

Journal of Black Psychology

<http://jbp.sagepub.com>

The Aftermath of Suicide among African Americans

Donna Holland Barnes

Journal of Black Psychology 2006; 32; 335

DOI: 10.1177/0095798406290470

The online version of this article can be found at:

<http://jbp.sagepub.com/cgi/content/abstract/32/3/335>

Published by:

 SAGE Publications

<http://www.sagepublications.com>

On behalf of:



[Association of Black Psychologists](#)

Additional services and information for *Journal of Black Psychology* can be found at:

Email Alerts: <http://jbp.sagepub.com/cgi/alerts>

Subscriptions: <http://jbp.sagepub.com/subscriptions>

Reprints: <http://www.sagepub.com/journalsReprints.nav>

Permissions: <http://www.sagepub.com/journalsPermissions.nav>

Citations (this article cites 15 articles hosted on the SAGE Journals Online and HighWire Press platforms):
<http://jbp.sagepub.com/cgi/content/refs/32/3/335>

The Aftermath of Suicide Among African Americans

Donna Holland Barnes

This article describes an exploratory qualitative study that examined the impact of suicide on a group of 19 African American families who lost a family member to suicide. The majority of suicide survivors were women who lost children to suicide. The participants were interviewed for an average of 2.5 hours using a semi-structured interview that was developed by the author. The majority of survivors felt that they had to go through the grieving process alone. Those survivors who did receive support most often received it from family members and friends. Most of the respondents felt that the support, if any, that was offered from the church was unhelpful. Negative attitudes about suicide from the broader community and from family members made it more difficult for these families to grieve.

Keywords: *suicide survivor; postvention; African American suicide; support groups; social support*

There is a paucity of research on suicide survivors and even fewer studies exist on African American suicide survivors. *Suicide survivors* are individuals who have lost a family member to suicide (Dunne, McIntosh, & Dunne-Maxim, 1987). Although suicide is a relatively rare event, particularly among African Americans, the recent dramatic increase in suicide among African American youth makes it critical to understand this phenomena. According to the Centers for Disease Control and Prevention (CDC), between 1980 and 1995, rates for African American youth aged 15 to 19 increased 128% compared to 19% for Whites (U.S. Department of Health and Human Services, 1998). Although there has been a recent decline in the suicide rates among African American youth, suicide continues to be the third-leading cause of death for 15- to 24-year-old African Americans (National Center for Injury Prevention and Control, 2004).

JOURNAL OF BLACK PSYCHOLOGY, Vol. 32 No. 3, August 2006 335-348

DOI: 10.1177/0095798406290470

© 2006 The Association of Black Psychologists

Unfortunately, some African Americans continue to deny that suicide is a problem within the Black community; this view is buttressed by the fact that suicide is a relatively rare behavior among all ethnic groups. This community denial makes it difficult for families to heal when they have lost someone to suicide. An important first step to the healing of survivors is that the word *suicide* has to become part of the language of the African American community. First, the language of suicide can facilitate the development of effective community-based and institutionally based services for African American survivors as well as prevention and intervention services within the broader community. If the rise of suicide in African American communities is addressed and talked about along with numerous other social ills, perhaps more education awareness would be welcomed and instituted in facilities that address risk factors such as substance abuse, domestic violence, and youth violence. The degree to which suicide is or is not denigrated within a community determines the ways in which the stress it engenders among survivors is managed. If it is not addressed and a family loses someone to suicide, how does that family go through the healing process without feeling a sense of stigma? If suicide is considered a taboo subject in African American communities and is rarely addressed (Early, 1992), then those who experience it are generally ashamed to openly discuss it. Earlier studies on suicide among African Americans have suggested that the rates were historically low because of misclassifications (Warshauer & Monk, 1988) and because families may be more likely to report suicide deaths as accidents to avoid the stigma associated with suicide (Poussaint & Alexander, 2000).

