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# Walden University

College of Social and Behavioral Sciences

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Marilyn Wiley

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

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Walden University
2016

Abstract

# Spirituality Among African American Christian Women Who Have Contemplated Suicide

by

Marilyn Wiley

MS, Walden University, 2009

BS, The Florida State University, 1996

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Clinical Psychology

Walden University

December 2016

## Abstract

The Centers for Disease Control and Prevention reported that African American women had the lowest recorded number of suicide completions among all ethnic and gender groups in the United States. In addition, the number of suicides among African American women continued to soar without a clear reason or understanding of their lowest completion rates. Further research in the area of spirituality among African American women may be critical in understanding why African American women's rates of completed suicides are statistically lower than other ethnic groups and how to prevent future rate increases. A phenomenological framework was used to examine the thoughts and opinions of African American Christian women on whether or not religion plays a vital part during the contemplation phase of suicidal ideations and on their reasons for living. The study explored the low rates of suicide completions among African American women from a religious and spiritual perspective. Fifteen African American Christian women who had contemplated suicide were recruited via flyers posted at a local church campus. Participants were individually interviewed about their lived experiences during suicidal behaviors. After the interviews were transcribed, data were coded by assigning numbers to common themes and placing the common themes into categories. The results indicated that among the small sample of 15 participants, religion and spirituality are highly considered as being a protective factor against repeated suicidal behavior, followed by family relationships, when compared to other reasons for living. The least likely protective factor was financial status. The findings suggest that spirituality can be used as a preventative measure to lower the risk of suicide completions among African American Christian women.

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Dedication

This dissertation is dedicated to those African American women who have lost their lives to suicide, and to those African American women who continue to struggle with suicidal behavior and thoughts. This dissertation is also dedicated to my deceased mother, Sallie Mae Moneyham. If it was not for her untimely and tragic demise along with my effort to remove the negative energy surrounding her death with positive energy, I would not have continued my education. As a means to cope with my mother's death, I channeled my energy and attention toward completing a Master's and now finally, a PhD degree.

## Acknowledgments

I would like to acknowledge my family for being the biggest support system imaginable during this journey. My father, James, and my siblings, Melinda, LaTasha, LaTessa, and Zachary, have been nothing but encouraging throughout this process.

I would also like to acknowledge my cohorts and my friends for their remarkable support and understanding on those days that I felt like giving up. I would specifically like to thank Dr. Jacqueline Ford, for being my motivator and mentor and step by step guide through this endeavor.

Last, but certainly not least, I would like to thank my amazing faculty for the countless revisions, reviews, feedback, and encouragement to get to the final stage. To Dr. Gerald Nissley, Jr., my committee chair; Dr. Grant Rich, my second committee member; and Dr. Rodney Ford, my URR, thank you, thank you, and thank you!!!

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# Chapter 1: Introduction to the Study

## Introduction

Suicide in the United States of America has been and continues to be an ongoing and pervasive epidemic that transcends a broad array of cultures, genders, and ethnic groups throughout the country. According to the American Foundation for Suicide Prevention (AFSP) (AFSP, 2015), suicide claimed the lives of 41,149 people in the United States alone in 2013. The AFSP also reported that in 2013, someone died by suicide every 12.8 minutes. A suicide attempt is made every minute of every day, resulting in nearly 1 million attempts made annually. On average, almost 40,000 people complete suicide in the United States yearly, based on the Center for Disease Control's (CDC) 2011 report (CDC, 2011). The number of suicide attempts per year is not as readily available or accounted for, but it is estimated that for every 25 attempts, there is at least one completion (CDC, 2011). Self-directed violence, commonly known as suicide, is the act of using physical force against oneself in order to inflict serious harm or life threatening injuries, ultimately resulting in death. Many times, self-directed violence is completed, and the desired effects or intentions are accomplished, which is death. However, others contemplate suicide or have suicidal ideations, yet are reluctant to attempt it. On the other hand, many attempt suicide but are unsuccessful, leaving the victim with both mental and physical scars. In fact, there are an estimated 4.5 million suicide survivors in the United States alone, according to the Suicide Awareness Voices of Education (SAVE) website and research provided by the American Association of Suicidology AAS (2014). As the research literature has suggested, suicide and suicide

injuries are major health problems in the United States of America (Goldsmith, Pellmar, Kleinman, & Bunney, 2002), and the problem can no longer afford to continue to go unnoticed, be unspoken of, or remain unresearched while the number of deaths from suicides increase.

The premise of this study was to explore the reluctant behavior of African American Christian women who have contemplated suicide without actually devising a plan or making an attempt (which will be referred to as contemplation), and those who, at the very least, have constructed a plan to commit suicide but may or may not have attempted to go through with it. Because African American women represent the lowest group of suicides amongst all demographics of study, great attention was given to the psychological, social, and spiritual tools implored by African American women once they have reached the contemplation phase. Core research has placed a generalized perspective on the devastating impacts of suicide, as it explores suicide from a broad perspective that incorporates groups as a whole. Therefore, a review of the literature is presented that suggests that further research is needed on the topics of suicide, suicide risk factors, and suicide prevention in an effort to inspect the phenomenon on a more focused level, dissecting the different ethnic and gender groups. In that review, I also present the major issues and areas of concern among researchers in regards to the rising number of suicide completions, attempts, suicidal contemplation, and ideations among the African American women ethnic group. Although African American women have the lowest recorded number of suicide completions among all ethnic and gender groups

in the United States of America (CDC, 2012), the statistical count continues to soar without a clear reason or understanding why they are the lowest.

As previously mentioned, research was conducted in this study to address the growing need to understand suicide and suicidal behavior among African American women. I aimed to explore these generalized themes of research relating to the dynamics of suicide and its effects on the mainstream American population. I examined those at risk of suicidal activities, with investigation into the specific research on the African American community, and addressed possible factors surrounding the low instances of suicide rates among African American women, which shaped the specific basis of research for the study.

Exploring religion and spirituality played a role in this research due to the tried and true beliefs in the African American culture that African Americans possess a strong religious foundation (Stack, 1998). According to Stack (1998), the spiritual beliefs held by African Americans were in heightened use back in the days of slavery and were used as a protective factor and a source of resilience toward all pain, suffering, and feelings of mental anguish. Stack examined data collected from European Americans and African American participants over a 20-year period on suicide acceptability that posited that church attendance lowered suicide risk among African American men and women. King, Hampton, Bernstein, and Schichor (1996) also found that African American college students who were affiliated with organized religious groups or identified with spirituality in some way were less accepting of suicide and those who were less accepting were also avid church goers. Furthermore, Ellison, Burr, and McCall (1997) found that

the protective factors against suicidal behaviors are strongest in areas of the United States with more religious homogeneity, such as in metropolitan locales in the Northeast and in the South, where there is a higher population of African Americans. Although many researchers have discovered a link between religiosity/religious behaviors and the reduced risks of suicidal behavior and suicide acceptability, Ellison et al. found that certain aspects of religiosity, including social support and networking, are also components of religion that form protective barriers against African American suicide attempts (Griffin-Fennell & Williams, 2006).

The results of this study provide awareness and insight into the personal views and opinions of those African American women participants of the study. Based on these views and findings, potential resources and protective factors can be put into place to aid in decreasing the overall number of suicides in society. Understanding the impact that spirituality and religion may have on resilience to suicidal behavior among African American women may also lead to the identification and use of positive resources and support groups provided in the community to help combat the sparking increase of suicide, nonfatal suicide attempts, and suicidal ideations. The phenomenological approach and methodology of this study, though focusing on resilience as it relates to spirituality, also allowed for the participants to share their thoughts on other potentially resilient and protective factors (i.e., family relationships status, hopefulness, positive coping skills, economic and financial status, or self-efficacy) that they feel decrease the risk for suicidal attempts and behaviors. The participants' shared views and opinions were recorded and analyzed for common and differing opinions. The findings and

recommendations based on the collected self-reported data are then presented in a conclusions chapter highlighting the main points of the study and summarizing the research.

## Background

Suicide has historically been associated with the European American nonminority group, and it has been viewed as a “rich people’s” problem (Earls, Escobar, & Manson, 1990). However, within the United States, Native Americans and Alaskan Natives have an increased rate of suicide when compared to other ethnicities (AAS USA Fact Sheet, 2014). According to Van Winkle and May (1993), the rates of suicide are highest in those tribes living in the Northern Plains. CDC reports indicated that in 2003, suicide was the $16^{th}$ leading cause of death among African Americans (CDC, 2012). This statement is backed by the recorded statistical data that showed that 28,177 African Americans died by suicide between 1990 and 2003 (CDC, 2012). These implications along with the fact that suicide is the leading cause of premature death and injuries among ethnic minorities is enough to warrant further research into how suicidal thoughts and behaviors affect other non-European ethnic groups (CDC, 2012). Since 90% of the national total of suicide deaths is among the European American population (CDC, 2012), most of the research conducted has been in reference to those suicide risk and protective factors associated with that particular population, leaving the research and information on risk and protective factors for other groups ambiguous and scarce.

In the past, suicide or suicidal ideations among African Americans received very little attention due to the universal belief that very few African Americans, if any at all,

committed suicide. This was also coupled with the historical notion that African Americans, who were then viewed as being a "psychologically unsophisticated race," were naturally high spirited people who had no burdens and no real sense of responsibility (Crosby & Molock, 2006; Prange & Vitols, 1962). Bevis (1921) claimed that "most of the race are carefree, live in the here and now with limited capacity to recall or profit by experiences of the past. Sadness and depression have little part of his psychological makeup" (p.11). It is this misguided research and misrepresentation of facts that deserve to be disputed and presented in light of new research and empirical evidence.

Ironically, African American scholars also suggested that African Americans did not have any problems with the suicide. A qualitative study was conducted by Early and Akers (1993), involving African American pastors who suggested that suicide was a "White thing." The African American pastors who participated explained that suicide was an anathema to a culture that was noted for having impeccable resiliency in the face of racial discrimination and oppression (Early & Akers, 1993). Wright (1985) explained suicide among "Blacks" as a method of genocide that was promoted and orchestrated by "Whites," therefore arguing that there was no such thing as "Black suicide." Researchers have since come to realize that "Black suicide" is alive and well and continues to thrive as the years go by, which implies that more research in this area may be beneficial (Rocket, 2010).

Researchers have indicated that the leading cause of suicidal death is untreated depression that is triggered by negative life experiences (Goldstein, Krasner, & Garfield,

1990). Negative life experiences may be situations such as the death of a loved one, a divorce, separation, or breakup of a relationship, losing custody of children, or a feeling that a child custody decision is not fair.

Without the proper coping skills or a good defense mechanism against mental distress due to unfortunate life situations such as a serious loss (i.e., of a job, house, or money), a serious or terminal illness of the person or a loved one, or a serious accident involving the person or someone close to them, the probability of suicidal behavior presenting itself may become very high (Goldstein et al., 1990).

Experiencing prolonged bouts with chronic physical pain, intense emotional pain, loss of hope, low self-esteem, being victimized (domestic violence, rape, assault,), or a loved one being victimized (child murder, child molestation, kidnapping, murder, rape, assault), as well as physical abuse, verbal abuse, sexual abuse, or any unresolved abuse (of any kind) from the past may also lead to depressed states and result in suicidal behavior (Goldstein et al., 1990).

Goldstein et al. (1990) also pointed out other feelings of despair that can contribute to a depressed state and if untreated can lead to suicidal behavior. These feelings include feeling trapped in a situation perceived as negative, feeling that things will never get better, feeling helpless, feeling taken advantage of, and the inability to deal with a perceived humiliating situation or a perceived failure. Goldstein et al. also mentioned feelings of not being accepted by family, friends, or society, experiencing a horrible disappointment, feeling like one has not lived up to his or her high expectations

or those of another, and being bullied as either a child or an adult as also causing feelings of despair leading to depression.

Other such negative life situations that can have a significant impact on a person's susceptibility to depression and suicidal behavior are serious legal problems, such as criminal prosecution or incarcerationand substance abuse, including drugs and alcohol abuse.

However, other untreated mental illnesses such as bipolar disorder and schizophrenia may also cause death by suicide (Goldstein et al.,1990). Perry, Oser, and Pullen (2012) explored the relationship between gender and racial discrimination and suicidal ideations, which include the desire to and thinking about committing suicide. They investigated the risk and protective factors of African American women who were deemed as having a low socioeconomic status (Perry et al., 2012). They also examined whether positive psychosocial resources (i.e., having a purpose in life, active coping skills, and positive self-esteem), which have previously been found to act as protective factors among Caucasian American women's mental health, can also be used to buffer the effects that racial and gender discrimination have on suicidal ideations among African American women with low socioeconomic status. The study was conducted by using data from 204 predominately African American women with low incomes, collected by the Black Women in the Study of Epidemics.

Perry et al. (2012) presented evidence-based findings that suggested that African American women who have experienced a significant amount of race and gender-based discrimination have a higher risk of exhibiting suicidal behaviors and ideations more so

than women who have experienced minimal discrimination. This particular finding lends support to previous research that has indicated that there is a positive correlation between poor mental health and discrimination. Furthermore, Perry et al. found that gendered racism has no effect on women with suicidal ideations who have moderate levels of self-esteem, active coping, and well-being. However, they posited that gender racism does have a strong adverse effect in those African American women with high and low levels of psychosocial resources. Perry et al posited that their study was beneficial, as it fills a gap in the knowledge of suicide risks in the African American women ethnic group. It is important to fill this gap since the suicide attempts among African American women have been very high over the past few years, as previously stated. According to the study's authors, their study shows the critical importance of examining culturally specific aspects of risk and protective factors in mental health and indicated that studying African American women as only a small part of an aggregated sample largely comprised of Caucasian American women is not sufficient in attempting to clearly identify, treat, and prevent suicidal behavior among the somewhat varying cultural groups (Perry et al., 2012). Assuming all cultures are the same and have the same risk and protective factors can negatively impact social change by hindering the effectiveness of treatment by using ambiguous information or research derived from a general group or sample that does not necessarily apply to a multicultured society with many subgroups.

Along with the many cultural differences that can be examined as positive psychosocial resources, researchers have also investigated positive mental health that is achieved through religious support and affiliations (Greening & Stoppelbein, 2002). The

topic of suicide among African Americans and African American women and religious diversity has been studied and implicated as a source of resilience by many psychologists (Greening & Stoppelbein, 2002). Taking religious diversity and the various religious and spiritual backgrounds of patients into consideration when assessing risk and protective factors can be beneficial when it comes to providing psychotherapy to patients who are suicidal. Empirical research into how religious diversity impacts suicidal behavior among African Americans has yielded useful information and findings that can be used in discussing whether or not a strong religious background or affiliation can be used as a buffer for suicide attempts. This information is helpful in investigating whether or not spirituality or positive religious beliefs can explain the low rates of suicide completion by African American women. However, qualitative research provides personal accounts and experiences of study participants that represent the opinions and views of individuals instead of a group as a whole. It gives participants the opportunity to share their lived experiences and whether or not the participant feels that his or her religious or spiritual beliefs indeed play a role in his or her experiences with suicidal behavior.

Several studies conducted across many cultures have revealed notable findings of how religion and religiosity, which is a person's self-perceived importance of religion (AbdelKhalek & Lester, 2007), may function as protective factors against suicidal behaviors (Greening & Stoppelbein, 2002). Previous researchers have suggested that among American and Kuwaiti college students (AbdelKhalek & Lester, 2007) and African American and White adults in the United States (Walker & Bishop, 2005), lower rates of suicidal thoughts are associated with an increased level of religiosity. It was also

found that higher self-reported religious well-being is associated with stronger reasons for living and not attempts at suicide (Ellis & Range, 1991).

Another notable finding is that regular participation in religious activities serves as a protective factor for both nonlethal and lethal suicide attempts (Nisbet, Duberstein, Conwell, & Seidlitz, 2000). According to Nisbet et al. (2000), participation in religious activities has been shown to be less frequent among older adults in the United States who died by suicide, compared to older adults who died by natural causes. Reductions in church attendance in the United States have also been shown to correlate with increased suicide rates (Martin, 1984). However, researchers have suggested that regular church attendance is protective against suicide attempts, while infrequent church attendance elevates risk for attempts when compared to nonattendance (Blackmore et al. 2008). Church attendance is also associated with lowered beliefs in the acceptability of suicide in both African American men and women (Stack, 1998).  Lizardi et al. (2008) posited that lower moral and religious objections to suicide are associated with a greater number of lifetime suicide attempts.  As mentioned above, infrequent church attendance has been shown to be associated with greater likelihood of a suicide attempt compared to individuals with no attendance (Blackmore et al., 2008).

On the other hand, not all aspects of religion/spirituality are protective against suicide. For example, certain religious strain, such as religious guilt, fears, and personal beliefs of having committed an unforgivable sin, were all associated with greater levels of suicidal ideation as well as a stronger desire to discuss these issues in psychotherapy (Exline, Yali, & Sanderson, , 2000).

These broad and general findings served as the basis for the current research. However, these findings need to be narrowly tailored and investigated to reflect the suicidal behaviors of underrepresented populations and smaller groups, such as African American women, and need to be reported based on their individual experiences. As previously mentioned, when the cookie-cutter approach is used to research suicidal behavior, conclusions are drawn based on a relative sample consisting mainly of Caucasian Americans, which assumes that those risk and protective factors associated with Caucasian Americans should also be deemed as important risk and protective factors among all ethnic groups in the United States.

In sum, the current study was needed to fill a gap in knowledge in the discipline regarding the experiences of African American women who have contemplated suicide and what they consider to be sources of resilience. Examining sources of resilience can provide insight into why African American women are the lowest amongst those racial groups completing suicide and may offer preventive measures for those at risk of suicide.

## Problem Statement

Past research has indicated that suicide rates among the African American community have been reported as being the lowest among all ethnic groups in the United States (CDC, 2011). Furthermore, African American females are ranked overall as having the lowest rate of suicide completion (CDC, 2011). Although rated as the lowest in comparison to other ethnic groups in suicide completions, African American women have a high number of reported suicide attempts as well as an increasing number of reports for having suicidal ideations (CDC, 2011). Though the current statistics hold true, there is

still a lack of qualitative evidence explaining the personal views and opinions of those African American women who experience such a phenomenon and what they deem as contributing factors during the contemplation and attempt phases of suicide (Larson & Larson, 2003).

Aside from the statistical overall ethnic group rates, where African Americans have the lowest suicide rate, there are some differences when comparing ethnic groups and age ranges. Suicide is an epidemic that is more prevalent among African American males between the ages of 25 to 29 and African American females between the ages of 15 to 19 than it is among Caucasian Americans in the same age groups (Davis, 1978). As historically reported, the rate of suicide among African Americans between the ages of 15 to 34 was higher in the 1970s than it had been in more than 50 years at the time (Davis, 1978). According to the urban stress hypothesis, also known as the frustration-aggression hypothesis, it is postulated that complex urban stressors such as migration, racism, unemployment, poor housing, poverty, and poor education often times result in violence among the African American culture group, in which the violence sometimes results in suicide (Davis, 1978). Researchers who are proponents of the status integration theory suggest that the increase in self-destructive and suicidal behavior occurs as a result of African Americans acquiring an increase in socioeconomic status, for example moving from lower classes into the middle and upper class status (Davis, 1978). This economic status integration then causes the African Americans to inherit more stressors and tensions related to competing economically, socially, and psychologically. African Americans are then faced with the need to develop the ability to cope with the

adjustments and assimilation into mainstream America that can, in turn, lead to increased anxiety and depression (Davis, 1978).

Researchers have indicated that for various previously mentioned reasons, there is currently a high rate of suicide attempts among African American women when compared to past rates of suicide attempts among this same group (Larson & Larson, 2003). If these attempts continue to rise or remain constant, then the greater the chances are for those attempts to result in completion, thus leading to increasing numbers of African American women dying by suicide. Due to such indications, further research is needed to identify risk and protective factors as well as to provide guidance for the treatment of mental illnesses such as depression and other such triggers of suicidal ideation. This type of research should be predicated on qualitative studies that take into account the recorded views and opinions of African American women who have been in such dire positions as to contemplate or attempt suicide. A positive social impact can be accomplished by providing awareness of suicide and examining preventive measures through the undertaking of this study.

## Purpose of the Study

The purpose of this study was to explore suicide risk and protective factors among African American Christian women and examine their resilience to suicidal ideation. In this study, I explored the dynamics of religion and spirituality as they exist among African American Christian women who have experienced suicidal behavior and ideations. I examined spirituality as a protective factor against suicide and suicide attempts based on African American Christian women's accounts and experiences.

Although there have been several studies performed that identified religion as a protective factor against suicide in this population (Neelemen, Wessely, & Lewis, 1998), researchers have identified a gap in the literature that could provide information into how not only religious participation among African American Women but an intrinsic aspect of religion like spirituality could deter suicide, thus seeking to promote understanding, according to African American women views, of a phenomenon that has baffled many social scientists (Gibbs, 1997; Hovey, 1999; Walker, Utsey, Bolden, & Williams, 2005). Neelemen et al. (1998) found that participation in organized religious practices, such as church attendance, has been linked to lower suicide risks in African Americans (Griffin-Fennell & Williams, 2006). However, according to Griffin-Fennell and Williams (2006), many of the current psychologists and their research efforts have moved away from the past studies of only considering religious practices and are now focusing on a more intrinsic factor. Many psychologists are now examining spirituality, meaning the perceived relationship that a person has with a higher being or God and how they internalize and interpret this relationship as well as what effect it has on African American women's suicidal behavior (Washington & Teague, 2005).

It is also worth noting that although spirituality and religiosity are used interchangeably in this study, not all psychologists who research religion agree that the two are the same, and some psychologists are proponents of separating the two. For example, Pargament (1999) postulated that when differentiating between religion and spirituality, it is clear that spirituality has taken some of the core elements that were formerly used to describe religion, making religion a more narrowly tailored and less

inclusive term. According to Pargament, though both terms are multidimensional constructs, the term religion historically had been viewed as a broad-band construct that captured both institutional and individual elements. However, now, with the emergence of spirituality, the term religion narrowly includes the institutional element only. Spirituality, which seems to be the widely favored term, describes the personal and individual elements such as supra-conscious sensitivity, personal transcendence, and meaningfulness, while in contrast, religion is identified with rigid religious institutions that have been formally structured that are perceived as placing restrictions or inhibitions on human potential (Spilka & McIntosh, 1996). Thus, there is the attitude of some researchers and believers that a person can be spiritual but not religious, meaning that although a person has spiritual beliefs, he or she does not necessary attend an orthodox church or engage in the traditional forms of worship services (Zinnbauer, Pargament, & Scott, 1999). For this study, religion and spirituality were used as one variable.

Colucci and Martin (2008) mentioned that over the last 100 years, the role of religion and spirituality as a deterrent to suicidal behavior has been studied under many different disciplines and theoretical perspectives such as the integration theory, religious commitment theory, and network theory. Although current researchers have attempted to look at spirituality under even more theoretical approaches, including cognitive and psychosocial approaches, both old and new research provides evidence supporting the conclusion that spirituality may serve as a buffer/protective factor against suicide (Colucci & Martin, 2008). There are also longitudinal studies that have been performed that found links between spirituality and increased religious involvement and increased

chances of living longer, which researchers have suggested points to the relevance of spirituality and religion as a protective factor against suicidal behavior (Larson & Larson, 2003).

Based on indications from peer-reviewed research literature, there has been very little research in the area of spirituality among African American women. Researchers have postulated that further research in this area will be critical and nothing short of beneficial in the understanding and prevention of suicidal behavior and may offer an explanation as well as to why African American women rates of completed suicides are statistically lower than other ethnic groups (Griffin-Fennell & Williams, 2006).

This study promotes social change by increasing awareness on how spirituality can be used to address suicidal ideations, not only among African American women, but all ethnic groups. By increasing awareness of the many cultural differences that exist in regards to suicidal behavior among African American women, such as the notion that there are some African Americans who exhibit little to no suicide intent or symptoms of depression during a suicidal crises, therapists and nontherapists will be encouraged to look outside the box when trying to recognize other subtle warning signs (National Institute for Mental Health (NIMH), 2012). Understanding that as a culture African Americans are less likely to use drugs during a suicide crisis (National Organization For People of Color Against Suicide (NOPCAS), 2012) and that depression-like behavior among African Americans is usually more pronounced than in other cultures (NIMH, 2012 ) lends to the efforts of identifying those at risk of attempting suicide (NIMH, 2012; NOPCAS, 2012).

This study provided qualitative insight into suicidal ideations, which is a strong indicator of suicide attempts (ten Have et al., 2009). Examining spirituality along with other reasons for living as they all relate to suicidal ideations will then promote social change by allowing therapists to remove treatment barriers and use those lessons learned to incorporate them during therapeutic treatment sessions as preventive measures to help address suicidal ideations early on for those who are at risk of attempting or completing suicide.

Furthermore, information found in this research helps promote social change by minimizing or removing the myths, stereotypes, and stigmas associated with whether gender roles and cultural differences contradict suicidal behaviors. This research affirms the myth that African Americans do not commit suicide because it is an unforgiveable sin, or the myth that African American women possess such resilience and strength that they can withstand the toughest of times and not crack under the extreme pressures placed upon them by life itself

## Research Questions

There are four questions this research is designed to examine:

1. How do African American Christian women contemplating suicide experience religious and spiritual dynamics?
2. How does spirituality compare to other sources of resilience and protective factors that decrease the risk of suicidal behavior?
3. How do African American Christian women between the ages of 21 to 55 experience sources of resilience and other protective factors differently from

African American Christian women between the ages of 56 to 65 before, during, and after contemplating suicide?

4. What role, if any, does spirituality and religiosity play in the reluctance of some African American Christian women who are contemplating suicide to discuss their ideation and to seek mental health services?

In this study, I examined whether spirituality and religious beliefs serve as deterrents or protective factors when considering suicide as a means to an end. I examined the differences of opinions about suicidal ideations among African American Christian women of varying age groups and in an in-group type of setting. I also investigated the likelihood of religious beliefs preventing African American women from seeking mental health. Furthermore, I investigated other reasons for living and how those reasons for living compare to spirituality as being protective factors. Lastly, I captured the opinions and views of African American women on suicide being a hidden topic in the African American community.

## Conceptual Framework

In this study, the phenomenological method was used to examine the thoughts, views, and opinions of African American Christian women on what they deem are suicide risk and protective factors among their social group. The main purpose of this study was to understand the perspective of African American Christian women on whether or not religion plays a vital part during the contemplation phase of suicidal ideations. The ability to participate in personal discussions and intimate interviews

encompassing such a topic as suicide is very key and fundamental in gathering phenomenological data for this study.

## Overviews and Principles of Phenomenological Method

Phenomenological studies describe the process of the product (Creswell, 2007) and are commonly used in psychology and other social science disciplines (Creswell, 2007; Moustakas, 1994; van Manen, 1990). Fellow and Liu (2008) stated that "phenomenology advocates the scientific study of immediate experiences and focuses on events, occurrences and happenings as one experiences them, with a minimum of regard for the external, physical reality" (p.70). In other words, this approach aims at determining what an experience means for those who have had the experience and are able to provide a comprehensive description of it.

Drawing primarily from Creswell (2007) and Moustakas (1994), this study makes deliberate use of the phenomenological research approach. Moustakas asserted that "he understanding of meaningful concrete relations implicit in the original description of experience in the context of a particular situation is the primary target of phenomenological knowledge" (p. 14). Phenomenological studies are used to highlight groups of people who rarely have been the topic of previous studies (Creswell, 2007).

Specific traditions within qualitative research have been considered. With a biography, the researcher explores the life of an individual. Although this is possible, this type of study is challenging to have approved because of potential basis in completing a biographical study. Ethnography is when the researcher is able to describe and interpret thoughts, feelings, and other variables of a specific culture or social group.

I considered this tradition, but it appears like these studies are primarily done over a longer period of time. In a case study, the researcher is able to develop an in-depth analysis regarding a single case or in regards to multiple cases. With this type of qualitative study, the researcher may gain additional insight into previously researched information based on the analysis. However, in this study, I desired to gain the perception of a group of individuals rather than an individual. A grounded theory begins with the collection of qualitative data (Creswell, 2007). The researcher reviews the collected data, identifies repeated ideas, and draws from the concepts or elements that become apparent. These themes extracted from the collected data are tagged with a specific coding. The more data collected, the better it is for the researcher to group common themes and categories (Creswell, 2007). According to Creswell (2007), these categories can be used as the basis for a new theory or theories. The grounded theory methodology contradicts the traditional model of research. In a traditional model, the researcher chooses an existing theoretical framework and collects data to affirm or deny whether the theory applies to the phenomenon (Creswell, 2007). In a grounded theory, and only then collects data to show how the theory does or does not apply to the phenomenon being studied (Creswell, 2007).

Previous studies of suicidal behavior have primarily addressed suicide based on large groups that did not represent smaller groups. Phenomenological studies allow researchers to view an abiding concern that has serious interest to a certain group such as African American women who have contemplated suicide, therefore allowing those particular women to embark upon central themes of real-life events within their contents

that establishes or constitutes the nature of the lived experience (Creswell, 2007; Moustakas, 1994; van Manen, 1990). Finally, phenomenological studies allow further research that provides an understanding of a complex social phenomenon, such as suicide risk and protective factors based on the participants accounts (van Manen, 1990; Moustakas, 1994; Creswell, 2007). These factors can impact suicidal behavior in both a positive or negative way, but can ultimately be used to promote awareness, explore effective treatment plans, and develop preventive measures.

