Black Deaths Matter: Critically Understanding Black Female Clinicians’ Perspectives About Suicide In Black Communities

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BLACK DEATHS MATTER: CRITICALLY UNDERSTANDING BLACK FEMALE CLINICIANS’ PERSPECTIVES ABOUT SUICIDE IN BLACK COMMUNITIES

A Dissertation
submitted by

HEATH H. HIGHTOWER

In partial fulfillment of the requirements for the degree of Doctor of Philosophy

LESLEY UNIVERSITY
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This dissertation, titled:
Black Deaths Matter: Critically Understanding Black Female Clinicians’ Perspectives about Suicide in Black Communities

as submitted for final approval by Heath H. Hightower under the direction of the chair of the dissertation committee listed below. It was submitted to the Counseling and Psychology Division and approved in partial fulfillment of the requirements for the degree of Doctor of Philosophy Degree at Lesley University.

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Dedication

To Larry: your suffering and death have been my best teachers. Witnessing your final moments re-shaped the course of my life and guided my thinking throughout this project.
Abstract

Suicide is a multi-faceted human experience that threatens and harms Black communities. Historical data, critical theories, and extant research literature suggest that such threats and harms result from interactions between macrosystemic systemic forces and individual level meaning-making processes. To explore the dynamic and nuanced complexities between systemic forces and deaths often labelled “suicides” in contemporary U.S. Black communities, this project centered and amplified the critical perspectives of fourteen Black female clinicians. Because of their marginalized identities, intersectional lived experiences, critical orientation, and clinical training, these participants were well-positioned to analyze and understand the degrees to which suicides in Black communities are associated with oppressive macrosystemic dynamics and/or individual-level psychological factors. Narrative inquiry and aspects of the Listening Guide voice-centered method (LG)—specifically I poem development—highlighted voices of intersectional consciousness, systemic shaming, and internalized anti-Black shame. These voices illuminated six central themes for critically understanding suicide in Black communities: shame, hopelessness, trauma, racism, systemic problems, and fear. Participants also noted that violence, anger, and guilt shaped their perspectives to a lesser degree. To address these themes’ harmful, suicide-potentiating effects on Black communities, language, research, policy, professional association, and psychosocial assessment and intervention reforms are discussed.
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Suicide is a multifaceted human experience that threatens and ends millions of lives each year (World Health Organization [WHO], 2018, 2019). Globally, one person dies by suicide every 40 seconds (WHO, 2018). That statistic translates into over 700,000 deaths annually. The World Health Organization estimates that for every death by suicide, four attempts likely occur. Additionally, while suicide occurs across the lifespan, it is the third leading cause of death for people between the ages of 15 and 29 worldwide (WHO, 2021). Although 90% of suicides occur in adolescents and young adults living in low- to middle-income countries, WHO (2021) found that high-income countries had the highest standardized suicide rate in 2016 (11.5 per 100,000 people). This report speculated that access to pesticides and limited social mobility significantly contributes to suicide in low- and middle-income countries, while easy access to guns and increasing social inequalities in high-income countries, specifically in the U.S., likely increase suicide mortality. Finally, WHO (2018) observed that suicide rates in North America have been increasing while global rates have been declining over the last decade.

Suicide and suicide attempts are leading causes of harm for people living in the United States. According to the Centers for Disease Control and Prevention (CDC, 2018), death by suicide among people living in the United States ranked 10th overall compared to other causes. In the United States, on average, one person dies by suicide every 11 minutes (Drapeau & McIntosh, 2020), and 132 people die by suicide each day (American Foundation for Suicide Prevention [AFSP], 2020). In total, nearly 50,000 people living in the United States die by suicide each year (CDC, 2018). This death-by-suicide total (48,334) was two and a half times greater than that for homicides (18,830) during the
same period. According to Hedegaard et al. (2020), current death-by-suicide totals have
increased 35% since 1999. These data underscore the significance of suicide as a leading
cause of death in the United States, and suicide attempt statistics accentuate the
magnitude of its harm.

In the United States, millions of people are affected by suicide and suicide
attempts. Research data estimates that between 1.2 and 1.4 million people attempt suicide
each year (AFSP, 2020; Drapeau & McIntosh, 2020). This means that for every death by
suicide, another three or four Americans attempt suicide. Additional scholarship
approximated that 6.9 million people know someone who died by suicide (Cerel et al.,
2019). Such loss of life, threat to life, grief, and trauma foregrounds a central fact: suicide
affects everyone in the United States. Finally, CDC (2020) highlighted that suicide risk
factors and suicide mortality disproportionately affect marginalized communities in the
U.S.

Specifically, suicide risk factors and deaths by suicide disproportionately affect
According to Al-Mateen and Rogers (2018), deaths by suicide among Black female youth
increased 182% between 2001 and 2017. During this same period, the authors reported a
60% increase in Black male teen suicide rates. Moreover, Bridge et al. (2018) discovered
that, compared to White cohorts between the ages of 5 and 12, similarly-aged Black
cohorts’ suicide rates were nearly double. Furthermore, CDC (2020) data revealed that
death by suicide is a leading cause of mortality for Black Americans ages 10 to 44.
Overwhelmingly, these deaths by suicide involve guns and potent substances like
opioids, and occur in multiple contexts. These contexts generally include risk factors such
as being resource deprived, having limited access to formal and informal social supports, experiencing a pervasive lack of control, and feeling indefinitely trapped (Halloran, 2019; Jones-Eversley et al., 2020; O’Connor et al., 2016). Moreover, deaths by suicide in Black communities occur in the additional contexts of the U.S.’s violent legacies: African enslavement, Caribbean colonization, multiple forms of institutional oppression, and the perpetuation of intra- and inter-generational trauma (Alexander, 2020; Kendi, 2016; Longman-Mills et al., 2019; Snyder, 2015). Such cruel legacies not only influence the bio-psycho-social-spiritual experiences that often contribute to death by suicide in Black communities, but they also shape the meaning of Black American identities (Halloran, 2019; Snyder, 2015; Spates, 2011, 2012, 2019; Spates et al., 2020; West, 1991).

An exploration of suicide and Black American identities involves a historical and ongoing examination of the trans-Atlantic slave trade, White American colonial views of suicide, slave suicides, anti-slavery politics, and Black American suicide perspectives. Such historical forces and lived experiences emphasize the imperative to contextualize contemporary public health and social science data regarding suicide in Black communities. Such contextualization would likely improve suicide prevention and intervention by addressing community-specific, intergenerational and current concerns such as racialized violence, and opportunity and wealth gaps. Additionally, these historical and contemporary perspectives also underscore the interconnections between language, power, property, personhood, public-policy, and lived experience (Marsh, 2020; Snyder, 2015; White, 2020). These interconnections manifest in dominant culture suicidology, which frames suicide as an individual, decontextualized, apolitical, and biomedical experience. Within mainstream suicidology, such experiences are best
understood and addressed by researchers and clinicians trained to use empirically-supported psychological assessment and intervention. These professionals—and their research, prevention, and practice paradigms—often reflect White North American and Euro-centric worldviews and exclude marginalized people’s perspectives (Collins, 2009, 2019).

Black community experiences of and perspectives about suicide are underrepresented in suicidology discourse and social science research more broadly (Spates, 2012, 2019). Jones’s (2020) scholarship further underscored the lack of Black clinician representation in clinical practice and research. Moreover, Evans-Winters (2019) noted that Black female researchers, activists, practitioners, and educators are often unacknowledged for their contributions to understanding and solving social problems. This dearth of representation and appreciation likely results from gendered racism (Spates et al., 2020).

Black and female identities compound the two most powerful and salient forms of oppression in the United States (Collins, 2009; Spates et al., 2020). For example, Crenshaw’s (1991) critical legal analysis of employment law revealed that hiring practices at a car company often protected Black men (based on their sex) and White women (based on race), but consistently and empirically failed to protect Black women (because of their marginalized race and sex identities). At the same time, the United States’ economic success and civic virtues would not be realized—historically or currently—without Black women’s forced labor and voluntary social engagement. This oppressed yet essential reality positions this cohort to expertly comment on oppressive macrosystemic forces and their effects on Black communities.
Black women who have graduate psychosocial training are situated in unique positions to discern between problems caused by psychopathology and issues that emerge from anti-Black systemic forces. Given their multiple marginalized identities and clinical education, these professionals possess unique vantage points regarding suicide in Black communities as a phenomenon shaped by intergenerational trauma, racialized and gendered violence, and racist social policies. Such lived experiences and critical perspectives are centered in this dissertation research project.

**Purpose and Problem Statements**

One of the purposes of this dissertation research study is to amplify Black female clinicians’ perspectives about suicide in Black communities. This aim addresses a significant knowledge gap in the academic literature (Spates, 2012). Another goal of this project involves critiquing mainstream suicidology’s *psy-focus*—an over-emphasis on empirical psychiatric and psychological conceptualizations of suicide (Marsh, 2010, 2020). While such an emphasis has contributed to understanding some deaths by suicide, new voices and perspectives are needed to understand “suicide” in Black communities. Moreover, as a social worker and researcher committed to social justice who has awareness of my White, cisgender male positionality, this study intends to challenge the White supremacist hegemony embedded in mainstream psychological theories, research, and practices by foregrounding Black female voices and perspectives about suicide in Black communities. In so doing, this project serves as an act of resistance against systemic violence by underscoring the role of insidious macrosystemic forces that contribute to suicides in Black communities. Concurrently, this research project de-emphasizes individual mental health frameworks that often obscure the violent contexts
in which suicides occur. Finally, this dissertation research project aspires to create
solidarity with Black communities by explicating the harmful connections among zero
sum paradigms, violence, resource deprivation, and unjust social policies that de-stabilize
communities and often result in increased mortality. Such connections must be integrated
into counseling and psychology research, theory, and practice if the fields are to maintain
their claimed ethical stances to “do good” and to “do no harm.”

**Theoretical Framework**

Suicide in Black communities occurs in multiple and socially unjust contexts
(Halloran, 2019; Jones-Eversley et al., 2020). This contextual complexity involves
histories of racialized and gendered violence and systemic oppression codified in public
policy (Alexander, 2020). Historical and intergenerational trauma lenses illuminate the
cumulative effects of such sinister legacies (Coleman, 2016; Williams-Washington &
Mills, 2018). Critical theories offer unique analytical tools to understand the interplay
among identities, power, systems, lived experience, and suicide in Black communities.
Moreover, Durkheim’s (1897/2006) suicide typologies offer a socio-historically
important perspective regarding macrosystemic forces and suicide. Additionally,
Bronfenbrenner (1994) and Ballou et al. (2002) both highlighted the influences of
systemic contexts on human experience. Their systemic models illuminate the
interconnections among an individual’s suicide, immediate social connections,
community relationships, cultural influences, and historical factors. Furthermore, critical
suicidology frames suicide as a complex, multi-layered experience that is best understood
from interdisciplinary vantage points that use qualitative inquiry approaches (Hjelmeland
& Knizek, 2016; White, 2017). Finally, Delgado and Stefancic’s (2017), Collins’s (2009,
2019), and Crenshaw’s (1991) works foregrounded critical race theory, Black feminist scholarship, and intersectionality as significant social justice paradigms. Such scholarship highlights the importance of understanding Black suicidality from the perspectives of Black female clinicians. These critical works also provide concepts germane to analyzing and reframing suicide in Black communities as an ecological systems problem that requires multi-pronged solutions.

**Research Question**

In an effort to amplify—and critically understand—Black female clinicians’ perspectives about suicide Black communities, this study aims to answer the following question: How do Black female clinicians critically understand suicide in Black communities? In the context of this study, *critical* means the ability to view interconnections between lived experiences, like suicidality, and the various systems in which those experiences are embedded. Additionally, this focus on Black female clinicians’ *perspectives* necessitates a qualitative research design (Carspecken, 1996; Hjelmeland & Knizek, 2016). The qualitative methodology for this project is narrative inquiry, and I poems—a feature of the Listening Guide—were used as part of data analysis. A more detailed description of this project’s research methodology and design is located in Chapter 3.

**Definition of Terms**

The research question is comprised of terms that merit definition. Additionally, this project uses important overarching concepts to promote critical understanding of suicide in Black communities from the vantage points of Black female clinicians. Definitions of such terms and concepts include:
**Black:** An inclusive term used to describe ethnically diverse individuals and groups of people who self-identify as Black (Mills, 2015). Examples of identities typically included are African American, African, Black, Black African, Black Caribbean, Caribbean, and/or Caribbean Black. This project includes anyone who self-identities with any of these identities. Furthermore, this project capitalizes all representations of racial identities to as a way to distinguish between people and color.

**Clinicians:** Refers to masters-level, or doctorate holding people with licenses to provide mental health counseling services. Such professional licenses include LADC, LCSW, LICSW, LISW, LMFT, LMHC, LP, LPC, MD, and NP.

**Communities:** “A group of people with a common characteristic or interest living together within a larger society” (Merriam-Webster, n.d.-a).

**Critical:** Epistemologies, theories, and methodologies that aim to critique and challenge dominant culture power structures (Habermas, 1971).

**Female:** A human with a pair of X chromosomes (Merriam-Webster, n.d.-b). This definition espouses biological essentialism and marginalizes members of transgender communities who experience *femaleness*. Therefore, this project affirms and includes anyone who self-identifies as female, transwoman, woman, or womyn.

**Gender:** An inclusive term that foregrounds an individual’s internal sense of being a female/woman, a male/man, non-binary, non-conforming, two-spirited, and/or without gender (National LGBT Health Education Center, 2021).

**Race:** “Any one of the groups that humans are often divided into based on physical traits regarded as common among people with shared ancestry” (Merriam-Webster, n.d.-c, para. 1). This definition exposes the arbitrary nature of racial categories and the potential
harms that often accompany human categorization. This definition is expanded upon in Chapter 2 when socio-demographic data is reviewed.

**Shame:** “A condition of humiliating disgrace or disrepute” (Merriam-Webster, n.d.-d, para. 1). Herberman Mash et al. (2020) further theorized shame as “a powerful emotional response to experiencing an unacceptable view of oneself, typically precipitated by interpersonal traumatization” (p. 40). In the contexts of trauma and/or prolonged exposure to shame, individuals often internalize a profound and pervasive self-concept experienced as “deficient,” “defective,” and/or “undeserving of life.” This observation suggests that shame is often generated by relational processes.

**Shaming:** “Causing feelings of shame” (Merriam-Webster, n.d.-e, para. 1). This study claims that acts of shaming across human systems of experience catalyze the suicidal ideation-to-actions processes that often result in death.

**Suicidality:** An overarching term that encompasses suicidal thoughts, ideation, attempts and deaths by suicide (CDC, 2015).

**Suicide:** The intentional and self-directed harms that result in death (CDC, 2015). This term, its origins, and its lack of operational universality across cultures raises conceptual, empirical, and ethical concerns explored throughout this project (Marsh, 2010, 2020; Silverman, 2016).

“**Suicide**”: Deaths often labelled as intentional and self-directed yet require closer examination of macrosystemic forces such as historical trauma, structural violence, systems of oppression, and chronic resource deprivation.

**White supremacy:** “The belief that the White race is inherently superior to other races and that White people should have control over people of other races” and “the social,
economic, and political systems that collectively enable white people to maintain power over people of other races” (Merriam-Webster, n.d.-f, para. 1).

These definitions underscore the insidious connection between distorted beliefs and the power to create intergenerational harms in perpetuity. A central argument of this study is that White privilege, power, and supremacy create and maintain complex power-over dynamics that both deprive Black communities of life-sustaining resources and punish those same communities via shaming public policies, media images, and acts of violence. This dissertation research project theorizes that such systems of anti-Black shaming significantly contribute to internalized anti-Black shame experiences. The deaths that are shaped by such sinister systemic and individual dynamics ought to be framed with quotation marks—“suicides” or “deaths by suicides”—to signify closer re-examination. The quotation marks challenge readers to reconsider cultural narratives about the role of mental illness and agency related to such deaths.

**Organization of the Remaining Chapters**

The remainder of this dissertation is organized into five chapters, reference pages, and appendices. Chapter 2 presents a literature review that contextualizes suicide in Black communities within a historical framework. This historical review helps frame current socio-demographic and epidemiological data related to suicide in Black communities. Then, my review details historically significant theories within mainstream suicidology, as well as contemporary theories that offer systemic and critical understandings of Black female clinicians’ perspectives about suicide in Black communities. Chapter 2 concludes with an examination of relevant quantitative and qualitative studies. These studies reveal epistemological, theoretical, and methodological
progress and gaps in the academic literature. Subsequently, Chapter 3 further delineates my epistemological stance and positionality, and establishes narrative inquiry as the overarching methodological framework for this project. This chapter also describes my study’s research design which includes discussions of sampling, data generation, data analysis, validity, and ethical considerations. Next, in Chapter 4 I introduce the project’s fourteen participants and summarize their lived experiences as Black female clinicians in the U.S. These lived experiences contextualize their critical understandings of suicide in Black communities. Each narrative summary also includes block quotations, I poems, and my reflections to bolster trustworthiness and data analysis transparency. Subsequently, Chapter 5 highlights this project’s findings by centering participant voices and exploring cross-participant themes in relationship to suicide in Black communities. Finally, in Chapter 6 I explore the implications of this study’s findings, provide recommendations for systemic change, discuss study limitations, and offer concluding thoughts.
CHAPTER 2

Literature Review

This literature review serves multiple purposes by examining scholarship germane to critically understanding suicide in Black communities from Black female clinician’s perspectives. First, an examination of the extant research reveals the strengths, limitations, and gaps in the knowledge base. For example, mainstream suicidology research has quantitatively validated a number of suicide risk factors. Such research has helped to save some lives. However, there is a dearth of scholarship that amplifies the understandings and meanings of suicide within marginalized communities (Hjelmeland & Knizek, 2016; Spates, 2012). Second, this literature review aims to critically contextualize suicide in Black communities by examining the historical, political, and violent macrosystemic forces in which suicide often unfolds. Such forces manifest in current epidemiological and socio-demographic data. These data—when interrogated through the lenses of critical and systemic theories—expose connections between suicide and social injustice. Such injustices are likely embedded in the narratives and lived experiences of Black communities. This truth leads to the third goal of this literature review: to amplify the voices, experiences, and works of Black authors. To achieve this goal, the literature review privileges historically significant literature authored by Black scholars and their anti-racist allies from the last 20 years.

To achieve these aims, this literature review begins with an examination of African enslavement, which shaped White slave traders’, slave owners’, and broader colonial views about slave suicides. The review then shifts to explore slave suicides and anti-slavery politics, including Black American slave perspectives on suicide. Next, it
connects the legacies of slave suicide to contemporary socio-demographic and public health data. This connection underscores the unique and complex interplay among Black community identities, oppression, suicide risk factors, and “deaths by suicide” in Black communities. Subsequently, the literature review examines significant theories within the mainstream suicidology canon. These include psychoanalytic, psychodynamic, cognitive, ideation-to-action, and biological theories. I then contrast the mainstream theories through an examination of historical and intergenerational trauma, sociological, systems, critical, and Black feminist frameworks. Finally, Chapter 2 concludes with a review of the relevant quantitative and qualitative literature.

**The Trans-Atlantic Slave Trade and African Suicide**

White Europeans began exploring the world to increase their wealth (Snyder, 2015). This aspiration resulted in the conquest, exploitation, and slaughter of indigenous peoples in the Americas for profit. McGhee (2021) reported, “The death toll of South and North American Indigenous people in the century after first contact was so massive—an estimated 56 million lives, or 90 percent of all of the lands’ original inhabitants” (p. 7). Initially, White Europeans enslaved indigenous people to extract precious metals. However, two emerging realities motivated White Europeans to enslave Africans. First, as precious metal resources became harder to find, Europeans needed new and sustainable profit-making ventures, like agriculture. Second, indigenous people increasingly fought to protect their lives, homes, cultures, and natural environments. This led White Europeans to seeks alternate forms of enslaved labor (Snyder, 2015).

The western African coast provided easy access to sea transport routes and a population of people visually and culturally distinct from White Europeans and
indigenous people of the Americas (Snyder, 2015). Both realities—coupled with individual greed and self-entitlement—provided the rationale for Europeans to enslave West Africans.

Some of the earliest descriptions of West African enslavement and European attitudes about slave suicides were authored by slave traders. In a translated journal entry published in 1688, the French slave trader Jean Barbot (as cited in Snyder, 2015) noted during an expedition to present-day Ghana:

These [B]lacks in general regard death very stoically… This is what makes them, without caution but with steadfastness, rush into the most dangerous circumstances. The women have the same spirit and the same resolution. On my 1679 voyage, a [B]lack woman of Aquambou, being unable, as she wished, to nurse a small child she had, and having further got it into her head that we were taking her and her child to eat, threw herself one day, unnoticed into the sea, leaving her child on the mast-strut… A canoe was sent to rescue her… She gave us to understand that she had done everything she could to make herself drown, but that she had not been able to succeed in this, nature obstructing her destruction and making her, in spite of herself, employ the swimming ability and buoyancy she had acquired. (p. 23)

Barbot’s journal entry exposed several White European beliefs that have likely shaped suicides in Black communities. First, Barbot connected “[t]hese [B]lacks” and suicide. This connection implied that Black people possess specific characteristics—stoic beliefs about death and suicide—that made them appear more indifferent to life than White Europeans. Such beliefs would have challenged Europeans’ sensibilities regarding
suicide: it was considered a sin. This religious sensibility and racialized associations with suicide probably helped slave tradesmen dehumanize the enslaved West Africans: they are not like us. Second, this same religious and cultural perspective framed the unnamed Aquambou woman’s trauma in terms of her irrational beliefs: “…having further got it into her head that we were taking her and her child to eat.” This framing misogynistically and culturally minimizes the woman’s experiences. For example, Africans, who did not drink red wine, often saw White Europeans drink red wine (the symbolic blood of Christ) while eating; thus, enslaved people interpreted this co-occurrence as cannibalism (Snyder, 2015). The woman likely feared being eaten. Third, Barbot conceptualized the woman’s actions—both jumping overboard and leaving her child on the mast-strut—in terms of her obstinance: she did not get to feed her child when she wanted to. Such a perspective both denies the woman’s agency and humanity and blames her for the series of events that resulted in her suicide attempt: this becomes a form of Black female erasure that echoes contemporary efforts at erasure (Epstein et al., 2017). Finally, the anecdote characterized the woman as a “bad mother”: she abandoned her child and yet failed to accomplish her goal. Thus, Barbot’s journal entry linked race, ethnicity, gender, and suicide. Such intersections shaped suicide among enslaved Black communities in North American colonies.

North American Slave Traders’ and Owners’ Views of Slave Suicides

Slave suicides in the North American colonies carried multiple meanings and occurred during the rise of medical, religious, and philosophical debates on the right to suicide (Snyder, 2015). Centrally, slave suicides exposed the grotesque cruelty and hypocrisy associated with owning people in an emerging society predicated on the
principles of life, liberty, and the pursuit of happiness. These meanings and hypocrisies forced American colonists to grapple with slave suicide, property, personhood, and legal questions (Snyder, 2015). These galvanized an abolitionist movement to end slavery. Thus, slave suicides helped broaden the scope of freedom in the United States.

In 1759 the *South Carolina Gazette* featured a story about an escaped slave named Caesar. He revealed to the newspaper that he ran away from his owner because his owner had commanded him to cut off the head of a fellow slave who had killed himself (Snyder, 2015). He had refused and ran away. Little did Caesar know that his story would be printed as an advertisement in the *Unclaimed Property* section of the newspaper for the next three months.

For White North American colonists, this story—and suicide’s central role in it—would have been understood as an egregious affront to church, community, and colony. True God-fearing people were expected to endure whatever lot in life Providence had planned for them (Snyder, 2015). Furthermore, suicide deprived the state of a subject and was considered one of the worst crimes as *felo de se*, or felony of the self. This view differed from suicide that resulted from *non compos mentis*, or suicide as a result of “insanity.” The former was viewed as an “offence against God, against the King, and against Nature” (Snyder, 2015, p. 8) and was considered worse than killing another person. Furthermore, among slave owners, suicidal slaves represented a challenge to their authority and defied the belief that slaves were property. Equally concerning to enslavers was the prospect of contagion effects emerging from slave suicide. Such effects would be economically ruinous and likely threatened enslaver-slave power dynamics (Kendi, 2016;
Snyder, 2015). As a result, slave tradesmen and owners alike employed grossly barbaric means, such as those Caesar described, to maintain power.

**Broader Colonial Views of Slave Suicides**

While slave traders and owners viewed slave suicide in terms of power and economics, a closer examination of American colonial views of slave suicides exposes paradoxes, contradictions, and hypocrisies. Between 1736 and 1752, the *Virginia Gazette* featured over 70 reports of slave suicides. Interestingly, these stories were placed next to advertisements for fine goods, local and international news reports, biblical quotations, and slave execution confessions. In regard to one edition of the *Virginia Gazette*, Snyder (2015) wrote,

> Both the printed text of the felon’s contrite confession as well as the Christian exhortation against Job’s suicid[ality] stressed the traditional importance of obeying God rather than succumbing to sin and despondency. In the same breath, the advertisements for slaves and luxury goods emphasized the secular values of marketplace and consumerism. (p. 65)

This juxtaposition of religious and secular values underscored competing views of slaves. On the one hand, a slave was viewed as product to be sold, yet simultaneously the same enslaved person possessed enough humanity—a self—to be capable of suicide. This tension between property and personhood increasingly expanded Americans’ views about suicide, slave suicides, slavery, and freedom.

**Slave Suicides and Antislavery Politics**

In response to a 1773 news report about a slave who died by suicide because he was prevented from marrying a White servant, two outraged British lawyers conspired to
challenge the slave trade and the institution of slavery. Day and Bicknell (1775/2010) crafted and published a poem, “The Dying Negro,” that revealed the harsh realities endured by enslaved people: “Arm’d with thy sad last gift—the pow’r to die / Thy shafts, stern fortune, now I can defy; / The dreadful mercy points in length the shore / Where all is peace, and men slaves no more” (p. 1). This protest poem telegraphed several messages to its 18th-century audiences. First, it situated the power to die with the enslaved man. Seating power with an enslaved Black man explicitly challenged dominant political, legal, and philosophical views of both personhood and freedom. Second, the poem makes clear the enslaved man’s suicidal motives: to protest the “stern of fortune” of enslavement. In so doing, the authors juxtapose the “sadness” and “dreadfulness” of slavery and the only means to achieve peace: the gift of death. Third, because the poem was written from the perspective of a man being deprived of his patriarchal right to marry, the authors hoped to evoke a sense of injustice in readers. The poem’s popularity inspired widespread distribution and several reprinted editions. “The Dying Negro” offered a blueprint for future anti-slavery literature and political activism by underscoring the incompatibility of democratic ideals and slave ownership. Such contradictions, paradoxes, and inconsistencies were further exposed in the published works of formerly enslaved people, as well as the intergenerational narratives shared in speeches, pamphlets, and interviews. These Black American voices, words, and texts also echo the lived experiences of present-day Black communities located throughout the United States.
Black Americans’ Slave Suicide Perspectives

Throughout the 18th and 19th centuries, Black American authors chronicled the personal, familial, and community atrocities directly and indirectly related to slave suicides. Works like Olaudah Equiano’s 1789 *The Interesting Narrative of the Life of Olaudah Equiano*, Charles Ball’s 1837 *Slavery in the United States*, and Matty J. Jackson’s 1866 *The Story of Matty J. Jackson* offered first-person accounts of violence, abuse, dehumanization, and deaths by suicide (Snyder, 2015). These accounts emphasized specific enslavement-related harms: violent abduction, the Middle Passage, familial separation, rape, and forced incest as a means of punishment and propagating future generations of enslaved people. Each harm shed light on the contextual circumstances that motivated men, women, and children to die in lieu of enslavement and its accompanying horrors. Interwoven throughout such retellings, Black Americans also shared personal and community survival schemas—rich, cultural, meaning-making beliefs. Such beliefs empowered Black Americans to reclaim their histories on their terms.

The memory of enslaved Black Americans played a central role in African American literature and cultural politics for decades after the American Civil War. Snyder (2015) wrote, “By focusing on the bygone tragedies of suicide, competing and distinct visions of the useable past of slavery were served up as lessons and reminders for the present national moment” (p. 157). Some narratives emphasized suicide as a means for triumphantly escaping slave owner brutality. Other accounts focused on the unnecessary tragedy of suicide. Such an account was described in Chesnutt’s (1889/2002) short story “Dave’s Neckliss.” According to Chesnutt’s telling, Dave was an enslaved
man wrongly accused of stealing bacon. As punishment, a ham wrapped in wire mesh was fashioned into a necklace that Dave was forced to wear. Having been humiliated among his fellow enslaved people, his rejection and isolation eventually resulted in his death by suicide. The juxtaposition of triumphant escape and humiliating tragedy underscores the thematic range and complexity of narrative meanings surrounding slave suicides.

Such narratives also took mythological forms. Since the first Black Africans were abducted as a part of the trans-Atlantic slave trade, mythologies and folklores about slave suicides have been told intergenerationally. According to the Georgia Writers’ Project (1986), tales of the “Flying Africans” are among the most lasting and powerful memories of slave suicide. In 1803, a collective suicide occurred among Igbo peoples who had survived the Middle Passage. Having endured a particularly cruel voyage, the Igbo broke free, revolted, and threw the ship’s crew and captain overboard where they drowned. When the vessel ran ashore, according to the folktale, the Igbo drowned themselves in a nearby marsh. This immediate drive to collectively die by suicide was likely due to a common belief among various enslaved African peoples (Gomez, 1998). Many African peoples believed that the only way to return home was to die by suicide as soon as possible. Such beliefs, to some degree, explain why most slave suicides occurred while the African coast was still visible from the slave ships (Gomez, 1998). For some African peoples, these beliefs also provided a reparative and healing way to reframe the atrocities endured as a result of White supremacist language, culture, institutions, and histories. Such reframing transformed victimization into empowerment.
In the 155 years since the Thirteenth Amendment of the U.S. Constitution abolished slavery—except for criminals—a range of social policies have continued to harm Black Americans. From Jim Crow laws to redlining housing policies, to segregated schools and mass incarceration, Black Americans uniquely face systemic and intergenerational forms of oppression that predispose their communities to “death by suicide” (Alexander, 2020; Halloran, 2019; West, 1991). Such oppression includes intersectional identity discrimination, limited access to healthcare, opportunity resources, and employment, and increased exposure to violence and other mental health risk factors (Alexander, 2020; Halloran, 2019; Joe et al., 2006; Jones-Eversley et al., 2020; McGhee, 2021).

**Contemporary Black American Suicide and Suicide-Related Experiences**

The legacies of White supremacy, enslaved African atrocities, the criminalization of Black identity, and ongoing racialized violence afflict bio-psycho-social-spiritual damages that likely contribute to suicides in Black communities. Such damages are revealed in public health and social science data related to Black community suicide risk factors and mortality.

**Black Communities’ Sociodemographic Suicide Risk Factors**

Race

The term *Black* is an inclusive category that typically comprises people who self-identify primarily as African American and/or Caribbean Black (Joe et al., 2006). According to Joe et al. (2006), “*African American* is used to describe individuals who self-identified as black but did not identify ancestral ties to the Caribbean. *Caribbean Blacks* are individuals who self-identified as Black and indicated that they were from a country included on a list of Caribbean-area countries” (p. 2113). However, the U.S. Census Bureau (2018) both omits Caribbean Blacks from its definition and uses the terms *Black* and *African American* interchangeably. Such definitions influence suicide-related data by establishing which categories of people—and therefore which people’s experiences—are represented or potentially erased. As a result, the latter definition—the official U.S. definition—likely obscures public health suicide risk and mortality data.

**Race and Suicide**

According to the CDC (2018), people who self-identify as Black comprise approximately 13% of the U.S. population, or nearly 43 million people. In this same year, there were 3,124 confirmed deaths by suicide among Black Americans. This translates into crude and age-adjusted suicide rates of 7.28 per 100,000 and 7.19 per 100,000 (CDC, 2018). The overall death by suicide rate—across all race-sex-age cohorts—in the United States during the same time period was 14.2 per 100,000. Furthermore, the CDC (2018) reported that suicide is a leading cause of death for Black populations ages 10 to 44. Additionally, approximately 4% of Black adults reported having serious thoughts of suicide in the past year, and another 1.2% revealed a non-lethal suicide attempt during the same time period (CDC, 2020). Such aggregated data distorts suicide-related threats and
harm. A closer examination of race, suicide, and other lived experience intersections underscores the seriousness of suicide in Black communities.

**Racism and Suicide**

Racial discrimination contributes to Black community suicides by exacerbating minority stress (Chu et al., 2020; Halloran, 2019; Madubata et al., 2019). According to Chu et al. (2020), “Minority stress—negative events related to one’s social identity stemming from acculturative stress, social disadvantages, or discrimination—can also serve as a stressful life event that precipitates suicide risk” (p. 2). Additionally, Jones-Eversley et al. (2020) indicated that “the enormity of suicidal ideation, suicidal attempts, and suicide in the Black community cannot be understated, and it parallels with the community deprivation many Blacks experience” (p. 258). Furthermore, Madubata et al. (2019) found a prospective relationship between Black adolescents’ suicidal ideation and perceptions of discrimination. Finally, Halloran (2019) noted that widespread implicit bias against Black Americans contributes to a range of suicide risk factors: poverty, decreased access to healthcare, and increased psychiatric symptoms.

**Race, Sex, and Suicide**

Within Black communities, suicide risks and mortality rates differ among cisgender cohorts (CDC, 2020; Joe et al., 2009; Spates, 2019). This fact highlights the need to consider race, sex, and gender intersectionality when creating suicide risk models and developing suicide prevention programs.

**Black Females and Suicide.** Black cisgender women historically experience the lowest suicide mortality rates of any race-gender cohort, despite experiencing multiple jeopardies (Joe et al., 2009; Spates, 2012, 2019; Spates et al., 2020; Wang et al., 2016).
These authors highlighted the fact that between 1950 and 2006, suicide rates for Black women were almost flat: 1.8 per 100,000 to 1.4 per 100,000. While still low compared to Whites and Black men, Black women’s suicide rate doubled in a decade (CDC, 2018). Concurrently, Black women experience symptoms of depression and stress as a result of persistent gender and racial discrimination, violence, poverty, and sizable intergenerational caregiving stressors (Barbee, 1992; Beauboef-Lafontant, 2008; Belle & Doucet, 2003; Spates et al., 2020). Furthermore, Walker (2020) argued that many Black women experience low-key suicides, or premature deaths related to limited access to health-promoting resources. Examples include access to healthy foods, primary medical care, and flexible work schedules and child care assistance to attend medical appointments. Finally, Sigurvinsdottir et al. (2020) noted the significant relationship between Black women’s disproportionate exposure to interpersonal violence and suicide. The authors emphasized the compounding effects of marginalized identities, sexual assault, self-blame, and suicide attempts. These data underscore the need to interrogate connections among statistical data interpretation, Black women’s lived experiences, and suicide risk conceptualizations (Spates, 2012).

**Black Males and Suicide.** Black male death by suicide is a serious problem (CDC, 2020; Joe et al., 2018; Lindsey et al., 2017). According to the CDC (2020), Black male death by suicide mortality rates (12.04 per 100,000) are almost six times higher than those of Black females (2.90 per 100,000). Overall, Black male suicide rates are the third highest among all sex-race cohorts. Furthermore, Joe et al. (2018) noted that males accounted for 80% of all deaths by suicide in Black communities. Finally, between 1999 and 2017 the
mean suicide mortality rate for Black males aged 10 to 44 increased by 35%, while for Black males aged 10 to 14 there was a 100% increase (Curtin & Hedegaard, 2019).

**Race, Socioeconomics, and Suicide**

In June 2020, labor statistics indicated that the Black unemployment rate for people aged 20 and older was 15.5%. In contrast, the White unemployment rate for the same age cohorts was 11.5% (U.S. Bureau of Labor Statistics, 2020). Furthermore, Black men were half as likely to earn a college degree as White men (Office of Minority Health, 2019). Cramer and Kapusta (2017) and Huang et al. (2017) both noted that employment and education statuses are associated with suicide risk. To underscore this relationship, the CDC (2020) surveyed 5,470 Americans between June 24 and 30, 2020 and discovered three significant findings. First, 15.1% of Black Americans had considered suicide in the previous 30 days (CDC, 2020). Second, 57.1% of people with a high school diploma or lower reported suicidal ideation in the prior month (CDC, 2020). Third, 44.6% of the participants who earned $49,999 or less annually revealed thoughts of suicide in the previous month (CDC, 2020). In concert, these data suggest a significant relationship among racism, socioeconomic opportunity and status, and suicide risk.

**Race, Age, and Suicide**

Age also affects Black community suicide rates. According to Price and Khubchandani (2019), child suicide rates from 1993 to 1997 and from 2008 to 2012 revealed that the rate of African American child suicide increased by 118%. In another study, Bridge et al. (2018) found that from 2001 to 2015, for youth aged 5 to 12, Black children and youths had a suicide rate approximately two times higher than White children and youths. These startling data are not limited to Black children and youths, as
age, period, and cohort (APC) analysis has exposed Black American adult suicide risk patterns. Wang et al. (2016) reported that, for Black Americans, “[t]he risk in males increased with age until peaking at ages 20–24 years, whereas the risk in females increased with age until peaking at ages 25–29 years and then declined except for slight increases at middle ages” (p. 4). This analysis indicates that Black suicide risk ought to be conceptualized and addressed across the human life span.

**Race, Sexual Orientation, Trans Identities, and Suicide**

Black Americans with marginalized sexual and gender identities experience a compounding suicide risk. Shadick et al. (2015) found that college-aged, sexual minorities of color were two to seven times more likely to attempt suicide than their White heterosexual peers. In a nation-wide sample of Black men who have sex with men (MSM) and transwomen, Wilton et al. (2018) reported that 36.6% of young Black MSM and transwomen revealed a lifetime history of suicidal thoughts, while 16.1% disclosed prior suicide attempts. The authors noted that these results are significantly higher than those observed in larger, general population samples of Black youth and young adults (7.5% for ideation, 2.7% for previous attempts). Thus, racial, sexual, and gender minority intersections magnify Black suicide risk.

**The Criminalization of Black Identity**

While Black identity has been framed in legalistic and criminal terms since Africans were enslaved (Alexander, 2020; Halloran, 2019; Snyder, 2015; St. Vil et al., 2019), Amendment XIII to the U. S. Constitution implicitly codified the relationship between race and criminality: “Neither slavery nor involuntary servitude, except as a punishment for crime whereof the party shall have been duly convicted, shall exist within
the United States, or any place subject to their jurisdiction.” The exceptions clause created a legal loophole that was used to create Black Codes: laws that limited Black Americans’ freedom and rights. In this way, Black Americans who were found loitering or who were unable to prove their employment status were effectively re-enslaved by the state. Such laws established the foundation for the present-day disproportionate mass incarceration of Black communities (Alexander, 2020; Kendi, 2019). According to the Bureau of Justice Statistics (2018), 34% of the nation’s prison population is Black. These data, when coupled with the reality that Black people comprise approximately 13% of the total population, reveal pernicious systemic injustices. These injustices increase suicide risk (Cramer & Kapusta, 2017).

**Violence**

Violence against Black communities is historical, intergenerational, pervasive, traumatizing, and life-limiting (Coleman, 2016; Halloran, 2019; Hooper et al., 2015; Jones-Eversley et al., 2020; Snyder, 2015; Spencer & Perlow, 2018; St. Vil et al., 2019). This violence has taken many forms: intergenerational enslavement, cultural and experiential erasure, family separation, torture, lynching, segregation, rape, political disenfranchisement, public health experimentation, eco-racism, lethal police brutality, and mass incarceration. Collectively, Spencer and Perlow (2018) conceptualized these interpersonal and systemic forms of cruelty as *Savage White American Terror*. Also, Jones-Eversley et al. (2020) noted that this violence prematurely and disproportionately results in Black community deaths by homicide and suicide. These authors revealed that these deaths significantly reduce life expectancy for Black males aged 1 to 24 by five to six decades compared to White people.
Health Disparities

Black communities experience significant health disparities that increase suicide risks (Halloran, 2019; Kendi, 2019; Spates, 2011; Walker, 2020). Volpe et al. (2019) reported that Black Americans experience significant health disparities across important health outcome measurements: “morbidity and mortality, cardiovascular disease, obesity, and diabetes” (p. 303). Furthermore, Mitchell et al. (2020) analyzed the primary healthcare experiences of 47,405 Black men between 2008 and 2016. Compared to non-Latino White groups, the researchers found that Black men had less access to primary care services, experienced poorer patient-provider communication, and received less comprehensive treatment. Finally, Uzogara (2017) revealed a relationship between skin color tones and health outcomes. For example, darker skinned Black women who self-reported more discrimination experienced higher measures of hypertension, blood sugar, and visceral abdominal fat. These data underscore the association between race, colorism, and serious illness. All of these factors contribute to suicide risk and mortality (Cramer & Kapusta, 2017; Spates, 2011; Spates et al., 2020).

Mental Health

Black communities face a range of unique and significant bio-psycho-social challenges that manifest in compromised mental health (Barlow, 2018; Hooper et al., 2015; Jones-Eversley et al., 2020; Liao et al., 2020; Mekawi et al., 2020; Spates, 2011, 2012; Walker, 2020; Wilkinson et al., 2020). Barlow (2018) postulated that the intergenerational effects of African slavery and Black American oppression results in post-traumatic slavery disorder and Black women’s post-slavery silence syndrome. Such conceptualizations offer a psychosocial framework for understanding Black mental health
and community attitudes about mental health and treatment. Both are commonly viewed by Black communities as White problems and White services. However, medicalizing oppression may obscure the underlying forms of violence that contribute to suicide in Black communities by emphasizing individual symptoms over systemic cruelty (Reynolds, 2016).

Additionally, Hooper et al. (2015) established a relationship between suicidal ideation, traumatic stress, gender, and race. These intersections can be exacerbated by cultural coping schema like the strong Black woman, or SBW (Green, 2019). Spates et al. (2020) characterized SBW as a double-edged stereotype that encourages Black women to project strength and self-sacrifice in response to daily pressures. Additionally, Liao et al. (2020) found that the SBW coping style often resulted in unrealistic perfectionism, low self-compassion, decreased use of social supports and mental health services, and increased suicidality. Mental health service utilization is further hindered by clinician cultural incompetency with Black communities and a dearth of Black clinicians (Jones, 2020; Mekawi et al., 2020). Furthermore, Kapoor et al. (2018) and Wilkinson et al. (2020) noted that Black communities experience a myriad of psychosocial stressors that predispose people in such communities to major depressive episodes. Likewise, Walker (2020) noted that racism and racial discrimination strongly correlate with Black Americans’ anxiety. Thus, the interplay of racism, depression, and anxiety likely contribute to the experienced shame, hopelessness, and isolation commonly associated with suicide.