Bereavement of a suicide has many emotional complexities that may evoke such symptoms as anxiety, difficulty concentrating, sleep disturbance, and depression. These same symptoms are listed as risk factors for suicide in the *Surgeon General's Call to Action* (U.S. Public Health Service, 1999), a report announcing suicide as a national epidemic. Unresolved grief can make it difficult for family members to reconstruct a meaningful personal reality (Neimeyer, 2002). Cultural experiences appear to have an impact on the bereavement experience (Rodgers, 2004). One study on accidental deaths of a loved one revealed that African Americans will turn to drugs to numb the pain of the loss, especially when feelings of abandonment are associated with the death (Ehrmin, 2002). Another study on bereavement among African Americans found that religious beliefs helped the grieving process in those who lost elderly mothers; beliefs in life after death or the reunification of family members helped to ease the grieving process for these individuals. Moore, Hazell, and Honeyghan (2001) noted that bereavement educators, counselors, clergy, and other specialists

have observed that African Americans tend to underutilize general bereavement resources. However, the literature suggests that involving clergy in outreach to the African American community may be a viable strategy for developing bereavement supports.

Recent studies emphasize that grief associated with suicide differs from those who grieve from other forms of death because of the emotional complexities that go along with losing someone this way (Jordan, 2001; Reed, 1998). The stigmatization can be painful for suicide survivors whose guilt, shame, and blame can be intensified and reinforced by the lack of discussion about suicide within a community (Fine & Myers, 2003). There has been a profusion of articles, papers, and chapters written on suicide survivorship in an effort to understand suicide bereavement (Dyregov, 2002; McIntosh, 1993; Ness & Pfeffer, 1990). However, this literature exclusively focuses on the experiences of Whites—with the exception of a few studies on suicides among the Chinese that do not focus primarily on survivors (He & Lester, 1997; Pearson & Liu, 2002). The current study was undertaken to address this gap by exploring how the loss of a loved one to suicide affected a group of African American suicide survivors.

METHOD

PARTICIPANTS

Nineteen participants from throughout the continental United States participated in this study. Many of the participants were recruited from national conferences that focused on suicidal behaviors, prevention, and intervention in persons of color. Others responded to an advertisement that was placed in a national newsletter for suicide survivors. The interviews were conducted during a 5-year period. Twelve of the survivors were mothers who lost sons to suicide, 3 were siblings who lost brothers, 2 were spouses who lost husbands, and 2 were children who lost mothers. The ages of participants varied from early twenties to mid-sixties. The majority of participants experienced a suicide within a 2- to 3-year period—recently enough to remember the initial impact of the suicide. There were only 2 respondents whose experience with suicide occurred more than 20 years ago—a son who had lost his mother when he was 9 and a sister who had lost her brother when she was 16. However, their family's reluctance to deal with it remained fresh in their mind. All of the respondents also felt that they still could recall the grieving process, although the suicide had occurred several years ago. Seventeen suicide victims were Black males

between the ages of 12 and 33, and the ages of the two women ranged from 34 to 44.

PROCEDURE

As previously noted, all of the participants were recruited through their attendance at national conferences on suicide and through a newsletter directed toward suicide survivors. The first interview took more than 18 hours in four separate sessions. The semistructured interview was developed from the information gathered from the first interview. Participants were interviewed either in person or via telephone. Questions on the semistructured interview ranged from those about the actual suicide (e.g., "What happened?") to specific questions about the grieving process and the types of social support the participants received from friends, family, neighbors, and churches. The semistructured interviewing process allowed participants to tell the interviewer, in their own voice, the whole story that led up to the day of the death of their loved one. The majority of the interviews were completed in one or two sessions and took an average of 2 hours to complete.

MEASURES

The author conducted all the interviews, which were audiotaped and then transcribed verbatim. Once the tapes were transcribed, general themes and patterns were extracted in an effort to begin a process of theory building. Accordingly, major thematic areas that developed from initial interviews were reframed to focus on social support, with the following questions being asked during a second interview: What was the main support system available? Was there ample support from friends and family? Is there a nearby suicide support group that has formed in your community? Where did you go for support? As previously noted, the questions were open ended and semistructured to allow the themes and topics to emerge naturalistically.

