



**NATIONAL CARES
MENTORING MOVEMENT**

BLACK CHILD SUICIDE

A REPORT

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on behalf of the

NATIONAL CARES MENTORING MOVEMENT

In Collaboration With

THE ASSOCIATION OF BLACK PSYCHOLOGISTS

Presented at a CONGRESSIONAL BLACK CAUCUS HEARING on BLACK CHILD SUICIDE

OCTOBER 15, 2019

Washington, D.C.

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SUMMARY

In the United States, suicide is one of the leading causes of death for youth (Stone et al., 2017). However, in the past quarter century, while suicide rates have declined among White children, they have shown a steady increase among Black children. In a recent study of suicide rates among Black adolescents, from 2001 to 2017, the rate of suicides for adolescent Black males increased by 60% and increased by 182% for adolescent Black females (Price & Khubchandani, 2019). This disproportionate increase in Black youth death by suicide constitutes a national public health crisis, but explanations remain speculative, research is limited, and interventions are culturally and contextually deficient.

Examining this alarming trend requires a thoughtful and thorough examination of Black children and adolescents' current lives as well as centuries of structural and institutional racism. Such societal forces have resulted in Black youth being chronically exposed to community violence, educational neglect and greater disciplinary action, and continued assaults by institutions such as law enforcement. In short, Black youth as a whole experience different amounts and types of psychological and emotional stressors than White youth.

When looking at Black youth suicide within a socio-ecological and historical context, economic and socio-political, psychological, emergent cultural and contextual factors become salient. Bronfenbrenner's social-ecological framework (1979) helps guide an understanding of contextual factors that may be contributing to Black child death by suicide in a specific and unique manner. Some of these include:

- **MULTIGENERATIONAL CULTURAL TRAUMA**
- **COMMUNITY VIOLENCE**
- **ADVERSE CHILDHOOD EXPERIENCES (ACEs) AND STRESS-RESPONSE PATTERNS (i.e., THE TOLL OF RACIAL TRAUMA AND COMMUNITY VIOLENCE)**
- **SYSTEMIC AND INSTITUTIONAL VIOLENCE**
- **BULLYING**

Common suicide risk factors (e.g., depression, poor social support, family dysfunction, substance abuse, access to firearms) cited for all populations may be relevant to Black child suicide but do not explain the uptick in the rates of suicide among Black children. These factors are helpful but become less predictive when a socio-ecological and historical context is not used and the intersection of racism and developmental age differences are not taken into consideration.



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Warning signs of reactions to chronic exposure and extreme stress—including physiological, mood, cognitive and behavioral signs of responses to stress—must be attended to as a means of prevention and early intervention. Vigilance for verbal and behavioral warning signs of active suicidality and imminent threat in Black children and adolescents is required for immediate intervention. First responders attending to both types of warning signs (stress and suicide) may be better able to help reduce Black youth death by suicide.

Broader (societal), multifaceted and more comprehensive prevention and intervention strategies can help disrupt the rise in Black child suicide. These can include:

- Looking at issues through the lens of social, historical and structural forces;
- Building protective factors, skills and tools in the Black child and the child's community to promote wellness (such as life affirming and relationally oriented, African-based cultural traditions);
- Engaging all first responders and healers (including the community, family, mentors, and peers as well as professionals);
- Supporting families and communities in their management of stressors (such as institutionalized racism) so they are better able to help Black children and adolescents);
- Conducting public health outreach to educate and de-stigmatize discussions of suicide and mental health services to prevent and intervene;
- Enhancing professional development with specific training on such areas as: intergenerational trauma, brain-behavior responses to trauma, and prevention and early intervention strategies created with Black children in mind;
- Increasing professional capacity to help Black children by increasing the African American/ Black work force in the mental health sector and cross-training faith leaders and mental health providers;
- Reducing the unquestioning, overuse of evidence-based practices and increasing the use of culturally defined and practice-based evidence approaches; and,
- Asking new questions and doing research to get more specific answers on Black youth and suicide to develop more culturally informed and effective suicide prevention and intervention practices. The focus may include obtaining more reliable information on prevalence rates, nonfatal suicidal behavior, non-psychiatric risk factors.

Successful prevention and intervention require focus not just on Black children and adolescents but on the social and environmental forces they must face. This is an interdisciplinary enterprise that needs the expertise of sociology, history, economics, demography, social work, public health, public policy, critical race studies, community organizing, theological studies, community wisdom, and more.



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INTRODUCTION

Our Children are killing themselves. In the United States, suicide is one of the leading causes of death for youth (Stone et al., 2017). In 2015, suicide in the US was ranked as the 10th leading cause of death for elementary school-aged children (5-11 years old) (CDC, 2019; Sheftall et al., 2016; Bridge et al., 2015). From 1993-1997 to 2008-2012, rates declined among White children (from 1.14 to 0.77 per 1 million) but showed a steady increase among Black elementary school-aged children (from 1.36 to 2.54 per 1 million) (Bridge et al., 2015). This was particularly so for Black boys (Bridge et al., 2015). In fact, suicide among Black children (5-11 years old) has been on the rise for several years (Joe, 2006) and has been cited as the third leading cause of death for young Black males (Joe, Scott, & Banks, 2018). According to the World Health Organization (WHO, 2016), the global suicide rate for children 10-14 years old is 2.237/100,000, and for those 15-19 years of age, the rate is 11.72/100,000.

Although Black child suicide is a public health crisis (Couto et al., 2018), explanations remain speculative, research is limited, and interventions are culturally and contextually deficient. Common suicide risk factors (e.g., depression, poor social support, family dysfunction, substance abuse, access to firearms) cited for all populations may be relevant to Black child suicide but do not explain the uptick in the rates of suicide among Black children. These factors become less predictive when the intersection of racism and developmental age differences are not taken into consideration.

This report will provide:

- **The Prevalence of Black Child Suicide**—including recent trends in suicide rates among Black children and youth
- **Possible Causes**—that are historical/contemporary, socio-ecological, developmental, and oppressive socio-political issues
- **What to Look for: Risk Factors and Warning Signs**—that should be at the top of potential first responders' minds (e.g., parents, caregivers, school staff, mentors, medical professionals, neighbors, peers, older siblings, community and recreation center staff, coaches, clergy, mentors, and child protective-services staff)
- **Strategies for Intervening to Disrupt the Rise in Black Child Suicide**—Strategies for and culturally affirming approaches, as well as broader systems approaches, and
- **The Way Forward**—considerations for prevention and early intervention (e.g., information and tools for parents/guardians and other first responders), including the important role of cultural protective factors.



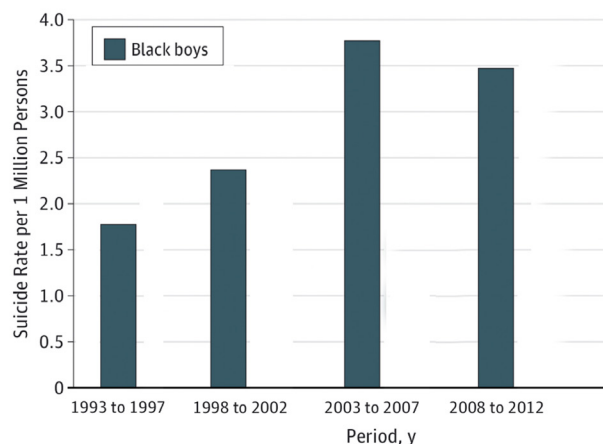
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THE PREVALENCE OF BLACK CHILD SUICIDE

Sheftall et al. (2016), using the National Violent Death Reporting System (NVDRS) surveillance data for suicide deaths from 2003 to 2012, found that 37% of the elementary school-aged children who died by suicide were Black and 12% of the early adolescents who died by suicide were Black. While suicide rates have declined among White children (from 1.14 to 0.77 per 1 million from the 1993-1997 to 2008-2012 periods), they have shown a steady increase among Black elementary school-aged children (from 1.36 to 2.54 per 1 million) (Bridge et al., 2015), resulting in a near doubling of death-by-suicide rates for Black children and early adolescents, with noteworthy age and gender differences. For example, from 1993 to 2002, the rates of suicide by hanging/suffocation increased significantly for Black boys (Bridge et al., 2015). The differential rates comparing Black and White children is statistically significant for boys and was trending toward significance for girls (from 0.68 to 1.23 per million between 1993-2002 and 2003-2012). Research by Joe et al. (2009), however, suggests the trend dates farther back than 1993, and they cite a 126% increase in the suicide rates for 15-19 year-old Black youth and a 233% increase in suicide among 10 and 14 year-old African American and Caribbean-born Black children. In 2015, suicide was the second leading cause of death among Black adolescents and youth 15 to 24 years of age (CDC, 2019), with firearms and suffocation cited as the most common method used.

There are notable gaps in the literature related to suicide among Black children, particularly in relation to race and developmental differences in the characteristics and precipitants of suicide (in elementary school-aged children relative to early adolescent suicide). There are developmentally distinct features of suicidal ideation, suicide attempts, and death by suicide among Black children compared to those in adolescence. Table 1 provides a summary of important age differences in the characteristics for Black children who died by suicide as reported in the literature and federal data bases by age group.

Figure 1. Suicide Rates Among Black Boys Aged 5 to 11 Years in the United States Between 1993 to 1997 and 2008 to 2012



Adapted from (Bridge et al., 2015)



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TABLE 1: Developmental Differences in Black Child Death by Suicide

CHILDREN WHO DIED BY SUICIDE	BLACK CHILDREN WHO DIED BY SUICIDE	BLACK TEENS WHO DIED BY SUICIDE
Ages 5-11 years	Ages 12-14 years	Ages 13-17 years
<ul style="list-style-type: none"> • Were more commonly Black males; • More often experienced relationship problems with family members/ friends; • Did not typically experience relationship problems with boyfriends/ girlfriends; • If diagnosed with a mental illness, were less likely to have experienced symptoms of depression and more likely to have experienced attention-deficit hyperactivity disorder (ADHD); • Did not have alcohol and other substance abuse problems or use at the time of death (Sheftall et al., 2016); • Did so impulsively in response to psychosocial stressors; • Tended not to give advanced warning or indicate their intention to commit suicide (except in about 29% of suicide cases); • Did not leave a suicide note; • Died by hanging/ strangulation/ suffocation; and, • Committed the act at home. 	<ul style="list-style-type: none"> • Were more likely to be male; • Were more likely to be experiencing symptoms of depression and emotional distress; • More often experienced boyfriend/ girlfriend relationship problems compared to younger children; • Tended not to give advanced warning or indicate their intention to commit suicide (except in about 29% of the suicide cases) (Sheftall et al., 2016) • May have left a suicide note; and, • Died by hanging/ strangulation/ suffocation. 	<ul style="list-style-type: none"> • Had relationships breakups and/ or interpersonal issues; • Had fewer than two supportive adults in their life, which increased suicide attempts threefold (Price, Drake, & Kucharewski, 2001); • Had lower levels of family closeness (O'Donnell, O'Donnell, Wardlaw, & Stueve; Merchant et al., 2009); and, • Had previous attempts (Merchant et al., 2009).

