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Religious coping style and cultural worldview are associated with lower suicide ideation among African American adults

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Abstract

Objective: The purpose of this study was to examine whether specific religious coping styles and cultural worldview would be associated with thoughts of suicide given higher levels of stress in a community-based sample of African American adults. **Method:** African American men and women (n=134) completed measures of religious coping, cultural worldview, stressful life events, depression symptoms, and suicide ideation. **Results**: Higher ratings of suicide ideation were observed for African Americans who endorsed a more self-directing religious coping style. The self-directing religious coping was more frequently endorsed by participants who identified with a more Eurocentric cultural worldview that espouses an individualist philosophy. **Conclusion**: Together, these findings provide some insight to how religious coping and culture are related to suicide vulnerability for African Americans who are not in clinical care.

Keywords: Religious coping, Worldview, Suicide, African American

Religious coping style and cultural worldview are associated with suicide ideation among African American adults

The non-adjusted rate of suicide for African Americans is 5.4/100,000 compared to the U.S. national average that is 13.0/100,000 (Xu, Murphy, Kochanek, & Bastian, 2016). Available studies suggest that the seeming suicide "resilience" that is observed for African Americans is associated with cultural milieu, more generally, and religiosity/religious beliefs in particular (Anglin, Gabriel, & Kaslow, 2005; Marion & Range, 2003). However, few studies have examined how religious coping in the face of stressful life events might be associated with lower self-reported suicide ideation in African American adults. We posit that religious coping that is more culturally congruent (e.g., deferring to or working collaboratively with a higher power) will be associated with lower self-reported ratings of suicide ideation. We posit that a self-directing coping style, though characterized as "active coping," may not be as adaptive among African Americans who embrace a culturally congruent, Africentric worldview.

Religiosity and suicide resilience

Religiosity has been defined as "systems of belief in and response to the divine, including the sacred books, cultic rituals, and ethnical practices of the adherents" (Koenig et al., 2001, p. 201). Its role as a potential mitigating factor in suicide ideation and attempts is well-established. Stack (1983a) found that suicide death rates across 25 countries decreased as religious commitment increased; the findings seemed to be true regardless of (Protestant, Catholic, other) religious affiliation. Stack and Lester (1991) noted that religious commitment, characterized by frequency of religious participation is directly associated with level of suicide ideation. However, the specific mechanism by which religiosity impacts suicide outcomes is unclear.

Insight to religious coping and problem-solving approaches provide a more nuanced

understanding of the role of religiosity in suicide behavior. Positive religious coping has been characterized by finding meaning in life and a sense of "spiritual connectedness to others" (p. 712) while negative religious coping is associated with religious struggle and an insecure relationship with God (Pargament, Smith, Koenig, & Perez, 1998). Ano and Vasconcelles (2005) found that positive religious coping tends to be associated with higher levels of positive affect and lower levels of emotional distress including depression and anxiety. Similarly, negative coping (believing that one is being punished by God) is associated with higher levels of psychological distress.

Religious coping styles are reflected in specific patterns of coping that encompass self-directing, collaborative, and other forms of religious coping (cf. Pargament, Smith, Koenig, & Smith, 1998). In the self-directing coping style, the responsibility to control one's life rests on the individual. Pargament et al. (1988) suggested that "God is viewed as giving people the freedom and resources to direct their own lives" and cited an example response that "God put me here on this earth and gave me the skills and strengths to solve my problems myself." (p. 91). In the deferring coping style, solutions are expected to come from God's active effort. In the collaborative coping style, the responsibility rests both on the individual and on God to deal with problems collectively. Self-directing coping has been associated with negative religious coping while collaborative has been associated with positive religious coping. One's capacity to engage in more adaptive coping methods is directly related to physical and emotional health outcomes given stressful life events (Underwood & Powell, 2006).

Religiosity as cultural buffer

In the African American community, suicide resilience has been linked to religiosity and cultural mores. The paradox of African American suicide, whereby African Americans experience elevated suicidogenic factors (untreated mental health problems, social marginalization, etc.) but less suicide death relative to seemingly less vulnerable groups (Gibbs, 199; Rockett et al., 2010) has been attributed, in part, to strong religious ties. Unfortunately, many studies default to religion as a proxy for African American culture. Though religiosity and culture are inextricably linked, religiosity is more likely subsumed under the umbrella of culture, the mechanism through which information processing, belief systems, appraisal, and behavior emerge (Kambon, 1998; Myers, 1988; Sue & Sue, 1999; Triandis, 1996).