Within a phenomenological study approach is the bounded systems approach. According to Creswell (2002), "bounded means that the case is separated out for research in terms of time, place, or some physical boundaries" (p. 485). In other words, it is possible to create limits around the object to be studied (Merriam, 1998) and serve as parameters of who or what will be included or excluded from the study (Creswell, 2007; Fisher & Zivani, 2004; Gerring, 2004; Hancock & Algozzine, 2006; Miles & Huberman, 1994;Padgett, 2008). Cases can be bounded physically like mental health facilities, church affiliations, or community settings, by time, place, or experience (Stake, 2006). Participants in this study were considered bounded by their shared experiences (i.e., involvement in religious groups or affiliations, having suicidal ideations), and ethnic and gender group (African American women).

## Application to the Study

There were several reasons the phenomenological approach was chosen for this study to understand resilience to suicidal ideation and behaviors. Although a quantitative study could categorize statistical data to reflect the number of completed suicides as well

as gain some insight into the increase in rates and attempts, a quantitative study would not be able to attain the degree of in-depth understanding that I hoped to achieve in this process based on the participants' views of the phenomena. In order to obtain that in-depth understanding of to what degree religion serves as a buffer for suicide ideations, a qualitative research design was considered to be the best option.

First, phenomenological studies are conducted when the researcher wants to investigate or determine problems or situations important to understand the shared experience of the phenomenon or issue (Creswell, 2007; Duke, 1984; Giorgi, 1985, 1994; Moustakas, 1994;Pokinghorne, 1989; Tesch, 1990). Qualitative research is an appropriate approach to take to answer the research questions governing the topic of this study: The experience of spirituality among African American Christian women who have contemplated suicide. The reason qualitative research is appropriate for this specific research topic is due to the goal of obtaining the personal views and experiences of the participants during the process. This experience is not something that can be gathered through a direct question/answer type of format.

## Nature of the Study

The nature of this study was presented using a qualitative approach that incorporated the phenomenological method**.** The phenomenological method was employed to better understand the thoughts, feelings, experiences, and views of African American women who have experienced suicidal ideations (Creswell, 2007). Qualitative data are used to better answer the research questions of this study and to gain a new perspective in the area where limited research has been conducted or in areas that would

benefit from a more in-depth investigation (Hoepfl, 1997). The qualitative approach allows the researcher to obtain firsthand knowledge of the opinions and lived experiences from African American women who have religious affiliations and have contemplated suicide. An understanding of their perspectives on risk and protective factors could lead to providing more awareness and effective therapeutic treatment and supports to the African American women population who may be in need of psycho-education, supportive services, insurances and financial subsidies, and positive outcomes towards those African American women who may suffer from and need mental health services. In addition, the desired goal of this research was to provide a greater understanding amongst professionals regarding suicide risk and protective factors or aspects that places treatment barriers between mental health professionals and the African American community. Through this research, I strive to obtain a comprehensive understanding of the lived experiences of African American women who may possibly be living with undiagnosed and untreated mental illnesses that gives rises to their community seeking professional mental help, and overcome any cultural stigmas that may prevent them getting help. The qualitative approach allows for the researcher to gain a better understanding of the participants' current mental state and provide referral assistance if needed to prevent future thoughts or suicidal behaviors.

This study's overall focus is to explore spirituality as a protective factor as it relates to suicidal ideations in the African American women community by examining spirituality as it compares to other noted protective factors (i.e., hopefulness, relationships, economic status) to see how spirituality ranks among the others when it

comes to deterring suicide attempts among African American Christian women of different age groups who have contemplated suicide. Instead of comparing African American women to Caucasian American women as in past studies, psychologists have suggested that researching suicidality in an African American in-group population, opposed to comparing African American women to another ethnic group, may yield group specific information that may provide insight into to the lower rates of suicide completion among that population as well (Walker et al., 2005). The goal of the study was to compare the effects of spirituality and reasons for living in African American adult women and African American elderly women as they relate to suicidal ideations.

## Definitions

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*Contemplation*: The choice to commit suicide or not. According to one publication (National Institute of Mental Health, 2001), contemplation plays an integral role in the decision making process

*Horizontalization*: Data instrumental to the development of this research study. The use of horizontalization allows the researcher to assign equal value to each of the participants' statements that represents a segment of meaning that will be clustered into common themes (Merriam, 2009; Moustakas, 1994). These segments and themes were grouped into a description of like views and opinions among those interviewed.

*Ideation*: A specific plan created, identified, and recited or communicated by the individuals to describe the way or ways in which they desire to commit violent and/or

passive harm against themselves, ultimately resulting in their death (Hawton & Heeringmen, 2002).

*Phenomenological*: The real time and present moment experience that takes place through the incident or occurrence.   Many of the themes of this study were explored using a phenomenological framework and approach (Creswell, 2007).

*Religion*: The institutional structure and organized affiliation with a group with like beliefs that are put in place and agreed upon among others in a group or community in order to provide guidance, maintain morality, and provide instruction, stability, and humility to gain spiritual freedom (Reich, 2004). Religion and spirituality were used as one variable for the purpose of this study.

*Spirituality* : The perception and/or acceptance of a higher calling of accountability, authority, personal/universal acceptance or being that is sovereign and ascribes a set of consequences to one's actions. I explored, based on personal views and accounts, the critical role of spirituality in the intervention process, which shapes the decision or contemplation process in suicide in both a broad base of cultures and ultimately in African American women (Reich, 2004). Spirituality is one's own connection with a higher being that exists in the supernatural.

## Assumptions

The credibility of the participants is a very vital part of a qualitative research study. Therefore, this study was conducted under the assumption that the interviews, testimonies, personal accounts, and survey data collected during the research process are true and accurate reports of behavior and experiences among participants. I assumed that

the cases of lying and malingering were minimal to nonexistent considering the use of a confidential affidavit that the participants were required to sign during the interviewing process.

I also assumed that the study results would not be altered and that I would not allow personal experiences, personal opinions, or personal biases to dictate or affect the interviewing process or influence the outcome of the data to be reported. I assumed that I, the researcher, would not lead or suggest words, feelings, and emotions to the interviewee during the interview, but would allow for the participant to use his or her own words and dialect to answer the interview questions.

## Scope and Delimitations

In this study, I examined the differences of opinions about suicidal ideations among African American women of varying age groups and in an in-group type of research setting. All of the subjects and participants in this study were African American women between the ages of 21 and 65, therefore eliminating African American men and all other ethnic groups and age groups outside of these specified parameters. The scope of this study has been narrowly tailored to only include a specific age group, gender, and number of the African American ethnic group. Therefore, all results and findings are limited to the opinions of only those participating in the study and met the study requirements and qualifications. This research only captured accounts of African American Christian women up to the age of 65 in one local Christian church, as there is an ample amount of existing research identifying risk factors of women reaching or approaching the age of life expectancy. There are race disparities in longevity that

suggest that African Americans’ life expectancy is 5 to 7 years shorter than the Caucasian Americans’ life expectancy of 70 years (LaVeist, 2003). Such factors found to increase the likelihood of suicide, assisted suicide, and suicidal attempts among women include terminal illness, being divorced or widowed, loneliness, major depression, the death and loss of friends, and feelings of hopelessness and helplessness (LaVeist, 2003).

In this qualitative study, I only explored African American Christian women in a local Baptist Church; therefore, it is limited in the types of religious participants. The study is limited due to not including participants of the Presbyterian, Catholic, Protestant, or any other religious affiliation.

## Limitations

Limitations in qualitative studies relate to validity and reliability (Creswell, 2007). I took necessary precautions to minimize the limitations in the study. First, I verified the validity of this study by examining current literature (Creswell, 2007). I explored the results of recent peer-reviewed articles and scholarly journals that have been written based on investigated evidence. By using this evidence based approach to literature, I was able to draw inferences and conclusions based on previous research in order to establish a credible foundation for the basis of this study. The major limitation in this task of the qualitative study relates to the lack of current evidence based research in the area of what degree spirituality deters suicide among African American Christian women. Another limitation was that the latest suicide statistics are outdated and neither the CDC nor any other agency has reported data on suicide rates since 2011, yielding a 3-year gap in literature.

Next, I bracketed past experiences, used an adequate sample, and employed an individual to review the data in addition to myself to authenticate the data and verbatim transcripts from audio-taped interviews and to verify the themes revealed from the data collection (Creswell, 2007). This helped to validate the information gathered. A limitation that also affects validity is the true account of experiences as recorded from the participants. Since suicide and suicidal ideation are very personal experiences, there was concern as to the trustworthiness of the participants' responses. However, I included an affidavit in which the participants had to attest to the creditworthiness and trustworthiness of their survey information. Finally, I reviewed interviews, data analysis, and coding and verified member checks by the participants.

## Significance of the Study

Historically, there has been a limited perspective and thus a limited body of research that addresses cultural aspects of suicide outside of the Caucasian American population, specifically the Non-Hispanic White population. However, because there are different multicultural dynamics that govern the quality of life, life expectancy, health, well-being, and resilience of the different ethnic and gender groups, there is a need for more prominent research into suicide and more importantly into the early signs and causes of suicidal ideation and contemplation. Exploring the root causes of people contemplating suicide can be a precursor to identifying risk factors and providing support and prevention in culturally specific groups. Therefore, the need to research smaller like or in-groups that have been underrepresented in research can have a significant impact. One such underrepresented group is the African American women group. Just as with

other groups, there are many cultural and historical aspects and lived experiences that influence resilience and vulnerability to suicidal behavior.

According to researchers, suicide attempts among the African American women population are high (Nauert, 2012). Researchers have explained that in order to prevent suicide and suicidal attempts among underrepresented smaller groups such as African American women, it cannot be assumed that the same risk and protective factors that govern Caucasian American women, which has been the focus of previous research, will also be indicative of African American women. Because of his assertion, this study is of great significance, as it delves into the cultural views and opinions about suicide, contemplation, risk, and protective factors based on the African American women perspectives.

## Summary

Though the overall rate of suicide among African American women is increasing, this research study covered many aspects of how religion and spirituality could possibly play a role in African American women having the lowest rate among all other ethnic groups. There is research, much that is dated, that suggests that religion and spirituality are protective factors among those that have contemplated suicide. However, there is not a substantial amount of research studying that possibility among the African American women ethnic group. Many of the previous studies have compared African American women to other ethnic groups in regards to suicide rates, protective factors, and risk factors, but not many have studied them within their own in-group. In this study, I attempted to provide insight on African American women and their religious affiliations

and what, if any, impact those affiliations have on their views and opinions on suicide and suicidal ideations. I also explored the attitudes toward discussing suicide in the African American community, and to what degree and extent African Americans refuse mental health care. Lastly, this study will increase awareness on suicide in the African American community and provide resources to those who may be at risk of attempting suicide.

# Chapter 2: Literature Review

## Introduction

Over the years, there has been a widespread hush and cover-up among African Americans about the truth of suicide occurrences in their communities (Street et al., 2012). This lack of openness on the topic has made it difficult to research this growing phenomenon, and the lack of coverage of the noncelebrity suicides of African Americans makes it even more difficult to see it as a steadily increasing problem. Because it is thought of as highly unlikely among African American women, there is even less research and literature addressing this undiscussed area of concern, and even less research on risk and protective factors as well as on prevention resources and outreach for those African American women diagnosed and undiagnosed with mental disorders.

As previously mentioned, past research has indicated that suicide rates among the African American community have been reported as being the lowest among all ethnic groups in the United States (CDC, 2011). Furthermore, African American females are ranked overall as having the lowest rate of suicide completion (CDC, 2011). In lieu of current research, there is still a small amount of qualitative evidence exploring the personal views and opinions of those African American women who experience such a phenomenon, and what protective factors they recognize as contributors to their resilience (Larson & Larson, 2003). Exploring these views may answer the question of what, if anything, can be done to prevent suicide among African American women and provide insight into what types of factors may circumvent African American women who have contemplated suicide.

However, in order to investigate the current study, a review of what literature does exist was necessary. In this chapter, there is a brief review of previous literature and discussions on present day suicide, attitudes, risk and protective factors, and the influence of spirituality on African Americans' mental health and suicidal ideations. In this chapter, I explore the epidemiology of suicide as well as different types of suicide models to provide a better understanding of the phenomenon. I also discuss the gaps in the literature and the current need for more qualitative research among the African American female community.

## Literature Search Strategy

A literature search was conducted using several sources of information. The following databases were accessed using search terms *African Americans, Black, Negro, Afro-American, spirituality, spiritual, religious and spiritual affiliations, religion, religiosity, suicide, suicidality, suicidal*, *suicidal ideation*, *suicidal behavior*, and *suicide contemplation* as the root of all inquiries: Walden University's Library – Dissertations, Journals, Peer Reviewed Articles, and PsycInfo database, PubMed, Center For Disease Control –BAM Disease Database, American Psychological Association-PsychArticles, and Google Scholar. In addition, a Google search of African American suicide, suicide risk, and protective factors, as well as religion and spirituality related data and websites was undertaken. These terms were used in conjunction with other search words such as *resilience*, *mental illness, reasons for living, suicidal contemplation, suicidal ideations, suicide rates*, and *suicide theories*.

## Data Quality Verification

Lincoln and Guba's (1985) verification of the trustworthiness process was used to examine the quality of the data presented in the articles researched during the literature search strategy. Trustworthiness of research findings requires proof or documentation of four components, according to Lincoln and Guban (1985). These four components include (a) credibility, (b) dependability, (c) transferability, and (d) confirmability (Lincoln & Guba, 1985). Lincoln and Guba (1985) noted that there are eight techniques that allow for verifying the trustworthiness of articles. These eight techniques are described as clarifying researcher bias, member checking, prolonged engagement and persistent observation, peer review or debriefing, triangulation, and negative analysis. The researched literature was evaluated to identify the goal of the research and the importance and relevance of the research, as well as to examine the appropriateness of the research design, the effectiveness of the recruitment strategy, and the proper us of the type of methodology needed to gather the data. This process was used to validate the quality of the literature used for the current investigation and explored how that current literature yields information that may spark new areas of research.

## Conceptual Framework

The conceptual framework of this study is predicated on the notion that religion and spirituality can be positive protective factors against suicide among African American women. If anything can be done to circumvent suicide among any ethnic community, in particular the African American women community, there needs to be a clear understanding and identification of what can be used as protective factors.

In previous research, the case has been made by theorists that suggests that religious association and spiritual affiliations have a positive correlation to suicide prevention (Zinnbauer, Pargament, & Scott, 1999). Previous researchers have also suggested that African American women have a strong religious foundation (Larson & Larson, 2003). This research has also cited such factors as religion as a support system and has subsequently deemed religion and the chosen belief and faith systems as reasons why African American women view suicide as "not being an option or means to an end" (Larson & Larson, 2003). This current research benefits from both of these theories of belief. Drawing from this qualitative research that supports the idea that religion and spirituality serve as positive protective factors for those considering suicide and the school of thought that suggests that African American women hold religion and spirituality in high regards when making life decisions, foundation is laid for the current study. This current qualitative examination into the religious views of African American Christian women and their thoughts behind suicide provide insight into whether or not religion or spirituality deters African American women from suicide, thus resulting in a lower rate of suicide completion compared to other ethnic and gender groups.

The current qualitative research expands on existing qualitative research by introducing a further dissection of the ethnic groups affected by suicide, specifically the African American women group. Where previous research was primarily based on a broad population of people, or mainly compared the African American women to Caucasian American women, in this study, I examined the views and experiences of African American women only.

Previous qualitative literature served as the foundational structure for this study, but the previous literature lacks tailored information that may address the specific informational needs and inquires in regards to why African American women suicide rates are lower than other ethnic groups. Previous research also lack information on how the religious and spiritual views of African American women may play a role in the lower rates of suicide completion among that group. In this current research, I also explored whether there is a positive correlation between religion and suicide prevention in an effort to promote the use of such protective factors to those with suicidal ideations.

There were key terms and definitions used in this framework to provide the reader with a clear understanding and clarification of the context in which the terms were used in this research. For example, in this study, and as in many previous studies, the words *religion* and *spirituality* were used interchangeably, though they hold differing meanings in concept (Hill & Pargament, 2003). Because some people may consider themselves as being spiritual, but not religious, it is important to distinguish the two.

Spirituality, as used in this study, refers to personal and covert behaviors involving such acts as engaging in transcendence, private meditation, and personal prayer on an individual level and basis (Hill & Pargament, 2003). According to Hill and Pargament (2003), spirituality fosters different faiths, relationships, and belief systems and can be viewed as a multidimensional type of belief that can incorporate multiple entities of higher beings in which to draw personal healing and inner strength from. These entities may include, but are not limited to a creator, a god, another human being, nature, or personal self-awareness (Hill & Pargament, 2003).

However, Hill and Pargament(2003) explained that religion refers to the overt behavior of attending a facility, temple, institution, or church organization for worship and prayer on a regular basis and in ritualistic type of way. Engaging in a religious affiliation is more of an overt and collective behavior among groups. Both religion and spirituality are key terms in this study due to past research suggesting that they are associated with lower risk for suicide. In this study, I narrowed down the research to focus on whether or not these suggestions apply to African American women, based on their experiences and views.

*Suicide* is another key term that is used quite frequently throughout this research, as it is the phenomenon that drives the very heart of the study and that has spearheaded national concern when it comes to the health and lives of individuals. Suicide is the intentional act of taking one's own life. Suicide can be committed in several different ways, but the ultimate completion of self-harm is what defines the act. However, there is still the nonfatal act of a suicide attempt, in which the suicide was not carried out completely, and did not result in death.

Another term key in this research study is *contemplation*. Contemplation as it relates to this study describes the mental process or stage of deciding, such things as reasons to live or die, and if they choose death as their ultimate sacrifice, then how will one carry out such a deed. The contemplation stage generally comes after the suicidal ideations, or the idea or thought that killing oneself is an option. The importance of contemplation and ideations in this study is to capture those experiences had by African American women during the times of contemplation and having ideations. It was key in

this study to find out if religion, spirituality, or other such protective factors played any role in the decision making process.

Before coming to the point of contemplation, usually a person's resilience is called into action. Resilience, and a person's ability to be resilient, plays a major role in how they cope with life stressors and traumatic events, the American Psychological Association (APA, 2015) suggested. Resilience is developed by the thoughts, actions, and behaviors that a person adapts to during adversity or tragedy (APA, 2015). Resilience can be viewed as a natural response to turmoil, serious health and relationship problems, and financial and career crises. However, it is the absence of this ability to bounce back after traumatic events and the lack of coping skills that can possibly lead a person down a long road of despair, perhaps ending in suicidal thoughts and ideations, and ultimately suicide. Research has been performed to identify certain resilient factors and strategies. Some of the notable resilience factors include having a genuine and loving and trusting support system as well as having a positive personal outlook and view on life. Developing attainable plans and goals and having good communication and problem solving skills are also great factors for having resilience. Being able to maintain positive self-esteem and confidence in one's strength and ability to survive, along with being able to control impulses and manage strong feelings also determines and develops resilience (APA, 2015). Although building resilience is personal among individuals, having a support system and a positive attitude toward life's happenings will aid in developing personal resilience strategies. Keeping an open and flexible outlook and learning from past mistakes are positive ways to build resilience according to APA (2015). Spirituality and

religion have been investigated in previous research probing for answers to whether or not those who are affiliated spiritually or religiously have a better ability to bounce back after an adversity. Gebauer, Nehrlich, Sedikides, and Neberich (2012) found that religious people are better adjusted psychologically and better equipped emotionally to handle adversity in social situations, but only in those parts of the country where religion is held in high regards. Gebauer et al. explained that the benefits of being religious are determined by the societal value placed on religion itself in a particular culture. Those with spiritual or religious orientations tend to exhibit better mental health, increased self-esteem, and continued hope and belief even during distressing circumstance. They develop resilience by using moral compasses, and finding meaning to life and helpful solutions to life's most tragic events.

Lastly, the key word *protective factors* was used quite frequently in this study, as one of the objectives was to discover whether or not religion and spirituality can be deemed as a protective factor against suicide among African American women. Protective factors, when present, alleviate risk factors that may impede the health and well-being of an individual or group of people. Protective factors can be viewed as positive buffers that help manage and control dangerous or harmful outcomes in families, societies, and larger communities. By identifying protective factors and promoting awareness, resources are formed that can aid in prevention of any risks or hazards that may threaten the well-being of society as a whole.

# Research on Suicide

## Epidemiology and Theory of Suicide

Suicide is steadily increasing at an alarming rate in the United States, which in turn is causing a public health concern. According to Nooraddini (2013), every 40 seconds another person commits suicide. Presently, suicide is the 11th leading cause of death in the United States (CDC, 2011), and it is reported that 11.1 out of every 100,000 people have succumbed to death by suicide (WHO, 2011). Suicide rates have gone up by 36% over the last 2 years and are rapidly climbing (Nooraddini, 2013). It is predicted that by the year 2020, the rate of suicide related deaths will increase to 1 every 20 seconds (Befrienders, 2009). Furthermore, it has been estimated that for every one successful suicide, there are 8 to 25 suicide attempts that were not completed (MedicineNet, 2011). According to the 2012 Fact Sheet on Suicide generated by the National Center for Injury Prevention and Division of Violence Prevention and published by the CDC (2012), during 2008 and 2009, an estimated 8.3 million adults reported having suicidal thoughts, 2.2 million reported having made suicide plans, and an estimated 1 million reported making a suicide attempt. In 2009 alone, the number of suicide related deaths superseded the number of deaths from motor vehicle crashes in the United States (Rocket, 2012). Based on reports from the National Center for Injury Prevention and Control (2012), in 2011, 487, 700 individuals were reported as being treated at a hospital emergency facility for self-inflicted injuries. There is an estimated 600,000 suicide attempts, referred to as parasuicides, per year in the United States, suggesting that there are more attempts made than completions. Because of these

concerning numbers of suicidal thoughts, ideations, suicide attempts, and completions, the need for treatment and preventative measures are being greatly emphasized.

Historically, suicide prevention efforts have focused mainly on youths and older adults. However, recent evidence has suggested that there has been a substantial increase in suicide rates among middle-aged adults in the United States (Baker, 2010). Over the last decade, in an attempt to further investigate trends in suicide rates among adults aged 35 to 64 years, the CDC analyzed National Vital Statistics System mortality data from 1999 to 2010. As part of the investigation into the trends, the CDC used such demographics as sex, age group, race/ethnicity, state and region of residence, and mechanism of suicide to compare suicide rates (CDC, 2010). The analytical results yielded information showed that the annual, age-adjusted suicide rate among persons aged 35 to 64 years had increased by 28.4%, from 13.7 per 100,000 population in 1999 to 17.6 in 2010 (CDC, 2010). Suicide is the second leading cause of death among those between the ages of 25 to 34, fourth among those aged 35 to 54, and eighth among those 55 to 64 (CDC, 2012).

According to the racial and ethnic disparity findings reported by the CDC, in 2010, 2,144 African Americans completed suicide in the United States. Of these, 1,755 (81.8%) were males (rate of 9.10 per 100,000). The suicide rate for females was 1.79 per 100,000 (CDC, 2010). The overall rate was 5.19 per 100,000. Also, in 2010, there were 389 African American female suicides (CDC, 2010). The ratio of African American male to female was 4.9 to 1 (CDC, 2010). The suicide rate among African American females was the lowest of all racial/gender groups (CDC, 2010). As with all racial

groups, African American females were more likely than males to attempt suicide and African American males were more likely to die by suicide (CDC, 2010). From 1993 to 2002, the rate of suicide for African Americans (all ages) showed a small but steady decline (CDC, 2010). In 2002, the rate has remained fairly flat, varying only between 4.9 and 5.2 per 100,000 annually (CDC, 2010). Though the statistics for African American suicide rates were the lowest, there is still enough evidence in the findings to suggest that there is a need for suicide preventive measures directed toward middle-aged populations and African Americans as the rates are on the incline. However, many of the figures that provide a count of suicides may be ambiguous, considering there are some intentional deaths that may be misclassified as an accident. For example, in a single car crash, although it may be considered an accidental traffic fatality, it is also possible, and not to be ruled out, that the person could have intentionally crashed their vehicle, which would actually be a suicide. In such events, we the possibility of suicide cannot be ruled out.

**Suicide models.** Edwin Shneidman, an eminent suicidologist, suggests that deaths are classified as natural, accidental, suicide, or a homicide (NASH) (Shneidman, 1973). He also defines suicide as being a self-inflicted intentional death in which an individual engages in an intentional, direct, and conscious effort to end one's own life. According to Shneidman, there are four different kinds of suicide seekers. These four types of suicide include, death seekers, death initiators, death ignorers and death darers. Death Seekers are those individuals who intend to end their lives. Death Initiators are those individuals that intend to end their lives because they believe that the process of death is already underway. Death Ignorers are those individuals who do not believe that their self-

inflicted death will mean the end of their existence. Death Darers are those individuals that have ambivalent feelings about death and show this in the act itself.

Shneidman classifies deaths that are unclear and deaths where individuals engage in hidden, partial, indirect, or unconscious roles in their own death, as being a "subintentional death" (Shneidman, 1973).

According to Emile Durkheim (Durkheim, 1897), there are three different types of suicide: anomic suicide, altruistic suicide, and egoistic suicide. Durkheim describes anomic suicide as suicide that results when people experience "disintegrating forces" in society which makes them feel alienated or lost. Those children or teenagers that have been sexually abused, bullied, or ostracized in some fashion are usually those that commit anomic suicide. Altruistic suicide is the result of an individual subjecting themselves to collective expectations which results in death. Durkheim describes altruistic suicide as happening when there is an excessive regulation of individuals by social forces (Anderson, 2009). An example of altruistic suicide is what is known in this day and time as a "suicide bomber". Durkheim explains that egoistic suicide occurs when a person is totally detached from society. People that commit egoistic suicide are those who have lost or have weakened bonds with and between those things that they use to engage in socially such as their families, community, jobs, and any other social bonds. According to Durkheim, the most susceptible to egoistic suicide are elderly people that either have no surviving family and friend, feel useless after retirement, or are consumed by the feeling of being worthless or a burden to others.

The one main challenge, for researchers who study completed suicide, is that their subjects are deceased, leaving them to ultimately strive to get answers to explain the phenomena by doing retrospective analysis and studying those individuals that attempted suicide but were not successful. There is a multitude of documentaries and research discussing and exploring the lives of suicide attempters and survivors, such as a 2006 documentary film by Eric Steel, entitled “The Bridge”. “The Bridge” was a documentary that captured the suicide of many jumpers from the San Francisco’s Golden Gate Bridge. The documentary presented interviews with the members of those that had jumped off the bridge and committed suicide. The documentary also featured interviews with the friends of some of those that jumped to their deaths. This documentary captured the jump of one individual that actually survived the jump. This jumper realized after he had taken the plunge that he no longer wanted to die. This attempter’s name was Kevin Hines, who despite his deliberate jump, was saved by a black seal that was swimming in the area beneath where he had jumped (Steel, 2006). According to the documentary, during their research project at The Bridge, there were other lives saved, by confronting and talking with the would be jumpers, and even grabbing onto the attempters and pulling them back to safety (Steel, 2006).

Media reports that there are known suicide attempts that have occurred among some of the most prominent and influential African American women celebrities such as Oprah Winfrey, Tina Turner, Donna Summers, Halle Barry, and Fantasia Barino to name a few (Anthony, 2013; Butler, 2015).

Oprah Winfrey, a popular talk show mogul, actress, and owner of her own television network, has been noted for overcoming the stereotypical constraints and economic disparities among African American women. But her past is not one without blemishes. Winfrey went through a time in her life when things were bleak (Anthony, 2013). Pregnant, at the age of 14-years-old, Winfrey tried to commit suicide by drinking a bottle of laundry detergent due to her fear of her father finding out about her pregnancy. Although Winfrey's baby died shortly after birth, she sees it as a blessing in disguise (Anthony, 2013). "When the baby died, I knew that it was my second chance," she said (Anthony, 2013).

In 1968, right before a show and after a fight with her husband, Tina Turner attempted to take her own life by swallowing 50 Valiums (Butler, 2015). In 1979, Donna Summer was found by a hotel maid on the ledge of her hotel room's window. According to Butler (2015), Summer confessed in 2003, "I wasn't getting a feel. I was jumping over. I was attempting to go. I didn't plan it. I just decided, I'm out of here." According to Butler's (2015) report, the maid finding her is what caused her to reconsider. Summer stated: "Then I sought help. I got help. I realized that I had a serious problem with depression, and I went to a doctor and he gave me some medication" (Butler, 2015).

Halle Berry, the "Most Beautiful Woman" as reported by a popular magazine encountered a period within her life that she felt she no longer wanted to live (Anthony, 2013; Butler, 2015). After a failed marriage to professional baseball player David Justice finally ended in divorce, Berry admitted to trying to kill herself by locking herself in the garage and turning on the car in an attempt to die from carbon monoxide poisoning

(Anthony, 2015). However, she claimed to have changed her mind when she suddenly had a mental picture of her mother finding her dead body (Anthony, 2013). Berry told *the magazine editor,* “I was sitting in my car, and I knew the gas was coming when I had an image of my mother finding me” (Butler, 2015). Berry explained that the image of her mother finding her is what saved her and she stated: “She sacrificed so much for her children, and to end my life would be an incredibly selfish thing to do. It was all about a relationship. My sense of worth was so low. I promised myself I would never be a coward again” (Butler, 2015).