Understanding these age differences is essential to the development of appropriate and effective prevention and early intervention strategies.

While the extant research provides indicators of prevalence and age differences related to suicide risk among Black children, several cautions are warranted. There are questions regarding the extent of underestimation and misclassification of suicide among children in general and Black children specifically (Cuoto et al., 2018). There are also sample size and race-specific data-analysis concerns. In several studies and databases, the percent of Black youth representation may be too small (Merchant et al., 2009) to conduct meaningful data analysis. In some instances, sample size is reasonable, but the researchers do not conduct analyses by race.



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Although there is some recognition that Black youth experience psychological and emotional stressors differently than White youth, few studies examine the unique pathways to suicidal behavior for Black youth and adolescents. And when placing suicide among Black children and youth within a socio-ecological context, emergent cultural and contextual factors become salient (e.g., structural/systemic racism, racial stress/trauma, implicit bias, internalized racism, poverty, etc.). These contextual factors have received limited attention in research studies or consideration in the development of prevention and early intervention strategies.

Black-youth-specific studies have led to important insights but also face some limitations. While informative, the Sheftall et al. (2016) and Bridge et al. (2015) studies do not reflect a nationally representative sample of Black children and early adolescents. They were only able to obtain data from 17 of the 32 states that participated in the NVDRS. While the trend was always lower suicide rates among U.S. Blacks compared to Whites. The Bridge et al. (2015) study was the first national study to observe a higher suicide rate among Black individuals compared with White individuals but was unable to elucidate what factors might be contributing to the increasing suicide rates among young Black children. They offered a few plausible hypotheses, which served to further reveal the dearth of research and study on this topic and a range of co-existing issues. They acknowledge this in their report:

Black children may experience disproportionate exposure to violence and traumatic stress and aggressive school discipline. Black children are also more likely to experience an early onset of puberty, which increases the risk of suicide, most likely owing to the greater liability to depression and impulsive aggression. Black youth are also less likely to seek help for depression, suicidal ideation, and suicide attempts. Nevertheless, it remains unclear if any of these factors are related to increasing suicide rates. Other potential influences include differential changes in social support and religiosity, 2 factors that have traditionally been hypothesized to protect Black youth from suicide but shifted significantly during the 2 decades in our study. (Bridge et al. 2015, p. 676.)

While data on completed suicides is informative, it presents a skewed and incomplete picture. More reliable data showing national prevalence estimates and correlates of Black child, early adolescent, and adolescent suicidal behavior is needed (Joe et al., 2009). The absence of such data limits our ability to develop data-driven prevention and early intervention strategies. This includes incorporating other factors not typically counted in the general suicide literature but relevant to the Black experience in the U.S., such as analysis of suicide by cop (SBC)—the intentional act of escalating situations so that police officers are more likely to employ deadly force (Lindsay & Lester, 2008). In a review of the Los Angeles Police Department Mental Evaluation Unit data, Jordan and colleagues (2019) reported that the primary SBC profile is that of a 38-year-old male with a wide range of ethnic/racial diversity and mental illness characteristics; however, they identified children as young as 14 years old that fit SBC behaviors. Lord's (2012) content analysis of the 2010 medical examiner and police-accompanying adult NVDRS data set narratives, found that 186 of the cases were under the age of 25 with no age range offered. This raises the probability that there may have been minors involved and points to a pressing need to determine other demographic qualities of these young people, especially race.



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Prevalence data must also examine contextual, cultural and age-specific determinants. According to Watkins and Melde's (2016) national study with adolescents in middle and high schools, prior to gang involvement, youth are more likely to have experienced significantly higher levels of depression, suicidal ideation and suicidal behaviors in comparison to their counterparts who did not seek gang involvement. These mental health issues increased for those youth who became involved with gangs (Watkins & Melde, 2016). Molock and colleagues (2006) cited findings from interviews with parents that African American or Black youth are more likely to provoke someone to kill them, including presenting with homicidal-like actions. It would follow that targeted research is warranted to explore the unique issues for Black youth in relation to suicide by cop, suicide by gang and provocations to be killed by others.

Prevalence data must also reflect the cultural diversity, gender diversity and varying mental health issues among Black people. Relatively little is known about the prevalence of fatal and nonfatal suicidal behavior, as well as intentional self-injury (e.g., cutting), of Black adolescents of Caribbean, continental African, or Central or South American heritage residing in the U.S. Related to suicide attempts among African American and Caribbean-born Black adolescents, Joe et al. (2009) found that:

- African American teens were approximately five times more likely than Caribbean-born Black adolescents to attempt suicide;
- among both groups of adolescents who had reported a suicide attempt, none had ever met criteria for any diagnosable disorders by the time of their attempts;
- in 12-month prevalence estimates, African American girls and Caribbean-born females reported significantly higher suicide attempt rates and suicidal ideation than boys; and,
- the odds of attempting suicide were 10 times higher among adolescents experiencing symptoms of low-grade persistent depression as well as generalized anxiety; 6 times higher for those suffering from major depressive disorder, and when controlling for the presence of all other disorders, the odds were 3 times higher in the presence of social anxiety disorder.

Finally, we must also be mindful about the sources of data used to draw population-wide conclusions about changes in the pattern of suicide rates among Black children and youth. There are two different research tracks: individual-level suicide risk studies and studies that identify population-level changes in suicide or suicide risk belief and behaviors (Joe, 2006). Individual risk studies provide one type of case-specific insight. Population-level changes cannot be fully understood by individual risk studies without tested explanatory models that provide more demographic and historical context. Joe (2006), for example, found certain time periods impacted suicide rates among Black males, 10-34 years old and 65-80 years old. Specifically, the rise in suicide rates in 1983 occurred during the peak of deindustrialization during the early 1980's, a social phenomenon that Joe (2006) noted disproportionately burdened Black families and communities. At the same time, crack cocaine's ravaging effect on community social structures and indigenous safety-net protective factors were taking its toll. Joe (2006) also notes of this period that:



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The rise in Black suicide rates could also reflect the period [in time] effects coinciding with social change and upheaval, including post-civil-rights-movement reactions, such as the onset of the ultraconservative political and policy movements and elimination of major social-service programs during the period. (p. 275)

More precisely, in our attempts to understand and disrupt suicide among Black children and youth, we cannot lose site of the role of structural and institutional racism that is often overlooked in individual risk studies of suicide.

POSSIBLE CAUSES

Despite the rise in the suicide rates, the number of research studies examining Black child death by suicide is low, and very little is known about causality—especially for elementary school-aged children (Kolves et al., 2017; Sheftall et al., 2016, Colucci & Martin, 2007). While there is some conjecture that disproportionate exposure to violence and trauma are precipitating factors and are associated with increased suicidality (Sheftall et al., 2016; Paxton, Robinson, Shah, & Schoeny, 2004; Zimmerman & Messner, 2013; and Colucci & Martin, 2007), to date, no research has further explored these possible associations.

The substantial increase in Black child death by suicide begs a number of questions. For example, what historical factors seeded current Black child suicide trends? What socio-political and economic forces were at play in the U.S. contributing to the recent rising trend? What, if any, structures, practices, and strains shifted in Black families and communities as a result of these forces? In the context of rising Black child death by suicide, what precipitating factors (e.g., socio-ecological, cultural, psychological, etc.) best help define race-specific predictors and prevention strategies for Black children younger than 12 years of age?

Any attempt to understand and/or intervene in the growing crisis of Black child suicide without placing this phenomenon within the context of the broader ecosystem impacting the lives of Black children would be inadequate. The social-ecological framework (see Figure 2, EEC Contextual Model, reproduced from Grills, Aird, and Frierson, in press) provides a lens for developing a more nuanced understanding of the relationship between mental health and multi-level social and environmental factors (Bronfenbrenner, 1979; Unger, 2012; Umemoto et al., 2009; Grills, Aird, and Frierson, in press). This model encourages attention to risk and protective factors at several levels that influence mental health, including individual, family, peer, school, neighborhood, community, and broader socio-political systems.

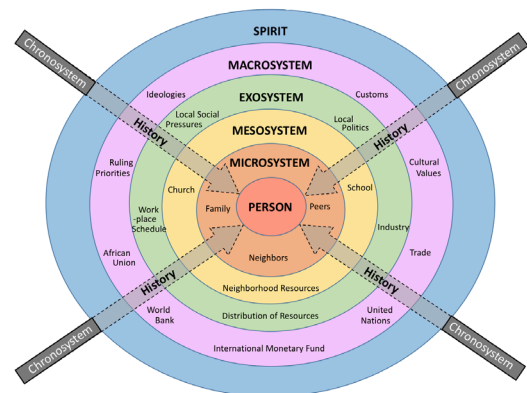


Figure 2

Bronfenbrenner’s ecological model suggests examining five interrelated subsystems. The most proximal level to the person is the microsystem (i.e., dyad relations with family, peers, neighbors, mentors et al.), followed by the mesosystem



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(which moves beyond the dyad and connects the dyad to other systems within which the family, child, and parents live). Immediately beyond these subsystems and nested within the surrounding broader macrosystem (consisting of laws, customs, cultural values, ideologies that characterize the society or social group) lies the exosystem (i.e., the social system consisting of community resources, social networks, local politics, industry, etc.). Finally, affecting all of these is the chronosystem, which takes into consideration the powerful force of time. Human behavior is embedded within historical contexts, and history can exert a powerful influence on all other levels in the ecosystem.

Against the backdrop of the ecological model, critical factors contributing to Black child death by suicide can be understood at each ecosystem level:

- 1. Multigenerational Cultural Trauma** (Chronosystem and Macrosystem Levels)
- 2. Community Violence** (Mesosystem Level)
- 3. Adverse Childhood Experiences** (ACEs) and Stress-response Patterns (Person Level)
- 4. Systemic and Institutional Violence** (Exosystem and Mesosystem Levels)
- 5. Bullying** (Microsystem Level)

The potential role of some of these factors is described below.

1. Multigenerational Cultural Trauma (Chronosystem and Macrosystem Levels). People of African ancestry born over the course of the last 600 years have come into a world that profoundly devalues their lives. They have entered life with a taint that generally marks them as ugly, unlovable, incompetent, dumb, worthless, useless, evil, and animal-like; not really part of the human family. Black people have lived under the oppressive weight of racism's unrelenting narrative that everything Black is inferior—Black skin, Black hair, Black culture, Black values, Black religion, Black relationships, Black families, Black communities and more. Under this multigenerational burden, Black children, parents, families and communities have contended with the systematic denigration of all things African (and Black). They have been forced to contend with physical and psychic terrorism and brutality, and a caste system that has ranked “White” people at the highest and “Black” people at the lowest rung—and often outside of the human family. The resulting stereotypes have adversely shaped the world's perceptions of Black people and, far too often, their perceptions of themselves, particularly Black children.