Current Study

Consistent with a buffering hypothesis, religious coping is believed to mitigate the effects of negative life events for African Americans. Other studies have noted, more broadly, that suicide resilience is a cultural phenomenon from which African Americans benefit. We posit that specific types of religious coping are associated with the presence or absence of suicide ideation and also that a more spiritual, Africentric cultural worldview is linked to one's religious coping style. The explicit hypotheses for the current study were:

1) The association between stressful life events and suicide ideation is moderated by a collaborative religious coping style (i.e., responsibility lies with the individual and God) such that stressful life events is associated with fewer ratings of suicide ideation for African Americans who report low (and not high) ratings of collaborative religious coping.
2) The association between stressful life events and suicide ideation is moderated by a

deferring religious coping strategy (i.e. God is responsible) such that stressful life events is associated with fewer ratings of suicide ideation for African Americans who report low (but not high) ratings of collaborative or deferring religious coping.

3) Stressful life events are associated with higher ratings of suicide ideation for African Americans who report high (and not low) ratings of self-directing coping.
4) Africentric and Eurocentric worldview orientations are associated with disparate religious coping strategies such that deferring and collaborative religious coping strategies are associated with an Africentric cultural worldview and self-directing religious coping (individual is responsible) is associated with a more Eurocentric worldview orientation.

Method

Participants

The participants were 134 self-identified, non-clinical, community-based African American adults. The mean age of the sample was 34.37 (*SD* = 11.74) years with age range of 18 to 59 years. Relationship status for the majority (65.7%) of the sample was characterized as "single, never married". Approximately 14.9% reported that they were married. Divorced participants represented 14.9% of the sample. Approximately 4.5% of participants reported that they were cohabitating. The majority of participants indicated that they, their parents, and at least one grandparent were born in the U.S. (73.1%); approximately 23.9% identified that they or their parents were born outside of the U.S. The highest level of education was reported as "some college" (31.3%).

Measures

Life Experiences Survey (Sarason, Johnson, & Siegel, 1978). Life Experiences Survey (LES). The LES is a 57-item self-report inventory that assesses common positive and negative

life changes in multiple domains. For the current study, we used the 30-item LONGSCAN adaptation of the LES. For each event that occurred (e.g., break up, married, lost job, new baby, family or friend die, serious illness or injury, crime victim, work promotion etc.), respondents were asked to rate the impact of the event on a 5-point scale ranging from 2 (Very Good) to -2 (Extremely Bad). If an event did not occur, the item was coded as 0. The LES yields three scores: a positive change score, a negative change score, and a total change score (the sum of the absolute value of each life event rating experienced as desirable and undesirable). The total change score was used for the current study and represents the total amount of rated change. Total possible scores range from 0 to 60 with lower scores being indicative of less life change and higher scores being indicative of more life change and stress. Other studies have used the total life change score as an index of life stress and correlate of psychological distress. (Constantino, Sekula, Rabin, & Stone, 2000; Edwards, Hershberger, Russell, & Markert, 2001).

Religious Coping Scale (RCS; Pargament et al., 1988). The RCS is a 36-item measure of religious problem solving or coping. Participants are asked to respond on a 5-point Likert scale ranging from (never) to (very often). The RCS assesses three religious coping styles characterized as self-directing, deferring, and collaborative. Sample questions include "I act to solve my problems without God's help" (self-directing), "God solves problems for me without my doing anything" (deferring) and "Together, God and I put my plans into action" (collaborative). In the self-directing coping style, the responsibility to control of one's life rests on the individual. In the deferring coping style, solutions are expected to come from God's active effort. In the collaborative coping style, the responsibility rests both on the individual and on God to deal with problems collectively. Alpha coefficients from the present sample were commensurate with previous studies: deferring (r = .95), collaborative (r = .97), and self-

directing (r = .94).