After winning the third season of a popular television singing competition, Fantasia Barrino, encountered some personal life struggles that led her to take an overdose of pills (Anthony, 2015). “I lost a lot of things. I lost a lot of friends, a lot of family. I lost a lot of money. I’m not sad about any of that and I wouldn’t change any of it because it made me the woman that I am today. It made me smarter and wiser,” Barrino said (Anthony, 2013).

Hawton (2001) suggests that the study of nearly lethal suicide attempts provide a significant benefit to research in the area of suicidal tendencies and behaviors. Hawton (2001) states that much of the prior research on suicidal behavior was reduced to the psychological autopsy approach in which researchers relied heavily on the information gathered from detailed records kept on the individual who committed suicide and those people that knew the suicide victim very well. These types of studies have proved to be relatively informative and widely used in many areas of the world to help explain the characteristics and sociodemographics of suicides (Hawton, 2001). Prior studies of

suicide, using the psychological autopsy approach, have also provided great detail into the methods of suicides used, the life events and tragedies leading up to and surrounding the suicide, as well as the mental capacity and psychological disorders and healthcare provided to suicide victims prior to their death (Hawton, 2001). Though this type of research was informative, it still lacked the ability to provide information on a more personal basis, in regards to the victim, and it was also limited due to its biased nature of the informants' recall of details, and their distorted views of the problems and livelihood of those victims they claim to have known. However, studying attempters and those who have contemplated suicide, provides personal insight, experiences, and views into what type of behaviors or social problems that preceded their attempts. The current research proposal, which involves studying those that have contemplated suicide can be deemed as critical and very fruitful in identifying those at risk for suicide, as well as provide measures for suicide awareness and prevention.

**Previous research.** The goal of this research is to find out if spirituality or other reasons for living have an effect on suicidal ideations. According to Clarke, Bannon, & Denihan (2003), many studies have proven that religion and spirituality have an inverse relationship with suicide and that positive spirituality is associated with lower suicidal ideation (Baetz & Bowen, 2010). It is suggested that through therapy which includes motivational change-talk and the reinforcement of positive spirituality, mental health is improved in the area of emotion regulation (Emmons, 2005). With improved emotion regulations such as coping mechanisms for stress (Pargament, Koenig, Tarakeshwar, & Hahn, 2004), managing hyper-arousal for anger (Harris, Luskin, Norman, Standard,

Bruning, Evans, et. Al., 2006), and low-arousal techniques (i.e. prayer and meditation (Watts, 2007), suicidal ideations can be lowered resulting in lower suicide attempts and completions.

Kaslow, Price, Wyckoff, Grall, Sherry, and Young (2004), performed a study that compared person risk factors among low-income, African American adults in a public hospital. Kaslow et al. (2004) compared groups of (1) suicide attempters and nonattempters, and (2) male and female attempters. They further divided those groups up into 50 female attempters, 50 female nonattempters, 50 male attempters, and 50 male nonattempters. In a study by Kaslow et. al (2004), ethnic identity, aggression, psychological distress, substance abuse, religiosity/spirituality, and cognitive process measures were completed by the participants. The study found that those who have attempted suicide, compared to nonattempters, had more reports of maladaptive coping strategies, psychological distress, substance use, and aggression, and had lower levels of ethnic identity and less association with religiosity and spirituality. The importance of this study as it relates to the current study, is to confirm that there is empirical evidence that proves that there is a positive link between religious involvement, spiritual well-being and suicidal behavior among African Americans. In Kaslow et. al's (2004) study, it is suggested that the protective role of both religious involvement and spiritual well-being is consistent with prior studies (Early, 1992: Neeleman, Wessley, & Lewis, 1998) that examined the link between church involvement, spirituality, religiosity, and suicidal behavior in the African American community.

In other studies conducted by King, Hampton, Bernstein, and Schichor (1996), it was found that college students who were affiliated with an organized religion were less accepting of suicide and of those that were less accepting were also avid church goers. In support of Neeleman, Wessely, and Lewis (1998), Stack (1998) found, after examining data gathered among European Americans and African American participants between 1974 and 1994 on suicide acceptability, that church attendance lowered suicide risk among African American men and women. Furthermore, Ellison, Burr, and McCall (1997) found that the protective factors against suicidal behaviors are strongest in areas of the United States with more religious homogeneity, such as in metropolitan locales in the Northeast and in the South, where there is a higher population of African Americans. Previous research literature suggests that although many of the studies performed have found that there is a link between religiosity/religious behaviors and the reduced risks of suicidal behavior and suicide acceptability, there is also evidence found by a study performed by Ellison, Burr, and McCall (1997), that there are certain aspects of religiosity, such as social support and networking, that are also components of religion that form protective barriers against African American suicide attempts (Griffin-Fennell & Williams, 2006).

One article, written by Street, Jones, Taha, Jones, Carr, Woods, Woodhall, & Kaslow (2012) discussed how a recent study was conducted to investigate racial identity and reasons for living among African American females who have attempted to commit suicide. In this article it mentions risk factors as well as protective factors such as "hopefulness, self-efficacy, coping skills, high levels of social support and effectiveness

in obtaining resources" (Street, Jones, Taha, et al., 2012), as reasons why the suicide rate among African Americans may be lower than other ethnic groups but there needs to be more research in this area. This research was based on an inventory given to 82 women between the ages of 18-64, who had attempted suicide in the prior year. The inventory used was the Multidimensional Inventory of Black Identity. The subjects were recruited from a public hospital serving at risk populations. However, it was also mentioned that there are other potential key protective factors that may be worth further investigation such as family social support, spiritual well-being and religiosity, and optimism due to evidence that they may also play a role in the low rates of African American suicide rates.

Yet, another groundbreaking sociological case study conducted by Emile Durkheim in 1897, compared the difference between suicide among Protestants and Catholics. Durkheim's study argued that lower suicide rates are a result of stronger social control among Catholics (Durkheim, 1897). In that same study, Durkheim made several other arguments, such as the rate of suicide among men is higher than the suicide rate among women, higher for single people than for married people, higher for those without kids than with kids, higher among military soldiers than civilians. Interestingly so, Durkheim also argued that suicide is higher during the times of peace than in times of war (Durkheim, 1897). More importantly, Durkheim suggested that many of the causes of suicide stemmed from social factors and not due to individual personalities. He proposed that suicide is linked more to sociological factors rather than being caused by emotional stress (Durkheim, 1897). Durkheim examined to what extent people feel

engaged in the structure of society, as well as their social surroundings as social factors that cause suicide. Based on this concept, Durkheim argued that different social contexts in which people emerge affects suicide rates.

In a more recent study, Eytan (2011) conducted a review of the literature to explore the topic of religion and mental health during incarceration. Incarceration is a situation that leads to extreme distress and even suicide. Eytan reported estimates are that there are around 9.8 million people incarcerated in penal institutions worldwide and nearly half of these are in the United States, China, or Russia. The United States has one of the highest prison population rates worldwide with 750 per 100,000 of the population incarcerated. The populations and policies differ by country and in some institutions, prisoners experience torture and extended sentences. These factors all impact the mental health of the prisoners.

Eytan (2011) reported that compared to the general population, prisoners demonstrate higher rates of mental disorders, with one in seven prisoners in Western countries demonstrating major depression or psychotic illnesses. Suicide is prevalent in jails and prisons in several countries. Rates of suicide among male prisoners are up to eight or fourteen times higher than found in the general population. This suicide is correlated with hopelessness and a lack of coping strategies and support. Prisoners are denied social networks and social support needed to deal with mental suffering. Spiritual support is a type of support needed by this population, but there is a lack of data regarding the impact of this support.

Eytan (2011) conducted a review of the literature to examine studies of religion and spirituality as a coping resources needed to face stressful life events. Religion and spirituality are linked to more positive outcomes among people with mental disorders. Eytan specifically examined studies of the association between religion and spirituality and the mental health of detainees. Quantitative and qualitative studies were reviewed. The review included 12 empirical studies with a total sample of 4,823 individuals. Findings were that religion and spirituality was related to lower frequency and severity of depressive episodes. Religion and spirituality in prisons was related to reduced incidents and disciplinary sanctions. Eytan reported further that more studies are needed to explore the impact of religion and spirituality on suicide among detainees and other populations.

Milner, Hjelmeland, Arensman, and De Leo (2013) reported that social-environmental factors are related to suicide mortality. These authors conducted a narrative review of more than 200 articles over a ten-year period, related to this topic. Milner et al. noted that suicide mortality is related to social, economic, and cultural factors. Thus, Milner et al. sought to examine the research on these relationships. Specific areas reviewed included: "the economy and income, unemployment, relationship status, fertility and birth rates, female participation in the workforce, religion, migration, location of residence, modernisation, media reporting, alcohol, and access to suicide methods" (p. 137).

Milner et al. (2013) reported findings that suicide mortality rates were related to multiple social factors. For example, divorce and unemployment were related to suicide mortality. However, relationships between suicide mortality and other social variables of

fertility, female participation in the workforce, and religion, were influenced by time and contextual factors. Specifically, Milner et al. (2013) reported that the studies of the relationship between suicide and religion demonstrated a negative link. This outcome was found whether the relationship was assessed indirectly or directly. For example, if assessed indirectly using factors such as "religious book production, proportion of a specific religion in the population," or "ordained clergy rate" (p. 141), there was a negative relationship between these religious factors and suicide. When religion was assess more directly with factors such as "church adherence, active membership in a religious group," or "strength of religious beliefs in society" (p. 141), there was also a negative relationship between these religious factors and suicide.

Milner et al. (2013) also reported findings that consistent with other ecological factors found to be relevant to suicide, the association between religion and suicide was influenced by gender and age, cultural contexts, and changing societal contexts and norms. For example, religion is linked with factors of strong affiliations and positive values, and strong family traditions that may protect against suicide. Milner et al. offered an explanation of how factors of strong faith and traditions can protect against suicide. These authors reported that there are higher male suicide rates in Protestant regions such as in Rio Grande do Sul. This finding may be due to the lower levels of integration and social cohesion found in Protestant societies, compared to Catholic societies. However, age is also a factor, regardless of religion. For example, elderly people in traditional Catholic or Orthodox locations have higher suicide rates, compared to those located in less traditional states. It may also be that strong religious affiliations result in a greater

negative attitude toward suicide which may result in a lack of reporting of this act. Thus, Milner et al. concluded that it is important to consider the relationship between all social factors as they are related to suicide.

While Milner et al. (2013) presented literature findings, they also discussed potential explanations for findings. These opinions may represent biased views even though supported by additional literature results. However, while limited, this study of the topic did reveal that religion is a factor that is potentially related to suicide. Thus, more information is needed to understand the influence of this factor in different social and other life contexts.

In past literature, many researchers mention the need to study African American Women within their own group in order to provide research that does not typically follow the patterns of past studies and they also pointed out that there are missing links that could provide some more possible information into the phenomenon, such as things like spirituality, family relationships, support groups and hopefulness (Chance, Kaslow, Summerville, & Wood, 1998).

## Common Themes of Research

In review of all the previous literature, there seems to be a common theme that suggests that religion and spirituality are linked to decreased rates of mental illness, as well as a decreased rate of suicide in those with religious affiliations or spiritual beliefs (Rasic, Belik, Elias, Katz, Enns, & Sareen, 2009). Furthermore, as described by Rasic et al. (2009), the association between suicidal behaviors in people, both diagnosed and undiagnosed with mental illness, and religion and spirituality are still understudied.

**The need for qualitative research on suicide.** Much of the previous research in the United States of America on suicidal behavior and spirituality has been quantitative approaches, conducted on Nonminority men and Nonminority women in regards to suicide and suicidal ideations which signifies a gap in literature that highlights qualitative research on African Americans (Chance, Kaslow, Summerville, & Wood, 1998). Wray, Colen, and Pescosolido (2011) study *Sociology of Suicide* analyzed over 41 articles from the past century, and noticed a tremendous gap in the current literature on suicide. More specifically, most, if not all, research has been geared toward a quantitative analysis. Though quantitative statistical numbers are provided in the CDC (2010) reports, very little is known or shared about those individual statistics and whether or not those 389 African American women in the report that committed suicide, had any known mental health issues. This lack of qualitative information, along with the idea that suicide and having suicidal ideations in the African American community is being swept under the rug within its own in-group, leads to the question of whether or not the concern is taken serious.

As explained in this literature review, though there is an abundance of information on suicide, most, if not all of it, is either from statisticians using nomothetic research and data, and none of the literature fully examines the relationship between suicide, spirituality and African American Women's reasons for living (Henry, 2012), or person-centered qualitative data gathered by psychologists. Little research has attempted to provide firsthand accounts of suicide. Moreover, measurements of suicidal

circumstances have been highly criticized (Rockett, 2010). Statistical data sets have come to represent the classical and contemporary views on suicide.

There has been some research carried out on African American women's reasons for living in regards to racial identity and suicide, but much of the research was explored in comparison to other ethnic groups, mainly European American women (Street, Jones, Taha, Jones, Carr, Woods, Woodhall, & Kaslow, 2012). Furthermore, several protective factors have been considered and looked at in the past as showing evidence of being reasons for the low suicide rates among African American women, but have not been thoroughly explored or examined further. Researchers have not performed qualitative research or presented evidence-based proof that positive association with religion and spirituality have any bearings on whether or not African American women attempt suicide or that it deters them altogether in some cases. There is little to no qualitative research that suggests that religion, religious beliefs, and spirituality play a major role in the thought process of African American women when having suicidal ideations. Furthermore, there is limited research that suggests that spirituality and religion are part of the reason why African American women have the lowest suicide rate among all ethnic and gender groups.

Because this information was not thoroughly examined and is possibly dated, Chance, Kaslow, Summerville, & Wood (1998) suggest that it is worth looking into some of these mentioned protective factors, such as religion and spirituality to see if there is any strong evidence that suggest that these reasons for living can explain the lower rates

of completed suicide among the African American Women ethnic group in future research.

More importantly, there is an overwhelming need for more research on this studies area of interest to provide updated information on the impact religion/spirituality plays when African American women are contemplating suicide. By exploring the importance or impact of spirituality when having suicidal ideations, the findings and research results may be used to increase awareness about suicide, as well as be used to develop preventive measures, for not only African American women, but for all who are at risk of suicide. Further examination of African American women and their beliefs, opinions, attitudes, and self-reports in regards to spirituality and suicide, may offer new explanations that either affirm or deny previous implications that African American Women are less likely to seek mental health services or self-awareness on topics such as suicide prevention (Larson & Larson, 2003).

**Suicide Risk Factors**

Suicide is often linked to depression, but can also be the result of other mental disorders. In many cases of suicide there are no diagnosed mental disorders, and there are usually no clear indicators that the suicide was a possible result of a mental disorder. According to the American Foundation for Suicide Prevention (2010), psychiatric disorders, past suicide attempts, symptom risk factors, sociodemographic risk factors, and environmental risk factors should all be taken into consideration when assessing those prone to suicidal behavior. As previously mentioned, depression, both major and bipolar depression constitutes a psychiatric disorder that poses as a risk for suicide. Other

psychiatric disorders include, but are not limited to, drug or alcohol abuse and dependence, eating disorders, post-traumatic stress disorder, antisocial personality disorder, borderline personality disorder, and schizophrenia (AFSP, 2015). It should be noted that when depression is accompanied by alcohol and/or drug abuse, the suicide risk is heightened.

Past suicide attempts are considered a possible alert of someone at risk for suicide. Research shows that one percent per year, of all attempters seen at an emergency room, takes their own life and approximately 10 percent of those attempters take their own lives within 10 years after their attempt (AFSP, 2015; Jenkins et al., 2002). In a research study, conducted by Carter et al. (2007), it was found that after following attempters for 22 years, seven percent died by suicide.

There are certain symptom related risk factors that should be considered in assessing suicide risks as well. These symptoms include desperation, hopelessness, anxiety and panic attacks, recent hospitalization for depression, any psychotic symptoms, and signs of whether or not the individual has made or rehearsed plans for a serious suicide attempt during previous episodes (AFSP, 2015). Other symptoms to consider are any major or recent physical illness, family history of death by suicide, chronic physical pain, and history of any sort of childhood abuse, bullying, or trauma.

Many of the common sociodemographic risk factors mentioned by the AFSP (2015) are narrowly tailored and limited to research based on general population demographics. These sociodemographics risk factors include the individual being a male, Caucasian American, over the age of 45-64, living alone, separated, widowed, divorced,

unemployed, retired, and engage in healthcare-related occupations (i.e. social worker, psychiatry, dentists, doctors, nurses). It was also noted that suicide risks are higher among women physicians (AFSP, 2015).

Notable environmental risk factors include a local cluster of suicides among social groups that have a contagious influence, and easy access to lethal weapons and drugs used to commit suicide (AFSP, 2015).

**Mental health and suicide.** As previously mentioned, suicide is often linked to depression, but can also be the result of other mental disorders and other factors. Riihimäki, Vuorilehto, Melartin, Haukka, and Isometsä (2014) reported on the incidence and predictors of suicide attempts in patients with depressive disorders. Findings from a five-year prospective study, the Vantaa Primary Care Depression Study, were reported. This study included an original stratified random sample of 1119 patients of whom, 137 patients were diagnosed with a DSM-IV depressive disorder. Only 82% of patients completed the 5-year follow-up and life charts were used to gather data. Findings were that there were 22 suicide attempts by 10.4% of the patients. Of these, risk of suicidal acts were mostly found among those with Major Depressive Episodes, with or without active substance abuse. Thus, major depressive episodes is a major risk factor linked to suicide.

Zhang and Li (2013) reported that hopelessness is a mediating factor in the link between depression and suicide. These authors hypothesized that the relationship between depression and suicide would decrease if hopelessness is controlled for. This hopelessness can be due to psychological strains resulting from social structure and

individual characteristics. These authors conducted a case-control psychological autopsy study, with face-to-face interviews with proxy informants for the suicide victims and with living subjects. The sample was related to 392 rural Chinese people, ages 15-34 years who died of suicide and a group of 416 living controls. The authors found a strong relationship between major depression and suicide after adjusting for socio-demographic characteristics. Hopelessness decreased the depression-suicide relationship. Zhang and Li concluded that while depression may be a risk factor for suicide, hopelessness due to psychological strains, social structure, and life events can be a protective or facilitating factor.

Uebelacker, Weisberg, Millman, Yen, and Keller (2013) studied suicidal risk factors in people with anxiety disorders. Anxiety disorders increase the risk for suicide attempts but predictors of increased risk among these individuals are unclear. The authors studied factors of physical health, co-morbid psychiatric disorders, and work or social functioning factors to determine their predictive ability for increased risk of suicide attempts among 676 individuals with anxiety disorders. A prospective study was conducted and participants were followed for an average of 12 years. Uebelacker et al. found that major depressive disorder, intermittent depressive disorder, post-traumatic stress disorder, pain, epilepsy, and poor work and social functioning were all predictors of suicide attempts. The authors concluded that mood disorders and past history of suicide attempts are the strongest predictors of a suicide attempt in those with an anxiety disorder.

Clements, Morriss, Jones, Peters, Roberts, and Kapur (2013) reported on bipolar disorder as a risk factor in suicide behavior. For this study a national English sample was included from data collected by the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. Suicide cases in those with a primary diagnosis of bipolar disorder were compared to cases in those with other diagnoses. The authors found that 1489 individuals with bipolar disorder died due to suicide and this was a rate of around 116 cases each year. Bipolar disorder patients who died from suicide, compared to those with other disorders: tended to be female, with over five years post-diagnosis and over five in-patient admissions; tended to be current or recent in-patients; and had depressive symptoms. The most common co-morbid diagnoses for those with bipolar disorder, were personality disorder and alcohol dependence. Of those who committed suicide, 40% were not prescribed mood stabilizers at the time and over 60% were in contact with services the week prior and were assessed as low risk for suicide. Clements et al. concluded that since there are high rates of suicide in bipolar disorder patients as well as low estimates of this risk, health professionals must understand this actual risk. Risk factors such as personality disorder, depression, alcohol dependence/misuse, and current or recent in-patient admission need to be understood and identified in this high-risk for suicide group.

Isometsä (2014) reported that one-half to two-thirds of suicides are found among those with mood disorders and it is important to understand suicide risk factors for prevention of suicide. This author reviewed related literature and found that lifetime risk of completed suicide among psychiatric patients diagnosed with mood disorders is

between 5% and 6% and suicidal acts tend to take place during major depressive episodes or mixed illness episodes. Factors such as substance use and cluster B personality disorders increase suicide behavior risk during mood episodes. Other risk factors include hopelessness, impulsive-aggressive traits, childhood adversity, recent negative life events, and poor social support. Isometsä concluded that illness factors explain only some aspects of suicidal behavior. Illness factors include problems with controlling impulsive and aggressive responses, but there are predisposing early exposures and life situations that are risk factors related to suicidal behaviors (thinking, planning, and acts).

**Childhood factors and suicide.** Geoffroy, Gunnell, and Power (2014) reported that there are other factors that serve as risk factors for suicide, such as prenatal and childhood factors. These authors conducted a 50-year follow-up study of the 1958 British birth cohort study. Data were collected at birth and at age seven years and suicides were identified from death certificates. Findings from Multivariable Cox proportional hazard models were that there were 44 suicides in a sample of 12399 participants with complete data. Results showed that the strongest prenatal suicide risk factors were: birth order (increased risk in later-born children), young maternal age, and low birth weight. At seven years, the strongest suicide risk factors were externalizing problems for males and number of emotional problems (domestic problems, divorce, parental death, neglected appearance, institutional care, contact with social services, and bullying) with higher risk for those with three or more problems. The authors concluded that birth and seven year risk factors influence long-term suicide risk.

Hooven, Nurius, Logan-Greene, and Thompson (2012) reported that childhood exposure to violence impacts adult mental health and is a risk factor for suicide. This experience is a public health problem. Hooven et al. conducted a longitudinal study with 123 young adults who were first identified in adolescence as being at-risk for high school dropout. These individuals were assessed for effects of childhood victimization on emotional distress and risk for suicide. They were also assessed for adolescent risk and protective factors such as family dysfunction. Findings supported the hypothesis that higher levels of childhood victimization would be significantly related to mental health maladjustment in young adulthood. However, the authors also found that victimization predictors of adult emotional distress differed from predictors of adult risk for suicide. Thus, prevention and intervention methods must include a thorough assessment and understanding of the individual to include information about childhood and adolescent problems that are related to psychological well-being in adulthood.

**Low stress tolerance and suicide.** Anestis, Pennings, Lavender, Tull, and Gratz, (2013) reported that a risk factor for suicide is low distress tolerance. Anestis et al. noted that the relationship between emotion dysregulation and suicidal behavior may be direct, or indirect and mediated by certain factors. For example, multiple experiences with certain behaviors such as self-injury which may be found among those with heightened emotion dysregulation, can influence suicide risk. These authors extended existing research and investigated the mediating role of non-suicidal self-injury in the relationship between low distress tolerance (one aspect of emotion dysregulation) and suicidal behavior. This clear intent to die among a sample of 93 substance use disorder patients in

residential treatment was explored. Data were gathered with a structured interview that assessed past suicidal behavior, distress tolerance, and non-suicidal self-injury. The authors found support for the hypotheses that there was a significant indirect relationship between low distress tolerance and lifetime suicide attempts via frequency of non-suicidal self-injury. The authors concluded that exposure to painful events through the experience of non-suicidal self-injury may be a way that emotion dysregulation increases the risk for suicidal behaviors. Anestis et al. concluded that it may be that those with low distress tolerance are not able or willing to engage in suicidal behavior unless they have experienced enough pain and/or painful events that change their views of pain and fear of death. While the link between self-injury and suicide behavior was shown, the authors' explanation for this link requires further exploration and substantiation.

**Self-harm and suicide**. Miller, Hempstead, Nguyen, Barber, Rosenberg-Wohl and Azrael (2013) reported that the choice of nonfatal self-harm method is a predictor of subsequent episodes of self-harm as well as suicide. These authors investigated time-varying and time-invariant characteristics of these nonfatal intentional self-harm episodes to explore the relationship between these and subsequent episodes of self-harm and suicide. A follow-up cohort study was conducted through 2007 and included 3600 patients that were discharged from New Jersey hospitals in 2003, with a primary diagnosis of intentional self-harm. Data regarding repetition of self-harm from hospital records was obtained and data about suicide was obtained from state registers. Findings were that use of self-harm events with methods other than drug overdose and cutting, increased medical severity of nonfatal episodes, and history of multiple self-harm

episodes were factors that increased suicide risk. However, the authors also found that most of the suicides took place without these factors and without episodes of self-harm. Most suicide events involved the use of a low-lethality method such as cutting or drug overdose in initial attempts and a more lethal method in the fatal suicide episode. Thus, the authors concluded that to prevent suicide among those with a history of self-harm, it must be understood that these people are likely use a method with a higher fatality ratio than they used before to commit suicide.

**Multiple factors and suicide.** Crump, Sundquist, Sundquist, and Winkleby (2014) studied psychiatric, sociodemographic, and somatic suicide risk factors using a Swedish national cohort study. Crump et al. explained that to prevent suicide, it is important to fully understand these factors. Specifically, the authors used data from a national cohort study that included 7, 140, 589 Swedish adults who were followed for a period of eight years to assess suicide mortality from 2001 to 2008. National census data were used to identify sociodemographic factors and psychiatric and somatic disorders were identified using nationwide out-patient and in-patient diagnoses. Crump et al. found that 8721 (12%) of deaths from suicide took place during this period and psychiatric disorders were strong risk factors for women and men. Depression was the strongest risk factor (15-fold) for women or men and this risk was up to 32-fold for those within the first three months of a depression diagnosis. Other significant risk factors included asthma, stroke, chronic obstructive pulmonary disease, cancer, and spine disorders for women and men. Modest risk factors included diabetes and ischemic heart disease for men. Male sex, unmarried status, or non-employment were socio-demographic risk

factors for men and women and low education or income was a risk factor for men. Crump et al. concluded that all psychiatric disorders, as well as the other factors identified were independent risk factors for suicide in this sample. Thus, the authors concluded that prevention of suicide must include a multifaceted approach that targets mental physical health problems. Prevention must take place in psychiatric and primary care settings and include social support.

Pilver, Libby, and Hoff (2013) reported that premenstrual dysphoric disorder is a risk factor for suicidal behaviors. These authors noted that psychopathology has been established as a risk factor in non-fatal suicidal behavior but whether Premenstrual Dysphoric Disorder, specific to women, is related to these outcomes needs further study. Thus, these authors conducted a secondary data analysis of data from 3,965 American women ages 18 to 40 years. These women were participants in the Collaborative Psychiatric Epidemiology Survey. Findings from descriptive statistics and forward stepwise logistic regression modeling were that prevalence of non-fatal suicidal behaviors was increased by Premenstrual Dysphoric Disorder status. These women were more likely to report suicidal ideation than women without this disorder. However, demographic characteristics and psychiatric comorbidity influenced outcomes. Compared to women with no premenstrual symptoms, suicidal ideation was significantly elevated in women with moderate to severe premenstrual syndrome and Premenstrual Dysphoric Disorder was independently related to non-fatal suicidal behaviors in a nationally representative sample. Thus, the authors provided support for the conclusion that women with Premenstrual Dysphoric Disorder need to be evaluated for suicide risk.

**Suicide Protective Factors**

Pan, Chang, Lee, Chen, Liao, and Caine (2013) reported that a strong predictor of suicide is a previous attempt to kill oneself and attempters have 66 times more risk of suicide than the general population, for suicide during the year following an index attempt. This history of a prior suicide attempt is more of a risk factor for future fatal suicide attempts than having mental disorder is. These authors also noted that there is a lack of studies to support methods that can reduce these odds and prevent suicide. Pan et al. reported on a nationwide aftercare program designed to help suicide attempters. These authors noted that the effectiveness of this large-scale intervention must be determined. This program, called the National Suicide Surveillance System (NSSS), was implemented in 2006, in Taiwan. Pan et al. conducted a naturalistic study to determine program effectiveness based on data from the first three years of operation. A logistic/proportional odds mixture model was used to examine eventual suicide outcomes. The time until death for those who died and related suicide factors were explored.

Pan et al. (2013) reported findings that those who received aftercare services had a reduced risk for suicide. Regarding those who received the service and did commit suicide, there was a longer duration between the index and the fatal suicide attempt. Shorter duration between these attempts was found for elderly attempters. Higher risk factors also included male gender, lethality potential of the index attempt, and a history of a mental disorder. This study was limited by the use of an existing sample and program, which may not allow for the generalization of findings. However, Pan et al. concluded

that the NSSS structured aftercare program decreased suicides and also delayed time to death for those who were still at risk for suicide.

