15.6	28.1
Employed		
Yes	32.8	27.3
Monthly Income		
≤ $250	16.8	29.3
$250-$499	22.7	22.8
$500-$999	27.7	23.6
$1000-$1999	20.2	13.8
> $2,000	12.6	10.6
Religion		
Baptist	57.5	57.6
Other Protestant	6.0	4.3
Catholic	2.2	1.4
Holiness	9.0	9.4
7th Day Adventist	1.5	1.5
Muslim	1.5	1.5
Non-denominational (Christian)	4.5	6.5
Other	9.0	5.8
None	9.0	12.2

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TABLE 2
Means and Standard Deviations of Subgroups for all Dependent Variables

	First-Time Attempters	*Repeat Attempters*
	(n = *135)*	(n = *139)*
Dependent Variable (Measure)	M *(*SD*)*	M *(*SD*)*
Suicide intent (SIS total score)	10.55 (6.92)	14.74 (7.19)
Lethality of intent (SIS lethality factor score)	5.71 (3.86)	7.77 (3.35)
Planning of attempt (SIS planning factor score)	4.51 (4.87)	6.58 (5.73)
Risk of attempt (R-RR total score)	28.14 (12.11)	32.26 (14.49)
Current level of global psychological distress (BSI-GSI)	1.53 (0.85)	2.25 (0.75)
Average level of psychological distress (BSI-PSDI)	2.32 (0.70)	2.74 (0.56)
Level of psychological symptoms (BSI-PST)	32.95 (13.05)	42.72 (8.98)
Hopelessness (BHS)	6.80 (5.48)	11.04 (6.03)
Alcohol use (Brief MAST)	3.32 (6.29)	7.51 (9.38)
Drug use (Brief DAST)	5.47 (4.63)	8.23 (4.98)
Traumatic events in past year (TSS)	1.37 (1.51)	1.82 (1.77)
Traumatic events in adulthood but prior to past year (TSS)	2.81 (2.07)	3.24 (2.29)
Traumatic events in childhood (TSS)	2.46 (1.97)	3.06 (1.92)

risk involved in the attempt, with scores ranging from 5 (*low risk*) to 15 (*high risk*). These items assess the method of self-injury, level of consciousness, extent of lesions or toxicity, expected degree of recovery, and degree of medical treatment required. The second five questions focus on the probability of rescue, with scores ranging from 5 (*least probability*) to 15 (*most probability*). These items indicate the likelihood of intervention as defined by observable circumstances and available resources at the time of the attempt. Each of the items has specific values, ranging from 0 to 3. Risk and rescue scores were transformed into a R-RR that ranged from 17 to 83; higher scores indicate greater attempt lethality. This scale has been shown to have strong internal consistency ($\alpha = .91$) as well as good concurrent validity (A. D. Weissman & Worden, 1972). The R-RR has good internal consistency reliability in the current sample as well ($\alpha = .90$).

Suicidal intent. Intent associated with the index attempt was assessed using the Suicide Intent Scale (SIS; A. T. Beck, Schuyler, & Herman, 1974).

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Objective circumstances related to the attempt (e.g., whether others were nearby or could possibly intervene, whether one prepared for the attempt, and whether one communicated intent), captured by Items 1 to 8, were assessed in addition to the intensity of the participant's wish to die at the time of the attempt (e.g., expectation of fatality, perception of the seriousness of the attempt, and attitude toward dying), captured by Items 9 to 15. A total score is calculated, which ranges from 0 to 30. The SIS has been found to have good internal consistency reliability by other researchers ($\alpha = .91$; Miezkowski et al., 1993) as well as with the current sample ($\alpha = .81$). The validity of the SIS has also been demonstrated, as it was shown to predict future attempts and to identify individuals who later completed suicide (A. T. Beck, Schuyler, et al., 1974; R. W. Beck, Morris, & Beck, 1974).

Psychological Distress and Symptomatology

Global distress. Current psychological distress and symptoms were measured using the Brief Symptom Inventory (BSI; Derogatis, 1993), a 53-item self-report scale. All items were scored on a 5-point scale of distress, ranging from 0 (*not at all*) to 4 (*extremely*), using the time frame of the previous week. Three global indices of psychological distress were obtained: Global Severity Index (BSI-GSI), Positive Symptom Distress Index (BSI-PSDI), and Positive Symptom Total (BSI-PST). Each of these indices uses all 53 items to generate composite statistics. The BSI-GSI is a summary score of symptom severity across all items, the BSI-PSDI is a measure of symptom severity corrected for the number of symptoms reported, and the BSI-PST is a count of the number of symptoms reported. Derogatis (1993) reported strong test-retest reliability for the symptom dimensions (coefficients ranging from .81 to .91) and the global severity index ($r = .90$). Convergent validity has been demonstrated in studies that have shown significant associations among subscales of the BSI and the clinical scales of the Minnesota Multiphasic Personality Inventory (MMPI; Derogatis, Rickels, & Rock, 1976). Numerous studies have demonstrated both the construct and predictive validity of the BSI (Derogatis, 1993). For the current sample, the global severity index had very good internal consistency reliability, $\alpha = .95$.

