Risk and Protective Factors: White Populations

White and *Caucasian* are terms used to describe people who are descended from any of the original peoples of Europe, the Middle East, or North Africa.[1] This can include people from many different ethnic backgrounds. In this information sheet we use the term “White.”

This information sheet covers the common risk and protective factors for White populations. For data on suicidal thoughts and behaviors and suicide deaths in these populations, go to the web page “White Populations.”

Risk and Protective Factors

Because the majority of the U.S. population is White (72.4%),[2] most research on risk and protective factors for suicide has been done with samples composed mainly of White people. For this reason, the risk and protective factors that have been identified as most important across all U.S. populations are especially relevant for White people.

Protective Factors

Across all racial and ethnic populations, some of the most significant protective factors are:[3, 4]

- Effective mental health care
- Connectedness to individuals, family, community, and social institutions
- Problem-solving skills
- Contacts with caregivers

Risk Factors

Across all racial and ethnic populations, some of the most significant risk factors are:[5, 6]

- Prior suicide attempt(s)
- Alcohol and drug abuse
- Mood and anxiety disorders
- Access to lethal means

For individuals who are already at risk, a “triggering” event causing shame or despair may make them more likely to attempt suicide. These events may include relationship problems and breakups, problems at work, financial hardships, legal difficulties, and worsening health.

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Risk factors among White Populations

Below are results from the small number of studies on suicide risk factors that compare White groups to other racial/ethnic groups in the United States and that have a significant sample size.

Alcohol and drug use: According to the National Violent Death Reporting System 2003–2009, of White suicide decedents tested for alcohol, about 22% were legally intoxicated at the time of death. Compared to the four racial/ethnic minority groups studied, White populations had a higher rate of alcohol use during an attempt than Black and Asian/Pacific Islander populations, but a lower rate than American Indian/Alaska Native and Hispanic populations. As with the other groups, among White suicide decedents, acute intoxication was associated with being male.[7]

Acculturative stress and family conflict: Among non-U.S. born White people, conflicts between the values of their family and the dominant culture are associated with suicide attempts.[8]

Mental health services access and use: In a large national survey, although White people who reported suicidal thoughts or attempts were much more likely than Asian and Pacific Islander, Black, or Hispanic people to seek or receive psychiatric services, there were still a significant number who did not.[9]

Percentages of Adults Who Did Not Seek or Receive Any Psychiatric Services in the Year Prior to Having Suicidal Thoughts or Attempts

	White Adults
Suicidal Thoughts	42.8%
Suicide Attempts	24.1%

Similar results were found in a nationally representative sample of White, Black, and Hispanic adolescents. Although a higher percentage of White adolescents who attempted suicide accessed mental health care, the rate was still only 44.76%.[10]

Serious psychological distress (SPD): SPD is defined as non-specific psychological distress as opposed to specific mental illnesses. Its symptoms overlap with those of disorders that are known risk factors for suicide, such as depression and anxiety. In a large national study, the prevalence of SPD was 3% among both U.S. born and foreign-born White people. However, among those who were foreign born, the prevalence was 6% for those from the Middle East, 3% for those from Europe, and 2% for those from Russia. Possible reasons for the higher rate among people from the Middle East are political and social conflicts, and stigma associated with mental illness in that region. In addition, White people from the Middle East were less likely to have seen a mental health provider than White people born in the U.S. or from Europe or Russia.[11]

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