In summary, Black community socio-demographics reveal the historical, intergenerational, and systemic effects of marginalization, violence, and trauma. Such
forces increase Black community exposure to suicide-contributing factors like poverty, un/underemployment, discrimination, legal system involvement, healthcare disparities, minority stress, and shame.

In light of the unique socio-demographic, historical, and oppressive forces that affect Black community experiences, we need new analytical frameworks to challenge psychiatry, psychology, suicidology, and the dominant cultural hegemony regarding suicide. Such frameworks need to critically interrogate “psy-theories” and inspire fresh, nuanced, and interdisciplinary analysis. This analysis aims to elevate and amplify typically underrepresented and/or erased voices, perspectives, and methodologies. In so doing, we may better understand and address the complexities of suicide.

**Theoretical Framework**

Throughout most of the 20th century, psychiatric and psychological theories dominated suicidology discourse, research, and practice (Hjelmeland, 2016; Marsh, 2010, 2016). These theories emphasized positivistic science and individual pathology. Furthermore, psychiatric and psychological theories benefited from societal perceptions that 19th-century and early 20th-century medical experts safeguarded community tranquility. Such perceptions emerged from the creation of asylums: places that removed and isolated individuals with mental illness from the broader community. Concurrently, it was also widely believed that these same medical experts provided the best hope to people living with mental illnesses and suicidality. This confluence of medical expertise, isolating individuals with suicidality, and societal perceptions of effective treatment (out of sight, out of mind) reinforced medicalized suicide theory. Such a confluence also contributed to widespread stigmas about mental health and the proliferation of political
and economic alliances between “psy”-fields and the pharmaceutical industry (Tatz & Tatz, 2019; White, 2020).

The alliance between “psy”-fields and medical industries established a contemporary political economy of truth (Foucault, 1977) in which “psy”-fields and pharmaceutical companies mutually profited from creating systems of “truth.” These systems increasingly framed human experiences in terms of individual psychiatric disorders that required medicalized interventions (Tatz & Tatz, 2019). For example, Tatz and Tatz (2019) noted that as mental health diagnostic categories increased, pharmaceutical industry profits rose and investments in empirical psychological research increased. Thus, this partnership financially incentivized the production, distribution, and regulation of medical model theories and practices during the last century.

For most of the 20th century, “psy”-fields developed theoretical frameworks that conceptualized suicide in personal, decontextualized, apolitical, and biomedical terms. The next section of this literature review provides an overview of these historical and contemporary theories. They emphasized individual drives, cognitive schemas, suicidal ideation, suicide attempts, and biological connections. Such theories tend to conceptualize suicide in positivistic terms.

In an effort to challenge mainstream suicidology’s focus on individual pathology, the ensuing discussion examines historical trauma, sociological, system, critical, and feminist theories to reframe suicide in complex, contextual, narrative, systemic, and social justice terms. These theories offer conceptual and analytical tools to re-interrogate suicidology’s reductive assumptions and re-image Black community suicide prevention, assessment, and intervention frameworks.
Psychoanalytic and Psychodynamic Theories

Early 20th century suicide perspectives reflected contemporary trends in psychoanalytic thought. Friedman (1967) noted that the Vienna Psychoanalytic Society convened a meeting to discuss suicide in 1910. Society members concluded that there was insufficient clinical data to support a suicide-specific psychoanalytic framework. However, in 1917, Freud authored *Mourning and Melancholia* in which he described the relationship between melancholic depression and suicide:

> If one listens patiently to the melancholic’s many and various self-accusations, one cannot in the end avoid the impression that often the most violent of them are hardly at all applicable to the patient himself, but that with insignificant modifications they do fit someone else, someone whom the patient loves or has loved or should love. (Freud, 1917/1957, p. 248)

Freud’s first insight was that pervasive depressive experiences transform intense love into violence. Freud (1917/1957) then extended his insight: “we perceive that the self-reproaches are reproaches against a loved object which have been shifted away from it on to the patient’s own ego” (p. 248). These insights underscored a central and early psychoanalytic belief about suicide: depression transforms love into self-directed violence through *narcissistic identification*. This psychological process unfolds in response to real and/or perceived abandonment by or loss of an important person (object). In the context of depression and suicide, narcissistic identification often creates an irresolvable love-hate dynamic: the person living with depression and suicidality attempts to resolve love-hate object ambivalence by attempting or dying by suicide.
In the next evolutionary stage of suicide-specific psychoanalytic theory, Menninger (1938) elaborated on Freud’s (1923/1961) formulation of suicide, which emphasized superego withdrawal. Such protective force withdrawal results from the weakening of survival instincts and the emergence of death instincts. These concurrent processes foster three death wishes that drive suicidality: the wish to kill, the wish to be killed, and the wish to die.

Following the works of Freud and Menninger, Klein (1935/1975, 1946, 1957) hypothesized that suicide stems from paranoid-schizoid, depressive, and narcissistic states. In the first state, an individual projects intense anger onto an object. Such projection evokes anxiety, fear of the bad object annihilating the good object, and self-disintegration. This disintegration—in some cases—leads to a projection of the bad object onto the self, and thus, evoking feelings of shame. Suicide is then an attempt to protect the good object by eliminating the bad object. Klein (1935/1975, 1946) further posited that depressive state-driven suicides result from the ego experiencing the good and bad objects as the same. This good-bad object relationship fosters depressive-anxiety, increases fear of object loss, and evokes guilt and shame. Such guilt and shame emerge from fantasies about destroying the object and may lead to suicide: an attempt to prevent one’s self from destroying the object. Finally, Klein (1957) argued that narcissistic states—any state in which the self safeguards its perceived interests—contribute to suicidality. She asserted that primitive envy (the most primal narcissistic state) is aggressive innately and is a derivative of the death instinct. In extreme cases, a person in a narcissistic state might perceive their “best interest” as dying by suicide, as seen, for example, in a person who dies by suicide in an attempt to keep their family intact. Klein’s
views, like Freud’s, framed suicide in terms of competing life and death instincts and attempts to resolve ego state conflicts. These concepts further evolved in Kohut’s self psychology.

Self psychology advanced the interconnections between rage, the ego state, and suicide. Kohut (1971) expounded on the roles of narcissistic rage, envy, shame, and ego-state conflicts:

This state of shame and envy may ultimately be followed by self-destructive impulses. These, too, are to be understood not as attacks of the superego on the ego but as attempts of the suffering ego to do away with the self in order to wipe out the offending, disappointing reality of failure. In other words, the self-destructive impulses are to be understood here not as analogous to the suicidal impulses of a depressed patient but as the expression of narcissistic rage. (p. 181)

Kohut (1972) argued that narcissistic rage-driven suicide emerged when an individual’s ego state lacks control over their environment and access to an unconditional, mirroring self-object such as a person, object, or activity that supports typical functioning. Such deprivation potentially leads to self-directed shame and violence. This self-psychological framework shapes contemporary psychoanalytic suicide perspectives.

Contemporary psychoanalytic suicide perspectives emphasize personality traits over ego states. Maltsberger (1986, 1993, 1998, 2004) suggested that specific personality traits predispose people to suicide. These predispositions—according to Maltsberger—include impaired self-perceptions, the internalization of others, and object constancy. Such impairment in essential psychological functioning diminishes self-regulation capacities and leads to over-reliance on external regulating forces. If these forces are
absent, an individual experiences isolation, self-contempt, and intense rage. The individual—in a state of frantic, psychological pain—often copes through substance use, self-injury, dissociation, and/or other help-seeking behaviors. Failure to regulate frequently results in grandiose, psychotic states wherein the individual attempts suicide for the purposes of rebirth, reunion, or pain amelioration.

Psychoanalytic and psychodynamic suicide theories offered researchers and clinicians important insights about the unconscious and intrapsychic nature of individual people’s suicidality. Such insights shed light on the roles that early life experiences, relationships, and unresolved conflicts play in predisposing people to suicidality. However, by mid-century, the fields of psychiatry and psychology emphasized observable and measurable aspects of individuals’ experiences and suicidality. This shift within the “psy”-fields emerged to mirror the objective theories, methodologies, and methods of the natural and medical sciences (Tatz & Tatz, 2019). These theories focused on the cognitive and cognitive-behavioral aspects of suicide.

**Cognitive and Cognitive-Behavioral Theories**

Beck (1967) hypothesized that connections between depression, hopelessness, shame and suicide resulted from negative cognitive schemas about the self, other people, and the future. Such schemas emerge from and are reinforced by cognitive distortions, or patterns of irrational thinking that shape affective experiences. For suicide-vulnerable people, according to Beck (1967), negative cognitive schemas generate feelings of hopelessness and constrict people’s abilities to adaptively solve problems. Furthermore, Rudd (2000) highlighted a cognitive-behavioral viewpoint that emphasized a *suicidal mode*. The author observed that negative thoughts and cognitions trigger “accompanying
affective, physiological, and behavioral-motivational systems associated with suicidality” (Karthick & Barwa, 2017, p. 104). Such processes unfold in mutually constituting ways. The process catalyzes with an individual’s negative guilt- or shame-centered thoughts, which generate mixed dysmorphic affective states. This interaction activates physiological experiences of pain that result in suicidal planning, rehearsing, and attempt behaviors. These reductionist and positivistic views of the complexity of suicide resulted in a proliferation of contemporary suicide theories, which typically underscore the progression from suicidal thoughts to suicidal actions.

**Ideation-to-Action Suicide Theories**

Contemporary theories of suicidality stress the “ideation-to-action” process (Klonsky & May, 2015). They emphasize connections between experiences of pain and/or isolation, interpretations of pain and/or isolation, and preparatory behaviors leading to suicide attempts or deaths by suicide. Joiner et al. (2009) conceptualized this continuum as two separate processes. The first process entails an individual’s shame-related experiences of thwarted belonging (I am alone) and perceived burdensomeness (I am a problem to others). These theorists postulated that combined low belongingness and high burdensomeness perceptions catalyze suicidal ideations. In concert with the second part of the process—high acquired suicidal capability (desensitization to death plus the means to attempt it)—lethal attempts occur frequently (Joiner et al., 2009).

Another ideation-to-action theory is O’Connor et al.’s (2016) Integrated Motivational-Volitional model, which proposed that perceptions of defeat and entrapment—coupled with acquired capability, access to lethal means, planning, and impulsivity—facilitate the suicidal ideation to attempt progression. The authors theorized
that predisposed genetic vulnerabilities, life events, and one’s social environments shape expectations that can result in feelings of defeat. This type of emotional state often triggers memories of other defeats or humiliations. These memories may produce *brooding rumination*: the repetitive pattern of comparing one’s current situation with an unachieved standard (O’Connor et al., 2016). Over time, brooding rumination frequently leads people to experience a sense of never-ending hopelessness, or *entrapment*. Suicide occurs to escape this pattern.

Finally, Klonsky and May (2015) developed the Three-Step Theory (3ST). These authors argued that the ideation-to-action process begins with experiences of inescapable pain. Such pain triggers a negative self-evaluation (shame) about the degrees to which an individual experiences connectedness to life. Connectedness to life is often experienced through meaningful attachments to people, roles, and/or interests. The presence of perpetual pain and the experience of low connectedness create the conditions for suicidal ideation. The progression from ideation to suicide attempt often depends on an individual’s capabilities. Klonsky and May broadened Joiner et al.’s (2009) conceptualization of capability to include *dispositional, acquired, and practical*. The first describes an individual’s biological sensitivities to pain or blood phobia. *Acquired capability* refers to death desensitization through exposure to pain, injury, or fear. The last emphasizes the concrete skills and means to attempt suicide, such as firearms training, access, and ownership. While these ideation-to-action frameworks may foster understanding of micro-level suicide forces, such conceptualizations ignore the contextual factors that frequently influence suicidality (Bryan, 2021). This omission
perpetuates the distorted view that suicide is primarily an individual, pathological, and biological experience.

**Neuro-Biological Theories**

Research developments in neuro- and genetic sciences have inspired biological theories of suicide. These theories often focus on associations between the functioning of atypical serotonergic, noradrenergic, and dopaminergic systems and suicidality. In the context of suicidality, the three neurobiological systems are involved in mood regulation and impulse control. Dwivedi (2012) noted connections between serotonin levels, the 5-HT transporter, and suicidality. Post-mortem studies revealed that reduced 5-HT transporter binding in the prefrontal cortex corresponded to reduced serotonin levels in people who died by suicide. Furthermore, Arango et al. (1993), De Luca et al. (2005), and Mann (2003) observed that high concentrations of norepinephrine with decreased alpha2-andrenergic bindings were found in the prefrontal cortex of people who died by suicide. Additionally, while research indicates a relationship between low dopamine levels in people who attempted suicide and experienced major depression, the neurotransmitter’s role in suicidality remains inconclusive (Karthick & Barwa, 2017). These neuro-biological theories provide important descriptions of the neural activity and brain chemistry associated with suicidality. Such descriptions may lead to interventions that address suicide with biogenic features. However, the human brain is situated in multiple contexts that shape its development and influence its functioning. While most suicidology theories acknowledge the role of person-in-environment relationships, individual pathology and biomedical conceptualizations of suicide dominate in academic and clinical discourses.
While mainstream suicidology has focused primarily on psychological and biological explanations for suicide, other perspectives foreground interdisciplinary understanding, qualitative inquiry, and decenter medical expert knowledge. These perspectives often use historical and intergenerational trauma, sociological, systems, and critical frameworks to re-contextualize suicidal experiences. In so doing, these theories re-situate suicide in the historical, cultural, political, communal, and interpersonal relationships in which an individual’s or groups’ suicide always unfolds. Thus, understanding suicide’s complexity necessitates frameworks that highlight systemic realities.

This research project aims to use a range of systemic and critically oriented perspectives to explore Black female clinicians’ critical understandings of suicide in Black communities. First, historical and intergenerational trauma research illuminate the sinister connections between past horrors and today’s increasing “death” by suicide rates in Black communities. Second, Durkheim’s suicide typologies offer historically significant concepts for understanding suicide as a social phenomenon. Third, Bronfenbrenner (1994) and Ballou et al.’s (2002) ecological systems theories provide the analytic tools to examine suicide’s systemic complexity. Finally, critical suicidology, critical race theory, and Black feminist thought frameworks further highlight systemic, power, intersectionality, and suicide interrelationships.

**Historical and Intergenerational Trauma**

The confluence of historical and intergenerational trauma affects suicidality in Black communities. Williams-Washington and Mills (2018) noted that historical and intergenerational trauma describes the compounding emotional, social, and physical
harms experienced within a life time and across generations that originated from horrific group experiences. Furthermore, Sotero (2006) remarked that historical trauma is the subjugation of one group by a dominant group, involving “overwhelming physical and psychological violence, segregation and/or displacement, economic deprivation, and cultural dispossession” (p. 99). Black communities have experienced and continue to experience all these conditions. Additionally, Hampton et al. (2010) defined Black community historical trauma as “the collective spiritual, psychological, emotional, and cognitive distress perpetuated intergenerationally deriving from multiple denigrating experiences originating with slavery and continuing with pattern forms of racism and discrimination to the present day” (p. 32). Such pervasive exposure and re-exposure to multiple forms of trauma produce unique and compounding harms for Black communities (Hampton-Anderson et al., 2021). These contributory life-limiting effects include significant neurological, immune, endocrine, and metabolic dysfunction, as well as depression, anxiety, posttraumatic stress, and suicidal behavior. Unlike in other racial/ethnic groups, increases in socio-economic status among Black communities does not mitigate these harms. This reality suggests that suicide prevention in Black communities requires significant and long-term systemic reforms. Such necessary reforms require practitioners and policy-makers to use analytical tools that illuminate societal and individual interconnections.

**Durkheim’s Suicide Theory**

During the mid- to late-19th century, the European continent experienced increased military conflict, political upheaval, economic transformation, and technological revolution. These forces coincided with increasing suicide rates (Barbagli,
2015; Durkheim, 1897/2006). Quetelet (1842/2013) and Morselli (1882/2015) hypothesized that these rising suicide rates correlated positively with modernity—increases in freedom, shifts from rural to urban communities, and changes from agrarian to free market economies. The empirical evidence suggested that forces greater than individual free-will and “insanity” explained the macro social patterns of suicide.

Building on the idea that social forces affect suicide rates, Durkheim (1897/2006) theorized that integration and regulation shape suicidal behavior. Integration describes the degree to which individuals experience a sense of belonging or inclusion. He concluded that “suicide rates vary inversely with the degree of integration of the social groups to which the individual belongs” (Durkheim, 1897/2006, p. 224). However, Durkheim also observed that too much social integration contributes to group suicide: groups that experience close ties often overvalue group cohesion over individual survival. Concurrently, Durkheim believed that regulation—or the influence that social connections have on individual behavior—affects suicide. In tandem, integration and regulation shape four suicide typologies: egoistic, altruistic, anomic, and fatalistic.

**Egoistic Suicides**

Egoistic suicide refers to suicides that result from low social integration. Durkheim (1897/2006) wrote, “Egoism is not merely a contributing factor; it is its generating cause. In this case the bond attaching man to life relaxes because that attaching him to society is itself slack” (pp. 214–215). Typically, family, friend, work, and other social ties provide a sense of belonging. When these connections are weakened or lost altogether, egoistic suicide is more probable. This suicide concept helps explain connections between enslaved Black people who are removed from their communities
and/or separated from their families and their suicides. Furthermore, among Black sexual minority populations who are alienated from traditional supports like church and family, egoistic suicides are common.

**Altruistic Suicides**

In contrast to egoistic suicide, *altruistic suicide* stems from extreme integration. Durkheim (1897/2006) highlighted the distinction: “Having given the name of *egoism* to the state of the ego living its own life and obeying itself alone, that of *altruism* adequately expresses the opposite state, where the ego is not its own property, where it is blended with something not itself, where the goal of conduct is exterior to itself, that is, in one of the groups in which it participates” (p. 221). Excessive integration with groups often results in a profound—and potentially life-threatening—sense of duty and obligation. Examples include kamikaze pilots, suicide bombers, and terrorists. In the context of Black suicides, mass enslaved peoples’ suicides could be understood as altruistic because the motivating force was a sense of higher purpose: collectively and spiritually rejoining their families and communities on the African continent.

**Anomic Suicides**

In additions to extremely low and high social integration, under- and over-regulation increases suicide risk. *Anomic suicide* characterizes a state of disillusionment caused by the rapid change of social norms, values, and institutions (Durkheim, 1897/2006). Examples include economic recessions and depressions, political revolutions, civil wars, and social justice movements. During such times, an individual may be deprived of the socially acceptable means to achieve desired goals. Given that Black communities historically and currently have limited access to resources of wealth,
power, prestige, and opportunity, some Black suicides may be attempts to regain a sense of control. Such control provides a substitute for prosocial forms of regulation. For example, a previously incarcerated man without employment or educational opportunities might engage in activities that prompt interactions with the police that result in suicide by cop. Such a suicide would end the man’s disillusionment on his own terms.

**Fatalistic Suicides**

Fatalistic suicide occurs when society exerts unyielding control over individuals (Durkheim, 1897/2006). Prison populations and citizens of totalitarian states experience a higher likelihood of fatalistic suicides than the general population. This suicide typology helps explain increasing suicide rates in Black communities affected by intergenerational legacies of enslavement, violent policing, and relentless mass incarceration. The fatalistic suicide framework also reveals society’s culpability for Black community deaths by suicide. Such culpability exists because society creates, maintains, and perpetuates the systems of social control that over-regulate Black communities. This type of hyper-control often instills unending despair, which is often associated with suicide.

The confluence of Durkheim’s (1897/2006) suicide typologies re-situates suicide in its social contexts. Such contexts are not merely backdrops for individual deaths. Rather, Durkheim’s emphasis on context, social forces, and behavior challenges individual pathology frameworks. In so doing, he created a theoretical foundation from which critical theories could evolve. These theories challenge the hegemony of mainstream suicidology by privileging the nuanced and complex dynamics between people, power, social environments, and suicide.
Critical Suicidology

Critical suicidology challenges the ontological, epistemological, methodological, and praxis underpinnings of mainstream suicidology (White, 2017). Mainstream suicidology espouses a positivistic stance that frequently conceptualizes suicide as a phenomenon resulting primarily from individual psychopathology. This framing privileges psychiatric and psychological theories that often foreground explanatory methodologies, the generation of numerical data, and statistical analysis (Hjelmeland, 2016; Hjelmeland & Knizek, 2016; Joiner et al., 2016; Marsh, 2016). These methodologies and methods typically yield aggregated information about suicide risk factors and warning signs. Such information reinforces the belief that people who live with suicidality have conditions that require protocolized therapies and/or who need to be medically incarcerated. While mainstream suicidology theories and research have positively shaped suicide prevention and clinical practice related to psycho-genic suicides, important limitations exist. Mainstream suicidology frequently decontextualizes suicidal experiences and obscures the macrosystemic forces that create, maintain, and perpetuate suicidality even while acknowledging the role of “life event” risk factors, such as poverty, unemployment, and violence in all of its forms (Reynolds, 2016). Critical suicidology emerged in an effort to reframe suicide as a multi-contextual phenomenon best understood from interdisciplinary vantage points (White, 2017, 2020).

In contrast to mainstream suicidology, critical suicidology promotes an alternative paradigm. First, critical suicidology asserts that suicide is a dynamic and contextual experience that cannot be depoliticized (Button, 2020; Marsh, 2020; Reynolds, 2016; White, 2017, 2020). Second, this framework acknowledges psychopathology’s role in
some suicide experiences, yet questions the primacy of mental health frames in suicidology (Hjelmeland & Knizek, 2017; Pridmore, 2014; White, 2017, 2020). Third, critical suicidology advocates for an increased interdisciplinary understanding of suicide that decenters psychological expertise and foregrounds indigenous, lived experience, activist, direct service provider, and academic collaboration (Reynolds, 2016; White, 2017, 2020). Fourth, this focus on collaborative understanding and meaning-making necessitates a methodological shift from empiricism to qualitative research (Hjelmeland, 2016; Hjelmeland & Knizek, 2016, 2017). Finally, critical suicidology’s explicit focus on suicide-contributing historical, social, cultural, economic, and political contexts highlights its dedication to social justice. Such an explicit commitment is missing from mainstream suicidology.

Critical suicidology’s emphasis on contexts and social justice necessitate ecological and critical theoretical frameworks that illuminate relationships between people and the environments in which they are situated. Bronfenbrenner’s (1994) ecological system theory and Ballou et al.’s (2002) feminist ecological systems theory examine relationships in terms of interconnected systems. An ecological systems perspective provides the conceptual and analytical tools to examine Black community suicides at the individual, social group, societal, planetary, and historical levels simultaneously.

**Feminist Ecological Systems Theory**

Suicidality unfolds across multiple contexts simultaneously. For example, a Black adolescent gay cisgender male living in Alabama during the 1940s exists in multiple systems that would likely contribute to his suicide risk. This risk would be heightened
due to racial, developmental age, sexual orientation, intracultural definitions of identities, geography, public policy, and historical factors that manifest across social systems. Bronfenbrenner (1994) asserted that individual experiences affect and are affected by interactions among people and five nested systems. Building on Bronfenbrenner’s model, Ballou et al. (2002) proposed a feminist ecological systems theory. This framework includes an examination of planetary (the natural environment) factors and identity-based lines of power that affect all human experiences.

**Microsystem**

The *microsystem* describes the interactions between an individual and their immediate social connections, such as parents, siblings, and peers (Ballou et al., 2002; Bronfenbrenner, 1994). Such systems directly influence daily experiences and significantly affect overall human development. Cramer and Kapusta (2017) noted that interpersonal conflicts or social support deficits within the microsystem increase suicide risk.

**Mesosystem**

The *mesosystem* depicts how individuals and microsystem interactions influence each other mutually (Bronfenbrenner, 1994). For example, a queer Black child harassed at school (one microsystem) and bullied at home (another microsystem) may experience an amplified suicide risk as a result of this interactive effect. Shadick et al. (2015) confirmed that Black LGB college students who experienced racialized harassment at school and intrafamilial homophobia reported greater levels of suicidal ideation than peers who experienced multiple microsystemic supports.
Exosystem

Exosystems comprise the local social environments in which an individual’s experience unfolds (Ballou et al., 2002; Bronfenbrenner, 1994). Examples include neighborhoods, communities, workplaces, and institutional and economic structures. Exosystemic forces may affect human development via direct and indirect interactions. For example, local zoning laws, school policies, and policing practices disproportionately harm Black communities via rent price gouging, poorly funded schools, and state-supported violence (Kendi, 2019). Such exosystemic forces limit life-enhancing opportunities and enable hopelessness, entrapment, and shame to metastasize (Cramer & Kapusta, 2017).

Macrosystem

Macrosystems refer to the cultural forces and societal-level laws that influence socialization processes, regulate social behavior, and codify institutional privilege and oppression (Ballou et al., 2002; Bronfenbrenner, 1994). Unlike exosystems that operate at the local level, macrosystems shape state and national cultural, social, and political systems. Embedded in each system are institutionalized forms of oppression and privilege that govern the distribution of resources and opportunities. Such distribution is neither equal nor equitable (Kendi, 2019). For Black communities intergenerationally deprived of such resources, suicide may seem like a reasonable response. Thus, from a macrosystemic perspective, suicide in Black communities needs to be reframed as a response to chronic and pervasive systemic racism.
Planetary System

All human experiences emerge and unfold on Earth (Ballou et al., 2002). The planet’s atmosphere, geography, and natural resources all enable human social systems to exist. Any planetary or climatic changes invariably affect human functioning and thriving. Dumont et al. (2020) noted that air pollution and global temperature increases due to human lifestyle and economic activities correlate with suicide risk. The same authors underscored that indigenous and marginalized communities are and will be disproportionately affected. This reality has implications for suicides in Black communities. Because of racist Jim Crow housing and urban development policies, Black communities are frequently located near carbon dioxide producing highways, factories, and waste storage and treatment facilities (Alvarez & Rosenfeld Evans, 2021). Such disproportionate exposure to environmental toxins likely compounds Black community suicide risks.

History and Time

Finally, history and time—the chronosystem—are the overarching contexts in which all other systems mutually interact (Ballou et al., 2002; Bronfenbrenner, 1994). This systemic context highlights the realities that deaths by suicide shape and are shaped by age, day, season, and historical events. For example, suicide mortality occurs more frequently for youths (CDC, 2020; WHO, 2019). Additionally, suicide attempts most frequently occur on Sundays and Mondays for adults, and Mondays and Tuesdays for people age 19 and younger (Beauchamp et al., 2014). These same authors also found a stronger association among spring, fall, and suicide attempts than among winter, summer, and suicide attempts.
Unlike the traditional “psy”-theories, a feminist ecological systems framework situates suicide experiences in multiple and co-occurring contexts. Such a person-in-environments perspective illuminates the connections between individuals and multisystemic forces. These illuminated connections reveal the inherent complexities associated with suicide. This complexity is more deeply understood when examining cross-cutting patterns of identity-based privilege and oppression (Ballou et al., 2002).

**Critical Race Theory**

Critical race theory (CRT) is an ever-evolving, interdisciplinary framework for understanding, resisting, and dismantling race-driven oppression globally (Collins, 2019; Delgado & Stefancic, 2017). Within the United States, Black, Asian, and Latinx feminist scholars and activists advanced CRT by interrogating color-conscious forms of power. This analysis revealed color-blind systems that obscured race-based suffering, such as housing and education policies that segregated American communities and schools. This antiracist analysis and activism has also unearthed connections between racism, violent policing practices, mass incarceration, and the legacies of Jim Crow laws. For the purposes of exploring Black female clinicians’ critical understandings of suicide in Black communities, this discussion centers Collins’s (2019) views on Black feminist thought and Crenshaw’s (1991) analysis on intersectionality. These frameworks provide a suite of theoretical assumptions and conceptual tools to understand the complex interplay among gender, race, power, contexts, and suicide.

**Black Feminist Thought**

Black feminist thought is an intergenerational, interdisciplinary, and dialectical framework that aims to resist oppression and empower Black women within intersecting
contexts of social injustice (Collins, 2009). In the U.S., Black feminist thought is a direct response to a central contradiction: promised individual freedom for all in contrast to limited access to freedom-producing resources and opportunities based on one’s social identities (Collins, 2009). Such contradictions produce systems of oppression that discriminate against, segregate, and violate marginalized groups. To counteract these insidious forces and inspire solidarity, Black feminist thought espouses six interconnected ideas (Collins, 2009).

**Connections Between Lived Experience and Consciousness.** First, Black feminist thought fosters linkages between lived experience and consciousness. Collins (2009) wrote, “[B]eing Black and female continues to expose African American women to certain common experiences…overall, U.S. Black women as a group live in a different world from that of people who are not Black or female” (p. 27). King (1988/1995) further observed, “Black women have long recognized the special circumstances of our lives in the United States. . . . We have also realized the interactive oppressions that circumscribe our lives provide a distinctive context for [B]lack womanhood” (p. 294). These pioneering and unique voices exemplify a duality often experienced by Black women: they have simultaneously unique and shared lived experiences. This duality may help researchers and clinicians refine their theories about the complex suicide paradox among Black women who have experienced gendered racism yet historically have the lowest rates of suicide mortality in the United States.

**The Duality of Common Struggles and Unique Experiences.** Second, Black feminist thought supports the duality that Black women as a group share common struggles, and
individual Black women’s lives concurrently unfold in unique ways. As Collins (2009) noted:

Not every individual Black woman consumer need experience being followed in a store as a potential shoplifter, ignored while others are waited on first, or seated near restaurant kitchens and restrooms, for African American women as a collectivity to recognize that differential group treatment is operating. (p. 29)

This principle recognizes that Black women collectively share unique legacies of racialized and gendered oppression and appreciates that individual Black women experience such oppression differently. Supporting such duality creates opportunities for solidarity and validates a range of diverse lived experiences (Russo, 2019).

**The Dialogic of Consciousness and Action.** Third, Black feminist thought highlights a dialogic relationship between ever-evolving consciousnesses and change-oriented actions. These have motivated abolitionist, civil rights, and anti-racist movements (Collins, 2009, 2019; Kendi, 2019). For example, the awareness of slave rapes as a form of social control inspired Black women’s club movements to organize and speak out. Additionally, the Black Lives Matter movement emerged out of righteous outrage regarding police brutality against Black Americans.

**The Dialogic of Practice and Theory.** Fourth, Black feminist thought embraces dialogic practice and theory-building connections. Such connections sparked the development of *intersectionality* (Collins, 2009, 2019). Crenshaw (1991) observed that the American legal system was ill-equipped to address the compounding injustices that Black women face based on their race and sex. In *DeGraffenreid et al. v. General Motors Assembly Division* (1976), Emma DeGraffenreid and four other Black women argued that they
were experiencing employment discrimination on the basis of their race and sex. Because General Motors employed White women as secretaries and Black men as factory workers, the court dismissed the case (*DeGraffenreid et al. v. General Motors Assembly Division*, 1976). This case inspired the development of a legal analytical framework that revealed the compounding harms experienced by people with multiple marginalized identities.

**Dynamism.** Fifth, Black feminist thought maintains a dynamic stance. This tenet acknowledges that Black feminist theories and practices evolve as Black women’s positionalities, successes, and struggles unfold across time and contexts. This evolution requires the inclusion of new and old voices and vantage points. Such inclusion must also foster self- and societal-critique as a means of holding Black feminism and the macro-culture simultaneously accountable (Collins, 2009)

**Social Justice Contexts.** Sixth, Black feminist thought situates itself within the context of other social justice projects. Collins (2009) highlighted Anna Cooper’s 1893 address to spotlight this point:

> We take our stand on the solidarity of humanity, the oneness of life, and the unnaturalness and injustice of all special favoritisms, whether of sex, race, country, or condition. . . . The colored woman feels that woman’s cause is one and universal; and that [...] not till race, color, sex, and condition are seen as accidents, and not the substance of life; not till then is woman’s lesson taught and woman’s cause won—[this is] the cause of every man and every woman who has writhed silently under a mighty wrong. (p. 46)
For Black feminist thinkers and activists like Collins, Cooper, Crenshaw, and King, social justice flourishes when humanity’s full dignities are recognized and safeguarded by the global community. Such commitments to dignity would likely reduce suicides related to historical and ongoing systemic anti-Black oppression.

These six aspects of Black feminist thought promote the ideas that identity-based forms of oppression are dynamic and multiple, and exist simultaneously across contexts (Collins, 2009, 2019). In so doing, this perspective illuminates the complex and unique vantage points Black female clinicians occupy as professionals who receive credentials from the dominant culture and as people marginalized because of their sex and race. Furthermore, Black feminist thought provides the conceptual tools to explore suicide in Black communities in new ways. For example, this perspective’s commitment to social justice helps reframe Black community suicide in terms of access to resources, equity, and human dignity, not mental illness. Such ideas, vantage points, and reframing have inspired and sharpened intersectionality as an analytical tool.

**Intersectionality**

Intersectionality examines how an individual’s identities create complex, nuanced, varying, and interlocking patterns of privilege and oppression across societal domains (Crenshaw, 1991). According to Murphy et al. (2009), “an intersectional perspective examines how two or more social constructions of oppression and/or privilege intersect to shape people’s social locations” (pp. 1–2). Furthermore, Collins (2019) characterized intersectionality as a type of analysis which claims that systems of race, social class, gender, sexuality, ethnicity, nation, and age form mutually constructing features of social organization. In practice, these social constructions and systems of
privilege and oppression manifest themselves in fluid personal, family, group, and community identities across all domains of socio-cultural organization (Moradi & Grzanka, 2017). To understand the interlocking nature of social identities and societal structures, the following pages outline several concepts central to intersectionality. Collins (2019) posited that six core constructs and corresponding premises constitute intersectionality as a paradigm, methodology, and practice.

**Relationality.** *Relationality* centrally emphasizes that systems of power are created, maintained, and perpetuated in relation to social positions and the constructed meanings of these relationships (Collins, 2019). For example, understanding the Black female experiences requires an awareness of the interrelationships among race, gender, other identities, contexts, and a particular experience. Such interrelationships affect Black female positionalities and shape the meanings they construct.

**Power.** *Power* refers to the ability to shape intersecting social relationships that produce divisive and reductionistic categories of experience (Collins, 2019). These discretely framed categories produce monolithic and oversimplified theories, research, and practice models. However, intersectionality reframes systems of power in terms of nuanced, mutually co-producing forces that affect people’s lived experiences in social hierarchies. As a result, analyses of power are crucial for understanding marginalized experiences like those of Black females.

**Social Inequality.** *Social inequality* is the condition whereby people experience limited access to important resources, services, and privileges on the basis of social constructions surrounding their identities. In framing inequality in terms of multiple identity interactions, “intersectionality points to the workings of power relations in producing
social inequalities and the social problems they engender” (Collins, 2019, p. 46). This concept provides an essential reframing of suicide in Black communities by emphasizing disproportionate societal deprivation over individual pathology.

**Social Context.** Social context foregrounds the importance of understanding the environments in which intersectional experiences are defined, lived, interrogated, understood, and/or erased (Collins, 2019). For example, suicides among Black people living in the United States occur in the contexts of intergenerational trauma, present-day institutional racism, un/under-employment, violence, and resource-deprived neighborhoods (Halloran, 2019; Jones-Eversley et al., 2020).

**Complexity.** Complexity acknowledges the reality that analyzing multiple and dynamic systems of power simultaneously across contexts necessitates a suite of analytic strategies (Collins, 2019). Such strategies—often interdisciplinary in nature—enable comprehensive and intricate analysis of multifactorial phenomenon like Black female clinicians’ critical understandings of suicides in Black communities.

**Social Justice:** Social justice as an intersectional construct elevates questions about theoretical, research, and practice ethics. Importantly, intersectionality centers the interplay between truth, justice, and power by highlighting the manufactured social processes that intentionally privilege some and unjustly disadvantage others (Collins, 2019).

In concert, these constructs constitute intersectionality’s four fundamental premises (Collins, 2019). First, systems of power are interdependent and mutually co-constructed. Second, intersecting power arrangements produce multiple and interconnected social inequalities. Third, the social locations of people and communities
within systems of power shape their experiences of and perspectives of self, others, and the social world at large. Fourth and finally, solving problems across multiple contexts requires an intersectional examination.

A lack of intersectionality-centered research persists in mainstream suicidology. Standley (2020) noted, “the neglect of intersecting social identities and a lack of focus on the extra-individual factors contributing to suicidality has resulted in a dearth of knowledge regarding the social and ecological factors impacting suicide” (p. 1). This neglect stems from suicidology’s emphasis on individual-level, quantifiable, psychological perspectives and interventions. This focus also aligns with suicidology’s preferred methodological orientation: positivism (Joiner et al., 2016). This research paradigm foregrounds statistical techniques that reduce the complexities of lived experience into aggregated results. Aggregation often results in the erasure of people’s nuanced and complex struggles. Specifically, aggregation eliminates the relational, cultural, and meaning-making contexts and dynamics that affect whether or not a person attempts suicide or dies by suicide (Bryan, 2021). Qualitative inquiry offers methodologies and methods that explore the unique and context-bound lived experiences of people affected by suicidality. The next section of this literature review examines quantitative and qualitative research germane to understanding suicide in Black communities.

**Quantitative Research Review**

Suicidology—influenced predominantly by empirical psychology—champions a positivistic point of view. Ponterotto (2005) characterized positivism as “a form of philosophical realism that adheres to the hypothetico-deductive method” (p. 128). This
tradition emphasizes the use of the scientific method to define concepts empirically and to develop explanatory and predictive theories related to a specific phenomenon.

Durkheim’s (1897/2006) classic multivariate statistical analysis established positivism as the dominant epistemology in the study of suicide (Selvin, 1958). Such dominance coincided with psychiatry and psychology’s desire to legitimize their disciplines as “sciences” (Marsh, 2010). This century-long focus manifests in contemporary suicidology’s views, theories, practices, and publications.

**Positivism and Contemporary Conceptualizations of Suicidology and Research**

In 2011, Joiner, as the editor-in-chief of the most prominent suicidology journal, *Suicide and Life-Threatening Behavior (SLTB)*, outlined the journal’s publication priorities. He argued that the set of editorial and publication standards that have yielded the best advances for science, scholarship, and humanity are “hypothesis testing with fair tests using valid and quantifiable metrics” (Joiner, 2011, p. 471). Joiner (2011) further clarified that, “by ‘valid and quantifiable metrics,’ I mean the accurate translation of complex phenomena into numbers, numbers then amenable to inferential statistical analysis, or, at the very least, descriptive statistical analysis” (p. 471). This view aligns with mainstream suicidology’s orthodoxy, which states that suicide is primarily an individual experience resulting from pathology.

Joiner, a former president of the American Association of Suicidology, and his colleagues clearly communicated their biases in their approach to conceptualizing and investigating suicide. Joiner et al. (2016) claimed, “[D]eath by suicide in humans is without exception a derangement” (p. 235). The authors further wrote that “this conceptualization views suicide as pathological—indeed an exemplar of
psychopathology—and thus our position offers no support for suicide itself as adaptive or as anything other than a pathological derangement involving (and producing) great misery” (Joiner et al., 2016, p. 235). This narrow view of suicide and suicide-related scholarship foregrounds quantitative research in academic publications.

Suicidology journals often promote experimental and multi-study inquiry projects. Hjelmeland (2016) conducted a descriptive analysis of the scholarship prioritized and published in the three leading suicidology journals, *SLBT*, *Crisis*, and *Archive of Suicide Research (ASR)*, between 2005 and 2012. The author cited that 45% of the scholarship published by the leading three journals were epidemiological studies. Another 41% of the published works were quantitative risk factor studies. After reviewing published studies between 2011 and 2012, Hjelmeland (2016) discovered that *SLTB* published two qualitative studies out of 110 total articles (1.8%). During the same time period, the author also revealed that the percentage of qualitative inquiry scholarship published by *ASR* and *Crisis* was low: 5% and 11%. These facts underscore that most suicidology studies emphasize five research types: risk factor, biological, psychological autopsy, randomized controlled trials, and epidemiological surveillance (Hjelmeland, 2016; Hjelmeland & Knizek, 2016, 2017). This quantitative research review examines each research type and concludes with an examination of empirical research related to Black female clinicians’ critical understandings of suicide in Black communities.

**Suicide Risk Factor Studies**

*Risk factors* refer to state or trait characteristics that increase an individual’s likelihood of experiencing a specific outcome. Glenn et al. (2017) noted, “Despite over five decades of research aimed at identifying risk factors for suicide, little progress has
been made in the field’s ability to understand, predict, or prevent suicide” (p. 65).

Multiple researchers have attributed this paucity of progress to two reasons (Franklin et al., 2017; Glenn et al., 2017; Glenn & Nock, 2014; Hjelmeland, 2016). First, for decades most risk factor research has examined or re-examined the same risk factors. Specifically, it has focused on the presence of mental health conditions, i.e., depression and/or related factors, such as hopelessness. These factors provide weak suicide behavior predictive power (Nock, 2009). Second, most risk factor research over the last 50 years has emphasized the cross-sectional analysis of risk factors instead of longitudinal investigations of actual risk factors that precede or predict future suicidal behavior (Franklin et al., 2017). Thus, new approaches are needed.

**Biological Research and Suicide**

New advances in behavioral cognitive-neuroscience, imagining technologies, and genomic understanding have led to suicidology’s *biologification* (Hjelmeland, 2013). Karthick and Barwa (2017) reviewed several biologically focused and empirically based suicide theories. These models include interest in the interplay between the brain’s serotonergic, noradrenergic, and dopaminergic systems and suicidality. Furthermore, Sokolowski et al. (2015) highlighted the proliferation of genetic and suicidal behavior research. Their analysis revealed that 212 gene symbols are associated with suicidal behaviors. According to Hjelmeland (2013), these biological studies have sparked concerning shifts. First, the author noted language shifts. For example, risk factors, biological or not, are increasingly referred to as “endophenotypes.” Second, the increasing emphasis on neuro-imaging research has spawned interest in the “suicidal brain.” Such a reframing shifts focus away from the person living with suicidality by
reducing their experiences to neural activity (or the lack thereof). Third, the increased *biologification* of suicide reinforces the belief that most (90%) of suicidal experiences are related to mental health disorders. This belief obscures the role of oppressive macrosystemic forces (i.e., poverty, discrimination, violence) by framing suicide as primarily a biomedical condition (Reynolds, 2016; White, 2017, 2020). Within this framework, medications and talk therapies that help people “cope with” or “accept” their realities become the standard suicide prevention methods (Hjelmeland, 2013; Tatz & Tatz, 2019).

