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Developing Suicide Prevention Programs for African American Youth in African American Churches

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Suicide prevention programs for African American youth in African American churches may have broad appeal because: (1) the Black Church has a strong history of helping community members, regardless of church membership; (2) African Americans have the highest level of public and private religiousness; and (3) the church can help shape religious and cultural norms about mental health and help-seeking. The proposed gatekeeper model trains lay helpers and clergy to recognize the risk and protective factors for depression and suicide, to make referrals to the appropriate community mental health resources, and to deliver a community education curriculum. Potential barriers and suggestions for how to overcome these barriers are discussed.

Suicide is the third leading cause of death for African American youth aged 15 to 24 (Centers for Disease Control [CDC], 2006). While completed youth suicides represent a major public health problem in the United States, they only represent a small fraction of suicidal behaviors. The Youth Risk Behavior Surveillance (YRBS) survey found that in the 12 months preceding the survey, 16.9% of high school students seriously considered making a suicide attempt, 13% made a suicide plan, and 8.4% made a suicide attempt in 2005. Among African American youth, 12.2% reported seriously considering a suicide attempt, 9.6% made a suicide plan, and 7.6% made a suicide attempt. White American and Hispanic students were more likely to seriously consider suicide and have a suicide plan than African American high schoolers but, in 2003, African American and Hispanic males surpassed White American males for the first time in suicide attempts that required medical attention (CDC, 2004). Firearms remain the most commonly used suicide method among African American youth, followed by suffocating (usually due to hanging), and poisoning (Joe & Marcus, 2003).

The few studies that have looked at suicide risk in African American adolescents suggest that depression, hopelessness, delinquent behavior, and substance abuse are risk factors for suicide ideation, attempts, and/or completions (Ialongo et al., 2004; O'Donnell, O'Donnell, Wardlaw, & Stueve, 2004). Protective factors for suicidality in African American teens include family support, religious coping, and in some cases negative attitudes toward suicide (Greening & Stoppelbein, 2002; Marion & Range, 2003).

To date, there are no suicide prevention programs that are specifically directed at

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African American youth. The CDC (2004) recently suggested developing suicide prevention programs that address multiple risk factors, are easily accessible, are attractive to youth, and are readily endorsed by peers, family members, and the broader community. The Black Church may provide an ideal context to develop suicide prevention programs because it is easily accessible; widely respected; endorsed by family members, peers, and the community; and has historically provided for the spiritual and emotional needs of the African American community (Lincoln & Mamiya, 1990).

It may be particularly helpful to anchor community-based interventions in culturally relevant contexts like the Black Church because African Americans are underrepresented in outpatient mental health treatment (U.S. Department of Health and Human Services [DHHS], 2001a). School-based programs have begun to make some inroads in suicide prevention for youth (Gould, Greenberg, Velting, & Shaffer, 2003), but church-based suicide preventive interventions could provide additional resources for African Americans, particularly because school-based interventions often have difficulty engaging and retaining minority group families (Kumpfer, Alvarado, Smith, Bellamy, 2002). Churches may be better able to engage families in prevention programs since African American families in general and African American adolescents attend church at a higher rate than any other ethnic group (Gallup & Bezilla, 1992), and families may be more likely to trust programs that are located in churches rather than school contexts (Molock, 2005). Church-based programs can also emphasize protective mechanisms (e.g., spirituality) that may be more difficult to use in schools because of concerns around presenting religious materials in school settings. The church context allows researchers to examine the potential for diffusion of suicide prevention messages in the broader community since the Black Church has provided an effective avenue for diffusion for prevention messages for other health behaviors (e.g., cancer) (Campbell et al., 1999).

Developing Suicide Preventions in the Black Church

The Black Church community provides a natural context for intervention programs because religion and spirituality are such central components of African American culture and thus has the potential to reach a wide audience. In multiple national samples, African Americans consistently engaged in more public and private religious devotion than other racial/ethnic groups (Chatters, Taylor, & Lincoln, 1999). Even African Americans who do not attend church regularly engage in more private devotional activities than other racial/ethnic groups (Taylor, Ellison, Chatters, Levin, & Lincoln, 2000).

While religious behaviors generally decline during adolescence, subjective religiousness is still widespread among adolescents (Gallup & Bezilla, 1992). African American adolescents engage in more personal and public religious behaviors than other ethnic groups, and see themselves as more religious than White American adolescents (Molock, Puri, Matlin, & Barksdale, 2006). Religiousness is associated with positive mental health outcomes and appears to inhibit delinquent behavior (Stark, Kent, & Doyle, 1982), substance and tobacco use (National Center on Substance Abuse and Addiction, 2001), as well as depression and suicide (Molock et al., 2006). Religion also provides youth with moral directives, normative bearings, spiritual experiences, access to important role models, and an opportunity to learn social competencies including community and leadership skills, and coping skills.