Caine (2013) reported on suicide prevention in the United States. Caine noted that suicide prevention is important since high rates of suicide continue, but this is a challenging task since there are many factors to consider. This prevention effort must include injury prevention methods as well as mental health views of common risk factors. Public health interventions must address the issue of population diversity and issues that contribute to suicide and attempted suicide. This author pointed out that preventive interventions must include strategies that focus on people and places, interpersonal factors, and social contexts in order to change the lives of people prior to them becoming suicidal. Prevention must target individuals in the middle years of age since these are at greater risk for suicide. This discussion was based on opinion supported by literature. However, Caine (2013) recommended that anyone trying to develop and implement a suicide prevention program must address such things as what are the broad goals and specific objectives of the intervention and the program, as well as where does the intended program fit, in an overall framework (i.e., mosaic, schema, model) of suicide prevention interventions. The program developer must decide who the intended targets are and who is expected to be reached with the program effort (Caine, 2013). According to Caine (2013) the program developer must give thought to who the program will be missing out on serving, as well as the types of changes the program is trying to seek for the population it serves. Suicide prevention programs should consider how it will measure those changes and use the information to rigorously evaluate and modify (or

disseminate or eliminate) the program as indicated, and; will these changes affect local, regional, and national suicide rates (Caine, 2013). Still other questions that Caine (2013) suggest the program be able to answer are, how confident is the program in its findings; can the program and its results be exported widely; and can the program be sustained after its ardent founders have moved on.

Caine (2013) reported that to date, there are no data to ensure or support the notion that public health suicide preventions will change the antecedents to suicide and lower suicide death rates. However, these approaches must include measures to ensure a safer community with less domestic abuse and trauma, reduce the misuse of substances, recognize and provide access to care for people with mental health issues, and to prevent school dropout or unemployment. If these measures are successful, benefits may include the saving of lives. Caine noted that lessons have been learned from the National Suicide Surveillance System (NSSS), such as the need for ongoing honest debate with vision, dedication, and energy. People with good intentions must continue to persist in the effort to develop a successful suicide prevention program.

Hatcher and Stubbersfield (2013) reviewed the literature to explore the concept of having a sense of belonging and related suicide. The authors reviewed 16 studies that investigated these factors. All of the studies provided support for the relationship between belonging and suicidality. However, most of the studies included nonclinical populations, and demonstrated weak associations without consideration for confounding factors. In fact, these studies demonstrated that a low sense of belonging had a weak relationship with suicidality. Hatcher and Stubbersfield reported that concepts studied

did not differentiate between loneliness and low sense of belonging and did not include measures of social support.

Hatcher and Stubbersfield (2013) reported that their review had limitations since it only included studies which used the English word "belonging" in the title or the abstract. The review was also limited by a focus on studies that examined the belonging concept and this focus did not include studies that may have considered this factor as a confounding variable or studies that explored related concepts such as loneliness. There was a lack of homogeneity in the study methods and populations which did not allow for a meta-analysis. Despite limitations, findings did support a weak link between belongingness and suicidiality. However, these authors pointed out that an alternative view of belongingness is needed to fully comprehend its impact on suicidiality. This belongingness may refer to a sense of connectedness to things as well as people, past and present. According to Hatcher and Stubbersfield, this view needs to be incorporated in the study of this factor as it relates to suicide and its prevention.

Kumar and George (2013) reported on the need for support and coping strategies to help prevent suicide. These authors noted that life events, coping strategies, social support, and quality of life are important factors related to attempted suicide. Kumar and George conducted a case-control study in India with the goal of comparing suicide attempters with matched normal controls to identify risk and protective factors related to suicide. The sample included 50 consecutive suicide attempters who were compared with matched controls for age, sex, and marital status. Findings from the Presumptive Stressful Life Events Scale, Social Support Questionnaire, AECOM Coping Style Scale,

and WHO QOL-Bref were used to match controls. Survey findings revealed that attempters reported significantly more undesirable life events compared to the control group. Attempters also reported significantly lower levels of social support, positive coping, and quality of life. Among all the factors studied, good education, desirable life events, and good social support served most to protect against suicide. While the study was limited by a small sample from India, Kumar and George concluded that suicide attempters differed from controls on all factors. Attempters found life to be more stressful and had lower levels of social support, poorer coping skills, and decreased quality of life. While one factor alone does not lead to suicide, there are protective factors that can help guard against suicide such as positive social support and a good education as well as positive life events.

**African Americans suicide risk and protective factors.** Trivedi, Morris, Wisniewski, Nierenberg, Gaynes, Kurian, and Rush (2013) explored sociodemographic and clinical factors related to suicidal ideation in a group of depressed outpatients. The authors analyzed data from 4041 treatment-seeking outpatients diagnosed with major depressive disorder. Baseline sociodemographic and clinical factors of those with and without suicidal ideation were compared and the presence or absence of depressive symptoms and psychiatric comorbidities in those with suicidal ideation was determined. The authors found that suicidal ideation was significantly related to sociodemographic factors of lower education level, gender, race/ethnicity (being Caucasian or African American), unemployment, and treatment in psychiatric care, and clinical features of young age of disorder onset, suicide attempt, increased depressive symptom severity and

numbers of depressive symptoms, and presence of agoraphobia and or generalized anxiety disorder. Increased suicide ideation levels at baseline were linked to decreased remission rates and increased depressive symptom severity. Trivedi et al. concluded that these findings support previous links between suicide ideation and panic and or phobic symptoms and anxiety. However, current study results were not consistent with previous conclusions that suicidal ideation was linked to alcohol or drug use and (or) dependence.

Gomez, Miranda, and Polanco (2011) reported that risk factors for suicide include acculturative stress and perceived discrimination. Thus, cultural factors can be related to suicidal behavior. Gomez et al. studied this notion to determine if acculturative stress and perceived discrimination were predictors of a suicide attempt in a sample of 969 ethnically diverse adults, ages 18 to 25 years. The sample consisted of mostly females (68%) who were Black, White, Asian, and Latino (US-born and non-US-born). Findings were that no statistically significant racial/ethnic differences were found to be related to a history of suicide attempts. Asian participants reported the highest degree of acculturative stress and Asian and Black participants reported higher levels of discrimination experienced during the previous year. Findings from logistic regression analyses were that familial acculturative stress was linked to two times higher odds of endorsing a past attempt of suicide for all. However, this two times higher odds were found among Asian participants. For other races, over four times higher odds was found among Black participants, and over three times higher odds was found among non-US-born White participants. Social acculturative stress was linked to over three times higher odds of a past suicide attempt for Latino participants. Overall, environmental

acculturative stress was related to decreased odds of a suicide attempt history. Perceived discrimination was linked to over five times higher odds of a suicide attempt overall, and specifically linked to over three times higher odds for Latino participants and over 10 times higher odds for White, US-born participants. Gomez et al. concluded that results support the need to consider culturally-related variables when identifying suicide risk factors and preventing and treating adults of diverse backgrounds for suicidal behavior.

Lincoln, Taylor, Chatters, and Joe (2012) studied suicide risk factors among African American and Caribbean black adults. Specifically, these authors studied factors of negative interaction with family members and emotional support as related to suicide. The authors used cross-sectional epidemiologic data from the National Survey of American Life. Multivariable logistic regression analyses were conducted with data from 3,570 African Americans and 1,621 Caribbean blacks ages 18 years and older. Lincoln et al. reported findings that perceived emotional support was related to decreased odds of suicide ideation and attempts for all participants. Negative family interaction was related to increased risk for suicide ideation among all participants. Ethnicity was a factor that influenced the impact of emotional support and negative family interaction on suicide attempts. For the Caribbean blacks, more frequent family emotional support was more related to increased reduced risk for suicide, compared to African Americans. The authors also found that the effect of negative family interaction on suicide attempts was increased for Caribbean blacks compared to African Americans. Lincoln et al. concluded that negative family interaction was a suicide ideation risk factor and family emotional support was a protective factor for suicide attempts and ideation. Findings were the same

after controlling for any mental disorder. The authors concluded the importance of social relationships as risk and protective suicide factors. The need to understand ethnic differences in suicidal ideation and attempts among African Americans was also made clear.

**African American women risk and protective factors.** Perry, Pullen, and Oser (2012) examined predictors of suicidal ideation in African American women. These authors stated that there is a lack of studies that have examined predictors of suicidal ideation in the African American female population. Thus, there is a lack of comprehension of culturally specific factors and psychosocial processes that are involved in suicide risk and protective factors for this population. Perry et al. explained that this lack of research is due to the lower rates of suicide for African Americans in the United States, compared to rates of suicide for whites. In addition, according to Perry et al., African American women, compared to all other subgroups, have the highest incidence of medically treated suicide attempts. This tendency supports the need to consider culturally specific factors that are related to suicidal ideation and behavior among these African American women. It is important to understand attitudes, values, behaviors, and risk and coping strategies specific to this group. Thus, these authors conducted a study with African American females. Specifically, psychosocial resources, gendered racism, and suicidal ideation were explored in a group of 204 mostly low socioeconomic status African American females. Perry et al. reported findings that risk for suicidal ideation in these women was linked to stressors due to social location based on gender and race. Gendered racism had no effect on suicidal ideation in those with moderate levels of well-

being, self-esteem, and active coping. However, gendered racism had a strong negative impact on those with high and low levels of psychosocial resources. This study was limited by the use of a sample that was not representative of the national population of African American females. For example, rates of marriages, college educated, and household income were lower than national averages for this study. In addition, all factors that might be related to the topic were not controlled for or studied. However, while limited, study results support the notion that African American women with higher levels of self-esteem and well-being that use active coping mechanisms are more protected from suicidal behaviors.

Not surprisingly, yet as quiet as it is kept, African American women do commit suicide and have thoughts of committing suicide, just as any other racial group. Evidence demonstrated by the American Foundation for Suicide Prevention (AFSP) in its report of the Center for Disease Control (CDC) data collected in 2010 supports this conclusion. According to reports and data collected, 389 African American Women committed suicide in 2010 (CDC, 2010).

Suicide among African American Women does not get very much media coverage, but there have been a few breakthrough incidents that made small media coverage such as LaShanda Armstrong (25 years old), who drove herself and her four children into the murky waters of the Hudson River in Newburgh, New York, in which the oldest son survived by swimming to safety through a cracked window; and, also Tonya Thomas (33 years old), of Port St. John, Florida, who shot and killed her four children, before turning the gun on herself and committing suicide. In each of these cases,

there is still the question of whether these two incidents were publicized due to the loss of the many innocent children, and whether the fact that an apparent suicide occurred as well. Were there warning signs, were there diagnosed and undiagnosed mental illness, what were the risk factors or protective factors in place for the mothers? It is these types of questions that further research can answer.

However, on a different note, does suicide only wreak havoc on the families of those African American women that are less known or unpopular? To answer that question, examine the tragic loss of popular African American singer, Phyllis Hyman. Phyllis Hyman overdosed at the age of 45 on pentobarbital and secobarbital, a few hours before she was to perform at the Apollo Theater. She was found in the bedroom of her New York City apartment with a suicide note. Below is an excerpt from the suicide note:

"I'm tired. I'm tired. Those of you that I love know who you are. May God bless you." (Hyman, 1995).

In the case of Phyllis Hyman, according to her biography, she reportedly endured a series of tragic events that included the deaths of a close friend, her mother, and her grandmother with a month's time in 1993, and was also battling with financial woes, alcohol abuse, depression, and bipolar disorder (R & B Haven, 2014). These combinations of struggles lead her to commit suicide by overdosing on sleeping pills and vodka, that day on June 30, 1995. She would have turned 46 the week. Was there something else that could have been done, more research, or available resources that could have prevented such a tragedy? Were any of these women religiously affiliated at all, did it even matter at the time of their contemplation of suicide?

**African American Women Views on Mental Health and Suicide**

For years, the attitude in the African American community has been that "black people do not kill themselves"; and that any problems that may surface among them, are things to be handled and prayed about in the church. This statement is supported by Amy Alexander, an African American female author that wrote the book "Lay My *Burdens Down".* "It is very much a misperception that black people don't commit suicide and that comes in part from a need the very real and legitimate need for black people for many years to be very strong," says Alexander (Gluck, 2008). According to Gluck (2008), Alexander teamed up with renowned Harvard psychiatrist Dr. Alvin Poussaint to dispel the thoughts, myths, and misperceptions of suicide among the African American community. "They see mental disorder and depression as a sign of personal weakness or moral failure," says psychiatrist Alvin Poussaint, M.D. of the Harvard Medical School (Gluck, 2008). Gluck (2008) reports that Poussaint contributes one reason African-Americans may not seek out professional help is due to the fact that only approximately 2.3% of all psychiatrists in the United States of America are African American.

Despite an increase in the rate of suicides among African Americans, Poussaint explains that the topic of suicide is still considered "taboo" (Gluck, 2008). Poussaint suggests that even though the discussion of suicide is shied away from in all cultures, the stigma is even stronger among the African American culture (Gluck, 2008). According to reports by Gluck (2008), Poussaint contributes this problem in part to the stigma being associated with depression. "More than 60 percent of black individuals don't see depression as a mental illness, which makes it unlikely they will seek help for it", said

Dr. Poussaint (Gluck, 2008). Poussaint further suggests that African Americans used blues music which was invented as a way to sing about their pain and daily distress. According to Poussaint's views, African Americans just consider life struggles as a part of life, and suggests that African Americans pride themselves on being strong after enduring years of discrimination and segregation and surviving 250 years of slavery (Gluck, 2008). Therefore, the African American community views depression as a sign of weakness (Gluck, 2008).

Many believe that family business and family secrets, should be kept within the family, and thought of sharing those things have always been shunned upon. Furthermore, often time family members were prayed over and many times hidden from society instead of being properly diagnosed and treated for mental illness. Yet today, there are still many of those attitudes and opinions that plague the beliefs and minds of African Americans, and many still hide the fact that they have family members that are not "bad seeds" or ailing from curses and multiple demonic spirits, but could possibly be suffering from undiagnosed mental disorders such as Post Traumatic Stress Disorders, Schizophrenia, or Multiple Personality Disorder.

According to a nationwide survey that was conducted by the Kaiser Family Foundation and the Washington Post (Washington Post, 2012 www.washintongpost.com/local/black-women), African American Women are among the nation's most religious groups. The survey revealed that 74 percent of African American Women compared to 70 percent of African American Men stated that "living a religious life" is very important. Based on the survey results, approximately 87 percent

of African American Women said that they turn to their faith to get them through tumultuous times (Washington Post, 2012). The survey revealed that African American Women, on varied education and income levels, stated that "living a religious life is a greater priority than being married or having children, and this call to faith either surpasses or pulls even with having a career as a life goal" (Washington Post, 2012).

Growing up in homes where the grandmothers and matriarchs have strong religious beliefs, and making sure that the family was not only engaged in regular attendance, but multiple attendances of several church functions, and sometimes daily worship, it would not be that far-fetched to understand the results of the Washington Post survey. It has been tradition in many African American homes and cultures to reverence "God the Almighty" as the Supreme Being above all, dating back to days of slavery when their African ancestors relied heavily on their religious faith and spirituality to lead, guide, and protect them (Washington Post, 2012). Many of the African forefather and mothers attribute their ability to withstand oppression, discrimination, racism; all while remaining dignified and non-violent, to their religious and spiritual beliefs (Washington Post, 2012).

"Black women have been the most mistreated and scandalized in U.S. society and culture as they wrestle both individually and collectively with the triple jeopardy of racism, sexism, and classism. If that is the case- and I believe it is – it is no wonder that black women, due to their experience of sexism, would seek out their faith as a way of finding relief, reprieve, resolution and redemption."(Floyd-Thomas, 2012, p. 63)

It is this personal relationship with God that African American women have that warrants research and investigation into how effective it is when it comes to suicidal ideations. Do this relationship with God and their religious beliefs prevent them from seeking mental health solutions and treatments are questions this research will aim to answer. Poussaint points out that the first step to getting and providing help is through public awareness (Gluck, 2008). "You can't prevent illness or suicide if you don't talk about it and gain some knowledge about it", says Poussaint (Gluck, 2008). Alexander explains the importance of culturally sensitive training and suggests that it is required as part of the standard mental healthcare education process. Based on Alexander's comments, she emphasizes that mental health problems can be treated through talk therapy or through psychopharmacology (Gluck, 2008).

**Relationship Between Religion, Spirituality, and Resilience**

Resilience is an aspect of positive psychology that has been defined as having "a positive adoption despite negative environmental influences" (Miller & MacIntosh, 1999, p. 159). According to Rutter (1993), both internal and external factors related to that person's exposure to turmoil and harsh environmental situations determines a person's ability to develop resilience. He also explains that the level of resilience a person develops depends on protective factors that have developed over the course of the individual's lifetime (Rutter, 1993).

Kallampally, Oakes, Lyons, Greer, & Gillespie (2007), postulates that religion, along with spirituality, provide strong resilient resources that people can draw strength and support from in order to cope with existential conflicts that may surface in life. There

has been a vast majority of theorists that linked religion and spirituality with resilience (Greene & Conrad, 2002).

In a study conducted by Long (2011), the relationship between religiousness/spirituality resilience was examined among three hundred seventy-five women and men. The participants were chosen from a university sample that completed the Brief Multidimensional Measure of Religiousness/Spirituality demographics questionnaire (Fetzer Institute/NIA, 1999), and the Resilience Scale (Wagnild & Young, 1993). Long's research hypotheses predicted that "increases in different dimensions of religiousness/spirituality would be related to increases in one's level of resilience" (Long, 2011). The results yielded evidence that suggests that such dimensions of religiousness/spirituality as positive coping, private religious practices, forgiveness, daily spiritual experiences, religious support, values/beliefs and overall self-ranking, were significantly related to resilience (Long, 2011). Further research is needed to explore the multidimensional nature of religiousness/spirituality and resilience among African American women.

African Americans struggle with many stressors that are presented by their environment. Many of the challenges and struggles are results of discrimination, racism, a lack of economic resources, and poverty (McLoyd, 1990). Based on their imminent struggles, it would be expected that most of them would succumb and be defeated by their challenges. Astonishingly, many of them are able to overcome their struggles and challenges, moving on with hope of better and more favorable outcomes. The role and importance of religion and spirituality among the African American community has been

studied from different points and perspectives throughout history. According to these research efforts, there is a commonality in the belief that spirituality and spiritual beliefs are what mold the lives of many African Americans (Mattis, Fontenot, Hatcher-Kay, Grayman, & Beale, 2004). Mattis, Fontenot, Hatcher-Kay, Grayman, & Beale (2004) came to the conclusion that "African Americans have cultivated particular traditions of Biblical interpretation that metaphorically link Black oppression to the oppression suffered by Biblical Israel. In their interpretative scheme, God is seen as the ultimate ally of the oppressed" (p. 191).

According to Boyd-Franklin (2010), spirituality is a protective factor in the African American community and serves as a powerful resource and strategy for survival. Spirituality and religion are also deemed as coping mechanism among African Americans for persevering through and rising above adversity, and for developing positive social bonds (Boyd-Franklin, 2010). It assists African American women in developing meaning to life's tragedies and hardships and coping life's challenges (Mattis, 2002). Spiritual well-being incorporates existential aspects, for example, meaning and purpose in life, as well as religious aspects which means a relationship with God (Paloutzian & Ellison, 1982). Among African Americans, existential and religious well-being combined, and independently, have been linked to positive adjustment (Douglas, Jiminez, Lin, & Frisman, 2008; Kaslow et al., 2002; Mitchell et al., 2006; Watlington & Murphy, 2006). Existential well-being has been associated with better quality of life (Dalmida, Holstad, Dilorio, & Laderman, 2011).

Brown and Gary (1987) found a gender difference in the stress buffering effects of religious activity on physical health. Among African American men, there was no relationship present; higher levels of life stress was associated with poorer health among moderately religious African American women; among those African American women who were less religious, stress and health were unrelated. The authors explained that African American women had tendencies to increase their religious participation in order to cope with stressful situations and concomitant personal and family health challenges (Brown & Gary, 1987). These findings suggest that the unique contributions of existential and religious well-being should be investigated in the context of risk and protective models (Levin, Chatters, L. & Taylor, 2005).

Overall, based on the extensive research findings that suggest that religion and spirituality is associated with promoting positive mental health and physical well-being (Taylor, Ellison, Chatter, Levin, & Lincoln, 2000), it is also worth noting that, although limited, research findings further suggest that religion and spirituality shapes cognitive appraisals and meanings that we associate with, or attach to our life's challenges (Mattis, 2002).

Robinson (2001) explains that a recent study published in *The American Journal of Psychiatry* claims that having a religious affiliation is directly associated with a significantly lower level of suicide as compared to not having any religious affiliation, such as with atheists and agnostics. Protestants are suggested as having the highest suicide rate among the most common faith groups in the U.S., followed by Roman Catholics, and with Jews having the lowest rate. Ironically, those who follow religious

groups that strongly prohibit suicide, such as Islam and Christianity, have a higher suicide rate than religions, like Hinduism and Buddhism, which have no strong prohibitions about suicide (Robinson, 2001). During the review of literature for this study, there was limited information that presented narrowly tailored statistics showing the rate of suicides among African Americans in the different religious groups mentioned.

**Implications of Religion and Spirituality on Seeking Help**

Based on a qualitative research effort carried out by Mayers, Leavey, Vallianatou, & Barker (2007), that explored the experience of helping-seeking and therapy among 10 of their "in treatment" clients with religious and spiritual beliefs, the experience of being in psychological distress and seeking therapeutic help were both viewed as a way of strengthening the clients faith and ultimately viewed as being part of their spiritual journey. However, prior to seeking help through therapy, the participants reported that there was a fear of their faith being weakened if they engaged in secular-based therapy and help with those psychological problems they were encountering (Mayers et al., 2007). The participants also reported that they heavily relied on their spiritual and religious beliefs before and during the therapy to help them to cope with their psychological problems. The conceptual framework of this qualitative study used an Interpretive Phenomenological Analysis (IPA), which is a systematic method for conducting qualitative research in health psychology and related areas (Smith & Osborn, 2003). The IPA approach is beneficial in capturing the perceptions of the participants, using interview guides, much like the interview guides used in this current study.

In the African American community, seeking help for social and psychological problems does not seem to be as main stream or culturally accepted as it is for other cultural group (Larson & Larson, 2003). African American women and men alike are taught to "mind your own business" in many cases. However, in lieu of the recent increase in African American suicide rates, this may be a teaching that needs to be revisited and reconsidered. Research shows that the number of African Americans that take advantage of mental health counseling is very low compared to other ethnic groups (Larson & Larson, 2003). This being a fact, the other alternative to keeping daily stressors and problems to oneself, would be to rely on religious affiliates, other family members, and possibly close friends. However, as the one seeking help, the advice given or genuineness of others listening, caring, and offering encouragement may create doubt or even a possible unwanted dependency on another person, leading to avoidance by them after sometime. On the other hand, for those offering the help, knowing what to say, how to say it, being overwhelmed with others problems on top of their own stress, and being able to determine what is too personal or intrusive in regards to the discussion, may cause some hesitation of getting too involved. It also may be true that others may not have the insight, ability or sanity to help as effectively as they wish or as the one seeking help may need, once again leaving the one seeking help and advice to fend for him or herself. Therefore, with this current research study, increased mental health awareness and understanding of risk and protective factors among African American women, there may be a way to help those that underutilize mental health services through other means. Once the African American women are equipped with the knowledge of

other resources, other than mental health, it is possible that they will then pass this information on to others that do not wish to take advantage of mental health services to help cope with those things that causes them to have suicidal thoughts, in an effort to prevent suicide completions among their population.

## Summary

Suicide continues to be a major social and health concern in the United States. Suicide rates among African American women are a growing concern among the African American community just as they are among any other ethnic group. There is a lack of qualitative research designed to isolate common and notable protective and risk factors that contribute to suicide and suicide prevention among the African American women ethnic group (Pearson & Brown, 2000). Linehan et. al. (1983) suggested that suicide prevention may possibly occur with an understanding of the elements, personal beliefs, and resilience factors governing those who chose to become non-suicidal. Under this notion, there is an assumption that those who chose to live must have certain resilience that prevented them from committing suicide or following through on their ideations. In Chapter 3, the methodology, research design, qualitative approach, and instruments that will be used to explore whether or not religiosity or spirituality, among African American women, serves as a protective measure or resilient factor in regards to their experiences with suicidal ideations will be presented.

# Chapter 3: Research Method

## Introduction

The purpose of this research was to investigate the attitudes, opinions, and awareness of suicide among African American Women in a local church in Phoenix, Arizona. I explored suicide risk and protective factors among African American Christian women and examined their resilience to suicidal ideation. I examined the relatedness of religion and spirituality as they exist among these African American women who have experienced suicidal behavior and ideations. This exploration allowed an investigation into spirituality as a protective factor against suicide and suicide attempts based on African American women's accounts and experiences. The uniqueness of this research provide insight solely into a specific race and gender group, African American Christian women, which is a group that has not been examined previously. Past research on suicide mostly compared African American women to other ethnic and gender groups. However, there is limited research that has addressed experiences among the demographic group sought after in this research effort. Conducting this research opens up dialogue into whether spirituality has a significant impact on African American women when contemplating suicide, as well as how spirituality compares to other reasons for living in regards to deterring suicidal behavior. A review of the current attitudes of African American women in regards to seeking mental health services and whether or not spiritual beliefs prevent seeking mental health services were closely investigated during this research. Lastly, based on the information collected in the present study, I examined whether there is a difference in the impact of reasons for living among African American

women between the ages of 21 and 55, and those African American women between the ages of 56 and 65.

## Research Design and Rationale

### Design Rationale

I used a qualitative approach. An exploratory, qualitative approach using the framework of an interpretive phenomenological analysis (IPA) was used to conduct this research effort. Qualitative methods have been recommended for research in areas where little is known, particularly where the researcher is exploring complex, little understood personal and interpersonal processes, and where it is important to preserve the subtlety and ambiguity of the phenomena under study (Elliott, Fischer, & Rennie, 1999).

This design provided a more encompassing view of the participants' attitudes and opinions from both a person-centered and group perspective, opposed to a quantitative approach analyzing and comparing statistical data among two or more groups. A qualitative approach allows for the exploration of attitudes and experiences in the participants' natural setting, while making it possible to compare ideas on a single phenomenon, which is the prevalence of suicide and suicidal ideations among African American women. The qualitative approach allows for the researcher to be involved with a face-to-face dialogue through interviewing participants to collect data. In the African American community, suicide is deemed as taboo and not often discussed (Walker, David, & Sean, 2006). However, a qualitative approach allowed for a more personal setting and a more intimate style of interviewing on such an intrusive topic by using a humanistic approach (Creswell, 2009).

Previous research has provided causal explanations to suicide through quantitative approaches. However there is a need for more qualitative measures of understanding the participants' perspectives and experiences. According to Hjelmeland and Knizek (2010), a qualitative study "focus[es] on the meaning suicidal behavior has for the individual, and how the individuals engaging in suicidal ideation and/or behavior interpret themselves, their actions, and their surroundings" (p. 75).

Based on Creswell's (2009) description of a qualitative research design, the suicide phenomenon would best fit into a phenomenological type study that is geared toward understanding like experiences or common themes among the participants such as African American women who attend church and are between the ages of 21 and 65. Furthermore, Fulford, Sallah, and Woodbridge (2007) suggested that phenomenological studies "provide tools for more effective and inclusive ways of understanding differences not only between individuals but also between cultures in the way they experience" (p. 39). A phenomenological study is a more beneficial study to understanding mental health (Fulford et al., 2007), as well as African American women's experiences and attitudes as they relate to suicide and religion. Therefore, the qualitative research methodology used for this study was the phenomenological approach.

**The research questions.** There are four research questions this research is designed to investigate:

1. How do African American Christian women contemplating suicide experience religious and spiritual dynamics?

2. How does spirituality compare to other sources of resilience and protective factors that decrease the risk of suicidal behavior?
3. How do African American Christian women between the ages of 21-55 experience sources of resilience and other protective factors differently from African American Christian women between the ages of 56-65 before, during, and after contemplating suicide?
4. What role, if any, does spirituality and religiosity play in the reluctance of some African American Christian women who are contemplating suicide to discuss their ideation and to seek mental health services?

## Role of the Researcher

### The Researcher

The role of the researcher for this study was to examine and accurately record the anecdotal views and opinions among the participants without exhibiting personal bias and without allowing my preconceived notions about suicide guide the research. Groenewald (2004) and Hammersly (2000) explained that no researcher can be or should otherwise pretend to be disconnected from their own personal beliefs about their research, but they should never construct their research investigation around those beliefs.

As an observer and an African American Christian woman, I have a biased opinion in favor of the idea that spirituality and religious affiliations acts as a protective factor against suicide among African American Christian women. I believe that resilience and the African American Christian women's ability to cope with the stressors and trials of life are deeply rooted in the spiritual background and foundation that most

African American Christian women were introduced to or raised on from birth. It was my spiritual belief system adopted as a child that provided and developed my belief system and that has held steadfast through many trials and tribulations encountered in my lifetime, especially during the time of the tragic death of my mother.

However, I also believe that it is those trying times and stressful life events that lead many African American women and African American men alike who do not affiliate themselves with a higher being to succumb to religious beliefs and spiritual practice to help them overcome tragedy and stressful life events. I also understand that the veridical aspects of suicide have shown that not only do those who do not believe or practice religion and spirituality commit suicide, but devout Christians tend to take their own lives as well. It is with this knowledge that I remain mindful of personal biases and refrain from subjective probability. Subject probability is arriving at conclusions about a specific outcome about the study based on my own personal judgments and are usually based on the researcher’s own past experiences. Documenting and identifying my personal opinions, as they relate to religion and suicide among African American Christian women, provide integrity to the research process (Creswell, 2007). Bracketing and setting aside my personal views is a vital step in not allowing preconceived notions to bias the data collection. According to Groenewald (2004), a researcher cannot be disconnected from his or her own preconceptions and is not expected to do so during scholarly research. Therefore, having such preconceptions, I did not allow those biases to guide the following research.