**Psychological Autopsy Research**

In addition to empirical risk factor and biological research, mainstream suicidology uses psychological autopsy (PA) to make empirical claims. PA is a posthumous diagnostic process whereby trained clinicians typically interview immediate relatives (Hjelmeland et al., 2012). In the United States, PA consistently reveals that 90% of suicides are “a consequence of mental disorder” (Insel & Cuthbert, 2015, p. 499). This statistic has been repeated for decades by mainstream suicidology and media and has been widely accepted as universal fact (Garcia-Haro et al., 2020; Hjelmeland & Knizek, 2017; Pridmore, 2014). However, this statistic and PA have been challenged more recently. Garcia-Haro et al. (2020) noted that selection and confirmation biases affect PA. The authors noted that PA relies on “clinically” trained professionals who “seek to confirm three things: a history of mental disorder, previous attempts, and substance use” (p. 35). Thus, clinicians who use their biased professional judgments may overestimate the presence of mental illness. Furthermore, Hjelmeland and Knizek (2017) argued that PA violates the most basic diagnostic tenet: “it is indeed impossible to assign a valid
psychiatric diagnosis to someone by interviewing someone else” (p. 481). Finally, Pridmore (2014) critiqued the cross-cultural universality of the 90% statistic. He noted that research in both India and China (where 47% of the world’s suicides occur) suggested that mental illness was only a factor in 40% to 50% of deaths by suicide. As a result of these biases, procedural problems, and contradictory cross-cultural findings, empirical data derived from PA, and the treatment and policy decisions that emerge from PA research, need to be re-examined.

**Randomized Controlled Trials**

Randomized controlled trials (RCT) aim to test the efficacy of psychometric tools and treatments by randomly assigning two similar samples of people to either a control or an experimental group (Hjelmeland & Knizek, 2016). Differences between the groups are then measured to determine practical and statistical significances. If the experimental group outcomes meet or exceed significance standards, the experimental variable is deemed efficacious. In suicidology, suicide screening tools and protocolized interventions subjected to RCT procedures are considered the *gold standard*, or the most empirically valid and reliable. The Beck Scale for Suicide Ideation, the Suicide Ideation Questionnaire, the Suicide Probability Scale, and the Columbia Suicide Severity Rating Scale have been validated in repeated RCTs (Erford et al., 2018).

In terms of empirically supported interventions, three appear most frequently in the suicidology literature. First, Linehan’s (1993) Dialectical Behavior Therapy (DBT) addresses the complex cognitive, affective, behavioral, and relational dysregulations that frequently co-occur with suicidality. DBT’s efficacy depends on highly coordinated individual therapy, group skills training, brief between-session interventions, intensive
clinician consultation, and protocol fidelity. Second, Jobes’s (2016) Collaborative Assessment and Management of Suicidality (CAMS) provides an intervention framework that emphasizes a detailed cognitive-behavioral suicide assessment, a humanistic clinician stance, and clinician and client cooperation. Hanratty et al. (2019) acknowledged that, while “CAMS appears to show great promise in managing suicidal patients” (p. 559), the authors expressed concerns about correlational data support, and the lack of randomization in trials, checks of protocol adherence, and fidelity in CAMS-specific RCT studies. Third, Stanley and Brown’s (2012) Safety Planning Intervention (SPI) offers a brief, stand-alone intervention that consists of “a written, prioritized list of coping strategies and resources of support that a patient can use to alleviate a suicidal crisis” (p. 256). Stanley et al. (2018) found that SPI was associated with decreased suicidal behavior and increased mental health service engagement among emergency department patients with suicidality.

While these interventions offer suicide reduction benefits for people whose suicidality is related to individual psychopathology, none specifically address suicides related to macrosystemic oppression. This limitation likely reduces the real and perceived relevance of mainstream suicidology assessment and intervention among many Black communities. Moreover, the disconnections among assessment, interventions, and community realities negatively affect help-seeking behavior and access to care (Mitchell et al., 2020; Volpe et al., 2019; Walker, 2020). These facts likely influence Black community surveillance data because populations that do not access or use services often do not get counted.
Epidemiological Surveillance and Suicide in Black Communities

Surveillance is a systematic method of collecting, analyzing, and interpreting public health data (CDC, 2021). This method typically generates numerical data that describe incidence (new cases) and prevalence (existing cases) patterns related to diseases, behavioral health diagnoses, accidents, injuries, and types of death among populations. In the context of suicide in Black communities, Joe et al. (2006) addressed a significant gap in the literature: information about the lifetime suicidality prevalence among people who belong to Black communities. This research significantly highlighted suicide as a significant problem in Black communities. Furthermore, Joe et al. (2009) noted that suicidality among Black youth is especially problematic because nearly 50% of surveyed youths never met the criteria for a DSM diagnosis. Even more arresting, Bridge et al. (2018) found race-age disparities between Black and White children ages 5 to 11 years old: Black children die by suicide more than White children in this age cohort. Finally, several authors have underscored concerns about research related to suicide in Black communities: a lack of data (Spates, 2012) and the misinterpretation of data (Rockett et al., 2010; Wang et al., 2016).

Quantitative Research and Black Female Understandings of Black Community Suicides

An empirical review of the literature related to Black female clinicians’ critical understandings of suicide in Black communities poses challenges. Based on database searches there is no specific quantitative data regarding Black female clinicians’ experiences of suicide in Black communities. This lack of representation may be indicative of sexism, racism, and/or intersectional erasure in mainstream research
Furthermore, there is limited quantitative literature germane to understanding Black clinicians in general (Goode-Cross & Grim, 2016; Spates, 2012). Also, Griffin-Fennell and Williams (2006), Kirk (2009), and Spates (2012, 2019) all noted that Black female experiences with and perspectives on suicide are underrepresented in the research. Additionally, Spates’s (2011, 2019) review and analysis of the literature revealed that there are no theories that explain racial differences in suicide mortality rates to date. As a result, researchers interested in exploring suicide in Black communities must begin their investigation with theories developed to conceptualize non-Black experiences. This lack of community-specific theory likely threatens statistical validity, reliability, and generalizability. Moreover, dominant mainstream suicidology and Black communities’ beliefs about Black suicide further hinder empirical research. Lester and Yang (1998) noted that the American Association of Suicidology initially declined to focus on minority suicides. The Association contended that conference attendance for sessions focusing on minority suicides was low. Finally, Early (1992) and Kirk (2009) both noted that Black leaders and institutions reinforced the belief that suicide was a White problem. Regardless of reasons and framings, these facts expose significant gaps in the quantitative research literature.

While Black suicide experiences are broadly underrepresented in the academy, scholarly journals, and public policy, the literature reveals four ominous realities (Goode-Cross & Grim, 2016; Spates, 2011, 2012, 2019). First, Black suicide experiences unfold in violent racialized and gendered contexts (Halloran, 2019; Jones-Eversley et al., 2020; Spates et al., 2020). Second, within these violent contexts, new and historically significant patterns of intergenerational trauma manifest and perpetuate Black community
suffering (Halloran, 2019; Hooper et al., 2015; Spencer & Perlow, 2018). Third, deaths by suicide are claiming the lives of Black children and youth at increasingly younger ages (Bridge et al., 2018; Joe et al., 2009, 2018; Lindsey et al., 2017). Fourth, mainstream suicidology’s conceptualization of suicide likely obscures suicides and violence in Black communities. Reynolds (2016) argued that the dominant language related to suicide operates in four distinct ways: “1. Obscuring violence, 2. Hiding the victims to violence, 3. Obscuring the perpetrator’s responsibility, and 4. Blaming the victim” (p. 171). Given this framing, and the reality that Black communities experience historical and ongoing violence, deaths by suicide within such communities need to be re-interrogated. These realities must be understood, not simply described numerically, in order to address the continued social injustices, violence, and “deaths by suicide” experienced in Black communities.

Qualitative inquiry offers methodologies and methods that promote personal understanding and existential meaning-making. Such inquiry provides an opportunity to explore Black female clinicians’ critical understandings of suicide in Black communities. This exploration may unearth community-specific suicide prevention assessments, interventions, and public policies. The next section of this literature review explores the qualitative research relevant to comprehending Black female perspectives about suicide in Black communities.

**Qualitative Research Review**

While quantitative methodology emphasizes explanatory, linear, hypothetico-deductive, and biomedical approaches to suicidology, qualitative methodology foregrounds the nuanced and complex ways individuals make meaning of suicidality.
Such foregrounding recontextualizes suicide meaning-making in person-in-environment terms. For example, suicidality occurs simultaneously in the contexts of intrapsychic experiences, interpersonal dynamics, community locations, cultural milieus, power systems, physical environments, and historical time. Understanding these suicide and inter-contextual relationships requires methods designed to illuminate complexity (Hjelmeland & Knizek, 2016).

Rigorous qualitative inquiry can illuminate suicidality processes. Hjelmeland and Knizek (2016) reasoned that death by suicide is the result of an individual-specific, conscious, intentional, and purposeful act. The authors further noted that all intentional acts have meanings that are situated socio-culturally. Since the structure of meaning is not numerical in nature, but rather an interactive and dynamic process, qualitative methodology’s focus on in-depth, individualized and contextualized meaning-making offers important approaches to understanding suicide. These approaches are vital to understanding suicide in marginalized groups, such as Black American communities, because dominant cultural explanations have often been misapplied to oppressed peoples (Collins, 2009, 2019).

Black Clinicians’ Training and Professional Experiences

Goode-Cross’s (2011) work explored the relationships between Black therapists and Black mental health trainees. This research highlighted relational and supervisory themes. Relationally, participants reported playing multiple roles in Black trainees’ lives: clinical supervisor, professional mentor, role model, and personal confidant. Furthermore, participants shared that those supervisory relationships often evolved into long-term friendships and collegial relationships. In terms of supervision differences, the author
noted that participants were more likely to have more explicit, nuanced, and deeper conversations with Black trainees about racism in clinical practice and work settings. This experience was attributed to increased feelings of mutual safety based on shared racial identities. Such experiences are likely complicated when Black clinicians work in predominantly White environments.

Jones (2020) used a voice-centered approach to investigate the experiences of nine Black clinicians working in predominantly White mental settings. He found three themes that significantly shaped his participants’ attitudes, feelings, and behaviors at work. The scholar noted that Black clinicians in the numerical minority often described feeling unique pressures to speak for or represent their entire racial group. Moreover, his participants revealed a *dueling consciousness* (Kendi, 2019), which emerged when they vacillated between intentionally using and rejecting racist-sexist language or behavior. Finally, Jones found that the Black clinicians in his study experienced *role encapsulation*. This phenomenon occurred only when his female participants were asked to fulfill roles without their consent. Examples included being a “Black cultural informant, expert, nurturer, and/or antiracist advocate” (Jones, 2020, p. 72). Such experiences may be mitigated somewhat when Black clinicians work with Black clients.

**Black Clinicians’ Professional Experiences with Black Clients**

Building on his Black therapist and Black trainee research, Goode-Cross and Grim (2016) examined Black clinician experiences of working with Black clients. Participants reported increased solidarity with clients because the participants’ and clients’ lived experiences frequently mirrored one another. Additionally, the participants revealed that therapeutic rapport with Black clients occurred faster and felt deeper than
with clients who had different racial identities. Also, the therapists interviewed for this study shared that they experienced a deeper commitment to their Black clients’ wellbeing. This commitment manifested in therapist-participants choosing to play atypical therapeutic roles. For example, a male therapist decided to share lunch with a male client who needed to be emotionally and nutritionally fed. Finally, the research participants also acknowledged the perils of working with racially similar clients such as over-identification, dual relationship challenges, and feeling a heightened need to use self-disclosure with clients. The perils and benefits associated with clinician and client identities probably influences the complexities related to client suicidality. This complexity often involves clinician power and client self-determination.

**Clinicians’ Experiences of Client Suicidality**

Levy et al.’s (2019) exploration of therapists’ experiences working with clients who were living with suicidal ideation revealed three common themes: self-of-the-therapist issues, issues relating to power, and issues relating to treatment. The first theme involved the “internal processes of the therapist” (Levy et al., 2019, p. 6). Such processes included a need for supervision to cope with client suicidality, identifying and managing anxiety about client death by suicide and being sued, and the essential need for ongoing self-care. The authors’ examination of therapist power exposed the realization that calling emergency responders, especially the police, was often experienced as an overuse and/or an abuse of power. However, the participants in this project also noted that power, when intentionally shared, often strengthened their relationships with the clients and evoked client self-empowerment. Finally, this study highlighted several potentially useful clinical strategies that seemed to bolster treatment outcomes with clients who were experiencing
suicidality: using direct and clear language about suicide, validating client struggles associated with suicidality, and including family as much as the client would permit. This investigation of therapists’ experiences of client suicides, which did not include participant racial identity information, underscores a dilemma that Black female clinicians may face as a result of their understandings of suicide in Black communities. The dilemma is whether to provide a professional standard of care that involves institutions that have harmed—and continue to harm—Black communities, i.e., police departments and hospitals, or to attempt to manage severe suicidality at a lower level of care and risk malpractice. Such dilemmas highlight the intersections of suicide, social injustices, Black communities’ help-seeking norms, Black female clinicians’ roles, and culture.

**Culture, Agency, and Suicide**

Broz and Münster (2015) edited a compilation of cross-cultural, suicide-specific investigations. The main through-line of the included works challenged Western ideas about the relationship between an agentic self and suicide. For example, Staples’s (2015) exploration of suicide in southern Indian revealed an Ayurvedic understanding of self as a vast, open, and continuous landscape as opposed to a “sealed container” (p. 28). He wrote, “If this is so, might the responsibility for suicide attempts be located not solely within the individuals who attempt it, but more broadly within the nexus of relationships they might have with other people and other things” (Staples, 2015, p. 28). This conceptualization questions suicidology’s orthodoxy about the relationship between a self and suicide.
Suicidology’s central claim about the self and suicide creates an ontological tension. Münster and Broz (2015) argued that mainstream suicidology relies on a specific notion of agency and subjectivity by defining “the object of study—suicide as intentional, agentive action” (p. 5). This framing differentiates suicide from “normal” causes of death. They further underscored that suicidology simultaneously denies free will and agency by attributing suicide to factors outside of one’s control, such as depression, gender, sexual orientations, or global financial crises. The authors concluded, “This tension of agency, the simultaneous reliance on and denial of agency, sometimes comes with the dismissal of situated political and cultural meanings of self-destructive acts in suicidology” (Münster & Broz, 2015, p. 5). This tension parallels the historical and present-day experiences of Black communities. On the one hand, society conveniently attributes agency to Black people when it comes to living in poverty. On the other hand, White dominant culture has created—and continues to create—public policies that constrain and deprive Black communities of their personhood and dignity (Alexander, 2020; Kendi, 2016, 2019; McGhee, 2021). This reality raises the question of whether “deaths by suicide” in Black communities ought to be called suicides at all. In the contexts of ongoing racialized violence and assaults on Black individuals’ and communities’ agency, the word suicide ought to be surrounded by quotation marks in an effort to challenge cultural narratives about its meaning and its causes. These narratives are further complicated by Black community perspectives about suicide.

**Black Community Understandings of Suicide**

Black communities, like all cohorts, represent a range of cultures that espouse a variety of diverse beliefs about suicide. Nevertheless, important themes exist that
contribute to critically understanding suicide in Black communities. Lincoln (1974) argued that the Black church is a crucially important historical, social, and spiritual institution in the lives of Black people:

The Church is the spiritual face of the Black community, and whether one is a “church member” or not is beside the point in any assessment of the importance and meaning of the Black Church. Because of the peculiar nature of the Black experience and the centrality of institutionalized religion in the development of that experience, the time was when the personal dignity of the Black individual was communicated almost entirely through his church affiliation. The Black Church, then, is in some sense a “universal church,” claiming and representing all Blacks out of a long tradition that looks back to the time when there was only the Black Church to bear witness to “who” or “what” a man was as he stood at the bar of his community. The Church still accepts a broad-gauge responsibility for the Black community inside and outside its formal communion. “The Church” is still in an important sense “the people,” and the Church leaders are still the people’s representatives. (p. 116)

The church’s centrality in Black lived experience probably shapes Black perspectives about suicide. Early and Akers (1993) interviewed 30 pastors about their views of suicide in Black communities. Their interviews revealed that suicide is viewed as “an unpardonable sin. . . that runs counter to the [B]lack soul” (p. 284). The pastors reportedly reasoned that human life and the Black soul are gifts from God that can only be taken by Him. The implication is that to die by suicide is not to be Black. In fact, one of the interviewed pastors in this study remarked, “suicide is a [W]hite thing” (Early &
Akers, 1993, p. 287). In espousing such beliefs, some Black people likely think twice about the costs and benefits of dying by suicide. For, others they may experience profound shame about the meanings of their suicidality and essential identities. In these instances, suicide may feel like the only option to escape these feelings. Such powerful and complex relationships among religious beliefs, shame, and suicide shape Black suicide bereavement experiences.

Sharpe et al. (2012) examined the suicide bereavement experiences of eight Black families. Their research found that research participants experienced a range of grief reactions including shock, rage, and numbness. While participants also acknowledged the importance of church and spiritual support, many of the families interviewed expressed reluctance to reach out for such support because of the church’s views. Taylor et al. (2004) found that shame and stigma often negatively influenced suicide survivors’ access to family and church supports. These findings underscore the fact that two of the most important forms of Black community coping, church and family, may be inaccessible to suicide bereaved survivors. Such limited support resources may have even more dire implications for the most suicide-vulnerable group in Black communities—Black youths.

Molock et al. (2007) explored the suicidality and help-seeking attitudes among 42 African American youth between the ages of 12 and 18. They found that their youth participants attributed suicidality to being humiliated, to avoid stress or humiliation, and to significant losses. The youth also reported that they felt that suicidality was “wrong... and manipulative cries for help” (Molock et al., 2007, p. 59). Moreover, the investigators observed that despite being exposed to suicidal peers, most participants minimized the hopelessness and helplessness associated with suicide, and therefore wouldn’t offer help
or seek help. The researchers speculated that this behavior may be attributed to typical adolescent “bravado” to protect one’s self from discomfort, or it may reflect general Black cultural attitudes about mental health seeking. Such attitudes and beliefs may also highlight the complexities of strength narratives in Black communities.

Black community lived, told, remembered, and retold stories about suicide emphasize the complex meaning-making processes that likely shape Black female clinician understandings of suicide in Black communities. For example, Spates (2019) observed that while suicide rates among Black youths have increased significantly over the last 30 years, religious beliefs about suicide as a sin, socio-historical views about strength, and racialized perspectives about suicide as a White problem remain pervasive within Black communities. These narratives probably intersect with Black women’s marginalized identities and contribute to their unique perspectives.

Black Women’s Experiences of Intersectional Oppression

Spates et al. (2020) explored Black female experiences of intersectional oppression. The researchers conducted in-depth interviews with 22 self-identified Black women between the ages of 18 and 69. Their research investigated participants’ experiences with gendered racism—the experience of compounded oppression based on marginalized female and Black identities. The authors’ analysis generated three themes: navigating societal expectations of being Black and female, navigating relationships (or the lack thereof), and navigating the lack of resources and limited opportunities. In regard to the first theme, the participants expressed feeling stressed by the need to maintain a double consciousness in public spaces. This double consciousness was described as a mask that required vigilance to maintain. Furthermore, the Black female participants
discussed the relational toll of having to play multiple roles in their families. One participant remarked, “The Black man believes that as a Black woman, our job is to cook, clean, have the kids, take care of the kids, and help him bring home the bacon” (Spates et al., 2020, p. 595). Finally, such expectations seemed more challenging because many Black women lack resources and opportunities. The women in this study shared that the resource they lacked most was time: time to get an education, time to go to the doctor, and time to meet family and community expectations. These insights emphasize the significant and unique challenges Black women face. Many of these challenges, like depression and SBW, also contribute to suicide risk in Black communities.

**Black Women, Depression, and the Strong Black Woman Construct**

Beauboeuf-Lafontant’s (2008) voice-centered analysis advanced knowledge about the intersections of race, gender, silence, selflessness, and strength among Black women. The researcher interviewed 58 participants with the goal of exploring depression and SBW relationships. Beauboeuf-Lafontant’s investigation unearthed shifts between *accommodating, muted critique,* and *acknowledged vulnerability* voices. The voice of accommodation “emanates from the socialization of girls who learn, as one woman described, to ‘pick up strength’” (Beauboeuf-Lafontant, 2008, p. 399). The author’s participants shared accounts of watching mothers and other respected women keep their needs, desires, and emotions out of public view. Simultaneously, the Black women in this study revealed a voice—*muted critique*—that revealed a psychological gap between the external performances of strength and inner experiences of emotional complexity. The participants described strategies like eating, shopping, and drinking to fill this space. Finally, for 7 of the 58 participants, a third co-occurring voice of *acknowledged*
vulnerability allowed these women to express themselves openly. Uniquely, according to the researcher, “this voice rarely speaks in the comfortable anonymity of ‘we,’ and instead forwards a decidedly experience-based ‘I’ vantage point” (Beauboeuf-Lafontant, 2008, p. 402). Such co-existing voices highlight the dynamic and concurrent multiplicities and complexities embedded in lived and told narratives. These stories likely offer Black women’s insights about suicide in Black communities.

**Black Women’s Perspectives About Suicide**

Borum (2014) explored the perceived socio-cultural determinants of suicide in African Americans among 40 Black women. The participants described three categories of suicide-contributing factors: racism, discrimination, and stereotyping; U.S. individualism, integration and assimilation issues, and the prison industrial complex. For the first category, the Black women commented on the chronic toll of racist interpersonal exchanges and mass media’s negative stereotyping of Black people on television and in news reports. According to the participants, these widespread racist interactions and messages create pervasive anxiety and stress. Suicide provides a permanent way to address these feelings. Furthermore, Borum’s research participants noted that the U.S. was not created for African Americans nor does it reflect their traditional collective values. Additionally, the Black women in this study related the “watering down of our culture and wanting to assimilate to the masses, the European culture” (Borum, 2014, p. 664) with suicidality. They reasoned that in order to be successful in the White U.S. dominant culture, Black people must accept White values and attitudes. From their vantage point, the cost of compromising one’s identity creates overwhelming feelings of loss that they believed contributes to suicide. Finally, the participants in this study shared
that mass incarceration of Black men has instilled a fatalistic belief (and statistical reality) in many Black men, and that suicide may be the only way to escape such hopelessness. These findings suggest that a number of systemic challenges influence Black women’s understandings about suicide in Black communities.

The relationships between Black female challenges and suicidality were explored by Spates in 2015. The researcher conducted semi-structured interviews with 32 women who self-identified with the African American racial group, and an additional respondent who self-identified as “other” due to her Creole/African heritage (n=33). Thematic analysis revealed that strong intergenerational ties to faith groups help Black communities reframe their specific struggles within historical and collective contexts. This reframing likely reduces the isolation and alienation associated with suicide. Furthermore, the author discovered that her participants attributed low suicide rates among Black women to their shared sense of mutual and community responsibility. The author’s participants speculated that these close social ties likely emerged as a survival strategy for enslaved Black women who were trying to protect their families. Finally, Spates’s (2015) interviews highlighted the belief that enduring hardships promote strength. Within this cultural context, strength is needed to protect both family and community. Without it, neither would not survive. Thus, strength and responsibility—bolstered by faith and social support—are often experienced as protective factors. Paradoxically, these same protective factors may also limit conversations about suicide in Black communities.

Spates’s (2019) examination of Black female experiences of discussing suicide within their communities illuminated important concepts that shape such conversations.
The author’s semi-structured interviews with 22 Black women revealed that participants viewed suicide as “an outlandish act,” “off-limits,” and “too heavy.” These themes underscore the prevalence of stigmatized beliefs about suicide in Black communities. Such beliefs—reinforced by religious values and cultural narratives about suicide as a White problem—pose significant challenges to suicide prevention efforts. These views and beliefs co-occurred with the fact that 45% of the participants described “close encounters” with friends, family members, or acquaintances who displayed suicidality at some point in their lifetimes. Such parallel realities—avoiding discussions of suicide while simultaneously knowing someone who is contemplating suicide—highlight the complex and multiple ways narratives can contribute to suicide-related alienation and shame.

Qualitative inquiry projects related to Black female understandings of suicide have advanced social science understandings about the intersections of race, gender, sex, class, culture, and suicide. Spates’s (2011, 2015) analyses revealed a suicide paradox specific to Black women: African American women disproportionately experience suicide risk factors, yet historically experience the lowest suicide mortality rates of any race-sex cohort in the United States. This empirical fact—when interrogated with critical and qualitative analytical tools—reveals complex interrelationships among multiple and ongoing forms of oppression, intergenerational trauma, and perpetual violence. When viewed through critical lenses and understood from a systemic perspective, suicide’s cultural, political, historical, economic, and philosophical meanings and contexts are revealed. These must be foregrounded and incorporated into mainstream suicidology if the field is genuinely committed to preventing deaths by suicide in Black communities.
Conclusion

This literature review has established that suicide is a complex and multi-faceted phenomenon that uniquely threatens the lives of Black people. Such multifaceted complexity results from a confluence of upstream-downstream dynamics. White, Euro-centric, male, and Christian institutions of exploration, exploitation, and enslavement established hierarchical social structures to codify privilege for White people and oppression for enslaved Africans and Black Americans: White supremacy. This historical, political, social, and economic arrangement produced power-over dynamics that have generated legacies of violence, despair, and shame. Such horrific racialized privilege and power sparked ongoing patterns of intergenerational traumas. The dire consequences of these intergenerational struggles are revealed in Black community narratives, social action movements, scholarship, and population-based epidemiological data. Furthermore, these sources underscore Black community exposure to multi-systemic suicide risk factors such as poverty, un/under-employment, discrimination, limited access to healthcare, and police brutality. Moreover, mainstream suicidology obscures such systemic forces by conceptualizing suicide in individual, biomedical, and decontextualized terms. This conceptualization is reinforced through positivistic and empirical research that reduces suicide’s complexity by aggregating experiences and describing linear relationships.

This confluence of factors results in insidious systems of despair that create, maintain, and perpetuate intricate patterns of violence, trauma, oppression, shame, hopelessness, resistance, and persistence. To better understand suicide in Black communities, this literature review proposes that we explore Black female clinicians’
perspectives. This research aims to amplify these underrepresented voices. They are situated at the intersections of mainstream suicidology training and racialized and gendered lived experiences. Straddling both dominant culture and marginalized communities offer crucial vantage points needed to improve community-specific suicide prevention, assessments, interventions, and public policies. An important way to understand the complex meanings of multiple and simultaneous vantage points involves listening to and understanding people’s narratives. Narrative inquiry and the Listening Guide voice-centered approach provide the methodological tools for understanding the multiple consonant, dissonant, and independent voices embedded in both dominant culture and Black community suicide narratives (Gilligan, 2015; Gilligan & Eddy, 2021; Tolman & Head, 2021). Such voices may strengthen the claim: Black deaths matter.
CHAPTER 3

Methodology

Exploring Black female clinicians’ critical understandings of suicide in Black communities necessitates a methodology that foregrounds complex and layered psychological meanings. Because such complex psychological meaning-making frequently takes the form of stories, narrative inquiry provides the overarching methodological framework for this project. Narrative inquiry highlights the human tendency to organize lived experiences into stories. Stories are detailed and sequenced accounts of events that unfold and change over time (Kim, 2016). These accounts use internal dialogue and expressed language to make iterative meanings. Narrative meaning-making provides opportunities to understand self, others, the world, cause and effect relationships, and systemic interconnections across temporal, physical, social, and intrapsychic contexts (Clandinin & Connelly, 2000). Such context-specific understandings often manifest as complex, layered, and poly-vocalized narratives about the same lived experience. Among marginalized groups, like Black communities, their perspectives and stories are further influenced by historical and ongoing social change efforts.

Issues of power, privilege, oppression, and empowerment often shape contextual dynamics and narratives. As Bloomberg and Volpe (2019) wrote,

Storytellers can empower others to tell their stories. Testimonios narrated by those who are marginalized or exploited and who lack social and political power can mobilize individuals and even communities against perceived social injustice, repression, and violence. Telling the stories of marginalized people can help
create a public space requiring others to hear what they might not want to
acknowledge or hear. (p. 58)
As a result of its ability to highlight the transformative power of stories, narrative inquiry
can foster individual and macrosystemic change. Such change is only possible if
storytellers critically reflect on their positionality and intentionally center the interests of
marginalized communities. These critical actions support efforts to forge mutually
beneficial relationships and reduce the likelihood of reproducing harms associated with
telling others’ stories, i.e., misrepresentation.

Human relationships are essential to narrative inquiry’s potential to promote
social change. Stories connect tellers and listeners. The processes of telling, listening, and
dialoging facilitate dialogic knowledge creation. Such knowledge includes mutually
created holistic (an over-arching theory) and categorical (thematic) content (Cherry,
2021). To better understand participants’ subjective vantage points and relational
processes, I developed I poems—a feature of the Listening Guide (LG) method. This
understanding enhanced my ability to analyze participants critical perspectives about
suicide in Black communities: perspectives emerge from complex and nuanced vantage
points shaped by lived experiences (Collins, 2009).

The Listening Guide (LG) voice-centered approach specifically attunes to the
multiple, layered, and complex voices embedded in stories (Gilligan, 2015; Gilligan &
Eddy, 2017, 2021; Gilligan et al., 2003; Tolman & Head, 2021). This method aligns well
with an exploration of Black female clinicians’ perspectives about suicide in Black
communities. First, suicide is a complex and culturally taboo subject that often evokes
myriad understandings simultaneously. Second, suicide in Black communities occurs in
traumatic, violent, and oppressive contexts that deeply affect all members of Black communities. Such effects were embedded in the narrative voices of research participants (Cruz, 2021). Third, LG emerged as a way to relationally understand the emotionally potent contexts embedded in peoples’ stories (Kiegelmann, 2021). Finally, to highlight the importance of relational connection, Gilligan (2015) noted LG’s emphasis on creating and maintaining relationships between participant content and humanity as a whole:

As qualitative researchers with an interest in people’s stories, we have a responsibility to create the conditions in which people can safely tell their stories to someone who is listening and who can be trusted to bring their voices into conversations about human experience. (p. 75)

Thus, narrative inquiry and LG privilege meaning-making processes that emerge from voices supported by trusting relationships between participants and researchers. These relational frameworks and processes guided my exploration of Black female clinicians’ lived experiences and their critical consciousness development. This relational exploration enabled me to better attune to the interrelationships among participants’ intrapsychic experiences, oppressive macrosystemic observations, and critical perspectives about suicide in their communities.

This chapter details the methodology and research design used to explore this study’s central research question: How is suicide in Black communities critically understood by Black female clinicians? I begin the chapter with a description of the epistemological framework that guided this study. Next, I offer a positionality and reflexivity statement. Additionally, I provide a description of the project’s sampling strategy. Then, I review data generation procedures and articulate the data analysis
methods. Subsequently, I examine the validity strategies and considerations for this project. After that examination, I discuss ethical and social justice considerations of this study. Finally, I summarize the methodology and research design chapter and briefly preview Chapter 4.

**Epistemological Framework**

My epistemological stance for this inquiry project drew from critical theories. According to Ponterotto (2005), “in critical theory, the relationship between researcher and participant is transactional and subjective; the relationship is also dialectic in nature, with the goal of inciting transformation in the participants that leads to group empowerment and emancipation from oppression” (p. 131). Such relationships and goals emerge from particular epistemological assumptions. Carspecken (1996) noted that criticalists believe socially and historically created power relations affect all forms of knowing, and that facts, truth claims, and researcher values interrelate. Finally, criticalists maintain that the confluence of power, values, and ideas about truth influence representations of knowing, such as thoughts, feelings, and behaviors (Carspecken, 1996). These epistemological stances supported my exploration of Black female clinicians’ critical understandings of suicide in Black communities. This project emphasized co-constructed interviews that examined Black female clinicians’ lived experiences and perspectives. Because these experiences are embedded in at least two oppressive power relationships—racism and sexism—critical paradigms offered the necessary analytical tools to reveal connections between Black female clinicians’ lived experiences and their understandings of suicide in Black communities. For example, intersectionality highlighted the compounding effects of racism, sexism, classism,
colonialism, and xenophobia in participants’ narratives about their lived experiences, critical consciousness development, and perspectives about suicide in Black communities. Furthermore, critical epistemology highlighted the unique relational and power dynamics between participants and me. Specifically, I am a White, gay, cisgender man who interviewed Black females. Such positionalities required attunement to the lines of unearned power that existed between participants and me. To address this issue, I candidly described my positionality in research recruitment materials, explicitly centered Black female scholarship throughout this project, and amplified Black female clinician participants voices through narrative summaries detailed in Chapter 4. Finally, I assembled a dissertation committee comprised of women from different gendered, racialized, and professional experiences. This decision reflected my intention to remain critically aware of my epistemology, reflexivity, and positionality.

**Reflexivity and Positionality**

As a White cisgender male, I have predominantly experienced unearned social, economic, and educational privileges across societal contexts. Also, as a person who self-identifies as gay, I have experienced moments of interpersonal homophobia, as well as the ongoing threats created by anti-gay policies in the United States and abroad. These co-existing experiences of privilege and marginalization sensitize me to the intersectional dynamics that often unfold between dominant culture and marginalized groups. Such heightened awareness of this complexity, coupled with a shared professional identity and commitment to continued critical consciousness, enhanced the researcher-participant relationship. For example, several participants communicated to me directly that I was “easy to open up to.” Concurrently, my White, gay, cisgender male identities posed
outsider challenges. The first prospective participant I interviewed remarked, “Ugh, I really want to participate in this study, but why do you have to be the one to do it.” Beals et al. (2020) discussed the tensions and liminal spaces between insider and outsider statuses. The authors concluded that qualitative researchers ought to consider being edgewalkers—people who embrace “the complexity of culture and identity to walk the edge between multiple worlds and positions” (Beals et al., 2020, p. 597). This stance requires ongoing, vigilant, and honest self-reflection. I took long walks with a tape recorder and spoke into it about my thoughts, feelings, and behaviors related to academic reading, dissertation writing, and interviewing participants. I then transcribed and read the transcripts. As I read, I asked myself a series of questions: Whose stories are embedded in this research journal? Which parts of my identities are dominant and/or on the periphery? How are the stories related to this project? This form of research journaling helped me manage my positionality throughout this research process.

In addition to my positionality as a White, gay, cisgender male, I am a social work educator, cancer survivor, and clinician. These identities have influenced my interest in suicide, and more specifically suicide in Black communities. I became aware of these influences gradually. Each identity and its significance are presented in the order in which I became conscious of it.

As a social work educator, the most frequent anxiety my students have expressed over the last 15 years pertains to client suicidality. This anxiety typically results from fears about potential legal liability, clinical incompetence, and death in general. I am particularly attuned to my students’ death anxieties because of my own cancer-related fears. The persistence of such student anxiety motivated me to explore the subject more
closely by pursuing a doctorate in counseling and psychology. It was in pursuit of my
doctorate—coupled with an exploration of my narrative identities—that led to my interest
in suicide in Black communities.

During a series of reflective writing assignments in doctoral education, I closely
examined my experience in a bone marrow transplant intensive care unit. I described
watching a young, Black combat veteran die from cancer related to his Gulf War service.
The emotional intensity of that experience re-emerged after listening to a 2019 NPR
broadcast about suicide among Black youth. In that moment, I began thinking about the
combat veteran’s death and suicide among Black youth in terms of Black communities’
experiences with violent forms of oppression and death. This realization compelled me to
think about Black cohorts who might possess fresh insights about suicide in Black
communities. Through reading and conducting two pilot projects with Black counseling
graduate students, I learned that Black female clinicians offer a unique and
underrepresented vantage point: many of them have experienced multiple forms of
oppression and have acquired the clinical training endorsed by mainstream suicidology.
Such vantage points were further illuminated by the Black female clinicians who
participated in this dissertation research project.

Throughout the research interview and data analysis processes, reflection and
journaling unearthed an early clinical practice connection to this research. In the mid-
1990s, I worked as an outreach social worker for the Northwest AIDS Foundation. In that
role, I provided safer sex counseling, social service referrals, and harm reduction kits to
mostly Black and Hispanic male sex workers. Several of the conversations I had with
men included “death by bug chasing”—intentionally becoming infected with HIV to
reduce existential uncertainty. These conversations formally sparked my professional interest in health, identities, and death intersections, and compelled me to earn a graduate degree in social work.

**Sampling Strategy**

This project used a *purposive sampling* strategy. According to Zhao et al. (2021), “With purposive sampling strategies, researchers handpick subjects to participate in the study based on identified issues being examined” (p. 249). This sampling strategy enabled me to recruit participants with unique and specific experiences: Black female clinicians. Using this strategy, I recruited 14 participants who met the inclusion criteria for this study. To recruit participants, I outreached to doctoral program faculty and student cohorts, LinkedIn contacts, Black professional groups, National Association for Social Workers (NASW) members via discussion boards, American Association of Suicidology members via the member listserv, and clinicians listed in the Psychology Today Therapist Directory. A standardized recruitment letter (Appendix A) was used on each internet platform. All enrolled participants learned about the study from either internet-based recruitment efforts or through *snowball sampling*, which occurred spontaneously without solicitation on my part. This strategy entailed recruiting new participants through current participant social and professional networks (Zhao et al., 2021).

Additionally, participant recruitment materials included a flyer describing the study (Appendix A) and listing my contact information. I contacted the prospective participants for a brief screening interview (Appendix B). Then, the screened participants were sent their compensation and a SurveyMonkey link. The link led to an informed
consent form followed by a socio-demographic questionnaire. Once the consent form and questionnaire were completed, I followed-up with the participants to answer questions, address concerns, and/or schedule a 60- to 90-minute semi-structured interview. After the interview was scheduled, a copy of the semi-structured interview questions and signed consent forms were sent to the participants. This decision was intended to foster transparency, reduce participant anxiety about the interview, and bolster the qualitative validity of participant responses by giving them time to reflect on the interview questions. Such efforts may also help address the cultural mistrust created by White researcher’s legacies of exploiting research participants with marginalized identities.

**Participant Selection Criteria**

Fourteen participants for this study met these five criteria:

1. Self-identify as Black or African American
2. Self-identify as female, transwoman, woman, and/or womyn
3. Be a fully licensed mental health clinician who is currently working as a clinician
4. Have personal or professional experience with a member of the Black community who experienced suicidal ideation, a suicide attempt, or a death by suicide
5. Live and practice in the United States

Since more than 12 people expressed interest in this project, preference was given to participants with multiple marginalized identities, participants who worked with multiply marginalized client populations, and/or participants who practiced in underrepresented geographical locations. These inclusion criteria aligned with the critical orientation of this
project, as well as the central aim: to amplify under-recognized perspectives.

Additionally, one prospective participant elected not to participate in this project because she expressed concerns about my positionality. She and I spoke for an hour in an attempt to address her concerns. While she expressed an appreciation of our conversation, she declined to participate. Furthermore, another participant was excluded because she was still a social work student and therefore did not meet the inclusion criteria. Finally, six prospective participants contacted me after data analysis began and so were not included. I contacted each person, thanked them for their interest, and gained permission to contact them again if and when future research opportunities arise.

Data Generation

Data generation connected to my epistemology and this study’s methodology and method. This process began with two pilot studies. Those projects refined both the research question and scope of inquiry for this dissertation research study. Then, I developed a recruitment flyer that explicated my positionality, research question, and goals. The intent of this transparency was to begin to establish my trustworthiness from the outset. Next, the brief telephone or Zoom screening interview was designed to determine the fitness between the participants’ experiences and this project. The screening interview also provided an opportunity to address questions and concerns. This opportunity further built trust and deepened rapport. Both are essential in critically-oriented, voice-centered research.

Once the screening interview and informed consent form were completed, I used a socio-demographic questionnaire (Appendix D) and semi-structured interview protocol (Appendices E [participant version] & F [researcher version with follow-up questions
The 19-item questionnaire was designed to accurately represent participants’ socio-demographic identities using their own language, not pre-determined categories. This focus on participant representation was important because, from a critical vantage point, Black research participants are frequently misrepresented by White researchers. This misrepresentation often leads to experiential erasure. Moreover, accurate descriptions of participants’ identities enhanced my ability to track intersectional privilege and marginalization dynamics embedded in each narrative. Furthermore, this project used a 60- to 90-minute semi-structured interview protocol in which participants chose the names that would represent them in this project. A semi-structured interview protocol enabled me to both focus the scope of inquiry and pursue spontaneous follow-up questions. This project’s protocol included non-leading, open-ended questions that invited participants to elaborate on the layers of meaning embedded in their experiences and perspectives. These meanings were further illuminated through follow-up questions. These questions highlighted connections between participants and the systems in which their experiences with and understandings of suicide in Black communities were situated. Finally, the interviews occurred via the Zoom teleconferencing platform due to the challenges of in-person interviews created by the COVID-19 pandemic. All interviews were video- and audio-recorded and then transcribed for analysis using the Rev.com transcription service.

**Data Analysis**

LG offers an approach to hearing, understanding, and representing multiple voices embedded in texts. LG is a feminist qualitative research method of psychosocial analysis that emphasizes inter-actions among voice, relationships, resonance patterns, material
contexts, social environments, and cultural milieus (Gilligan, 2015; Sorsoli & Tolman, 2008; Tolman & Head, 2021). Gilligan et al. (2003) wrote,

Thus, each person’s voice is distinct—a footprint of the psyche, bearing the marks of the body, of that person’s history, of culture in the form of language, and the myriad ways in which human society and history shape the voice and thus leave their imprints on the human soul. (p. 157)

To better understand the significance of voice, LG involves a series of at least three sequential listenings. Each listening is designed to connect the researcher more deeply to the multi-layered experiences of the participant. These steps typically include first listening for plot, then for first-person narrative voices, and finally contrapuntal voices—the multiple, simultaneous, and dynamic voices embedded in human speech or writing that create complex and unique patterns of meaning, and that are understood in the contexts of a researcher’s questions (Gilligan, 2015). In listening for the first-person narrative voices, each instance of “I” and its corresponding verb (and sometimes direct object) are highlighted and re-written sequentially on separate lines to form I poems. Gilligan et al. (2003) remarked upon this process:

Cutting the text close and focusing in on just the I pronoun, the associated verb and few other words moves this aspect of subjectivity to the foreground, providing the listener with the opportunity to attend just to the sounds, rhythms, and shifts in this person’s usages of “I” in [their] narratives. (p. 163)

The “I” poem’s structure highlights the contrapuntal voices that create unique understandings of self, others, and experiences. For this project, I tracked participants’ voices using I poems only as a means to better understand the complex and nuanced lived
experiences from which their critical understandings emerged. Due to this emphasis, I did not include an entire contrapuntal analysis.