Although African American churches are not monolithic, research suggests that there is a common religious/cultural ethos that underlies many African American churches, hence the reference to the "Black Church" (Lincoln & Mamiya, 1990; Simms, 2000). The Black Church refers to those independent, historic, and totally African American controlled denominations that constitute the core religious experience of the majority of African American Christians

(e.g., African Methodist Episcopal Church [AME]; National Baptist Convention, USA, Inc., [NBC]; Church of God in Christ [COGIC]). The majority of African Americans (56.1%) belong to one of the Baptist denominations. The Black Church has much in common with Christian churches in other racial/ethnic communities, but there are consistent differences in the emphases and valences given to particular theological perspectives (e.g., oppression and liberation), styles of worship, and the centrality placed on the preached word in the worship experience (Lincoln & Mamiya, 1990). While there has been some decline in its influence on voting patterns and the mentoring of leadership at the national level, the Black Church continues to have a positive influence on the African American community by providing social support and promoting self-reliance and political activism. It also has a persuasive leadership that is uniquely situated to influence the community and its ministerial peers (Wilmore, 1998).

Many African American churches already provide a number of social services to the African American community. Research suggests that two-thirds of the social service programs provided by churches pertain to families and youth (Rubin, Billingsley, & Caldwell, 1994). Qualitative studies have found that African American pastors and churches are open to adopting mental health interventions in church contexts, particularly when the programs are aimed at strengthening families and youth (Molock, 2005). Even youth are open to suicide prevention programs that involve young adult gatekeepers or trusted church leaders (Molock, Barksdale, Matlin, Puri, & Spann, 2007).

The Black Church also provides an ideal location in which to develop suicide interventions because African Americans are more likely to seek help from clergy for mental health concerns, report greater satisfaction with the services provided by clergy, are less likely to seek help from mental health professionals once they have seen clergy, and often view clergy as formal mental health providers (Molock, Spann, Barksdale, Gaiber, & Plourd, 2004; Neighbors, Musick, & Williams, 1998; Young, Griffith, & Williams, 2003). Advantages to receiving help from clergy include the reduction of stigma, affordable services, and the elimination of cumbersome referral systems.

While some may argue that youth who attend church are at low risk for suicide, the protective mechanisms of religion and spirituality are complex. For example, Molock et al. (2006) found that certain religious coping styles (e.g., self-directive) actually place adolescents at risk for suicidality. The church context may also present barriers to prevention programs. In general, clergy are less likely to recognize suicide lethality (Domino & Swain, 1986) and make fewer referrals to mental health professionals (Blank, Mahmood, Fox, & Guterbock, 2002). Churches that adopt an "other-worldly" theology that focuses more on heaven and eternal life tend to believe that individual salvation is the solution to social problems and prefer interventions that are Biblically based (Gray, 2001). On the other hand, churches that adopt a "this-worldly" theology tend to be actively involved in the political and/or social concerns of the community and are more likely to have social outreach programs that attempt to address the psychosocial needs of the immediate community (Becker, 1999; Lincoln & Mamiya, 1990).

Others have noted that the cultural/religious taboo against suicide has been protective of African Americans (Early & Akers, 1993) and have raised concerns that prevention programs that focus on youth suicide may inadvertently "normalize" suicidal behavior in this community (Chambers et al., 2005). This is an important issue to address since some research suggests that focusing too much attention on negative behaviors may inadvertently de-stigmatize the behaviors to the point where there is an actual increase in the very behaviors one is trying to eliminate (Cialdini, 2003). However, suicide prevention programs can address these concerns by developing programs that emphasize risk reduction and enhancement of protective mechanisms, minimize descriptive norms (e.g.,

current suicide trends), and emphasize changing injunctive norms (e.g., promoting treatment seeking).

These potential barriers suggest that implementing programs that are congruent with the implicit and explicit values of the church is critical. Research suggests that barriers specific to the church context can be minimized by integrating intervention programs into already existing ministries, recognizing the importance of using "lay helpers" (i.e., nonprofessional caregivers), and building and maintaining good relations with church leaders (Eng & Hatch, 1991). These techniques have already been used to successfully implement and sustain health intervention programs (e.g., smoking cessation programs, exercise and nutrition programs) in African American churches (Swanson, Crowther, Green, & Armstrong, 2004), and in developing prevention programs around other sensitive topics in black churches (such as domestic violence.