DATA COLLECTION

This study began when the author participated in a support group attended by predominantly White survivors of suicide to acquire an understanding of what other survivors had experienced. This support group, called "A Safe Place," was sponsored by the Samaritans and located in a New England community. The author attended this group from 1996 to 1998. Through that experience, the significance of race and culture in the experience of survivorship began to emerge. The question became: Do

Black suicide survivors go through the same emotional complexities? The interviews with Black survivors began after the first 6 months of attending the support group in Somerville. At times, the interviewer was a member of the support group while she was interviewing Black survivors.

This study used an ethnographic approach with qualitative research techniques that primarily relied on personal narratives or stories. The goal of ethnography is to learn about a culture from the people who actually live in that culture (Spradley, 1979). A culture can be defined not only as an ethnic population but also as a society, a community, an organization, a spatial location, or a social world (Hammersley, 1992). The process of ethnography is characterized by intensive, ongoing, face-to-face involvement, with participants of the culture being studied and by participating in their settings such as the suicide prevention conferences from where many participants were recruited. The essential data-collection methods of in-depth interviewing enabled knowledge to be obtained about the meanings that informants attach to behaviors and activities (Germain, 1993).

Personal accounts help researchers understand how one deals with an unexpected event and the impact the experience has on the individual. It was the author's objective to create a discourse on the subject of the suicide in an effort to build knowledge. This knowledge would hopefully help survivors understand the world of surviving a suicide and purposive ways of coping with it.

The project was initiated when it became apparent that very few African Americans were attending support groups, conferences, and other venues of healing even though the rates of suicide among African Americans increased substantially from 1980-1995. The interviewer's own participation in the various venues of healing made it possible to relate to the interviewees, who became available on a level consistent with their experience. In this way, both trust and a sense of shared meaning were features of the interview process in ways not typical of most field researchers (Lofland, 1995; Spradley, 1979). The author/interviewer served as an "insider" participant/observer because the author is an African American suicide survivor. This insider perspective should result in less distortion of the meaningfulness of the data yielded from the study, as the author/interviewer has the same cultural/experiential framework as the participants. Research suggests that when the investigator comes from a different cultural community than the respondents, the findings from qualitative research are more likely to be misrepresented and/or misinterpreted (Spradley, 1979). Chances for misrepresentation in this study on suicide survivors were minimized by the insider status of the interviewer and by recording material verbatim.

TABLE 1
**“What Was Your Main Support System
 in Grieving the Suicide?”**

<i>Where Support Was Sought</i>	<i>Survivors (n = 19)</i>
Support groups outside of my community	2
Church	1
Family members/friends	6
Nowhere to turn	10

RESULTS

This article will present data using case materials rather than rates and will propose a theoretical framework. The following analytic domains and major thematic areas were identified.

AVAILABLE SUPPORT

Black suicide survivors who chose to grieve via support groups had to go outside of their community to do so, as shown in Table 1, whereas others depended on family and friends or had nowhere to turn. A mother who has lost a son attended three support groups and was the only African American in all three groups. Soon she became tired of traveling so far to attend meetings and looked into starting a group in her own African American community. She said,

There was a need that I felt was not recognized. People need to grieve, whether they have lost a house, suffered financially, lost a job...whatever...but we, as Blacks, tend not to do it.

It is obvious that we don't do it because of the number of tragedies and losses that folks go through in my own church, and we have over 6,000 members, and people do not show up for the support groups that are available. We have at least eight different support groups at our church.

For those who chose to do nothing, the grieving process took the form of either denial or projection or both, which were supported by an unspoken but pervasive code of silence. It was easy for some to deny their feelings and try to get on with their life, as was expected by family and friends, rather than go through the grieving process. In two cases of mothers who had lost sons, their denial caused them to become extremely overwhelmed and out of touch with their feelings, which later resulted in hospitalization for anxiety.

Most respondents reported that African American churches were not helpful. Having nowhere to turn retards the healing process. In many churches, suicide is considered to be an unpardonable sin (Early, 1992). It is this strong religious taboo that is the source of shame and denial for many African Americans. In another case, a young man who lost his mother at the age of 9 turned to the church as a teen to help him through a process of grief that he was never allowed to complete. He was told to pray and read the Bible more often and that this should help him through his grieving process. He relied on the church for 2 years and finally decided to seek professional help at the age of 21. He was ultimately diagnosed with depression and treated for his grief, which resulted in complications of mental instability. Only 1 respondent endorsed two responses and felt that family and friends as well as church were supportive, giving a total of 20 responses rather than 19.