LG provides innovative analytical tools to understand Black female clinicians’ unique understandings of suicide in Black communities. Beauboeuf-Lafontant (2008) wrote, “Voice-centered scholarship examines the interplay of societal representations of gender with the actual experiences of individuals” (p. 395). This project’s emphasis on Black female clinicians’ critical understandings foregrounds the interplay among dominant culture constructions of race and gender, and their clinical training, lived experiences, and critical consciousness development. Such interplay manifested in varied and co-existing vantage points expressed through language. Furthermore, voice-focused inquiry creates the relational context in which subjugated knowledge (Collins, 2009) about a taboo topic like suicide can be discussed. Participants voiced insights about the intersectional forces that contribute to suicide in Black communities. For example, many Black female clinicians discussed gender, race, class, colonialism, intergenerational trauma, shame, and suicide intersections. Moreover, in voice-centered research focused on marginalized communities, relationships between dominant narratives and individual experiences often reveal poignant reflections about empowerment and powerlessness (Beauboeuf-Lafontant, 2008). The participants in this study consistently underscored the dynamics among social injustices, White privilege and power dynamics, and suicidality. Attending to such reflections is essential to a social justice and human rights reframing of suicide. Thus, LG provided an ideal method for analyzing the nuanced, complex, and multi-layered critical perspectives embedded in Black female clinicians’ narratives about suicide in Black communities.
For this project, LG data analysis involved several steps. After each interview, I wrote a reflective journal entry about the thoughts, feelings, questions, and/or concerns that arose during the interview. Then, I converted the audio-recorded interviews into files that could be uploaded to the Rev.com transcription service. Once I received the transcripts, I listened to the interview and read the transcript concurrently. Next, I journaled about the overarching plot of the interview and compared this journal entry with the initial post-interview journal entry. Specifically, I noted similarities and differences between the entries as a way to check my interpretations. After that comparison, I listened to the transcript a second time and highlighted each instance of “I” plus its corresponding verb and direct objects to create an I phrase. In a new Microsoft Word document, I sequenced each I phrase to create I poems. Subsequently, I read each I poem several times with the overall research question, interview questions, and theoretical framework concepts in mind. These subsequent listenings revealed contrapuntal patterns within each individual I poem. These patterns enabled me to better contextualize and analyze each participant’s lived experiences as it shaped their critical understandings of suicide in Black communities. However, I did not complete an entire contrapuntal analysis because this project emphasized participants’ critical perspectives, not their subjective intrapsychic experiences embedded in their voices. Moreover, I juxtaposed the participants’ “I” poems to discern individual voice patterns, cross-participant themes, and overarching meanings. Then, I watched each video recorded interview and made notes on each transcript about my body language and tone, as well as the non-verbal and verbal patterns of participants. Finally, using a combination of Microsoft Word macros (customized search programs) and word find functions, I
analyzed and quantified the cross-participant key words used to describe their critical understandings of suicide in Black communities. Table 1 in Chapter 5 showcases this data.

Validity

Validity entails the degrees to which epistemological assumptions, research methodology, and methods accurately represent a studied phenomenon. These representations emerge from a researcher’s conceptualization of truth (Carspecken, 1996; Zhao et al., 2021). This research project’s critical orientation aligns best with a dialogic theory of truth. A dialogic theory of truth posits that knowing is grounded in subject-subject relationships. The relationships between a researcher and participant foreground “truth as a dialogue that is always unfolding” (Zhao et al., 2021, p. 143). Validity, in the context of unfolding dialogue, increases as consensus between the researcher, participant, and people affected most directly by the research, increases. Furthermore, Zhao et al. (2021) noted that validity from this perspective involves creating the relational and emotional contexts that facilitate consensus. This examination of validity and the dialogic theory of truth relate to the three knowledge claims this study makes: objective, subjective, and normative.

Validity and Objective Knowledge Claims

Objective knowledge claims emerge from direct measurement or observation. These knowledge claims are open to multiple access by different observers, and validity is framed in terms of consensus, repeated measures, and prediction accuracy (Zhao et al., 2021). For this study, my interview transcripts, interview audio-visual recordings, written plot-based record created after my first listening, field notes, and research journal entries
offered multiple access to others (Gilligan, 2015; Gilligan et al., 2003; Woodcock, 2016). Furthermore, LG data analysis method explicitly establishes the expectation that researchers will engage in transparent reflexive practices. One practice includes ongoing reflection about researcher positionality. To operationalize this practice, I kept a reflexivity journal throughout each stage of the inquiry process. This practice emphasized the cognitive, affective, and behavioral dimensions of my insider and outsider statuses in relation to each participant. Summaries of my reflective practice are provided alongside each narrative summary in the next chapter. Additionally, I assembled a dissertation committee comprised of female scholars who self-identify as South Asian, White, and Black biracial. My dissertation committee chair is a neuropsychologist whose academic work and interests center on structural violence, transnational feminism, and mutually emancipatory grassroots community organizing. Another committee member is an established LG expert with a background in literature and developmental psychology. The third committee member is a clinical community psychologist whose practice and scholarship focuses on suicide in Black communities. Thus, this committee offers vantage points that enhance the objective validity of this study, as consensus among diverse perspectives from a criticalist stance bolsters validity.

**Validity and Subjective Knowledge Claims**

Subjective knowledge claims involve the internal experiences of an individual, such as their feelings, motivations, thoughts, and sensations. Because these experiences exist outside of an observer’s direct experience, Zhao et al. (2021) described such claims as having *privileged access* (p. 154). As a result, subjective knowledge claim validity in
research is contingent upon the sincerity and authenticity of participants as they describe their experiences.

For this research project, I aimed to create the conditions that fostered comfort with genuineness between the Black female clinician participants and myself. I attempted to communicate clearly and candidly in writing and verbally. Furthermore, I shared my semi-structured interview protocol with the participants in advance to promote transparency. This protocol included non-leading, open-ended questions that communicated a sincere interest in understanding. Moreover, I intended to bolster the subjective knowledge claims by using the rapport-building skills I have cultivated as a clinical social worker over the last 25 years. Finally, I consistently updated participants about my data analysis and writing progress—I sent participants draft copies of Chapters 4 to 6 and solicited feedback. Five of the 14 participants responded. Three participants specifically indicated that they liked the I poems. Two participants commented that they did not like the fact that they said “um” a lot. I responded to both participants that the use of “um” is quite common. To ease their concerns, I sent them both the verbatim transcripts of our interviews to normalize the fact that I verbally used “um” as well. Each participant expressed feeling reassured. No other comments were provided.

Validity and Normative Knowledge Claims

Normative knowledge claims concern the cultural norms and contexts in which such claims evolve and manifest. Zhao et al. (2021) highlighted that normative knowledge claims require “us to understand things from the perspective of people in a given culture and context, which involves grasping assumptions about what is right, wrong, good, bad, largely accepted, and circulated in a given culture” (p. 155). Thus,
normative knowledge claim validity requires understanding a cultural insider’s perspective as fully as possible. This understanding, and the process to achieve it, requires time and relational investments.


In tandem with these efforts, I worked with three Black doctoral students at Lesley University since fall 2019 to pilot earlier iterations of this project. Their feedback and insights have significantly contributed to my development as an emerging edgewalker (Beals et al., 2020). Specifically, I gained invaluable feedback about naming and addressing possible concerns Black research participants might have about working collaboratively with me—a self-identified White, gay, cisgender male. This feedback reinforced the importance of explicitly describing the purpose of this project in terms of amplifying underrepresented voices instead of centering myself. Also, I learned the significance of candidly sharing my positionality with participants and initiating
conversations about how my positionality may affect them and influence their involvement with this project. These efforts seemed to facilitate rapport-building with participants. Such rapport generated candid and emotionally potent participant narratives. Finally, my efforts to increase normative knowledge validity were bolstered by the use of member-checking throughout this project’s data analysis and interpretation phases.

*Member-checking* is a qualitative research strategy designed to bolster the internal validity of a study (Creswell & Creswell, 2018). The strategy involves ongoing dialogues between the researcher and participants about the researcher’s interpretations of the data. The goal is to ensure accuracy between the participants’ meanings and the researcher’s conceptualization of those meanings. While commonly conceived of as a *gold standard* validity measurement, Motulsky (2021) cautioned that researchers should be critical and intentional about its use. Given my positionality as a White man, the historical under- and mis-representation of Black women in research, the relational nature of this project, and my explicit social justice goals for this project, I used this strategy. Prior to the formal member-checking interview, I emailed participants their raw transcript data to review. I offered member-checking interviews to all participants four to six weeks after the semi-structured interview. During the interview, I reviewed themes, corresponding direct quotations, and the original interview question that elicited the quotation. Then, I asked the participants: To what degree does this data represent understandings? To what degree does it reflect the subtleties of your perspective? Five of the 14 participants responded and indicated that my representations of their experiences and critical understandings of suicide in Black communities were accurate. A sixth participant requested further de-identification of their information and I made the requested changes. While less than 50%
of participants engaged in the member-checking process, Motulsky (2021) noted that a number of factors might influence member-checking participation, such as being burdened with daily living responsibilities or not feeling as invested in the research project as the investigator.

**Ethical Considerations**

Suicide is a taboo subject that often evokes powerful reactions. In reflecting on suicide-focused research, I examined possible ethical concerns. First, I considered the potential stress participants might experience related to sharing their lived experiences, critical consciousness development, and understandings of suicide in Black communities. However, these concerns lack empirical support (Blades et al., 2018) and consequently never arose in this study.

While discussing suicide with research participants did not pose an increased risk of suicidality for participants, many of them expressed intense feelings of anger, sadness, grief, and resistance. I addressed such feelings through non-verbal supportive gestures such as head nods and eye contact, silent witness-bearing, and verbal validation. These empathic responses matched the supportive efforts I promised to offer in the informed consent form, which also described the potential risks and benefits of participation. Additionally, the scripted introduction of the semi-structured interview protocol encouraged participants to take breaks as needed. Finally, I embedded a supportive check-in question within the interview protocol to help safeguard participant wellbeing. Consistently, most research participants expressed appreciation for the question even though many did not use the break.
In addition to ethical concerns about discussing suicide with Black female clinicians, I compensated the participants with $100.00. While seemingly a lot of money to some, I viewed this compensation as a social justice issue. Black women’s time, energies, and efforts are often undervalued in material ways; I did not want to replicate that fact. Also, because the research participants were drawing from their professional expertise and lived experiences, compensating participants the current, average, private practice hourly rate in Massachusetts was not only appropriate, but also ethical. This compensation was provided to the participants before the interview to address concerns about coercion.

Beyond concerns about discussing suicide with research participants, compensation, and coercion, this project’s informed consent form clearly addressed central ethical considerations. First, participation was voluntary. Second, the participants could withdraw from the project at any time for any reason without penalty. Third, the form identified and described the research benefits and possible risks. Fourth, the participants were explicitly asked for input regarding the use of the research findings. Fifth, the participants were offered a post-interview debriefing opportunity as well as follow-up conversations about the accuracy of data analysis and interpretation. This accuracy not only improves validity, but it ensures the ethics of representation in research.

**Summary**

In this chapter, I described the over-arching methodological framework, research design, and inquiry methods for this project. Chapter 3 began with a reiteration of this study’s research question and the intent to use a narrative inquiry methodology. Then, the
chapter transitioned to an examination of my critical epistemological framework. This examination led to a discussion about my positionality as a White, gay, cisgender male. It also highlighted important connections between my lived experiences as an educator, cancer survivor, and social worker, and my interest in Black female clinicians’ critical understandings of suicide in Black communities. Next, I discussed purposive sampling strategies and participant selection criteria. Furthermore, I explained my use of semi-structured interviews to generate data and outlined LG as a data analysis method. Following the method description, I reviewed the connections between my epistemology, methodology, methods, validity, and knowledge claims. Finally, this chapter concluded by considering the possible ethical issues related to this dissertation research project.
CHAPTER 4

Narrative Interview and Reflection Summaries

In this chapter, I briefly review the LG data analysis. Then, I introduce each of the 14 participants who chose the names that represent their stories. The introductions include sociodemographic information gleaned from a 16-item questionnaire. In addition to an introduction, each participant’s narrative is organized into four thematic areas: experiences of being a Black female clinician in the United States, critical consciousness development, multi-sensory perspectives of the phrase “death by suicide in Black communities,” and understandings of suicide in Black communities. I intersperse thick descriptions, participant quotations, and I poems (in bold within block quotations) to contextualize the participants’ experiences, illuminate salient themes, and track the movements of each participant’s voices. At the end of each participant profile, I reflect on my reactions, insights, and positionality. Such in-depth descriptive work lays the foundation for the subsequent chapter. The next chapter highlights cross-participant themes, illuminates unique participant voices, and integrates themes, participant data, and extant literature in an effort to promote a more critical understanding of suicide in Black communities among mainstream theorists, researchers, and clinicians.

Data Analysis Process Review

I interviewed 14 Black female clinicians in August and September 2021. Participants discussed the complexities of their intersectional identities across ecological systems for approximately 60 to 90 minutes. Their explorations—presented in chronological order—began with reflections about being Black female clinicians in the United States, and progressively shifted to historically significant experiences. Then, I
asked questions about their critical consciousness development as it related to iterative understandings of themselves, their relationships, and the contexts in which they live and work. These discussions established participants’ critical awareness and perspectives. Furthermore, many of the follow-up questions I asked invited the participants to share connections among their lived experiences, development of critical consciousness, clinical practice, and critical understandings about suicide in Black communities. These follow-up questions were consistent with the Black feminist scholarship, critical theories, methodology, and data analytical method that support this project. All theoretical and methodological frameworks in this project highlighted a dialogic relationship between lived experience and knowledge creation (Collins, 2009).

I started data analysis with the first of multiple sequential listenings (Gilligan, 2015; Gilligan & Eddy, 2021; Gilligan et al., 2003; Woodcock, 2016). My initial analysis included the actual interview, two subsequent audio-visual listenings spaced two weeks apart, and three transcript-only readings. During each first listening, I focused on plot, my reactions, key terms, main ideas, meaning-making patterns, and voice movements across the narrative. I attended closely to the racial and gender differences between participants and me as these differences often shape what is said by participants and what can be known by researchers (Gilligan, 2015). This process generated several iterations of overarching and interview-specific themes that revealed cross-cutting concepts (Gilligan, 2015). With each reading, themes evolved and merged and resulted in the suite of concepts explored in the next chapter. In the second listenings, I attended to the first-person voice of each participant by highlighting every instance of “I” and “You” (that served as an “I” proxy) plus the corresponding verbs and/or meaningful phrases
(Koelsch, 2015). Then, I used these I phrases to craft I poems by arranging each phrase sequentially on a separate line. I present selected I poems in this chapter to foreground participant subjectivities and voices as it related to their lived experiences. While I did not complete a contrapuntal analysis for this study, individual participant’s I poems revealed contrapuntal patterns. These patterns emerged when a participant shared multiple perspectives concurrently (Sorsoli & Tolman, 2008; Tolman & Head, 2021). This polyvocality—resonant, neutral, and/or dissonant—enabled me to understand the nuances, complexities, conflicts, and context-specific patterns that emerged from each participant’s narrative without reducing their experiences into discrete or binary categories (Harel-Shalev & Daphna-Tekoah, 2021). Unique patterns arose in the Black female clinicians’ narratives about suicide in Black communities. Their stories dynamically revealed nuanced connections among Black history, oppressive systemic forces, and suicide. Interwoven throughout these connections, participants often voiced intersectional marginalization, myriad traumas, hopelessness, fear, pride, strength, resilience, exasperation with systems that perpetuate or ignore systemic violence, and shame.

Elizabeth

Elizabeth (she/her) is a 33-year-old licensed mental health counselor (LMHC) who self-identifies as African American, Liberian, straight, middle-class, and Christian. She lives and works in a large New England city as a generalist outpatient clinician and as an adjunct instructor at a local university. Elizabeth has nine years of clinical experience and is socio-economically situated in the working-middle class.
Being a Black Female Clinician in the United States

From the outset of the interview, Elizabeth observed that Black female clinicians seemed to be in demand, yet she was not offered the same financial benefits that other in-demand clinicians often received. She reflected:

Uh, um, so the first thing that comes to mind is that (laughs) everybody, you know, is apparently looking for a black clinician, or a clinician of color. Um, at least that’s what I hear. Um, I don’t know that that’s the way you feel when you arrive somewhere, and there certainly, right, isn’t, um. . .I don’t know what the right word is, but for instance, like, uh, when there’s, like, there’s been a huge push to get bilinguals, especially Spanish speaking and Portuguese speaking, at least in [inaudible 00:04:11] the two languages they’re really looking for, there’s always been financial incentive. Like if you speak one of the languages, either there’s a sign-on bonus or, you know, that adds like two – I think from two to five grand on the salary, but I don’t necessarily see, you know, where there’s all these people looking for someone of color. I don’t see the same kind of incentive, or push, which doesn’t seem. . .which doesn’t send the same message.

Embedded in these observations is a voice that is deeply attuned to the intersections of dominant cultural messages about being “essential” and the workplace realities that differentially value concrete skills over cultural competency. Furthermore, Elizabeth’s observation underscored the need for workplaces to better attend to all structural and institutional needs equally—linguistic and cultural. Such attunement to this need is evidenced in Elizabeth’s first I poem:

You (I) know
I hear
I don’t know
You (I) feel
You (I) arrive
I don’t know
You (I) know
I think
I don’t necessarily see
You (I) know
I don’t see.

In this I poem, Elizabeth observed workplace narratives about value and worth, and attempted to reconcile those narratives with her own experiences: she noted discrepancies that raised professional status questions for her. Elizabeth then reflected more broadly on her experiences of being a Black female clinician in other settings:

Um, so that's kind of, like, how I feel and, you know, um... I feel probably one of the f- it's weird. Uh, well, there's two times that being a black clinician in, um, different settings where it was in my mind, and one is, uh, when I came into an emergency service setting, an office. And there's one very grouchy old lady who'd been there for years, and she really took to me. Um, and I, you know, she came-she's, like, part Indigenous, part Caucasian. Um, identified as bisexual, um, kind of, you know, two wives. And- but also just kind of had, like, this history of, like, a little bit of trauma, but also, um, difficulty at home, like a broken home situation. And I feel like out of the [inaudible 00:05:46] kind of heterosexual,
Caucasian, um, spouse, two kids, and a dog, and a white picket fence, like, everybody else in the office kind of, like, [inaudible 00:05:57] mold. And so I think- I used to joke with people and be like, they always would ask me like, I guess she liked you. Like, she doesn't like anybody, and, like, you're new, you know? Like, why does she like you? And I used to always think it's because I'm black.

In this recounting, she observed being different from most of her colleagues and further connected the ways her differences may have facilitated a good working relationship with another co-worker with marginalized identities. Elizabeth’s I poem revealed connections between her meaning-making process and her identity as a Black woman:

I feel
You (I) know
I feel probably
I came
I
You (I) know
I feel
I think
I used to joke
I used to always think
I’m Black.

Across both sequential I poems, Elizabeth moved from sensing, to being uncertain, to analyzing, to feeling, to questioning, to knowing, to joking, to thinking, to self-
identifying. This progression echoes the ways critical consciousness—the awareness that lived experiences are shaped by oppressive systemic forces—often emerges and unfolds (Mosley et al., 2021).

**Critical Consciousness Development**

Elizabeth noted that her consciousness has been heightened in the last year as a result of working in predominantly White institutions (PWI). In this context, she had to manage the demands of her professional identity and personal need to support the 2020 protests against police violence. Elizabeth recounted:

And then the other time it really spoke out to me is in the year 2020 being in this office and being only one- two people of color, if things with, you know, George Floyd and Trump, Breonna Taylor, like all of those things. When you walk in this building, when you walk through the halls of this office, when you hear the, um, conversations among peers, you wouldn’t even know what’s happening, like there’d be no- there’s nothing. And that made me feel like should I make noise and say like, do you guys at least want to get one of those like Black Lives Matter if you get things, like put it outside? Like- Uh, does anybody want to check in maybe and ask how I’m doing? I mean, I am managing clients in your office space. You might want to make sure that I’m keeping it together, even if it’s just for your own self-serving bias. Right?

Elizabeth’s recollection highlighted a powerful truth: critical consciousness frequently reveals the ways systems ignore, silence, exploit, and/or erase marginalized experiences. Her corresponding I poem directly confronted this truth:

You (I) know
You (I) walk
You (I) walk
You (I) hear
You (I) wouldn’t even know
should I make noise
ask how I’m doing?
I mean
I am managing clients
I’m keeping it together

The poem began with a dialogue between a significant historical moment and Elizabeth. That internal dialogue sparked a feeling that no one else in her immediate work environment seemed to notice or share. Her realization of invisibility evoked both a call to action and a desire for connection. Simultaneously, she fulfilled her professional responsibilities and coped in isolation. I thought about Elizabeth’s poem: it appeared to mirror an internal narrative similar to the Strong Black Woman (SBW) survival strategy noted in the research literature I reviewed (Green, 2019; Liao et al., 2020; Spates et al., 2020). I further considered the degrees to which her possible internalization of such narratives—and the dearth of systemic support—may have influenced Elizabeth’s experiences of suicide in Black communities.

**Experiences of Suicide in Black Communities**

Poignantly, Elizabeth’s most personal experience with suicidal ideation was her own. She described struggling with prenatal and postpartum depression. Her story included fears about being seen in the same hospital where she worked, as well as sitting
in emergency department waiting areas with current and former clients. Elizabeth shared both the nadir of her experience and the hope that emerged:

Um, so it lasted the entire time. And, um, I ended up losing my job at the emergency room, um, seven months pregnant. And so, now I had lost this career that really was probably the best thing that I felt, that I felt was the best thing about me. And I’m seven months pregnant, already in a prenatal depression.

I’m already off my meds. Um, and you know, I, that was different. That one, I often went back and forth between, like, harming myself or harming the pregnancy. Um, often considered, like, just falling down the stairs and seeing which one of us survived. Um, so that was a really rocky period. But coming out of it I discovered, um, this thing called PSI, Postpartum Support International.

Elizabeth’s experience starkly underscored the importance of loss, resource deprivation, biology, and suicidality. Her corresponding I poem mapped out a journey of loss, discovery, and empowerment:

I ended up losing my job
I had lost this career
I felt
I felt
I’m seven months pregnant
I’m already off my meds
You (I) know
I
I often went back and forth between
I discovered.

Elizabeth’s discovery of and participation in PSI gave her a renewed sense of purpose. Moreover, her personal experience with suicidality broadened and included race, gender, ethnic, age, family, community, religion, and historical intersections. Additionally, her use of the phrases “I ended up losing my job” and “I had lost this career that really was probably the best thing that I felt, that I felt was the best thing about me” imply fear, grief, and shame. Instead of attributing these losses to unsupportive systems, Elizabeth believed she caused them by using “I ended…” and “I had lost…” instead of, for example, “They fired me.” While many people in non-Black communities may experience similar emotions related to job loss, dominant culture’s narratives about Black’s poor work ethic and Black women as “Welfare Queens” likely complicate unemployment experiences such as Elizabeth’s. These oppressive systemic, fear, grief, and shame intersections seemed to undergird her understanding of suicide in Black communities.

**Understanding of Suicide in Black Communities**

Elizabeth organized her understandings of suicide in Black communities by differentiating between Black African immigrant and African American communities. Within each community category, she discussed differences between women, men, and teens. A central theme that emerged across each category was intersectional manifestations of *shame*. Examples included “faith shaming” which related to a “kind of wickedness in the person that they couldn’t talk to God or their pastor [about],” and “family shaming.” Concurrently, her narrative voice typically shifted away from a self-referential “I” to an “I” or “you” that represented a ventriloquized, racialized, gendered,
cultured, and/or religionized community voice. For example, when asked “What comes up for you when you hear the phrase ‘suicide in Black communities’?” she discussed family shame at length:

And then there’s family shaming, right? Like, “Oh, you sat down there and you let your husband or your wife go and kill themselves because of what? What were you doing? Why you didn’t help them? Why you didn’t bring them to the church? Why you didn’t call somebody?” You know, um, there’s, like, there’s no room for understanding, compassion or empathy for this at all. Um, and then there’s like, um, the children. Like, a child would be told, “Don’t I cook for you? Don’t I clean for you? Don’t you go to school with a uniform on? Don’t you, uh, have bed to sleep in? Don’t you have water to shower? Don’t you go and play with your friend? Don’t I work hard for you? Don’t you see the bags under my eyes? I have been taking care of you. So there’s no, what reason should you have to talk about killing yourself? What kind of nonsense is that?”

Elizabeth’s depiction of a Black-Liberian family shame narrative piqued my curiosity about the ways shaming manifests in different systems, as well as its impacts on recipients. While shaming in the contexts of trusting and loving relationships may be a means of appropriate social control, shame in violent and oppressive environments contributes to experienced harms (Chandler, 2020; Hastings et al., 2002). Shame typically refers to the deeply held belief and intense emotional experience that one’s entire self is “bad” (Herberman Mash et al., 2020) Given this definition of shame—and the historical and ongoing ways dominant culture has framed “Black” as “bad”—the confluence of shame and power likely compound suicide risk in Black communities in (Johnson, 2020;
Historical and ongoing racialized discrimination and violence are two ways shame and power increase suicide risk among Black cohorts (Halloran, 2019; Jones-Eversley et al., 2020).

Additionally, Elizabeth’s stories about the relationships among identities, ethnocultural forces, historical trauma, and shame manifested most profoundly in her response to my question, “What images come up for you when you hear the phrase ‘suicide in Black communities?’” She responded immediately: “Um, it’s weird I, I think like a bunch of different [inaudible 00:57:48] hangings and burning process, are, are flashing in my mind.” Her brief and arresting response connected suicide in Black communities to heinous forms of violence. Lynchings are public displays of lethal violence designed to kill and humiliate the individual, and to transmit a power-over message to families and communities who observe such horrors. In short, lynchings frequently create and codify systems of shame by linking power, power-over violence, and Black identity: death by lynching was chosen specifically to denigrate Black identity. Furthermore, burnings are visually dramatic and viscerally trigger a fear response in most human beings due to fire’s destructive potential. Both images share a common theme: annihilation of personhood by publicly stripping a person of their dignity and life or literally rendering a person completely unrecognizable. These intentional acts of violence likely serve multiple purposes from a critical vantage point. Such cruelty reinforces dominance through the abuse of power, makes horrific examples of some to instill fear in the masses, and intentionally creates and perpetuates social structures and institutions that privilege some identities and marginalize others in perpetuity.
Interview Reflections

I was both excited and anxious about this interview. It was my first interview and I felt myself working hard to stay present, be authentic, listen deeply, and maintain curiosity. At the beginning of the interview, I was immediately struck by Elizabeth’s willingness to share her thoughts and feelings freely and openly with me, a person she had never met. I often found myself wondering if I could or would make myself vulnerable with a researcher. Her vulnerability, courage, and candor inspired important insights.

In reviewing the interview transcript and video, I noticed a pattern of shifting voices that seemed to correspond to shifting consciousnesses. The self-referential “I” typically narrated autobiographical details with ease. When discussing suicide and shame in family or community contexts, Elizabeth’s voice frequently changed to an “I” or “you” voice that seemed to foreground a collective point of view. I wondered if such voice fluctuations exemplified contrapuntal voices, or conscious choices to distance the self from taboo, traumatic content, and/or a response to my positionality as a White man. The latter thought emerged from my reading about plantation culture and communication patterns between enslaved Black people and White enslavers. Specifically, Stuckey (2013) noted that it was common for enslaved Blacks to use plural pronouns and voices when describing problems or failures to White enslavers. This “safety in numbers” practice reportedly spared many individuals from cruel or lethal punishment because White enslavers were less likely to harm groups of enslaved Blacks. To do so would have negatively affected their financial bottom lines.
In addition to reflecting on Elizabeth’s narrative voice patterns, I thought about her grief, despair, resourcefulness, and the experiences she shared with me that appeared to necessitate her resilience, i.e., depression and her mother’s ongoing struggles with substance use. Her mother seemed to be a source of sadness, anger, and shame. Elizabeth revealed that she often wondered how she would respond if her mother showed up at her workplace, a hospital emergency. “What would I tell my co-workers or supervisor? How would I respond? As her daughter or as a clinician,” she questioned. Her exploration of feelings, and family and workplace systems compelled me to think about one of the emotions she discussed in-depth differently—shame. I wondered about the various types of shame she described and where she located the sources of shame. Elizabeth voiced her own shame about needing help as a Black female clinician experiencing depression. She culturally situated her depression in both Black community’s Strong Black Woman (SBW) frame and dominant culture’s otherizing narrative about Black people’s extraordinary pain tolerance. These dual experiences compelled her to question what was wrong with her. Furthermore, her gendered and racialized experiences at work—and ethnocultural, faith, and family shaming narratives about suicide—prompted me to think about macrosystemic and individual level connections. This consideration sparked the image of a river that flows from upstream to downstream.

Upstream macrosystems include large scale and over-arching forces that shape human experiences like history and culture. Like water, these forces are dynamic and influence smaller systems downstream like families and individuals. These smaller systems are also dynamic and can also shape larger systems through community, political, economic, and cultural participation. This metaphor provided a conceptual
image: systemic relationships. Applying this framework to Elizabeth’s narratives about personal, professional, cultural, and religious forms of shame, I became curious about the degrees to which systems of shame might help explain the rise in suicidality among Black communities. My curiosity about power, systems, and shame led me to review Joy’s (2019) work that explored the ways oppressive hierarchies and systems result in powerarchies. An essential element of powerarchies is a dominant group’s use of shame to maintain and perpetuate control.

Finally, my interview with Elizabeth evoked one last reflection. As I became aware of voice shifts and various forms of shame, I questioned whether I was also noticing a form of consciousness commonly experienced by Black female insiders and commonly overlooked by White male outsiders like myself. Specifically, I wondered if I was hearing a voice of intersectional consciousness—a dynamic, context-specific awareness that constantly analyzes, anticipates, and adapts to multiple co-occurring identity-based power dynamics. I noted that I needed to conduct more interviews and review previous literature on critical consciousness, double consciousness, and dueling consciousness before drawing conclusions.

Sonya

Sonya (she/her) is a 38-year-old licensed clinical social worker (LCSW) who self-identifies as African American, heterosexual, middle-class, and non-denominational Christian. She resides in a large southern state and works in a metropolitan area as a generalist telehealth clinician and as an adjunct instructor at a local school of social work. Sonya holds a doctorate in counseling education, has 10 years of clinical experience, and
straddles middle and upper middle classes depending on the number of courses she teaches each semester.

**Being a Black Female Clinician in the United States**

Sonya entered the interview space prepared to share candidly and express unfiltered emotion. Two minutes into our conversation, she shared:

Well, I *feel* like just as a Black female, just like an African American female, you *have to be aware* of your, like the oppressors, you *know*. It’s everyday oppression, like certainly in your workplace. You’re, uh, definitely in the workplace, like in school, like it’s everywhere and you *have to be aware* of it and make sure that you *have to be prepared and ready to tackle* it because as a . . . I’m *just going to be really raw*. Like it’s hard, like just being like Black in America, you *know*, it’s just hard and it’s just, people don’t understand, like, it’s like every day you’re *oppressed*. Like every day, like you *have to fight* it. And it’s like, man, you *get tired sometimes*, but you *have to be aware*, you *have to be strong* and you be- you *gotta* be able to like, just stand your ground and be aware of what’s going on and be. That’s why it was so important for me to get a doctorate, ’cause knowledge is power. You *know*, and suddenly with these, these certain forces of oppression, you *know*, you *have to*, I *don’t know*, you just *have to be strong* and you *have to be able to fight back* with like empirical data li- like, you *know*, just know your stuff and just don’t let them put you down and you *gotta fight* for your people. You *know*? So that they can have the same kind of, I *don’t know*, benefits maybe.
Sonya’s words—and the underlying emotions that fueled each word—communicated the multi-faceted burdens that White dominant institutions and structures place on Black people. Concurrently, her narrative voiced the necessary strengths and resiliencies to live and thrive in predominately White spaces. Sonya’s first I poem succinctly illustrated the complexities of shouldering such burdens and sustaining these attributes:

I feel
You (I) have to be aware
You (I) know
You’re (I am)
You (I) have to be aware
You (I) have to be prepared and ready to tackle
I’m just going to be really raw
You (I) know
You’re (I am) oppressed
You (I) have to fight it
You (I) get tired sometimes
You (I) have to be aware
You (I) have to be strong
You (I)
You (I) gotta
You (I) know
You (I) know
You (I) knew
You (I) have to
I don’t know
You (I) have to be strong
You (I) have to be able to fight back
You (I) know
You (I) gotta fight
You (I) know?
I don’t know

Sonya’s I poem revealed nuanced relationships among feeling, being raw, fighting, being tired, resisting, power, knowing, and the state of not knowing simultaneously. In the same way that power is sandwiched between feeling and not knowing in this I poem, her narrative spoke to being wedged among Strong Black Woman expectations, stereotypes, and gendered racism. Such dueling forces likely complicate Black women’s empowerment via contradictory societal and community narratives about being essential and expendable simultaneously. Black women are considered vanguards of democracy, yet as a group they disproportionately experience the harms of capitalism (Collins, 2009, 2019). These harms include working high risk exposure, low status, and low paying jobs such as nursing home aides and hospital custodial staff. Such harms related to risk exposure and low status have been particularly salient during the current COVID-19 pandemic.

**Critical Consciousness Development**

Sonya laughed when I asked her to describe the evolution of her critical consciousness. She remarked that what educated people call “critical consciousness” is known in her community as “survival common sense.” I then asked Sonya if she recalled
a particularly significant lived experience that exemplified her critical awareness. She reported:

But i- it was the worst exp- it was like the best, but the worst experience [working at a mental health prison], you know? But I was glad I had the experience of like being there for them and being able to like help them with like therapy and case management and everything as a, as an African-American female, like most Black men are there like in prison, you know, but to see how they are treated, it was like the most inhumane thing I’ve ever seen, like modern-day slavery. And like they were being called N word. Their food was being, being taken. They were being gassed every day and . . . as a clinician, I was being gassed too, because I was treating them.

Sonya’s anecdote highlighted connections between racialized violence, the criminalization of mental illness, and dehumanization through incarceration. Perhaps even more arresting was the reality that her professional identity in this context offered no protection from suffering the similar mistreatment as the Black male prison residents: her race and gender likely trumped her professional identity. Such victimization underscored the significant ways in which critical awareness empowers people to reframe their suffering in political and historical terms. This reframing clarifies the origins of such suffering and pinpoints responsibility on the perpetrator, not the victim. In this way, critical consciousness may be a protective factor against oppression-related suicidality (Mosley et al., 2021).
**Experiences of Suicide in Black Communities**

Sonya retold me a story of racialized treatment disparities in her work setting. She described two men, one White and one Black, who presented with myriad and similar concerns at the same time. Both requested similar treatments. Her role was to assess each client’s needs and make a recommendation to the treatment team. Sonya recalled:

But the Black man, had also . . . He had a heroin issue. And he was like, “Well, I need Suboxone. I need, I do need that for like, I am just absolutely hopeless.”

Like, “I just cannot move on.” He had no future plans, no future goals, no kind of orientation at all. And he was co- he was like coming up here, so it’s kind of like, sci-fi like, he was like hearing their voices, delusional. And it was kinda like, well, you can tell that he needed substance abuse treatment, but like something else was going on. But he had a history of schizophrenia too. But you got to kind of watch that because sometimes people miss [schizophrenia spectrum disorders], you know, [mis]diagnosis because they see them with the drug issue. But that wasn’t a problem. The problem is they kept the White man and said he was, he needed help. But they said, well, he’s [the Black man] just playing. He just, the Black man, he’s just homeless.

Sonya’s narrative revealed the distorted and racialized classist rationale predominantly White institutions use to justify resource allocation, or, in this case, resource deprivation. Sonya went on to indicate that another Black man living without a home returned to the emergency department a month after his initial visit. In this instance, she reported that the man began expressing anger because the treatment team was “refusing to help him.” Sonya shared that the staff seemed to be intimidated by the man because he was “a tall
Black man.” Then, the staff called security, and the man left the hospital abruptly. Later that day, the man died by jumping off a nearby highway overpass.

When she finished recounting this experience, I sat quietly. Sonya’s affect shifted from animated to grief-stricken. Her gaze shifted from looking into the camera to staring at the floor. She wiped her eyes with her hands and shared:

Like, I just want to cry. Like I just want to, like, I'm so upset. You know, I'm very upset. I'm very upset. I'm sad. You feel it, you feel like you feel the hopelessness, is hopeless, it is pure hopelessness. And like when you talk to them, it's really hard. So I don't know. I just feel that, I feel that I felt that the tension in my head, I feel. . .like just like my heart beating, you know—Like I'm sorry but like—it’s sad and it’s like people in their hopelessness, like even when they talk to you, you can tell how hopeless they are. Because like nobody’s helping them. There's nothing. I don't know. I’m sorry.

Sonya’s I poem associated with this retelling unearthed the intense experience of bearing witness to racialized disparities, trauma, and suicide:

I just want to cry
I just want to
I’m so upset
I’m very upset
You (I) know
I’m very upset
I’m sad
You (I) feel it
You (I) feel
You (I) feel the hopelessness
You (I) talk to them
I don’t know
I just feel that
I feel that
I felt
I feel
You (I) know
I’m sorry
You (I)
You (I) can tell
I don’t know
I’m sorry

Her I poem voiced a desire to grieve, and to feel and express the anger, sadness, and hopelessness she and her clients experience. Sonya’s voice also identified the disorientation and somatic experiences often associated with trauma, i.e., feeling overwhelmed and head tension. She further voiced relational concern for me by trying to contain the depth of her grief by apologizing. Such concern may have emerged in the context of any relationship, and yet I wondered about the ways my White identity may have elicited her caretaking response toward me. This experience prompted me to think about the ways complex grief, racialized trauma, and constantly attending to White
people’s comfort likely contributes to hopelessness undergirding some suicides in Black communities.

**Understanding of Suicide in Black Communities**

Sonya’s perspective about suicide in Black communities foregrounded resource deprivation, cultural messages about strength, and feelings of hopelessness:

Like just from, from what I’ve seen, if I gather everything together, it feels like most people, either they’re not aware of the resource or they don’t own the resources. And as Black people, you’re like w- like just as a whole, your sometimes like certainly Black men there, they have to hold it on the inside, be strong and then told to be strong. But women are told to be strong, you know? But you have to be prepared for a world that wants you. You can be strong but it’s probably not, you f- you might not be ready to be strong enough for it, you know? Um . . . and I’ve seen like just poverty. Um, some people, like they say, like they don’t want to talk to, like, they don’t feel comfortable talking to like a White clinician or they feel c- more comfortable with a Black cli- clinician but there’s not enough Black clinicians. There aren’t resources in our community, you know, or they going to go to a church instead of, you know, going to a therapist. I don’t know. I just think it just so many different factors, you know, that the people tell you and it’s just like a lot. But you’ve done it. I think across the board is a hopelessness, you know? And it’s like so much oppression, you know?

Sonya’s understanding of suicide challenged conventional views that frame suicide in terms of psychopathology. By highlighting poverty, dearth of community resources, and oppression, she located hopelessness in macrosystems, not in individual people. This
reorientation toward systemic analysis and intervention appeared to affirm one of this project’s central arguments: systemic forces influence human experiences, like suicide, significantly.

In addition to discussing hopelessness, systemic forces, and suicide, Sonya offered another poignant insight about shame and suicide in Black communities:

they [Black people] try to kill themselves because life is hard or they didn’t get a job because of who they were or they just, they weren’t enough or they feel like they did not wo-enough because the world makes them feel like they’re not enough.

This insight seemed to speak to possible connections among hopelessness, shaming, and shame. Hopelessness seems to be compounded by an systemic flow of shaming from upstream to downstream: “the world makes you feel like you’re not enough.” I pondered the mechanisms by which that link could be possible. I contemplated the possibility of multiple systems operating in concert simultaneously. Such a system could intentionally deprive someone of community, family, material resources, and self-fulfillment opportunities. I then became curious about the systemic forces that could both maintain the dominant culture’s status and perpetuate the subjugation of others. I thought about violence which is an effective tool of dominant culture to exert power-over others. Budden (2009) and Weiner (1986) both noted that shame often co-occurs with violence, especially when violence is perpetrated against an individual or group with marginalized statuses.
Interview Reflections

After my conversation with Sonya, I noticed that I felt sad, angry, and a little numb. I noticed that my head felt full and heavy. I knew that if I didn’t move my body, I would begin to feel stuck in my head and heart. I went for an hour-long walk and began to process each segment of the interview. I brought my tape recorder with me and spoke into it episodically. After listening to the recording and reviewing the original interview transcript a sixth time, I noted themes that I would continue to track throughout the research process: participant somatic experiences and critical understandings of the phrase “suicide in Black communities” in relation to hopelessness, historical forms of trauma, systemic forces, shame, and suicide.

The first theme emerged the moment Sonya identified body locations that corresponded to her experience of suicide in Black communities. During my walk, I recalled van der Kolk’s (2014) book about trauma, The Body Keeps the Score. His work discussed the ways traumatic events get stored in the body and manifest as physiological and psychological symptoms. I gravitate toward the idea that symptoms are embodied stories that need to be told and understood. Such stories often unearth important meaning-making details concealed by a traumatized psyche. These revealed details often promote healing. Perhaps a similar revelatory process could be scaled up to understand historical traumas and suicide. Such processes might prompt macro-level truth, justice, and reparation proceedings, as well as other critical action responses.

Additionally, Sonya’s narrated experiences about working in predominantly White institutions that serve large Black communities elucidated the ways that systems, even “helping” systems, reproduce insidious forms of violence. These systems frequently
contribute to immediate and enduring harms including limited access, resource deprivation, and the compounding effects of persistent dehumanization. Such harms must be named and explicitly connected to the historical and ongoing oppressive forces from which these harms emerged. This recognition needs to inform suicidology’s theories of and practices with marginalized, suicide-vulnerable communities to uphold its stated value of diversity and fulfill its ethical obligations to “do no harm.”

Virginia

Virginia (she/her) is a 41-year-old licensed clinical psychologist (LCP) who self-identifies as Black, heterosexual, middle-class, and spiritual. She lives and works in a mid-Atlantic, southern state. Virginia maintains a private practice and works primarily with people who have experienced intense adverse life events. She has eight years of clinical experience and is socio-economically situated in the middle class.