Intense racism, particularly over the course of time, creates multiple forms of trauma, one of which is cultural trauma. Cultural trauma is the “dramatic loss of identity and meaning, a tear in the social fabric, affecting a group of people that has achieved some degree of cohesion” (Eyerman, 2001, p.2). At its core, it is a collective experience of major disruption and a social crisis of meaning and identity. It is the result of a direct assault on the integrity of African cultural values, principles, practices, and identity, supplanting African standards of ethics, philosophy, psychology, civic engagement, aesthetics, spirituality, and more in favor of European standards. It is a pervasive assault that uses multiple vehicles, including literature, scholarship, television, newspapers, radio, and social media to establish and maintain its authority (Grills, Aird, and Frierson, in press). Cultural trauma forces its victims to grapple with making sense of assaults to their humanity, the pain inflicted, and perplexing attributions of responsibility (Alexander et al., 2001). And it undermines the powerful



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protective role culture can play in the presence of intense racism. While challenging enough for adults, this can be overwhelming for children and youth, who may not yet have developed the psychological “armor” older Black people have cultivated in response to oppressive experiences. This increases children and youth vulnerability to suicidality.

Cultural trauma creates a climate of alienation that has a profound effect on the Black personality, psychological functioning, and response to stress. It can challenge the nervous system, impacting self-regulation and sensory motor development (Ryan, Lane, & Powers, 2017). However, to date, there are no studies looking at the neurodevelopmental impact of chronic exposure to cultural trauma for Black children. Epigenetic research suggests that the stress response of current generations (for example, heightened stress response, hypervigilance, allostatic load, adaptability to constant states of stress, hardiness, capacity to recover, etc.) is in part inherited from the stress-load responses of prior generations. This includes epigenetic research investigating suicide risk (Guintivano et al., 2014). A more trauma- and neurobiologically informed multidisciplinary approach is required.

When an individual is preoccupied with managing racial stress, “space, time, energy, mobility, bonding, and identity are compromised” (Chester Pierce, as cited in Bulhan, 1985, p.124). In the face of steady doses of implicit bias, racism, and dehumanization, Black children must constantly fight against negative perceptions of themselves, fractious relationships, and struggles to maintain optimal emotional and physical health. Ponterotto et al. (2006) suggest there are five psychological consequences to this assault on a person’s humanity and identity. They are: 1) alienation (resulting from adopting the cultural and racial reality of Whiteness); 2) internalized racism (the process of accepting the racial stereotypes of the oppressor); 3) race-related trauma (psychic trauma resulting from exposure to multiple forms of racial stress); 4) race-related fatigue (mental fatigue resulting from the exposure and vigilance associated with microaggressions etc.); and 5) racial mistrust (defensive reactions of mistrust toward Whites in response to repeated discrimination). For adults and children, feelings of anger, anxiety, paranoia, helplessness, hopelessness, frustration, resentment, fear, lowered self-esteem, and lower levels of psychological functioning can emerge (Fisher, Wallace, & Fenton, 2000; Jencks & Phillips, 2011; Sellers & Shelton, 2003). Greater vulnerability to stereotype threat—e.g., the fear that one is or may be at risk of conforming to stereotypes about their social group—can also occur. This can undermine emotional and physical well-being, help-seeking, and academic success (Chavous, Rivas-Drake, Smalls, Griffin, & Cogburn, 2008; Neblett, Philip, Cogburn, & Sellers, 2006; Neblett, Smalls, Ford, Nguyễn, & Sellers, 2009; Smalls, White, Chavous, & Sellers, 2007; Stevenson & Arrington, 2009; Wong, Eccles, & Sameroff, 2003). Clearly, more research is needed to better understand the above dynamics in response to chronic multigenerational oppression and its contribution to suicide risk among Black children at different stages of development.

A child’s close relationships (such as those with family networks, mentors, or community members) are crucial to the child’s positive development. Children rely on interpersonal relationships to develop their coping skills, and they are guided and shaped by what they see the people closest to them do (Lee, Cheung, and Kwong, 2012). Strong relational ties to family and communal networks not only supports a child’s overall well-being and development of coping skills, those ties protect them against seeing suicide as the only recourse to stress and trauma (Masten, 2018). However, the healthy process of learning to cope through relationships is jeopardized for Black children by the toll that multigenerational,



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institutionalized racism and a racialized society takes on their families and communities. While there have always been many examples of resiliency and thriving amidst the trauma inflicted by racism, the fact still remains that the chronic and cumulative trauma that Black adults must face can deplete their strength, lead to less healthy coping strategies, and result in compromised, fractured, and inconsistent relationships—including relationships with children. In fact, Black families have suffered from broken relationships as a direct result of racism (pre and post enslavement) for centuries. One wonders how Black children learn and use healthy coping skills, and develop resiliency from close relational ties while suffering under the weight of racism. How can Black children learn to navigate their stress to achieve positive youth development (Lerner et al., 2017)? Future research should focus on ways Black adults and families can foster and maintain resilience “to buffer stress, reduce the risk of dysfunction, and support optimal adaptation” (Walsh, 2012; Grills, et al., 2016).

As children age, peer support becomes a primary social network that can be both a protective factor and potential risk for new suicidal thoughts. In a 2010 *Newsroom* article, “Daily Media Use Among Children and Teens Up Dramatically from Five Years Ago”, the CEO of the Kaiser Family Foundation was quoted to have stated:

The amount of time young people spend with media has grown to where it's even more than a full-time work week. When children are spending this much time doing anything, we need to understand how it's affecting them – for good and bad.—Drew Altman, Ph.D., President and CEO of the Kaiser Family Foundation. (Kaiser Family Foundation [KFF], 2010)

This ushers in the idea that another source of cultural trauma—social media—plays a particular role in secondary exposure to suicide by others. Howard (2018) found that 56% of all U.S. children, ages 8-18, have their own social media accounts. The digital universe has expanded the world, community, and/or social support system for Black youth with greater connection to family, friends, and role models, for better or worst. Abrutyn and Mueller (2014) argue that simply knowing someone who committed suicide can lead to new thoughts of suicide among youth. In a longitudinal study of data from the National Longitudinal Study of Adolescent Health, they found evidence to support the idea of “contagion effect” when children lose a friend, family, and/or role model to suicide. As with other studies, children of color were included, yet their unique cultural experiences were not addressed. Social contagion also appears more salient for girls than boys, with both friends and family being more impactful for girls. Friends, as role models, have a greater impact on boys.

The digital world also increases familiarity with Black celebrities who have committed suicide. Black celebrities who reportedly posted to social media before taking their own lives included:

- Role model and creator of the For Brown Girls website (promoted self-love among Black girls), Karyn Washington, took her own life at the age of 22 in April 2014.
- Seattle rapper Freddie E (Frederick Eugene Buhl) committed suicide at the age of 22 years old in January 2013, reportedly after tweeting his intentions to his fans; “If there’s a God, then He’s calling me back home....”



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- Actor Lee Thompson Young—who appeared to have “made it” both in terms of his success as a former child Disney star in *The Famous Jett Jackson*, and as an adult actor on the hit TNT show *Rizzoli & Isles*—took his own life at the age of 29 in August 2013.
- Activist, Black Lives Matter organizer and Pursuing Our Dream founder, MarShawn McCarrel, took his own life in February 2016 at the age of 23.

More attention and research specific to the use of social media among Black children, and its relationship to suicide risk and the impact of negative cultural messages, is imperative.

The risks of contagion can be exacerbated by the exposure to cyberbullying, leaving young people vulnerable to feelings of despair because they may not know how to stop aggressive and damaging attacks. Even more disturbing is the immediate access to planning a suicide and/or establishing suicidal pacts beyond geographical boundaries to try to resolve issues like cyberbullying. The cell phone as a multimedia tool affords youth continuous access to social media. Altman’s (1992) caution regarding the detrimental impacts of a “more than 40-hour-work-week utility” may apply here as well. It is quite probable that many youths are spending more time on social media than they are in face-to-face interactions. Given this, social media may present unique opportunities for the prevention of and interventions with suicidal thoughts and behaviors. Specifically, public education postings, screening instruments and monitoring algorithms may enhance and extend prevention efforts. Social media-based interventions that are culturally specific and developmentally appropriate may lead to lower fatality rates and better positive outcomes for Black children and adolescents in distress.

2. Community Violence (Mesosystem Level). Exposure to community violence is a matter of significant concern for Black children. As a case in point, South Los Angeles, which is representative of many Black urban communities in the U.S., provides some insights. In 2017, the South Los Angeles Polling Project highlighted the top safety concerns of more than 400 South L.A. residents, including youth (Grills, 2017). Many Black youth who participated reported having safety concerns surrounding gangs, violence, and robberies. Sixty-three percent of youth participants felt that their school environments are “somewhat safe or not safe at all.” Additionally, 54% felt that their personal safety is “somewhat safe to not safe at all.” When asked how they think public dollars should be spent in their communities, 46% of youth said that public dollars should be spent on trauma-informed support services. These data highlight the types of stressors that youth in South L.A. encounter on a daily basis in their communities and the lack of adequate support to deal with these stressors. When these same youth were asked who they talk to about these daily stressors, 61% reported that they “keep it to themselves.” This context is further complicated for those Black children and youth living in the intersectionality of exposure to oppression as it relates to their sexual orientation (e.g., lesbian, gay, transgender, etc.), racial/ethnic identity, and religious or spiritual beliefs (Buchman-Schmitt et al., 2014; Sutter & Perrin, 2016). Multiple sources of stressors like these may make it difficult for a Black child to know where and with whom it is safe to seek help. In short, these data highlight the combined reality of extremely stressful environments, the need for appropriately targeted resources, and the current reality of few outlets of support to help Black youth manage their stress and distress.



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3. Systemic and Institutional Violence (Exosystem and Mesosystem Levels). Every system that touches Black children hurts them; this includes the child welfare, juvenile justice, education, and law enforcement systems. Black children are disproportionately represented in the child welfare system, often with serious consequences for their life outcomes. In 2017, the National Foster Youth Institute Transition Aged Youth Survey (NFYI-TAY), administered to transition aged youth (TAY) to better understand the types of support they need to prepare for life outside the foster care system, found that only 66% of Black TAY males and 48% of Black TAY females between 18 and 20 years of age reported that they felt ready to be on their own, compared to 88% of 18-20-year-old White TAY males and 53% of White TAY females. The very system put in place to provide temporary, safe living arrangements and therapeutic services to alleviate the stressors foster youth face are inadequate for Black children. Child welfare system-involved Black children have disproportionate rates of high school incompleteness, incarceration, teen pregnancy, homicide and suicide compared to their White counterparts (Johnson, 2010). Although Black 18-20-year-old youth were the focus of the needs assessment, the resulting data point to how early adverse childhood experiences (ACEs), combined with underdeveloped support networks, leave Black youth in foster care susceptible to poor outcomes in adulthood. Furthermore, it suggests that signs of the effects of these adverse experiences did not emerge in their teenage years but were present throughout childhood and manifested later in life.