All but 3 of the respondents had no support systems for survivors of suicide in their community (see Table 2). If suicide has no clear meaning in the African American community, then members will not work collectively to develop facilities for suicide prevention and suicide-survivor support groups. Walking through such a community, we see many community-based organizations that address gang violence, gun control, drug abuse, and alcoholism but none directly concerned with suicide prevention or support for survivors. When a Black woman who was troubled about her child's abuse of drugs needed someone to talk to, she went to her personal phone book and made a couple of calls before gathering an informal support team. There were institutions that were prepared to address her needs when her child had difficulty with substance abuse, but there was no readily available support mechanism to address her child's suicide. The two afflictions—the parental experience with a wayward child and the experience of surviving the suicide of a child—are not equally integrated into the mental health care facilities in the community. The former, drug abuse, is typically seen as a momentary deviation, correctable through the normal intervention of community-based agencies. It does not raise questions about the community itself.

This study suggests that suicide challenges the sense of community solidarity. For African Americans who value communalism and collectivism (looking out for one's neighbor), suicide may represent not only an individual failure but also the failure of the community. This adds another layer of stigmatization to a community that already feels stigmatized because of racism and oppression. Although survivors who attended White support groups found them to be helpful, they also noted that they had to travel long distances to attend meetings and that they were at times tired of being the "pioneers" who racially integrated these forums. For example, 1 respondent replied that she had integrated many groups before, that this was one group

TABLE 2
**“Is There a Nearby Suicide Support
 Group in Your Community?”**

<i>Support Group Available</i>	<i>Survivors (n = 19)</i>
None in my community	16
Yes but all White	3

she had no desire to integrate, and that she had never thought she would be integrating a group of suicide survivors.

RESPONSE FROM FAMILY AND FRIENDS

Individuals interviewed had to deal with a myriad of responses to their attempts to heal from the loss of a loved one to suicide. Some found that family members simply did not understand why they had to seek outside support systems, whereas others looked for someone to “blame” for their loved one’s suicide. Others had to come to grips with never receiving an answer to the question of “why” their loved one committed suicide, but others were actually able to develop closer bonds with family members (see Table 3). For example, when one woman, after losing her husband to suicide, needed to mourn through the support of other survivors, she attempted to start her own support group in her community only to have her in-laws ask her not to make an issue of the suicide and move on. Two other respondents, mothers of sons who killed themselves, complained of no longer speaking to the spouse of the decedent and often of blaming them for the suicide.

Alleviating stress came in the form of scapegoating and caused friction between family members. One of the 2 mothers who lost a son stopped speaking to the wife of her son because the wife was in the process of divorcing him at the time of his death. The mother was angry at the wife for having an extramarital affair and felt that the impending divorce itself was largely responsible for his suicide. The conflict between the mother and wife caused the wife to keep the children (the mother’s grandchildren) away from her. In this study, survivors blamed everyone from other family members to God. Research suggests that the need to hold someone else responsible for the suicide and focusing on “blaming” someone tends to result in a number of health problems, including physical impairment and emotional stress (Tennen & Affleck, 1990). Tennen and Affleck’s (1990) study notes that individuals who blame others for a catastrophic event tend to suffer from moodiness, depression, and inability to adapt to new circumstances. In some of these cases,

TABLE 3
“Was There Ample Support From Friends and Family?”

<i>Ample Support</i>	<i>Survivors (n = 19)</i>
Brought family closer together	7
Created a silence	4
Caused friction between family members	5
No answer	3

survivors may have felt cheated. When interviewing spouses who had lost husbands, the feeling that they were accused of being responsible for the suicide only deepened the already open wound of losing someone to suicide, which further complicates the healing process.