Being a Black Female Clinician in the United States

Virginia stated that her experience of being a Black female clinician varied depending on practice context and client identities. She mused that her name often leads people to assume that she is White:

With my name most people don't assume that I am African-American or identify as black, um, or even a brown person, which is still fascinating to me. People will see my name and lock the door and I get that look and I'm like, okay. Yeah, you were expecting, um, maybe, uh, any, anybody, anybody like [crosstalk 00:08:57] but not me, which is fine. Um, so that piece is always kind of the first thing in the room, um, having to have, usually, usually I can see an age difference where that, um, is important or significant. Um, where it seems that an older population,
especially older White men seems to be a challenge initially where it's like, yeah, I know we are brown personnel but that's off the table, what brings you in (laughs)? Um, with my younger, uh, clients, it doesn't seem to even be a blip on the radar, which is a lovely thing to see and experience. Um, but as far as to how do I, I would describe it is that definitely in a lot of the spaces where I work, so I work with a lot of trauma, with [emergency services professionals]. They seem to, those individuals who come in seem to resonate a little bit more. I don't know if it's the fact that I am a person of color.

Virginia’s subjective experiences of her clients’ racialized assumptions are vividly revealed in the I poem related to this narrative:

I am
I get that look
I'm like
I can see
I know
how do I
I would describe
I work
I work
I don’t know
I am a person of color

Her I poem reflected the efforts she makes to manage client assumptions: she maintains awareness about the assumption, takes a curious stance, notices how clients view her,
questions herself, allows herself to not know, and re-establishes knowing by clearly
declaring her identity. Virginia made it clear that while the initial moments of client
interaction are often awkward, the awkwardness dissipates through naming it or using
humor. In summarizing her experience, she stated, “And, and so I definitely, um, have
seen it both be incredibly opening and incredibly awkward.” According to Virginia, the
former typically happens with younger clients or clients of color, and the latter most
frequently occurs with male clients who work in emergency response professions.

**Critical Consciousness Development**

Over the course of the interview, Virginia discussed her critical consciousness in
the contexts of her education at a historically Black university (HBU) and graduate
internship. She recalled that her clinical work with an Indigenous American woman
brought her critical consciousness into focus:

And I had a Native American woman, um, whose parental rights have been
terminated twice by the tribes. So, I got to learn a lot about tribal adoption rules
and, and that was really, um, helpful. And, but I remember the thing that stuck out
was that no matter what, she always had her papers. And I had, so she would
literally lose everything except for the clothes on her back. And her paperwork
identified her as a Native American. And, and I, when we were talking, um, it
dawned on me. I was like, that’s no different than when slaves or individuals who
were previously held in slavery for free and had their paperwork saying that they
were free. And it really, like in that moment kind of resonated a lot of similarities
among, among marginalized groups of people in a way that was really, for me,
really, really salient, really, really present.
Virginia’s critical insight exposed connections among Black enslavement, Indigenous American displacement, and cruel dominant culture systems. Such systems simultaneously strip marginalized people of their personhood and create bureaucratic tools—like identity paperwork—to codify ongoing oppression. The impact of these systems likely contributes to the alienating and isolating contexts in which many suicides in Black communities occur.

**Experiences of Suicides in Black Communities**

Virginia’s narrative explored a variety of multi-sensory experiences of suicide in Black communities. The images that came to her mind included “death by cop,” “small children crying,” and “the faces of older Black women.” Interoceptively, she described “modulating” sensations of “heart pain,” “weight in the chest,” and a “sinking stomach.” Emotionally, Virginia described “sadness.” When asked to discuss her first memory of a suicide in a Black community, she recalled:

> Um, so the first, like once again, the first memory was the first story that I’ve heard of a person, suicide by a cop and then finding out the officer and the investigators finding out later, um, that this was intentional, um, to the like kind of the first, I guess maybe words, thoughts which like I still remember the officer going, “Damn it. He made me shoot him.” Like, that’s literally the phrase that (laughs), that came up. And I [Virginia said], “I’m sorry, what? He made you shoot him?” [The officer replied.] “He didn’t give me any other option. And, um, I had to.”

Virginia’s memory situated suicide in the context of structurally-supported violence that mirrors the historical and ongoing relationships between White dominant culture and
Black populations. This recollection also reproduced a common dominant culture narrative that obfuscates culpability by blaming the victim—a form of shaming. Bhuptani and Messman (2021) noted, “Receiving victim-blame responses as well as self-blame tendencies are funneled into shame which is known to be a silent but powerful driver of both PTSD and depression” (p. 7). Their findings and Virginia’s observations bolster likely connections among shaming, shame, and suicidality by emphasizing the directionality of these relationships.

**Understanding of Suicide in Black Communities**

In articulating her understanding of suicide in Black communities, Virginia conceptualized suicide in Black communities as an upstream, macrosystemic problem. She remarked,

 Uh, well, I say depression of the core. Um, limited access, systematic, uh, being oppressed, um, lack of hope and, uh, you know, [inaudible 00:29:37] generation stuck in this particular spot. Um, and I don’t really see how I’m gonna get out, ‘cause I haven’t really seen anyone get out. And so why, why try? So, I don’t do it when everyone else around me has done even if I can tell you on one hand it’s not healthy, on the other hand, what else am I gonna do ‘cause I don’t know any other options. And you come in talk to me, talking to therapists ain’t gonna work (laughs).

Virginia’s analysis moved upstream from individual psychopathology to intergenerational hopelessness caused by thwarted resource access and systemic oppression. This critical analysis ended with a blistering and explicit critique of counseling and psychology. Interestingly, distinct and intersectional “I’s” narrated her
critique. The “psychologist-I” possessed the dominant culture credentials to
authoritatively differentiate pathologies and the “Black experience-I” drew from lived
experience. The latter situated suicidality in systems designed to reinforce perpetual
hopelessness in Black communities. Such systemic hopelessness is immune to individual
psychosocial intervention. However, collective actions like community organizing,
consciousness-raising, and political involvement may create solidarity and opportunities
for collective empowerment.

**Interview Reflections**

Upon reflection, I was struck by the way Virginia’s narratives ebbed and flowed
between upstream macrosystemic forces and downstream individual level experiences.
Her “depression of the core” remark seemed to have parallel meanings: a clinical
diagnosis and a description about a constrained essential dimension of the self. Given
Virginia’s subsequent comments about “limited access,” “systematic,” and “oppression,”
I wondered if she was naming a shamed subjugation-of-the-self affected by intentional
systemic, identity-based deprivation. I thought about the ways systems transmit narratives
that explain “limited access” and “oppression.” These narratives often otherize and vilify
marginalized people by framing them as “lazy,” “dumb,” “criminals,” and/or “bad.” If
reinforced across systems over long enough time periods, such messages probably
become validated and normalized simply through repetition. For members of
marginalized communities, these intentionally harmful messages—if internalized—could
lead some people to believe that their lack of access and ongoing oppression is directly
connected with their identities, and therefore, outside of their control to change. This
internalized conclusion captures the shaming-shame dynamic that may contribute to some suicidality in Black communities.

Another result of my interview with Virginia was my increased awareness of a framework for understanding suicide in Black communities that centered systemic challenges. As I thought about depression and hopelessness, I was reminded of the questions raised in the previous two interviews: What is the relationship among depression, hopelessness, and shame? Where does hopelessness and shame experienced by Black communities originate? What are the connections among intergenerational and historically-rooted systemic violence, shame, and suicide? Are these connections reproducing systems of despair that compound suicidality risk in multiply marginalized Black cohorts? These questions prompted me to repeatedly remind myself: keep looking upstream.

Looking upstream also motivated me to question whether the absence of hope universally contributes to suicide. I recalled my time as a hospice social worker. In the context of a terminal illness, hope often takes the form of pain management, wanting control over some aspect of life, or a desire to be in familiar surroundings. For Black communities that have never experienced full personhood, justice, or reparations, hope likely necessitates a truth, justice, and reconciliation process that dismantles White supremacy in all its guises. This process includes suicidology, psychology, and counseling.

Noelle

Noelle (she/her) is a 36-year-old doctorate-level licensed marriage and family therapist (LMFT) who self-identifies as African American, straight, upper-middle class,
and non-denominational Christian. She resides in a large, upper-midwestern state where
she owns a group private practice. Noelle has nine-and-a-half years of clinical experience
and specializes in attachment-based trauma recovery.

**Being a Black Female Clinician in the United States**

Noelle’s narrative underscored the reality that predominantly White workplaces
pose challenges for Black professionals. Such concerns can include being alienated for
advocating “too aggressively,” having one’s ideas stolen by authority figures, having
one’s clinical skills and judgement questioned disproportionately, and receiving few
professional development opportunities. She elaborated,

Um, so, man, that’s a, that’s . . . I’m trying to where I can go with that. Well, so,
I think, um, my experience in a private practice setting, um, is probably the best
that it has been as a, as a Black female clinician in the U.S. today, uh, as opposed
to, like, being in, uh, other settings that I’ve been in the past such as community
mental health agencies, um, in-patient hospitals, or even in academia. Um, I find
that working in private practice as a Black female clinician is the safest, um,
whether it h- it has been, um, the sa- the safest for me, um, in terms of, you know,
particularly my, my race. Um, and so, it’s, it’s where I will more than likely
remain.

Noelle’s experience highlighted the fact that most public mental health spaces were not
built for her, or for Black communities more broadly. For her, entrepreneurship has
empowered her and many of her friends to create workplaces created by Black
professionals for Black community members. Noelle’s I poem acknowledged efforts to
work in public mental health spaces. Those efforts resulted in a heightened awareness that her safety is her responsibility to create and maintain:

I’m trying
I can go
I think
I’ve been
I find that working
I will more than likely remain

Interestingly, her narrative voice transitioned from present day to the past and then to the present and future where she hopes to “remain.” These temporal shifts in voice seemed to correspond to a shift in consciousness, power, and agency. The past is filled with experiences that required a vigilant consciousness to manage White authority figures and navigate predominantly White spaces where she felt unsafe. In contrast, Noelle’s sense of present day and future safety emerges from building her own practice and creating alternative systems of care for her Black community. While such innovations undoubtedly reflect her empowerment and commitment to the Black community, it also underscores the influence of White segregation beliefs.

**Critical Consciousness Development**

Noelle’s consciousness about self-empowerment, race, and navigating White spaces vividly unfolded at an early age. She recalled:

So, before that, I went to, like, a Black Christian school…Well, there was a big incident in fourth grade when I still went to this, this Black Christian school. The teachers were all White, though. Now, the fourth-grade teacher, we had this thing
where you had, like, a spelling bee, and whoever won your class, other people get to go to this, like, consortium kinda spelling bee. So, the two spellers left were myself and a White boy, and I beat the White boy. The teacher said, “Well, you always get to go to the spelling bee, let’s let him go.” [Noelle replied to the teacher.] “But I beat them. He, he messed up on the word, I spelled it correctly.” So, there was one Black teacher in the whole school, the first-grade teacher, Mrs. Lee, and she came and told the teacher off, you know, ‘cause he, she knew what it was. I was . . . I mean, I knew it was unfair, but no one ever said race. But I knew he was white, I was Black, obviously, you know, I knew- . . . I knew r- from very young being Black and whatever, but, um, but then it wasn’t until, like, a year, and then a year later, after I left that school, ‘cause my mother, like, came up there and told the teacher off and all this kinda stuff. This incident foregrounded a common rationale used to enable White male dominant culture’s cognitive distortion regarding gendered and racialized meritocracy: bend the rules to privilege White male experiences when an outcome threatens perceptions of their status. Noelle’s I poem depicted her clarity about why this tie occurred:

I went to
I still went
I beat the White boy
I beat them
I spelled it correctly
I was
I mean
I knew it was unfair
I knew
I was Black
I knew
I knew
I left

The poem revealed the fact that despite “knowing,” “spelling,” and fairly “beating” the White male student, her identities required her achievement to be manipulated by a system designed to serve him. Such a powerful example of critical consciousness development highlighted the ways oppressive systems attempt to strip Black community members’ dignity and pride. Moreover, Noelle’s narrative and I poem also illuminated the significance of advocacy and internal dialogues shaped by critical consciousness. The fact that Noelle knew that Mrs. Lee and her mother supported her probably empowered her to internalize a critically-informed story about the meaning of the spelling bee experience. Perhaps fostering a critical consciousness at an early age is an important protective factor against suicide by preventing harmful, self-shaming narratives from being internalized.

**Experiences of Suicide in Black Communities**

Noelle’s first response to my question about suicide in Black communities prompted a response that seemed to have layered meanings:

I mean, ugh, well, I guess my eyes, I fee- . . . I notice my eyes squinting. Like, (laughs) I don’t know if you’ve seen that meme, have you seen that meme?

Where it’s, like, this, a Black woman, and she’s like really squinting, and she has
on glasses, and she’s, like, really s- peering through. So, yeah, I, I feel it in my eyes. Um, I don’t feel it as mu- . . . I would maybe say, like, a slight heaviness in the chest. Um, I definitely don’t feel it in my stomach or my feet, but maybe, you know, and maybe in my hands.

Noelle’s narrative centered her eyes while also acknowledging other bodily sensations. On one level, she seemed to be questioning—seeing—if “suicide in Black communities” was really suicide or something else. She then explicitly asked me—another kind of seeing—why I am doing this research project. After hearing my explanation, she wondered:

Yeah, like, I kinda, like, wanna go like, like, I’m scrutinizing it [suicide in Black communities], if that makes sense. . .about the scrutiny of it. And how people are kind of, like, scrutinizing. And here it goes back to, like, can these people be trusted? What is their agenda? And I think some of the things that I was alluding to, probably, uh, you know, we're making money in some way off of, you know, the bodies of Black people, the mental health, the minds of Black people. . .but do we really care about Black people? And so, maybe when, when I'm thinking of . . . you know, suicide in Black communities, I'm like, "Hm," you know. . .kind of scrutinizing it, like, should, you know, let's examine this.

Noelle’s I poem centered the ways her interrogation of suicide in Black communities dynamically vacillates between knowing and not knowing:

I kinda, like, wanna go like

I’m scrutinizing

I think
I was alluding
I’m thinking
You (I) know
I’m like
You (I) know
You (I) know

Her use of the verb “scrutinizing” encapsulated a critical view of suicide. This view both skeptically questioned the concept of suicide and the people who have the power to label experience as *suicides*. This interrogation of suicide as a concept—and its causes—manifested in Noelle’s insights about contributing factors to suicide in Black communities.

**Understanding of Suicide in Black Communities**

Noelle’s understanding of suicide was influenced by her training as a marriage and family therapist who specializes in trauma recovery work. These professional lenses, coupled with her lived experience and critical worldview, emphasized connections between hopelessness, trauma, and racism:

Um, I understand it as . . . Okay, so, like, hopelessness. Um, I think that more than likely can be im- pretty m- and I hate to sp- paint a really broad picture, but in pretty much many, pretty much every circumstance, uh, can be linked to systemic racism. Of course, in instances, of course, sometimes it’s just personal, uh, individual kinda racism. But I think that what we’re looking at, um, like, especially children, um, et cetera, committing suicide that, you know, you’re, you’re witnessing an intense amount of pressure on, uh, the f- uh, the family, um,
system, or even the individual, that is certainly amplified, or intensified, by, um, by systemic racism. And, you know, in the end we’re looking at . . . I look at racism as, as trauma. And so, you know, of course, like, suicidal thought and suicide, you know-can be very, all very real parts of trauma.

Noelle postulated that suicides in Black communities likely occur due to the convergence of trauma, racism, and insecure attachments. She implicitly theorized that insecure attachments enable mistrust in self and others: Dominant culture has undermined marginalized people’s trust formation within and across systems for centuries (Kendi, 2016). Such widespread and severe mistrust of social systems can rupture the systemic bonds that ground people to their lives. This rupture can result in death.

**Interview Reflections**

My interview with Noelle compelled me to reflect on her observations about trauma, insecure attachments, and suicide. The first associations that came to my mind were Erikson’s first two psychosocial stages of development involving trust, mistrust, autonomy, and shame (Bowlby, 1998; Coles, 2001; Kass, 2017). I thought about the basic mistrust White dominant culture has instilled in Black communities for over 400 years. I attempted to imagine the first White European who conceived of the idea to enslave Black Africans. I tried to conjure up in my imagination the moment that a Black African realized they and their kin were going to be violently abducted, transformed from a person to property, and enslaved indefinitely. I wondered about the parallel and sinister transformations of Whites. I interrogated the ways Whites could manage their sense of “enlightened” agency with the dual reality of greedy sociopathy. Of course, the human capacity to rationalize away cognitive dissonance is well-established, and yet I wondered
about the long-term psychological and material costs of prolonged and ongoing rationalization for White communities. This reflection prompted me to circle back to Erikson’s theory.

According to Erikson’s psychosocial theory of development, insecure attachments and shame emerge from mistrust and a lack of personal control (Coles, 2001). I wondered about the connections among betrayal—perpetration of mistrust—, dominance—excessive control, and shame in the contexts of traumatic relationships and suicide in Black communities. According to DeCou et al. (2019), “trauma-related shame leads survivors to feel as though there is something inherently ‘wrong’ about themselves to such a degree that they may believe they are not able to belong within a social network” (p. 135). Their study suggested that trauma-related shame acts as a mediator between the correlation of trauma and suicidality. Thus, historical and ongoing acts of anti-Black violent traumas likely catalyze internalized shame experiences that contribute to some “deaths by suicide.”

Joanna

Joanna (she/her) is a 32-year-old doctorate-level LMHC who self-identifies as Black, Cape Verdean, middle-class, straight, and Christian. She lives and works in a large metropolitan city located in New England. Joanna provides clinical supervision, maintains a small generalist private practice, and offers counseling services at a university. She has seven years of clinical experience and is socio-economically situated in the middle class.
Being a Black Female Clinician in the United States

Joanna’s sense of a self as a Black female clinician wove threads of immigrant pride and responsibility together:

Well, yeah, my parents are immigrants and so I think it’s a really like interesting, you know, it’s really interesting because I feel like I, as a clinician can not only understand, um, or identify with the issues of both being an immigrant or a child of an immigrant, but also being Black, you know? Um, so there’s those two things happening. And so, I think being a clinician, so for me, sometimes it feels like I have this responsibility on my shoulders to, um, bring healing to my community. But not in a savior way mentality, but in a way that’s like, this is available to you. I want you to have this. And so I connect both with like, you know, the immigrant population and Black community. So like, um, which I happen to be like a Black and just you know my family is Black immigrants, African American imm- I mean African immigrants.

Her voices of community pride and responsibility contributed to her multi-faceted, ever-evolving, and critical view of the United States.

Critical Consciousness Development

Joanna’s heightened awareness about White supremacist influences on the counseling profession inspired her to challenge therapeutic conventions in predominantly White institutions. She observed:

I’m constantly judging, critiquing everything with a critical lens and even other clinicians’ work. And so that becomes exhausting because not only am I a black female who has to like educate people just on that experience of being a black
female, but then now I'm like educating clinicians or like I supervise clinicians. Um, you know, and so sometimes I feel like, okay, now I have to teach not only about the black experience, but how like about this, like, you know, how to view, how to view the social problems from like a critical lens. So, uh, again, it feels like that show, that weight kind of just constantly having to, um, educate people. Um, and so it's exhausting. Um, and, and, some of that, I think I bring it on myself 'cause I'm like, maybe I can just like, turn it off. I don't have to educate everybody.

Joanna’s corresponding I poem amplified the energy she expends and the responsible she feels to represent her community and champion her social justice commitments:

I'm constantly judging, critiquing
I'm like educating
I supervise
I feel like
I have to teach
I think
I bring on myself
I'm like
I can just like, turn
I don't have to educate

The I poem illuminated a drive to challenge orthodoxy, mentor emerging clinicians, and facilitate change through learning processes. Her narrative also established a voice of discernment, a voice that differentiated between people and social spaces that can change
and those that cannot or will not. This voice attempted to hold activism and self-care in a
dynamic balance that never reaches equilibrium. All too often, predominantly White
spaces and White dominant culture silence such voices through oppressive forces like
racial gaslighting, “the process whereby people of color [POC] question their own
thoughts and actions due to systemically delivered racialized messages that make them
second guess their own lived experiences and realities with racism” (Wood & Harris,
2021, p. 8). Such punitive systems often weaponize POC critical voices against them. For example, a clinician who advocates “too assertively” on behalf of marginalized clients
may be told they are “personalizing” or “projecting” or “not seeing the big picture
clearly.” Over time, systemic and pervasive racial gaslighting can produce weathering
effects (Simons et al., 2021)—biopsychosocial health erosion—that may contribute to
suicide in Black communities.

Experiences of Suicide in Black Communities

Joanna centered the complexities of shame in her discussion of suicide in Black
communities. Her narrative gave voice to immigrant identity and shame intersections:

Yeah. You know, shame. Shame comes up for me right away. Shame, I think
even around, shame around feeling like just having suicidal, from, so just thinking
about suicidal ideation, like having that thought. Um, I think shame around
talking about it. Like, we don’t really talk about it. Being an immigrant, being
from an immigrant family, it was like, you do not talk about it. Like that was like,
there’s not even a word in Creole for it [suicide]. That my mom recently, she, I
was giving the, ‘cause I’ve done some suicide prevention and stuff with AFSP.
And I wanted to do us, I did something for Cape Verdean community. This is a
few years ago actually. And my mom helped, like had to, we used the Portuguese word [for suicide] ‘cause Creole is a dialect of Portuguese. There was no word in Creole for that [suicide]. And so from my knowledge, but I think shame is what’s really coming up for me.

Joanna’s experience of suicide in Black Cape Verdean immigrant communities illuminated interrelated points. The fact that the word suicide exists in Portuguese—the language of the first European enslavers—and does not exist in the language—Creole—of oppressed people underscored the colonial power to erase a ubiquitous human experience like suicide linguistically. Such erasure deletes the significance of enslaved Black African protest suicides from cultural consciousness (Longman-Mills et al., 2019; Snyder, 2015). Those protest suicides could be an ethno-psychological resource to fuel liberation efforts. Furthermore, the confluence of suicide-specific language dearth, protest suicide memory suppression, and Black resiliency narrative proliferation may enable systems of shame to metastasize and ultimately contribute to death by suicide by reinforcing silence, erasure, stigma, and alienation. This convergence of forces was emphasized in Joanna’s description of images she associated with suicide:

- **I did have** a flashing light that just a, a marquee that's when you just did that (laughs). Um, **I just, I think I have, I, I visualize whispering. I visualize whispers. I visualize, I can see clo- behind closed doors** and several closed doors. Behind your door and behind that, **you know, in the bathroom, I visualize isolation I see. . . I see**, um, just, just, yeah, **I guess. Yeah. I think isolation**

Her related I poem voiced connections among behaviors frequently associated with shame (Johnson, 2006):
Joanna’s I poem recognized suicide’s taboo and named that taboo’s signature manifestation—whispering—which, like a last gasp of air before death, becomes knowingly invisible “seeing . . . behind closed doors.” Such concurrent knowing and invisibility appeared to speak to another menacing fact about systems of shame: they produce and replicate the experience of feeling shame about feeling shame. For example, imagine a Black boy who internalizes religious shame about being gay and White supremacist shame about being Black. Now in a state of compounded shame, imagine that the same boy receives family or community messages he has it better than his
ancestors, and thus, should feel grateful. In this way, systems of shame entrap people and create enduring patterns of hopelessness and despair that make “death by suicide” more probable.

**Understanding of Suicide in Black Communities**

Joanna’s analysis about suicide in Black communities integrated her immigrant, clinical, and critical perspectives. Her framing elucidated relationships among economic policy, political philosophy, social structures, and suicide:

All these things. And I think it’s unique being in a cli- clinician in America, you know, being Black, being a Black clinician from immigrant parents. ‘Cause I, I can understand, I can understand where that would come from. Like it comes from a place of like all colon- like, you know, thinking about colonial, colonialism. And, but also being, you know, being, thinking about what this country values, which is productivity. And so not only are we being taught that from like our cultural perspective, right? Like we need to honor our ancestors or we need to honor our pe-, people, our, our parents who work so hard for us. So you’re just going to like, you know, but also like this country is teaching us that. I mean, this country values productivity and capitalism. So it’s telling us to like keep working, keep going, don’t rest, ignore your feelings, grind, like grind culture. It doesn’t, and so those things contribute to this iso- being isolated. That you’re getting both like, just leave messages from the world, but then also your family. And I think that’s a unique experience for Black people because I don’t think like necessarily, I don’t know about, I don’t know about White families, right (laughs).
Joanna’s critique exposed a central lie in the dominant culture’s economic view and social contract: hard work in service of the United States’s interests leads to prosperity, which objectively measures the value of your existence. Systems of shaming reinforce this ethos. This ethos is starkly exemplified in U.S. immigration policy. Central American refugees are incarcerated indefinitely for trying to escape violent conditions produced by failed U.S. interventions, while immigrants who provide military intelligence and tactical support for our wars are elevated. The former group is treated like security threats and the latter cohort is often valorized. This hierarchy of human life that is reinforced by shaming some and elevating others both dehumanizes marginalized people and potentiates suicide risk.

**Interview Reflections**

I was first struck by the number of times Joanna used the term *shame* to describe her experiences with and understandings of suicide in Black communities: fourteen times in a 28-minute period. These references to shame emerged when I asked questions about words, feelings, bodily sensations, and images associated with the phrase “suicide in Black communities.” Additionally, the theme of shame re-emerged later in the interview when I asked, “Are there forces or experiences unique to Black communities that contribute to suicide?” Joanna replied, “I think shame is big and in the ways that we talked about earlier. Uh, you know, um, I think shame is, yeah, I think shame is big, right.” Her emphasis on the links between shame and suicide—in the contexts of the previous four interviews and extant literature—compelled me to maintain my focus on this theme while remaining open to other important themes.
Beyond the descriptive statistics and her shame-forward narrative, I also felt overwhelmed by the myriad connections Joanna made among colonialism, colonized and immigrant community shame, capitalism, and suicide. In feeling overwhelmed, I realized that this feeling was intentionally evoked by questioning dominant culture social structures. Dominant culture gets its power, in part, through sheer intimidation: the perception that it is pervasive, inevitable, and entrenched. Such perceptions, if internalized, can result in apathy, inaction, despair, shame, and suicide (DeCou et al., 2019; Johnson, 2020; Shi et al., 2021). This reflection reminded me that critical consciousness combined with social action may help inoculate people from such harms. Such interventions, scaled up to macrosystems, may promote social justice and reduce suicides linked to systemic shaming by problematizing oppressive, fear-based beliefs and socio-economic structures. These ideas seemed to be building on my reflections about Noelle’s (previous research participant) systems of oppression insights.

**Natasha**

Natasha (she/her) is a 35-year-old LCSW who self-identifies as Black, middle-class, straight, and Christian. She lives and practices clinical social work in a large southern state. Natasha works in a hospital psychiatric consultation department and maintains a generalist private practice. She has seven years of experience and is situated in the upper middle class.

**Being a Black Female Clinician in the United States**

Natasha began our interview with a candid description of her experiences as a Black female clinician in the United States today:
It is very rough. Um, I feel that it’s a growing population. Um, it’s quite small. It’s much needed. And I think that kinda like with the circumstances in media, with everything that’s been going on with, like, the Black Lives Matter and everything, that it’s really come to attention, um, the need for Black voices to, to really stand out. And having that support for our own community. And so I feel like it’s kind of growing in this area. Like, the movement, uh, kinda being, supporting each other in our mental health. And so I feel like it’s something that has definitely been getting more attention. Like, certainly there have always been Black clinicians, but, you know, I feel like the need is more, um, kinda like out in the forefront now. And it’s really not something to be embarrassed to, like, talk about, and so more people are able to kind of come out, promote it, be more willing to talk about it. Um, and so there is definitely a growing need and a growing number of mental health clinicians, which is why I wanted to be a clinician, you know. I’m like, if I needed to talk to somebody, I would certainly feel more comfortable reaching out to somebody that looked like me, that I felt understood me. And so, vice versa, you know, I want to be able to give women like me opportunities to have options and feel like they can go and talk to somebody that will understand them.

Natasha’s story emphasized the political and personal contexts that shape her experience. In Black feminist tradition, the dialogic relationship between political realities and lived experience foster consciousness-raising. Her I poem reflected the ways her consciousness emotionally, intellectually, and relationally unfolds:

I feel
I think
I feel
I feel
You (I) know
I feel
I wanted to be
You (I) know
I’m like
I need to talk
I would certainly feel more comfortable reaching out
I felt understood
You (I) know
I want to be able to give

Natasha’s voiced narrative spoke to Du Bois’s (1903/2007) concept of *double consciousness* and Kendi’s (2019) construct of *dueling consciousness*. Both ideas emphasize the reality that Black people constantly manage perceptions and conflicts about their racial identities. However, Natasha’s narrative and voice also identified the complexities of *intersectional consciousness*—the shifting, nuanced, and context-specific awareness that one’s multiple identities influence all forms of interpersonal and systemic interactions. Her poem explicated the intersectional desire to be seen and understood fully, not just unidimensionally.
Critical Consciousness Development

Natasha’s intersectional consciousness and desire to succeed foregrounded family and intergenerational roots:

Um, I think probably from a very young age. Um, I mean, I feel like probably more so in the Black community that that's something that like your parents and family have to be like upfront with you about, like. . .probably a lot sooner. Um, and so I know that my dad's always very verbal about it, like a lot of people, like my grandparents, like they've just always been like very verbal about like what they went through, you know, how things were when they grew up. Like my grandma's about to be 99, so she's like, you know, experienced (laughs) everything. So she remembers everything. So they've always like been very verbal about things that they've gone through and like just the need to like. . .do well, and, you know, so you can do better for yourself and succeed. So-It's like I've always been like aware in the back of my head, like I have to succeed and do well, 'cause, you know, my family went through a lot.

Natasha’s awareness of the connections between her family’s intergenerational struggles and her drive to succeed was showcased in the I poem associated with her narrative:

I think probably
I mean
I feel like
I know
I’ve always been like aware
I have to succeed.
The poem centered thinking, feeling, and awareness. Natasha’s narrative specifically named that her sources of knowing are “my dad,” “my grandparents,” and “my grandma.” In citing these sources, she elevated the generational, gender, racial, and oppression intersections that have contributed to her consciousness development. Intersectional consciousness may be an important concept for understanding the complex and context-bound experiences of suicide in Black communities.

**Experiences of Suicide in Black Communities**

Natasha’s responses to questions about her experience of suicide in Black communities bolstered the idea that individual suicidality is influenced by shaming systems:

> Um, I mean, for me, it’s some like, I mean, it’s disheartening, um, and kind of frustrating. Um, just because I feel like it’s something that could definitely be more prevented if it was, there was more education and like less shame around it. Um, I feel like it’s something that is happening a lot, but it’s not . . . a lot of people don’t notice because it’s not something that’s talked about. You know, like, like, the Black community just really doesn’t talk. You know, “I don’t really talk about myself. If you have issues, just go deal with it.” Like, “That’s your business. You don’t put your business out to people. You know? You keep that to yourself.”

Natasha identified associations between feeling shame and cultural norms about privacy and secrecy. Here again, patterns of systemic shame manifested as silence and secrecy. These patterns mimic Black plantation community norms: obedient silence enabled survival and disobedience frequently involved public displays of violent humiliation—
whippings and lynching. It is also true that some enslaved Black people divulged other enslaved Black people’s secrets to curry favor. Such humiliations and betrayals likely reinforced self-protective silence. While silence may have context-specific benefits, like protection, it also reinforces historical and ongoing power-over dynamics in the U.S. For example, perpetrators of violent traumas—such as the Catholic sexual abuse scandals—often rely on victims’ silence to maintain their status. Interestingly, Natasha narrated her own coping strategy with suicide in the workplace:

*I mean, because I deal with it so much, like, I, honestly it's, it's probably bad. It's kinda like desensitized me just 'cause like I deal with just like suicidal topics like so much on a daily ba- (laughs) basis, 'cause with working in the hospital setting, that's probably like 50% of the people come there for being suicidal. So I'm just so used to it. So probably for me, it's not so much like, "Oh my gosh." But, um, yeah. I'm definitely a little bit more desensitized to it so it's not really like a, there's not, like doesn't like cause anxiety or anything for me.*

Her corresponding I poem depicted emotional coping through exposure and habituation, which can have both adaptive and potentially harmful consequences like “burn out”:

*I mean
I deal
I
I deal
I’m just so used to
I’m definitely a little bit more desensitized*
The reality of Natasha and other Black people’s survival through exposure became evident when I asked her about the first images that came to mind when she heard the phrase “suicide in Black communities.” She reported:

Uh, I mean, the first like thing that actually that pops into my head would be Sandra Bland. And that’s just ‘cause of the whole story around it, ‘cause like, like I never believed that she really killed herself. Like it doesn’t add up to me. When you’re talking to suicidal people, like, for 7 years, you know, like for 40 hours a week, the story didn’t add up to me. So that’s like the first thing that kinda stands out in my head and then just knowing that there’s probably like hundreds of other stories that are similar to this, and then just like kinda the anger that it’s not getting the… I mean, it got the recognition, but I feel like… it didn’t get the justice that it deserved, like her family.

Natasha’s reaction maintained a critical stance and underscored the reality that for every spotlighted Black murder due to dominant culture violence, countless others occur outside of the public’s view. Her response also punctuated another fact about Black deaths: recognition and justice are not the same thing. Finally, Natasha’s experience highlighted the extreme strategies needed to survive in a culture that kills marginalized people without consequence. One can understand that ongoing exposure to such violence could attract people to death by suicide as a means of escape or protest.

**Understanding of Suicide in Black Communities**

Natasha’s views reflected an intersectional consciousness framing of suicide in Black communities:
I guess just in the Black community, just not wanting to, I guess have the negative attention and again, it’s something that’s not talked about. Like you always, like, you know, that I wanna portray that everything’s going well, and then have to explain something like that, you know, that just kinda shatters your whole façade that you just (laughs) have been putting on. Like, you know, obviously things aren’t going that well if this happened. And this kind of just like I feel like a Black woman in general you’re supposed to be able to, be able to handle anything and everything, you know? We’re just expected to be . . . strong, and no matter what happens to us.

Her understanding unveiled connections among general Black community norms, and gender and racial interconnections. Natasha’s perspective exposed yet another way that systems of shame promulgate Black community stereotypes: mythologized standards of physical and psychological strength establish distorted expectations that are selectively applied to instill shame and induce social control.

**Interview Reflections**

In thinking about my interview with Natasha, I observed myself ruminating about the first image that spontaneously emerged for her: Sandra Bland. In thinking about initial police reports and media coverage surrounding her death—labelled “a suicide”—I was reminded of Reynolds’s (2016) observation that perpetrators of violence often use language to obscure their culpability by shifting causality to their victims. In Sandra Bland’s case, her mental fragility was highlighted and evidence was mischaracterized to frame her death as “a suicide.”
Additionally, the interview with Natasha made me think about dominant culture fear narratives about Black people. I thought about the possibility that White people seem to have two converging fears: White inferiority (shame) and Black people’s superiority. Embedded in each narrative is the cognitive distortion of minimization and maximization. Both distortions seem to serve the same end: dominant culture privilege and power. Such distortions often exaggerate Black strength, endurance, speed, sexual appetites, and pain tolerances while simultaneously dismissing Black intellectual prowess, religious traditions, and cultural contributions. These distortions appear to get weaponized into forces that quell White fear and exert control over Black lives.

Subsequently, I pondered the relationship between fear and ever-evolving and intensifying systems of harm that intentionally produce cascading upstream-downstream pressures for Black communities. These pressures likely converge to create death by suicide contexts such as colonized physical spaces, over-regulated bodies via mass incarceration, resource-deprived communities, forced family separations, and alienated individuals. Based on these contextual examples derived from participant interviews, violence, trauma, oppression, and shame appeared to be cross-cutting themes. I then asked myself, “Is there a thematic through-line among these themes?” Power seemed like an obvious candidate. I then shifted to thinking about the power-over dynamics that the Black female participants had already identified. A recurring dynamic appeared to be dominant culture shaming, either in conjunction with other forces or on its own. Such forces appeared to produce or compound internalized Black shame—the intentional use of systemic power to instill and deeply embed the belief that to be Black is to be bad. I
concluded that I needed to both pay attention to this possibility and remain open to other data patterns.

**Brandi**

Brandi (she/her) is a 36-year-old LCSW who self-identifies as biracial and Black, middle-class (though grew up working class), heterosexual, and Christian. She resides in a small southern state and maintains a generalist private practice in a medium-sized city. Brandi has 11 years of practice experience and is situated in the middle class.

**Being a Black Female Clinician in the United States**

Brandi’s story began with the observation that she is being sought out more because of her racial identity, and that fact creates pressure and evokes a sense of responsibility:

Um, I feel like today, I think that Black female clinicians are probably more sought out, I think, than they’ve ever been. So probably within the past year or so, I’ve had more people ask about my racial identity or say that they were seeking someone that they felt looked like them. Um, and that’s something that’s kind of new or different that hasn’t been, I guess, directly verbalized . . . when people were seeking out providers. Um, I think there was pressure, or I feel pressure, um, to do a good job, or take care of other people, um, who are Black, or people of color, um, because I don’t want to let them down. Um, because I’ve heard stories of other providers who have let them down. Um, so I do feel, I think, a sense of pressure or responsibility to take care of people that are like me, or similar to me, or relate to me.
Her story provided another example of the ways Black women shoulder community caregiving responsibilities. Brandi’s narrative also situated such responsibility in the contexts of dual pandemics: COVID and anti-Black violence. These contexts intensify a sense of pressure to help because both crises have triggered compounding forms of fear and anxiety. Her pressure to serve Black clients well is likely connected to her world-view as a Black biracial woman.

**Critical Consciousness Development**

Brandi’s consciousness emerged from her intersectional experience of being biracial and female:

Yeah. I think that’s an interesting question because I don’t know if I was ever not aware. Which is kind of a big, a big statement. But I don’t, I don’t know if I was ever not aware. And so, um, I don’t know when I would’ve heard the story of my birth. I’m sure very young. But my mom is White and my dad is Black, um, which was just not allowed, um, in the family that my mom grew up in. Um, and so she ran away on the day that she was scheduled to have an abortion with me.

Her narrative unearthed the heart-breaking reality that White supremacist purity almost resulted in her death. It also uncovered another insidious system of oppression that often operates in tandem with White supremacy: misogyny. Being Black and female compounds the likelihood of erasure (Epstein et al., 2017). Such compounding experiences of oppression probably heightens suicidality risk in Black females.

**Experiences of Suicide in Black Communities**

Brandi’s thoughts about suicide in Black communities linked individual emotional states, marginalization, and resource deprivation:
Um, I think sadness, um, comes to mind. Um, fear that things will continue. Um, and then just anything that’s kind of expressly identified by race, I tend to think of, like, marginalized or oppressed, or maybe lacking resources. And so, when I hear suicide in the Black community, I think of a community that may be lacking resources. Um, and I think of suicide as something that can be, maybe not 100% preventable. Um, but that can be prevented in some cases. Um, or that treatments or interventions can be offered. And so, lack of resources without intervention, um, that idea makes me sad. That’s what comes to mind.

Her experience reinforced perspectives offered by previously interviewed participants: resource deprivation plus oppression contributes to suicidal crisis. This crisis is probably further intensified by dominant culture and Black community narratives about resiliency.

**Understanding of Suicide in Black Communities**

Brandi’s understanding of suicide in Black communities centered on isolation and alienation related to beliefs about strength and survival:

So I think of suicide in the Black communities as s- something, I guess, that is not to be talked about, I guess, or just the emotional struggles in general may be something to just not talk about or discuss. You’re just supposed to keep moving or survive or take things as they come. Um, and so I think of suicide in the Black community as some, I think of a person that has maybe not felt as though they can have an outlet for their emotions or even to process them or to acknowledge them. Um, and just carrying a heavy burden of feeling like they couldn’t express themselves.
Brandi’s perspective underscored a common feature of anti-Black shaming systems. A Black person encounters a systemic shaming force and experiences an intense emotion that triggers an internalized coping belief: “be strong,” or “work harder.” The individual exerts effort to be strong or resilient. The Black person’s response is likely to fail because the strength narrative contains distorted elements (Black people are stronger than others) and systems of shaming are designed to increase the likelihood of failed outcomes. Failure to improve one’s situation frequently results in learned helplessness and hopelessness. These states produce, sustain, or operate in tandem with shame. To escape feelings of helplessness, hopelessness, and shame, people may gravitate toward death by suicide.

**Interview Reflections**

Brandi’s interview triggered memories of my work at a Romanian orphanage. One of my jobs was to work in a nursery with infants diagnosed with HIV/AIDS. I recalled my first day walking into a gymnasium-sized room with rows of cribs lining the floors. My most vivid memory was of the eerie silence I noticed. In a room filled with healthy infants, one should hear babbling, cooing, and/or crying. All I heard was silence. Most of the infants died of complications related to failure-to-thrive—the psycho-physiological condition that emerges, in part, from human isolation and alienation (Sciarrino et al., 2018). I noted the parallels between death by suicide in Black communities and Romanian orphans who died by failure-to-thrive. Universally, human beings need connection that instills a sense of belonging (Bryan, 2021). Such belonging literally grounds us to life. Absent this belonging, we lose our humanity, our health, and often our lives.
As I thought about the basic human need for connection, I wondered about the stories people are told and retell to themselves about their belonging, or lack thereof. I thought about the countless survivors of chronic sexual abuse who internalize narratives that their abuse was caused by “something essential about me” (a former client’s direct quotation). Another gay male client of mine once reported that he often sought out abusive relationships because being with abusive men made him feel both “intimately connected” to his father and “bad about myself.” These memories compelled me to revisit questions about internalized shame narratives and suicide because they seemed to echo participants’ stories about shame and suicide.

Ciara

Ciara (she/her) is a 32-year-old LCSW who self-identifies as Black, middle-class, straight, and as not having a religion. She lives and works in the suburbs of a centrally-situated midwestern state. Ciara maintains a generalist private practice that predominantly serves Black women and works per diem in a hospital emergency department. She has seven years of clinical practice experience and is situated in the upper middle class.

Being a Black Female Clinician in the United States

Ciara’s experience of being a Black female clinician has been overwhelmingly positive. She reported,

Um, today? What is it? I think, um, [inaudible 00:02:30], I think it’s a really good time to be a, um, basically any person of color in, in therapy. I feel like a lot of people come to me, like, [inaudible 00:02:40] my practice, I have a private practice and I’m working at another job, but our practice built up so fast. I think a
lot of people wanna work with people who look like them. And it, it’s not, it’s not
a lot, but it’s becoming to be a lot of, um, people of color as therapists.

Ciara’s narrative echoed what other participants described: people want to see themselves in others and they want to be seen. Her narrative also revealed another interesting fact.

Ciara, like several other participants, works more than one job: a job that provides material benefits and a private practice that offers autonomy. Such autonomy likely offers personal and professional benefits. For example, private practices typically empower clinicians to choose their clients and offer services that align with their interests. It is also likely that this autonomy and empowerment is integral to self-care while trying live and work in predominantly White systems. Ciara’s sense of optimism and empowerment manifested in her consciousness.