Hopelessness. Negative expectancies about the future were measured by the 20-item Beck Hopelessness Scale (BHS; A. T. Beck, Weissman, Lester, & Trexler, 1974), which has strong internal consistency and interrater reliability and construct validity in a wide range of samples (A. T. Beck & Steer, 1993; A. T. Beck, Steer, Kovacs, & Garrison, 1985; A. T. Beck,

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Weissman et al., 1974). The BHS has been reported by other researchers to have strong internal consistency (α = .93; A. T. Beck, Weissman et al., 1974). The measure also has demonstrated excellent internal consistency reliability in the current sample, α = .94. The convergent validity of the BHS has been evaluated in a wide range of samples, using bivariate correlations with the Beck Depression Inventory (BDI; r = .68) as well as clinical ratings of hopelessness (r = .74; A. T. Beck & Steer, 1993).

Substance abuse. Alcohol use was assessed using the 10-item Brief Michigan Alcoholism Screening Test (Brief MAST; Pokorny, Miller, & Kaplan, 1972). Scores range from 0 to 29, with extra weight given to items found to be more discriminating (Pokorny et al., 1972). As recommended by the scale's authors, responses are weighted 0, 2, or 5 based on the symptom severity. Participants who answer 6 or more of the yes/no questions in the affirmative are identified as alcoholics, a method that has been shown to correctly identify all true-positives and misidentify only 11% of nonalcoholics (Pokorny et al., 1972; Zung, 1979). The Brief MAST has strong internal consistency and test-retest reliability (Skinner & Sheu, 1982), including good internal consistency reliability for this sample of α = .84. Lifetime history of drug abuse was assessed using the 20-item Brief Drug Abuse Screening Test (Brief DAST; Skinner, 1983), which is scored similarly to the MAST. This measure has good internal consistency reliability and concurrent and discriminant validity (Gavin, Ross, & Skinner, 1989; Skinner, 1983). The internal consistency reliability for the DAST in this sample is excellent, as evidenced by an alpha = .94.

Traumatic Life Events

A revised version of the Traumatic Stress Schedule (TSS; Norris, 1990) tapped lifetime occurrence of 15 interpersonal (e.g., rape, physical attack, mugging) and noninterpersonal (e.g., auto accidents, natural disasters, evictions), potentially traumatic life events that a participant may have experienced prior to age 18, during adulthood but prior to the past year, and in the past year. The TSS assessed, in a yes/no format, whether the respondent had experienced each event and also assessed, in a yes/no format, whether she felt that an event had been traumatic. Summary scores were created for the frequency of events and for the perception of events as having been traumatic. The TSS has shown good test-retest reliability (Norris, 1990), indicating that participants' responses appear to remain stable across administrations. For the current sample, the TSS has good internal consistency reliability (α = .87).

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RESULTS

To address whether demographic differences existed between the groups on age, marital status, education level, homelessness status, employment status, monthly household income, number of children, and religious affiliation, *t* tests and chi-squares were used. The groups were largely similar, except on marital status (χ^2 [273] = 25.49, $p < .01$), homelessness status (χ^2 [273] = 6.36, $p < .05$), and psychiatric treatment history (χ^2 [273] = 28.89, $p < .01$). Repeat attempters were more likely than first-time attempters to be either divorced, separated, or widowed; to be homeless (28% vs. 16%); and to have a history of psychiatric or substance abuse treatment (58% vs. 42%). These variables served as covariates in subsequent analyses.

To minimize Type I error, multivariate analyses of covariance (MANOVAS) were used. When significant effects were found, Bonferroni post hoc tests were used to identify significant differences in the model.

SUICIDE ATTEMPT VARIABLES

Regarding risk factors for attempting suicide, compared to first-time attempters, repeat attempters had more previous psychiatric and/or substance abuse treatment (χ^2 [1, 271] = 28.89, $p < .01$) and more hospitalizations for a medical/physical reason (χ^2 [1, 271] = 15.86, $p < .01$). Pertaining to precipitants of the index attempt, the women differed in whether drugs had been involved (χ^2 [1, 269] = 10.96, $p < .01$); 33% of first-time attempters and 53% of repeat attempters reported that drugs had been involved.