Stress and trauma exposure are magnified for Black youth in the juvenile justice system. While youth of color experience chronic racial stress in their communities, coming into contact with law enforcement and juvenile detention and confinement amplifies this stress, given rampant implicit bias and structural racism. Black youth are 5 times more likely to be incarcerated and confined compared to their White peers (Cancio, Grills, & Garcia, 2019). As Black children are over-policed and detained at disproportionate rates in the juvenile justice system, their preoccupation with their own mortality cannot help but intensify. Abram and colleagues (2008) reported in a longitudinal study with 1,829 detained youth between the ages of 10 and 18 that incarcerated youth die by suicide at a rate of 2 and 3 times greater than that of their counterparts in the general population. They also found that one in every 10 newly incarcerated youth presented with a history of attempted suicide, which is the greatest predictor for future attempts. The authors conclude by advocating for a) screening for suicide among detained youth, b) training of staff in detection and response, and c) improving the quality of demographic information (54.9% African American, 16.2% non-Hispanic whites, and 28.7% Hispanic), which is notable in that more than one half of the detained youth were Black. Unfortunately, it did not focus specifically on the unique experience of Black children in the social-ecological contexts that give rise to the disproportionate rates of incarceration.

Black children and adolescents are at particular risk for “death by cop” through impulsive interactions with police officers. Given the frequency and deadly intensity of law enforcement’s response to Black children and adolescents, this could lead to an almost certain death. *The Los Angeles Times* (Khan, 2019) recently posted an article that highlights the patterns of vulnerability for Blacks at risk for “death by cop.” About 1 in 1,000 Black men and boys in America can expect to die at the hands of police, according to a new analysis of deaths involving law enforcement officers. That makes them 2.5 times more likely than White men and boys to die during an encounter with police officers. The analysis also showed that Latino men and boys, Black women and girls, and Native American men, women and children are also killed by police at higher



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rates than their White counterparts. But the vulnerability of Black males was particularly striking. It can be deduced that this racialized social context can only create and exacerbate a sense of hopelessness and depression for Black youth.

The U.S. educational system is also implicated as a source of stress and trauma for Black children, instigating suicidality and suicide attempts. Black students have long been disproportionately overrepresented in referrals for special education (Ahrum et al., 2011) and disciplinary actions such as office referrals and out-of-school suspensions and expulsions (Nicholson et al., 2009; Skiba et. al., 2002) to a far greater degree than students of other racial backgrounds. Race and gender differences remain as significant factors in discipline referrals even when controlling for socio-economic status (SES). This means that Black male students are referred for discipline regardless of whether they come from low, middle or high economic backgrounds (Skiba et al., 2002).

There are a multitude of damaging consequences from these inequities. Ahrum et al. (2011) identified several long-term detrimental outcomes associated with Black and Latino students being classified as disabled and marginalized into special education. They include: stigmatization from being labeled as disabled or deficient; fewer opportunities to interact with mainstream or high-achieving peers; less exposure to rigorous curricula; lower eligibility to postsecondary academic institutions; diminished employment opportunities; and, higher likelihood of continuing on in special education tracks resulting in greater difficulty in re-integrating into larger society. Disciplinary actions can also increase the likelihood of contact with the juvenile justice systems. An analysis of education and justice system data has revealed a direct correlation between racially disproportionate out-of-school suspensions and racially disproportionate referrals to juvenile courts (Nicholson et. al., 2009). These results were not explained by differences in delinquent behavior and persisted even when controlling for poverty, urbanization, and other relevant factors (Skiba et. al., 2002). Implicit bias and racism within the school and juvenile justice systems matters in the lives of Black children and adds to their suicide risk.

4. ACEs, and Stress-response Patterns (Person Level). Recognizing the serious toll racism can have on children, the American Academy of Pediatrics (AAP) issued a statement on July 29, 2019, calling for action to reduce the harmful impact of racism on children (AAP, 2019). In their policy statement, AAP asserts that racism harms children's physical and mental health. For example, under the weight of chronic stress, children's bodies are flooded with stress hormones such as cortisol, which after prolonged exposure, leads to inflammatory reactions. This can cause short-term and long-term health problems in children, like heart disease, diabetes and depression. Racial stress exposure impacts health and development, and in the case of suicide, when used as a coping strategy, it can be lethal.

Adverse Childhood Experiences (ACEs) research suggests that adverse childhood experiences (e.g., physical, verbal and sexual abuse; physical and emotional neglect; parent/guardian with a substance use addiction or with a diagnosable mental health issue; family member who is incarcerated; witnessing of mother being physically assaulted; and loss of a parent/guardian as a result of abandonment) have an adverse effect on physical and mental health, including suicidal behaviors for children (Stevens, 2013). While the percentage of suicide attempts for adults with a history of adverse childhood experiences is 64%, the relationship for children and adolescents is 80% (Dube, Anda, Felitti, Chapman, Williamson, & Giles, 2001). The experiences of Black people and Black children are not fully captured in ACEs research. Adverse childhood experiences associated with community violence and racial trauma are not typically assessed. In fact,



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and the original ACEs study consisted of predominately White middle-aged and middle-class men. And while it included more than 900 African American cases, no secondary analyses by race were conducted (Felitti, Anda, & Nordenberg, 1998). The Philadelphia ACEs (Research & Evaluation Group, 2013) study expanded upon the original ACEs by including predominately Black adults and included trauma-specific events associated with inner-city life, like children being exposed to hearing gunshots or seeing dead bodies and other forms of community violence. The findings revealed a significant increase in exposure to a number of ACEs that compromised adult development, including childhood sexual abuse and suicide attempts later in life. These and other ACE findings beg the question of the relationship between childhood sexual abuse and suicide among Black children.

Recent efforts to broaden the ACEs to include more representative samples of people of color and to include historical/ racial trauma, community violence, microaggressions, and implicit bias (Burke Harris, 2018 & Dhaliwal, 2017) are promising. Future research that explores the implications of ACEs within a contextual understanding of Black children can build upon existing research on factors which may have short- and long-term effects on their mental health, particularly the rising rates of suicide. The extant literature details the disproportionate exposure of Black children living in low-income areas to community violence (Thomas, Carey, Prewitt, Romero, Richards, & Velsor-Frederich, 2012), Black children being more likely to experience bullying (Love, 2017 & Timsit, 2018), and the role of distinct as well as everyday racial traumas impacting the development of trauma responses and symptoms (Bryant-Davis & Ocampo, 2005; Butts, 2002; Carter, 2007; Comas-Diaz & Jacobsen, 2001; Helms, Nicolas, & Green, 2016; Loo et al., 2001; & Scurfield & Mackey, 2001).

While it is important to understand how ACEs can impact development and later-life outcomes, it is useful to also have an understanding of how individuals react to stress and to these adverse experiences. Examining stress-response patterns can deepen the understanding of how suicide can come to be a coping strategy in the lives of Black children. In other words, how can the intersection of oppressive social influences (such as racism), ACEs and patterns of responses to stressors and traumas increase our understanding and prevention of suicide?

Basic human biology and brain functioning may lend some insight into findings that suicide, particularly among 5-11-year-olds, may be driven more by impulse than planning and intent. MacLean's (1985) Triune Brain model offers a broad but informative way to understand the interface between brain functioning, stress responses and potential for suicidal behavior. According to MacLean, although the human brain has evolved over millions of years, its older structures still actively respond to current stressors and can drive a person's reactions and response to stress. One of the earliest structures, what MacLean refers to as the *reptile brain*, operates off of pure instinct. When danger is sensed and a quick response is required for self-preservation and survival, the reptilian structure is aroused and prepares the person for action by initiating the release of chemicals throughout the body. Since this area of the brain reacts instinctually, there is no judgment and the person may or may not correctly assess the level of danger at hand. At a higher level of evolution, the brain developed the *old mammalian brain* or the limbic system. This area, he argued, operates driven by emotions in response to stress. When activated, chemicals are released, creating an emotional experience



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which can prompt action. Again, there is no thinking, analyzing or judgment about what is the best course of action. Pure raw emotion drives behavior. Eventually, much later in our evolution, our brains evolved into the *thinking human brain*. It operates based on rational thought, planning and realistic evaluation of stressors and situations. When making decisions, solving problems or reasoning, the neocortex (the thinking brain) is engaged, without the involvement of the older brain structures. This is where human beings are different from the rest of the animals. This is also where children are less developed than adults and why their impulsive responses to stress may be more likely come from the emotional centers of the older limbic structure.

While MacLean's model is an oversimplification, and neuroscience has advanced beyond this model, the concept of a triune brain provides a useful way to understand stress-response patterns of adults and children. The thinking brain that can protect humans from rash judgments and action can be hijacked by the limbic or reptilian systems. The thinking brain, that can protect against harmful actions toward oneself, goes offline, leaving a person more vulnerable to influence of emotions and instincts on behavior. When the thinking brain is hijacked, a person can "flip his lid"; that protective function of the thinking brain to drive behavior is no longer operating, and his or her interaction with the world is driven by instinct and emotion. This model has been adopted by psychiatrist Daniel Siegel to promote self-regulation in children in school and clinical settings (Siegel, 2010). This model appears particularly relevant to understanding how a person—particularly a child—could turn to suicide as a means of alleviating stress. In short, the child's instinctual and emotional brain takes over and leads to extreme response and impulsive reactions to stressors.

5. Bullying (Microsystem Level). Recent media coverage of Black children who have died by suicide often links these deaths with experiences of being bullied. While youth suicide is a complex event that represents the co-occurrence of a number of risk factors (American Foundation for Suicide Prevention, 2019), the media often presents bullying as the singular cause of suicide for Black children. This narrow focus on one cause of suicide among Black children does not lend itself to a contextual exploration of bullying for Black children. This is concerning given research findings that suggest that Black children have higher rates of bullying not only as a target but as an aggressor, or even a bystander (Albdour & Krouse, 2014). A contextual exploration of bullying for Black children would allow for an identification of possible reasons of how attempts to gain acceptance, manage emotions, and resolve conflict are impacted by living in a society that devalues Black people. Adult family members who may experience their own coping challenges to oppressive conditions may displace their angst onto children, which may then result in these children dealing with their unresolved pain by bullying other children (Love, 2017). As targets of bullying when they themselves are bystanders, Black children may have an added layer to deal with—the threat of being viewed as a "snitch." Given historically disproportionate community violence, discipline and incarceration of Black people, such a label can instill fear of violent retribution. This is yet another potentially desperate situation that young Black people may not know how to resolve other than by taking their own life.



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There is no dearth of destructive factors pressing on the lives of Black children and Black communities. Resilience is clearly present, but, there can only be but so much resilience in the face multi-level assaults to the integrity of a child's well-being and identity.

The effects of these multiple assaults against the psyche of Black children and adolescents can manifest in a variety of ways, including death by suicide. Recognizing that there is no singular cause but a cast of primary suspects, provides first responders (parents, family, mentors, teachers, peers et al.) with visible cues that should sound an alarm for the potential of self-harm and suicide among Black children and youth.