Critical Consciousness Development

Ciara’s critical consciousness development was not influenced by a particular critical incident or defining moment. Rather, it unfolded gradually over time:

Hmm, I would say I probably experienced it or saw it when I was younger, but I didn’t know, uh, how to put it, you know, or put a definition or term to it. I don’t feel like I really became conscious or aware maybe until like sometime in undergrad.

Her consciousness burgeoned when she began working as a parole officer. That experience, coupled with her clinical work at hospitals and with Black LGBTQ+ youth, broadened her consciousness about the ways oppressive systems often shape life outcomes. This awareness framed the way she experiences and understands suicide in Black communities.
Experiences of Suicide in Black Communities

Ciara’s experiences of suicidality among Black groups underscored shame: fearing judgment and secrecy behavior are often associated with shame (Johnson, 2006). She remarked,

Um, I think a lot of judgment, uh, when I’m working with clients, they, in them, it’s like this, uh, thing. Like they, I think a lot of Black people, they have like high respect for their, um, you know, parents and elders and they just feel like, you know, I don’t know. And when you were, um, I don’t know. I think, and then you hear this term too. Like what happens in this house stays in this house. Like it’s a lot of secrecy in the um, Black community. They don’t wanna deal with it or, or even talk about what’s going on in there, in, in the inside. Like I said, it’s not . . . when I was in class, and I wasn’t getting partner up because everybody was partnering up and I, and I just quit the class. I didn’t talk to anybody about it.

Ciara referenced an experience she had in a college class where she was the only person of color. It was a lab course and no one would partner with her. Poignantly, she shared her own experience of shame and secrecy as she discussed the broader cultural concerns about being judged: “I didn’t want anyone to know because of judgment.” These themes also emerged in Ciara’s discussion about suicide in different Black cohorts.

Understanding of Suicide in Black Communities

Ciara discussed her understandings of suicide in Black communities by examining three client populations she has worked with clinically: men on parole, emergency department patients with COVID-19, and LGBTQ + clients. In her work with men on parole, she shared that most of her parolees reported grief about not knowing their fathers
or having male role models more generally. Ciara remarked that this father-figure absence often meant that her parolees often felt pressure “to become the men of the house at young ages because they saw their mothers working two jobs.” The dual burdens of grief and parentification often fueled an intense build-up of “pressure.” In the context of racialized, male strength narratives that produce shame, Ciara’s parolees shared with her stories “that sounded like suicide notes.”

In addition to her work with male parolees, Ciara commented that her work with Black COVID-19 patients in an outpatient hospital setting further shaped her understanding of suicide. She noted,

COVID, it really had an impact on people because, you know, staying in the house and really having to deal with their thoughts and not being able to have things as a distracted, distraction. And, um, I was seeing so many people come in with suicidal ideation and it was like, so, it was so many people. And I think like having to be in a quarant- like getting quarantine, like really having to sit in your thoughts and really dealing with that, or I think that in lagging depression increased because people really had to sit in their issues. Like it was hard for people.

Ciara’s observation linked feelings of entrapment and pervasive systemic threats to suicidality. This convergence of inescapable lived experiences and oppressive systemic dangers also manifested in her work with Black LGBTQ+ clients. Ciara stated that she provides support services at the Open Door Project, which offers clinical services to the LGBTQ+ community. Based on this work, she shared,
I have a lot of clients who, a lot of my clients are like hated. They haven’t come out to their parents and they, and I feel like, uh, any even like living a double life, they talk about living a double life. Like I’m going out on a weekend and being able to dress the way they want to dress. And then coming back home and having to be another way, like it’s, it’s… that’s causing them the, the depression and anxiety. Like people, like, I don’t know, they just talk about like, just being really stressed out about that. And, um, I hear a lot of people who have, um, suicidal thoughts dealing with, um, just coming out. And I think in a, in a, in the Black community, I don’t know why it’s just such a, a thing that people just don’t wanna admit or come out to. They’re scared because they say like, um, people, their family will disown them.

Ciara’s anecdote unearthed the intersecting and compounding effects of anti-LGBTQ and anti-Black systems of shame that commonly drive suicidality in this population.

Ciara’s differential understandings of suicide in Black communities highlighted the importance of using intersectional and systemic lenses to illuminate suicide’s complexity across groups. Her examples also challenged the efficacy of large-scale, one-size-fits-all approaches to suicide prevention and intervention.

**Interview Reflections**

My interview with Ciara prompted me to consider the ways systems of shame operate in my own life. As a gay man who teaches full-time at a conservative Catholic university, I experience varied forms of vigilance. In the introductory courses I teach, I refer to “my spouse.” Only in upper-division courses in which I have taught all of the students previously will I disclose a reference to “my husband.” While that negotiation
feels weird to me, I am most guarded when it comes to public bathrooms. Because of the stereotypes about gay men as sexual predators and the Catholic Church’s sexual abuse scandals, I will not use campus bathrooms that can occupy more than one person. While I intellectually know the risk of being accused of inappropriate student contact is relatively small, the reality that my career could be ended by a disgruntled student who makes a false accusation compels me to be extra cautious. Here, I can see the system of heteronormative shaming play out in my own life in all of its insidious manifestations. I am a fearful victim and I continue to re-enact the internalized shame I experience. In this way, my own lived experience resembles the shame narratives described by Ciara. Such narratives increasingly influenced my understanding of shame and suicide in Black communities.

Paula

Paula (she/her) is a 38-year-old LCSW who self-identifies as Black, Caribbean, middle-class, straight, and Christian. She lives and practices in a large metropolitan city located on the East Coast. Paula works in a large public school system providing clinical services to adolescent students. She has seven years of clinical experience and is situated in the working-middle class.

Being a Black Female Clinician in the United States

Paula’s description of being a Black female clinician in the United States today affirmed concerns expressed by other participants. She observed,

Um, let’s see. I feel like that’s like a 10-page paper question. Um, let me see. I would say it’s difficult. So, so yes. I had a parent. And so here in [omitted to maintain privacy], I work with a lot of Black and Brown students, families, um,
and so this experience happened when I was in [a West Coast state] for a residential program, um, for the summer. Um, and, you know, you get parents who, you know, we call them the private pay ‘cause they’re able to pay just out-of-pocket and it’s not a cheap program. (laughs) And so, you know if they’re paying for that, that they’re coming in, you know, sort of from like, the higher, upper class or whatever you wanna call it, um, which obviously comes with their, the baggage, right? (laughs) Um, the baggage that’s the privilege for nothi- for doing nothing. You just have the privilege for being born White. Um, and so I just had a parent ask me, like, “So, tell me about you. Like, tell me, like, what are your credentials? Like, tell me about yourself.” And I just feel like it was odd. Um, I feel like that’s a question that I would ask like at a cocktail party. (laughs)

Paula’s narrative incisively exposed dominant culture class privilege. This privilege, especially among upper-class Whites, often presents as “curious inquiry.” However, the implicit classist question is: Are you important enough to serve my child? Such questions are yet another potential weapon in the arsenal of shaming systems. Experiences of systemic shaming appeared to be revealed in Paula’s description of her critical consciousness.

**Critical Consciousness Development**

Paula stated that her critical awareness is a recent development. She noted that she has attended several school district trainings about diversity, equity, and inclusion. These trainings exposed her to aspects of American history that she never knew. For example, she attended a continuing education workshop that detailed the evolution and impact of redlining banking and housing policies. Paula went on to recall an interaction with a
Black female student who believed she was ugly because of the color of her skin. This interaction triggered memories of when Paula felt the same way. This experience revealed to her connections between gendered racism and beauty. In a world in which women’s survival and success is still contingent upon conformity to dominant culture’s standards of beauty, Black women often experience shame related to hairism, sizeism, colorism, and lookism.

Experiences of Suicide in Black Communities

Paula’s experience of suicide in Black communities stressed hopelessness as a key factor. Specifically, she emphatically expressed a connection between individual hopelessness and upstream causes like oppressive beauty standards and public policies that over-regulate Black and Brown bodies. These forces inhibit Black people’s sense of worth and hinder their ability to access sources of security (i.e., jobs). These barriers, especially when experienced intergenerationally, can contribute to suicide by enabling the belief that progress will never be achieved. Such despair may become more deeply entrenched in communities, families, and individuals that internalize narratives that center themselves as the cause of stagnation—shame.

Understanding of Suicide in Black Communities

Paula’s framing of suicide in the communities focused on historical and intergenerational trauma. She proposed,

Um, so, I feel like, wow, that’s like a loaded question. ‘Cause it’s like so many things that, you know, you think of just trauma, and then you have generational trauma. Um, and then there’s like the post-traumatic slave, um, syndrome. And, like, that stuff is real and it does have a trickle-down effect and so, um, when we
see that the same thing is still happening, uh, or something very similar, right? Like, if you think of the protests from last year and you think of the Civil Rights Movement, we can look at them and it’s like, parallels, right? Like, and it’s like, we’re still doing this how many years later? And I feel that’s where, like, if we wanted to go to, like, the core of things, we could start there. Um, because um, right? You keep seeing the same thing over and over again, you’re like, it’s happening and it’s never gonna change. Um, and then you look at your own personal life and you’re like, nothing’s changed here, um, so you figure, this is it, and I don’t wanna deal with it anymore, and I wanna go.

Paula’s theory underscored the weathering effects of trauma and the lack of substantive social justice progress. This dearth of progress, despite the tremendous actions of civil rights and social justice movements, reinforces hopelessness and likely intensifies feelings of shame, i.e., no matter what we do, we’ll never be good enough.

**Interview Reflections**

The interview with Paula represented a critical moment in the research process for me. After the interview concluded, an organizing metaphor for this research project crystallized for me because of Paula’s use of the phrase “trickle-down effect”: water flowing from upstream to downstream. As I thought about the narrative voices of Paula and the previous participants, different water-specific images sprung into my head. I pictured voices of feeling and not feeling, knowing and not knowing, and being and not being ebb and flow like tidal patterns. Furthermore, many of the I poems read like white water rapids swiftly twisting and turning from certainty, to questioning, to interrogating, to wondering, to knowing, to asserting, to silencing. These images also led me to think
about bodies of water like oceans, lakes, rivers, and streams. I noticed myself gravitating towards stream imagery.

Literally and metaphorically, streams are dynamic; they both remain relatively the same and are always changing simultaneously. Streams have sources and origins and they have final destinations before they empty into different or bigger bodies of water. In this way, streams are systems within systems. The stream imagery also lends itself to a widely used metaphor to examine complex and dynamic relationships: upstream causes and downstream consequences. The interview data and my critical frameworks seemed to be reinforcing the need to look as far upstream as possible to better understand suicide in Black communities.

**Dominique**

Dominique (she/her/hers) is a 30-year-old LCSW who self-identifies as Black, middle-class, straight, and Christian. She lives and works in a large East Coast city. Dominique’s clinical practice includes school-based with children and adolescents, as well as work with military populations. She has six years of experience and is situated in the working-middle class.

**Being a Black Female Clinician in the United States**

Dominique’s perspective bluntly reflected her frustration with her role and the systems that shape her work:

The first word that comes to my mind is bullshit. (laughs) But, um, excuse my French but it’s, it’s very hard. Um, you know, I joined this field because I wanted to help. Um, and when entering into the field I often ask myself, am I part of the problem or am I part of the solution? And a lot of my fellow coworkers would
like, “What do you mean?” It’s like, we’re feeding into a system that does not work for the people that we serve. Um, and so I, and then also recognizing my power and my privilege as someone who can make someone’s day upside down by making a phone call, right?

Her frank analysis exposed conflicts between the intent and impact of helping roles and systems. Such conflicts exist because the roles and systems are not designed by or for the people impacted. Rather, most roles and systems are created by people with power for people with power to codify their privilege in perpetuity. For example, capitalists created capitalism to maintain and perpetuate their Protestant work ethic, laissez-faire business philosophy, and social Darwinist views about people living in poverty (Marx, 1867/1990). Dominique’s insights inspired the development of a critical awareness that emphasizes humility.

**Critical Consciousness Development**

Dominique’s critical awareness manifested most profoundly in her description of its evolution, “Um, I accept that I know nothing. Um, as, as much as I learn and acquire over time I just know that I know nothing.” Her associated I poem amplified empowering connections among acceptance, learning, knowing, and humility:

I accept
I know nothing
I learn and acquire
I just know
I know nothing
Dominique’s awareness and acceptance of “knowing nothing” aligns well with a critical consciousness. Such consciousness privileges the intentional and ongoing examination of oppressive systems and one’s role in them. This examination—when done with humility—both liberates one from the delusional self-satisfaction of having “good intentions” and reminds individuals that true freedom only exists with the extinction of oppression for all people. Dominique’s humble and critical awareness informed her experiences of suicide.

**Experiences of Suicide in Black Communities**

Dominique’s views about suicide in Black communities re-affirmed the fundamental role of shame:

Fear, shame, abandonment. Fear that people are gonna judge them as weak. Um, I was thinking about this before we got on the call, I’m thinking about, you know, how certain people are labeled, you know, White people may be labeled a certain way, right? Or things are more, maybe more accessible or, um, maybe they’re more willing to ask for help but there’s just this stigma attached to asking for help, um, when you’re a Black person or a person of color. And, you know, it could be religion or it could be your parents and just, you know, the fear that, that person will be labeled or somebody is gonna say that they’re weak because this, they couldn’t ex- they felt like they couldn’t exist here . . . And it’s like, the shame that you’re gonna feel if you are, if you name how you’re feeling or if you are vulnerable, um, or if you communicate certain things. It’s just the shame that’s attached to, you know, saying like, “I need help.” Um, and then in terms of
suicide, that, just that, that label . . . that’s, that’s put on someone, again, for being weak.

Dominique’s analysis emphasized the ways that fear, abandonment, and shaming subvert the prosocial potential of family structures and faith traditions. Anti-Black racist shaming systems perniciously tap into fears about being weak—exploiting community strength narratives—and alienates individuals from themselves and others. This marginalization likely potentiates suicidality because death provides a permanent solution to the problem of weakness and alienation.

**Understanding of Suicide in Black Communities**

Dominique’s theory of suicide in Black communities featured trauma and socio-political intersections. These intersections produce disparities associated with deaths by suicide:

I’m gonna say is exposure, um, and exposure to more trauma. Um, for me, I think that like when you, when you’re exposed to so many Black bodies being harmed on social media and nothing being done about it, um, it almost gives you the sense false of freedom. I think that’s what America kind of feels like for people who are Black or Brown, who are immigrants. It’s like a false sense of freedom. Um, you think that, you know, you’ve come here and you have freedom of speech, freedom of, you know, to just live your life and do the things that you, and it’s not really that when you start to learn about these different things, um, and you start to learn about how these systems are very oppressive and in, in combination with that mental illness, right?
Her point of view promulgated the idea that political trauma and oppression rob people of their dignity by denying them their basic human rights. This dehumanization both exacerbates pre-existing mental health conditions and promotes new psychopathology emergence. These experiences frequently involve shame and suicidality (DeCou et al., 2019; Johnson, 2020; Shi et al., 2021).

**Interview Reflections**

Throughout my interview with Dominique, she explicitly centered racialized violence, trauma, oppression, and shame themes. When asked “What comes up for you when you hear the phrase ‘suicide in Black communities’?” she responded, “Fear, shame, abandonment.” I then followed up by asking, “Where do you think that sense of shame comes from?” Dominique replied, “Trauma.” In this exchange, she linked suicide, shame, and trauma explicitly.

Dominique’s critical observations encouraged me to reflect on the ways shaming flows downstream from historically bound atrocities to ongoing, present-day violence. I thought about the ways such atrocities influenced the physical environments and geographic locations of enslaved Blacks and shape today’s Black communities. I contemplated the connections between power and oppression in the form of eco-racism. I then reflected on dominant culture policies that likely harm community health and well-being. That reflection revealed thoughts about the ways institutional disregard might affect the ways Black people make meaning of and internalize the compounding effects of shaming. This stream of consciousness seemed to embody movement—the flow—of participant voices and my understanding of suicide in Black communities.
Andrea

Andrea (she/her) is a 35-year-old LCSW who self-identifies as Black, middle-class, heterosexual, and Christian. She resides in a large southern state and provides clinical services in hospital and private practice settings. Her hospital-based work focuses on psychiatric assessment and triage. Andrea’s private practice emphasizes a range of concerns experienced by Black women. She has 11 years of experience and is socio-economically situated in the upper-middle middle class.

Being a Black Female Clinician in the United States

Andrea’s story about being a clinician in the United States juxtaposed and contrasted private practice and public clinical work. She noted,

Um, I would describe being a Black female clinician . . . Well, I do like it because this is what I do, it’s my norm, (laughs) um, but I do feel like there is a lot of, um, navigation in certain senses as a- as a private, um, practice clinician. Um, it’s like freeing, it’s independent and then, um, a lot of my clients that come to me are Black females, and so it’s really an opportunity to connect and provide services with somebody that looks like you and perhaps certainly has, um, similar experiences, um, as you, and kinda also understanding some of the things that seems to transcend like of that or- in the Black community related to like mental health or feelings, emotions and things like that. Um, and, I guess, corporate America in a hospital setting, being a Black clinician is different. Um, I frequently feel like I have to prove myself, um, my skillset, my knowledge. Um, I also have to navigate, um, perception and, frequently, like the microaggressions, um, like, “I think you’re aggressive,” because I was firm or,
“You’re being rude,” because of my perceived tone, even though this is like a general interaction every time, so it doesn’t change.

The stark contrast in Andrea’s narrative underscored the aggressive and toxic ways predominantly White institutions treat Black professionals. Her I poem revealed an intersectional consciousness that shifts as her context shifts:

I would describe being
I do like
I do
I do feel like
You (I)
You (I)
I guess
I frequently feel like
I have to prove myself
I also have to navigate, um, perception
I was firm.

Andrea’s poem denoted self-confidence and joy and then abruptly became careful, cautious: “I do” to “I guess.” By the end of the I poem, she expressed feeling strained. Furthermore, her intersectional consciousness centered her abilities to anticipate, adapt to, and cope with White colleagues’ appraisals of her. Such awareness has been embedded in Andrea’s experience since childhood.
Critical Consciousness Development

Andrea’s critical awareness was described the way that most people would describe an in-born sense like taste or touch:

Um, and then, I guess, I don’t know. Maybe . . . I don’t know if I wanna say innately I’ve known . . . because I just think about like childhood, adulthood and things like that, there was- there is . . . I- I feel like there’s kind of always been a understanding that not everybody is gonna experience things exactly how I experienced them.

Her experience underscored an “innate” alienation, a life-long perception that most spaces will not include other people with similar lived experiences. Such perceptions, coupled with ongoing challenges to one’s professional skill set, likely contributes to workplace stress, vigilance, and burn-out. These experiences all carry the potential to trigger suicidality.

Experiences of Suicide in Black Communities

Andrea’s story about suicide reflected both family and professional experiences. These experiences bolstered previously described perspectives about Black families, suicide, and stigma. Her narrative also revealed the formidable challenge in addressing stigma through education:

So I feel like suicide in Black communities is not frequently talked about, um, it’s taboo, and it’s- it’s just like an avoided kinda topic, um, and stigma. And so, frequently speaking, um, when I think about like suicide in the Black community, I see it ‘cause I see people that have attempts. They come to the hospital and are in a crisis. Um, uh, in my own family, my niece, when she was younger, was
suicidal, but the response from like my grandmother was essentially like, “Well, I
wouldn’t do anything to help safe- safety plan,” like, “I’m not gonna put away my
meds to . . . If she’s gonna take ‘em, she’s gonna take ‘em,” that kinda thing. And
so even having to like coach my sister through it, coach my grandmother, and I’m
like, “That is not okay. You can’t say that.” (laughing) And I say, “You would
feel horrible if something happened.” Like, “You can’t do that.”
Andrea’s family story exposed a fatalism about suicide that probably reflects the learned
helplessness and hopelessness generated and promulgated by dominant systems. Such
systems reinforce the belief, “I have no control.”

**Understanding of Suicide in Black Communities**

Andrea’s understanding of suicide in Black communities mirrored other
perspectives that centered on Black strength and resilience:

Um, the nar- the strength narrative, that, um, like, I guess it’s like almost like a
catch-22, so like that- the narrative that, “Look how resilient Black people are,
they’re super strong,” that kinda thing, so I feel like if needing help is often seen
as a weakness, and then there’s also like, I guess it’s . . . I don’t wanna say it’s an
unwritten rule, but it’s very much taught, I feel like in a Black community, is that
we don’t talk about our feelings, or expressing or showing feelings is a sign of
weakness, especially like if you think about men, and then, um, essentially, I
don’t have time to sit in these feelings or experience these feelings because I have
people that depend on me, in a certain sense. And so, frequently, um, in the Black
community, women are like the matriarchs of families and hold everything
together, so if I’m not holding everything together then it’s going to fall by the
wayside. Um, so I think those kind of things, uh, we don’t talk about what goes on at home, we don’t talk about it to other people, helps fuel that narrative.

While Andrea’s narrative predominantly supported previous participants’ stories, one important insight she voiced pertained to “showing feelings.” When one’s life is organized around basic survival, emotional awareness and expression are often framed as self-indulgent luxuries. This framing further robs Black people of their humanity and a resource: emotions are necessary for human survival and thriving.

**Interview Reflections**

My interview with Andrea unearthed in me the recognition that mental illness was mentioned infrequently in relationship to suicide in Black communities. I expected, because I was interviewing clinicians, to hear more about the role of psychopathology. Even when trauma was mentioned in other interviews, it was always framed in social, political, or historical terms. Because psychiatry, psychology, and counseling are inept at understanding and applying such frameworks, I wondered if this limitation leads Black people to forgo mainstream psychosocial support even when they have access to it. I also reflected on the ways Black community members are over-diagnosed with the most stigmatizing mental health conditions. This line of thought spurred me to be curious about the intersections of clinician race, client race, and diagnostic outcomes. This intersection has implications for who labels whose experience as death by suicide and/or death by oppressive systemic forces.

Finally, Andrea frequently associated the themes of “trauma,” “stigma,” and “denial” with suicide in Black communities. She noted that the topic of suicide, even with Black clients experiencing suicidality, is often “avoided.” When I asked her to
hypothesize the cause of such avoidance, she replied, “The strength narrative.”

Interestingly, avoidance is a typical behavior related to feeling shame (Johnson, 2006). Such avoidance and shame connections seemed even more probable given the taboo associated with suicide and the premium placed on strength and hiding weakness in Black communities.

**Artistine**

Artistine (she/her) is a 35-year-old licensed independent social worker who self-identifies as Black, upper-middle-class, straight, and Baptist. She resides and works in a midwestern state suburb. Artistine maintains a generalist private practice that predominantly serves Black female populations. Her clinical experience spans over ten years.

**Being a Black Female Clinician in the United States**

Artistine’s perspective about her intersecting personal and professional identities illustrated the complexities of working in roles and systems created by White dominant culture. As her story unfolded, one could feel the myriad tensions Artistine and other Black professionals experience:

Um, I would say it’s a . . . I would say it’s very interesting, I think, even just last night, um, I like retweet it. Um, there was a tweet where, um, this woman was saying like part of her struggle with like imposter syndrome as a therapist is because, um, a lot of the things that we learn is based in like very Eurocentric, um, values and, um, ways of like knowing and doing things and all that. And so it’s hard to always like bring yourself when that’s not been your experience. So I was, that is a part of my experience. So sometimes having imposter syndrome,
and like, um, you know, I was feeling like I have to double-check myself and kind of, um, police myself sometimes. Um, so I’m not either like too much or too something, whatever that may be. But, um, then there’s another part where then I know like I’m healed, I’m educated, I know how to do the job. I know how to work with my clients. Um, I love working with my clients, you know, it’s enjoyable. Um, more recently with the pandemic, I’ve been tired (laughs). Um, and with everything that has gone on, um, with like George Floyd and like all that like I’m tired, there’s just a lot of stuff going on. And I feel like everything . . . And I’ll talk about this in supervision too but it’s like, um, when things are happening, it’s like happening on like one level and then it’s also ha-
then there’s like all these intersecting things that are happening, too.

Artistine explicitly named the unique and depleting exhaustion that accompanies her intersectional consciousness. Her I poem revealed the ways she traverses White privileging roles and systems:

I would say
I would say
I think
I like retweet
I was
You (I) know
I was feeling
I have to double check myself
I’m not either
I know like
I’m healed
I’m educated
I know how to do the job
I know how to work with my clients
I love working with my clients
You (I) know
I’ve been tired
I’m tired
I feel like everything
I’ll talk

The I poem amplified Artistine’s contrapuntal voices that narrate her lived experience as a Black female clinician: she monitors and regulates herself while simultaneously feeling self-possessed, joy, and exhausted. Her use of the word “police” as a verb seemed especially significant. It implied an internalization of dominant culture oppression: protection by policing. However, her empowered and joyful voices seemed to protect her from being and feeling completely subjugated. Additionally, Artistine’s fatigue is both historical and present as evidenced by the verb tenses she used. Such voiced experiences elucidated the malevolent ways dominant culture exerts control over external systems and the inner lives of Black communities. Critical consciousness offers the tools to protect Black people from the most deleterious effects of oppressive hegemony (Mosley et al., 2021).
Critical Consciousness Development

Artistine’s critical awareness began gradually with her observations about social class differences in schools. As she progressed through school, she noticed the intersection of race and class:

So I think, for me, it happened in kind of like bits and pieces, I think. Um, initially. . .Well, probably like, probably high school. Um, so in high school, I went from . . .So I grew up in Cleveland and went to Cleveland public schools. So I went to school that were predominantly Black, um, for elementary school. So kindergarten through you know, kindergarten through fifth grade. And then middle school, too. But then high school, I transitioned to private school. Um, I’d gotten a scholarship and I went to, um, a private school in Cleveland. And it was Catholic high school, and it was all girls. And so, um, I think that was, that was a point. Um, it was very interesting being like, you know, not in the majority having growing up in predominantly Black schools. But it was, um, a very, very, very, um, wealthy, um, private school, and I was very not wealthy. So I don’t know that I necessarily focused on race as much but I definitely noticed the difference in like kind of, you know, um, like class was, was a big thing, initially. Um, and race was there. But I don’t think that I was as [inaudible 00:22:50] as critical of it, but I definitely became very conscious of the Black, um, the class differences.

Artistine’s narrative revealed another significant dimension of shaming systems: social class. Class manifests itself in numerous ways: the way people talk, the clothes they wear, the places they live, and the opportunities they can access. Such manifestations in a capitalist society are used to ascribe differential privileges across social systems. These
privileges typically include access to power, prestige, and/or material wealth. Limited or denied access to such resources increases the likelihood that people will experience poverty. Poverty is a risk for suicide in Black communities (CDC, 2020).

Experiences of Suicide in Black Communities

Artistine’s thoughts about suicide in Black communities focused on her involvement in church:

Um, I think a lot about the church. Um, and I think that that comes up specifically because . . . Um, you know, I definitely think, you know, in a church we need to, which is, you know, a heavy influence on the Black community. Like we need to be talking about this kind of stuff. Um, it is not something . . . You know, mental health in general, I feel like it’s, I mean, I think it’s growing, right? But I think in a general sense, it has been pushed off until, you know, maybe very recently when everything, everybody was told just pray it away, just kinda, you know. And not that I think that it is to blame. But I certainly think that there is a heavy influence of like the Black church within the Black community to kind of like, you know, if, if this is something that has happened, you know, somebody has died by suicide, they had to be crazy or they had to be, you know, um, they didn’t pray enough. Artistine’s story explicitly identified the importance of Black churches in Black communities. Black churches emerged as a defiant response to White enslavers. Initially, Black churches provided enslaved Black Africans an opportunity to congregate and tell stories about shared experiences (Stuckey, 2013). Over time, the confluence of African and Christian religious traditions evolved into several Black church denominations. These denominations emphasized charismatic call-and-response sermons, song and
dance, and the power of prayer. The latter is an essential spiritual resource and an important psychological survival strategy: it is one of the few community-accepted ways to express and share one’s burdens. Due to their historical, community, and spiritual significance, Black churches and religious rituals are often the primary interventions employed during times of crisis. This reality has important implications for understanding and preventing suicides in Black communities (Spates, 2015).

**Understanding of Suicide in Black Communities**

Artistine’s views about suicide in Black communities underscored the importance of an intersectional framework:

I mean, I think, I think specifically like anti-Black racism, I think police brutality, I think dealing with just kind of the day-to-day traumas like microaggressions and, um, like I, I had a, um, I had a client that, you know, she’s very educated. Like master, then like chemical engineering, and you know, all this stuff. And, um, she was like, “You know what? I almost killed myself because I go to work every day. I’m the only Black woman in this space.” And it got to the point where, you know, y- you know, they, they touched her hair, they, um, make comments to her. Um, a guy groped her at work. And so she, you know, already kind of struggling with like some mental health stuff anyway, like with depression and anxiety, I think, just in general. And they go into this space and it’s exacerbated and you’re kind of like, “Well, I don’t wanna lose my $90,000 a year job because I’m a Black girl. I got a $90,000 a year job, right? And so how do I balance that with now, I want to report these men to, you know, HR, or whatever?” And HR is like, “Well, there’s nothing we can do about it.” Right?
Like, so kind of having . . . So like, “Do I leave my $90,000 a year job and not be able to take care of myself? Or do I go into work and tolerate . . . Like, is this gonna be my life?” So kind of like getting to that point where she was like, “Is this gonna be my life?” Like, “I didn’t want to school and did everything that I needed to do, right, to get to this position. And here I am and I’m making money, I can afford, I can take care of myself, everything. And I gotta go to work and deal with people. And I can’t even get any type of life support or help for it. So is this gonna be my life, because this is my only job.”

Artistine’s intersectional consciousness and analysis exposed the racialized gender violence that compounds suicide risk for Black women. Her narration of a client’s experience illuminated the internal conflicts created by White supremacist misogyny. Such violence evokes inner dialogues about self-determination, self-worth, and existence itself. These experiences are frequently associated with internalized shame (Bhuptani & Messman, 2021; DeCou et al., 2019; Johnson, 2020; Watts-Jones, 2002). In the contexts of these horrific traumas and corrosive dialogues, suicide may provide the only hope for respite.

**Interview Reflections**

I was viscerally struck in the gut by an obvious insight that had been evident all along. Black female clinicians both embody their gendered racist trauma and they are chiefly involved in bearing witness to Black community sufferings. Intellectually, I knew from the outset that I needed to speak with Black female clinicians to better grasp suicide. I think after hearing about 12 participants’ struggles in predominantly White institutions—who were simultaneously bearing witness to Black clients’ pains—I finally
felt, in the most superficial way, a sliver of the burden that Black women live with most of their lives. This sliver, while infinitesimal compared to the reality, gave me a glimpse of the multi-faceted burdens that have probably resulted in the increase in “deaths by suicide” among members of Black communities.

In addition to reflecting on White supremacist trauma and suicide, I also reviewed Artistine’s insights about Black churches. She shared a personal experience about a church friend who died by suicide. Artistine recounted that nothing was publicly mentioned. Rather, she overheard congregation members say—“in hushed tones”—“she [church friend] didn’t pray enough” and “she [church friend] was depressed.” I focused on her use of the phrase “hushed tones” because it reminded me of previous comments made by other research participants, i.e., “whispering behind closed doors” and “faith shaming.” Such tones and comments led me to question their function. The comments probably provide a simple explanatory narrative that fits with pre-existing world-views. Moreover, the hushed tones likely reflected the taboo associated with suicide, survivor guilt (What signs did I miss?), and/or survivors shaming of the person who “died by suicide” (How could the person do that?). This form of shame seems particularly salient given that Black communities have historically framed suicide as a “White person’s thing.”

Faith

Faith (she/her/hers) is a 58-year-old licensed social worker who self-identifies as African American, heterosexual, and Christian. She lives and practices in a suburb in a northeastern state. Faith maintains a generalist private practice. She has 11 years of experience and is socio-economically situated in the working-middle class.
Being a Black Female Clinician in the United States

Faith’s narrative stood out as the most optimistic among the 14 participants. Having raised two children and managed the divorce process, her outlook seemed motivated by a desire to savor her achievements:

I’m gonna say it’s empowering. Um, I live in a community that is, um, hmm. It is becoming diversified, but I’m the only African-American clinician in the area. And, um, I was empowered to go back to graduate school and to make sure that others like me could see we are just as qualified if we get the proper training. And what is it like for me being a clinician? Um, I, I, I just think of the word empowering because the number of people that I meet often who look at me and they say, “Well, I never met an African American who went to college or an African American, who’s a therapist.”

Her story radiated with pride. The pride seemed related to two facts that occurred simultaneously: her divorce and going back to graduate school. Both facilitated personal, professional, and economic liberation. Such liberation is also related to the evolution of her critical consciousness.

Critical Consciousness Development

Faith recalled growing up in a family that espoused “keep the business within the family.” She mentioned feeling hurt and compelled to remain silent. Faith concluded that her parents demanded silence about personal matters because they did not have solutions to her problems or their own. These experiences instilled a silent, internal defiance that served her at a critical moment in her life when she was struggling to balance child-rearing, work, and graduate school responsibilities. Faith remembered someone saying to
her, “You’re not gonna make it in this world because Black people don’t have any value other than selling drugs.” In defiance, she thought, “they’re wrong, they’re wrong, they’re wrong. And the way to make it right is to prove them wrong.” She realized that defiance could catalyze positive change, in herself and others. Such empowerment through defiance characterized Faith’s path to critical awareness. This awareness also shaped her experiences of suicide in Black communities.

Experiences of Suicide in Black Communities

Faith characterized her experiences of suicide in Black communities in terms of the transmission of shame. Her narrative moved from internalized shame and guilt to family shame, media shaming, and misleading portrayals of murders termed *suicides*:

A couple of things come up, shame, guilt, secrets, um, and just like, wow. Um, I *think shame* for the family. And *I think shame* for the person who is carrying all that hurt, um, guilt. But *I just say wow* because *I wonder back* to my childhood, as we talked about things at home and my parents didn’t have answers. *I wonder* how many other people and not just Black male, Black deaths, how many other people feel like there’s no way out or no answers because of what their peers or their family are not able to help them with. And, and *I’ll just say* this too, the world is different and *I know* that, um, sometimes what’s reported is not always true. And just with the media coverage over the last year and the racial violence and the riots and stuff, *I think* that, um, there have been many instances that were termed *suicide*, but they were not actual suicides. And, um, people being hung and people being, or people being killed, slaves running away, and these are things that happened, and their, um, how do I *say*? Perpetrator, the perpetrator
was never found, no one was ever identified as the murderer. So they were
demed death by suicide, but the reality is, it’s not true.

Faith’s experiences revealed a cross-cutting pattern of shaming that runs often through
stitutions like slavery, media, and families. This confluence of systemic shaming
appears to flow downstream to an individual person. The impact of systemic waves of
shaming—when they crash into an individual—likely overwhelms them and increasingly
tributes to death by suicide. Faith’s I poem voiced the way shame can manifest in and
operate on human experience:

I think shame
I think shame
I just say wow
I wonder back
I wonder how many
I’ll just say this too
I know
I think
how do I say?

Her poem identified parallel sources of shame that originate further upstream to
macrosystemic institutions and forces. Temporally, Faith’s voice ebbed and flowed from
present to past: shame is often situated simultaneously in both experiences of time. Her
states of intersectional consciousness shifted among curiosity, knowing, and cautiously
aming the real “perpetrator” of alleged suicides. Shame often compels people to be
cautious because it frequently strips people of their dignity and exposes their most
guarded vulnerabilities (DeCou et al., 2019). Moreover, shame also obscures. Specifically, it distorts perpetrator responsibility by pathologically displacing it on victims (Reynolds, 2016). If internalized, shame can lead victims to turn on themselves by way of negative thoughts, self-harm, and death (Herberman Mash et al., 2020). In short, shame in the contexts of oppression, trauma, and/or violence significantly contributes to suffering that likely catalyzes suicidal processes.

**Understanding of Suicide in Black Communities**

Faith’s understanding of suicide in Black communities centered a succinct yet powerful point of view: “I think people suffer. I think we all suffer. I think, um, feeling alone.” Her thoughts about suffering ranged. At first, she half-jokingly responded that only God knew why people in the Black community died by suicide. Faith then discussed the role of media. She stated that the news media’s portrayal of who and what are problems influences people’s sense of self and hope. She reasoned that if people are constantly seeing images that problematize them, sooner or later that is going to lead to despair, suffering, and a desire to end such suffering. Faith went on to say that suicide gives suffering people “an internal locus of control over their destinies.” This sense of control, according to her, serves as a substitute for life-sustaining hope.

**Interview Reflections**

I was most struck by Faith’s optimism. The level of empowerment she expressed set her apart from the other participants in this project. She had recently moved into a new home and was leaving for a vacation the week after our interview. Faith also mentioned that her adult son recently questioned her about why she “always ha[s] to be like White people?” Her response to him seemed to reflect a self-confidence that has
evolved from lived experience and healthy pride. She indicated that she wasn’t being White, just herself. Faith rejoined that wanting and having nice things were reflections of her sense of self, not what others’ have or don’t have.

Subsequently, I thought more about her son’s comment to her. What are the meanings of wanting nice things? If wanting nice things is equated with “being White,” what is “being Black” equated with from her son’s vantage point? I concluded this particular reflection with a commitment to hold all of the possibilities as reasonable interpretations and elected to offer them here to bolster transparency and trustworthiness.

Finally, I was curious about the softness and calm with which she expressed her critical consciousness. Her awareness appeared to be clear-eyed: she clearly knew that systems of oppression operate in destructive ways, yet her affective presentation was more reserved when discussing issues of race and suicide compared to other participants. I wondered about the potential effect of my positionality on her narrative. Was my Whiteness evoking a more careful delivery? Or was I seeing one person’s individual differences manifest? After all, Black female clinicians, like all cohorts, are not monolithic.

**Nicole**

Nicole (pronoun survey question skipped) is a 39-year-old LCSW who self-identifies as Black, upper-middle-class, straight, a fan of all divinations, and as having ancestral connections to Nigeria, Mali, Madagascar, Congo, Portugal, Ireland, Scotland, Wales, and Scandinavia. She lives and practices in a Mountain time zone state. Nicole maintains a generalist private clinical practice and a school consultation business. She has ten years of experience.
**Being a Black Female Clinician in the United States**

Nicole’s narrative exemplified the complexities of having intersectional identities and the necessities of having an intersectional consciousness to navigate professional spaces:

Um, **I really**, like, **I think** that there’s, there’s somewhat of a niche, right, factor in that it’s really necessary for people to see themselves reflected when they come for help. Um, **you know**, in my own experience **I don’t typically look like everybody else**. And so **I’ve never been** in a room with a lot of people that look like me. Um, but when it does happen, **I’m like**, “Oh, is this, **I see similarities**.”

So **I think** my experience has been, **I’ve been, you know, ostracized** for serving [a] marginalized group and then having a lot of White women typically be upset because people are drawn to me because of my race and ethnicity and gender. Um, but it’s also kind of like a good feeling, um, as well, (laughs) to be able to serve and know that **I’m in the right place**. So those have been my experiences.

**I’ve been ostracized** for it but then also been brought in by clientele.

Her story vacillated between experiencing challenges and maintaining a positive perspective. Nicole’s I poem situated herself as simultaneously an outsider and insider:

I really

I think

You (I) know

I don’t typically look like everyone else

I’ve never been

I’m like
I see similarities
I think
I have been, you know, ostracized
I’m in the right place
I’ve been ostracized.

The poem spoke to the intersectional complexities and tensions of occupying liminal spaces. In such spaces, Nicole explained that people are both drawn to her and otherize her. Despite being otherized and often intersectionally isolated, she has concluded that this space is a good fit for her. Such positionality shapes and is shaped by the evolution of her critical awareness.

**Critical Consciousness Development**

Nicole’s intersectional complexity seemed to emerge from her formative life experiences. Such experiences empowered her to observe, learn, and internalize a curious and critical awareness about herself, other people, and the world at large:

Um, I think, you know, having a White presenting mother, um, this happened very early when people asked me, asked her where she got me, right? And then so many people asked that I started to question if she was my parent, um, because there’s no similarity in how we look at all. Um, so I think that was the first awareness. And then coming from a large multicultural family, I identify as Black, I present in this world as Black, but being privy to many different conversations as a young person going, “That’s how you really feel? That’s how you really feel?” Like the stereotypes are on all sides . . . Everyone’s a little bit racist sometimes, you know, when we’re talking about religion, when talking
about race, when talking about neighborhood, when talking about money a lot around me as a small child. And I started to just develop this, “Okay, this is this way for you here, but this is this way for these people here. I don’t fit into a lot of these categories. Is this how the world sees me because I am privy to these conversations?” So I think that’s when I started. But then it wasn’t fully like developed in actual life, I think until my, what would be like my junior year when I got to [University], because I went to community college first. And then really my, um, work with [Professor] in his classes that I was like, “There’s a name for this, what I’m experiencing.” Definitely, through the work of W. E. B. Du Bois. Like that was like, “Oh, you know, this is something, this is something that’s been studied. (laughs) This is something that’s been experienced by other people.” So I think definitely the full actualization of it happened then.

Nicole’s narrative highlighted connections among her lived experience, internal dialogue about her experiences, and formal study of historically significant Black sociology. Such connections illuminated the importance of critical consciousness as a framework for self-understanding and as a psychological resource for self-empowerment. This framework informed her analysis related to suicide in Black communities.

**Experiences of Suicide in Black Communities**

Nicole’s experience of suicide in Black communities revealed the multitude of ways that dominant culture’s oppressive forces contribute to deaths often labelled as *suicides*:

Is it suicide or genocide? I feel like the actual act of like quickly transitioning yourself so to do, you know, do violent acts, do whatever, you know, like, it’s just
like, I go in and I’m gonna kill myself now. But then I think about it on this, like, different plane of, like, this slow death of, like, alcohol, drugs, risky behavior, you know, the types of behavior that we see that people are, have a passive wish to die. And so I think about that as like while there was like a very quick genocide that happened with indigenous folks here to the Americas. It almost seems like the slow burn of allowing people to cope in a way that’s killing themselves too. So I think about it in both ways.

Her story foregrounded an explicit question that critical suicidology has been posing for years: Are the deaths we call suicide really murder or genocide? Nicole went on to discuss the ways White supremacy brought diseases, substances, religious traditions, and economic practices to Black, Brown, and indigenous communities that we now label individual risk factors and self-injurious behaviors. This awareness has compelled her to understand suicide in more historical terms.