In sum, while there is very little research on church-based mental health interventions targeted for youth, the Black Church provides an ideal context to develop interventions for depression and suicide in the African American community. The Black Church is in a strategically ideal position to develop suicide prevention programs because religiosity is a core tenet of African American culture, the Black Church has been influential in other social behaviors, and churches are the sociocultural context in which many African Americans already engage in help-seeking behaviors. Pilot work by the authors indicate that churches from a variety of denominations are interested in developing mental health interventions which focus on youth in general and on depression and suicide, particularly if mental health professionals are open to recognizing and respecting the expertise of clergy and to work with clergy as equal partners (Molock et al., 2004).

In the following sections, we present a proposed gatekeeper suicide prevention model for African American adolescents—Helping Alleviate Valley Experiences Now (Haven). The model has four key components: lay helpers, gatekeepers, a mental health resource directory (MHRD), and community education curriculum (Figure 1). It is important to note that the proposed HAVEN uses a population versus targeted approach to suicide prevention in that the entire church community is exposed to the intervention. There is considerable debate in the literature on whether population-based approaches to suicide prevention are efficacious (Shaffer, Garland, Vieland, Underwood, & Busner, 1991) or cost-effective (Gould et al., 2003). Indicated interventions with methodologically rigorous designs often fail to demonstrate effectiveness outside the laboratory context (Rossi, Freeman, & Lipsey, 1999). There are also ethical concerns with providing mental health referrals to at-risk youth but omitting such services to church members in general. Most importantly, designing an indicated program for at-risk youth in the context of the African American church violates the strong religious and cultural norm to help *all* who come through the doors of the church. It may also inadvertently reinforce the marginalization that many African Americans already experience trying to access mental health services. Recently, studies that have used statistical simulations comparing the impacts of different approaches to suicide prevention (e.g., population vs. targeted approaches) suggest that population-based strategies may have the greatest impact in reducing overall suicide risk (CDC, 2004).

THE GATEKEEPER SUICIDE PREVENTION PROGRAM MODEL

The Role of Lay Helpers

The HAVEN uses a lay health advisor model (referred to as the Lay Helper model) to facilitate the contextualization of the suicide prevention program. The lay health advisor model had been successfully used in Black churches by promoting the church as a mediated structure to negotiate mental health services with professional agencies for church participants (Eng & Hatch, 1991).

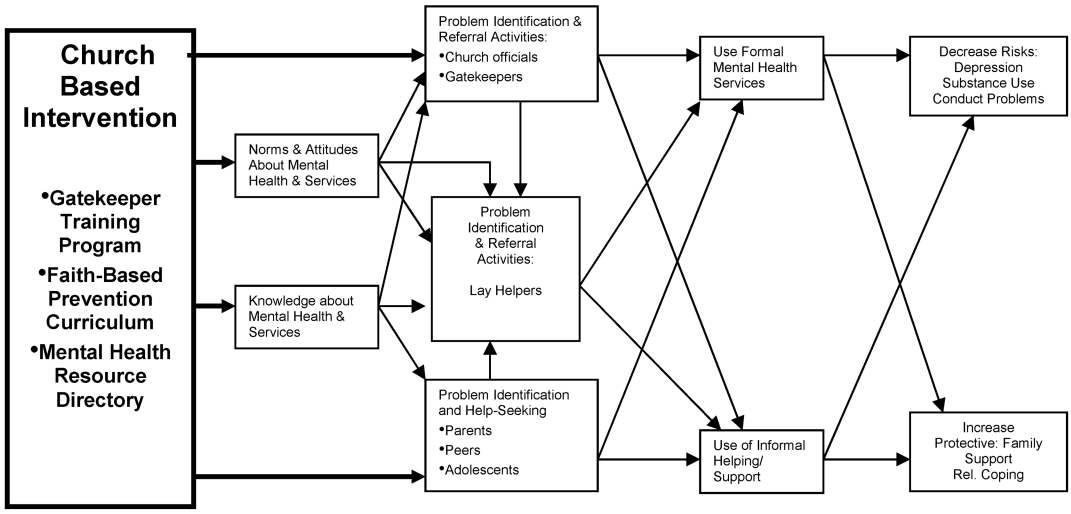

Figure 1. HAVEN Intervention model.

Lay helpers are "natural caregivers" who provide emotional support and tangible assistance for church members. These natural helpers are taught to identify risk and protective factors, educate church members, make referrals to outside agencies, and increase the exchange of self-care resources among members.