While we have come far, and survived immense assaults, these remain trying times. We must take charge of the affairs affecting our lives for our own sake and the sake of our children, our families, our communities, and the generations yet to come. As Dr. Martin Luther King, Jr. (1967 speech), said, ***“(W)e must massively assert our dignity and worth. We must stand up amidst a system that still oppresses us and develop an unassailable and majestic sense of values. We must no longer be ashamed of being black.”*** Forty-five years later, Dr. King's charge to us as a people is needed even more. (Grills & Rowe, 2016)

WHAT TO LOOK FOR: RISK FACTORS AND WARNING SIGNS

Reliably detecting suicidality in and predicting imminent threat of a suicide attempt in Black children and adolescents is desperately needed but a long way off. Ways to do so must be culturally and developmentally informed. Many instruments have been created to assess for conditions implicated in suicidality (e.g., depression) and suicidality itself (Lotito & Cook, 2015), but cultural context had not been incorporated into a measure until the development of the Cultural Assessment of Risk for Suicide or CARS (Chu et al., 2013). While an important advancement, the CARS was created and validated on adults, thus not attending to important development issues in young people. Assessment tools that have been developed to identify suicidality in young people are also lacking in that they have often been created by adapting measures developed for adults and have predominately focused on assessing suicidality in adolescents (Runeson et al., 2017). More and more professionals are looking to screen for suicide and identify youth at risk where they spend most of their time—in schools. While this is a promising step, there are very few studies that have used such screeners with a focus, again, on Black youth (Husky et al., 2012), and results from such studies continue to reveal a lack of culturally contextual questions.

Risk Factors. Although urgently needed, there is still no validated measure for identifying risk of suicide in Black youth. Until this need is met, first responders must rely on looking for risk factors that may make a child or adolescent vulnerable to suicidal thought and action. Table 2 provides some of the most common suicide risk factors.



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TABLE 2: Suicidality Risk Factors

<ul style="list-style-type: none"> • Psychiatric disorders, particularly mood disorders, schizophrenia, and certain personality disorders in the young person and/or his or her family history 	<ul style="list-style-type: none"> • Prior suicide attempts and/or family history of attempts and/or completed suicide 	<ul style="list-style-type: none"> • Chronic feelings of helplessness and/or hopelessness
<ul style="list-style-type: none"> • Substance use disorders (alcohol or drugs, including prescription drugs) in the young person and/or his family history 	<ul style="list-style-type: none"> • Exposure to others who have died by suicide (in real life, the media and Internet), especially local clusters of suicide 	<ul style="list-style-type: none"> • Impulsive and/or aggressive tendencies
<ul style="list-style-type: none"> • History of trauma or abuse 	<ul style="list-style-type: none"> • Easy access to lethal means 	<ul style="list-style-type: none"> • Loss of relationship(s), especially with family
<ul style="list-style-type: none"> • Major physical illnesses or significant recent injury 	<ul style="list-style-type: none"> • Death or loss of loved one 	<ul style="list-style-type: none"> • Lack of social support and sense of isolation
<ul style="list-style-type: none"> • Family/relational turmoil 	<ul style="list-style-type: none"> • Triggering event(s) leading to shame, humiliation or despair 	<ul style="list-style-type: none"> • Change in treatment and/or treatment provider (particularly mental health treatment)

Adapted in part from <https://suicidepreventionlifeline.org/how-we-can-all-prevent-suicide/>

For Black youth, the lack of adequate healthcare, particularly mental health and substance abuse treatment for themselves and their family members, may make attenuating the risk of medical and psychiatric disorders almost impossible.

WARNING SIGNS – REACTIONS TO STRESS AND TRAUMA

Vulnerability to suicidal thoughts and actions significantly increases when stressors and trauma are added to what the young Black person is already trying to manage. Her risk for suicide comes not just from risk factors, but also from the cumulative effects of chronic and acute stress that can result in allostatic load or overload. This is the wear and tear on the body and brain that result from being “stressed out” for long periods of time (McEwen, 2005). A person can be left physically depleted, emotionally depressed and psychologically defeated, and looking for immediate relief. For Black youth growing up in a society that negates, neglects and attacks them, there are no shortages of stressors (e.g., academic challenges without adequate school resources) and trauma (e.g., police violence) that are unique to their experience as a result of institutionalized racism. Stressors and trauma affecting the individual also occur on a communal level, and the community’s response (e.g., increased gang violence) may or may not exacerbate the young person’s situation. This is an important context to understand the constant stressors that Black children face in their communities.



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It is therefore imperative to be vigilant to unexpected changes in a Black child or adolescent’s physiological, emotional, cognitive and/or behavioral presentation and/or functioning. Onset and persistent changes in any of these areas could signal that the child or adolescent is contending with acute or chronic stress or significant trauma in their lives.

Bodily Changes. An observable and unexpected change in how a young person’s body looks and functions can signal that she is contending with more stress than she can manage. Table 3 presents some of these signs.

TABLE 3: Signs of Stress – Body

• Chronic fatigue or tiredness	• Significant weight loss or gain.	• Immune system disorders (e.g., catching more colds)
• Sleep disturbances	• Drastic and/or persistent change in eating patterns	• Visual disturbances
• Changes in sleeping patterns	• Headaches, other aches and pains or body tension	• Sweating or chills
• Changes in eating patterns and appetite	• Stomach aches or problems	• Tremors or muscle twitching

One should ensure that any change is not the result of a medical condition (including acute injury and chronic illness). Parsing out the difference between physiological changes caused by stress or trauma on a child from those caused by stress on a communal level can be particularly challenging when it comes to Black children and youth. Poor public health care (e.g., not having a private doctor that attends to and follows through with a child throughout the child’s development), less health education and information (like that needed for best nutrition), and toxic physical environments (such as noise and air pollution in the poorest neighborhoods) are a few issues that make connecting physiological reactions to stress (and not a systemic issue) in Black youth more challenging.

Mood Changes. A child or adolescent may show changes in his or her emotional experience and functioning in response to stress or trauma. This can be detected in how she appears or what he says. Such changes can include any of those indicated in in Table 4 and should be more than merely fleeting.



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TABLE 4: Signs of Stress – Mood

• Depressed mood	• Irritability/Crankiness	• Feeling heroic, euphoric, or invulnerable
• Sadness	• Excessive fear, anxiety and/or worry	• Unexpected and extreme mood changes or swings
• Apathy	• Denial	• Loneliness
• Grief	• Guilt	• Increased temper/temper tantrums

It is important to be mindful that positive emotional changes that may appear to be healthy adjustment and improvement may actually be cause for concern. In a meta-analysis of clinical studies from 1991 to 2013, Gordon & Melvin (2014) found consistent evidence of an increased risk of suicidal thoughts and behaviors (along the order of 7 to 20 incidents per 1000) in adolescents in the beginning of treatment with anti-depressants versus those taking a placebo. A person's mood may have improved, but he may be contending with suicidal thoughts that he now has more energy to act upon. In addition, a child with long-standing depression, whose mood unexpectedly improves, may be seen as "getting better" when in fact he may have come to some sort of peace in his decision to die by suicide. Unfortunately, the research is sparse in this area, and none is focused on Black children and adolescents. However, it points to how crucial it is to follow up on any significant changes in a young person's mood.

Changes in Thinking. Changes in cognitive capacity (how one thinks) and thinking content (what one thinks) can be both observed and heard in what a young person is saying. As in all warning signs, it is important to look for significant and persistent changes from usual experience and functioning.

TABLE 5: Signs of Stress – Thinking

• Negative attitude	• Disorientation and confusion	• Difficulty setting priorities or making decisions
• Poor judgment	• Slowed thought processes	• Loss of objectivity
• Low self-esteem	• Poor concentration	• Hopelessness
• Negative self-talk	• Memory problems	• Helplessness
• Increased self-criticism	• Obsessive rumination (thinking over 85 and over) about death and/or ways to kill themselves	• Lack of self-confidence



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These warning signs in change of thinking take on a particular meaning when it comes to Black children and adolescents. Growing up in the United States they must contend with the ever-present message that they are “less than” based only on their racial heritage and appearance. As such, they may understandably have low self-esteem and feelings of hopelessness. Indicators such as the ones above are risk factors and warning signs.

Overrepresentation of Black students in special education referrals and assignments (also known as disproportionality) points to factors that can complicate and/or impede professionals from accurately detecting cognitive warning signs of distress in Black children. In their review of the extant literature and their own interventions with school districts, Ahran et. al. (2011) connected higher rates of disproportionality with, among other factors, teachers’ subjective evaluations of student behavior in class, and their beliefs about their home environments. They note as others have that Black children’s behavior does not always fit the expectations of the class and that teachers use “cultural deficit thinking” (i.e., the belief that Black children come to school ill-equipped due to deficiencies in their environments) to determine whether to refer a child to special education. This points to a situation in which it may be harder for educators to detect cognitive warning signs of distress—particularly as they relate to and show up in academic performance—if they already view Black children as deficient due to their in-class behavior and their beliefs that they come from deficient homes. Educational professionals may miss changes in thinking in Black youth, not knowing their true baseline functioning and what a meaningful change would look like.

Changes in Behavior. Stress and trauma reactions may also be seen in how children and adolescents act in their world and particularly in relation to others. As with other warning signs, there should be a notable, persistent change that is not explained by a known medical illness or situation event. Some signs of distress that may show up in behaviors are summarized in Table 6.

TABLE 6: Signs of Stress – Behavioral

• Decrease or increase in activity level	• Angry outbursts	• Acting more anxious or agitated
• Lethargy or inability to calm or relax	• Argumentativeness	• Hyper-vigilance or looking out for danger
• Sluggishness or Fidgetiness	• Frequent crying	• Being easily startled
• Unusually quiet or non-stop talking	• Difficulty communicating	• Becoming accident prone
• Loss of interest in previously enjoyable activities	• Difficulty listening	• Distraction or dissociation



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<ul style="list-style-type: none"> • Isolation 	<ul style="list-style-type: none"> • Avoidance of people, places or activities that may trigger trauma 	<ul style="list-style-type: none"> • Difficulty in giving or accepting support or help
<ul style="list-style-type: none"> • Withdrawing from others 	<ul style="list-style-type: none"> • Fear of individual(s) (e.g., in the case of bullying) 	<ul style="list-style-type: none"> • Detachment or avoidance of previous sources of support (e.g., church)
<ul style="list-style-type: none"> • Inability to experience pleasure/fun in previously enjoyable social interactions 	<ul style="list-style-type: none"> • Blaming/ revenge seeking 	<ul style="list-style-type: none"> • Risk taking and/or failure to protect oneself in dangerous situations

Adapted in part from the Center for Mental Health Services. (2004). Mental health response to mass violence and terrorism: A training manual.

Of course, developmental stage, maturity level and context matter. In very young children behavioral changes may also include changes in the quality of their play (e.g., themes of dolls hurting themselves); “acting out” (e.g., pretending to hurt oneself); self-injurious commentary; out-of-character destruction of personal belongings; giving away of belongings; and/or significant lack of interest in all enjoyable play. In older children and adolescents, one might see a decline in academic and/or job performance; substance use, abuse or dependence (alcohol, drugs and/or prescription drugs); and/or placing themselves at risk for harm despite knowing better (e.g., unprotected sex with many partners)

As with other warning signs, changes in behavior must be considered within the context that Black children and adolescents live. For example, many of these young people are raised in family-oriented households distinguished by respect for elders. Black children may restrain themselves from disrespecting adults and elders as it is antithetical to what they know or—on a more practical level—to avoid reprimands for “talking back.”