AWARENESS

Finally, the information in Table 4 suggests that most survivors were taken by complete surprise by the suicide and did not have a sense of the decedent's suicidal crisis. More than half of the respondents had no idea that suicide was on the minds of their loved ones, yet others may have been aware that it was on their minds but wanted to believe that they could work out whatever problems they were having. One parent simply got upset about the fact that her son wrecked her car because he ran into a tree trying to kill himself. She paid no attention to his explanation of why her car was damaged and thought that he could not be serious. Another parent said about her son who committed suicide, "Depression, or any other types of disorder, never entered my mind even though my son was becoming very emotional." With all the suffering African Americans have gone through, she truly thought that her son could have toughed out anything. Both parents found it difficult to react to something of which they were not aware, and therefore, they remained helpless in performing any kind of intervention.

DISCUSSION

Although this study did not include interviews with White suicide survivors, the major difference between Whites reported in the literature and the African Americans in the study was that the Black suicide survivors were always the only person of color when they attended suicide-survivor support groups. Similarly, there were no African American support groups available

TABLE 4
**“Were You Aware of Any Signs of Mental
 or Emotional Disorders?”**

<i>Allowed to Discuss</i>	<i>Survivors (n = 19)</i>
Had no idea	9
Thought it would work itself out	4
Had total understanding of signs	3
No answer	3

in their communities. Is suicide a novel phenomenon in the Black community? Or is it something we just do not choose to talk about or even report?

The circumstances surrounding the completed suicides typically involved young people who were experiencing personal crises. The majority were Black men who tended to be enterprising young men who were involved in their community and diligently trying to come to terms with the dominant culture. The survivors of their suicides all report that their loved ones came from a culture that was ill equipped to provide the requisite support that their loved ones needed to deal effectively with the conditions of depression, especially among young men. The same barriers that made it difficult for survivors to openly express themselves to facilitate the healing process had made it difficult for these men to express their dysphoria in ways that were less self-destructive.

Lack of overall social support within the Black community was prevalent in the majority of the cases, and this lack of support made it difficult to get through the healing process. Generally, the findings from this study suggest that survivors of suicide in African American communities are expected to “get on with their life” and that there is little room for grieving. In the past, African Americans have appeared to overcome many social ills, and suicide was expected to be no different. Also, given the centrality of religious institutions in African American communities and given the historical role that such institutions have played in shaping the community’s norms and values (Early, 1992), it is somewhat alarming that churches were not always receptive to discussing the topic of suicide with the families.

CATEGORIZATION OF RESPONDENTS AND PERSPECTIVE RESPONDENTS

It was a difficult task to carry out research on a vulnerable group of suicide survivors, especially at a time when they were working through their grief. When recruiting for participants, it was quickly discovered that

survivors come in various categories, and it is important to understand this categorization when doing research with survivors. It was apparent that survivors differ when it comes to disclosing information about their grief. The following three main categories were derived from the qualitative data from this study:

1. The *voiceless*, or the silent, group wishes not to speak about the death of their loved one because of their cultural practices, their shame, or their amount of pain or because their grief is uncomplicated and they simply wish to get on with their lives.
2. The *utterers* believe in the power of speech, knowing that if they talk about it, then their pain will somehow lessen. They wanted to share their experience, hoping their story will help others. They generally join the suicide prevention and intervention network and want to do anything they can to prevent another suicide. Often it is simply filling the emptiness that they are suddenly feeling after the death of the family member.
3. The *apathetic* have no real concern about telling their story. They are not certain how they feel about the death of their loved one, their grief can be either complicated or uncomplicated, and they may or may not speak with a researcher.

In a few instances, those who were coming out and speaking about their experience as survivors were occasionally criticized by those survivors who either did not want to speak out or did not consider it appropriate to do so. For example, the parents of a decedent got angry with the wife for being outspoken about the suicide of her husband. Another critic said to a woman who lost her son and wanted to start a support group in the Black community, "Why not just forget it and get on with your life? We have survived hundreds of years of strife, and we should be able to handle this."