**Understanding of Suicide in Black Communities**

Nicole’s understanding of suicide in Black communities is grounded in the belief that present manifestations of depression, anxiety, and suicidality are rooted in trauma, encoded genetically, and transmitted intergenerationally:

I’m a firm believer in like our genetic code changes based on, um, experiences of our ancestor. Like, especially if you’re a part of the ancestral history here in the United States of enslaved Africans, um, there’s like a period of 500 years that has been encoded in our DNA. And so when anyone comes to see me, I come from that perspective of that, we’re not only healing you today, but we’re healing every person in your lineage, seven generations backwards and forward. Um, and so I’m
a really firm believer that- a lot of the traumas and a lot of societal issues that we have in the United States are a direct result, um, of the enslavement of Africans.

So breaking those things down and making sure that people understand, you think you’re showing up today with depression and anxiety- um, but actually it’s ancestral, um, and we’re breaking these patterns.

Her analysis of ancestral trauma and current problems underscored the need to center Black, Brown, and indigenous healing paradigms and practices when it comes to suicide prevention, assessment, intervention, and postvention. It also amplified the need to conceptualize suicide in social justice terms. Such a reframing would necessitate the inclusion of currently marginalized viewpoints and solutions: youth, people living with chronic suicidality, people with multiple intersectional identities, and non-Western, non-English speaking peoples.

**Interview Reflections**

Nicole’s world-view critically centered essential questions raised throughout this project. Her belief that she is treating every generation of a client’s ancestry beautifully spoke to upstream-downstream connections. Furthermore, when I asked her about her first reactions to the phrase “suicide in Black communities,” she questioned, “Is it suicide or is it genocide?” Nicole’s interrogation of the ways deaths are deemed *suicides* instead of *genocides* aligns with a central critique posed by critical suicidologists and me.

Moreover, the juxtaposition of suicide and genocide reinforced the significance of shame for me. Genocide is the intentional murder of an entire group of people *because* of who they are. This fact seems to echo the relationship between dominant culture’s anti-Black shaming and internalized shame: to intentionally cause harm by communicating and
instilling the belief that a person or community is “bad” because of their race—not just their behavior. In the contexts of historical and ongoing racialized violence, trauma, and oppression, co-occurring shaming and internalized shame processes likely compound suicide risk by linking the causes of suffering to fundamental aspects of identity like race.

Finally, Nicole’s perspectives about suicide, and her expansive view of time and ancestral relationships offered an affirmative case for Black community reparations. While reparations cannot undo the horrific past, it is an essential process to bringing about and ensuring justice. Without justice, reconciliation and other forms of societal healing cannot and will not occur. Without reparations, systems of shaming, like flood waters, will likely continue to infiltrate, saturate, and harm Black communities.

**Summary**

This chapter chronicled 14 Black female clinicians’ critical understandings of suicide in Black communities. Their perspectives were presented as participant-specific narrative summaries. Each summary included a brief sociodemographic description and explored four thematic topic areas. These areas included the Black female clinicians’ experiences in the United States, their critical consciousness development, their multisensory perspectives of suicide in Black communities, and their critical understandings of suicide in Black communities. Extended block quotations were frequently used to amplify the contextual nuances and complexities of each participant’s experiences and viewpoints. Additionally, I poems foregrounded the participants’ voiced selves that were woven throughout their stories. Each summary concluded with my reflections and iterative interpretations.
The narrative summaries, LG analytical methods, and my reflections revealed that suicide in Black communities is understood in the contexts of historical and intergenerational violence, trauma, and oppression. Additionally, themes of hopelessness, anger, despair, guilt, grief, and shame emerged. Consistently, participants foregrounded systems of shaming and Black peoples’ internalized shame as significant suicide-contributing factors. This important relationship was indicated by the frequency in which this thematic connection appeared in their narratives. While previous research has established connections between the aforementioned themes and suicidality at the micro-level (Bhuptani & Messman, 2021; CDC, 2020; Halloran, 2019; Hastings et al., 2002; Hendin, 1969; Herberman Mash et al., 2020; Hoekstra & Katz, 2021; Joe et al., 2006, 2009; Johnson, 2020; Kirk, 2009; Lund, 2021; Madsen & Harris, 2021; Shneidman, 1985; Spates, 2011, 2019; Watts-Jones, 2002), critical understandings of macrosystemic shaming, individual shame experiences, and suicidality are currently underexamined by mainstream suicidology, clinicians, policy-makers, and researchers. Such understandings and examinations are likely important to preventing or reducing suicide mortality in Black communities.

The next chapter details the cross-participant themes and voices that emerged from the participants’ narratives about understanding suicide in Black communities. These themes and voices are integrated with additional extant research literature to bolster connections among previous research, this study’s findings, and implications and proposed systemic changes proposed in Chapter 6.
CHAPTER 5

Findings

Building on the interview data, narrative summaries, and my reflections from Chapter 4, I begin this chapter by detailing cross-participant themes related to critically understanding suicide in Black communities. Furthermore, I discuss the interrelationships among the predominant themes of shame, hopelessness, trauma, racism, fear, violence and suicide. This discussion includes references to extant literature and quotations from the Black female clinicians I interviewed. Additionally, this integration of themes, previous research, and participant narratives further bolsters the contention that the complexities of suicide in Black communities are better understood in terms of macrosystemic and individual level interactions that produce internalized shame. Such understanding is often missing among mainstream researchers, clinicians, and policy-makers. Next, I identify and describe three cross-participant voices that emerged from multiple interview transcript listenings and ongoing reflections about this project’s foregrounded themes: the voice of intersectional consciousness, the voice of systemic shaming, and the voice of internalized shame. In concert, these participant voices offered critical perspectives that amplify and detail the historical, ongoing, intersectional, and systemic dynamics among this study’s central themes and “death by suicide” in Black communities. Finally, this chapter ends by summarizing findings and bringing participants’ voices into conversation with important macrosystemic forces.

Cross-Participant Themes

Key words emerged during each interview and listening. I kept a running list of words and phrases each participant used to describe their experiences and understandings
of suicide in Black communities. Then, I conducted a formal word occurrence count for all 14 interview transcripts. The count specifically focused on words used during participant responses to questions related to their experiences and understandings of suicide. Word frequency, context of word use, and extant research literature shaped my decisions about thematic categories and theme/word clusters. Table 1 summarizes these findings.

Table 1

*Cross-Participant Word Occurrence Count*

<table>
<thead>
<tr>
<th>Word/related concept cluster</th>
<th>Occurrences</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shame</td>
<td>42</td>
</tr>
<tr>
<td>Stigma</td>
<td>22</td>
</tr>
<tr>
<td>Hidden</td>
<td>7</td>
</tr>
<tr>
<td>Taboo</td>
<td>7</td>
</tr>
<tr>
<td>Avoid</td>
<td>6</td>
</tr>
<tr>
<td>Weakness</td>
<td>5</td>
</tr>
<tr>
<td>Whisper</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>91</td>
</tr>
<tr>
<td>Hopelessness</td>
<td>35</td>
</tr>
<tr>
<td>Depression</td>
<td>15</td>
</tr>
<tr>
<td>Sadness</td>
<td>14</td>
</tr>
<tr>
<td>Helplessness</td>
<td>6</td>
</tr>
<tr>
<td>Despair</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>73</td>
</tr>
<tr>
<td>Trauma</td>
<td>56</td>
</tr>
<tr>
<td>Historical</td>
<td>7</td>
</tr>
<tr>
<td>Intergenerational</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>66</td>
</tr>
<tr>
<td>Racism</td>
<td>39</td>
</tr>
<tr>
<td>Oppression</td>
<td>13</td>
</tr>
<tr>
<td>Marginalization</td>
<td>11</td>
</tr>
<tr>
<td>Total</td>
<td>63</td>
</tr>
<tr>
<td>Systems</td>
<td>40</td>
</tr>
<tr>
<td>Systemic</td>
<td>12</td>
</tr>
</tbody>
</table>
As shown in Table 1, cross-participant words and related concepts are clustered in the left-hand column with the number of occurrences located in the right-hand column. The word and concept clusters are arranged in terms of overall frequency, context used, and relatedness based on previous studies. Shame (91), hopelessness (67), trauma (66), racism (63), systems (52), fear (26) and their related concepts appeared most frequently. Furthermore, three other terms appeared at least twice in the interview transcripts that the extant research literature often cited as factors for understanding suicide: violence (Jones-Eversley et al., 2020; Jordan & McNiel, 2020), anger (Hejdenberg & Andrews, 2011; Klein, 1935/1975; Shneidman, 1985), and guilt (Shi et al., 2021; Wetterlöv et al., 2021). Additionally, while the term grief was never specifically used by participants in the context of suicidality, the theme could be inferred when they spoke about sadness, anger, anxiety, and despair as suicide-contributing factors. These findings emphasize shame and situate it in the context of other factors often associated with suicide.

### Conceptual Overview of Shame

Shame is a powerful experience that influences human emotions and behaviors. It comprises “primarily negative, global, [and] stable evaluations of the self” (Wetterlöv et al., 2021, p. 866). It is defined as “an emotional process of internalized, negative self-concept” (Hoekstra & Katz, 2021, p. 329). Examples of shame beliefs include “I am
worthless, I’m a piece of crap, and I don’t deserve to live” (Madsen & Harris, 2021, p. 5). When experienced as a temporary state, shame is believed to function as a motivator for self-appraisal, personal change, or the self-acceptance of imperfections (Taylor, 2015). Moreover, Chandler (2020) remarked, “shame, more than any other emotion is the ‘master emotion’” (p. 33) because it shapes human social bonds more than any other emotion. She noted that humans are social and shame emerges from real and perceived threats to social bonds. To decrease such threats and avoid feeling the pain of shame, people may try to alter their sense of self if they believe they have the power to do so, or withdraw and hide (Johnson, 2006; Scheff, 2000, 2003). Finally, the effects of shame on individuals and groups are primarily determined by recipient interpretation and internalization processes (Bhuptani & Messman, 2021; Budden, 2009; DeCou et al., 2019; Johnson, 2020; Watts-Jones, 2002). This body of research highlights shame’s significant influences on human emotions, and its effects on behavior and an individual’s sense of self. These influences and effects have implications for critically understanding suicide in Black communities.

The significance of shame for critically understanding suicide in Black communities manifested in participant narratives. When responding to the question, “What word or words come to mind when you hear the phrase ‘suicide in Black communities’?” Dominique responded, “Fear, shame, and abandonment.” Additionally, Noelle replied, “Shame, guilt, secrets.” Moreover, when I asked participants, “What would help me critically understand suicide in Black communities?” Virginia stated, “shame around having those [suicidal] thoughts.” To that same question, Joanna emphatically reported, “I think shame is, yeah, I think shame is big.”
Shame, Other Predominant Themes, and Suicide

The 14 Black female clinicians who participated in this study both underscored the significance of shame in their critical perspectives about suicide in Black communities and identified others. In this section, I discuss links among shame, the other predominant themes, and suicide. This examination integrates previous research and participants’ narrative data to further support this study’s findings. Such findings also create opportunities to bring participant voices into conversation with systemic forces like mainstream language, research methodology, public policy, professional association standards, psychosocial higher education curricula, and psychosocial clinical practices.

Shame, Hopelessness, and Suicide

Shame and hopelessness frequently co-occur among people who experience suicidality or have died by suicide (Hastings et al., 2002). These authors noted that hopelessness—the expectation that good things will never happen and bad things will continue indefinitely—often results from shame or exists in a co-constitutive relationship. This connection was bolstered by Madsen and Harris’s (2021) findings that negative self-appraisal, i.e., “I am worthless. . .[and] don’t deserve to live” (p. 5) was the strongest predictor of suicidality among 713 participants with suicide lived experience: hopelessness was the second strongest predictive factor. Their examples of negative self-appraisal mirrored examples typically used to define shame (Lewis, 1971; Wetterlöv et al., 2021). This connection between shame and hopelessness was illuminated by research participants.

In describing her perspective about suicide in Black communities, Noelle’s remarks linked racism, hopelessness, and shame:
you know, the theme of racism, you know, or the theme of, uh, implicit bias, be, to be more specific. Um, and thinking of racism as trauma. And then it could just be, like, those thoughts, those, those, "I am hopeless," or, "I am powerless kind of thoughts," are one of many thoughts under those themes.

To be hopeless and powerless likely taps into feelings of shame associated with feeling or perceiving one’s self to be weak. Experiences of weakness likely threaten Black strength narratives and suicide attempts or deaths may be experienced as either an act of strength, i.e., self-determination, or a means for escaping such feelings. Noelle’s insights also underscored the role of trauma.

**Shame, Trauma, and Suicide**

Shame, trauma, and suicide interrelate. Herberman Mash et al. (2020) theorized shame as “a powerful emotional response to experiencing an unacceptable view of oneself, typically precipitated by interpersonal traumatization” (p. 40). In the contexts of trauma, oppression, and/or prolonged exposure to shame, individuals often internalize a profound and pervasive self-concept experienced as deficient, defective, and/or undeserving of life (Madsen & Harris, 2021). Furthermore, Wetterlöv et al. (2021) found that shame intensity often predicted PTSD symptom severity among trauma victims who perceived a lack of control over the harmful event. Moreover, shame mediates trauma treatment efficacy especially among trauma survivors who blame themselves for the horrific event (Ginzburg et al., 2009; Semb et al., 2011). Also, DeCou et al. (2019) reported “our findings demonstrated the role of trauma-related shame as a mediator of the association between sexual assault severity and the desire to die by suicide” (p. 138). This
research suggests a connection among shame, trauma, and suicide that may be compounded by racialized trauma or oppression.

During my interview with Dominique, she noted that shame was an important theme for critically understanding suicide in Black communities. When I asked her the follow up question, “Where do you think that sense of shame comes from?” she replied, “generational trauma.” Additionally, Paula answered:

Um, so, I feel like, wow, that's like a loaded question. 'Cause it's like so many things that, you know, you think of just trauma, and then you have generational trauma. Um, and then there's like the post-traumatic slave, um, syndrome.

These participant observations about shame, trauma, and suicide revealed that intergenerational racialized traumas contribute to suicide in Black communities.

**Shame, Racism, and Suicide**

The empirical literature reveals connections between experiences of shame and anti-Black racism. Johnson (2020) examined the associations among racism, internalized shame, and self-esteem. The author found that racists events (past month, past year, and lifetime) correlated with diminished self-esteem and heightened internalized shame. Harris-Perry (2011) further noted that negative stereotypes about Black people—communicated in interpersonal relationships, mass media, and public policies—perpetuate and amplify experiences of shame. Additionally, Watts-Jones (2002) discussed the harmful confluence of historical trauma, internalized racism, and shame:

“Internalized racism involves two levels of shame: the shame associated with our African-ness, as a result of slavery and racism, and the shame of being shamed” (p. 593).

The literature suggests that anti-Black shaming is both unique to Black communities and
pervasive. It originated as a tool of enslavement and has been embedded in every
dominant culture system to codify racialized power.

In discussing their perspectives about suicide in Black communities, participants
noted the interplay among, shame, racism, and suicide. Sonya commented “It's like bias,
it's racism. It's just like lack of resources” to describe her views about shame,
hopelessness, and suicide. Furthermore, Artistine observed:

I mean, I think, I think specifically like anti-Black racism, I think police brutality,
I think dealing with just kind of the day-to-day traumas like microaggressions
and, um, like I, I had a, um, I had a client that, you know, she's very educated.
Like master then like chemical engineering, and you know, all this stuff. And, um,
she was like, "You know what? I almost killed myself because I go to work every
day. I'm the only Black woman in this space." And it got to the point where, you
know, y- you know, they, they touched her hair, they, um, make comments to her.
Um, a guy groped her at work.

The extant research literature, Sonya’s views, and Artistine’s observations all highlight
intersectional acts of interpersonal, structural, and institutional violence that harm Black
communities physically, socially, politically, and psychologically (Galtung, 1969). A
significant harm is anti-Black internalized shame that is produced by White dominant
culture and transmitted across human systems.

Shame, Systems, and Suicide

Shaming practices and experiences of shame exist in complex, multifaceted
interrelationships. These relationships are often known as systems: “a set of
interconnected parts that form a whole” (Joy, 2019, p. 44). Human systems typically
involve people, who choose or are ascribed roles, and rules, or expectations about role-bound thoughts, feelings, and behaviors. Through complex processes of cultural socialization, systemic roles and rules can be both implicit and explicit. In systems of shaming, those parties who do the shaming occupy positions of power and explicitly codify and perpetuate their power by establishing rules and using power-over shaming tactics. For people being shamed, such rules and tactics can be internalized, resulting in a sense of subjugation and despair. Joy (2019) described such power-over systems as “powerarchies,” or systems “organized around the belief in a hierarchy of moral worth” (p. 47). Joy (2019) further underscored the destructive potential of shame on human social systems:

Shame is arguably the foundation of human psychological dysfunction and, by extension social dysfunction. The essential need to feel worthy is so powerful, and shame so disruptive to our psychological security and well-being, that we will often do just about anything to avoid this feeling. . . suicide is considered a better alternative to having one’s shame exposed. (p. 37)

The author’s analysis essentialized the links between shame, individual despair, social pathos, and suicidality. These connections emphasize the deleterious effects of shame on human systems.

A system of anti-Black shaming involves dominant cultural beliefs in superiority enabled by anxiety-reducing defense mechanisms (i.e., denial, projective identification) and cognitive distortions (i.e., rationalization, emotional reasoning). These beliefs get externalized through narratives that both eliminate cognitive dissonance (doubt or disbelief) and evoke violent, dehumanizing anti-Black shaming practices such as
enslavement, forced rape, family separation (often used with animals to prevent bonding), and public police brutality. Such beliefs, narratives, and practices uniquely manifest within and across intrapsychic, interpersonal, societal, cultural, and historical systems and likely contribute to suicide in Black communities by denigrating Black identity and depriving Blacks of life-sustaining resources.

In discussing her perspective about suicide in Black communities, Noelle theorized:

you know, race-based trauma in the form of systemic racism, you're automatically putting pressure on a system. So, you know, if you're putting that pressure on and, you know, people have, you know, depending on where they're at in terms of, uh, you know, situations and socioeconomic status, in addition to the pressure of everyday life, systems break. And part of how it may look is, you know, somebody may choose to exit the system. You know, it's broken, they're disconnected, you know, from maybe the other parts or, or, or people in the system, and this is, you know, what happens when systems fail.

Her analysis linked racialized trauma to White dominant culture’s systems of oppression like racism and classism. These systems otherize and often isolate and alienate people and communities with such marginalized identities. Isolation and alienation are common experiences associated with shame (Johnson, 2006; Lewis, 1971). These experiences also significantly contribute to suicide (Herberman Mash et al., 2020; Shneidman, 1985)

**Shame, Fear, and Suicide**

Shame often influences fear experiences in which suicide may seem like the only means for escape. Lewis (1971) found that shame regulates both awareness and
expression of anger, fear, grief, and anxiety. Moreover, Hejdenberg and Andrews (2011) observed that emotions such as fear and anger are often preceded by shame. This observation makes sense given that threats to the self frequently evoke fight or flight emotions (van der Kolk, 2014). Furthermore, Duffy et al. (2019) observed that suicidal thoughts that included shame-related content predicted self-reported anxiety and suicide attempts.

Among the Black female clinician participants in this study, shame, fear, and suicide relationships were described in two primary ways. Participants noted a general fear within Black communities about discussing suicide because as Andrea noted “it’s taboo. . .it threatens the strength narrative. So it’s avoided.” Additionally, Virginia and Dominique both commented that their Black clients with suicidality often cited “being weak” or being “judged weak” as a contributing factor to a desire to die. This community standard about strength and intrapsychic fear of weakness likely contribute to feelings of isolation from Black social support networks and alienation from an important facet of Black identity. One way to resolve such fears and anxieties is death by suicide.

Shame and the other predominant themes emerged from participants’ reflections about their experiences as Black female clinicians and critical consciousness development. These narrated experiences also contextualized their multisensory experiences of and critical understandings about suicide in Black communities. By listening to participant narratives, examining interview transcripts, and reviewing my research field notes several times, I noticed three cross-participant voices germane to my research question.
Cross-Participant Voices

Three over-arching voices identified the themes for this project and critically foregrounded systemic forms of shaming and shame experience connections. These voices emerged from multiple listenings, consistently reviewing research journal entries, and frequently thinking about this project’s research question and purpose (Tolman & Head, 2021). The first voice that evolved from this process was the voice of intersectional consciousness. This voice often narrated participants’ experiences as Black female clinicians working in predominantly White institutions, manifested in discussions about their critical consciousness development, and shaped their understandings of suicide in Black communities. Such understandings contributed to the emergence of two other voices: voice of systemic shaming and voice of internalized shame. The voice of systemic shaming manifested when participants described receiving or observing forms of shaming that emerged from institutional or structural power structures. Additionally, the voice of internalized shame presented when the Black female clinicians in this study reflected on their own shame or witnessed others’ shame. These voices exist in an upstream-macrosystemic and downstream-intrapsychic relationship: both are distinct and interconnected. In the next three sections of this chapter, I describe each voice.

Voice of Intersectional Consciousness

This voice featured a dynamic, context-specific awareness that constantly analyzes, anticipates, and/or adapts to identity-based relational and/or power dynamics. Elizabeth’s intersectional consciousness emerged when she described being at work during the 2020 protests against anti-Black police violence:
And then the other time it [intersectional consciousness] really spoke out to me is in the year 2020 being in this office and being only one- two people of color, if things with, you know, George Floyd and Trump, Breonna Taylor, like all of those things. When you walk in this building, when you walk through the halls of this office, when you hear the, um, conversations among peers, you wouldn’t even know what’s happening, like there’d be no- there’s nothing. And that made me feel like should I make noise and say like, do you guys at least want to get one of those like Black Lives Matter [signs] if you get things, like put it outside? Like-Uh, does anybody want to check in maybe and ask how I’m doing? I mean, I am managing clients in your office space. You might want to make sure that I’m keeping it together, even if it’s just for your own self-serving bias. Right?

In this example, Elizabeth’s intersectional consciousness attuned her to the racialized and political dimensions of her workplace culture. Moreover, her awareness allowed her to notice and question her invisibility as a colleague and as a Black woman in that historical moment.

Another example of the voice of intersectional consciousness manifested when Nicole described the ways her biracial identity shaped her understandings of herself, others, and the world:

Um, I think, you know, having a White presenting mother, um, this [her consciousness] happened very early when people asked me, asked her where she got me, right? And then so many people asked that I started to question if she was my parent, um, because there’s no similarity in how we look at all. Um, so I think that was the first awareness. And then coming from a large multicultural family, I
identify as Black, I present in this world as Black, but being privy to many
different conversations as a young person going, “That’s how you really feel?
That’s how you really feel?” Like the stereotypes are on all sides . . . Everyone’s a
little bit racist sometimes, you know, when we’re talking about religion, when
talking about race, when talking about neighborhood, when talking about money a
lot around me as a small child.

Nicole’s narrative illuminated the ways her biracial intersectional consciousness evolved
and enabled her to access and interrogate racialized (Black and White) conversations and
information about religion, money, community living spaces, and multicultural
stereotypes. These formative experiences enhanced her ability to cope with being and
feeling “ostracized” by White women “because of my race and ethnicity and gender.”

**Voice of Systemic Shaming**

This voice typically presented when participants described the ways various
systems engage in shaming—acts of transmitting messages that a person or group is
worthless or bad *because* of who they are. These descriptions included personal
experiences with systemic shaming or bearing witness to others being shamed by social,
cultural, and/or political institutions. For example, Paula recounted an interaction with a
student being bullied at school because of her skin color:

Um, I remember there was a student who, she was just sorta like, “I'm not pretty,”
um, and she made reference to, like, her skin color and, like, stuff like that. And
you're like, and you're like, “No, no, no. You're beautiful. You're perfect.” I feel
it's super important to validate and, um, just sort of like praise, um, like, all kids.
But in particular, especially Black children. Um, and I feel like Black girls even
more so, um, just because of, you know, gender stuff. Then you add race and you add, you're just adding all of these other things and you're seeing the images on TV and in the movies. Um, so I think those kinda things really, like, trigger stuff in me.

Her narrative centered racialized and gendered dominant culture standards of beauty and the internalized shame such oppressive norms evoke, i.e., “I’m not pretty.” Furthermore, Paula’s remarks about “adding all of these other things” underscored the compounding effects such shaming systems can produce. Moreover, her comments about “images on TV and in the movies” emphasized a significant means by which shaming systems communicate messages: media (Joy, 2019). Finally, Paula’s final revelation featured the historical and intergenerational nature of shaming systems: two people from different generations who developed in two different time periods received similar messages about their skin color and worth.

A second example, provided by Dominique, described the compounding effects of systemic shaming generated within and across both dominant culture and Black communities as it relates to suicide:

Um, and then in terms of suicide, that, just that, that label. . .that's, that's put on someone, again, of being weak. . .um, that they couldn't handle things because, you know, you should've, you should've prayed about it. Um, which is one thing that I, I hate that people say and it's used a lot in the Black community. You should have prayed about it, you should have went to God or you're gonna go to Hell because you took your own life. And it's like, you don't know what is gonna
happen to them. So why do you feel the need to judge them instead of saying,

“Well, how could I have helped this person? Why didn't they reach out to me?”

In the first line of the quotation, Dominique’s use of the phrase “that label. . .that’s, that’s put on someone” implied an authority or system with the power to label, to place value on another person’s or group’s experience (Joy, 2019). Furthermore, her comment about “being weak” spoke to the complicated Black community beliefs and values about strength, which connects to dominant culture’s self-serving stereotypes about Black strength, endurance, and pain tolerance (Green, 2019; Liao et al., 2020; Spates, 2015). These belief and stereotype systems facilitate the internalization of shame process by communicating distorted expectations about an individual’s sense of self. Moreover, Dominique’s interrogation critiqued religious meanings and responses to suicide. Religious systems often use spiritual judgment as a shaming strategy to foster conformity and strengthen social bonds (Early & Akers, 1993; Lincoln, 1974). However, her belief appeared to be that religious shaming may make it difficult for suicide-vulnerable people to seek help. In this way, systemic shaming contributes to suicide by silencing and further alienating people who would benefit from spiritual support and community.

**Voice of Internalized Shame**

This voice reflected personal and witnessed experiences of feeling and believing one is worthless or bad because of an immutable quality, trait, characteristic, or identity, such as racial or ethnic identities. Joanna noted that generational, cultural, and gender identity intersections may exacerbate internalized shame experiences and contribute to suicide:
I think about like, well, our ancestors went through more than us and you're going to kill yourself? Your ancestors, you know, fought for us so hard and they didn't give up until we got freedom. We were liberated, you know? Um, so how dare we complain about our lives? So you just be quiet, keep going, keep going to work, take care of your kids, particularly for Black women, this like idea of like being a strong Black woman, right? So, we just bury those things that, you know, the hardest parts of ourselves so that we can, um, honor our fre- like our quote unquote freedom.

Her narrative centered the challenges of honoring ancestral sacrifices for liberation and being a person with multiple needs and limitations. Additionally, in this cultural context, suicide equates to giving up and failing to be like one’s strong relatives. Joanna further observed gendered ways Black Cape Verdean women avoid complaining about their lives: being quiet, working, and burying “the hardest parts of ourselves.” Silencing and/or avoiding suicide-contributing thoughts and feelings often result(s) in feeling alienated which increases the risk of death by suicide (Spates, 2015). On the other hand, failure to maintain this culturally-expected façade may elicit shaming responses that facilitate the internalization of shame, i.e., you have nothing to complain about compared to our family’s ancestors. This process also contributes to suicide mortality by minimizing people’s lived experiences.

In the context of her clinical work with Black men in a hospital emergency department, Sonya described connections between racialized employment discrimination, shame, and suicide:
They [hospital clients] try to kill themselves because life is hard or they didn't get a job because of who they were or they just, they weren't enough or they feel like they did not wo- enough because the world makes them feel like they're not enough

The phrases “because of who they are,” and “because the world makes them feel like they’re not enough” links her clients’ Black identities, unemployment, and the internalized sense of worthlessness and badness frequently associated shame.

The three voices that emerged from participants’ narratives—the voice of intersectional consciousness, voice of systemic shaming, and voice of internalized shame—illuminated an often underexamined aspect of suicide in Black communities. Specifically, systemic shaming and internalized shame connections are frequently missing from mainstream discourse about Black suicides. The confluence of upstream historical, cultural, social, political, family, and relational messages about worthlessness appear to funnel downstream to individuals and increase suicide mortality. By highlighting upstream and downstream connections in their narratives, participants seemed to be attempting to bring their lived experiences, and those of their clients, into conversation with larger systemic forces.

Summary

In this chapter, I presented findings based on 14 interviews with Black female clinicians. These participants shared stories about their experiences as clinicians in the U.S. Their narratives included details about feeling essential, expendable, responsible, proud, exhausted, sad, fear, anxious, and angry in the contexts of predominantly White spaces. Furthermore, participants shared their critical consciousness development which
highlighted a range of intersectional awareness. Such awareness seemed to sensitize them to the complex, dynamic, and nuanced interplay among their identities, Black communities, dominant culture systems, and racialized privilege and power. From this vantage point, participants offered their experiences and critical understandings of suicide in Black communities. The Black female clinicians centered shame in the contexts of hopelessness, trauma, racism, fear, and violent systemic forces as significant contributing factors to suicidality among Black peoples. As a result of their experiences and perspectives, three important narratives voices emerged: the voice of intersectional consciousness, voice of systemic shaming, and voice of internalized shame. These voices were bolstered by extant research literature that affirmed shame and other themes’ significant influences on suicide risk factors and associations with “deaths by suicide.”

The confluence of the participants’ voiced-knowledge and social science literature revealed interconnected dynamics germane to understanding suicide in Black communities. Systemic shaming describes the use of racialized power to constrain Black personhood, agency, and lives, and to affirm dominant culture. For Black communities in the U.S., this shaming insidiously originated and evolved in the contexts of European and North American Whites’ domestic and global violence, oppression, and socio-political power (Kendi, 2016). These dehumanizing power-over arrangements spread across human systems of experience. Systemic dehumanization—“denial of essential human attributes” (Haslam, 2006, p. 262)—and shaming—the act of communicating a negative evaluation of an individual or group’s sense of worth—likely work in concert to create the life-limiting experience—anti-Black shame—that contributes to some deaths often labelled “suicide.” Such deaths are significantly attributable to upstream macrosystemic
forces being transmitted downstream to a receiving community or individual. This
dynamic implies that preventing Black deaths by suicide may require listening to new
voices, re-imagining world-views, and reforming systems.

In Chapter 3 I cited a Gilligan (2015) quotation that described a researcher’s
responsibility to “bring their [participant] voices into conversations about human
experience” (p. 75). For me, that means connecting participant voices to important
aspects of human experience relevant to this project and psychosocial fields. For
example, when Nicole questioned, “Is it suicide or genocide?” she was interrogating
language and the power to label. The term suicide has a particular history (Marsh, 2010)
and is embedded in particular White power structures like academic research, policy-
making, professional organizations, and psychosocial practice. Within each structure,
specific harms are produced that may contribute to suicide in Black communities. In the
next chapter I will extend participants’ critical perspectives by interrogating the
aforementioned structures and offering suggestions for structural improvements. In doing
so, some Black lives may be saved.
CHAPTER 6

Discussion and Conclusion

Inspired by participants’ voices, lived experiences, and critical understandings about suicide in Black communities, this chapter brings their perspectives into conversation with the broader world by exploring in-depth the manifestations of and interconnections among White-constructed shaming forces, internalized anti-Black shame, and “suicide.” Such detail emphasizes the linguistic, historical, intergenerational, and systemic complexities identified by the Black women in this study. Moreover, these complex interconnections emerge in the macro-culture via language, research, public policy, professional association guidelines, graduate training programs, and psychosocial assessment and intervention practices. Each domain is examined. This examination underscores the ways direct, indirect, structural, and cultural violence emerges and becomes codified within and across human systems (Galtung, 1969). Such examination may enhance activists’ and other social change agents’ efforts to challenge and dismantle oppressive forces that contribute to suicide in Black communities. Furthermore, I discuss recommendations for addressing racialized oppression, violence, and deaths deemed “suicides” within each macrosystemic domain. Also, Chapter 6 examines this project’s limitations and offers suggestions for future critical action research that bridges data, lived experiences, and activism. Finally, the chapter concludes by summarizing this project’s key goals and findings.

Language

The White European socio-historical origins and evolution of the term *suicide* contributes to its conceptual complexity and undergirds its oppressive power (Barbagli,
Prior to the 17th century, Western nomenclature related to an “individual causing their own death” included Saint Augustine’s *crimens homicidi*, or criminal death, as well as various English translations of French, Italian, and Spanish words that meant *one’s slaughter, one’s homicide, one’s murder* (Barbagli, 2015; Marsh, 2010). However, literary, cultural, and secular forces inspired attitudinal and linguistic changes. Most notably, William Shakespeare’s use of suicide in over 32 of his staged works reframed “death by one’s own hand” as a meaningful act that resulted from existential dilemmas, not sin, crime, or mental illness (Barbagli, 2015; Marsh, 2010; Snyder, 2015). Such authentic depictions of the human condition and suicide, coupled with increased Western secularization and the emergence of the European Enlightenment, likely propelled the change from *one’s death* to *self-death* in Western cultures (Barbagli, 2015; Marsh, 2010; Tatz & Tatz, 2019).

In the mid-17th century, the term *suicide* emerged for the first time in recorded history (Barbagli, 2015; Marsh, 2010). According to Marsh (2010), Sir Thomas Browne, an English physician and nobleman, coined the term in his 1642 work, *Religio Medici*. Browne created the term to differentiate between the pagan Cato’s suicide and the self-killing condemned by the Christian religion. Of this distinction, the American psychologist Shneidman (1985) wrote,

> The difference between self-killing or self-slaughter (and all the circumlocutions and phrases) on the one hand, and “suicide,” on the other may seem to be a small one, but it is not a trivial distinction. It is a significant, albeit subtle difference, reflecting a major shift in man’s relationship to himself and God—and to his disavowal of gods—and of his role in his own ultimate fate. It is as old as history
that a man could destroy himself by ruining his reputation and career or take his own life; but it was a seventeenth century insight and invention that a man could forever terminate his not-so-immortal existence and do more inimical things to himself. He could—dispensing the notion of soul and hereafter—for the first time “commit suicide.” (p. 14)

This transformation of belief and language reflected the emergence of a central paradigm shift among White Europeans: White individuals are self-determining agents, not merely subject to God or a monarch. This shift also heightened the awareness that individuals possess *interiority*, a substantive inner psychological experience driven by personal needs, desires, instincts, and impulses. These evolving experiences and drives—especially self-determination—made “suicide” possible. Moreover, the confluence of individualism and the emergence of capitalistic thinking to fulfill personal needs likely sparked European ambitions to colonize North America and bolstered rationalizations to enslave Black Africans (Snyder, 2015). The enslavement of Black Africans was the most economically efficient (low-cost labor) and culturally effective (easier to dehumanize because of differences) means for White Europeans to self-actualize in material ways (Kendi, 2016; McGhee, 2021). This emerging language about a complex White self—capable of dying by suicide—paralleled the evolution of a White self whose ability to live free of tyranny was contingent upon systematically dehumanizing, incarcerating, and killing an entire race. These parallels manifested as language and power converged.

**Language, White Power, and Dominant Views of Suicide**

The origins and evolution of the term *suicide* increasingly reflected the links among language, knowledge, power, hierarchy, object, and subject interrelationships in
White European society. Marsh (2010) offered a Foucauldian analysis. The author postulated that Sir Thomas Browne’s royal and professional privileges likely contributed to the eventual and widespread view that suicide results primarily from individual pathology. By problematizing suicide as a “disease of the self,” doctors became society’s suicide experts. Experts typically require specialized training that necessitates the creation of authoritative fields of study that produce new generations of professionals. Such experts, fields of study, and professionals create “regimes of truth” through the generation of theories and production of research. These production and circulation tools often create and reinforce knowledge-to-power and power-to-knowledge relationships among experts, suicide-vulnerable people, and the general public. Thus, the origins and evolution of the term suicide influenced modern-day psychiatry, psychology, and suicidology’s perspectives about people who die by suicide (Marsh, 2010; Tatz & Tatz, 2019).

Because of these knowledge-to-power and power-to-knowledge histories, contemporary and dominant views of suicide focus narrowly on individual mental illness. Battin (2005) wrote:

For much of the twentieth and on into the twenty-first century, thinking about suicide in the West has been normatively monolithic: suicide has come to be seen by the public and particularly by health professionals as primarily a matter of mental illness, perhaps compounded by biochemical factors and social stressors, the sad result of depression or other treatable disease—a tragedy to be prevented. (p. 164)
Such a narrow view excludes Eastern viewpoints, many social science perspectives, and most humanities frameworks. For example, some Muslim women attempt suicide to draw attention to abusive and oppressive patriarchal relationships, as they occasionally result in negative social sanctions for the men involved (Canetto & Rezaeian, 2020). These suicides are often political protests, not the product of mental illness. Additionally, excluding social science perspectives like those in the fields of anthropology and political science perpetuates the fallacy which holds that suicides occur in cultural and power relationship vacuums (Button, 2020; Colucci, 2012). Finally, the exclusion of the humanities from discourses about suicide limits important discussions about the historical and unethical contexts in which suicidality unfolds (White, 2020). White privilege and power frequently aim to deny or obscure these historical and ethical discussions to avoid culpability.

History reflects that the English term *suicide* as it is currently and broadly understood originated in a White, male, European, and elitist context that privileged individual personhood, agency, and liberty for a select class of people. Such contexts and beliefs undergirded the evolution of White identity, entitlement, and the dynamics of power over non-White peoples (Joy, 2019; Kendi, 2016). U.S. history in particular exposes the cruel hypocrisy and irony of White founders’ yearning for freedom while depriving BIPOC communities of their basic humanity through enslavement, internment, and massacre (Alexander, 2020; Kendi, 2016). Given this complex and violent history, one must carefully question the term *suicide*’s relevance to Black communities. The term likely obscures the ways cultural, historical, and power-over forces influence Black personhood and agency. Perhaps the word, and its broadly understood meanings, blur
important contributing factors like systemic shaming and the corresponding experience of internalized shame. This misapplication of language frequently serves as a tool to embed and entrench White privilege and power pervasively.

Language Implications and Recommendations Related to Black Suicides

Truth-telling uses language accurately to expose lies. Once a lie is exposed and examined, learning can occur. Such learning often takes many forms. A person may discover deeper and more profound truths about themselves, other people, and the world. Such discovery may include increased justice, forgiveness, reconciliation, and a new shared vision for the future. As I think about the Western term *suicide*, its origins, meanings, and intentional misuses to describe some Black deaths, e.g., Sandra Bland, I am reminded of one of Lorde’s (1984/2007) most famous quotations: “For the master’s tools will never dismantle the master’s house. They may allow us temporarily to beat him at his own game, but they will never enable us to bring about genuine change” (p. 113). Given the historical and ongoing ways European and U.S. Whites have exerted violent, traumatic, oppressive, and systemic forces to denigrate Black identity and constrain Black agency, using the term *suicide* complicates its applicability to some deaths among Black communities. Continued use of the word further promotes the idea that “suicide” occurs because of individual pathology and decontextualized hopelessness. In doing so, the role of violence, oppression, and systemic shaming are both obscured and absolved. Thus, one of the master’s tools—the use and abuse of language and terms like *suicide*—reflects White perspectives about agency, power, causality, and death, and likely excludes Black realities and experiences. One possible reason that national suicide prevention campaigns have been less effective among Black populations is because they
rely on frameworks developed from White Euro-centric paradigms (Borum, 2014). As a result, language related to deaths typically labelled “suicide” ought to be expanded to describe upstream-downstream mortality connections more fully. Such language expansion has research implications.

**Research**

Language defines the entire scope of inquiry, and thus powerfully determines knowledge generation. The research process typically starts with an observation about reality that is translated into a question. That translation process involves using language. Furthermore, the relationships between ontology, inquiry, and language are influenced by the person or people doing the “experiencing,” “observing,” and “using language.” People, as agents of inquiry, possess different capacities to pose questions, conduct research, distribute findings, and influence public beliefs. Such differential capacities are often attributable to power (Foucault, 1977; Taylor, 2014). This connection between power, knowledge, and language underscores the interrelationships among White power, knowledge suppression, and suicidality labels. White Enlightenment-era noblemen, philosophers, and scientists sparked privileged knowledge traditions (specialized fields of study) and developed gate-keeping institutions (professional guilds and the Academy) to consolidate power. This power became codified into law (Alexander, 2020; Kendi, 2016; Marsh, 2010). The result of these forces: the emergence of specialized people, with specialized skills, who oversee powerful institutions that generate, indoctrinate, maintain, and perpetuate self-interest in the form of “knowledge.” As mentioned in the literature review chapter, this evolutionary process produced the fields of psychology, psychiatry, and eventually suicidology. Such processes centered White dominant culture and
excluded epistemologies, perspectives, and research methods that attempted to disrupt its systems of privilege. These enabling and excluding processes continue to operate in the present.

While mainstream psychiatry and psychology exclude other perspectives, concurrently and paradoxically, contemporary suicidology’s “psy-focused” language often obscures—rather than clarifies—experiences of suicidality (Marsh, 2016, 2020; Tatz & Tatz, 2019). The current state of mainstream suicide-related language poses conceptual, research, and practical challenges. Shneidman (1985) noted,

Surely, “suicide” is one of those patently self-evident terms, the definition of which, it is felt, need not detain a thoughtful mind for even a moment… It is the act of taking one’s life. But, in the very moment that one utters this simple formula one also appreciates that there is something more to the human drama of self-destruction than is contained in this simple view of it. And that “something more” is the periphery of satisfactory definition. (p. 6)

In problematizing suicide’s definition, Shneidman’s observation concedes that suicide is more complex than an intentional individual act. Yet, psychiatry, psychology, and suicidology’s responses have emphasized increased orthodoxy, the proliferation of psy-specific language, theories, methodologies, and methods that emphasize quantifiable psychopathology (Marsh, 2016, 2020). Far from unifying researchers, clinicians, policymakers, and people with suicide-related lived experiences, these responses have hindered progress. Additionally, Silverman (2016) observed of suicidology, “Put simply, the absence of a universally accepted nomenclature and diagnostic criteria has limited our attempts to accurately quantify the extent of the problem, identify interventions, both
clinical and preventative, as well as useful markers of vulnerability” (p. 13). Such fundamental problems make it difficult to accurately measure incidences of suicide and prevalence rates; to differentiate between suicide attempts and non-suicidal self-injuries; and to communicate among and between researchers, clinicians, clients, and stakeholders. These limitations also affect suicide prevention efforts: it is almost impossible to solve a problem or fund solutions without definitional clarity. Thus, Silverman’s critique highlights contemporary suicidology’s failed monolithic approach to studying and preventing suicide.

