# SCREENING FOR SUICIDALITY IN AFRICAN AMERICAN CHURCHES

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## INTRODUCTION

- Suicide deaths rates in African Americans (AA) increased from 7.3 to 8.7% over 2018-2021, a significant 19.2% jump.(1)
  - In AA females, rates of suicide completion rose over 102% from 1999-2022. (1)
  - AA aged 15-24 and 25-34 have seen age-adjusted rates increase significantly by 16% and 12%, respectively. (2)
- Depression is a major risk factor for suicide ideation (SI): In nationally representative samples, depressed AA adults were more likely to report SI or make an attempt than compared to Non-Hispanic White adults (4). For attempts, this association was seen regardless of previous depressive episodes
- Considering persistent racial treatment disparities for depression (5-7) which worsened during the pandemic (8), novel settings should be used to identify AA at increased suicide risk
- The Black Church may be a culturally relevant, trusted community setting to identify people with increased risk (9)
  - AAs have the highest rates of church attendance and self-rated religious importance of all US racial groups (10,11)
  - When AA with a serious personal problem (including SI and depression) seek help from clergy, over 72% utilize resources in Black churches rather than other health locations (12,13)
- To explore this, the authors conducted a secondary analysis of a church-based sample to identify SI correlates among AA within a trusted, faith-based setting

## METHODOLOGY

- 122 participants were screened from three AA mega-churches in Oct/Nov 2012 in a large Northeastern US city. Inclusion criteria were being aged 18-70 and having English fluency
  - Full data collection design and community collaboration is described in the original paper (14)
- Depression was screened for using the Patient Health Questionnaire-9, a valid and reliable screener in AA samples (15,16). Item 9 of this measure was used to screen for SI
- Bivariate logistic regression assessed associations between SI screen and each demographic variable
- Chi-Square analysis assessed associations between help-seeking behavior, suicidality, depression, and other demographics

## DEMOGRAPHICS

- The sample (N=122) consisted of men (n=48, 44.1%) and women (n=63, 55.9%; 11 unreported). Mean age was 53.7 (SD= 13.3)
- The sample was evenly split between married (31%), divorced, (32%), and single individuals (31%). 6% were widowed
- A plurality had a total household income of $35-69.9k (33.3%). 70k+ (26.3%) was the 2nd most frequent level, followed by <$19k (21.1%) and $20-35k (19.3%)

**Table 1. Bivariate associations between SI, demographics, and depressive symptoms**

| Category | Total N (%) | Suicidal Ideation Positive N (%) | Suicidal Ideation Negative N (%) | Odds Ratio (95% C.I.) | | p-value |
|---|---|---|---|---|---|---|
| **Employment Status** | | | | | | 0.042* |
| Worker for pay [Ref] | 46 (38.0) | 3 (6.5) | 43 (93.5) | 1 | | |
| Retired | 31 (25.6) | 2 (6.5) | 29 (93.5) | 1.0 | 0.2-5.6 | |
| Student, disabled, homemaker, or multi | 32 (26.5) | 29 (90.6) | 3 (9.4) | 1.4 | 0.3-6.7 | |
| Unemployed | 12 (9.9) | 4 (33.3) | 8 (66.7) | **5.1** | **1.3-19.8** | |
| **Insurance Type** | | | | | | 0.07† |
| Private Insurance[Ref] | 62 (52.5) | 3 (4.8) | 59(95.2) | 1 | | |
| Medicaid, Medicare, Public insurance | 45 (38.1) | 7 (15.6) | 38 (84.4) | 3.2 | 0.9-11.7 | |
| No coverage/Self-pay | 11 (9.4) | 2 (18.2) | 9 (81.8) | **3.8** | **0.7-20.0** | |
| **Depressive Symptom Severity** | | | | | | 0.025* |
| Minimal (0-4) [Ref] | 70 (57.4) | 1 (1.4) | 69 (98.6) | 1 | | |
| Mild (5-9) | 28 (23.0) | 5 (17.9) | 23 (82.1) | **12.5** | **1.5-102.3** | **0.019*** |
| Moderate/Severe(10+) | 24 (19.6) | 6 (25) | 18 (75) | **17.5** | **2.2-138.0** | **0.007**** |

*p < 0.05, **p < 0.01*

**Table 2. Bivariate associations between help-seeking, suicidality, depression severity and education**

| VARIABLE | Professional Help seeking No (n=38) | Professional Help seeking Yes (n=77) | Chi-square (df) | p-value |
|---|---|---|---|---|
| **SUICIDALITY** | | | 0.001 (1) | .982 |
| Negative | 34 (89.5) | 69 (89.6) | | |
| Positive | 4 (10.5) | 8 (10.4) | | |
| **DEPRESSION** | | | | .057† |
| None | 26 (68.4) | 38 (49.4) | 5.7 (2) | .053† |
| Mild | 4 (10.5) | **23 (29.9)*a** | | **.021*** |
| Moderate-Severe | 8 (21.1) | 16 (20.8) | | |
| **EDUCATION** | | | 8.3 (3) | **.041*** |
| < 12 years | 1 (2.6) | 6 (7.8) | | |
| HS graduate | 6 (15.8) | 5 (6.5) | | |
| Some college/Tech Sch. | 9 (23.7) | **35 (45.5)*a** | | **.024*** |
| 4 years+ college | 22 (57.9) | 31 (40.3) | | |

*p < 0.05, ªBonferroni adjusted

Regression estimates obtained using Generalized Estimating Equations (GEE) analysis, Poisson distribution, log link function. Significance levels, two-tailed, Bonferroni adjusted for pairwise comparisons.

## RESULTS

- Overall, only 10% screened positive for SI (N=12)
- There were no significant group differences by gender, education, marital status, or income
- Unemployed people were significantly more likely to report SI than workers for pay [OR=5.1,95% CI=1.3-19.8)
- Respondents with Medicare/Medicaid/other Gov. program trended more likely to report SI than those with private insurance (OR= 3.2, 95% CI=0.9-11.7, p=0.07)
- Compared to the minimally depressed, the mildly (OR=12.5, p=.019) and moderate-severely depressed group (OR=17.5, p=.007) were significantly more likely to report SI
- Considering help-seeking, a significantly higher amount of mildly depressed people sought help than not (p=.021)
  - Conversely, those with moderate-severe depression were not more likely to seek help
- Finally, respondents with some college education were more likely to seek help than HS or college graduates (p < .024)

## DISCUSSION

- This study affirms that a valid measure can be used in Black churches to screen for SI in AAs
- Participants with mild depression were significantly more likely to screen for SI than those with minimal, highlighting a stark concern: <u>there exists a prevalence of SI in those without clinically significant depressive symptoms</u>
  - This "**silent suicidality**" is an under-studied phenomenon with high clinical implications (17)
- After depressive symptoms, employment status was the strongest SI predictor, unemployment specifically
  - This relation is supported by the literature in AA (18,19) and worsened in the pandemic (20)
- The Black church can function as a natural network to address treatment disparities in hosting screenings (21) and employment fairs (22,23). It can also naturally strengthen protective factors such as social bonds, cohesion, and help-seeking to decrease suicide risk
- Future studies should explore this phenomenon in larger SI samples to confirm generalizability of results

REFERENCE DOCUMENT

BGSU

NEW YORK STATE

New York State Psychiatric Institute

Columbia University Department of Psychiatry