The findings from this qualitative study suggest that attitudes toward suicide remain negative in African American communities. The findings also support Early's (1992) landmark study that found that Black churches are loathe to address this problem within the African American community. Interestingly, several Black churches declined to respond to requests to contact suicide survivors in their congregation when seeking respondents for this study. It is important to note that some of the negative reactions to talking openly about suicide come from the notion that such negative attitudes may serve as a protective mechanism against suicide, a notion that has received some support in the research literature (Marion & Range, 2003).

This study suggests that grief may be processed differently for African American suicide survivors when compared to Whites. Although White suicide survivors have similar difficulties with stigmatization and finding a forum to discuss their problems (Demi & Howell, 1991; Dunne et al.,

1987), suicide is more likely to be considered the product of a mental illness in this community, which gives White survivors "permission" to seek help when grieving. As a result, survivors are less reluctant to speak about their experience, more likely to find others who will do so, and more likely to find support groups, therapists, and counselors who specialize in suicide, as discovered from attending the support groups.

LIMITATIONS

This is a preliminary study in which a small sample was used and is not representative of the African American population. A convenience sample was used, and the lack of randomization probably resulted in some selection bias. However, this is the first study that has examined the thoughts and grieving processes of African American suicide survivors and represents an important beginning to research that needs to explore the needs of this woefully underserved group.

CONCLUSION

What emerged from this study were two possible theories: (a) Grief is difficult if there is no means of social or community support and (b) when suicide lacks meaning and understanding, no course of prevention and intervention are present within a community. Although all cultures mourn, the mourning process itself may differ between cultural groups. The grieving process becomes more difficult for African Americans, according to most respondents, simply because there was nowhere to grieve in their own cultural community. The Black churches in their community did not embrace suicide survivors because many of the churches preferred not to have attention drawn to suicide. The fact that suicide still remains taboo in African American communities makes it difficult to complete the mourning processes for most suicide survivors. They are expected to get on with their lives as African Americans have been conditioned to endure pain and persevere. But because suicide survivors encounter more emotional manifestations, there is a whole healing process that needs to be addressed. Survivors in this study felt that suicide remains hidden in the African American community. Suicide needs to be redefined as a way of death that is most likely to occur under certain conditions, and not as evidence of personal weakness, giving up, selfishness, getting revenge, or any of the other simplistic labels that are often associated with it. Some authors have even argued that suicidal behaviors may need to be redefined in some cultural groups because the current

categorizations suggested by the CDC tend to underestimate suicides in the African American community (Lester, 1998; Poussaint & Alexander, 2000). For example, some authors have suggested that victim-precipitated suicide or "suicide by cop" should be recognized as a form of suicide among African American and Latino males (Parent, 1999).

Cross-cultural studies in thanatology (the study of death) suggest that cultures also mourn differently (Nandan, 2005; Parry & Ryan, 1995). According to a large number of respondents, the grieving process becomes more difficult for African Americans simply because they had no forum in which to grieve when they lost a loved one to suicide. Individuals are very selective about when to come out and when to stay in the closet. People want to enjoy a certain level of respectability that they might have always had and want to maintain (Arluke, 1991). They do not want to be subjected to increasing public scrutiny. If people view suicide as a family failure, then this can be the determining factor of whether or not to come out.

Further research is needed to clarify the community's response to suicide survivors in minority communities. We have to begin to openly dialogue with suicide survivors so that we can ensure that the community is able to address the needs of this underserved population. More research needs to explore how the community understands suicide and how this community reacts to families who have lost someone to suicide. Finally, survivors need to be surveyed on their views about the community response to them so that the responses of both the community and the survivors can be compared to better understand which types of intervention and prevention programs need to be developed in the African American community.

REFERENCES

- Arluke, A. (1991). Going into the closet with science. *Journal of Contemporary Ethnography*, 20(3).
- Demi, A. S., & Howell, C. (1991). Hiding and healing. *Archives of Psychiatry and Nursing*, 5(6), 350-356.
- Dunne, E., McIntosh, J., & Dunne-Maxim, K. (1987). *Suicide and its aftermath*. New York: Norton.
- Dyregov, K. (2002). Assistance from local authorities versus survivors' need for support after suicide. *Death Studies*, 26, 647-668.
- Early, K. (1992). *Religion and suicide in the African American community*. Westport, CT: Greenwood.
- Ehrmin, J. T. (2002). That feeling of not feeling: Numbing the pain for substance-dependent African American women. *Quality Health Resource*, 12(6), 780-791.
- Fine, C., & Myers, M. (2003). Suicide survivors: Tips for health professionals, *Medscape General Medicine*, 5(3).