A MANCOVA with SIS total, SIS planning, and SIS lethal intent scores yielded a significant multivariate effect, F (3, 264) = 7.07, $p < .001$, $\eta^2 = .07$. A moderate association between group status and the combined dependent variables was found. Follow-up ANCOVAs revealed significant univariate effects for group status on each of the three scale scores. Effect sizes were small to moderate. Mean levels of suicidal intent, planning, and lethality of intent were higher among repeat than first-time attempters. To further explore differences in index attempt lethality, a MANCOVA was run on the R-RR, which revealed a nonsignificant multivariate effect for group status; no additional analyses were conducted.

Interestingly, compared to first-time attempters, repeat attempters reacted differently to the index attempt ($\chi^2 = 29.12$, $p < .01$); fewer repeat attempters (43.1%) than first-time attempters (68.4%) indicated feeling sorry for having made an attempt. However, more repeat attempters (34.3%) than first-time attempters (8.3%) indicated regret about having survived the attempt. In addition, repeat attempters reported that their

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visualization of death differed from that of first-time attempters ($\chi^2 = 9.98$, $p < .05$); repeat attempters visualized life after death, never-ending sleep, and entry into heaven or hell more often than did their first-time attempting counterparts.

PSYCHOLOGICAL SYMPTOMATOLOGY

Regarding global psychological distress, a MANCOVA yielded a significant multivariate effect for group status, F (3, 263) = 10.25, $p < .01$, $\eta^2 = .11$. Follow-up ANCOVAs yielded significant univariate effects. Results indicated moderate associations between group status and each of the dependent variables (BSI-GSI, BSI-PST, and BSI-PSDI). Repeat attempters reported higher levels of global psychological distress, number of symptoms experienced, and level of psychological distress experienced on average compared to first-time attempters. In terms of hopelessness, a MANCOVA revealed a moderate association between group status and level of hopelessness, F (1, 265) = 23.258, $p < .01$, $\eta = .08$. As expected, repeat attempters self-reported higher levels of hopelessness than did first-time attempters. Furthermore, a greater number of repeat attempters indicated a severe level of hopelessness. Regarding substance abuse, a significant multivariate effect was generated when both the Brief MAST and Brief DAST were considered, F (2, 263) = 4.36, $p < .05$, $\eta^2 = .03$. Follow-up ANCOVAs yielded significant univariate effects with small effect sizes for group status. Specifically, repeat attempters reported more drug and alcohol use than did first-time attempters.

TRAUMATIC LIFE EVENTS

Pertaining to trauma, repeat attempters were expected to report greater numbers of traumatic life events than first-time attempters. Considering lifetime trauma (i.e., the number of events described by each participant as having been traumatic across the life span: childhood, early adulthood, and recent adulthood), a small but significant multivariate effect was observed for group status, F (3, 263) = 2.91, $p < .05$, $\eta^2 = .032$. Separate ANCOVAs revealed only one significant univariate effect for group status with a small effect size. Repeat attempters experienced more traumatic life events during childhood than did first-time attempters. No between-group differences were found with respect to number of traumatic life events experienced in the past year or number of traumatic life events experienced during adulthood and prior to the past year.

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DISCUSSION

The first of its kind, this study explored differences between female, low-income, African American first-time and repeat attempters. Regarding suicide attempt variables, as hypothesized, female, low-income, African American repeat attempters reported having had higher levels of suicidal intent for the index attempt than did first-time attempters. Furthermore, this higher intent level was associated with higher levels of perceived lethality of means and method chosen as well as higher levels of planning involved in the attempt. Interestingly, the latter finding is inconsistent with some prior research suggesting that repeat attempters are more impulsive than first-time attempters, specifically with regard to making an attempt (Courtet et al., 2004). For repeat attempters, making a suicide attempt might become an overdetermined, conditioned, maladaptive response to stress that is easily triggered. This highlights the need to teach individuals who attempt suicide alternative and less injurious approaches for coping with stress.

Consistent with prior literature, this study found that female, low-income, African American repeat attempters reported higher levels of global psychological distress, hopelessness, and alcohol and drug use than did their first-time attempting counterparts. Taken together, these results further substantiate that repeat attempters, as a group, are more distressed clinically than are first-time attempters. Given that higher levels of psychological distress, hopelessness, and comorbidity of psychological problems and substance abuse problems all serve to elevate suicide risk, the results suggest that low-income African American women with a history of repeat attempts may be at elevated risk for eventually completing suicide. These findings underscore the importance of providing appropriate biopsychosocial mental health interventions for suicide attempters who belong to a traditionally marginalized group with limited access to care. A combination of psychotherapy, substance abuse treatment, and pharmacological interventions may be warranted.