Worldview Analysis Scale (WAS; Obasi et al., 2009). The Worldview Analysis Scale (WAS) is a 45-item instrument that measures cultural dimensions of worldview that range on a continuum from a more Eurocentric to a more Africentric worldview orientation (Obasi et al., 2009). The scale consists of seven conceptual dimensions of worldview characterized as materialistic universe, spirituality, immortality, communalism, knowledge of self, tangible realism, and indigenous value systems. Example items include "My ultimate goal is to improve my community's current condition" and "Things that cannot be measured do not exist [reverse scored]." For the purpose of this study, the total scale score for the Worldview Analysis Scale was used to characterize the extent to which participants endorsed a more Africentric or more Eurocentric worldview. Item responses are organized as a 6-point Likert scale ranging from (1) "strongly disagree" to (6) to "strongly agree" and yield a total score that ranges from 45–270. Items were keyed such that higher scores are indicative of an Africentric worldview that reflects a strong social orientation, spiritual belief system, connection to family, and present/past orientation to time (Grills, 2002; Jones, 2003; Nobles, 2004; Taylor, Chatters, & Levin, 2004). Lower scores are more indicative of a Eurocentric worldview characterized by preferences for materialism and individualism, future time orientation, and belief in mastery over nature (Asante, 1980; Dana, 1993). Obasi et al. (2009) reported good reliability (test retest .95, internal consistency .92) and discriminant validity associated with measures of affect and well-being in a sample of African American and European American adults. In the current study, alpha reliability =.87.

The Adult Scale for Suicide Ideation (ASIQ; Reynolds, 199l). The ASIQ is a 25-item self-report measure of the severity of suicide ideation in adults age 18 and older. Participants

were asked to respond on a seven-point scale regarding the frequency of suicidal thoughts ranging from 0 (never had the thought) to 6 (had the thought almost every day). A total score is produced by summing the ratings, with higher scores reflecting greater levels of suicidal ideation. The scale has shown high reliability and validity data for a community of adults and college student samples (Reynolds, 1991; Fu & Yip, 2007; Reynolds, Kobak, & Griest, 1990). Additionally the ASIQ has been found to correlate significantly with the related constructs of depression, hopelessness, anxiety, self-esteem, and history of prior suicide attempts, providing evidence of construct validity (Reynolds, Kobak, & Griest, 1990). In the current study, $\alpha = .98$.

Demographics form. Participants reported race, ethnicity, age, sex, level of education, and generation status.

Procedure

The present study was granted human subjects research approval by the University of Georgia (U.S.) institutional review board. Potential study volunteers were recruited from a moderately-sized, southeastern U.S. community via posted flyers at personal care businesses, apartment residences, and churches that serve primarily African Americans, as well as online Craigslist advertisements, and word-of-mouth. Flyers and advertisements invited potential participants to a brief phone interview to assess appropriateness for participation in a study of stress and coping. Interviewees who were less than 18 years of age or who did not identify as Black/African American were not included in the current study. Small groups of approximately 5-15 participants were invited to the university-based research lab for study participation. Each participant was informed that she or he would be administered a paper and pencil set of questionnaires that included questions about her/his culture and also experiences of stress, and emotional crisis. Upon consent, participants were administered the battery of questionnaires and

informed that participation in the study could cease at any time and referral for psychological services would be available if needed. One participant discontinued participation and is not included in the total sample. However, none requested a referral for psychological services or demonstrated imminent risk for danger. Approximately 60 minutes were required to complete the packet of questionnaires as part of a larger study of stress and emotional well-being among African Americans. Each participant received $25 as incentive for participating in the study.

Results

Preliminary Analyses

Means, *SD*s, and intercorrelations for all measures as well as demographic variables (i.e., age, sex) are presented in Table 1. A significant association was found between self-reported stressful life events and thoughts of suicide (r = .252, p =.006), such that as the number of stressful events increased, thoughts of suicide also increased. Self-directing coping style was associated with thoughts of suicide, such that as ratings of self-directed coping increased, so did thoughts of suicide (r = .264, p = .009). Neither deferring (r = -.151, p = .08), nor collaborative religious coping (r = -.163, p = .06) were significantly associated with thoughts of suicide though estimates approached significance at p <.10 and in the predicted directions. An Africentric worldview was positively associated with self-deferring (r = .341, p < .01) and collaborative (r = .372, p < .01) religious coping, and negatively associated with self-directing (r = -.364, p < .01) religious coping.