I was also viewed as a participant in the research project. It was my role to clearly describe and identify any perspectives or relationships they may have in regards to the target population in order to effectively address perceived bias in the study (McCaslin & Scott, 2003). The researcher should understand that having individual bias does not signify a weakness but increase the strength of the study's objectivity and shows proof that the researcher's role as an observer was adequately managed. Peer review was also obtained in order to ensure high ethical standards. In order to evaluate my bias, a peer review was requested from and conducted by Dr. Gerald Nissley and Dr. Grant Rich.

I conducted the interviews and then organized and analyzed the data. The research study was conducted in an establishment in Phoenix, Arizona. I collected data by gathering the participants through a local church. My role was to ask pertinent questions relating to the research questions, listen and record the participants' responses, and engage in dialogue to sufficiently capture the experiences of the participants.

As suggested by McCasin and Scott (2003), the procedures used to implement this study included ethical procedures, selection of participants, data collection techniques, data analysis techniques, verification of trustworthiness/authenticity, data interpretation, and dissemination of findings.

I was responsible for ensuring that the information collected and reported was indeed the sole experiences of the interviewees and not my opinions. My approach to investigation was one that maintained and preserved the validness of all responses given by the participants and adhered to strict and narrowly tailored confidentiality guidelines.

The need for trust, an open and clear line of communication, as well as respect is very important for a successful interview outcome (Conoley & Conoley, 1991)

I did not have any personal or professional relationship with the participants, especially in the regards of holding a supervisory position or a position of power over the participants. The only possible related connection would be that I am of the same ethnic and gender group and have spiritual and religious affiliations.

I offered a small incentive in the form of a 5 dollar Starbuck's gift card to each of the participants as a sign of gratitude for participation in the research. However, that token of appreciation was not used in any way to encourage answers to the questionnaires or in an attempt to solicit any other performance aside from willing participation in the interview process.

## Ethical Procedures

### Ethical Procedures

Procedures were in place to ensure the ethical protection of participants. When conducting the interview process for a research study, there are major ethical and legal issues to adhere to as explained by Ivey, Ivey, and Zalaquett (2010). Some of these ethical and legal issues include confidentiality, obtaining an informed consent, being competent, knowledgeable, skillful, and being able to use clinical research and reasoning in an effort to explore and collect personal information from the participant. Confidentiality and informing clients of the benefits and risks of using guided interviews are very important as well when abiding by the ethical and legal codes.

Confidentiality or protecting the privacy of participants and their confidential information was first and foremost on the priority list. Careful consideration was taken to not divulge any harmful information provided by the participant. When exploring the lives and personal experiences of participants, some issues may come up that the participants may not want to be shared when it comes to the secretive nature of discussing mental health and suicide. Confidentiality was explained as well as notification of how to contact individuals with any questions or concerns.

It is preferred that the informed consent process take place as early as at the very beginning of the session following the formal introduction and before the session begins (Ivey et al., 2010).The informed consent form provided background information about the study and its purpose, described the procedures of the study and interview process, explained that the participation was voluntary, discussed any possible risks and benefits of the study, and explained that no compensation would be provided, explained privacy/confidentiality, and provided the participant with contact information of a person they could contact should they have any questions or concerns. After discussing all the appropriate details of the study, the participant was asked if they would like to continue with the study or withdraw participation. The consent document explained the requirements of the study and why the participant was chosen to participate in the research. I disclosed my role in the study to the participants and provided an understandable explanation as to why the study was needed and its significance. It was also important that the participants were made aware of any professional in training, such as me being a doctoral student, and my limited competency in the field (Fisher, 2009). No

part of the research was a surprise to the participants, and there nothing was left unclear and misunderstood by the participants.

I discussed the expected time limit per participant. It was important that the participants understood that their participation was on a voluntary basis and they were not pressured to participate in any way. I explained that there was not a penalty if they decided to discontinue their engagement in the study. Within this process, potential conflicts were addressed and the participants were given a copy of the informed consent form.

Another ethical procedure that must be adhered to is respect for the research sites visited to obtain information through the process of interviewing and observing participants. Because different agencies and facilities have planned daily activities and routines I needed to be aware of normal hours of operation and be cognizant of time and participants' attention span. Being careful that the data collection process is thorough, yet not prolonged or disruptive, as suggested by Creswell (2009), was imperative.

## Methodology

### Participants

The participant population included African American Christian women between the ages of 21 and 65 who had a religious affiliation. Over the past 10 years, there has been a sharp economic downturn. Researchers have suggested that as a result of those stressful times and events, the suicide rate sharply rose among middle-aged Americans between 1999 and 2010 (CDC, 2010).

According to the CDC (2010), the annual rate of suicide increased 28% among Americans between the ages of 35 and 64 during that time period, but had little to no change among the older and younger population. It is worth noting that suicide numbers doubled during that time frame among people in their 50s (Robinson, 2001).

Historically, the focus of many suicide prevention campaigns has been on the younger and older population and has not focused very much on middle-aged people (Robinson, 2001). In lieu of the recent CDC (2010) report, there is an apparent need to investigate and address any presenting mental health issues and challenges that may plague the middle-aged population.

Volunteers were recruited from a local church. The chief clergy, of the local church at which participants were selected, was contacted through a letter requesting approval to conduct the study (see Appendix A). These participants were targeted due to the likelihood of the respondents having Christian religious beliefs, and this group of African American women would fall into the median ages of onset for suicide ideations (Joe, Stein, Seedat, Herman, & Williams, 2008). Permission was sought after from the Institutional Review Board in order to protect the rights of human participants as suggested by Creswell (2007), by providing copies of the informed consent, confidentiality, and interview guides for approval through a test piloting process. The test pilot documents can be found in the Appendix (see Appendix B).

**Sample**

Participants were purposefully selected to interview in order to help the researcher to better understand the religion and suicide among African American Christian women

and answer the research questions. According to Creswell (2007), neither random sampling or a selection of a huge number of sites and participants is suggested in order to conduct a qualitative study. Therefore, a judgement sample was used. In a judgment sample, the researcher selects participants depending on the particular research question (Marshall, 1996).

The sample size was determined by the type of study being conducted and the desired information to be collected to adequately represent the population and answer the proposed research questions. Interviews were conducted and responses from 15 respondents were recorded and analyzed for the purpose of answering the research questions. According to Mason (2010), the qualitative research sample size should be large enough to explore and capture various perceptions, but not so large that the information becomes repetitive.

The target sample number was determined by taking into consideration the taboo of African Americans openly discussing suicide and having suicidal ideations, with or without an actual suicide attempt. Another factor that determined the sample number is the age of the participants and their Christian faith.

**Instruments**

A demographic questionnaire was developed to gather demographic information: Race/Ethnicity, Gender, Age, Income, Familial status, and education. See Appendix B. The interview guide was developed to determine whether or not the person has had any suicidal ideations within the last year. The guide also includes a list of reasons for living listed for the participants to rank from 1-6 (the number of reasons listed) that they feel are

important or that applied to them while having suicidal ideations. The guide was developed in order to capture opinions regarding various aspects and experiences with suicide and to describe the relationship between attitudes surrounding suicide and suicidal behavior. The ultimate goal of the instrument was to assess the religious views and reasons for not committing suicide. The interview guide engaged participation from those that have had direct and indirect contact with those who have experienced suicidality and suicidal ideations (see Appendix C).

**Procedure**

The objective of this study was to gather information to examine the shared, or difference of, opinions and attitudes on suicide and suicidal ideations among African American women who identifies with or have religious beliefs through face-to-face interviewing, private journals kept by the researcher, and audio taped interviews. The study also explored views of participants as their views relate to risk and protective factors of suicide.

In order to gather such information, flyers were posted around the vicinity of the chosen church venue, and were also handed out in order to recruit willing participants to take part in the study (see Appendix D). The flyer included pertinent information explaining the study, as well as contact information, dates, and times of how and where to participate in a personal interview or telephone questionnaire.

A questionnaire was given to those willing participants to screen for those interested subjects that meet the study requirements. Demographic questions (i.e. age, gender, classification, ethnicity, religious affiliation) as well as open-ended type

questionnaires were used to probe for information about the participants' personal experience with suicide and suicidal ideations in order to narrowly tailor the participant selection for the study (see Appendix B).

There was no compensation, but a Starbuck's gift card in the amount of five dollars was given as an incentive for participation in the study. Free referrals to psychological service providers, at the local mental health site chosen for this study, were given to those participants that requested it or that met the requirements of being at risk of suicide, or having suicidal ideations, per the sites approval.

In order to lessen the burden of any expenses, the researcher met with the participants at a convenient location. Since there was not any compensation or re-imbursement for time or travel, the researcher willingly met the participants, and also provided telephone interviews. The participants were met in a location where they felt the most comfortable and safe.

Following the pre-screening process, participants were notified of their selection to participate in the study and were scheduled to participate in a preliminary meeting to discuss informed consent and confidentiality rules. The participants then signed the forms and were given a copy. There was a second round of interviewing which included, either a semi-structured face-to-face interview, or a telephone interview, that lasted no more than 30-45 minutes. Each participants were once again briefly advised of the informed consent and confidentiality and were asked for permission to audiotape their interview for accuracy. The participants were allowed to freely ask any questions pertaining to the informed consent, confidentiality clause, and the study in general.  During this process,

any personal or potential conflicts were discussed. To protect the identity of the participant and abide by the confidentiality rules, the interview documents and instruments were coded and encrypted, and the documents were stamped "confidential' and locked away in a filing cabinet. These documents will be stored for a period no longer than three years and will then be purged or destroyed pursuant to the human research protection rule (45 CFR 46.115(b)). However, any electronic files will be safely stored on a USB card that is password protected and locked away.

**Data Collection Techniques**

The qualitative research technique that was used to collect data is interviewing. An analysis of any personal records that the participants wish to share was also be considered in the research project. A phenomenological approach is appropriate for this study. This type of approach allowed the researcher to gain a better understanding of how the phenomenon that has occurred with many individuals has affected the individual's life (Schwandt, 2000). In this circumstance, the research aimed to understand the challenges of the participants' social and emotional system. A phenomenological approach aims to study the experience of the participants from the research participant's perspective (Lester, 1999). Understanding the challenges and experiences of African American women who have considered suicide is the primary goal of the research project. This contribution to positive social change is possible with interpretive approach to research.

Interviewing was the data collection method the researcher performed. As previously mentioned, interviews were conducted via judgment sample.

**Reliability and Validity**

Reliability and validity is highly expected when conducting any data analysis (Welsh, 2002). According to Creswell (2008), the research data collected is not credible if it is not collected using reliable and valid research methods. It is important that the quality of data, within the qualitative research process, be accurate and reliable. Peer review and debriefing were used to provide the research committee the opportunity to provide alternatives to assumptions and interpretations made by the researcher. This peer review will provide a fresh look and new perspective on data collection, analyses, and findings. The researcher also employ reflective journaling during the research process in order to document the researcher's own thoughts. These types of procedures insured the appropriateness, quality, accuracy, reliability, and verification of findings.

Data obtained from participants was analyzed and coded into different categories based on common themes by hand. Although there are various capabilities of new software programs and the use of software is vastly increasing (Bourdon, 2002), the use of data analysis software in this qualitative study was not used due to the small number of participants. The information was hand coded based on common and recurring themes that are identified in the collected data during the research efforts. Coding allowed the researcher to carefully and strategically identify similar patterns and themes within the data to develop robust descriptions of the experiences. According to Basit (2003), coding is one of the most important aspects of analyzing and then organizing the data. The process of coding allowed the researcher to incorporate a various range of information and details that will add depth to the research findings and outcomes.

**Verification of Trustworthiness/Authenticity**

Techniques that were used to ensure verification of the trustworthiness or authenticity of findings included the researcher's journal, the use of an audit trail, audiotapes, transcripts, notes, early data analysis and interpretation, as well as constant and effective communication with the peer reviewers and research participants (Byrne, 2001). These techniques aided in verifying authenticity of the findings and keep the researcher organized and dedicated toward assuring the data is trustworthy. Even researchers with well intentions are apt to make mistakes, therefore utilizing necessary and appropriate techniques will limit or prevent the likelihood of presenting subpar data.

Another step, that the researcher took to hereby enhance the rigor and trustworthiness of this research, was the use of bracketing (Lincoln and Guba, 1995; Eisenhardt 1989; Creswell, 2007; Padgett, 2008). One of the first steps in this phenomenological study was to reduce and set aside any perceived or experiences that might get in the way of the researcher being able to understand the lived experiences of the participants in this study. According to Padgett (2008), bracketing is a way circumvent or reduce those perceived experiences of the researcher.

In order to establish credibility, Byrne (2001) suggests that the researcher be credible and able to document experience, qualifications, perspectives, as well as assumptions based on their own history. Establishing credible research methods is another critical element of credibility (Byrne, 2001). The interviewing method is a credible form of research utilized for gaining an in-depth understanding of the experiences and challenges within a specific population. Traditionally, reliability is a

concept used within the context of quantitative research. However, the term itself and the use of it is also quite relevant in the process of evaluating qualitative research (Golafshani, 2003). Another term to consider in regard to qualitative research that is described in various ways throughout qualitative research is the term validity (Golafshani, 2003). Both concepts, of validity and reliability, are extremely relevant to qualitative research being performed in this era of research.

The quality of the data collected must be preserved during qualitative research. Research strategies must be in place to properly document the transfer of information and data into the appropriate categories for the reporting of the findings. Strategies used to document transferability will include using sufficient description in order to allow others the ability to draw conclusions regarding the transfer of the data to other populations.

Integrating data from more than one source is a task to consider when conducting a study using the phenomenological research approach. This integration of data must be evaluated appropriately. The research proposal and approach aimed to gain insight and perspective of the experiences of African American women and their vulnerability to suicidal thoughts. Integrating the research would need to be done by obtaining appropriate data to store and sort the elements of the various interviews into to themes as previously discussed. This integration of data is expected to be a daunting task but a necessary task.

Data gathered was used to answer the research questions based on the interview method and through general observations. This data ideally increased understanding regarding the experience of African American Christian women and their experiences

with contemplating suicide and their religious and spiritual affiliations. This data may lead to additional research questions that may need to be answered through a follow-up interview process. The use of a follow-up interview served as a way to gain clarity to participants' answers to questions asked during the interviewing process, and serve to aid in the researcher's understanding of things that were unclear during and after the assessment of the information collected.

The researcher also took notes during the interview, and supplement those notes with the information from the audiotapes. The audio-taped responses were transcribed verbatim and used in the study's findings.

Themes were drawn based on commonalities of likeness and differences of findings and opinions, as well as on those attitudes that deviated from the common themes.

## Summary

The proposed research study was designed to investigate the experience of spirituality and suicide among African American women. The study investigated this phenomenon, by examining the attitudes and experiences of African American women who considers themselves as spiritual or identifies with a religious affiliation, and who have experienced suicidal behavior and suicidal ideations. This study took on a qualitative approach using the framework of an Interpretive Phenomenological Analysis (IPA) and was conducted using questionnaires and interview guides. The goal was to draw or develop common themes in the data gathered, and to explore if there are other reasons for living that may provide insight into why the rates of suicide is lower among

African American women than it is for any other ethnic group. The research presented provides insight into whether or not there are other resilient factors among those African American Christian Women that ultimately prevented them from following through with taking their own lives by suicide.

In Chapter 4, the results of the Interpretive Phenomenological Analysis (IPA), are presented in full detail.

# Chapter 4: Results

## Introduction

The purpose of this qualitative phenomenological study was to explore the experience of spirituality among African-American Christian women who have contemplated suicide. I explored the risk and protective factors involving suicide among African American Christian women and examined their resilience to suicidal ideation. This study explored the existence of religion and spirituality among African American Christian women who have battled with suicidal thoughts and ideations, some which evolved into attempts. During this study, spirituality was examined as a possible protective factor against suicide and suicide attempts based on African American Christian women's accounts and experiences.

There were four research questions presented for examination:

1. How do African American Christian women contemplating suicide experience religious and spiritual dynamics?
2. How does spirituality compare to other sources of resilience and protective factors that decrease the risk of suicidal behavior?
3. How do African American Christian women between the ages of 21 to 55 experience sources of resilience and other protective factors differently from African American Women between the ages of 56 to 65 before, during, and after contemplating suicide?

4. What role, if any, does spirituality and religiosity play in the reluctance of some African American women who are contemplating suicide to discuss their ideation and to seek mental health services?

Chapter 4 provides an overview of the study's research methodology and provides insight into the qualitative data collection process used to examine the research questions. Chapter 4 also provides findings yielded, in the form of coded themes, from investigating the opinions and personal experiences of the participants. The findings are followed by a conclusion that gives a brief recap of the information presented within the Chapter.

## Research Setting

The research setting involved recruiting participants who were affiliated with church organizations, considered themselves as being of the Christian faith, and were solicited from a local church establishment in the Phoenix, AZ area. There were also qualified participants who met the requirements whom completed the interview via teleconference as an alternative means to interviewing in person.

I placed calls and sent emails to the bishop of the local church facility, also referred to as the community partner, to set up an appointment to personally speak with the community partner to introduce the study and the purpose of the study. During the scheduled appointment, the possibility of using the church congregation for recruiting volunteers for the study was discussed. The letter of cooperation was signed, and before distributing the recruitment flyers, the study recruitment process was agreed upon and approved by the community leader.

A minor setback was experienced while trying to coordinate the initial meeting with the community partner due to a lack of response, feedback, and cooperation of the local church establishment's staff responsible for coordinating the appointments and activities. Prior travel engagements and commitments of the community partner also delayed the initial meeting between the community partner and I. After several attempts, flyers were passed out and posted in the local area near the research setting that subsequently yielded participation.

The face-to-face interviews took place outside of the church establishment, my private office located in Phoenix, AZ. This venue was chosen to ensure confidentiality and lessen the odds of the participants being identified by other church attendees or fellow participants. The private office provided a safe, secure, and convenient location for participants to openly discuss a sensitive topic, such as suicidal behavior.

## Peer Reviewers

I relied on two peer reviewers who provided their assistance in addressing the need of triangulation for the collected data from this study. These peer reviewers were given thorough information about the main purpose of the study, and why the study was deemed as being important. Both peer reviewers have completed research in the areas of suicide, religion, and qualitative inquiry. The peer reviewers of this study currently review dissertations for Walden University and have careers as psychologists in addition to teaching at the university level. The study's proposal and data collection procedures were discussed with the peer reviewers in depth to ensure proper collection and reporting of the findings. The peer reviewers verified whether or not the tools used to collect the

data were indeed appropriate and captured the needed information to answer the research questions.

## Solicitation for Participants

I created flyers soliciting participation for the study. These flyers were distributed at and around a local mega-church in downtown Phoenix, AZ. Potential participants were asked to call or email me if they were interested in participating. There was an initial interview to determine if the interested participant met the study's criteria, and if so, they were recruited to take part in the interview for data collection purposes.

### Initial Phone Calls to Solicit Participation

I contacted 23 potential participants, 11 via telephone and 12 via email, upon receiving notification of their willingness to participate. I introduced myself and the research study to the potential participants. All 23 of the potential participants agreed to answer the questions on the demographic questionnaire to help screen the participants for the study requirements. Nineteen of the 23 potential participants met the requirements. Since the study sample size was 15, it was explained to the 19 potential participants that all of their coded names would be placed inside of an unmarked sealed envelope from which 15 coded names would be randomly selected from the envelope. Once selected, I contacted each of them and schedule an interview time and date. Participants who met the criteria based on the demographic questionnaire, but were not randomly selected to participate as one of the first 15 participants, were placed in reserve in case they were needed later in the study to supplement for those who were not able to complete the interview process due to unforeseen happenings. It is important to point out that the

study's sample size was determined according to Creswell's guidelines for a phenomenological qualitative research study. According to Creswell (1998), when using the phenomenological qualitative research method, the sample size should be between five to 25 participants. I began with 15 randomly selected participants picked by hand. Ichose this process to ensure that once saturation was reached, the interviews would end. Upon completion of the data collection, the remaining qualifying participants who were not interviewed were referred to a local agency for therapeutic support if needed.

Each of the participants was given a scheduled time and date to discuss and sign the consent form and complete the initial interview. Only 11 out of the 15 participants followed through and completed the process initially. In order to reach the original sample size of 15, I selected the remaining four participants in the envelope, which only yielded three more completed interviews. UltimatelyI handed out a second round of flyers and repeated the recruitment and solicitation process in order to successfully gain the one final participant who met the requirement in order to reach the sample size and complete the data collection process.

## Introduction of Study and Consent Signing by Participants

I explained and entertained questions about the informed consent form with each of the participants prior to moving into the interview phase of the study. I further explained the purpose of the research and thoroughly explained the rules of confidentiality that governs the study. After discussion and understanding of the consent and confidentiality rules, I obtained a signed letter of participation from each of the individual participants. These letters are referred to as consent forms.

## Qualifying for the Study

The participants were required to meet certain criteria in order to participate in the study. In order to qualify, the participants (a) had to be between the ages of 21 to 65 year old, (b) have a religious or spiritual affiliation, and (c) have contemplated suicide or engaged in suicidal behavior.

## Demographics

The participant population included 15 African American Christian women between the ages of 21 and 65 who have a religious affiliation with the local church. Table 1 provides a demographic breakdown of the 15 participants.

Table 1

*Demographic Questionnaire Results*

| Participants | Participant 1 | Participant 2 | Participant 3 | Participant 4 | Participant 5 | Participant 6 | Participant 7 | Participant 8 |
|---|---|---|---|---|---|---|---|---|
| Age | 63 | 53 | 25 | 27 | 32 | 57 | 48 | 40 |
| Gender | Female | Female | Female | Female | Female | Female | Female | Female |
| Ethnicity | African American/ German | African American | African American | African American | African American | African American | African American | African American |
| Marital status | Married | Divorced | Single | Single | Single | Divorced | Married | Married |
| Income | $50k and Above | $50k and Above | Between $25K and $49 | Between $25K and $49 | Unemployed | $50k and Above | $50k and Above | $50k and Above |
| Level of education | Bachelors | Professional Degree | Bachelors | Bachelors | Graduate | Professional Degree | Graduate | Graduate |
| Level of religion | Extremely Religious | Extremely Religious | Somewhat Religious | Somewhat Religious | Extremely Religious | Somewhat Religious | Extremely Religious | Extremely Religious |
| Religious affiliation | Christian | Christian | Christian | Christian | Christian | Christian | Christian | Christian |
| Overall health | Good | Good | Good | Excellent | Good | Excellent | Excellent | Good |
| Life satisfaction | Extremely Satisfied | Extremely Satisfied | Somewhat Satisfied | Somewhat Satisfied | Somewhat Dissatisfied | Somewhat Satisfied | Extremely Satisfied | Somewhat Satisfied |
| How did you hear about the study | Flyer and Word of Mouth | Flyer | Referral from friend | Flyer | Flyer | Flyer | Flyer | Friend |
| Had suicidal thoughts/ behaviors | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes |

| Participants | Participant 9 | Participant 10 | Participant 11 | Participant 12 | Participant 13 | Participant 14 | Participant 15 |
|---|---|---|---|---|---|---|---|
| Age | 61 | 55 | 36 | 34 | 56 | 42 | 50 |
| Gender | Female | Female | Female | Female | Female | Female | Female |
| Ethnicity | African American | African American | African American | African American | African American/ Caucasian American | African American | African American |
| Marital Status | Married | Single | Divorced | Married | Single | Widowed | Married |
| Income | Retired | $50k and Above | Between $25K and $49 | Between $25K and $49 | $50k and Above | $50k and Above | $50k and Above |
| Level of Education | High School | Professional Degree | Graduate | Bachelors | Bachelors | Graduate | Bachelors |
| Level of Religion | Extremely Religious | Extremely Religious | Somewhat Religious | Extremely Religious | Extremely Religious | Extremely Religious | Extremely Religious |
| Religious Affiliation | Christian | Christian | Christian | Christian | Christian | Christian | Christian |
| Overall Health | Fair | Fair | Excellent | Excellent | Fair | Good | Excellent |
| Life Satisfaction | Extremely Satisfied | Somewhat Satisfied | Extremely Satisfied | Somewhat Satisfied | Extremely Satisfied | Somewhat Dissatisfied | Somewhat Satisfied |
| How did you hear about the study | Flyer | Word of Mouth | Friend Referral | Flyer | Email | Email | Flyer |
| Had Suicidal thoughts/behaviors | Yes | Yes | Yes | Yes | Yes | Yes | Yes |

*Note*. Demographic questionnaire responses. See Appendix C for Dissertation Demographic Questionnaire IRB#08-26-15-0020319.

As shown in Table 1, participants were African American women between the ages of 21 years old and 63 years old, which complied with the study's requirements. Of the 15 participants, 13 identified themselves as being African American only, while two

identified themselves as being biracial, one with African American and German parents and one with African American and Caucasian American parents. In the case of the latter two participants, they both considered themselves as African American.

Six of the participants were married, five were single/never married, three were divorced, and one was widowed. Eleven of the 15 participants had children, and only four of the participants were without children. Nine of the participants had an income of $50,000 and above, while four had an income between the $25,000 and $49,000 range. One participant was unemployed and one participant was retired.

In regards to the participants' level of education, three had professional level degrees, five had a Graduate's level degree, six had a Bachelor's degree, and one had a high school diploma. All the participants stated that they were Christians. However, 11 participants identified themselves as being extremely religious and four only somewhat religious. As it relates to health, six participants responded as having excellent health, six in good health, and three responded as being in fair health.

When asked about their current, overall satisfaction with life, six of the participants stated that they were extremely satisfied, seven were somewhat satisfied, and two were somewhat dissatisfied. All 15 participants have had suicidal thoughts and engaged in suicidal behaviors.

Of the various recruiting measures, nine of the participants learned of the study through flyers, two via email, two through referrals, and two by word-of-mouth.

## Data Collection Approach

A phenomenological qualitative approach was applied for this study to investigate the participants' opinions and awareness of suicide as a relevant problem in the African American community. In the remainder of this chapter, I present the detailed analyses of the qualitative data collected from the African American Christian women participants.

### Data Collection

Data collection was performed by using an IRB approved interview guide and by using audio recording and handwritten notes in instances where the participant was not willing to be audio taped. In the consent form, the participants were notified and given an option for their interview to be audio taped/recorded. The maximum length of time for an interview was 1 hour and 20 minutes, and the minimum length of an interview was 45 minutes. The variations in length of time for the interviews was determined by the participants' elaboration on the open-ended questions contained in the interview guide.

Six of the 15 participants required follow-up interviews, none which lasted more than 30 minutes, due to having to clarify responses and get further detail to interview questions. Three participants contacted me after the interview process to provide more insight and more details to their responses. Once all interviews were completed successfully, I presented each of the 15 participants with a $5 Starbuck's Coffee gift card.

Due to the nature of the study and the reluctance of several potential to discuss their suicidal behavior, much of the information and intricate details were requested to be left out of the recording by respondents. During the data collection, several of the participants mentioned being somewhat embarrassed of their suicidal behavior, while

others became very emotional when discussing and reliving their suicidal accounts. Many of the shared accounts were touching and sad accounts that produced painful memories for the participants and teary-eyed moments for all involved.

It was that same reluctance of discussing such an issue that also deterred at least three potential participants from agreeing to participate in the study. One of the women's group leaders at the local church explained that she had spoken with her group about the study, as she knew several women in her group who met the criteria but was unwilling to rehash such terrible times of their previous life. There was one potential participant who called and cancelled and withdrew from participating, after signing the confidentiality form, who explained that she was in the process of dealing with some major life changes, one which required her to engage in mental health services and counseling, and felt that now would not be a good time, meaning in her current state of mental health, to continue or engage in such an "emotional venture." Though she was willing to help in any way she could, she did not feel that it was in her best interest at the time to be interviewed.

Two of the participants that heard about the study from a friend, both agreed to participate in the study. One of the two had just been released, only days prior to contacting the researcher, from the hospital from a suicide attempt, but had a history of contemplation prior to the actual attempt. The other, had just been released two weeks prior, from a 48hr hold at a local mental health facility following an incident in which she shared with a close friend her thoughts and intentions to take her own life, although she never acted on those thoughts. Because the friend was uncertain of the participant's behavior at the time, but felt it was a serious threat, she contacted the suicide hotline who

thus contacted the local authorities. After an onsite assessment, the authorities thought it would be best that the participant be placed on suicide watch.

Recruiting participants, and scheduling the interviews in a manner that was considerate of the participants' and the researcher's time was a huge challenge at times during the data collection process. Because of the different work schedules and the different family and life demands for all involved, setting an appropriate time and abiding by that time was met with many cancellations and rescheduling havoc. There were five potential participants that volunteered for participation in the study but never completed the interview process, even after three follow-up attempts. There were four interested participants that once the demographic interview was completed, they did not meet the study requirements and criteria.

For the present study, the participants' responses, to the interview guide questions, were audio taped, transcribed, hand coded, grouped into like themes, and presented for discussion. The following section presents the data analysis.

## Data Analysis

The interview guide was developed in order to yield coded themes from the data collected based on categories. The categories were derived from the researcher's attempt to answer the study's four core research questions. The preliminary categories were as follows: "Personal Experiences", "Family and Friends", "Religion", "Awareness", and "Reasons for Living". Each of the categories asked questions pertaining to each of the specific categories.