The findings also indicated that repeat attempters experienced a greater number of traumatic events during childhood than did first-time attempters. However, these groups did not differ with respect to the number of traumatic events experienced during the previous year or during adulthood but prior to the past year. This finding highlights the need for understanding the role of childhood and early adolescent risk factors in the development of a “suicide career,” at least among low-income African American women. These results add further evidence to the finding that childhood maltreatment is associated with elevated risk for suicidal behavior in adulthood (Thompson, Kaslow, Bradshaw, et al., 2000) and suggest that childhood maltreatment may be a

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precursor for a particularly persistent and severe course of suicidal behavior in this population. As a result, assessments for this group of suicide attempters need to include questions about childhood abuse and neglect, and intervention strategies that help women heal from such traumas must be implemented. Some empirically supported treatments for trauma that might be useful include cognitive-behavioral approaches (e.g., exposure therapy, core-belief work; see Foa, 2000; Hembree & Feeny, 2006; Najavits, 2002), group therapy (Foy, Schnurr, & Weiss, 2001; Heron, Twomey, Jacobs, & Kaslow, 1997), and narrative therapy (Keats & Arvay, 2004).

Study findings must be considered in light of several limitations. The generalizability of the findings are limited to a hospital-based population of women who belong to specific racial (i.e., African American) and socioeconomic status (i.e., low-SES) groups. In addition, although results were statistically significant and largely consistent with a priori hypotheses, effect sizes were generally small or moderate. Therefore, inferences drawn from these data should be tentative pending replication with a similar sample. Another limitation was the verbal administration of measures, as it may have increased risk of reactions that might have interfered with accurate reporting (e.g., social desirability, shame). However, efforts to standardize the verbal administration of measures did provide some control for this potentially confounding factor. A final consideration is that, given the cross-sectional nature of the study design, it is not possible to say with certainty whether the variables on which these groups differed were risk factors or outcomes of the suicide attempt.

Despite these limitations, this study possesses several strengths. For one, the inclusion of low-income African American women as this population has not been well-represented in investigations of suicide attempts. Moreover, no studies comparing repeat and first-time suicide attempters have been conducted using a sample of this type. The careful measurement of suicide-attempt status was an additional strength, as some investigations have relied on self-reports to assess suicide-attempt status. Furthermore, the narrow time frame between the index suicide attempt and the data collection interview was a positive aspect of the design, as it limited potential recall biases in responding to the measures. In addition, the findings have the potential to contribute to our understanding of the mechanisms through which prior suicidality enhances the risk for the enactment of later and potentially more serious suicidal behavior (Joiner et al., 2005).

Findings suggest a number of avenues for future research. Studies should be developed that separate race and SES factors as they relate to first-time and repeat suicide attempts. Also, given the links between suicidal behavior and various psychiatric disorders, it would be advantageous for a structured

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diagnostic interview to be included in subsequent study protocols. In addition, future studies should incorporate data from multiple sources (e.g., medical records, family members, friends, clinicians) to corroborate self-report data and enhance understanding of the differences between repeat and first-time suicide attempters. Future studies should also use prospective designs to explore what factors might reduce the likelihood that first-time attempters become repeat attempters. In a related vein, future designs should focus on those variables that protect attempters from re-attempting. Such designs should incorporate a theoretical framework, such as the interpersonal-psychological theory of suicidal behavior proposed by Joiner (2005).

In closing, in light of the clinical picture presented by repeat attempters, these findings suggest the need to consider them as a group characterized by greater levels of psychological difficulties with more traumatic histories. This conclusion is consistent with the fact that the care of repeat attempters demands significant financial and institutional resources (U.S. Department of Health and Human Services, 2001). Furthermore, these individuals have been found to be challenging to engage in follow-up treatment (Monti, Cedereke, & Ojehagen, 2003; van der Sande et al., 1997) and are prone to help negation (Rudd, Joiner, & Rajab, 1995). Therefore, it is imperative that we develop culturally competent interventions (Heron et al., 1997) specifically designed for low-income African American women with a history of repeat suicide attempts. For interventions to be culturally competent, they must be cognizant of culture-specific issues that affect the therapeutic process, use examples and materials that are culturally relevant, facilitate empowerment, take into account the strengths of African American women and their communities, and promote supportive relationships in a manner that is consistent with each woman's sociocultural context (Heron et al., 1997; Jackson & Greene, 2000).

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