WARNINGS OF ACTUAL SUICIDALITY AND SUICIDE THREAT

Most frightening is when Black children and adolescents give verbal and behavioral signs indicating more imminent suicidal threat. Feelings of unbearable pain, defeat, being trapped are consistent with suicidal thoughts and attempts for any person. However, such feelings are understandable in Black children and adolescents who face institutionalized racism, community violence and extreme economic hardship on a daily basis. How these feelings translate into what they say and do is the concern here.

Verbal Warning Signs. When examining what a child or adolescent says, it’s important to assess the level of imminent threat. Comments can reflect passive suicidality in which she does not have a plan—just prefer not to be alive. Alternatively, she can represent active wishes and thinking of ways to do with a plan to kill herself. Black youth at risk of imminent or immediate threat of suicidal actions will have a plan (such as hanging themselves), opportunity (a time when they may be alone or secluded) and means (easy access to rope). Table 7 presents some things a child may say that could indicate he or she is actively considering suicide.



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TABLE 7: Verbal Warnings of Suicidality

• “I don’t want to live/be alive.”	• “I don’t matter.”	• “There’s no point of being here.”
• “I wish I were dead.”	• “Who cares about me anyway?”	• “Why bother, I don’t expect to live that long.”
• “I want to kill myself.”	• “I’m not important.”	• “It would be better for my family if I weren’t here.”
• Glorifying another’s suicide (e.g., “At least he did it on his terms.” “Good for her.”)	• “I’d be better off if I weren’t here/ dead.”	• “I don’t want to be a burden to anyone.”

Our young people at more immediate risk might say that they do not see a future. They may question their own worth—a message society often gives to Black children and adolescents. Many Black children and adolescents may say that they are or do not want to be a burden to others. This could be particularly true for those in Black households in which family members are often required to work long, hard hours in multiple jobs to manage desperate economic situations that they face to a disproportionate degree compared to families in other ethnic/racial groups. Embarrassment over their thoughts, perceived inability to manage problems, and resulting negative evaluations may lead Black children and adolescents to avoid saying any of the above. And they may not feel that there are individuals who they can trust to tell without the fear of judgment. Black children and adolescents who indicate such thoughts may have lost touch with their higher power or not feel cared about by a transcendent higher power. As a result, they may actively retreat from what they, their family and their communities have relied on for comfort and help.

It is important to remember that Black children and adolescents have words and phrasing unique to being young and Black within specific social and cultural contexts and identities. For example, a quiet honors student, an athlete or young person being recruited by a gang may all talk about death and suicide in distinctly different ways. Adults and professionals need to keep up with new terminology so as not to overlook these verbal warnings of suicidality.

Behavioral Warning Signs. In addition to what they might say, children and youth will also reveal their internal state through their actions. Table 8 presents some common ways this can occur.



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TABLE 8: Behavioral Warnings of Suicidality

<ul style="list-style-type: none"> • Interest in and/or researching those who have suicided 	<ul style="list-style-type: none"> • Comments/drawings in schoolbooks or journals that indicate thoughts of death, dying and/or suicide 	<ul style="list-style-type: none"> • Engaging in risky, reckless behaviors (e.g., jumping off high places or into traffic)
<ul style="list-style-type: none"> • Interest in and/or researching ways to kill themselves 	<ul style="list-style-type: none"> • Social media postings/texts of comments related to suicide (e.g., “I wish that I was no longer here,” “No one would even care if I wasn’t here,” “Living is hard,” etc.) 	<ul style="list-style-type: none"> • Joining and/or involvement in gangs and viewing their life as disposable
<ul style="list-style-type: none"> • Seeking a means to kill themselves (e.g., getting rope or a gun) 	<ul style="list-style-type: none"> • Engaging in self-injurious behaviors (e.g., cutting). Of note: such behaviors are not the same as suicide. However, those who do engage in self-injurious behaviors are more at risk for suicide. 	<ul style="list-style-type: none"> • Intentionally provoking others to violence (e.g., identifying oneself to rival gang members verbally and/or by style of dress; challenging police)

Developmental considerations. Age and developmental stage directly affect the experience and expression of thoughts and behaviors. For example, very young children have not mastered the concept of irreversibility. This refers to the fact that some actions lead to results that cannot be changed. In the case of suicide, a young Black child may not realize the ultimate, final consequence that she will not be able to return to life and her loved ones. It is important to ask questions that can help children tell what they think will happen after they kill themselves. In addition, young children may not realize that there can be different degrees of upset and that some may be more easily managed than others. If they do not have this understanding, they may believe that suicide is the only answer for all levels of distress. Finally, young children may not have learned the words to accurately or fully express their distress, thoughts and intent. Without this ability, they may not be able to share their distress, and first responders may not have advanced warning to prevent a suicide. Concrete, simple questions like those requiring a yes or no response (e.g., “Do you want to kill yourself?”) is one way to help these young ones share what is wrong.

Detecting the risks in Black adolescents presents its own challenges. They are contending with the rapid physiological and cognitive development all adolescents face. Cognitive changes, including increased capacity for symbolic and creative thinking, can lead a Black teen to begin to wonder about the meaning of existence and his place in society (a society that is often dismissive and even cruel to him). Negative evaluations can lead to depressed thoughts, harmful self-evaluations and despair. Hormonal changes can exacerbate affective intensity and experience. In a society that over-sexualizes Blacks, outward bodily changes put Black teens at risk for sexual abuse, assault and human trafficking.



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All of the above factors can combine to result in impulsive and risk-taking behavior, which can be all the more fatal in communities with high levels and frequency of violence. Finally, the increase in independence and focus on social supports outside the home can make Black teens reluctant to disclose their feelings and intent. As with younger children, starting with closed-ended questions like yes/no questions (e.g., Have you thought about dying?) or providing short answers (e.g., What day do you plan to kill yourself?) can provide an opening that could lead to more open-ended questions requiring a more detailed response (e.g., Tell me what happened to make you think of suicide?).

Considering location. It is worth remembering that first responders must actively observe and ask Black children and adolescents about their lives “in real time” (or in person, face to face) and online via social media presence. Detecting suicidality in Black youth needs to be done in all the places they live, including home, school, and the community, but also the ever evolving and increasing number of online platforms, whether general like Snapchat or confessional sites like Whisper. First responders need to remember to look for signs not just in words, but in artwork (in journals, schoolbooks and online). Children, particularly those in elementary and middle school, may produce drawings, paintings or song lyrics containing reference to violence, death or suicide.

INTERVENING TO DISRUPT THE RISE IN BLACK CHILD SUICIDE

There are multiple pathways to disrupting the rising trend in Black child suicide. While it is already known that these efforts require a consideration of the previously described contextual, biological, and resilience factors, the following caveats are offered. There is a need for a new lens with which to examine the many issues involved; all healers can and must be engaged; new questions must be asked to get more answers; and the way forward requires a larger share of the village to protect and heal its children. Ultimately, prevention is better than cure. Investment in upstream suicide-prevention approaches that occur prior to the onset of suicidal behavior may have the strongest potential to reduce the rising tide of Black child suicide (Bridge et al., 2015).

A NEW LENS

A focus that ignores the broader social, historical and structural forces at play perpetuates a focus on the individual when it is the context that should occupy equal if not greater attention. It broadens the lens such that suicide can also be understood as a “solitary answer to a set of collective and institutional questions about the conditions of a dignified human existence that we (i.e., most political societies) have not confronted in a meaningful or sustained way” (Button, 2016, p. 270). This suggests that suicide must also be understood in the context of resource inequities, political and ethical problems, and conditions that do not support a dignified human existence.

Examining suicide through a socio-ecological and political lens expands the list of predictors, mediators, and moderators of Black child suicide.



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[T]he list of symptoms and risk factors for suicide would need to be expanded to incorporate things like social fragmentation (Trovato and Jarvis, 1986) and social isolation; community depopulation, blight, and crime; unemployment (Platt and Hawton, 2000), measures of union concentration, and real median incomes for working-class citizens; degree of community investment and community programming; access to mental health services...regulations governing the possession and safe storage of firearms. (Brent and Bridge, 2003) (Button, 2016, p. 277)

Addressing racism and building skills and tools associated with stress can positively impact the lives of Black children and their first responders (parents, family, friends, faith-based groups, and community). The essential shifts to promote wellness are:

- increased knowledge and understanding of racism, racial stress/trauma, the lie and how it operates across space and time;
- increased sense of community, connection, compassion, empathy, reciprocity, and responsibility for one another (i.e., addressing relational needs);
- increased awareness of and application of cultural heritage and principles;
- increased sense of positive ethnic/racial identity and Pan-African solidarity;
- increased civic engagement, community social capital, and empowerment in the service of eradicating the lie from institutionalized racism and its social and personal consequences;
- increased general well-being and resilience;
- greater spiritual attunement (i.e., seeing serendipity and intuition as signs of spiritual connection and growth);
- stronger, more harmonious and respectful community relations and community safety nets (youth- and family-centered activities and supports, community activism, community rituals to support wellness, development and decreased community and family violence);
- decreased alienation and psychic suffering;
- decreased internalized racism and adherence to the lies;
- decreased symptoms of racial stress, depression, anxiety and self-doubt, and
- increased supports for particularly challenged populations (e.g., children in the child welfare system,

To save the lives of Black children and youth, greater investment in protective factors, including social and emotional supports, is needed (Joe et al., 2018) while simultaneously addressing structural racism; the social determinants of their health, mental health stigma, and help-seeking; and culturally tailored treatment opportunities. And all of this must occur within the context of history, the socio-ecological environment, and generational shifts.



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New generations of Blacks have been raised amid extreme developmental contexts that often leave many without access to traditional symbols of hope (Gibbs, 1998) and the adaptive coping styles (e.g., religious coping, external attribution orientation) that helped many in earlier generations face the challenges of adverse life circumstances and to have lower rates of suicidal behavior. (Joe, 2006, p. 276)

A number of questions arise related to generational shifts within American Black society that are worthy of deeper examination. By way of example:

- 1.** Has there been a shift from an “external attributional orientation” (system blaming) to an “internal attributional orientation” (self-blaming) among younger generations of Black people as a result of the high psychosocial stressors of a racialized society that limits their success?
- 2.** To what extent did the Civil Rights Movement affect generational attributional styles by raising personal expectations, achievement opportunities, and aspirations among younger generations of Black people even though there were not corollary structural and practical changes in American society to warrant a shift in attributions? Did younger generations of Black youth drink the proverbial Kool-Aid that their opportunities are limited only by their skills and motivation?
- 3.** Has there been a shift in the adoption of cultural values, beliefs and principles (e.g., regarding religiosity, communalism, views about suicide etc.) among younger generations, diminishing the protective role that culture played in prior generations?