During the qualitative research process, I prepared and organized the 15 interviews, by first transcribing the audio recordings of each interview. After transcribing the audio recordings, the researcher examined all the transcripts to search for common themes. Common responses were grouped together, sorted, and arranged to identify clusters of descriptive statements relevant to examining the research questions. These statements were condensed and hand coded according to the essential thematic categories. Before finalizing the process, the researcher re-evaluated the transcripts and reviewed the data to determine whether the shared personal experiences gave sufficient and accurate accounts to address the research questions.

Out of the fifteen transcripts, several notable statements were extracted. Once these prominent responses were arranged into clusters, 16 significant themes were developed. These themes are presented in this data analysis section of Chapter 4.

**Theme 1: Participants' Personal Views on Suicide**

The first category of discussion was "Personal Views". The questions contained in this section of the interview guide were used to explore the participants' own personal views, and thoughts on suicide. One of the many common views shared among participants is their belief that suicide, among the African American community, is on the rise and is much higher presently, than in the past.

One participant, when asked what her thoughts were, in general, about suicide, stated the following:

> I could be wrong, but I don't think that we are committing suicide like white people do. We may end up getting on drugs. We may end up being a victim of

> murder or we are murdering each other, but I don't think we are killing ourselves. That's just my take on it.

Another participant stated, “It's (suicide) on the rise. It's on the rise. Unfortunately we see it more than what we've seen it in the past.” One of the fifteen participants explained that suicide is now happening in the African American community because the African American community was not utilizing the available mental health services. She went on to explain

> I don't know how it compares to other ones, but I think that the reason why it would occur more so is because I've seen a lot in the black community where they tend to not really acknowledge behavioral health services. They tend to say, "Pray about it. Go to God. God will fix it," instead of realizing that God has provided us with psychologists, and medication and those advances to help with these things. Therefore, they're not getting the treatment. They're not available for them. That's the only thing I've really noticed.

After speaking with all the participants, it is clear that they understood that suicide does exist among African Americans, and is steadily on the rise. However, the majority, 53 percent, of the participants felt that suicide is happening more among Caucasian Americans than any other ethnic group.

**Theme 2: Participants’ Personal Experience With Suicidal Behavior**

Upon being asked about personal experiences with suicide and suicidal behavior, another participant which needed reassuring that her name would not be mentioned prior to sharing her experiences, shared that she has had “a lot of them (suicidal experiences)

and went on to add, “so I don't know which one you want.” After clarifying that I would like her to share as many or as little of her experiences as she would like to discuss, she began to share the following accounts: “Okay. I know definitely when I was, [I want to say?] 16, 17 I was having suicidal thoughts quite a bit, and I think that's why I allowed myself to get in a domestic violence relationship. I completely went against everything. I don't know (pause) actually, I do know why. Originally it started in 2006. My Mimi passed away, and then I started to gain a ton of weight, and then in 2008, when I finally got some therapy to adjust to her death and my depression-- I don't remember everything, but I know on a Tuesday I had therapy, and later that week - I want to say Wednesday or Thursday, somewhere around then - my other grandmother passed away. So everybody tried to do the whole surrounding me with love, and prayer and all this stuff, and I don't-- not that I don't believe, but I'm just like, "I don't want to hear that." I thought it was something that needed to be addressed with mental health, and not to go down this whole, "Let's pray about it" road. Not that I don't believe prayer works, but still. That's why I really think that that's the problem with the black community, is they just go into that, and there's other things that can help. So I kept going down the road of just pretty much self-destructive behaviors. Like I said, that domestic violence relationship, which did not help depression at all. I remember multiple times getting medications from them and taking all kinds of pills. Fortunately for me, my body acts very differently with drugs. It does not do what the drugs are intended to do, so I ended up being very high instead of passing out. I don't even know what it was - a ton of pills, and then most of that day is gone. But I remember being high in a [movie store to the guy in a car with the person I

was with?]. And then [stayed long?] inside that relationship, and I know that one was a bad one because I was dating a girl and just doing everything to go against what I was raised. I'm just trying to think. I've blocked a lot of that time out. Pretty much, during that relationship I tried pills multiple times, and then I remember one time I got so wrapped up in that that when they weren't going to come and do something or I knew that person was cheating on me, I had tried cutting my wrists with a knife. I have no pain tolerance, so that didn't work, but I did [?] that this is what I'm going to do, and then I [?] a week because I could actually do that and cause [pain?]. So I got to take a nice drive to Saint Mary's Hospital in Tucson, and they kept me there for a while. They didn't keep me overnight or anything. They let me go. And then I don't know about any attempts between that and 2010, but once around 2010 I was just having a hard time because I was still stuck in that stupid relationship, and then working a lot, tired, school and just really stressed out. And I used to fantasize - I don't know if fantasize is the right word - but pretty much of falling asleep and crashing into a pole. I would fantasize about me getting hurt, and then not knowing what was going to happen. I got into a car accident. After that car accident, that's actually how I got free from that domestic violence relationship, but I actually ended up getting very depressed after my car accident because I lost my left thumb and have a ridiculous amount of scarring. I got into the accident a couple days after my 20th birthday, and I had to go back to my mom helping me do everything from brushing my teeth to getting dressed. Everything. I couldn't do anything. I was depressed, and I thought about it, but fortunately, I didn't try anything. But most of my attempts were while I was a teenager, and in that really stupid toxic relationship.”

Yet, in another personal account, a participant, shared these gripping details of her experiences: “I remember that a woman that I used to ski with - she was absolutely drop dead gorgeous and beautiful - her name was Gloria. We used to call her Peddles. And that's when I lived in Detroit. She came to New York one year to visit her girlfriend, and her girlfriend went to work and she opened up the window and jumped out of the 22nd story of her girlfriend's building. And I remember that and I remember I hit a stage - this is when I was in my 20s, about 25 or so, maybe a little bit older, maybe about 26, 27, - and I stood up in my window. I lived on the 18th floor of an apartment building in Manhattan and I opened up the window, and I was very seriously considering doing the same thing - jumping out. But there was this little voice that kept saying, "Don't do it. Things will get better. Don't do it. Things will get better. Get down, get down." I thought about it, thought about it, and then I climbed down out of the window. Then, I realized that I needed to get some help. And I was at a party one night and somebody was telling me about their - I think it was their cousin - who was a psychiatrist. She was a black female psychiatrist. And so I found her, and I made an appointment and I started seeing her to talk about why I was so depressed.”

All of the participants had some very interesting experiences, and ironically, many of the participants had made more than one attempt to commit suicide and had suicidal thoughts on more than one occasion. The number of times of contemplation among the participants was much higher than the number of actual attempts.

**Theme 3: Reasons for Wanting to Commit Suicide**

During the interview process there were several reasons that were mentioned as to why, and what events led the participants to feel the need to end it all. There were such things mentioned as “everyday life”, “losing my mother”, “losing my grandmother”, and due to “failed relationships”.

A 63 years old participant stated “It seemed kind of like life seemed very hopeless to me. And even though I was successful in my career, I mean from an outward appearance, I'm on television. I've got a good name. Things seemed to be going well, but I was afraid that somebody was going to find me out. That had been one of my biggest fears in life - that people would find out, one: I'm not as smart as they thought I was. I don't have it going on like they think I do. And a lot of this stems, Marilyn, from my growing up. See, I was adopted. And my mom, that adopted me, was African American. She thought it was mental illness. If you go back now and do a diagnosis, probably say that she is bipolar. But this woman used to tell me that I would grow up to amount to nothing, and that I would have a house full of babies, I would disgrace the family, just all kinds of-- she was very abusive emotionally, physically, and I was always thinking, "Why did she adopt me?" I thought I was going to be-- I always knew I was adopted, but I just didn't feel like I should be getting whipped all the time. But on the other hand, she gave me a strength that I probably wouldn't have had. And I know a lot of brown babies like myself we've either done extremely well or we have tanked.”

One of the participants shared that a divorce and losing her mother contributed to her suicidal ideations but also referenced a third situation that she did not care to share.

She stated “Well, there was a couple of different times. As a teenager, something had gone wrong and I was not happy or satisfied with what happened. That one I would not like to describe. And I guess as a teen, you feel unwanted, unloved, and had no purpose. Even though family is all around, I didn't have any friends. Later in life, it surrounded something very bad that had happened, and I was not able to go through the grieving process. There was one other serious sign, and it was when I was going through being married and I kept blacking out, getting sick. The doctor told me I was under so much stress and pressure in the relationship I was in. And I remember telling him, "Well, I'll give up." The doctor said, "Well, who's going to raise your kids?" I said, "My parents will raise my kids." And the doctor said, "But in the state of California--" And at that time with that situation, I said, "Well, I'm not going to have somebody else raise them, and I wasn't going to let their father raise them." She continued with “The second one, it was just that things were going wrong. I was having to work full-time and be a full-time mom. And I'd come home, and I felt like a full-time maid. And I felt like my kids weren't being taken care of. I just felt like if I couldn't handle it, the one that could handle it would be my parents to raise them.” This participant went on to explain that it was during the times that she contemplated suicide is when she spent more time “crying out to God”.

When reviewing the transcript of the interviews, some of the things that stood out about the reasons why the participants wanted to commit suicide, varied from failed relationships, fear of failure, financial stressors, and losing a loved one.

**Theme 4: What Deterred the Suicidal Attempts**

When discussing some of the things that ultimately deterred the participants from committing suicide, many things were mentioned, such as the “grace of God” or some reference to spiritual beliefs playing a part rang true for 11 of the 15 participants. The other four gave credit to such things as their children and other family members, such as parents and younger siblings. They thought about how much it would hurt their families and felt that their children needed them.

One participant stated: “Of course, my children. My children were my life. But my relationship with God outweighed everything. I understand fully that I am not my own. I belong to him. So I felt like going back over the things that I had learned as a child…..that it was something that I was forced to be able to get through, and that he was going to be there to help me get through it. God first, then family”” One of the younger participants in the 21-55 range explained: “My brothers. Yeah. That's it. My brothers. I mean, it was a strong enough depression that I didn't care. I know that if you commit suicide you go to hell - an unforgivable sin, you don't have time to repent, but that didn't stop me. So it was only my brothers. That was it. Just not wanting them to come in and see that or have to deal with that.” To give credit to the belief and assumption that spirituality plays a role in suicidal tendencies, one participant added, “honestly, the only reason why I'm still here is because the grace of God…. I should have been gone, and for some reason my body didn't take-- the medicine didn't take the full effect it should. So I mean, that's only God. There's nothing else that accounts for that.”

One of the participants gave this account in regards to the possible things that ultimately deterred her: “Not a one, except for the little voice that said, "Things will get better."”

**Theme 5: Feelings of Being Alone**

As part of the interview, the participants were asked if they were alone or were there other people around them at the time of contemplation. One participant stated while chuckling, “I was by myself. I look back now and I said, "Oh, it was me and the Holy Ghost that kept me from jumping out that window.” Another participant stated: “I had people, I had family and I had support, but because I was in that relationship I didn't have access to that, because that person-- I had to get permission to go see my mom, I had to get permission to go do anything except for work and school. I had to check in and all that stuff. So I had people, but I don't know how to explain that one. But the other thing also is I had my mom, who's a therapist and everything like that, so I feel like she was there but she wasn't there. So it's kind of like one of those-- she can help others but she can't help her daughter. So I had the support, but I was alone because nobody could see or help me. It's was like having a stroke in a hospital, there's a bunch of people there but nobody's helping. Another time, the person that I was in a relationship with was in the house and I just went in the room, and I went and grabbed them and took them. But the time that I got high that person was there. The time I took Aleve and cut my wrists, she had just left the house, and I was in the house alone.”

It seemed not to matter to the participants whether they were completely alone or surrounded by family and friends during their times of contemplation. However, the

presence of others did have a positive effect on 90 percent of the participants interviewed, when it came to attempts. The participants were less likely to act on their suicidal thoughts when others were around and “could possibly stop” them or “intervene”, as several of them put it.

**Theme 6: Emotional State**

While discussing their personal experiences, the interviewer asked the participants to describe their emotional state during their attempts. Most of the response had the common feeling of being depressed as one of the emotional states. Eight of the fifteen participants were previously diagnosed with having major depression. Two were diagnosed with Bipolar Disorder, five with anxiety, and 1 with ADHD.

One 25 year old participant added: “So the time that I took the pills and I cut myself, I was angry. I was angry, sad and hurt. I knew the person was cheating on me, and I was [?] and everything because of them. So that was that time. The other time, the only way I can describe that - and I know the word for it - like, dissociated. It was like a fog. I wasn't thinking. Not that I wasn't thinking. I knew what I was doing, but there was no emotion there. I didn't care. I didn't care what happened after. I was just like robotic and wanted to end it. I had depression and everything. I don't know, I had a strong depression and everything, and then once I had the car accident I never took my - I was still on bipolar and depression medication - I've never had to take them since. Except for the obvious depression that comes with becoming an amputee and all the [?], I've not had any depression since.”

One participant explained that she was crying and was in deep thought. Yet another participant explained the following in regards to her emotional state: I wasn't crying. I was just standing up in the window looking out saying, "I need to jump out of this window - and then that will end everything - and then I won't have to worry. I won't be in this pain anymore." Boy that was the biggest lie from the pits of hell [chuckles]. I did not know then what I know now. I would have gone straight to hell on a greased pole with gasoline drawers. That would have been terrible. I just felt like I wanted to end it all, I had had enough. I was tired. In fact, I'm going to be honest with you. About a week or so ago, that same feeling came over me. Now I recognize it for what it is. It's war. It is warfare. It is spiritual warfare." It was at this point that the interviewer provided the participant with referrals and resources to seek help for her mood and suicidal thoughts.

As a follow-up question to feelings of depression, the interviewer asked one of the participants is there a way to identify those feelings of depression that may lead to suicidal ideations and she responded, "now I recognize it and I know what some of the triggers are. And I have had enough of those triggers of late, when I've said, "I could let myself go there." In fact, I've been dealing with some depression-- maybe about six months ago. And I did, but I said to myself, "Self, you got to come out of this. You cannot go there." All I could hear Dr. Thompson saying was, "Every time you spiral, you go down further and it's harder to come up." Apart from Jesus, honey it would be all jacked up. I know when I've allowed it to get out of hand."

Overall, in many instances the participants recalled a feeling of being alone, being upset, stressed, or depressed during the times of contemplation or during their attempts.

**Theme 7: Is Suicide Acceptable**

To further examine their opinions, the participants were asked if they felt there was any occasion or situation in which they thought suicide would be understandable or viewed as an acceptable act. One of the participants who was very influential in her community had this to say: “Funny you would ask that question because a friend of mine was just telling me yesterday that another friend of ours was talking about moving to Montana where I think assisted suicide is legal. I don't know. You know what, Marilyn, it's something I've been thinking about. Because I think if I found out that I had Alzheimer's, and the possibility of me living a long, long time with Alzheimer's and not being in my right mind, my body is working and my mind is gone. I think-- I don't know. It's just a thought, okay? I haven't put any teeth to it. But I think that I would not want to be here.” She further added: “When my physical body is not going, well, I don't want to be here. I don't want to be a burden. I don't want to be a financial burden. I don't want to be a mental, emotional burden. Let me go. You know? I don't know how to explain it except that I've been thinking about that and I'm, like, Lord just don't let me get Alzheimer's. Let me go right as an old person and just go dead one day and wake up, you know in heaven.”

Another 25 years old participant shared: “I mean, it would have to be some weird, wonky, weird situation, like you're killing yourself so that way someone else may live. I don't think it's okay in any other situation. So if maybe, God forbid-- they're all crazy. So, like if I was in a situation and I knew there wasn't enough oxygen for me and the other person, I would give up myself so they could have more air. Or jumping on a bomb or

something like that. Like, getting in the way of a bullet, which is not really suicide. I don't think it's okay. But when it’s a terminal illness, I feel conflicted about it, but I feel when I watch the documentary How to Die or the one in Oregon, watching it is really hard for me, but I firmly believe that it's okay for them to do, as long as it's done humanely. But even then, I still think they're going to hell. Like, if they do it to themselves. The people that are given the pills and they take them themselves to die. I don't know. Part of me thinks they're going to hell and part of me thinks they've already done the option and they just go ask for forgiveness before they die, but I don't know. But, [I'm sure?] that's not up to me where they go. It's a private thing, so it's okay, but it's very conflicted.”

However, one participant in her 50’s adamantly stated when asked: “No! I know people may think, "Oh, they're ill." When it's your time to go, he'll come and take you. He don't need no help from nobody else.”

Although many of the participants eluded to terminal illness being a possible reason that suicide might be accepted, all of them were still hesitant in their answer, seeming unsure if they really believed it was acceptable at all. Most of the participant followed up their answer by saying that they still feel, that after their various experiences, that “there is always a better solution than suicide.” A few of the participants explained how taking your own life is unacceptable and felt that “God is the giver and taker of human life”. All of the participants agreed that even if a person did not believe in God or a higher being, there is still a way out, and many available resources and support systems to reach out to for help.

**Theme 8: Discussion of Suicide in the African American Community**

The second category explored by the interview guide pertained to the ways in which the participants' family members and friends in the community viewed the topic of suicide, based on conversations the participants have had with those family members and friends, or the lack thereof. In many of the interviews, the participants shared that the topic was rarely discussed or mentioned in their households, and even less in their communities.

An overwhelming majority of the 15 participants reported that suicide was "hardly ever" mentioned, talked about, thought about or discussed, in their families or even in the African American communities where they lived.

When asked what she thought about suicide in the Black community, a 63-year-old female participant stated, "I could be wrong, but I don't think that we are committing suicide like white people do. We may end up getting on drugs. We may end up being a victim of murder or we are murdering each other, but I don't think we are killing ourselves. That's just my take on it.

Yet, another participant viewed suicide in the African American community as: "Suicide is an issue that is rarely brought up or addressed in the Black community. If it is happening, it's not being exposed on the media, and the only way I think the subject would come up would be if a family member in a particular community killed themselves."

She added: "I think black people are ignorant to the fact that suicide is not just something happening in the white community. Because typically Black people are very

spiritual and heavy into church, I think they cast a blind eye to suicide thinking that black people don't get that low and if they do they can solve it in church."

Several of the other participants' responses were in support of the fact that many African Americans are not knowledgeable about mental illness and suicide. Many of the participants were alarmed at the statistics in regards to suicide among African Americans, and even more alarmed at the fact that African American women had the lowest rate among all ethnic and gender groups. This interesting concept will be discussed further in Theme 14.

Nine out of the 15 participants agreed that they never heard of or "paid any attention" to suicide among African Americans because it is not something that has happened in their community or to anyone they know. The participants mentioned that the only time they really hear anything about suicide is when the media publicize the death, by suicide, of a celebrity and most times those celebrities are Caucasian American.

Upon asking one of the participants what she thought about the topic of suicide among the African American community, she responded, "That is a very "hush hush" topic in my community, and we never talk about it or bring it up in my home now or when I was growing up. It was not until recently that I noticed people talking about it on the news but I think that is because it was a celebrity that killed himself." In probing the participant's response, the researcher asked if there were a particular reason why the topic is "hush hush" in her family and community, she responded that growing up the two topics people never talked about were homosexuality and suicide". Another participant added: That is something that I am trying to figure out because it's one of the topics that

is taboo because it's among African Americans, yet we don't like to talk about suicide. We don't like to talk about our problems. We don't like to go see doctors. Many African Americans do not go and seek out any psychological or mental help at all."

The participants unanimously agreed that suicide is rarely, if ever talked about or discussed in their homes and community. The participants all shared the fact that the mention of suicide is always something heard in the media or on television, but never really a topic that is brought up for discussion in the past, nor the present in "Black" households or communities. The thought or idea of suicide being a "taboo" or a "hush hush" topic that "no one" likes to talk about, was overly expressed by all participants.

**Theme 9: Suicide and the African American Church**

This section of questions provided in depth conversation and discussions on how the participants' religious doctrines and teachings explain suicide, or whether or not suicide is mentioned in their religious affiliations. The participants were asked to share their thoughts on other known Christians that have committed suicide.

One of the older participants stated that suicide is never brought up or talked about in her church. She stated: "You know what? I don't think I know. I've been at this church-- it'll be three years, I don't think that's something that has come up. I would have to go back and look at our doctrine of faith or something. But I could ask my pastor." She also added, "If you do the Catholic church, they tell you it's a sin. I've never heard that in any of the nondenominational or denominational churches outside of the Catholic church." There were other participants that agreed that suicide has never been discussed in their church facilities and agreed that suicide is an extremely controversial topic. One of

the participants that is in her 50's revealed: "We were taught that depression was of the devil and that it was not what God wants for us. We were taught in church not say or claim that we were depressed, but to say we are going through something and waiting for God to bring us out."

Another participant in her late 30's agreed that suicide has been a taboo at her church and shared that "church folk are too blessed to be stressed and depressed." She further mentioned that "the church is full of hypocrites and judgmental people that look at you strange when you mention being depressed, so most people do not bring up depression or suicide in fear of being judged or feeling uncomfortable in the church environment".

Others acknowledged that "religious and spiritual people" in the African American church community could do more to make people feel more comfortable about feelings of suicide and depression without shunning people's who's faith has wavered. Several participants mentioned that instead of judging people, the church should act as a "safe haven" and should have some type of obligation to further assist those that have fallen victim to the circumstances of life that has ultimately brought them to a point of considering harming themselves.

One of the participants explained that she felt that people tend to lose their faith behind the actions of people in the church. When asked what she meant by that, she stated:

"Church people can be so mean and nasty at times. So realistically speaking, if a person turns to the church for help and they are treated worse than they get treated in the

streets, then why go to church or believe that the perception of the church is real and that God sends those people to help us? I don't blame some people for giving up on faith, hope, and giving up on the idea that God will fix it. No one wants to believe that God has forgotten about them or choose to let them suffer. I think it is at this point that people give up on life and either consider suicide, or even go through with it."

A participant that explained her thoughts on church and suicide confessed "I am so secretive and was so busy hiding things that I'd rather end it all than to let anyone in the church, in on the secrets I was hiding".

A few of the participants made the point that the "Black Church" needs to do more to address and prevent suicide "instead of focusing more on increasing in size and taking people's money". The participants explained that the church is not the place for people to go to for help because often times it is not discussed or addressed. Participants shared personal experiences when they considered getting help from the local church, but did not go through with it for fear of being judged, or told they need to just have faith. A younger participant mentioned: "When I was going through my rough patch, my faith had wavered. So for someone to tell me about my faith being weak was not going to do the trick". One middle aged participant explained that she feel that Christians that commit suicide or attempt it feels as if not only the church, but God Himself had forgotten about them. She stated: " Part of me feels they've (Christians that commit or attempt suicide) been so fake for so long, trying to put up this front that they're Mr. and Ms. Perfect, or, "I'm okay". I don't know, I think they're just having to put on a front face so long that they just can't. Or they have this weird belief that you're not going to go through

problems, that if you're a good enough Christian, God's going to fix everything, and then they get frustrated when he doesn't fix everything. I think it’s because we're never promised to be happy. We're just promised to be content, and people expect that if they prayed a lot louder or act like their holier than thou, that everything will go away. And also there's the people putting on a front, and then, like I said, people will just believe in, "Let's just pray about it." And, you know, God sends you a friend or a therapist, and you're like, "Oh, I'm just going to keep praying about it." You keep believing these things, and then you get frustrated when He's not there, but He’s saying, "I've already sent you a bunch of stuff." I think that's why they get weak. Yeah, I think that's it. It's just they're not hopeful anymore. I don't know, but I feel really bad for them, but I really think that's why.”

There was a consensus among the participants that the “Black Church” can and should do more to help address suicide, in both the church and in the local communities. They all agree that suicide is not a topic of the church, but that their faith and not “the church” is what has kept them from having suicidal thoughts currently.

**Theme 10: Suicide Being Unforgivable Sin**

The talk of suicide and suicide being the ultimate sin that one cannot be forgiven for were a few of the themes touched on in the third category of the interview guide. While discussing the topic of religion and suicide, the participant were asked to share their views of suicide from a religious standpoint. The idea that suicide is an unforgivable and unacceptable sin within their church doctrine and community was a commonality that surfaced among all the participants. One participant shared that in her church doctrine, she

was taught that "It's an unforgiven sin. It's not the ultimate. Blaspheming against the Holy Spirit is the ultimate. And you just signed your death certificate there. But, it's unforgivable. Because how can you ask for forgiveness? You're already gone."

Another participant declared: "we are to remember our bodies are a temple of the Holy Spirit. And how can I ever be able to live with Him if I did something like that? How can I expect to?"

Fifty-three percent of the participants believe that suicide is unforgivable because you never have the opportunity to ask God for forgiveness. There was one interesting response in which the participant explained that she felt that if one asks God for forgiveness in advance then there is a possibility that it (suicide) can be forgiven.

**Theme 11: Seeking Professional Help**

The participants were asked, if they ever reached out to a psychologist or a religious clergy to discuss suicide or having suicidal thoughts. The participants unanimously agreed that historically, "black people have not taken advantage of or sought out available mental health services. Instead, they heavily rely on the church and on their personal relationship with their Higher Being.

However, six of the fifteen participants in this study, sought professional help or had spoken with a religious clergy, though none of them ever called a suicide hotline. A participant mentioned that her suicide hotline was "the mainline to Heaven" and that she "look up to Heaven and talk to God". One participant shared: "I reached out. The first woman I talked to where I really felt like I seriously had to deal with the depression, she was a black psychiatrist. And that was when I was living in New York. And then the

second time I reached out to someone was - Roberta Martin is her name - she is a former psychiatric nurse but a pastoral counsellor. And then she referred me to a psychiatrist who happens to be a Christian." Another participant discussed her experience with seeking professional help from a psychiatrist. She mentioned "I did voluntarily go over to co-behavioral services, and I went and signed up to get pain management and therapy, and the person I was with tried to convince me that there was more wrong than I thought was wrong. But I was pretty vulnerable at that point, and then-- I don't know if it was a psychiatrist or a therapist. Whoever can prescribe medication…. She convinced me that I had bipolar disorder within like 15 minutes of reading me. I went to cope to deal with the depression with my grandparents, but when I got there to get help, then my dating relationship got mixed into those sessions. They put me on medication, which did not help at all. I did try to get services to address both, mainly the depression with grandparents, and I think it did more so to escape from that relationship I was in."

One of the participants between the 55-65 age range shared the following experience when they reached out to a professional for help: "when I met with the psychiatrist - I met with him for a couple of months - what he explained to me was really eye opening, because I did not know this. He said when you deal with depression like that, he said that every time you hit a point where you're really depressed, he said you spiral down even further, he said. And it's harder to come back up and out of it. So I think I was in my 50s, and I just said to myself, "Self, you will never go there again. You cannot afford to. You will die." And I just said, "I'm not dying. I'm not dying like that."

One of the women discussed how she felt that her mother should have been there for her to help instead of her having to seek other professional help. When questioned about why she felt her mother should have helped her, she stated “I think that my mother should be able to be there for me and she wasn't, so I didn't do anything. It's kind of like the same thing now it's always been, not that I'm holding it against her. Part of me does, but still. She's a single mom. It's not that I regret any of my siblings, but she had two kids, and then she added on more kids, and then she went to school, and she kept going to school and all these things, and just never had time to be a mom. But on top of that, she has all of this training as a therapist and she could help all these other people, but why can't she help her kid? I just felt like my mom-- a lot of people can go to their mom just because they're their mom, and then a lot of people can go to a therapist. I have a two-for-one combo, and how come she can't catch on that I'm going through this, but she can catch it for all of her clients?” She continued by stating, “I think she understood and-- I don't know. I think she understood what I was going through, but she-- I don't know if she thought she was just projecting her work onto us, or she was just too tired to deal with stuff at home [that she's dealing with at work?]. I honestly have no clue, but I don't think she's oblivious to any of it, especially when-- I don't know why, but lately she's been bringing up how I was as a teenager. She's been way-- she has such a negative tone about it lately. She knew what was going on. There's no way she didn't know when-- and then she knew a whole lot more other stuff. I don't know.”

Another participant explained that she felt that the pastoral counselor she spoke with was both a psychiatrist and a woman of religion. She added: “The person I saw was

a Pastoral counselor. Like I said, her training is-- she was a psychiatric nurse who decided to become a pastoral counselor. She was not a pastor. She took some kind of... pastoral counselling training."

An overwhelming majority of the participants agreed that African Americans do not seek professional help when it comes to mental health issues. There were several reasons why this fact is true, but the one that stood out the most in the interviews is the belief that mental illness is something that people are embarrassed about, and that most of them were taught to take all their troubles to God in prayer, or to other members of the church. Some participants noted that seeing someone for depression means you are weak or that "something was wrong with you" and from that comes a stigmatism that labels you as being "crazy".

**Theme 12: Is Suicide a Preventable Act**

The participants were asked if they thought suicide was a preventable act. All of the participants agreed that suicide could be prevented.

One of the older participants that thought suicide was preventable, expressed: "I do. I do. But I think it really depends on the person who's contemplating suicide. I believe that if they could get some help, it would turn them around, but I think they have to put themselves somewhere in a position where they want help. Then they have to know that help is available. I'm looking at all these guys coming back from the war, and they are committing suicide. And then they want to kill other people."