A hallmark of this model is that it focuses on strengthening network ties of all church members, not just those at high risk. Thus, while the primary focus of the HAVEN is on youth, all members of the church who need a mental health referral will be able to have access to care. Prevention programs involved in changing health behaviors in African American churches have generally been successful when all members were allowed to benefit from the services (Eng & Hatch, 1991; Yanek, Becker, Moy, Gittelsohn, & Koffman, 2001).

Gatekeeper Training

The HAVEN proposes to use gatekeeper training as the foundation of its intervention model. The National Strategy for Suicide Prevention (NSSP; DHHS, 2001b) noted that a critical function of suicide prevention programs is linking participants to appropriate mental health resources. In a comprehensive review of youth suicide prevention programs, Gould and colleagues (2003) noted that gatekeeper programs demonstrate substantial promise in program effectiveness and efficacy. Gatekeeper programs are designed to provide training to nonprofessionals to help them identify risk and protective factors associated with suicidal behaviors, determine risk levels, and make appropriate mental health referrals when necessary. Gatekeeper models often contain a screening component as well. The gatekeeper model has been successfully used in secondary schools, universities, hospitals, fire and police departments, and the U.S. Air Force (King & Smith, 2000; Knox, Litts, Talcott, Feig, & Caine, 2003; Quinnett, 1998). While long-term outcomes for these programs have yet to be assessed, research to date indicates that gatekeeper programs receive positive evaluations from both school administrators and gatekeepers, and that gatekeepers show evidence of gains in knowledge and intervention skills (Evans et al., 2005).

The HAVEN is modeled after the QPR gatekeeper program (Quinnett, 1998), a widely used suicide intervention that has three components: *Questioning* the meaning of possible suicidal communications; *Persuad-*

ing the person in crisis to accept help; and *Referring* the person to the appropriate mental health resource. QPR is modeled on the chain of survival model that is used in cardiopulminary resuscitation, which suggests that early detection and early, swift, and appropriate interventions save lives. It also assumes that the entire community must become involved in preventing suicides, a population approach that has been used successfully in the U.S. Air Force (Knox et al., 2003).

One of the strengths of the QPR model is that it strongly recommends tailoring the program to meet the needs of individual settings (P. Quinnett, personal communication, September 13, 2004). Thus, the QPR model can be contextualized to the Black Church setting by including information on the epidemiology of suicide among African Americans, including information on the risk and protective factors specifically associated with suicide in African American youth, addressing questions and concerns about "suicidal" behaviors that are specific to minority communities (e.g., victim-precipitated suicide; Joe & Kaplan, 2001), and using the discussion of risk and protective factors associated with suicide to promote more general awareness of and detection of mental health problems. Gatekeepers can also receive some training in detecting signs of general mental illness by learning about the link between suicide risk factors (e.g., depression) and other disorders (e.g., substance abuse).

In the HAVEN, gatekeepers are tentatively defined as members of the church who are leaders who regularly interact with youth (e.g., youth choir director, scout leader), members of the administrative body of the church (e.g., deacons, trustees, church administers), and/or young adult members of the church. Pastors can also add gatekeepers depending on the needs of their respective churches. All pastors, ministerial staff, Sunday School teachers, and Bible study instructors should receive gatekeeper training because they already serve as first responders to congregants' crises.

It is most likely beneficial to include the pastors of the churches in the identification of lay helpers and gatekeepers to not only maximize participation in the programs, but to recognize and respect the authority pastors have as "shepherds" of their congregations (Toth, 1999). The first author's ongoing research in African American churches and experience as a minister suggests that churches are more receptive to interventions if social scientists respect pre-existing lines of authority and decision-making norms within the church. Concerted efforts should also be made to recruit young adult and male gatekeepers. In a qualitative study of the feasibility of developing suicide prevention programs for youth in African American churches, Molock and colleagues (2007) found that African American adolescents who attended church regularly stated a clear preference for young adult helpers/gatekeepers because of concerns about confidentiality and the inability of older adults to identify with adolescent concerns. Male gatekeepers may also serve as role models and as a resource to men in the broader community.

The trained gatekeepers will refer at-risk youth by conveying the information to a lay helper who will coordinate and track mental health referrals using the mental health resource directory (see below). The lay helper will also assist the consumer in making his/her first appointment and will make follow-up calls to assess appointment-keeping for subsequent appointments. Follow-up calls can be explained in the context of concern about the well-being of the church member to minimize potential concerns about the intrusiveness of follow-up calls.