- Germain, C. P. (1993). Ethnography: The method. In P. L. Munhall & C. O. Boyd (Eds.), *Nursing research: A qualitative perspective* (2nd ed., pp. 237-268). New York: National League for Nurses Press.
- Hammersley, M. (1992). *What's wrong with ethnography? Methodological explorations*. New York: Routledge.
- He, Z. X., & Lester, D. (1997). The gender differences in Chinese suicide rates. *Archives of Suicide Research, 3*, 91-89.
- Jordan, J. R. (2001). Is suicide bereavement different? A reassessment of the literature. *Suicide and Life-Threatening Behavior, 31*, 91-102.
- Lester, D. (1998). *Suicide in African Americans*. Commack, NY: Nova Science Publishers.
- Lofland, J. (1995). *Analyzing social settings*. Belmont, CA: Wadsworth.
- Marion, M. S., & Range, L. M. (2003, Spring). African American college women's suicide buffers. *Suicide and Life-Threatening Behavior, 33*, 1.
- McIntosh, J. L. (1993, Summer). Control group studies of suicide survivors: A review and critique. *Suicide and Life-Threatening Behavior, 23*(2), 146-161.
- Moore, P., Hazell, L., & Honeyghan, E. (2001). *A profile of bereavement supports in African American church congregations*. Retrieved from <https://www.iona.edu/academic/artsscience/orgs/pastoral/issues/2003.pdf>
- Nandan, M. (2005). Cross-cultural perspectives in thanatology: Through a prism of religious faiths. *Gerontology & Geriatrics Education, 26*(1), 43-56.
- National Center for Injury Prevention and Control, Centers for Disease Control. (2004). *Suicide injury deaths and rates*. Retrieved from <http://www.cdc.gov>
- Neimeyer, R. A. (2002). Mourning and meaning. *American Behavioral Scientist, 46*(2), 235-251.
- Ness, D. E., & Pfeffer, C. R. (1990). Sequelae of bereavement resulting from suicide. *American Journal of Psychiatry, 147*(3), 279-285.
- Parent, R. B. (1999). Victim-precipitated homicide: Police use of deadly force. *American Association of Suicidology Newslink, 25*, 16-17.
- Parry, J. K., & Ryan, A. S. (1995). *A cross-cultural look at death, dying and religion* (The Nelson-Hall Series in Social Work). Chicago: Nelson-Hall.
- Pearson, V., & Liu, M. (2002). Ling's death: An ethnography of a Chinese woman's suicide. *Suicide and Life-Threatening Behavior, 32*(4), 347-358.
- Poussaint, A., & Alexander, A. (2000). *Lay my burden down: Unraveling suicide and the mental health crisis among African-Americans*. Boston: Beacon.
- Reed, M. D. (1998). Predicting grief symptomatology among the suddenly bereaved. *Suicide and Life-Threatening Behavior, 28*, 285-300.
- Rodgers, L. S. (2004). Meaning of bereavement among older African American widows. *Geriatric Nursing, 25*(3), 133.
- Spradley, J. P. (1979). *The ethnographic interview*. New York: Holt, Rinehart & Winston.
- Tennen, H., & Affleck, G. (1990). Blaming others for threatening events. *Psychological Bulletin, 108*, 2.
- U.S. Department of Health and Human Services. (1998, March). Center for Disease Control surveillance summaries. *Morbidity and Mortality Weekly Report, 47*(10), 193-196.
- U.S. Public Health Service. (1999). *The Surgeon General's call to action to prevent suicide*. Washington, DC: Author.
- Warshauer, M., & Monk, M. (1988). Problems in suicide statistics for Whites and Blacks. *American Journal of Public Health, 68*, 383-388.