Another participant shared: "I think it can be prevented. It's going to be, how strong of a support group do you have in place? How free are you to really talk about

things that are going on, and have somebody that's not going to spit it back in your face? But they're going to be there to support you and walk you through. That's what we are as human beings we were created to need one another. When you have that in place no matter how much you get, if you have that one individual that you know is going to be there no matter what, and is going to be there to support you, to help you, and to walk you through it, you can handle anything."

Although most of the participants, young and old, felt that suicide was preventable, there were still a few that stated that it depends on the person and the circumstances. They explained that sometimes when a person really wants to harm, or kill themselves, there are no warning signs and no cries for help. One of the younger participants shared that she looked at suicide as a "silent killer" because many times it is not until after the act is attempted or completed, do people realize or notice that the individual was in emotional or mental distress. She explained that when she went through her first stage of contemplation and attempts, many of her family and friends proclaimed that they never knew she was dealing with anything or going through problems, physically or mentally. She further explained that she did her best to hide her feelings and emotions during her despairing times, by smiling and only crying when no one was around.

An older participants stated that "God himself is the preventer of such acts, and I can vouch for that."

**Theme 13: Religion and Spirituality as a Preventative Factor**

One section of the interview guide examined the participants' opinions on whether or not religious and spiritual affiliations and beliefs acted as a preventative factor during the times they experienced suicidal ideations and behaviors. In this section, the participants were asked to relive moments during the times of their distress and most vulnerable moments of contemplating suicide and were asked if, and at what time did their religious or spiritual beliefs come into to play. They were asked if being "unforgiven" was a thought that led to deterrence in the heat of the moment, or if there were other factors that more strongly influenced their decision not to follow through.

The participants were also queried on ways in which religion and spirituality can be used to prevent others from going down the despairing road of contemplating suicidal behavior, and how religious and spiritual affiliations can be used along with other mental health services in an effort to help those who are dealing with life struggles, and who are on the verge of considering doing harm to themselves.

Many of the older participants shared their there are different boards and groups established within the church that can be used to welcome those in that are going through a struggle. One of the groups mentioned was the "Women's Missionary Group" or "Women's Ministry". One participant explained that she is a part of this group and it is comprised of older women in the church who are "seasoned" and have been through things in life similar to what the younger and some of the older African American women are currently experiencing. The older Christians were very assertive in making the point that there are "Mothers of the Church" and other ministries such as the "Young Adult

Ministry" in several of their churches that are geared toward grooming and providing any needed support for the young adults in the church. Not only is this support related to emotional health, but they also offer advice and financial support as well. The older participants insisted that these groups can be used or geared toward discussing more of the topics such as suicide and homosexuality, which is often times topics overlooked and not discussed.

**Theme 14: Suicide Awareness in the African American Community**

The fourteenth theme taken from the interview guide focused on the participants' awareness about suicide and suicide prevention. Many of the statistics surrounding suicide as a whole was discussed. As the conversation progressed, general statistics were shared in regards to African Americans, and subsequently, more specific statistics were shared about suicidal ideations, attempted suicide, and completed suicide among African American women. However, three of the fifteen participants were unaware of suicide rates in general, and were somewhat taken aback at the startling statistics of suicide rates among the African American ethnic group.

The participants were asked if they were aware of the prevalence of suicide in the African American community.  Of the 15 participants only 4 participants, were aware that suicide is a rising problem within the African American ethnic group. This information is shown in a table presented later in this section, Table 4-2. Interview results show that 53% (8 of the 15 participants) of the women interviewed generally thought that suicide was only happening primarily among Caucasian Americans.

During the interview, the participants were told of existing statistics that indicates that African American women have the lowest rates of suicide among all ethnic groups and genders. This particular statistic, though seemingly unbeknownst to the participants prior to their interviews, was met with a response from the participants that was less shocking than some of the other suicide statistics mentioned. All of the women implied that they were not at all shocked or met surprised that African American women have the lowest suicide completion rate. When told that the number of attempts were increasing, a few of the participants raised a brow. It was the same reason they gave as to why African American women had the lowest completions that they used when becoming aware of the increased attempts.

The youngest participant explained: “I didn't know that. It's a little bit of a believable stat. I would say that Asian women would be the highest if I had to guess, so I wouldn't put them (African American women) in the list as the highest.

On a different note, while discussing their awareness of suicide, the participants were asked if they were personally aware of anyone in their family or community that has committed or attempted suicide. A younger participant shared these details: “I know for a fact that, except for the younger children, we've all tried it. I know my mom's tried it. She's shared that in the past. I know my brother has tried it. I know both of my other sisters have tried it. My sister has done it multiple times. One has scars. So except for the youngest two-- and I hope they never do or never have to go through that, but I know they have such a bad past that, who knows? But then again, I think it's all because our mother is a therapist. I don't know. But four or five of us have tried.” When asked if she

could share how her siblings tried to harm themselves, she responded: “I don't know how my mom tried. I know my brother, XXX (name/identifier has been removed due to confidentiality and under age children) was kind of a different version. I guess you could also say it's like extreme risk-taking behavior that we know are going to have a deadly outcome. I would put that in the same category as suicide attempts. He stopped taking his diabetes medication, and he had multiple diabetic seizures with the kids there. I know he drank and did some other stuff. And he didn't tell me completely, because I'm like mom for all of the kids except for my older sister, because that's kind of the role I took on. My sister, XXX (name/identifier has been removed due to confidentiality and under age children) tried. I know she cut her thighs and her wrists because she told me about that when we were in high school. And my younger sister, XXX (name/identifier has been removed due to confidentiality and under age children) has cut herself. Yeah, sure did. Yeah.”

In Table 2, the participants’ level of awareness about suicide is presented. As previously mentioned, 27% of the participants were aware of the prevalence or issues of suicide in the African American community. None of the women were aware that African American women had the lowest suicide rate among all ethnic and gender groups. When asked if they believed that suicide only exist among Caucasian Americans, the results showed that 53% believed this to be true. Only a few of the participant knew of other or family members that have attempted or actually completed suicide, accounting for 20% and 7% respectively.

Table 2

*Suicide Awareness Among African American Christian Women*

| Awareness | Number of participants | Percent of participants |
|---|---|---|
| Aware of the Prevalence Suicide In African American Community | 4 | 27% |
| Aware that African American Women have lowest suicide rates | 0 | 0% |
| Thought that Suicide Only Exist Among Caucasian Americans | 8 | 53% |
| Aware of Anyone in their Family or Community who Attempted Suicide | 3 | 20% |
| Aware of Anyone in their Family or Community that Completed Suicide | 1 | 7% |
| OVERALL NUMBER OF PARTICIPANTS | 15 | |

*Note.* Demographic Questionnaire Responses. See Appendix C for Dissertation Demographic Questionnaire IRB#08-26-15-0020319.

**Theme 15: Strength and Resilience of African American Women**

Several of the women felt that due to "building resilience from years of oppression", "gaining strength from daily struggles and being discriminated against", as well as having a strong spiritual foundation" African American women have the ability to rise above life crisis and challenges. In quite a few of the interviews, the ideas of African American women having a strong zeal to "adapt", "overcome", and "excel" were common sentiments. As one participant so stated: "I think we are resilient, and I think also that the vicissitudes of life will move us in a more spiritual direction where we will find hope and help. I mean, that's what I feel about us as Black women. Plus, we run to Jesus. Based on what you said your statistics are. I would understand that."

Another participant shared: "I believe in faith. African-American women are some of the strongest women out there. We have gone through a lot. I would think that suicide is higher in men and that's just me stating it because men don't know what it is to go through the pain, and struggle, and prevail. Women will feel different and handle the load, stress, and burdens better. They tend to be able to wear many hats, and even endure

being single moms and sole providers in a household, and making sure ends meet, and all is fed. And the African-American woman has gone through so much that they are stronger than any other race."

The women interviewed gave a lot of credit to the strength developed during the times of slavery, and the fact that during those times, the woman kept her family in prayer, and established religious roots that would last throughout generations to come. One of the participants eluded to the fact that "the only thing that got the slaves through slavery, being beat, being hanged, raped, and discriminated against was their strong faith in God, and by singing old spirituals to help the long hours and days, in the cotton fields, go by". She further added: "I just feel that Black women easily bounce back from trials and tribulations, and will take on many roles in order to survive and overcome obstacles. Every Black family knows that it's the women in the family that keeps the family together most of the time. Granted some fall short, most are still the true backbone and problem solver in the Black Family. They are known prayer warriors. If no one else needs the Black Woman and her strength and power, the Black Family surely does. Many of us are still here due to the prayers of our mothers and grandmothers, and their teachings of taking care of a family even when daddy is absent. Every mom will make sure their children eat, but there are some that will make sure their children are provided for by any means necessary and therefore couldn't think of killing themselves due to their children being dependent on them."

During the review of the transcripts, the word "strong" was a universal term used by all the participants when describing the African American woman and their ability to

endure. The second notable term used to describe African American women was "faithful". It was a combination of these two words that set the premise for the discussion and explanation as to why African American women have the lowest rate of suicide among all ethnic groups and genders, and there overall resilience to life struggles.

**Theme 16: Reasons for Living Among African American Christian Women**

The interview ended by the researcher asking the participants to rank six reasons for living in order of importance from highest to lowest (with 1 being the highest of importance) in regards to being the most important factor for the participant "not" committing suicide when they were having suicidal thoughts. The reasons for living included Spiritual/Religious Beliefs, Family/Relationship Status, Hopefulness, Positive Coping Skills, Economic/ Financial Status, and Self-Efficacy.

Table 3

*Ranking of Potential Protective Factors Against Suicide*

| Participants | Spiritual/Religious beliefs | Family/Relationship status | Hopefulness | Positive coping skills | Economic /Financial status | Self-efficacy |
|---|---|---|---|---|---|---|
| | | | Rankings (1 Highest - 6 Lowest) | | | |
| Participant 1 | 1 | 2 | 3 | 5 | 6 | 4 |
| Participant 2 | 3 | 1 | 5 | 4 | 6 | 2 |
| Participant 3 | 1 | 3 | 2 | 4 | 5 | 6 |
| Participant 4 | 2 | 3 | 1 | 4 | 6 | 5 |
| Participant 5 | 2 | 3 | 4 | 5 | 6 | 1 |
| Participant 6 | 1 | 2 | 3 | 5 | 6 | 4 |
| Participant 7 | 1 | 2 | 3 | 6 | 5 | 4 |
| Participant 8 | 1 | 2 | 4 | 5 | 6 | 3 |
| Participant 9 | 2 | 1 | 6 | 4 | 5 | 3 |
| Participant 10 | 1 | 2 | 4 | 5 | 6 | 3 |
| Participant 11 | 1 | 4 | 3 | 2 | 6 | 5 |
| Participant 12 | 1 | 3 | 4 | 5 | 6 | 2 |
| Participant 13 | 1 | 2 | 4 | 5 | 6 | 3 |
| Participant 14 | 2 | 1 | 3 | 4 | 6 | 5 |
| Participant 15 | 3 | 1 | 2 | 4 | 6 | 5 |

*Note.* Demographic Questionnaire Responses. See Appendix C for Dissertation Demographic Questionnaire IRB#08-26-15-0020319.

As presented in Table 4, spiritual and religious beliefs was selected as the number one protective factor against suicide by 9 (60%) of the 15 participants. The second highest ranked protective factor was Family/Relationship Status with 4 out of 15 (26.7%) scored as a 1. Twelve (80%) out of 15 participants scored Economic and Financial Status as a 6 which is the least likely to prevent or deter suicide.

Table 4

*Percent of Responses*

| | Spiritual/ Religious beliefs | | Family/ Relationship status | | Hopefulness | | Positive coping skills | | Economic/ Financial status | | Se |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Ranking (1 Highest To 6 Lowest) | # Times Selected | (%) | # Times Selected | (%) | # Times Selected | (%) | # Times Selected | (%) | # Times Selected | (%) | # Ti Sele |
| 1 | 9 | 60.0% | 4 | 26.7% | 1 | 6.7% | 0 | 0.0% | 0 | 0.0% | 1 |
| 2 | 4 | 26.7% | 6 | 40.0% | 2 | 13.3% | 1 | 6.7% | 0 | 0.0% | 2 |
| 3 | 2 | 13.3% | 4 | 26.7% | 5 | 33.3% | 0 | 0.0% | 0 | 0.0% | 4 |
| 4 | 0 | 0.0% | 1 | 6.7% | 5 | 33.3% | 6 | 40.0% | 0 | 0.0% | 3 |
| 5 | 0 | 0.0% | 0 | 0.0% | 1 | 6.7% | 7 | 46.7% | 3 | 20.0% | 4 |
| 6 | 0 | 0.0% | 0 | 0.0% | 1 | 6.7% | 1 | 6.7% | 12 | 80.0% | 1 |
| Total Responses | 15 | | 15 | | 15 | | 15 | | 15 | | 1 |

*Note.* Demographic Questionnaire Responses. See Appendix C for Dissertation Demographic Questionnaire IRB#08-26-15-0020319.

## Conclusion

### Findings and Conclusions

The findings and conclusions drawn from the qualitative interviews in Chapter 4 have provided significant information, based on the participants' accounts that reasonably provide an exploration of all of the study's research questions.

There were four research questions presented for examination:

1. How do African American Christian women contemplating suicide experience religious and spiritual dynamics?

2. How does spirituality compare to other sources of resilience and protective factors that decrease the risk of suicidal behavior?
3. How do African American Christian women between the ages of 21-55 experience sources of resilience and other protective factors differently from African American Women between the ages of 56-65 before, during, and after contemplating suicide?
4. What role, if any, does spirituality and religiosity play in the reluctance of some African American women who are contemplating suicide to discuss their ideation and to seek mental health services?

Differences between younger participants (21-55) and older participants (56-65) where not significant overall, but included the fact that the older participants believed that any life crisis experienced should ultimately be dealt with within the church ministry, while the younger generation believed that mental Health professionals should be utilized more. There were several streamline responses in which many of the participants' answers were similar. However, the most notable difference was in the responses to the discussion on seeking professional help. Participants under the age of 50 were more likely to seek professional help than those over 50. The younger participants expressed how times have changed and how they would be more apt to going to see a mental health professional before going to a church clergy. On the other hand, many of the older participants maintained the position that there are certain things and problems in daily life that should be addressed in a spiritual or religious manner and "not in a doctor's office".

The younger generation stated that the church is not the place to divulge all your personal information, but a place to build a relationship with God or a supreme deity, and through that personal relationship, you will receive guidance as to what help you should seek and what's available and appropriate for your own personal sake and situation. The younger generation felt that the church is a judgmental organization in terms of the congregants, and feel that no human had the answers, but only God himself. They felt that seeking professional help was non-biased and non-judgmental. The older group of participants felt the need to "keep our business out of the street and keep it in the House of the Lord". The young generation believed that you should pray for guidance and answers, while the older generation believed that "you should pray for God to fix it".

Table 5 summarizes some of the primary themes brought out during the interview process.

Table 5

*Primary Themes and Corresponding Statements*

| Notable themes | Number of participants | Percent of participants |
|---|---|---|
| Contemplated suicide | 15 | 100.00% |
| Attempted suicide | 8 | 53.33% |
| Agree that suicide is a taboo | 15 | 100.00% |
| Sought professional help | 6 | 40.00% |
| Sought help from clergy | 4 | 26.67% |
| Suicide is preventable | 13 | 86.67% |
| Aware of suicide rates in African American community | 7 | 46.67% |
| Suicide is unforgivable sin | 8 | 53.33% |
| Religion/Spirituality prevent suicide | 10 | 66.67% |
| Suicide is the ultimate sin | 9 | 60.00% |
| Total participants | 15 | |

*Note.* Demographic Questionnaire Responses. See Appendix C for Dissertation Demographic Questionnaire IRB#08-26-15-0020319.

**Reliability and Validity**

In order to establish a base for trustworthiness and provide evidence of validity, the researcher used a member check technique. Often times viewed as a controversial technique, a member check allows the researcher the opportunity to meet with the participant in a formal or informal manner in order to do a follow-up and cross-check with the participants to verify the accuracy of the data received. During the second phase of the interview and research process, participants were given the opportunity to review their transcripts in an attempt to correct any visible errors. At that time, the researcher and the participants were able to challenge any misinterpretations within the transcripts. Through member checking, participants were also given the opportunity to provide more information, if desired. The researcher was able to draw preliminary conclusions based on particular data received through the member checking technique.

Other techniques used to ensure verification of the trustworthiness or authenticity of findings included the researcher keeping a written journal, taking notes during the interview, and the use audiotapes. By using these techniques the researcher was able to ensure that the data was accurately transferred and presented.

**Future Research**

The purpose of this study was to examine the opinions and views of African American Christian women who have contemplated suicide. However, future studies should examine the religious and spiritual coping mechanisms and techniques that African American Christian women use in order to deflect and overcome life challenges without resorting to suicidal behavior.

In Chapter 5, the overall conclusion to the study will be presented. Chapter 5 will include a summary of the phenomenological based research study's processes and the conclusions drawn from the data collection process.

# Chapter 5: Discussion, Conclusions, and Recommendations

## Introduction

African American women have endured many struggles and obstacles over the years. However, African American women currently represent the ethnic and gender group that has the lowest rate of suicide completions (CDC, 2012). It was this fact that pioneered this study. The purpose of this study was to examine the dynamics of religion and spirituality among African American Christian women who have contemplated suicide. The study was conducted using personal interviews, which allowed the participants to relive and share their personal accounts with suicidal behavior. The 15 women interviewed displayed an array of opinions on the acceptance, forgiveness, teachings, discussions, prevention, and deterrence of suicide among the African American community and church, as well as in their own families. Varied opinions existed among the participants, but there were many similarities in their responses that themes were drawn from. In order to accurately capture such detailed experiences,I deemed it necessary to take the time to attentively listen to each of the participants lived experiences and perform follow-up interviews when needed for clarity. This chapter presents a summation of the study's results and provide conclusions drawn from the qualitative phenomenological research conducting.

Upon completion of this study, one observation and conclusion drawn was the notion that the 27% of the participants were aware that suicide does exist among African Americans though they were unsure to what extent. The participants agreed that suicide rates are on the rise, but 53% of the participants understood suicide to be a phenomenon

primarily affecting Caucasian Americans. As predicted, none of the participants were aware of African American women having the lowest suicide rate among all ethnic and gender groups.

All of the participants had some interesting experiences, and many of the participants had made more than one attempt to commit suicide and had suicidal thoughts on more than one occasion. The number of times of contemplation among the participants was much higher than the number of actual attempts.

The reasons participants cited for contemplating and attempting to commit suicide included such triggers as terminal illness, fear of failure, financial stressors, failed relationships, and losing loved ones. On the other hand, when discussing some of the factors that ultimately deterred the participants from committing suicide, many reasons were mentioned, such as the "grace of God" or some reference to spiritual beliefs for 11 of the 15 participants. The other four gave credit to such attributes as their children and other family members, such as parents and younger siblings. They thought about how much it would hurt their families and felt that their children needed them.

It seemed not to matter to the participants whether they were completely alone or surrounded by family and friends during their times of contemplation. However, the presence of others did have a positive effect on 90% of the participants interviewed, when it came to attempts. The participants were less likely to act on their suicidal thoughts when others were around and "could possibly stop" them or "intervene," as several of them put it.

Overall, in many instances, the participants recalled a feeling of being alone, upset, stressed, or depressed during the times of contemplation or during their attempts. This notion supports previous literature that indicated that depression has a direct link to suicidal behavior. Zhang and Li (2013) reported that hopelessness is a mediating factor in the link between depression and suicide. As discussed in the literature review, Zhang and Li suggested that the relationship between depression and suicide would decrease if hopelessness is controlled for.

Although many of the participants alluded to terminal illness being a possible reason that suicide might be accepted, all of them were still hesitant in their answer, seeming unsure if they really believed it was acceptable at all. Most of the participants followed up their answer by saying that they still feel that after their various experiences, that "there is always a better solution than suicide." A few of the participants explained how taking your own life is unacceptable and felt that "God is the giver and taker of human life." All of the participants agreed that even if a person did not believe in God or a higher being, there is still a way out and many available resources and support systems to reach out to for help.

It was unanimously shared and expressed among all participants that suicide is a taboo and a topic that is rarely talked about in their homes and communities. This fact has been supported by previous research (Hamm, 2012).

There was a consensus among the participants that the "Black Church" can and should do more to help address suicide, in both the church and in the local communities.

They all agreed that suicide is not a topic of the church, but that their faith and not the church is what has kept them from having suicidal thoughts currently.

An overwhelming majority of the participants agreed that African Americans do not seek professional help when it comes to mental health issues. There were several reasons why this fact is true, but the one that stood out the most in the interviews is the belief that mental illness is something that people are embarrassed about, and that most of them were taught to take all their troubles to God in prayer, or to other members of the church. Some participants noted that seeing someone for depression means the person is weak or that "something was wrong with you" and from that comes a stigmatism that labels you as being crazy.

Several of the participants alluded to the resilience and ability to adapt of African American women as being the root and foundation of their survival and longevity of life. The mention of "surviving oppression, discrimination, and abuse" was common among many of the interviews when describing the building up and development of resilience among African American women over the years.

During the review of the transcripts, the word *strong* was a universal term used by all the participants when describing African American women and their ability to endure. The second notable term used to describe African American women was *faithful*. It was a combination of these two words that set the premise for the discussion and explanation as to why African American women have the lowest rate of suicide among all ethnic groups and genders and their overall resilience to life struggles. However, this differs from a statement made by African American female author Alexander (as cited in Gluck, 2008)

in which she stated, “It is very much a misperception that black people don't commit suicide and that comes in part from a need, which is a very real and legitimate need for black people for many years to be very strong.”

In this research study, nine out of 15 participants chose spiritual and religious beliefs as the number one protective factor against suicide. Family/Relationship status was ranked as the second highest protective factor, and economic and financial status was selected as the least likely to prevent or deter suicide.

## Interpretation of the Findings

In this section of Chapter 5, discussion is presented that provides insight into the four research questions asked. A brief summary of findings for each of the four research questions is shared, based on related responses and themes, and a comparison is made describing how the findings affirm or deny previous peer-reviewed literature as presented in Chapter 2.

The first research question to be addressed is the following: How do African American Christian women contemplating suicide experience religious and spiritual dynamics?

The participants in this study all held their religious and spiritual beliefs in high regards. Eleven of the 15 participants were avid church goers. The other four participants explained that even though they do not attend church on a regular basis, they do pray constantly, if not several times a day. Each of the participants shared that their religious beliefs have served as their strength and is ultimately the source that has allowed them to “keep it together” during the worst of times; they also give credit to their spirituality for

being blessed during the best of times. The participants were very candid about sharing experiences in which they felt they would not have been able to survive if it was not for “the Grace of God.”

All of the participants recalled being raised by parents and families that had strong faith and strong religious and spiritual ties with churches and other religious groups. Nine of the participants remember growing up singing in the church choirs as a child, and six of the participants currently sing in their associated church choir as adults. When asked if they felt that religion was forced upon them as children, several of them said yes, while others mentioned that it was just a natural thing to attend church or to believe in a Higher Being or Power. Twelve of the participants recalled being taught to pray at an early age by either a parent, a grandparent, or other matriarchs of their families. According to Milner et Al. (2013), there was a negative relationship between such religious factors as "church adherence, active membership in a religious group" or "strength of religious beliefs in society" (p. 141) and suicide.

In spite of their strong Christian faith and church affiliations, all of the participants admitted to going through a period that signified a moment of weakness and doubt. It is during this time of weakness and doubt that they described feeling lost and if God was not listening to them or had turned a deaf ear to their “supplications and lamenting.” However, some of the participants recalled that after overcoming their ordeal, they looked back on the trials and tribulations they endured and viewed them as lessons from God, which he ordained in order to “make us stronger.” One of the participants explained,

> I get weak at times, but those are the times I know that I need to pray harder and re-evaluate my relationship with God. Sometimes it isn't until I go through something that I realize how strong He made me. I may get bruised by life, but never broken.

She continued on adding, "I almost gave up many times, even in my Christian journey, but being that I am still alive speaks volumes that God is real and prayer really changes things. I'm a witness to that."

The research question that generally allowed the researcher to probe into the participants' opinion on how spirituality compares to other sources of resilience and protective factors that decrease the risk of suicidal behavior generated various responses. As presented in Chapter 2, in previous research efforts, Street et al. (2012) investigated reasons for living among African American females who have attempted to commit suicide. These reasons for living included protective and risk factors such as hopefulness, self-efficacy, coping skills, high levels of social support, and effectiveness in obtaining resources as reasons why the suicide rate among African Americans may be lower than other ethnic groups. However, one of the recommendations of that study suggested the need to engage in further research in this area, thus the current study.

The participants' responses supported Miller and MacIntosh's (1999) position that resilience is a major vessel off positive psychology. In addition, in previous research, Rutter (1993) reported that the level of a person's resilience is dependent upon protective factors that the individual has developed over the course of their lifetime when dealing with harsh realities of life struggles. According to a lethality assessment conducted by

Lincoln et al. (2012), positive social and family interactions and support have been proven to significantly reduce the overall risk of suicide attempts among African Americans as a group compared to other ethnic groups.

Kallampally et al. (2007) argued that religion, along with spirituality, provide strong resilient resources that people can draw strength and support from in order to cope with existential conflicts that may surface in life. There have been many theorists that have linked religion and spirituality with resilience (Greene & Conrad, 2002).

Religious and spiritual beliefs received the highest ranking (60%) over all the other factors considered for comparison as a reason participants would not make further attempts to end their lives. The other factors included family relationships, hopefulness, self-efficacy, economic and financial status, and having positive coping skills. Molock et al. (1994) concluded that over the past decade, religion has been held as the chief protective factor against suicidal ideations and behaviors in the African American population. This notion supports the study's expected outcome that religion would receive the greatest number of responses from the participants.

Recent statistics suggested that over 13% of the individuals who completed suicide in 2008 were having financial and career setbacks (Gallucci, 2012). Milner et al. (2013) reported findings that suicide completion rates were related to such social factors as unemployment and divorce.  None of the African American Christian women interviewed, admitted to a financial downfall as reasoning for their attempts, or for the attempts and completions of other that they mentioned knowing to have also tried to commit suicide. . The closest encounter to a participant mentioning employment was a

participant who shared that she personally did not feel that she was good enough to compete in her career and had a tremendous fear of failure. However, in this study, as it relates to African American Christian women, financial and economic status was ranked the lowest as a reason for not committing suicide. This suggests that of all the factors that could prevent suicidal ideations and behavior, finances would be the least likely to have an effect among African American Christian women according to the participants.

Spirituality played a major role, as proclaimed by the participants, in the participants being able to circumvent many of the obstacles presented in life, which ultimately gave the participants the source of resiliency needed to shy away from potential self-harm. These findings support a study by Kaslow et al. (2004) discussed in Chapter 2, where researchers posited that those who have attempted suicide, compared to nonattempters, had more reports of maladaptive coping strategies, psychological distress, and less association with religiosity and spirituality. Mattis (2002) reported that African American women are more apt to increasing their religious practices and participation during the times crisis in an attempt to help develop more coping strategies when compared to African American men and other ethnic and gender groups. During the interviews, one participant shared that her husband attended church less often when they were having personal struggles within their marriage, while she felt the need to attend church and be around supportive people from her church more often. Another participant shared that she read the Bible more and prayed for strength a lot more during the trying times in her life and in her marriage.

Another area of comparison and discussion centered around the question of how African American Christian women between the ages of 21 to 55 experience sources of resilience and other protective factors differently from African American women between the ages of 56 to 65 before, during, and after contemplating suicide. Milner et al. (2013) reported findings that the association between religion and suicide was influenced by gender and age as well as by changing societal contexts and norms and cultural contexts. Milner et al. provided research evidence of how strong faith and religious traditions protect against suicide.

Of the many differing observations shared among the participants of varying age groups, it was no mistaking the idea that the older generation and the younger generation agreed that African American women have a very high level of resilience and tolerance for life's challenges. There were not very many differing opinions in regards to what they considered to be the protective factor that outweighed and outnumbered all others. This protective factor was religious and spiritual beliefs.

When discussing the suicide statistics and the number, age, and ethnic groups that are being affected by suicide and suicidal behavior, the older group attributed the statistics to how well individuals know God or a Higher Being. The older generation felt that there must have been some sort of disconnect between the individuals, not a particular race or gender, but the individual, and their personal faith and spiritual journey or relationship with God. The younger generation more so attributed the suicide statistics to whether or not the individual reached out for professional help, moral support, or had education or knowledge of available services and medications. It was the lack of

knowledge and lack of effort that played an intricate part in those who have contemplated, attempted, and ultimately completed suicide, according to the younger generation. Where the older generation expressed the need to have religious faith and pray without ceasing, the younger generation proposed to not only pray but get the professional help that is often times needed, but avoided due to being frowned upon.

The discussion of seeking professional help is a segue into the fourth research question which examines what role, if any, does spirituality and religiosity play in the reluctance of some African American women who are contemplating suicide to discuss their ideation and to seek mental health services? According to a national survey investigating the lethality of suicide, African Americans who reported suicidal thoughts or attempts were less likely than Caucasian Americans to seek mental health services (Ahmedani, Perron, Ilgen, Abdon, Vaughn, & Epperson, 2012). In the year prior to having suicidal thoughts or attempts, 59.7 percent of African Americans compared to 48.2 percent of Caucasian Americans with suicidal thoughts, and 57.8 percent African Americans compared to 27.1 percent of Caucasian Americans who attempted suicide, did not seek or receive any mental health services.