Religious Coping as Moderator

To test the hypothesis that religious coping style moderates the association between life events and suicide ideation, we conducted hierarchical regressions with each of the three religious coping style subscales interacting with life events in association with suicidal ideation (see Table 2). The dependent variable in this analysis was the ASIQ (suicide ideation) scores. To

evaluate interaction effects in relation to suicidal ideation and to limit Type 1 error, all three interactions were entered into the same regression model. In the first step of the hierarchical regression equation, the covariates (i.e., age, gender, and depression symptoms) were entered. In the second step of the regression equation, life events and the three religious coping styles (i.e., self-directing, collaborative and self-deferring) were entered. Scores for life events and the three religious coping subscales were centered in order to ensure that the coefficient for the interaction variables would be interpretable given the range of values in the data (Hayes, Glynn, & Huge, 2012). Results revealed that life events (β = .16, p = .05) but not self-directing (β = .12, p = 0.17), collaborative (β = −0.04 p = 0.74) nor deferring (β = 0.00, p = 0.99) religious coping were significantly associated with suicidal ideation (see Table 2).

In the third step of the regression equation, the life events by religious coping interaction constructs (i.e., life events X self-directing, life events X collaborative, and life events X self-deferring) were entered. As seen in Table 2, the interaction between life events and the self-directing religious coping scale (β = .19, p = 0.02) was significantly associated with suicidal ideation and provided preliminary evidence that self-directing religious coping was a moderator for experiencing life stress. **Figure 1** depicts a graphical illustration of the interaction whereby the unstandardized simple slope for life events predicting suicide ideation were significant at 1 SD above (B= 6.95, p < .001) and at the mean level of self-directed religious coping 3.30 (p = 0.02). However, the unstandardized simple slope for life events at 1 SD below the mean of self-directed religious coping was not significant (B= -.35, p = 0.41). Thus, stressful life events were associated with suicide ideation for participants who endorsed self-directing religious coping at the mean or higher (but not lower) levels of self-directing coping. The interaction between life events and self-deferring (β = −.16, p = 0.13) as well as life events and collaborative (β = .09, p =

0.40) coping styles were not significantly associated with suicidal ideation. The overall model with all covariates and interaction terms accounted for 29% [F (10, 123) = 5.06, $p < 0.001$] of the variance on suicidal ideation.

Religious coping style differs by worldview orientation

To test the hypothesis that Africentric and Eurocentric worldview orientations are likely associated with different religious coping strategies, a one-way multivariate analysis of variance (MANOVA) was conducted. In this analysis, worldview orientation was the independent variable and scores for deferring, collaborative, and self-directing religious coping were the dependent variables. WAS scores were dummy-coded such that one standard deviation below the mean of WAS scores was categorized as Eurocentric worldview and one standard deviation above the mean of WAS scores was categorized as Africentric worldview. The MANOVA produced a significant multivariate effect for cultural worldview, Wilks' $\lambda = .72$, F (3, 24) = 3.055, $p < .05$. A follow-up univariate analysis of variance (ANOVA), detailed in Table 3, revealed a significant main effect for cultural worldview on religious coping style such that African American participants who endorsed a more Eurocentric worldview were more significantly likely to engage in a self-directing religious coping style relative to persons who endorsed a more Africentric worldview (Ms = 36.78 and 23.00, respectively). A collaborative coping style, however, was more likely endorsed by persons who identify with an Africentric worldview (M = 48.11) than persons who endorsed a more Eurocentric worldview (M = 34.00).

Discussion

Overall, the results from this study provided partial support for our hypothesis that suicide ideation among African Americans is related to religious coping style and cultural worldview. Our findings revealed that after controlling for age, gender, and symptoms of

depression, persons who reported higher levels of stressful life events coupled with a more self-directing style of coping reported having more thoughts of suicide. These results are notable as they highlight non-religious coping as a potential risk for suicide ideation among African Americans who are not in clinical care. Bickel, Ciarrocchi, Sheers, Estadt Powell, and Pargament (1998) similarly found that, in high stress situations, a self-directing style is related to increased symptoms of depression. As predicted, we also found that the self-directing style of coping was observed more so among persons who identified with a more Eurocentric worldview compared to those who endorsed a more Africentric worldview. That is, those who reported utilizing the more self-directing coping style were more likely to identify with a culturally incongruent worldview orientation. It is unclear whether the worldview orientation would render one vulnerable to suicide ideation perhaps through increased suicide acceptance or via the potential emotional disturbance of being African American and adopting a discordant cultural worldview. Some studies have found that positive group identity was associated with decreased psychiatric disturbance while higher acculturation (to mainstream society) was associated with increased odds of psychiatric disturbance for Black, Latino and (Burnett-Zeigler, Bohnert, & Ilgen, 2013). Future studies might examine cultural mismatch and suicide risk in an ethnically and racially diverse psychiatric setting.