A new lens also calls for reflection and correction of long-standing cultural messages. Culturally adaptive behaviors to the historical and persistent systemic oppression against Black children and their families may inadvertently contribute to the silence or the missing suicidal warning signs. For example, messages like “man up; boys don’t cry” as well as the myth of the strong Black woman (i.e., the socialization of coping with everything on your own, including placing others’ needs before your own at the risk of poor self-care,) (Dow, 2015) or perpetuation of John Henryism (derived from the fable and epitomizing the cultural value of actively coping with ongoing stress with no attention to the risks; James, 2002) may promote messages of suffering in silence or glorifying dealing with increased stress without recognizing the physical, psychological, and emotional risks. These messages or scripts can have both positive (promoting resilience) and negative (poor self-care, depression, poor coping skills, isolation etc.) outcomes. There is a need to reposition strength to include the capacity to have courageous healing conversations (Jackson, 2018) that allow for Black adults to model for Black children how to ask for help, utilize resources, and push back on messages that glorify suffering in silence as a cultural value.

ENGAGING ALL HEALERS

It is imperative that the countering of suicide among Black youth be conceptualized in a village construct, where many are responsible for the healing; not just professionals. In doing so, all members of the village should perceive themselves as healers and address the necessity of healing individually and collectively from the physical, psychological, emotional, and spiritual residuals of exposure to persistent socio-ecological cultural trauma in order to protect our children and



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foster their resilience. The prevalence of suicide among Black children warrants collective, integrative, multifaceted, and culturally affirming responses. This section is intended to offer such efforts that should be considered as interdependent.

Community. Under the weight of racial trauma and oppression, pivotal questions arise: How can families be first responders when they need a first responder? How can Black children be first responders for one another and supported by adults? How can communities be a first responder when they, too, need a first responder? At a minimum, to counter the harmful effects of racial stress, Black children, families, and communities need community-based resources to promote critical consciousness, expose implicit biases and internalized racism, explain and heal the personal and collective wounds of racial trauma, present healthy counter narratives to anti-Black racial narratives, and foster resilience, as well as tools for understanding and managing stress (Grills and Aird, in press).

To offset the negative effects of racial stress and trauma, Black children, parents, families, and communities need:

- an increase in critical consciousness (examining what we think know and re-authoring or discovering new knowledge);
- an increased awareness of culturally affirming knowledge and ethnic identification;
- a repertoire of skills to understand racism and the lie, as well as manage racial stress;
- increased cognitive and physical self-awareness of the signs of stress;
- an increased sense of compassion for self and others who are experiencing racial stress;
- improved communication and interpersonal skills;
- self-care—emotional, spiritual, and physical;
- knowledge and understanding of African cultural principles and value;
- greater access to global historical facts about Black people to correct the mis-education fostered by the lie of White superiority and Black inferiority; and,

Family. Caring for the Caregivers. In light of research suggesting that the existence of a supportive caregiver can mitigate the impact of toxic stress for children (Burke Harris, 2018), the importance of supporting parents/guardians in the challenging work of raising a Black child in a hostile socio-political climate cannot be stressed enough. Black parents/guardians often express realistic fears for their child's safety due to violence, including walking to and from school (Kohli & Lee, 2019). As Black parents/guardians often walk a stressful fine line of trying to preserve their child's innocence, on the one side, and having the necessary conversations about safety in relation to harm and mortality on the other, it may be helpful for schools to offer workshops facilitated by school-based social workers for Black parents/guardians on ways to offer support to their child, particularly in relation to situations that may pose a danger to physical and/or psychological safety, while also practicing self-care/wellness strategies for themselves. These workshops could also provide an opportunity to share community resources with parents/guardians about practicing wellness by participating in mental health services,



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if needed, as parents/guardians may have their own unresolved issues of trauma that surpass those experiences of their child (Burke Harris, 2018).

Peers. Support Peer Support. Many times, peers are the first to hear of a safety concern in a child or adolescent. To expand community reach and increase village enrichment, training children's peers on how to recognize and respond when presented with suicidality and safety concerns is imperative. A critical, age-appropriate conversation is needed to support the peer and help her to discern between appropriately seeking help and "squealing," "snitching," or not keeping a peer's confidence. Helping young people is best done by coaching and/or collaborating with them instead of imposing on them. Of course, available, accessible and culturally responsive support resources are absolutely necessary. These may include 24-hour hotlines with staff that know how to speak to and listen for the realities of Black youth. It may require the inclusion of school-based wellness centers in elementary schools, as success has been demonstrated at the middle and high school levels (Cokley et al., 2014). Researchers should utilize methodologies like participant action research or community-defined practices that position youth as co-researchers or experts to further our understanding of the stressors they experience, how suicide manifests among peers, and how they support one another, as such a holistic approach would further prevention, assessment, and intervention.

Professionals. Any professional seeking to address suicide in Black children must convey a sense of respect and compassion regardless of the child's life circumstance (such as involvement in foster care or the juvenile justice system). Radical transformative healing for Black children is based upon the ability of first responders to understand, accept and convey the sense that "I see you," "I hear you," and "I am here for you."

Taking this one step further, first responders—particularly professionals—need to take advantage of a rarely utilized resource: Black children and adolescents who have experienced suicidal ideation and/or attempts and survived to lead healthier lives. This represents a strengths-based, culturally affirming, child-affirming and centering perspective. It is also a practical approach, as these are the best people to learn from. Questions that can be asked include: What were their experiences? What got them through? What was common or unique to being of African ancestry? What would they recommend to help other Black youth and/or their loved ones? This is a paradigm shift from the context of racism and its threats to young Black people to how those young Black people live despite such contexts.

Going beyond respect and compassion, mental health providers must be responsive to the complexities of Black youths' experiences and should critically consider the role of social justice in the delivery of services. Odegard and Vereen (2010) postulated that attention to social justice in practice would be predicated upon adopting a systemic perspective that takes into consideration the impact of oppression and social injustices on the psychological and socio-emotional well-being of clients and the implications of such for innovative treatment approaches. To address the root causes of oppression and social injustices, professionals are called to act with activism and political advocacy to demand systemic changes in school systems, medical/mental health care, law enforcement and other institutions to ensure the safety and promote the healthy existence of Black children. Other ways that professionals can help are detailed in the following areas.



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1. PREVENTION AND EARLY INTERVENTION STRATEGIES. Interventions that are sensitive to different developmental stages have the potential for greater effectiveness in reducing suicidal behavior (Daniel and Goldston, 2009). There are common and unique characteristics of suicidality for elementary school-aged and early adolescent Black youth, suggesting the need for differential suicide prevention strategies for these distinct age groups. Extant literature suggests a need for both common and developmentally specific suicide prevention strategies during the elementary school-aged and early adolescent years (Sheftall et al., 2016; Zainum & Cohen, 2017). Lee and colleagues' (2019) review of the literature substantiates this stance. Risk factors for suicide among adolescents is predominately related to mental illness (50-70% determined postmortem), whereas children under the age of 15 who die by suicide are less likely to have an underlying mental illness. The study (Lee et al., 2019) found that elementary school-aged children's death by suicide appeared to be related to family stress/conflict (e.g., divorce), more likely during vacation or school breaks, suggesting that elementary school settings might be a protective factor.

2. TRIUNE BRAIN MODEL. As noted earlier, Siegel (2010) has used the triune brain model to teach children (and adults) about a hierarchical set of brain structures, how they influence responses to stress, and how to engage the thinking brain to manage stress. In his "flipping your lid" (Siegel, 2010) analogy of the triune brain, Siegel trains children and adults to become more reflective and intentional about which of the brain structures is driving their response to stress. The simple question: "What part of the brain am I living in?" can engage the thinking brain to help Black children and adolescents make healthier decisions in the face of stress. This brief video clip provides a quick, two-minute overview by Siegel (<https://www.youtube.com/watch?v=gm9CIJ74Oxw>).

3. TRAINING. The complexities of combatting the threat of suicide in the lives of Black children require innovative and intentional change from all professional first responders in how this phenomenon has been approached. It is imperative that professional training progresses from cultural competence to social justice accountability through the inclusion of cultural humility—the idea of professionals as life-long learners engaged in self-exploration, self-critique, and a willingness to learn from others (Trevalon & Murray-Garcia, 1998)—and cultural equity. Almeida and colleagues (2011) defined cultural equity as the "systemic analysis of systems of domination and subordination across and within cultures, by addressing the interplay of power, privilege, and oppression in family and community life" (p. 49), as well as in clinical practice. In doing so, unexamined yet long-standing contributing factors of implicit bias and systemic oppression (such as lower access to quality care) of Black communities may be curtailed.

Professional training must also address service providers' perception of Black children and adolescents. Black children and youth are not at-risk, they are at-potential in at-risk environments (Jackson, 2018). And trauma-informed approaches advocate a shift from "what is wrong with you?" to "what happened to you?" ensuring that all involved understand that it is not the Black child who is at fault or constitutionally deficient, but that a real situation/ trauma/ event occurred, and the young person is having an understandable reaction. First responders' skills in determining what happened and how to intervene systemically and effectively to triggers specific to Black children must be honed. Unresolved persistent cultural trauma mandates that mental health providers, as first responders, should be trained to screen for suicidal ideation and/or behaviors, regardless of the presence or absence of a diagnostic disorder (Joe et al, 2009).



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The prevalence of suicide thoughts and behaviors among young Black children can bring up a range of thoughts and feelings for first responders. Given this, training professionals to screen and intervene with suicidal Black youth needs to be accompanied by training in vicarious trauma, secondary trauma, compassion fatigue and—most important of all—self-care. Professionals who care for themselves may also be more likely to care about monitoring their own feelings, biases and actions so that they do not add to the harm being done to Black children.

4. COURAGEOUS HEARTFELT LISTENING. Black children and youth are contending with complexities unlike any previous generation, and the cumulative impact on them can be overwhelming and challenging to navigate. First responders are strongly encouraged to actively listen, resist the temptation to teach or correct, and instead, validate and affirm them. Black youth benefit from reassurance that their feelings are real, that those feelings are valid given their situation, and that they are not alone. First responders, particularly family members, can help by letting Black children and adolescents know they are appreciated for sharing and effectively inviting those they have confided in to join with them in seeking assistance. When a child or adolescent youth seeks services, professionals can ensure that the youth's community, especially the family, is included in the care. The child's concern is not solely an individual problem with and for him but for the whole "village" (which is often the best able to heal one of its own). Professionals can learn, teach and lead efforts for all to listen in a genuine, courageous and heartfelt manner.

5. EMPATHETICALLY UNMASKING SECRETS. Black children and adolescents may not reveal their thoughts about death and dying by suicide. When they do, many, even mental health professionals, fear that directly naming and addressing the topic of death and suicide may bring the idea to the young person's mind or even encourage her. The reality is that Black youth at risk have already been thinking about it. If they have not, the conversation can be one that informs and, if handled appropriately, dissuades them. Another concern is that the child or teen who shares thoughts about suicide is only doing so to get attention or manipulate others. While this is a possibility, the mere choice of introducing death and suicide as topics for discussion is extreme enough to warrant response. Once again, when handled appropriately, one can determine the reasons behind the comments and teach Black children healthier ways to get help and comfort.