The Mental Health Resource Directory

Since all gatekeeper models emphasize the importance of referring individuals in suicide crisis to the appropriate mental health resources, it is critical that suicide prevention programs have mental health resources that are accessible, affordable, and culturally compatible with potential consumers. Thus, in addition to using the QPR gatekeeper program, the HAVEN proposes to develop a men-

tal health resource directory (MHRD) with input from key stakeholders in both the faith-based and mental health communities. This community participatory approach will help contextualize the MHRD, which should enhance the adoptability and sustainability of the HAVEN (Yali & Revenson, 2004). Pastors, ministerial staff, lay members, community mental health agencies, local county and state mental health associations (C/SMHAs), national professional associations for people of color (e.g., National Organization of People of Color Against Suicide, Association of Black Psychologists), local and regional faith-based organizations, and nominations from key consumers of mental health services can be utilized to develop a list of local mental health resources/providers.

Mental health providers should be recruited to be listed in the MHRD. In addition to providing geographic location and contact information, each provider/agency can be contacted and surveyed about their experience with: (1) depressed/suicidal clients; (2) other specialized areas of mental health treatment (e.g., substance use disorders); (3) ethnic minority clients; (4) members of faith-based communities; and (5) acceptance of third party insurance and use of sliding scale fees. This information can then be developed into the MHRD. The process of developing the MHRD should be manualized so that it can be used to guide the development of other suicide prevention programs. The lay helpers can also be trained to update the information in the MHRD on a regular basis.

Community Education Component

In addition to the gatekeeper program, church members should have access to information about both risk and protective factors for suicide through a community education component of the HAVEN. While awareness alone does not prevent suicide, increasing awareness of suicide risk and protective factors is an important aim of many suicide prevention efforts (DHHS, 2001b). Problem recognition is an important aspect of help-seeking behaviors as well (Cauce et al., 2002). The proposed community education component will be delivered through the Faith Based Prevention Curriculum (FBPC; Molock, 2006). The FBPC is a condensed version of a semester-long course that the first author teaches to graduate students at an accredited seminary in a historically black college/university, and is designed to increase awareness of suicide risk and protective factors by targeting two sets of factors that have been found to influence mental health service utilization: (1) beliefs and norms about emotional problems and suicidal behavior and (2) beliefs and norms about the use of mental health services. The FBPC has also been used as a training tool for a number of clergy and lay persons and has been well received. The curriculum involves providing church members with information about the risk and protective factors associated with suicidal behaviors using communication mediums that have cultural and religious relevance in the Black Church context: sermons, Bible Study and Sunday School lessons. The sermons and Christian education lessons also contain strong messages that support mental health help-seeking behaviors. This is a critical component of the HAVEN, because we believe that the use of sermons and Bible study lessons to convey messages about suicide and treatment seeking will help to de-stigmatize suicide, and thus change attitudes and norms about mental health service utilization by giving parishioners "permission" to talk about and seek treatment for suicidality. Sermons that focus on the risk and protective factors associated with suicide can be delivered at regular intervals throughout the church year. It is recommended that Bible study and Sunday School lessons focusing on the same material are conducted during the same week as the sermons to maximize the saturation of the information to congregants.

In addition to the faith-based curriculum, churches can also be assisted in developing a formal alliance between representatives from the church and mental health communities. Attempts should be made to match mental health agencies with churches based

on geographic location and common interests between the two communities. This committee could meet on a regular basis (e.g., quarterly) to discuss common concerns about mental health problems and services in the two communities.

CONCLUSIONS AND FUTURE DIRECTIONS FOR RESEARCH

Despite the documented need, there is very little research on mental health interventions targeted for African American youth. The authors propose that the Black Church may provide an ideal context in which to develop interventions for depression and suicide in the African American community because of its broad acceptance and strong history of helping all community members. The advantages to providing suicide prevention programs in African American churches include ease of accessibility and programs held in a more family-friendly context (e.g., holding programs after working hours, providing child care). These programs would also occur in a context that does not have to overcome the burden of distrust or history of cultural insensitivity that has been associated with other community institutions (e.g., school settings, mental health, and/or health settings). The Black Church may also have a wider impact in the African American community because of the high level of religiousness in this ethnic group. The church can provide a therapeutic milieu while simultaneously working to reduce the stigma associated with help-seeking and may be the one institution that has the greatest potential to shape religious and cultural norms about mental health and help-seeking.

We proposed a gatekeeper training model to develop a suicide prevention program in African American churches. Gatekeeper training models have demonstrated promising results in program effectiveness and efficacy and can be easily used to train nonprofessionals to help youth and church members receive mental health services. This model should be fairly easy to adapt to the context of Black Churches because it readily fits into the service-oriented mission of most Christian churches. The proposed model also stresses the collaborative development of a mental health resource directory to refer individuals to appropriate mental health resources as necessary. The use of community-based participatory research (CBPR) strategies in developing the HAVEN is recommended because research suggests that the use of CBPR models enhance the development, implementation, evaluation, and dissemination of prevention programs (Israel, Schulz, Parker, & Becker, 2001; Williams, Belle, Houston, Haire-Joshu, & Auslander, 2001). Furthermore, we recommend including a community education component in the intervention to increase awareness.