Contrary to prediction, we did not find that African American men and women who engage in a more deferring or collaborative coping approach are less likely to consider suicide relative to those who do not use such coping. While religious coping may not offset thoughts of suicide, it may impact downstream suicide planning and attempts. That is, coping style may not mitigate one's sense of hopelessness about the future, but may mitigate the behavioral manifestations whereby one constructs (and follows through with) a suicide plan. Future studies

should examine religious coping style among African Americans who consider suicide and generate a plan compared to those who do not develop a plan.

Alternatively, factors other than religious coping may buffer the impact of stress on suicide ideation and behavior. Joiner, Perez, and Walker (2002) posited that there may be important, unexamined mediators that account for the role of religiosity in psychological health and that much more rigorous research is needed. Joiner et al. proposed that social support could be the active ingredient in religious settings. That is, religious groups rather than religious ideology offer support that engenders emotional resilience. In an integrative analysis of individual and macrolevel dimensions of religiosity, Stack and Kposowa (2011) found that community religiosity (from neighborhood to nation) impacts individual level suicide acceptability. Individual level acceptability was also accounted for in part by one's integration in the religious community, adherence to religious doctrine that discouraged suicide behavior, and support from religious networks suggesting multiple processes by which religiosity dissuades suicide. In a community-based study of race-related stress, religiosity and suicide, the more socially-oriented religiosity was linked to fewer thoughts of suicide for African Americans who reported higher levels of race-related discrimination stress (Walker, Salami, Carter, & Flowers, 2014). It may be that the type of stressor elicits a specific type of coping response. Nevertheless, prospective studies of religious beliefs, coping strategies, and suicide resilience are warranted.

Study Limitations and Future Directions

Though this study provides some insight to the pathway by which religiosity and cultural orientation might contribute to suicide resilience and risk among African American adults, some study limitations should be noted. First, the results are based on cross-sectional data. As such, no causal associations regarding the role of religious coping in higher ratings of suicide ideation for

persons who endorse the self-directing religious coping style can be inferred from the current results. Though persons who prefer such a coping style may consider suicide in times of heightened stress, suicide is a complex phenomenon by which multiple factors facilitate risk and resilience. Future studies might employ a prospective design to examine this temporal association and the intermediate role of religious coping style and suicide vulnerability. The non-probabilistic sampling methodology is another study limitation. The inclusion of community-based African Americans who are not currently in clinical care provides preliminary insight to suicide risk for a subgroup of vulnerable persons who are currently understudied in suicide research. However, future studies might recruit a random sample of African American/Black adults to increase the generalizability of findings. A third limitation of the current study is the challenge in extrapolating differential risk for African American men and women. Though women, including African American women, consider suicide more frequently than do men, men are more likely to engage in fatal suicide attempts. Future studies may independently test models of religious coping preferences and suicide resilience and risk among African American men and women. Finally, it is uncertain as to whether the construct of self-directing coping assesses one's "empowerment" from God to make decisions or an altogether anti-religious disposition. Given the risk for suicide thoughts and behavior, such a distinction is important for identifying at-risk persons.

Conclusion

There is considerable within group variability for persons of African descent who reside in the U.S. Though the overall suicide death rate is relatively low, it remains a leading cause of death for vulnerable subgroups of African Americans. Overall, the current findings may have important implications for future research and models of intervention. Since culturally-appropriate public health initiatives are paramount for eliminating suicide vulnerability,

understanding the role of religious coping in suicide resilience and how coping is shaped by cultural worldview is critical. Available research suggests that cultural determinants are critically important to understanding the impact of stress on ethnically diverse groups (Matsumoto & Yoo, 2006). A more nuanced understanding of how sociocultural factors can enhance individual resilience to suicide crisis and improve overall public health efforts.

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