According to Mayers et al. (2007) there is a common drawback among several ethnic groups in regards to fearing that their faith is weakened upon engaging in professional mental help. Though proven to be more likely to be the case among African Americans, there is somewhat of a universal thought across racial and gender lines. Participants in the current study support these findings.

The younger generation seemed to think that a protective factor that is not being tapped into or sought after because of religiosity, is mental health resources. The younger generation appeared to be a stickler for African Americans overcoming their stigmas about seeking mental health services. They also felt that instead of shunning the idea of embracing talks about suicide and suicidal behavior, that the “church” or “religious doctrines” should incorporate programs within the church for the sole purpose of helping those who are battling suicidal tendencies. The younger generation shared that the “Black Church” makes it very difficult to talk about suicide. One of the participants explained that she found it to be contradicting how the “older members” of the congregation and the church clergy want those members suffering with depression and suicidal thoughts, to rely and depend on the church to help them, yet it’s an unspoken of [xxx delete of] issue both in the community and in private homes. One of the participants in her 30’s stated, “I’d rather talk to a stranger that’s trained to deal with suicidal issues, than someone that I know and who will possible judge me or tell my business”.

On the other hand, the older generation were proponents against seeking professional help outside the religious realm. There were some older participants that shared that they are not opposed to “this new age of seeking professional help”, but explained that even with seeking out mental health, one should ultimately seek God’s guidance and leave “everything in His hands”.

Overall, the discussion and exploration into the participants’ lived experiences provided a plethora of insight into a topic that is very important, but shied away from. The discussions rendered by this study provided the researcher with a tool to use in future

discussions, as well as in treatment plans for those contemplating suicide or dealing with someone who has suicidal tendencies are lost someone to suicide. This discussion evoked thoughtful and meaningful feedback from the clients that can be incorporated into real life situations, and constructed in a way to adequately treat, prevent, intervene and educate all ethnic and gender groups. The questions examined were tailored in a way that allowed open and authentic dialogue that can be shared for years to come.

## Study Challenges

One of the study's challenges was finding fifteen African American women that were willing to discuss their experience with suicide. It appeared that some of the participants were reluctant at first for fear of bringing up past hurt and traumatic ordeals. Another challenge was the thought that others in the chosen research sight might hear of their participation in the study and began to inquire or gossip among other members.

Another challenge was scheduling time for the interviews. This made for a real challenge, as most of the participants had families and jobs and lifestyles that were not conducive to keeping set appointments at times. Scheduling the interview times was not as big of a challenge as actually keeping the appointment time. This limitation caused the interview process and the research completion to be slightly longer than the anticipated research time period. Scheduling follow-up appointments also proved to be a daunting task. In order to meet this challenge several of the follow-up interviews were conducted via phone. The phone interview was acceptable. It did not allow for the researcher to have a one-on-one direct interview, but the participants did allow the researcher to audio record the phone interview as well.

A third challenge that the researcher experienced was scheduling a meeting with the church clergy to discuss the procedural aspects and proper protocol for conducting the study in the local church facility chosen for the research. Due to the roles and responsibilities of the key clergy that needed to sign-off on and approve the use of the facility, there was a delay in starting the research process. The research could not take place or begin without the approval of the flyers, announcements, and materials to be used at the facility during research and data collection. Because suicide is generally not a topic that is discussed or even mentioned in the church, per the Church Clergy, the researcher was asked to provide the clergy enough time to think through an appropriate strategy to approach the study and the topic. After several weeks, the researcher again met with the clergy and given proper procedures and approval to begin the study.

Lastly, a challenge occurred when one of the participants withdrew from the study after becoming emotionally overwhelmed when recounting her experiences which led her to a state of suicidal behavior. The interview was stopped abruptly and the participant was consoled and counseled by the researcher and was allowed to leave the interview. The participant was given numbers to local mental health resources and given a referral by the researcher. This participant was later replaced by another participant. The process of replacing the participant took a little over two weeks.

**Limitations of the Study**

Limitations to the research were encountered. Though few in number, these limitations are worth noting. One limitation of the study is the chosen sample size. This small sample size was chosen for feasibility of soliciting participants to discuss such a

topic, and because the sample size was deemed appropriate for this type of phenomenological qualitative research study. Though small in size, this sample provided sufficient information for the current study. However, the researcher suggests that future research on this topic cover a broader number of participants, thus a larger sample size, as time would not allow for more participants in the current study. Due to such a small sample, the current study could not establish external validity. The possibility of a national generalization of African American Christian women's opinions about suicide is less likely to occur considering the constraints of the study's sample size, and the confined area and location of the study.

Another limitation of the study lies within the collection of data from Christian women only. This limitation excluded the opinions of those African American Women that may identify themselves as being of Catholic, Protestant, Buddhist, or other religious denominations. In future research, it will be worth exploring the thoughts and beliefs of other religious groups, or even investigating African American women without a religious affiliation.

The age group of the participants, from 21 to 65, may also be considered as a study limitation, as it does not incorporate the views and opinions of African American women with age ranges outside this study's parameters.

Lastly, another limitation of the study is that the participants were all members of the same church congregation. This limitation could potentially skew the results of the participants' opinions about the African American Church's true involvement in the topic and prevention of suicide.

## Recommendations for Future Research

In addition to a larger sample size in future research, more qualitative research is needed geared toward exploring the various religious and spiritual coping mechanisms employed by African American Christian women during troubled times. The techniques that African American Christian women use in order to deflect and overcome life challenges without resorting to suicidal behavior can be a catalyst for suicide intervention and prevention. According to a literature provided by Kumar and George (2013), there is a strong need for support and development of coping strategies that can be employed to help prevent suicide. Kumar and George (2013) further purported that social support, life events, quality of life, and coping strategies are all very important factors related to prevention of attempted suicide.

Future research efforts should focus on examining the African American churches' reluctance to discuss and address the topic of suicide. This research should aim towards educating and providing awareness to African American churches as well as communities on the importance of being a vessel for providing an open forum for people to have an outlet to discuss issues and to get positive feedback from objective peers and listeners without judgement.

Another future research goal should focus on investigating the stigma surrounding reasons why African Americans rarely seek professional mental health services, in order to clear up any misconceptions.

Future research endeavors should include participants from various locations and a variety of religious affiliations, and not just of the Christian faith. Generalizing the

experience of suicide from one ethnic and gender group, all from one location excludes the valid views and opinions of others that have had notable experiences with suicide and suicidal behavior. Looking beyond one church organization and considering many walks of faith, researchers will be privy to a multitude of information on different doctrines and teachings among several church facilities opposed to being limited to the opinions of one population of participants.

Understanding other age groups**,** not captured in this study's age criteria, from age 21-65 years old, should be investigated in future research. By incorporating other age groups, conclusions can be drawn to help those, during the early and late stages of life, deal with suicidal behavior and thus prevent an increase in completed suicides among those age groups.

Inquiring about the opinions of other African American women that may not identify with any religious or spiritual groups may also prove beneficial in future research as a form of comparison of coping mechanisms and reasons for living. It would be worthwhile to explore preventive measures, as well as risk and protective factors that are deemed as important to those individuals that do not identify with God, Faith and a Higher Being. Since the current research support religion and spirituality as a "saving grace", it would be worth noting what non-believers attribute their decision not to proceed with self-harming behavior.

Yet, another area of future research should examine and compare the similarities and differences between African American Christian Women and other Christian women, such as Caucasian, Asian, Native, Hispanic, and various other ethnic women groups.

From the current research, though opinions were presented, it is still unclear how and why the opinions of the younger generation and older generation differ in situations where the opinions seemed to cross a generational gap. Some of the younger generation still maintain the views of their family matriarch in regards to dealing with personal and family troubles, due to generational teachings that have lasted over decades. There is still the question of whether adhering to the "old way" of thinking is appropriate in the current era, or if the "old way" of thinking is slowly fading considering the responses provided by the younger participants in the study. These responses led the researcher to believe that the younger generation tend to think that the Black Church is not a good resource or outlet for those contemplating suicide or experiencing suicidal behaviors. The younger generation further implied that there is professional help available, that African Americans are not utilizing, that may be a better and healthier avenue for those in need of mental health services opposed to the local church clergy.

Another area of interest for future research would be to explore reasons or life situations that participants feel suicide is acceptable and justified. By zeroing in on these potential acceptances, researchers may be able to counteract those thoughts of suicide being viewed as appropriate, and begin to project and discuss positive ways of dealing with those situations in which suicide may be viewed as acceptable, ultimately circumventing future suicide attempts and completions based on terminal illnesses or other extenuating circumstances.

## Implication for Social Change

The current study's implications for social change are very broad. The overall goal for social change is to understand the perspective of African American women who have contemplated suicide in an attempt to help others that may have or will experience similar accounts. By knowing those triggers and risk factors of suicide, and identifying educational and awareness gaps, therapists and mental health professionals can adequately address health concerns, stereotypes about seeking mental health help, and provide help to those underserved. Knowing the needs and concerns, as well as the views and opinions of others about suicide allows for social change from the standpoint of equipping mental health professionals with the answers to questions that can lead to helping to alter unhealthy thoughts and ways of living, to positive thoughts and a healthy way of life.

It is the examination and exploration of true lived experiences that allow for careful consideration into effective treatment plans. It is learning the needs of those suffering and addressing the inadequacies of mental health services, religious groups, and any other potential protective factors that is failing to meet the needs of those suffering, that will ultimately provide the necessary information and research needed to improve the intervention and prevention methods and overall quality of life. The current study provides much of those avenues to embark on such important social changes.

Now that the fact that African American Christian women rarely seek professional mental health services is known, psychologists should become advocates of their services, and provide outreach services to this population of women as well as to all.

All psychologists or mental health practitioners should embark on such an outreach, but there is a need for African American mental health professionals to also reach out among this group of women to make them aware and comfortable with tapping into the available services.

Mental Health Providers should collaborate with local churches and religious affiliations to spearhead spiritual health and wellness among avid Christians and bridge the gap of knowledge and extend the realm of resources among the two, to cohesively join together to attack the growing problems of suicidal behaviors. Instead of there being a division between the two, there should be solidarity without the thought of either overstepping their boundaries, or being out of line with the doctrine of faith. Religion, spirituality, and mental health should all be comingled in an effort to assist with individuals living the best quality of life on both a spiritual and mental plateau without the negative stigma that one is better or worse than the other. Knowing that there are some things that the church clergy cannot and are not equipped to treat, psychologist and church clergy should work hand in hand to develop the best wellness treatment for the struggling Christian. The joining of forces among Church clergy and Mental Health Professionals prevents either from having to over step their realm of expertise, but at the same time allows for a professional collaboration in the best interest of suicidal Christians. The Church of Scientology disagrees with many of the doctrines of psychology, (Morgans, 2013), and thus many other church related groups. However, in order to embark on social change for the betterment and preservation of human life, there needs to be a certain degree of solidarity between the disciplines.

In order to evoke social change, mental health providers should continue to stay abreast of the cultural changes, and key in on ethnic/gender specific strengths and weakness that can help or harm those who are dealing with life struggles. It is those strengths and weaknesses that can help tailor treatment plans; and it's those cultural changes and differences that may help fine tune treatment geared toward using religion and spirituality as support systems and protective factors against suicidal behavior.

## Conclusion

Black Americans die by suicide a full decade earlier than White Americans. The average age of Black suicide decedents is 32, and that of White decedents is 44. (Garlow, Purselle, & Heninger, 2005). In a national survey conducted in 2011 by the Substance Abuse and Mental Health Services Administration, it was found that within the last 12 months of the study's occurrence, 3.3% of African Americans and 3.7% of the total U.S. Population had serious thoughts of suicide; 0.9% of African Americans and 1.0% of the total U.S. Population made suicide plans, 0.7% of African Americans and 0.5% of the total U.S. Population attempted suicide; and 0.3% of African Americans and 0.3% of the total U.S. Population had gotten medical attention for a suicide attempt. In 2011, the lifetime prevalence of suicidal ideation and attempts among African American was placed at 11.82% and 4.15%, respectively, as reported by Borges, Orozco, Rafful, Miller, & Breslau, (2012).

Much of the research in previous years, has concentrated their efforts on examining the phenomenon of suicide among other ethnic and gender groups, notably Caucasian Americans, here in the United States of America, and have compared African

Americans to those various groups. However, this study focused its efforts on examining a group that has not been in the realm of research that often. African American women were chosen in this study to tell their stories, share their opinions, and relive their experiences with suicide and suicidal behavior.

As a result of this study, it was shown that there are people in the African American community that are oblivious to the statistics that are surrounding such a crucial and life-threatening issue. This study has provided African American Christian women with awareness of suicide, spirituality, protective factors, mental health services, and suicide prevention in hopes that these intricate details can be shared with others in the African American community and other communities as well. By increasing the knowledge of those participants that have experienced suicidal behavior, this study has the potential to provide education to many of those searching for people that share like experiences.

African American Christian women that participated in this study implied that more open discussions into the topic of suicide is relatively needed in a world and community where African American women "must remain quiet, secretive and yet strong, even though they are falling apart on the inside". Although it is this perceived strength that they hold in high regard as an explanation for African American women low rates of suicide, this same strength has in some cases affected them negatively. It is this strength, silence, and fear of appearing weak that has hindered them from becoming vocal about their suicidal thoughts and behaviors, thus not seeking help or guidance. They expressed that through education, awareness, and seeking mental health services,

suicide along with several other mental health issues that cannot be addressed or talk about in the "Black Church" can be treated and resolved.

The findings in this study support previous research that African Americans do not take advantage of the professional mental health services that are available. This research's findings also support the fact that African Americans are generally unaware of existing statistics regarding African Americans and suicide completions, attempts, and ideations. Furthermore, this study found evidence that supports that fact that religion and spirituality do function as a protective factor against suicide. Yet another finding of previous research, that was also found in this current study, is the fact that suicide remains a forbidden/hidden topic in the "Black Community and the Black Church". The research results demonstrates that African Americans are reluctant to seeking professional help in part, due to religious beliefs and controversial and judgmental views of the "Black Church".

When exploring whether or not suicide was acceptable, most of the participants agreed that it was not acceptable and that suicide was the ultimate unforgiven sin. However, there were a few of the participants that felt that suicide may acceptable in the case of long-term or terminal illness.

Overall, the conclusions drawn from this research study have set the stage for future research endeavors, and have thoroughly explored the experience of spirituality among African-American women who have contemplated suicide. This study addressed the research questions, by providing information collected during the interview process. The information collected allowed the researcher to present the findings in themes and

provide a clear overview of the lived experiences, thoughts, and opinions of African American Christian women who have contemplated suicide. The researcher was able to gain valuable insight into a phenomenon that is steadily increasing, in an attempt to embark on social change by implementing and conducting sound and effective mental health treatment and counseling to those that may be plagued with suicidal thoughts, ideations, or behavior.

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# Appendix A: Letter of Cooperation

Appendix A
Letter of Cooperation

August 27, 2015

Bishop Alexis Thomas
Pilgrim Rest Baptist Church
1401 E. Jefferson St.
Phoenix, AZ 85034

RE: Permission to Conduct Research Study

Dear Bishop Thomas:

I am writing to request your permission to conduct a research study at your institution. I currently attend Pilgrim Rest Baptist Church and have for the last seven years. I am also enrolled in the Clinical Psychology PhD Program at Walden University in Minneapolis, MN, and am in the process of writing my Dissertation for completion of the program. The study is entitled "The experience of spirituality among African American Christian women who have contemplated suicide".

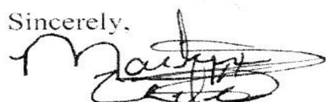
I hope that the church administration will allow me to recruit 15 to 20 African American women between the ages of 25-65 from the church to anonymously complete a face-to-face interview that will include a demographic survey, attitudes to suicide questionnaire, a religion scale, and reasons for living questionnaire (copies enclosed). Due to the nature of the study, I hope to recruit African American women who consider themselves as spiritual and having religious affiliations, and who've experienced having thoughts of suicide. Interested African American Christian women, who volunteer to participate, will be given a consent form to be signed (copy enclosed) and returned to the primary researcher at the beginning of the study process.

If approval is granted, participants will complete the face-to-face interview and survey in a designated area, or other quiet setting on the church's site. The activities will take place during a time that does not interrupt normal church business, programs, and worship services. The interview and survey process should take no longer than 1hr per participant. The study results will be pooled for the dissertation project and individual results of this study will remain absolutely confidential and anonymous. Should this study be published, only pooled results will be documented. No costs will be incurred by either your church facility or the individual participants.

Your approval to conduct this study will be greatly appreciated. I will follow up with a telephone call next week and would be happy to answer any questions or concerns that you may have at that time. You may contact me at my email address: Marilyn.wiley@waldenu.edu or call me at 520-431-7491.

If you agree, kindly sign below and return the signed form in the enclosed self-addressed envelope. Alternatively, kindly submit a signed letter of permission on your institution's letterhead acknowledging your consent and permission for me to conduct this survey/study at your institution.

Sincerely,



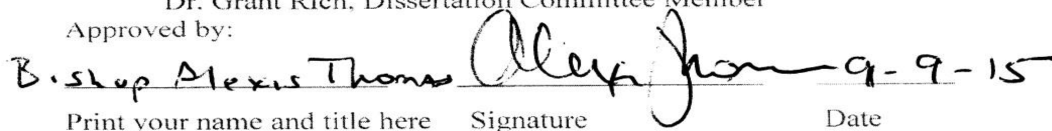
Marilyn Wiley, MSPsych
Research Investigator
Doctoral Candidate
Walden University

Enclosures

Informed Consent Form
Demographic Survey
Interview Guide

cc: Dr. Gerald Nissley, Dissertation Chair
Dr. Grant Rich, Dissertation Committee Member

Approved by:



Print your name and title here Signature Date

Appendix B: Informed Consent
IRB#08-26-15-0020319

You are invited to take part in a research study to examine African American Christian women that have contemplated suicide. The researcher is inviting you to be in the study because you are an African American Christian woman between the ages of 25-65 and have contemplated suicide. This form is part of a process called "informed consent" to allow you to understand this study before deciding whether to take part.

This study is being conducted by a researcher named Marilyn Wiley, who is a doctoral student at Walden University.

**Background Information:**
The purpose of this study is to explore what role, if any, does religion play in deterring African American Christian women from committing suicide.

**Procedures:**
If you agree to be in this study, you will be asked to:

- Particpate in the prescreening process that will take 20 minutes,
- Particpate in a face-to-face or phone interview that will take 30-45 minutes; and
- Participate in a follow-up interview, if needed, for clarifying interview questions that will take 20 minutes

Total estimated time of commitment for the participant will be 1 hr and 45 minutes. The interviews will be tape-recorded, with the particpant's permission.

Here are some sample questions:

1. What are your thoughts, in general, about suicide in the Black community?

2. Have you ever seriously considered committing suicide or had suicidal thoughts or ideations? If so, can you share what that experience was like and the events surrounding that experience?

3. Was there a particular event that lead to your thoughts of suicide? If so, what was that event, and if it was multiple things can you share those as well?

4. Were you alone or totally isolated, when the suicidal thoughts began, or were there others present?

**Voluntary Nature of the Study:**
This study is voluntary. Everyone will respect your decision of whether or not you choose to be in the study. No one will treat you differently if you decide not to be in

the study. If you decide to join the study now, you can still change your mind later. You may stop at any time.

**Risks and Benefits of Being in the Study:**
Being in this type of study involves minimal risk of the minor discomforts that can be encountered in daily life, such as becoming upset, crying, or feeling emotional discomfort due to the topic of the research. Being in this study would not pose risk to your safety or wellbeing. Furthermore, participation in this study may not benefit the participant in any way.

**Payment:**
There will be no payment to the participant. However, a $5 dollar gift card to Starbuck's will be given to the participant for their completed participation.

**Privacy:**
Any information you provide will be kept confidential. The researcher will not use your personal information for any purposes outside of this research project. Also, the researcher will not include your name or anything else that could identify you in the study reports. The data will be stored and locked away in a secured filing cabinet. These documents will be stored for a period no longer than three years and will then be purged or destroyed as required by the university. The interviews will take place at a convenient and private office location in Phoenix, AZ.

**Contacts and Questions:**
You may ask any questions you have now. Or if you have questions later, you may contact the researcher via phone or email (520-431-7491 or marilyn.wiley@waldenu.edu). If you want to talk privately about your rights as a participant, you can call Dr. Leilani Endicott. She is the Walden University representative who can discuss this with you. Her phone number is 612-312-1210. Walden University's approval number for this study is **08-26-15-0020319** and it expires on **August 25, 2016.**

The researcher will give you a copy of this form to keep.

**Statement of Consent:**

I have read the above information and I feel I understand the study well enough to make a decision about my involvement. By signing below, I understand that I am agreeing to the terms described above.

Printed Name of

______________________________

______________________________

Participant Date

of consent

Participant’s Signature

Researcher’s Signature

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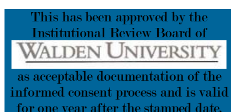

Appendix C: Demographic Questionnaire

IRB#08-26-15-0020319

1. What is your Age? ____

2. What is your Gender?
   a. Male
   b. Female

3. What is your Race?
   a. African American
   b. Native American
   c. Asian American
   d. White or Caucasian
   e. Latin American
   f. Hispanic American

4. What is your current Marital Status?
   a. Single
   b. Married
   c. Divorced
   d. Widowed
   e. Other___________ (please specify)

5. What is your annual income?
   a. 0-12k;
   b. 13-24k; 2
   c. 5-49k; 50k & above

6. What is the highest level of education you completed?
   a. Some high school;
   b. High School Diploma;
   c. Bachelors;
   d. Graduate or
   e. Professional Degree

7. Would you describe yourself as a religious person?
   a. Extremely Religious;
   b. Somewhat Religious;
   c. Not Religious

7a. What religion, religious denomination or body do you belong to?

a. Christian;
b. Protestant,
c. Muslim; Buddhist;
d. Jewish;
e. Catholic;
f. Atheist;
g. Agnostic;
h. Other (please specify) ___________________________

8. How would you rate your overall health at the present time?
a. Excellent
b. Good
c. Fair
d. Poor

9. How satisfied are you with your life?
a. Extremely Satisfied
b. Somewhat Satisfied
c. Neither Satisfied nor Dissatisfied
d. Somewhat Dissatisfied
e. Extremely Dissatisfied

10. How did you hear about this research study? _Flyer _Church

11. Have you ever seriously considered committing suicide or had suicidal thoughts or ideations?

# Appendix D: Interview Guide

IRB#08-26-15-0020319

**Personal Experiences**

1. What are your thoughts, in general, about suicide in the Black community?

2. Have you ever seriously considered committing suicide or had suicidal thoughts or ideations? If so, can you share what that experience was like and the events surrounding that experience?

3. Was there a particular event that lead to your thoughts of suicide? If so, what was that event, and if it was multiple things can you share those as well?

4. Were you alone or totally isolated, when the suicidal thoughts began, or were there others present?

5. Can you explain a little about your emotional state at the time of the experiences? (crying, upset, deep thought, despair, afraid, nervous, anxious, sad, depressed, panic, calm)

6. When contemplating suicide, did you act on it in any way? Preparation? Letter? Expressed your intent verbally? Attempted self-harm (if so what form)?

7. In the heat of the moment of your suicidal thoughts, what positive factors for living crossed your mind? What negative factors were wearing against you at the time? (pros and cons).

8. Have you ever contacted or called a suicide hotline?

9. What are some of the things that ultimately deterred you from going through with harming yourself?

**Family and Friends**

10. Is suicide frowned upon in your family or community?

11. If someone, family, friend, or stranger, alerted you that they were having suicidal thoughts, what would be some of the things that you would say or mention to them as being an important reason to "not" end their life?

12. Do you know of someone, other than yourself, that has committed suicide, or have exhibited suicidal tendencies, behaviors, or ideations?

13. After experiencing your own bout with suicidal thoughts and tendencies, how do you view other women that may be going through the same experiences that you had or have? Does looking at things from someone else's standpoint change your thoughts about suicide at all?

14. Is there a particular family member, or close friend that you were able to confide in during your time of experiencing suicidal behaviors and tendencies?

**Religion**

15. Have you ever spoken to clergy or a psychologist about suicide or having suicidal thoughts? If so, what was their guidance or feedback given if you can recall?

16. What does your church or doctrine teach about suicide?

17. Does knowing your spiritual affiliation's position on suicide play a role in how you think of suicide personally? Or do you feel that there are personal boundaries between religion and your personal beliefs on suicide?

18. In your opinion, what is a situation in which suicide could be acceptable? Can you think of any situation in which suicide would be acceptable? What would prevent you from seeing suicide as acceptable?

19. Do you think that suicide is the "ultimate sin"?

20. What are your thoughts on Christians committing suicide? Does it happen? What does it signify about faith or religion if anything?

21. Are there times that you have been faced with a crisis or life struggle that you feel your spiritual ties is what pulled you through? Do you mind sharing those times and experiences?

22. Do you feel like religion or spirituality is a strong support and necessity in your life?

23. During your suicidal behavior, did you pray at all, or read scriptures or religious doctrines?

**Awareness**

24. What do you think about suicide being a taboo among the African American community and being a hidden topic?

25. With whom have you ever discussed the topic of suicide? (i.e. family, friends, or even in church) What was the outcome?

26. What are your thoughts on suicide being only something that affect the Caucasian American community?

27. Are you aware that since October 2010 there have been at least five suicides publicized in the media that were committed by African Americans ages 18-26? What is your reaction to this information?

28. Were you aware that studies have shown that Black men experienced a steady increase in rates of suicide beginning in the 1980s? Why do you believe that this increase occurred?

29. Were you aware that more and more children are committing suicide daily?

30. What is your opinion on the thought that suicide only affects the mentally ill?

31. Were you aware that studies have shown that Black women have some of the lowest rates of suicide amongst all ethnicities and genders? In your opinion, why are suicide rates so low for this group?

32. What are your thoughts on suicide being something that is preventable?

**Reasons for Living**

33. On a scale from 1-6 (with 6 being the lowest), how would you rank the following in regards to being the most important factor for you "not" committing suicide when you were having suicidal thoughts:

    ___ 1. Spiritual/Religious Beliefs

    ___ 2. Family/Relationship Status

___ 3. Hopefulness

___ 4. Positive Coping Skills

___ 5. Economic/ Financial Status

___ 6. Self-Efficacy

(Participants Name), that concludes my interview at this time. I would like to personally thank you for volunteering to be a part of this very important research study. I would like to make you aware that there will be a brief follow-up interview after assessing this interview, in an effort to gain understanding and clarity of some of your answers. Again your personal information will be kept in the strictest confidence and will not be shared, nor names divulged in the study. I would like to thank you for your participation by giving you a $5 gift card to Starbuck’s Coffee. And once again thank you for your time and I will be back in touch with you to schedule the follow-up interview in the upcoming weeks via phone or email.

Appendix E: Study Flyer

IRB#08-26-15-0020319

**LET'S TALK!!!**
**VOLUNTEERS NEEDED FOR**
**RESEARCH STUDY ON**
**THE EXPERIENCE OF RELIGION AND SUICIDE AMONG AFRICAN AMERICAN CHRISTIAN WOMEN**

We are looking for volunteers to participate in a qualitative research study. As a participant in this study, you would be asked to participate in a face-to-face interview in which you will be asked to share your thoughts and experiences on suicide, suicidal ideations, suicide attempts and having spiritual/religious beliefs. The interview will take approximately 1 hour and may require a follow-up interview. In appreciation of your time, you will receive a $5 Starbucks Gift Card.

If you are interested, please inquire here.
Thank you!

This study has been reviewed and approved by the Institutional Review Board of Walden University

Thank you!
This study has been reviewed and approved by the

**WEB ADDRESS**

**AGE:** 25-65

**ETHNIC GROUP:**
AFRICAN AMERICAN WOMEN

**SIGN UP:**
Email Ms. Marilyn Wiley at Marilyn.Wiley@waldenu.edu
Or call (520)-431-7491

**DEADLINE FOR SIGN-UP:**
Sept. 27th, 2015

**BENEFITING**
The School of Psychology and African American Studies

**Confidential**

Appendix F: Resources

IRB#08-26-15-0020319

**Note: If you feel that you may be in danger of committing suicide, or if you know of someone who may be in danger, please do not hesitate to contact the following sources:**

## Professional Organizations That Can Provide Information or a Referral

- American Psychiatric Association
  www.psych.org
  apa@psych.org
  1-888-357-7924 and press 0
- American Psychological Association
  www.apa.org
  http://locator.apa.org/
  1-800-964-2000
- National Association of Social Workers
  www.naswdc.org
  www.helppro.com/nasw/BasicSearch.aspx
- Department of Veterans Affairs
  www.mentalhealth.va.gov/gethelp.asp
- U.S. Substance and Mental Health Services Administration (SAMHSA)
  http://findtreatment.samhsa.gov/

## National Grassroots Support Organizations

- Depression & Bipolar Support Alliance
  www.dbsalliance.org
- Anxiety Disorders of America Association
  www.adaa.org/findinghelp/treatment
- Mental Health America
  www.mha.org

- National Alliance for the Mentally Ill (NAMI)
  www.nami.org

## In an Emergency, Contact:

- —Suicide Prevention Hotline: 1-800-273-TALK (8255)
- —Psychiatric hospital walk-in clinic
- —Hospital emergency room
- —Urgent care center/clinic
- —Call 911