There are several factors that one should consider in implementing a model like the HAVEN. Initially, relatively larger, stable churches should be solicited for partnerships since research suggests that these churches are more likely to have the resources to develop, implement, and sustain social support programs. Stability in leadership also maximizes the likelihood that the programs can be developed and implemented (Routhauge, 1990; Williams, Griffith, Young, Collins, & Dodson, 1999). The churches' polity and the hierarchical structure of the church should also be considered in program development. For example, it may be easier to engage churches with a congregational polity (e.g., Baptist churches) because leadership is exercised at the level of the local church. Style of worship (e.g., demonstrative or meditative), theological principles (e.g., this worldly vs. other worldly), and doctrine (e.g., views on women in ministry, homosexuality, etc.) may also influence a church's readiness to develop the interventions. Finally, it may be easier to embed a suicide prevention program in a larger program designed to address the concerns of the faith community. Churches may be better able to invest resources in programs that address behaviors that occur more frequently and are less stigmatized (e.g., substance abuse).

In presenting the HAVEN model, there

is no presumption that the model will generalize to all African American churches. For example, the HAVEN would probably not generalize to churches located in rural areas with scarce mental health resources and smaller congregations. Although this may be viewed as an inherent weakness in the model, the aim of the HAVEN is not to develop universal suicide prevention programs for all African American churches, but to explore how this program might work in particular contexts. It is our hope that information from this model can then be refined so that further studies can see how well this model adapts to smaller churches, churches in rural areas, and churches in non-Protestant faith-traditions.

Despite the potential barriers to implementing suicide prevention programs in Black churches, we believe that collaborating with the Black Church to develop suicide prevention programs provides a promising approach to better address the unmet needs of many African American individuals and communities. The program proposed in this article is presumed to work because it will provide information about suicide risk and protective factors in an institution that is already highly trusted and valued in the African American community and presents information in a format (e.g., sermons) that is already culturally salient, relevant, and acceptable in the church context. We believe the program will be more readily accepted and adopted into church context because the program is managed by persons who are already well known and trusted within the church community (lay helpers). The HAVEN also maximizes the possibility of changing social norms about mental health and help-seeking behaviors by using messengers that are already highly valued, trusted, and familiar in the community (ministers and lay educators), and by using models or metaphors that the congregants are already comfortable and familiar with (i.e., through the use of sermons, Sunday, school, and Bible study). It is also believed that the program's sustainability will be enhanced by using mechanisms to educate Church communities about suicide risk, to enhance known protective factors (e.g., church attendance, church involvement, and religious coping), and to provide important links to professional mental health services in a context that is already highly valued and trusted in the African American community (i.e., the Black Church).

REFERENCES

Becker, P. E. (1999). *Congregations in conflict: Cultural models of local religious life*. New York: Cambridge University Press.

Blank, M. B., Mahmood, M., Fox, J. C., & Guterbock, T. (2002). Alternative mental health services: The role of the black church in the South. *American Journal of Public Health*, *92*, 1668–1672.

Campbell, M. K., Demark-Wahnefried, W., Symons, M., Kalsbeek, W. D., Dodds, J., Cowan, A., et al. (1999). Fruit and vegetable consumption and prevention of cancer: The black churches united for better health project. *American Journal of Public Health*, *89*, 1390–1398.

Cauce, A. M., Domenech-Rodriguez, M., Paradise, M., Cochran, B., Shea, J. M., Srebnik, D., & Baydar, N. (2002). Cultural and contextual influences in mental health help seeking: A focus on ethnic minority youth. *Journal of Consulting and Clinical Psychology*, *70*, 44–55.

Centers for Disease Control and Prevention. (2004). CDC surveillance summaries. *Morbidity and Mortality Weekly Reports*, *53*, SS–2.

Centers for Disease Control and Prevention. (2006). CDC surveillance summaries: Youth Risk behavior surveillance—United States, 2005. *Morbidity and Mortality Weekly Reports*, *55*, SS–5.

Chambers, D. A., Pearson, J. L., Lubell, K., Brandon, S., O'Brien, K., & Zinn, J. (2005). The science of public messages for suicide prevention: A workshop summary. *Suicide and Life-Threatening Behavior*, *35*, 134–145.