As a result of suicide-language origins, the evolution of suicidology’s narrow “psy-focus,” and the field’s entrenched power to determine research question framing and funding, suicide-specific epidemiological data are both limited and the best available at this time. Moreover, the muddled and reductionistic use of the term “suicide” likely blurs systemic shaming and internalized shame dynamics by primarily foregrounding individual-level factors.

Research Implications and Recommendations Related to Black Suicides

One of the explicit goals of this project is to interrogate and transform the White Euro- and U.S. power structures embedded in suicidology and the psychosocial helping professions. In order to achieve this transformation, historically erased perspectives need to be uplifted more in research to prevent ongoing epistemic violence (Teo, 2010). For instance, the viewpoints of transwomen, indigenous peoples, people living in socio-economically developing places, political asylum-seekers, and/or environmental refugees should be centered more. Amplifying such perspectives exposes the complex intents and
impacts of White Euro- and U.S.-centered language, power, and institutions through critical storytelling, testimony-giving, and witness-bearing.

While foregrounding marginalized voices and perspectives is necessary, it is not sufficient. Such voices and perspectives must be engaged with critical and mutually emancipatory research praxis. These research paradigms privilege relationships, human dignity, and liberation for all people. Moreover, critical and liberation-focused methodologies and methods highlight complex human processes of meaning-making. This emphasis promotes an understanding of people’s interpretations of themselves, others, and the world in different contexts. These contextual interpretations are essential for conceptualizing and addressing the interplay between systemic shaming, internalized anti-Black shame, and deaths frequently labelled “suicides” (Chandler, 2020). For example, in order to prevent deaths related to systemic shaming and internalized shame, researchers, advocates, policymakers, and clinicians need to understand the dynamics between systemic anti-Black shaming forces and shame internalization processes. Thus, our research paradigms, methods, and findings ought to be evaluated in terms of their ability to foster upstream-downstream understandings and change.

*Psychopolitical validity* promotes epistemic and transformational change. Prilleltensky (2008) argued, “The main objective of psychopolitical validity is to infuse in community psychology and the social sciences an awareness of the role of power in wellness, oppression, and liberation at the personal, relational, and collective domains” (p. 129). The scholar further contended that research projects and structural change actions should be assessed using a three-by-three concerns (wellness, oppression, liberation) and domains (collective, relational, and personal) matrix. Projects and actions
would be considered more or less “valid” depending on the number of criteria they addressed: the higher the number of concerns and domains addressed, the more “valid.” This type of standard would also help assess the intent and impact of public policies.

**Public Policy**

White dominant culture’s corruption of language and “scientific research” frequently undergirds public policy. Kendi (2016) noted that White supremacist Puritans of the 1600s used Aristotle’s writings about climate and race to organize their human hierarchy of worth. Such writings claimed a relationship between climate, skin color, and value. For example, the Greek philosopher “labelled Africans ‘burnt faces’—the original meaning of ‘Ethiopian’—and viewed the ‘ugly’ extremes of pale and dark skins as the effect of extreme cold or hot climates” (Kendi, 2016, p. 17). This color-based hierarchy of human worth converged with the emergence of the Enlightenment’s scientific revolution.

White puritanical language and religious beliefs morphed as secular knowledge and intellectual movements spread across Europe and eventually around the “New World.” Kendi (2016) observed:

For Enlightenment intellectuals, the metaphor of light typically had double meaning. Europeans had discovered learning after a thousand years in religious darkness, and their bright continental beacon of insight existed in the midst of a ‘dark’ world not yet touched by light. Light, then, became a metaphor for Europeanness, and therefore Whiteness, a notion that Benjamin Franklin and his philosophical society eagerly embraced and imported to the colonies. (p. 80)
Such beliefs about virtue and worth became embedded in the U.S. Constitution and Bill of Rights. This confluence of values and laws codified White supremacy and relegated all non-Whites to subordinated statuses. Even as laws and public policies evolved, White supremacy swiftly and insidiously crafted legal loopholes to retain its dominance. For instance, the Thirteenth Amendment of the U.S. Constitution freed all slaves following the Civil War. However, the embedded phrase “except for criminals” catalyzed the criminalization of Black identity and accounts for the disproportionate incarceration of Black men today (Alexander, 2020). Such historical and present-day connections emphasize the persistence and pervasiveness of White dominant culture’s use of language, “evidence,” and power to maintain control over all non-Whites. However, anti-Black racism costs all members of society when White dominant culture equates the word “public” with “Black,” and results in fewer social welfare benefits for everyone.

White-centered public policy language and pseudoscience reflect a racist zero-sum gain paradigm that hurts everyone. McGhee (2021) wrote:

What’s clearer now in our growing inequality is that the economic benefit of the racial bargain is shrinking for all but the richest. The logic that launched the zero-sum paradigm—I will profit at your expense—is no longer sparing millions of [W]hite Americans from the degradations of American economic life as people of color have always known it. As racist structures force people of color into the mines as the canary, racist indifference makes the warnings we give go unheard—from the war on drugs to the financial crisis to climate disasters. The coronavirus pandemic is a tragic example of governments and corporations failing
to protect Black, [B]rown, and Indigenous lives—though, if they had, everyone
would have been safer. (p. xxi)

McGhee’s analysis reveals that White perceptions of Black advancement trigger
dominant culture’s anxiety about its status. Such status anxiety results in public policy
decisions like school segregation, welfare reform, and divestment in public services.
Invariably, these decisions negatively affect Black, Brown, and Indigenous communities
disproportionately, as well as working-class Whites and those living in poverty. These
policy decisions not only harm everyone materially, but such decisions are often
accompanied by shaming rhetoric. “Takers,” “freeloaders,” “welfare queens,” and “anti-
American” are otherizing terms used to dehumanize people of color and citizens who live
in poverty. Terms like these—in concert with resource deprivation—create the conditions
by which people often internalize shame and end their lives. To address these lethal links
between shaming language, punitive policies, and deaths labelled “suicide” in Black
communities, we need to re-examine and re-imagine our zero-sum beliefs and legislation.

Public Policy Implications and Recommendations Related to Black Suicides

Genuine and mutual solidarity helps counteract the zero-sum gain paradigm.

McGhee (2021) investigated examples of solidarity movements in unlikely places. The
author amplified the story of Ben Chin, a multi-racial Millennial community-organizer
and Episcopalian lay minister who coalition-built with 32,000 Maine residents to win a
series of public service job elections. These victories removed entrenched xenophobic
and White supremacist politicians from office. According to McGhee (2021),

The winning coalition included, for the first time, immigrant-led political action
committees, and the get-out-the-vote effort was anchored by a network of Somali
taxi drivers who used their infrastructure of radios and vehicles to get elderly, homebound immigrants, and poor Mainers to the polls safely. (p. 269)

These victories prompted policy reforms that targeted opioid addiction, state healthcare system overhaul, and a guaranteed paid-time-off law for Maine workers. These efforts have catalyzed many White Mainers to support racial justice issues. McGhee (2021) further remarked:

In the Whitest state in the union, there are promising signs that this is happening: a slate of progressive school board candidates in Maine are running explicitly on racial equity. The slate includes a White suburban mom in Bangor; a Somali social worker; a South Sudanese graduate of Maine public schools; a twenty-five-year-old queer grocery clerk with Asperger’s syndrome; and a White transgender man with twenty-four-years’ experience as a schoolteacher, who wears a T-shirt in his campaign video that reads: “I’m Not Black, But I Will Fight For You.” (p. 270)

These coalition-centered victories illustrate that cross-racial solidarity exists and affects change for everyone. This type of cross-racial solidarity serves as a suggested model for addressing the complexities of suicide in under-resourced and -served groups such as Black communities. While such examples highlight the transformative potential of multi-racial collective action at the local and state levels, societal-level solidarity between Black and White communities necessitates truth-telling and recompense.

Centuries of White privilege and power at the expense of Black communities requires reparations. Darity and Mullen (2020) articulated a three-pronged reparations program. The program involves acknowledgement, redress, and closure. This process
requires that everyone who benefits from White supremacy recognizes and admits the historical and present-day injustices experienced by Black people. Furthermore, redress entails restoring Black communities to “a more equitable position commensurate with the status they would have attained in the absence of the injustices” (Darity & Mullen, 2020, p. 3). This restoration would involve significant financial investment in Black institutions and payment to the descendants of enslaved Black people. While this economic restitution addresses past and present-day harms, closure connotes an official end of White supremacy and conciliation between Black people and the beneficiaries of discrimination, segregation, and slavery. This process would entail confronting past cruelties, eliminating present-day abuses, and then re-imagining a truly transformed and united society.

In re-imagining future public policy within the context of diminishing White supremacist anti-Black shaming systems, I recommend that all future policies be scored in terms of their impact on marginalized communities. Currently, the Congressional Budget Office (CBO) scores every piece of legislation in terms of its economic benefits and financial costs. This accounting is public and typically bipartisan (as much as possible). During the closure phase of the reparations process, metrics could be mutually designed to score public policies in terms of their intersectional effects. For example, every proposed law would have to be scored based on the degree to which that policy disproportionally helps or harms a group based on their cohort memberships. Costs and benefits would have to be distributed fairly in order for that policy to be enacted. Such fair and transparent efforts would strengthen trust between White and Black communities and bolster faith in our shared institutions. Trust-inspiring reforms such as these may also
compel professional associations to re-evaluate their White supremacist history and practices, as well as their commitment to suicide prevention.

**Psychosocial Professions, White Supremacy, and Suicide Prevention Competency**

Psychosocial professions face two challenges related to the connection between White supremacy and suicide in Black communities: anti-Black racist legacies, and poor suicide prevention education and training. Historically, psychology and social work reflect White supremacist beliefs and enable dominant culture power structures. Hoffman et al. (2016) remarked, “[W]ith regard to racism and other forms of prejudice, psychology too often has encouraged people to become comfortable in their role of being oppressed and marginalized instead of empowering people to stand up to injustice” (p. 607). Such misuse of therapeutic processes violates ethical standards that nominally stress the importance of client dignity. Furthermore, Klukoff et al. (2021) critiqued the Society for Police and Psychology’s 2020 statement regarding police reform in the wake of George Floyd’s murder:

> Their statement does not explicitly address police violence against the Black community, nor does it even mention one of the names of the many Black people who have been killed by police just this year. In fact, the statement includes no meaningful reflection on the current and historical harms caused by police, no specific goals or action steps to decrease state-sanctioned police violence, and it emphasizes standing in solidarity with the status quo of law enforcement and social control. (pp. 452–453)

The authors’ observations underscored typical patterns of White supremacist behavior: no admission of guilt, no mention of justice, and no meaningful commitments to change.
Moreover, psychology’s White supremacist disregard for human dignity is exemplified in its knowledge of and complicity with national security interrogations and torture of prisoners suspected to be terrorists (Risen, 2015). These examples stress that psychology—the leading doctoral-level research and clinical discipline in the United States—has consistently enabled White supremacist beliefs and power structures. And, while the American Psychological Association (APA) recently issued a formal apology for its racist legacy, some Black psychologists have questioned its impact in affecting meaningful changes within the field (DeAngelis & Andoh, 2022). However, the profession that provides most of the psychosocial services in the United States also embodies White supremacy.

Social work delivers most of the human services in the United States. Heisler (2018) reported, “[E]stimates show that clinical social workers are the most abundant of the mental health professions… The OES [Occupational Employment Statistics] estimates 112,040 mental health and substance abuse social workers in 2017, excluding those who are self-employed” (p. 9). This fact means that most people who come into contact with a mental health professional are being served by a profession with strong White supremacist connections. Aguilar and Counselman-Carpenter (2021) contended, White supremacy has been at the roots of social work since its inception. While Ida B. Wells and other women of color were just as important as Jane Addams to the history of social work, it is often Addams and her [W]hite sisters that are the focus of social work history. The phenomenon of “friendly visiting” and the Charity Organization Society (COS), through which middle-class [W]hite women “helped” under the auspices of providing moral guidance, evolved into casework.
Additionally, throughout the birth and infancy of the United States of America, [W]hite supremacy acted as a sieve during the developing racial contract that was codified into laws enabling whiteness to be protected through social capital. White supremacy thus buoyed friendly visiting and consequently wormed its way into casework, social work practice, research, education, licensing, and accreditation. (p. 1022)

The authors’ argument reveals that even under the best circumstances of “White good intentions,” White supremacy corrupts motivations and often results in devastating racial impacts. Applebaum (2017) noted that well-intentioned professions like social work often do harm when seemingly benign suggestions, like, “Let’s do a survey to find out more,” are employed. Such suggestions are often experienced by marginalized people as delay tactics. Additionally, survey data—when aggregated—frequently obscure calls for structural change. Such data, especially when represented numerically, can be further erased literally: numbers neutralize the power of the language of lived experience.

Beyond epistemic violence, the social work profession has been complicit in thousands of racialized family separations in the United States (Park, 2020). These separations explicitly violate standards of trauma-informed practice, as well as the dignity and worth of people. Thus, like psychology, social work collaborates with and benefits from White supremacy. Both professions engage in social control functions and are rewarded for these functions in terms of public funding and influence.

In addition to White supremacy’s influence on psychosocial professions, psychologists, counselors, and social workers lack suicide-specific competency. Shannonhouse et al. (2018) reported, “Despite the Council for Accreditation of
Counseling and Related Educational Programs’ (CACREP) mandate for suicide prevention and intervention training, new counselors are underprepared to respond to at-risk clients” (pp. 194–195). This lack of preparation raises ethical concerns. For example, the American Psychological Association (APA, 2017) emphasizes the principles of beneficence (doing good) and nonmaleficence (do no harm). However, this governing body does not mandate suicide prevention, assessment, or intervention training for psychologists. The result: psychologists are generally ill-prepared “to do good” or “prevent harm” when it comes to suicide-vulnerable populations.

The social work profession also neglects to train professionals in suicide prevention. Mirick et al. (2020) noted:

> Similar to graduate study in other mental health professions, social work graduate programs have not typically offered thorough, standardized, evidence-based instruction in assessment, management, and intervention of clients with suicidal thoughts and behaviors even in their field internships while working with clients with suicidal presentations. (pp. 31–32)

Social work’s failure to promote suicide prevention competency poses potential violations of the Code of Ethics of the National Association of Social Workers. For examples, Section 1.01 of the NASW (2018) Code of Ethics describes a social worker’s obligation to promote a client’s general welfare. Promoting a client’s welfare requires the knowledge and skills to prevent, assess, and manage client suicidality. Additionally, Section 1.02 of the Code of Ethics outlines a social worker’s duty to safeguard client self-determination unless doing so poses an imminent harm to the client or others (NASW, 2018). This duty requires the knowledge and skills to differentiate between acts of self-
determination and self-termination. Finally, Section 1.04 emphasizes the importance of social worker competence (NASW, 2018). Given that social workers provide most of the mental health services in the United States and are exposed to suicide vulnerable populations frequently, the social work profession—and the institutions that educate social workers—have an ethical obligation to mandate suicide prevention, assessment, intervention, and postvention competency.

**Psychosocial Graduate Training Curricula**

The lack of White supremacy divestment and the dearth of suicide-specific training among the psychosocial professions negatively affect graduate education. Clinical and counseling psychology graduate programs historically offer infrequent and low-quality suicide risk assessment training (Cramer et al., 2016). Mirick et al. (2016) further noted that most mental health graduate students learn suicide assessment and intervention content from their internship supervisors. The authors warned that relying on internship supervisors to provide such critical training poses risks. These risks include the very real possibility that outdated methods like “safety contracts” will be taught. Finally, the same scholars remarked that because most state licensing boards and accrediting bodies do not require suicide assessment and intervention training, graduate programs are further disincentivized to offer formal course work.

Social work graduate education programs also offer little suicide assessment and intervention training. Ruth et al. (2012) found that less than 25% of NASW members surveyed received formal suicide prevention training. Moreover, Feldman and Freedenthal (2006) discovered that most clinicians believed their suicide prevention training was insufficient. Forty percent of advanced social work students and field
supervisors in a small study (n=116) revealed some degree of unpreparedness when it
came to suicide, and 23% of the participants reported not receiving any suicide education
in their MSW program (Ruth et al., 2008). Furthermore, in a national, 3-year
investigation, Ruth et al. (2012) discovered:

Suicide education was included in MSW programs, with 57.4% (n=31) of
respondents estimating that their students received four or fewer hours of suicide
education. Most deans and directors (85.2%, n=46) noted that suicide education
was not required of MSW students in their programs, and only 1.9% (n=1)
reported that their program offered a specific course dedicated to suicide
prevention education. Additionally, although 61.1% (n=33) stated that suicide
education was integrated through students’ MSW field education internships, no
dean reported that his or her school’s program provided suicide training to field
instructors, and 53.7% (n=29) reported that their programs provided no
continuing education or professional development courses in suicide education.
(p. 504)

This study exposes the neglect in social work education of suicide-specific content and
raises questions about its absence. Almeida et al. (2017) explained that the lack of
suicide-specific coursework in social work education results from faculty discomfort with
suicide. This discomfort contributes to MSW students’ fears about addressing suicide and
leads social workers to refer suicide-vulnerable clients to other professionals. These fears
and referral practices undermine the social work profession’s credibility to provide
mental health services. Thus, social work education’s failure to promote suicide
prevention competency increases social worker liability when working with suicide-vulnerable clients.

Psychosocial Training Implications and Recommendations Related to Suicide

Psychosocial professions and the graduate programs that train such professionals need to address the dual challenges of White supremacy and suicide prevention incompetence. At the macro-level, professions need to critically evaluate the composition of their leadership structures in terms of diverse intersectional identities, and knowledge base and skills representation. Such representational leadership would be necessary to interrogate profession-specific mission statements, codes of ethics, training requirements, licensing guidelines, and continuing education mandates. This systemic examination would further require professions and graduate programs to develop theories, practices, and curricula that foreground systemic assessments and interventions. These efforts would bridge critical analysis, clinical practice skills, community organizing competencies, and policy development ingenuity. This creative synthesis bolsters the likelihood that solutions to problems with complex upstream-downstream dynamics—like “suicide” in Black communities—will emerge.

Psychosocial Assessment and Intervention

Re-imagining psychosocial professional organizational culture and graduate training offers an opportunity to review and build on current assessment and intervention practices. For example, conventional safety planning assessment and interventions mitigate suicidality risk effectively (McCabe et al., 2018). Stanley and Brown (2012) developed one of the most widely cited and used safety planning tools. According to the authors:
The basic components of the safety plan include (a) recognizing warning signs of an impending suicidal crisis; (b) employing internal coping strategies; (c) utilizing social contacts as a means of distraction from suicidal thoughts; (d) contacting family members or friends who may help to resolve the crisis; (e) contacting mental health professionals or agencies; and (f) reducing the potential use of lethal means. (p. 258)

These components are collaboratively explored between a client and practitioner during a clinical interview if and when suicidality emerges. Typically, a clinician asks a client, “What are your warning signs that a suicidal crisis is about to occur? What personal coping strategies will you use to prevent a suicidal crisis? What social contacts can you use to distract yourself when you’re having suicidal thoughts? What friends and family members will you call to resolve the crisis? What mental health professionals or community agencies will you contact if you’re experiencing suicidal crisis? How will you reduce the potential use of lethal means?” This framework, while generally effective, emphasizes individual agency, i.e., “what are you going to do?” This emphasis implies that suicide is primarily a personal mental health experience to be managed by an individual (Joiner et al., 2016).

While mental illness may contribute to some suicidality, an appropriately skeptical analysis of research data highlights a more complex view (Hjelmeland & Knizek, 2017). This view reframes suicidality as an interplay between individuals and social injustices situated across ecological systems. A critical systemic framework—unlike mainstream suicidology—conceptualizes and responds to the person-in-
environment complexities that uniquely contribute to suicidality among marginalized groups like Black communities.

**Assessment and Intervention Implications and Recommendations Related to Suicide**

In an effort to expand the scope of suicide assessment and intervention, I have outlined the critical systemic model. The framework synthesizes critical suicidology, ecological systems theory, and intersectionality. Critical suicidology challenges the mainstream frameworks that shape suicide theory, research, and interventions. White (2017) offered this critical view: “the solutions that are developed typically target individuals for change but leave the specific social, political, and cultural contexts of people’s lives—including the corrosive effects of structural inequalities—unaccounted for” (p. 472). In contrast to mainstream suicidology’s emphasis on individual, decontextualized, and biomedical frameworks, critical suicidology contextualizes suicidality as a social, political, economic, and cultural experience (Standley, 2020). This reconceptualization promotes a more comprehensive bio-psycho-social-spiritual view of suicide.

Critical suicidology’s more comprehensive view also highlights the social justice dimensions of suicidality. White and Kral (2014) contended that macro-contexts “produce environments of discrimination and social inequality, which place a disproportionate burden of suffering on some groups of people and not others” (p. 130). Reynolds (2016) bolstered this argument:

> Events occur in context, and because we [all] live in a society that has not delivered on the promises of social justice, which we are well-qualified [to] and
able to deliver, we have to structure into our analysis of a person’s death the context of social injustice in which they lived. (p. 170)

Thus, re-contextualizing suicidality supports this conclusion: *social justice is suicide prevention*. This conclusion requires systemic assessment and intervention to address the complexity of marginalized people’s suicidality.

**Clinical Implications: Critical Systemic Safety Planning**

Typically, when safety planning, clinicians inquire: “How will *you* know you are at risk for suicide?” or “What internal coping strategies will *you* use to reduce your risk?” While these questions are not inherently inappropriate, each question presumes a particular framework: that suicidality is primarily an individual experience that is mitigated chiefly by internal coping strategies. Crucially, the individual is responsible for managing these experiences. However, critical systemic clinicians would not assume an individual pathogenesis framework. Rather, these clinicians—with their emphasis on contextually-situated lived experience—would likely ask: “How will the *various social systems* you’re connected to know that your suicidality risk is increasing? How should *we* understand coping as a way to reduce your suicidality? In what *contexts* is risk highest? Lowest? What *strengths* across your *systems* can *we* use to mitigate suicide risk?” From these questions, specific warning signs, coping strategies, and strengths emerge to shape the elements of safety planning.

Critical systemic safety planning emerges from a critical awareness and assessment of a specific client’s unique systemic experiences. For example:
To explore a client’s temporal-developmental systems, a psychologist could ask: “In what ways, if any, does the year or the age you are today, contribute to wanting to die by suicide?”

To examine a client’s enviro-geographic systems, a licensed mental health counselor might inquire: “In what ways do cold, heat, seasonal changes, or physical location affect your desire to die?”

To assess a client’s structural-institutional systems, a clinician could question: “To what degree, if at all, do you experience a desire to die as a function of social injustice, oppression, or marginalization?”

To understand a client’s neighborhood-community systems, a case worker may wonder with a client: “How do relationships with local political, social, religious, education, health, and other community systems contribute to your suicidality?”

These questions help establish possible macrosystemic forces that contribute to suicide (Ballou et al., 2002; Bronfenbrenner, 1994). Such queries would also reduce stigma because the primary unit of analysis is systemic dynamics, not individual pathology. This shift in focus also expands possible interventions, like connecting people with affinity organizations, becoming politically active, changing physical environment conditions, and/or reframing personal troubles as historically rooted and intergenerationally transmitted. This model also includes mezzo- and micro-systemic assessment and intervention:
• To explore relational-family systems factors, a counselor might say, “How might the people in your life be influencing your wish to die right now? Historically?”
• To assess a person’s I-self systems, a family therapist could ask, “What’s going on for you internally that contributes to your desire to die by suicide?”

In concert, these questions comprise a critical systemic approach and not only expand the scope of suicide assessment and intervention but also defy the usual “yes/no” format embedded in most screening tools and assessments. The examples provided are not designed to be prescriptive. Rather, each question should be viewed as a flexible template that could be adapted based on a respondent’s age and literacy. Finally, such an assessment re-contextualizes suicide and empowers clinicians and clients to collaboratively imagine solutions beyond medication and cognitive restructuring. An expanded repertoire of macro-level interventions is essential for addressing suicide in Black communities because such deaths are likely shaped by historically entrenched and structurally reinforced forms of power.

**Limitations and Future Research Directions**

Fourteen Black female clinicians between the ages of 30 and 58 offered their stories and insights about their intersectional identity experiences in predominantly White institutions and understandings of suicide in Black communities. Moreover, the participants were situated geographically in nine different states from the Mountain West to New England. Furthermore, the Black female clinicians represented social work, clinical psychology, counseling psychology, and marriage and family therapy professions across a range of practice settings. Despite this diversity, limitations existed.
The participants in this research project all were required to have full licensure status to be included in this study, which excluded human services professionals who provide non-clinical psychosocial services. Such professionals are on the service delivery frontlines, and future research efforts should explore their experiences to better understand the breadth of perspectives about “suicide” in Black communities. Furthermore, this project did not reflect the range of gender, or sexual orientation identities that exist in Black communities. Future projects need to include more diverse dimensions of these important identities to better understand the intersectional experiences of LGBTQI+ Black cohorts in relation to important community institutions like church and family. This intersectional dynamic can be a suicide protective and/or risk factor depending on the nature of the relationship between individuals and these institutions. Additionally, future research ought to intentionally expand and include more categories of identity—i.e., ability, social class, religion—to more fully investigate the nuanced and intersectional complexities of “suicide” in Black communities. Finally, the qualitative methodology of this inquiry project poses generalizability challenges. However, the dialogic knowledge generated by this project provides a springboard to future research that might focus on quantifying the relationships between systemic shaming, internalized anti-Black shame, and mortality rates.

**Conclusion**

This dissertation research project underscored the reality that suicide is a problem that significantly harms Black communities in the U.S. Pre-project interviews with Black doctoral counseling students and preliminary reviews of Joe et al. (2006) and Lindsey et al. (2017) supported this hypothesis. These sources suggested that historical, social,
political, and economic factors like racism, poverty, mass incarceration, and violence contribute to suicide. My pilot interview with a Black female mental health clinician and reading of Spates’s (2015) work shaped my decision to center Black female clinicians’ perspectives. The interview and reading highlighted complex identity-contextual-suicidality relationships, which led me to interview research participants whose lived experiences reflected a similar multifaceted positionality.

I chose to interview Black female clinicians with a critical worldview because they are situated in the two most persistently oppressed cohorts in the United States—female and Black—and have received advanced psychosocial training (Collins, 2009, 2019; Spates, 2012; Spates et al., 2020). Coupled with their critical orientation, these participants were well-positioned to analyze and understand the degrees to which suicide is shaped by macrosystemic and/or individual-level psychological factors. Then, I reviewed the extant historical, socio-demographic, psychological, and sociological literature. This review compelled me to seek out critical theories. These theories consistently guided me toward qualitative methodologies that privilege human relationships, dialogic knowledge generation, and complex meaning-making processes. Within this research tradition, narrative inquiry resonated with me because suicide in Black communities seemed connected to the historical and intergenerational trauma stories rooted in Black African enslavement and White dominant culture’s power-over systems. Such complex and taboo stories required a method that allowed the complexities of participant voices to be heard and represented. For this reason, I elected to use I poems to better understand the participants’ subjective vantage points from which their critical
perspectives about suicide in Black communities emerged (Gilligan, 2015; Gilligan & Eddy, 2021; Tolman & Head, 2021).

The 14 Black female clinician participants in this project amplified the nuanced, complex, and dynamic interplay among shame, racism, hopelessness, trauma, systemic forces, and fear. These women critically examined their own experiences of gendered racism while simultaneously narrating the shame, hopelessness, grief, and suffering many Black community members must cope with routinely. This examination and narration unearthed voices of intersectional consciousness. Several participants noted that they persisted in predominantly White institutions for practical reasons like maintaining health, dental, and retirement benefits. These benefits empowered most of the clinicians to resist White privilege and power by opening their own private practices that focused on Black community psychosocial wellness. These spaces serve as sanctuaries where shaming and shame experiences can be reframed in terms of complex systemic and intrapsychic relationships, not simply individual pathology. Furthermore, the voice of intersectional consciousness narrated patterns of internal conflict and contentment. When in conflict, many of the participants expressed dilemmas between self-care and community-care. These dilemmas often resulted in clinicians’ decisions to continue working in toxic predominantly White institutions that serve primarily Black populations: their people needed them. Yet, for others, these dilemmas were resolved by developing networks of Black providers to create alternative service delivery systems. Participant voices also offered lived-experience vantage points for understanding suicide in Black communities.
From the critical lived-experience vantage points of the research participants, voices of *systemic shaming* and *internalized shame* emerged. The shaming voice typically presented when participants described the ways various systems engage in shaming—acts of transmitting messages that a person or group is worthless or bad *because* of who they are. Concurrently, the voice of internalized shame reflected personal and witnessed experiences of feeling and believing one is worthless or bad because of an immutable quality, trait, characteristic, or identity, such as racial or ethnic identities. Moreover, the connections between systemic shaming practices and Black community members’ internalized shame compelled me to reconsider the term “suicide.” I concluded that the term was inaccurate because it often obscured the culpability of White privilege and power in all its guises. As a result, I offered a form of resistance: placing quotation marks around the word “suicide” to compel readers to question the common narratives about such deaths. The confluence of participant voices, extant research, and my reflections and shifts in language inspired me to focus on a dynamic often underexamined by mainstream researchers, clinicians, and policy-makers—systemic shaming, internalized shame, and suicide.

Systemic shaming manifests within and transmits across multiple systems of human experience. With each shaming manifestation and transmission, shame is produced and uniquely internalized. This process likely catalyzes several appraisals about one’s humanity, capacities to meet basic needs, and ability to access or mobilize resources. When systemic violent, traumatic, and identity-based shaming deprives an individual of their personhood and basic needs, the impact likely contributes to death. This possibility highlights the reason this project’s title starts with the phrase “Black
Deaths Matter.” While these deaths matter intrinsically because life was lost and grief was experienced, Black deaths also matter because the manner in which a person dies often reflects the conditions under which they lived, or were forced to live (Reynolds, 2016). Medical autopsies generally indicate the physical cause of death. However, this decontextualized analysis only reveals part of the story. A critical and systemic analysis of death would likely reveal a more nuanced and complex story. These revelations, if attended to, might result in better cultures and communities of care for all. Such cultures and communities require the painful yet necessary work of acknowledging harms, redressing suffering, and engaging in authentic, mutual, and sustained solidarity efforts. Only when these efforts emerge will All Lives Matter.
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Black Deaths Matter


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APPENDIX A

Recruitment Email

Dear Colleague:

My name is Heath Hightower. I am a White, gay, cisgender male social worker and doctoral student at Lesley University. My doctoral research explores Black female clinicians’ experiences of suicide in Black communities. Historically, such perspectives have been erased, ignored, or exploited in the social sciences. My aim is to use my unearned White and male privileges to amplify Black female clinician perspectives in suicidology, contribute to the development of suicide theory specific to Black communities, and raise awareness about White supremacist violence that likely contributes to deaths by suicide in Black communities. To achieve these goals, I want to create collaborative research relationships with participants who:

❖ Self-identify as Black or African American
❖ Self-identify as female, transwoman, woman, and/or womyn
❖ Are a fully licensed mental health professional who currently works as a clinician
❖ Have personal or professional experiences with members of the Black community who have experienced suicidal ideation, a suicide attempt, or a death by suicide
❖ Live and practice in the United States

If you are interested in participating, but have some questions or concerns, please do not hesitate to contact me at hhightow@lesley.edu, or (860) 204-2051. Phone calls and text message inquiries are welcomed.

If you are interested in collaborating with me as a research participant, please contact me at hhightow@lesley.edu or (860) 204-2051 so that we can schedule a brief conversation about the study and your experiences. Enrolled participants will receive a $100 Amazon gift card. Once enrolled in the study, an email message with a survey link will be sent to your email address. This link connects to the informed consent form and a 19-item socio-demographic questionnaire. Completing these forms takes approximately 10 to 15 minutes. Once both forms are completed, I will contact you about scheduling a 60- to 90-minute interview.

I look forward to connecting with you soon.

Best,
Heath Hightower
APPENDIX B

Brief Telephone Screening Questions

1. What questions or concerns do you have about participating in this study?
2. Do you identify as a Black, female, transwoman, woman, and/or womyn?
3. Do you currently work as a licensed mental health clinician in the United States?
4. What personal or professional experiences do you have with suicide in Black communities?
5. How would you describe your relationship with the people who contemplated, attempted, or died by suicide?
6. Would you like to be listed as a co-author or would you prefer to remain anonymous?
7. If you would like to remain anonymous, is there another name you’d like me to use to represent you in this study?
APPENDIX C

Informed Consent

You are invited to participate in a research project titled Black Deaths Matter: A Critical, Voice-centered Exploration of Black Female Clinicians’ Experiences of Suicide in Black Communities. The aims of this research study are to amplify underrepresented Black female clinicians’ perspectives in suicidology, contribute to the development of suicide theory specific to Black communities, and raise awareness about violence that contributes to deaths by suicide in Black communities. Such aims may also improve cultural competency education related to clinical practice with Black client systems.

- Your participation will entail completing this form and an online questionnaire consisting of 19 questions related to your contact information, personal background, and professional experiences. The purposes of the background and professional experience questions are to establish participant eligibility and ensure accurate participant representation. The questionnaire should take approximately 10 to 15 minutes to complete.

- Once this informed consent form and the online questionnaire have been completed and submitted, the principal investigator for this study, Heath Hightower, will contact you to schedule a 60- to 90-minute interview. Interviews will be conducted via the Zoom teleconferencing platform. The interview will be video- and audio-recorded. Audio-recordings will then be transcribed. Transcriptions will not include participant names without explicit permission (verbal or written). Rather, participant pseudonyms will be used in the transcript. All recordings and transcripts are maintained on encrypted platforms, using password protected files, and on a password protected laptop computer that only the principal investigator uses. This laptop computer is located in a locked file cabinet housed in a locked office.

- After the interview has been transcribed and analyzed, findings will be presented at a public dissertation defense, and may be discussed at professional conferences and in academic journals. All recordings and documents associated with this project will be destroyed after 5 years in 2028.

- To ensure accurate data interpretation and participant representation, the principal investigator will contact you and share his findings before being presented. Any concerns about and/or differences of interpretation between the investigator and participant will be fully described in the research findings chapter.

In addition:

- You are free to choose not to participate in the research and to discontinue your participation in the research at any time without facing negative consequences.
Your identifying details will be kept confidential by the researcher. Your identity will never be revealed by the researcher, and only the researcher will have access to the data collected.

Any, and all, of your questions will be answered at any time and you are free to consult with anyone (i.e., friend, family) about your decision to participate in the research and/or to discontinue your participation.

Your participation in this project poses risk in the form of discomfort related to discussing your personal and professional experiences associated with suicide in Black communities. However, given your training as a clinical professional, and scholarship indicating mild benefits associated with research participant discussions about suicide, you are not likely to experience any harms. While risk to you is low, you may decline to answer any question or withdraw from the project at any time.

Your participation may lead to personal and professional insights about suicide in Black communities. These insights may improve your clinical practice with members of Black communities who experience suicidality, and thus save lives. Additionally, your participation will bolster the representation of Black female clinician perspectives about suicide in Black communities in counseling, psychology, and suicidology. Such representation further amplifies the important contributions Black female clinicians make across mental health professions and in society more broadly. Finally, Black female clinician contributions to psychosocial knowledge bases may help further elevate connections between social injustices, violence, public policy, and suicide. These connections may help reform the insidious systems that create suicide-related despair.

If any problem in connection to the research arises, you can contact the researcher: Heath Hightower at (860) 204-2051 or by email at hhightow@lesley.edu. Additionally, participants may also contact Dr. Rakhshanda Saleem, (617) 349-8394, or rsaleem@lesley.edu, with questions or concerns related to this project. Dr. Saleem is the dissertation committee chairperson for this project. Finally, there is a Standing Committee for Human Subjects in Research at Lesley University to which complaints or problems concerning any research project may, and should, be reported if they arise. Contact the Committee Chairperson at irb@lesley.edu.

The researcher may present the outcomes of this study for academic purposes (i.e., articles, teaching, conference presentations, supervision etc.)

Signature of Researcher:________________________________________________________
Date:____________

By typing your name and date in the space provided you are indicating that you are voluntarily consenting to participate in this study and you know that you may terminate or withdrawn from this study at any time:

________________________________________________________
Date:____________
APPENDIX D

Socio-Demographic Questionnaire

Description and Instructions

The purpose of this questionnaire is to obtain self-descriptions of your contact information, personal background, and professional experiences. Each question will ask you to type in the requested information. Examples of possible answers are provided in parentheses for clarification purposes only. These examples are not meant to be prescriptive in any way. All personal background and professional experiences information will ensure you are represented accurately in this project. Once the survey is completed and submitted, Heath Hightower will contact you to schedule a 60- to 90-minute Zoom videoconferencing interview. If you have any questions or concerns, please contact Heath at hhightow@lesley.edu or (860) 204-2051. Thank you for completing this survey and expressing interest in this project.

Questions

1. Please list your first and last names
2. What pronouns do you use to describe yourself? (She/her, they/them)
3. What is your telephone number (Area Code + 7-digits)?
4. What is your e-mail address?
5. What is your age?
6. Please describe your Gender (female, transwoman, woman, womyn):
7. Please describe your Race (Black, African American):
8. Please describe your Ethnicity (Haitian, Jamaican, Nigerian,)
9. Please describe your socioeconomic Status (Working Class, Middle Class, Upper-Middle Class):
10. What is your annual income in U.S. dollars?
11. Please describe your sexual orientation: (Bisexual, Lesbian, Straight):
12. Please describe your religious/spiritual tradition (Atheist, Baptist, Catholic, Jewish):
13. Please describe your graduate degree (MA, MFT, MS, MSW, PhD)
14. Please describe your clinical license (LADC, LMHC, LCSW, LICSW, LISW, LMFT, LPC)
15. Please describe your work setting (hospital, private practice, outpatient clinic)
16. How long have you been a clinician?

17. How many people do you know—personally and/or professionally—in the Black community who have thought about suicide?

18. How many people do you know—personally and/or professionally—in the Black community who have attempted suicide?

19. How many people do you know—personally and/or professionally—in the Black community who have died by suicide?
APPENDIX E

Interview Protocol (Participant Copy)

Pre-Interview Questions
What, if any, questions do you have before we get started?
What, if any, concerns do you have about being interviewed by a White gay man?

Interview Questions
1. How would you describe the experience of being a Black female clinician in the United States?
2. What comes up for you when you hear the phrase “suicide in Black communities?”
3. Describe your earliest experience with suicide in Black communities.
4. Describe an experience with suicide in Black communities that impacted you most.
5. Describe your most recent experience with suicide in Black communities.
6. Drawing on your personal and professional lived experiences, how do you understand suicide in Black communities?
   - Historically?
   - Culturally?
   - Systemically/Societally/Structurally
   - Immediate Community/Neighborhood
   - Relationally?
   - At the individual level?
     - Describe your understanding of a Black individual from your personal or professional life who thought about, attempted, or died by suicide.
   - What clinical theories do you find most helpful in conceptualizing suicide in Black communities? Please elaborate
   - Least helpful? Please elaborate.
   - If you were developing a theory to understand suicides in Black communities specifically, what would it include?

Check-in: Before I ask another question, I want to check-in to see how you’re doing. Do you need or want anything right now?

7. What else, if anything, would help me understand your experience of suicide in Black communities?

8. How would you like me to use the information you provided me today?

9. Are there ways you do not want me to use the information you provided today? Please specify.
10. May I follow-up with you in the near future to ensure my work is accurate?
APPENDIX F

Interview Protocol (Researcher Copy)

Scripted Introduction
Thank you for generously offering me the opportunity to discuss your experiences about suicide in Black communities. The aim of this project is to amplify perspectives that have been historically exploited, ignored, and/or erased from mainstream psychology and suicidology. Additionally, I hope our work together will improve suicide prevention theory and practices related to Black communities. Please let me know if there are specific ways you would like me to use our work.

The central question we will be exploring together is: How do Black female clinicians’ experience suicide in Black communities? To illuminate your experiences, I have developed a list of interview questions below. I provided you with this list of questions in advance of our interview because knowing the questions beforehand builds trust, strengthens rapport, and bolsters the accuracy of our work. At the same time, unscripted questions will likely arise as our conversation unfolds. So, my plan is to go wherever our conversation leads us. Additionally, I have built in several check-ins between topic areas as a way of offering respite and support. Please note that you can take a break at any point during the interview for any reason. Any questions before we get started?

Interview Questions

Pre-Interview Question
What, if any, concerns do you have about being interviewed by a White gay man?
   If yes, address concerns until the participant either chooses to withdraw from the project or affirmatively consents to continue
   If no, explicitly state that if concerns arise at any point during the project, please let me know as soon possible so that those concerns can be addressed.

1. How would you describe the experience of being a Black female clinician in the United States?
   Chronosystem
      Now?
      When you first started?
   Macrosystem
      Culturally?
      Within primarily White spaces?
      Within primarily Black spaces?
      Within multicultural spaces?
   Exosystem
      Professional/work spaces?
   Micro-/Meso-system
With colleagues?
With friends?
Family?
  Immediate?
  Extended?
  Of choice?
Individual
  Professional Identity?
  Professional Education?
  Personal-Professional Intersections?

2. What comes up for you when you hear the phrase “suicide in Black communities?”
3. Describe your earliest experience with suicide in Black communities.
4. Describe an experience with suicide in Black communities that impacted you most.
5. Describe your most recent experience with suicide in Black communities.
6. Drawing on your personal and professional lived experiences, how do you understand suicide in Black communities?
   - Historically?
   - Culturally?
   - Systemically/Societally/Structurally
   - Immediate Community/Neighborhood
   - Relationally?
   - Individual?
      - Describe your understanding of a Black individual from your personal or professional life who thought about, attempted, or died by suicide.
      - What clinical theories do you find most helpful in conceptualizing suicide in Black communities? Please elaborate
      - Least? Please elaborate.
      - If you were developing a theory to understand suicide in Black communities specifically, what would it include?

Check-in: Before I ask another question, I want to check-in to see how you’re doing.
Do you need or want anything right now?

7. What else, if anything, would help me understand your experience of suicide in Black communities?
8. How would you like me to use the information you provided me today?
9. Are there ways you do not want me to use the information you provided today? Please specify.
10. May I follow-up with you in the near-future to ensure my work is accurate?
APPENDIX G

Online Participant Recruitment Sites

- American Association of Suicidology listserv:
  SUICIDOLOGY@LISTS.APA.ORG

- LinkedIn: https://www.linkedin.com/mynetwork/

- National Association of Social Workers’ members discussion board:
  https://mynasw.socialworkers.org/communities/community-
  home/digestviewer?tab=digestviewer&CommunityKey=457588b1-5824-
  404d-a6a0-1f03acff57fd

- Psychology Today’s Therapist Directory: https://www.psychologytoday.com