Additionally, the literature documents that Black children and families may be less likely to reach out for help or state what is going wrong based on a number of factors. These often include fear of families being adversely impacted (e.g., broken up and separated) based on the history of racial/ethnic disparities in responses from law enforcement, educational institutions, child protective services, and/or healthcare systems. This may contribute to a culture of silence. First responders (family, faith leaders, community leaders et al.) can be more intentional and creative in their willingness to hear and discuss. Bell (2017) found that African American adult survivors of a sibling who died by suicide while both were adolescents felt like there was nowhere to discuss it and that they had to hold the secret. The youth were left alone in their grief, which could contribute to their own tendency to consider self-harm. This may have been informed by messages that to die by suicide is a sin or a sign of weakness. Being able to have courageous healing conversations (Jackson, 2018) may counter the prevalence of suicide and/or aid in the recovery after losing a loved one to death by suicide, as well as inform assessment, prevention, and intervention.



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6. REDUCING THE OVERUSE OF EVIDENCE-BASED PRACTICES (EBP). The failure to critically examine and question the appropriateness and effectiveness of using long-established mental health approaches and services with Black youth interferes with meeting their complex needs. Specifically, manualized evidence-based approaches do not address the socio-ecological factors that Black children face. The assumption of universality of EBPs may inadvertently contribute to the increasing prevalence of Black youth death by suicide. The failure to take context into account and the omission of culturally relevant factors results in services that will not effectively help—and possibly harm—Black children and adolescents. In short, the intention to help might exist (using an EBP), but the impact on the young person may be less than optimal, non-existent, or possibly even harmful. At minimum, Cokley and colleagues (2014) advocate for cultural adaptation of evidence-based practice as promising practices. This might include cultural adaptation of established programs with specific input from cultural brokers or community leaders as to where there can be inclusion of cultural practices and beliefs (Molock et al., 2014).

7. INCREASING THE USE OF CULTURALLY DEFINED AND PRACTICE-BASED EVIDENCE APPROACHES. Western therapeutic approaches are predicated upon independent or individual approaches, whereas people of African ancestry value more collective or communal approaches (Grills, Nobles, & Hill, 2018). What would assessment, prevention, and intervention look like starting from healing as a collective point of reality? At minimal, it would include consideration and care for those who are caring for the child. There should be strategic funding for culturally specific approaches that draw upon African worldviews and pedagogy. Culturally affirming approaches that intentionally foster ethnic identity formation is a well-documented protective factor in the context of oppression and racism (Eccles, Wong, & Peck, 2006; Shin, Daly, & Vera, 2007). They could prove to be particularly effective in countering culturally specific causes of suicide. This requires intentionally seeking out community knowledge and cultural practices. Researchers and providers should spend time in Black communities and take their lead from community residents, cultural brokers, and leaders to discern what is needed to support them in addressing the threat of suicide among Black children (Molock et al., 2014). A useful model for developing and implementing community-defined evidence practices is the California Reducing Disparities Project, which is currently examining 35 community-designed prevention and early intervention strategies grounded in the culture and context of various racial/ethnic communities in the state. It is hypothesized that these community-defined approaches can better address the mental health needs of the unserved, underserved, and inappropriately served ethno-racial groups (Abe et al., 2018).

8. INCREASE AFRICAN AMERICAN/BLACK WORKFORCE. It is imperative to move beyond cultural competencies and cultural humility to more cultural equity by increasing the Black workforce of mental health providers. Although one can appreciate the benefits of cultural competence, one cannot truly experience another's cultural experience. Cultural humility affords the benefit of increased provider/researcher self-awareness in working with diverse communities, but careful monitoring for the potential of missing relevant cultural knowledge is still warranted. Whaley (2001) purports that many Black children and youth may avoid treatment due to cultural mistrust and fear that they will not be understood by non-Black providers or that the non-Black provider can deal with their realities. Further diversifying the workforce may lead to more help-seeking and increased service utilization among Black families and communities. It is through the increased numbers of Black providers and researchers who are grounded in tenets of Black or African-centered psychology and



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born out of the realities of the experiences of Black youth that more culturally specific, efficacious assessments, prevention models, and treatment/intervention can be established.

This workforce development should also include paraprofessional community interventionists. An untapped source of social capital, they are an underutilized and invaluable resource in the promotion of wellness and the prevention of distress, mental illness, and suicide. They might assume the role of mentors, *promotores* (to borrow from Latino mental health practices), peer responders, and the next generation of licensed professionals.

9. CROSS-TRAINING BETWEEN FAITH LEADERS AND MENTAL HEALTH PROVIDERS. There is a plethora of data that spirituality or religiosity may be protective factors against suicide (Molock et al., 2006). However, the typical separation of religious or spiritual and mental health services may be counter-productive for Black children and communities. For example, many Black communities socialize and teach their children that death by suicide is a sin. This may prevent Black youth from seeking help from faith leaders. It can also leave faith leaders ill-prepared to deal with the complexities of mental illness, as it cannot be “prayed away.” Conversely, many mental health providers have limited, if any, training in or receptiveness to faith-based or spiritual interventions, which may further alienate Black children from benefitting from services. Collaborative cross-training, research, and approaches may foster a stronger “holding” environment for Black youth in recognizing, preventing, and responding to suicidal thoughts and/or behaviors. Such integrative efforts would contribute to the positioning of religiosity and spirituality as a protective factor among Black children.

ASKING NEW QUESTIONS – GETTING MORE ANSWERS

Current research on suicidality and practices to address it are woefully insufficient for understanding, preventing and intervening to help keep Black children and adolescents safe. There needs to be more systematic and primary data sources available related to nonfatal suicidal behavior. As Joe et al. (2009, p. 272) note:

Despite the emerging health issue of suicidal behavior and the availability of annual data on suicide, there remains no single primary data source for nationally representative information on adolescent nonfatal suicidal behavior. Research on nonfatal suicidal behavior is significant because attempted suicide may occur up to 10 to 40 times more frequently than suicide. For instance, annually, 30,000 people in the United States die by suicide, yet it is estimated that approximately 650,000 people per year are seen in emergency departments after attempting suicide.

Given the low reporting of previous psychopathology (Joe et al., 2009), more research is also needed to determine non-psychiatric risk factors that may be unique to the use of nonfatal suicidal behavior by Black children, early adolescents, and adolescents.

Research to determine non-psychiatric risk factors specific to Black children would have a profound impact on the development of culturally informed prevention and intervention practices. As Black children spend the majority of their



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waking hours during the week at school, and trauma symptoms may be misinterpreted as defiance (Cokley et al., 2014), it is essential that school staff participate in training and ongoing consultation on ways that cultural contextual issues (e.g., historical/racial traumas, microaggressions, implicit biases, etc.) influence the development, maintenance, and perpetuation of trauma. Toxic stress related to the aforementioned issues may result in educational outcomes such as frequent absences, lower academic performance/test scores, increased suspensions, higher number of referrals for special education services, and school drop-out rates (Redford, Pritzker, Norwood, & Boekelheide, 2015).

Framing participation in mental health services as a form of wellness or healing may be needed to address the stigma of mental health and mental health treatment in general as well as specifically in the Black community. Building upon the village concept—it takes a village to raise a child—and increased awareness of promoting community healing, the stigma may also be addressed by providing mental health awareness trainings at churches, parks and recreation facilities, community centers, hair salons, and barber shops.

Providing mental health awareness trainings in settings that personify a sense of safety based on established relationships and cultural traditions as forms of healing addresses a convergence of key elements for the healing of Black children as well as their parents/guardians. The historical degradation of Black people highlights the emphasis on the need for perceived safety. This is particularly relevant to Black children given the aforementioned reports of concerns of safety while walking to and from school. In addition to the need to address the manifestations of societal/institutional oppression within schools, mental health agencies, law enforcement, etc. that give rise to safety issues, there is a need for the implementation of Safe Passage programs (the coordinated effort between schools, law enforcement, and communities implemented in Chicago to provide safe routes to and from school for students) nationally for children walking to and from school.

Building upon the concepts of relationships and cultural traditions as forms of healing is often overlooked in the initial engagement for mental health treatment. Keeping in mind the negative societal stereotypes of Black parents/guardians, the initial engagement with parents/guardians has to convey a sense of respect and interest in working together to support their child. Black parents/guardians, due to a historical cultural safety practice of assessing people for their trustworthiness, may be especially attuned to this initial engagement in terms of the “vibes” they get from the person. In addition to being mindful of the interaction style with Black parents/guardians during the engagement for mental health services, it is also important to address any possible barriers to their child participating in mental health services, such as stigma, access, historical mistrust of systems, concerns about “airing dirty laundry” and getting a therapist who misunderstands/judges, and/or expressed preference for a Black therapist. There is a risk of referrals to mental health services being “closed” due to “non-compliance” without being mindful of these essential trust- and rapport-building considerations.

While Black parents/guardians may verbalize an interest in their child working with a Black mental health practitioner, the likelihood is often low due to the relatively small number of Black psychiatrists, psychologists, and social workers in the U.S. Concerted efforts are needed to increase the representation of Black mental health practitioners. For example, this could be accomplished by establishing education/career pathways for Black high school students studying psychology, psychiatry, and social work, as well as support for existing Black mental health providers.



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Additional recommendations include:

- Having mental health professionals inquire about those individuals whom the child may be close to and engaging these supports in a treatment plan;
- Connecting the child and family to a mentorship program (having a close relationship with at least one supportive adult is a significant resilience factor for children);
- Providing support to parents on how to help their child deal with racial and other forms of stress;
- Deepening the child and family's connection to the broader community to support relational ties for the family;
- Recognizing that individual-level change is hard to sustain in the absence of environmental change that is supportive of individual efforts (Trickett, 2009), which means addressing the factors associated with structural racism must be part of any meaningful mental health intervention
- Strategically employing community organizing as a public health strategy (Douglas, Grills, Villaneuva, & Subica, 2016) to empower parents and guardians to become change agents in their community. An individually based intervention can target systems change by empowering individuals to affect systems change (Trickett, 2009)
- Prioritizing and promoting multilevel community-based (rather than community-placed) culturally situated interventions (Trickett, 2009). Consistent with Recommendation 18 of the Institute of Medicine, "Efforts to develop the next generation of preventive interventions must focus on building relationships with communities' assessment of their needs and priorities. Models should be developed that encourage members of the community and researchers to work together to design, train for, and conduct such programs." (Smedley and Syme, 2000, p. 23)

THE WAY FORWARD

Strategies focused solely on individual suicide prevention and early intervention may bring diminishing returns. Population-level changes beg the question: What are the social and environmental-level causes and interventions?

[R]ecent changes in the pattern of suicide among younger Blacks may reflect their experience of growing up in more extreme and concentrated poverty at a time in which the protection provided by parents, the church, and other community institutions has been considerably weakened. (Joe, 2006, p. 276).

Insights will not be gleaned from the discipline of psychology alone. This is an interdisciplinary enterprise that needs the expertise of sociology, history, economics, demography, social work, public health, public policy, critical race studies, community organizing, theological studies, community wisdom, and more.



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ⁱ This was a first time ever study of national estimates of 12-month and lifetime prevalence of suicidal ideation and attempts among 13- to 17-year-old Black adolescents in the United States (from 1980 to 1995).

ⁱⁱ Bridge et al. (2015) used the Web-based Injury Statistics Query and Reporting System (WISQRS) of the Centers for Disease Control and Prevention which revealed a clear rise in suicide rates among Black children.