Chatters, L. M., Taylor, R. J., & Lincoln, K. D. (1999). African American religious participation: A multi-sample comparison. *Journal of the Scientific Study of Religion*, *38*, 441–456.

Cialdini, R. B. (2003). Crafting normative messages to protect the environment. *Current Directions in Psychological Science*, *12*, 105–109.

Domino, G., & Swain, B. J. (1986). Recognition of suicide lethality and attitudes toward sui-

cide in mental health professionals. *Omega*, *16*, 301–308.

EARLY, K. E., & AKERS, R. L. (1993). "It's a white thing." An exploration of beliefs about suicide in the African American community. *Deviant Behavior*, *14*, 277–296.

ENG, E., & HATCH, J. W. (1991). Networking between agencies and black churches: The lay health advisor model. *Prevention in Human Services*, *10*, 123–146.

EVANS, D. L., FOA, E. B., GUR, R. E., HENDIN, H., O'BRIEN, C. P., & SELIGMAN, M.E.P. (EDS.). (2005). *Treating and preventing adolescent mental health problems: What we know and what we don't know*. New York: Oxford University Press.

GALLUP, G. H., & BEZILLA, R. (1992). *The religious life of young Americans*. Princeton, NJ: The George H. Gallup International Institute.

GOULD, M. S., GREENBERG, T., VELTING, D., & SHAFFER, D. (2003). Youth suicide risk and preventive interventions: A review of the past 10 years. *Journal of the American Academy of Child and Adolescent Psychiatry*, *42*, 386–405.

GRAY, A. J. (2001). Attitudes of the public to mental health: A church congregation. *Mental Health, Religion & Culture*, *4*, 71–79.

GREENING, L., & STOPPELBEIN, L. (2002). Religiosity, attributional style, and social support as psychosocial buffers for African American and white adolescents' perceived risk for suicide. *Suicide and Life-Threatening Behavior*, *32*, 404–417.

IALONGO, N. S., KOENIG-MCNAUGHT, A. L., WAGNER B. M., PEARSON, J. L., MCCREARY, B. K., PODUSKA, J., ET AL. (2004). African American children's report of depressed mood, hopelessness, and suicidal ideation and later suicide attempts. *Suicide and Life-Threatening Behavior*, *34*, 395–407.

ISRAEL, B. A., SCHULZ, A. J., PARKER, E. A., & BECKER, A. B. (2001). Community-based participatory research: Policy recommendations for promoting a partnership approach in health research. *Education for Health*, *14*, 182–197.

JOE, S., & KAPLAN, M. S. (2001). Suicide among African American men. *Suicide and Life-Threatening Behavior*, *31*, 106–121.

JOE, S., & MARCUS, S. (2003). Datapoints: Trends by race and gender in suicide attempts among U.S. adolescents, 1991–2001. *Psychiatric Services*, *54*, 454.

KING, K. A., & SMITH, J. (2000). Project SOAR: A training program to increase school counselors' knowledge and confidence regarding suicide prevention and intervention. *Journal of School Health*, *70*, 402–407.

KNOX, K. L., LITTS, D. A., TALCOTT, G. W., FEIG, J. C., & CAINE, E. C. (2003). Risk of suicide and related adverse outcomes after exposure to a suicide prevention programme in the US Air Force: Cohort study. *British Medical Journal (International edition)*, *327*, 1376–1379.

KUMPFER, K. L., ALVARADO, R., SMITH, P., & BELLAMY, N. (2002). Cultural sensitivity and adaptation in family-based prevention interventions. *Prevention Science*, *3*, 241–246.

LINCOLN, C. E., & MAMIYA, L. H. (1990). *The black church in the African-American experience*. Durham, NC: Duke University Press.

MARION, M. S., & RANGE, L. M. (2003). Do extenuating circumstances influence African American women's attitudes toward suicide? *Suicide and Life-Threatening Behavior*, *33*, 44–51.

MOLOCK, S. D. (2005, May). *Proposed model for developing a suicide prevention program for African American churches*. Paper presented at the annual meeting of the Society for Prevention Science, Washington, DC.

MOLOCK, S. D. (2006). *Faith-based prevention curriculum (FBPC)*. Unpublished manuscript, The George Washington University.

MOLOCK, S. D., BARKSDALE, C. B., MATLIN, S., PURI, R., & SPANN, M. (2007). Qualitative study of suicidality and help-seeking in African American adolescents. *American Journal of Community Psychology*.

MOLOCK, S. D., PURI, R., MATLIN, S., & BARKSDALE, C. (2006). Relationship between religious coping and suicidal behaviors among African American adolescents. *Journal of Black Psychology*, *32*, 366–389.

MOLOCK, S. D., SPANN, M. N., BARKSDALE, C. L., GAIBER, S., & PLOURD, A. (2004, April). *Risk and protective factors for suicidal behaviors in African American adolescents*. Paper presented at the meeting of the American Association of Suicidology, Miami, FL.

NATIONAL CENTER ON SUBSTANCE ABUSE AND ADDICTION. (2001). *So help me God: Substance abuse, religion and spirituality*. New York: Author.

NEIGHBORS, H. W., MUSICK, M. A., & WILLIAMS, D. R. (1998). The African American minister as a source of help for serious personal crises: Bride or barrier to mental health care? *Health Education and Behavior*, *25*, 759–777.

O'DONNELL, L., O'DONNELL, C., WARDLAW, D. M., & STUEVE, A. (2004). Risk and resiliency factors influencing suicidal behaviors among urban African American and Latino youth. *American Journal of Community Psychology*, *33*, 37–49.

QUINNETT, P. (1998, July). QPR: Police suicide prevention: Questioning, persuading, referring. *FBI: Law Enforcement Bulletin*, 19–24.

ROSSI, P. H., FREEMAN, H. E., & LIPSEY, M. W. (1999). *Evaluation: A strategic approach*. Thousand Oaks, CA: Sage.

ROUTHAUGE, A. J. (1990). *Sizing up congregation for new member ministry*. Washington, DC: Alban Institute, On Demand Publications.

RUBIN, R. H., BILLINGSLEY, A., & CALDWELL, C. H. (1994). The role of the black church

in working with black adolescents. *Adolescence*, *29*, 251–266.

SHAFFER, D., GARLAND, A., VIELAND, V., UNDERWOOD, M. M., & BUSNER, C. (1991). The impact of curriculum-based suicide prevention programs for teenagers. *Journal of the American Academy of Child Adolescent Psychiatry*, *30*, 588–596.

SIMMS, R. (2000). Christ is black with a capital "B": African American Christianity and the black studies project. *The Western Journal of Black Studies*, *24*, 100–111.

STARK, R., KENT, L., & DOYLE, D. P. (1982). Religion and delinquency: The ecology of a "lost" relationship. *Journal of Research in Crime and Delinquency*, *19*, 4–24.

SWANSON, L., CROWTHER, M., GREEN, L., & ARMSTRONG, T. (2004). African Americans, faith and health disparities. *African American Research Perspectives*, *10*, 79–88. Retrieved August 12, 2004, from http://www.rcgd.isr.umich.edu/prba/perspectives/ springsummer2004/swanson.pdf.

TAYLOR, R. J., ELLISON, C. G., CHATTERS, L. M., LEVIN, J. S., & LINCOLN, K. D. (2000). Mental health services in faith communities: The role of clergy in black churches. *Social Work*, *45*, 73–87.

TOTH, J. F. (1999). Power and paradox in an African American congregation. *Review of Religious Research*, *40*, 213–229.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES. (2001a). *Mental health: Culture, race, and ethnicity. A supplement to mental health: A report of the Surgeon General.* Rockville, MD: Author.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES. (2001b). *U.S. Surgeon General's Report on the National Strategy for Suicide Prevention*. Accessed 2 October 2002 from http:// www.mentalhealth.samhsa.gov/suicideprevention/strategy.asp

WILLIAMS, D. R., GRIFFITH, E.E.H., YOUNG, J. L., COLLINS, C., & DODSON, J. (1999). Structure and provision of services in black churches in New Haven, Connecticut. *Cultural Diversity and Ethnic Minority Psychology*, *5*, 118–133.

WILLIAMS, J. H., BELLE, G. A., HOUSTON, C., HAIRE-JOSHU, D., & AUSLANDER, W. F. (2001). Process evaluation methods of a peer-delivered health promotion program for African American women. *Health Promotion Practice*, *2*, 135–142.

WILMORE, G. (1998). *Black religion and black radicalism: An interpretation of the religious history of Afro-American people.* New York: Orbis.

YALI, A. M., & REVENSON, T. A. (2004). How changes in population demographics will impact health psychology: Incorporating a broader notion of cultural competence into the field. *Health Psychology*, *23*, 156–157.

YANEK, L. R., BECKER, D. M., MOY, T. F., GITTELSOHN, J., & KOFFMAN, D. M. (2001). Project joy: Faith-based cardiovascular health promotion for African American women. *Public Health Reports*, *116*, 68–81.

YOUNG, J. L., GRIFFITH, E.E.H., & WILLIAMS, D. R. (2003). The integral role of pastoral counseling by African American clergy in Community mental health. *Psychiatric Services*, *54*, 688–692.

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