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Suicide and Life-Threatening BEHAVIOR

ORIGINAL ARTICLE

# Cultural Consensus Modeling to identify culturally relevant reasons for and against suicide among Black adolescents

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## Abstract

**Introduction:** The development of evidence-based treatments relies on accurate theoretical frameworks sensitive to the lived realities of the populations from which they are derived. Yet, the perspectives of Black youth are vastly underrepresented in extant theories of suicidal behavior. Cultural Consensus Modeling provides an evidence-based approach for developing a culturally informed understanding of suicide risk among Black youth.

**Method:** Participants were 50 Black adolescents ($M_{age}$ = 16.20 years; 76.0% male) who completed Phase 1 of a Cultural Consensus Modeling study. Participants freely listed reasons for suicide and reasons for living among similar peer Black youth. Responses were synthesized and coded for major themes.

**Results:** The most common reasons for suicide were racism (40%), depression (32%), poverty (26%), and bullying (22%). The most common reasons for living were family (58%), having a purpose or goals (36%), friends (30%), and hope for a better future (26%).

**Conclusion:** Responses highlighted issues of racism and social justice, depression, and poverty, as well as the protective role of relationships, living for the future, and contributing to Black empowerment. Future research should utilize Cultural Consensus Modeling to elevate the voices of Black youth, improving extant theories of suicide, and identifying unique mechanisms or opportunities for prevention.

**KEYWORDS**
cultural consensus modeling, minoritized population, youth

## INTRODUCTION

Black youth under 13 are twice as likely to die by suicide compared to their White peers, and the suicide rate among Black youth is increasing faster than any other racial/ethnic group (Bridge et al., 2015). From 2010 to 2020, suicide rates among Black youth increased by 108.9% among 15–19 year olds and 78.5% among 20–24 year olds, compared with 31.9% and 25.4% among White youth, respectively (Centers for Disease Control and Prevention, 2022). The same is true of

suicide attempts. Between 1991 and 2017, there was a 73% increase in suicide attempts among Black youth, while attempts among White youth decreased (Lindsey et al., 2019). In response, the Congressional Black Caucus convened an emergency Taskforce in 2019 and released its report, *Ring the Alarm: The Crisis of Black Youth Suicide in America*, as a call to action to increase research on suicide prevention for Black youth (Congressional Black Caucus, 2019).

Yet, the perspectives of Black youth are vastly underrepresented in extant theories of suicidal behavior. Modern theories of suicidal behavior utilize ideation-to-action frameworks, which suggest a stepped progression from passive suicidal ideation to active ideation and suicidal behaviors. These theories provide a more nuanced approach to understanding and predicting suicidal behaviors compared to earlier psychiatric or medical models of suicide. One prominent ideation-to-action theory is the Interpersonal-Psychological Theory of Suicide (IPTS; Joiner, 2005; Van Orden et al., 2010). Perhaps the most well-established, the IPTS has received considerable empirical support among adults (Ma et al., 2016), as well as adolescents (Barzilay et al., 2015; Horton et al., 2016; Stewart et al., 2017). The IPTS outlines three primary risk factors for suicidal behavior: perceived burdensomeness, thwarted belongingness, and acquired capability for suicide. Despite evidence in support of ideation-to-action theories, their relevance for Black youth is largely untested. In a review of the IPTS, Stewart et al. (2017) identified 15 studies of the IPTS constructs among adolescents, of which 13 examined predominantly white samples, one examined a predominantly Asian American sample, and one examined a predominantly Latinx sample. The neglect of the perspectives of Black youth in theory development has been noted, as well as the need to integrate these theories with an intersectional framework (Opara et al., 2020; Standley, 2022), though such integrated models have yet to be investigated empirically. In fact, Opara and colleagues (2020) established an integrated framework that intersects the Interpersonal-Psychological Theory of Suicide and Intersectionality Theory. Their work aims to prevent suicide among Black children by providing a framework for researchers, clinicians, and practitioners to incorporate culturally appropriate topics and techniques in their work. Topics may include addressing the significant role of racial discrimination, mental health, socioeconomic status, and sexual/gender minority status related to suicide risk among Black children in the United States. While Opara and colleagues (2020) established the importance of intersectionality and cultural factors, such integrated models have yet to be investigated empirically.

The role of culture in Black youth suicide is undeniably critical. Prior research indicates there are culturally specific factors that contribute to depressive symptomology and other mental illnesses in Black children in the United States. One significant factor contributing to the onset of depressive symptoms and suicide among Black youth is the experience of racial discrimination (Lanier et al., 2017; Seaton et al., 2010). English et al. (2014) found that racial discrimination was linked with participation in delinquency and suicide ideation among Black children. Lambert et al. (2022) found that Black children's knowledge of their family and peers' exposure to community violence was associated with increased suicidal ideation. In contrast, prior research has also identified a protective function of African American culture, with religion, spirituality, and familial variables helping reduce the risk of suicide among African Americans (e.g., Anglin et al., 2005; Kaslow et al., 2004; for a review of risk and protective factors for suicide in Black youth, see Molock et al., 2021).

The perspectives of Black youth are also vastly underrepresented in treatment development research. A recent examination of Black youth representation in suicide prevention and treatment research found that out of 22 identified trials, only one (Robinson et al., 2018) specifically investigated treatment efficacy for Black youth (Sumlin et al., under review). Furthermore, only 20.8% of treatment evaluation studies had sufficient samples of Black youth to detect differences in treatment efficacy with adequate power, and only one study (Huey et al., 2004) actually did so (Sumlin et al., under review). Similarly, Joe et al. (2018) conducted a review of youth-focused clinical trials for suicide-related thoughts and behaviors and concluded that empirical research on treatments for suicide-related thoughts and behaviors among young Black males is grossly underdeveloped. Research in treatment development has shown that, broadly, culturally informed treatment practices improve the efficacy of research (Griner & Smith, 2006). Yet the limited research on suicide risk among Black youth precludes the ability to develop culturally informed suicide prevention approaches for this population. As a result, interventions have not yet been modified or adapted to address the unique needs and experiences of Black youth, resulting in recent calls for a "ground zero research agenda" that relies on mixed-method approaches to conceptualize Black youth suicide research and to examine larger systemic issues that may be linked to suicide risk among Black youth (Sheftall & Miller, 2021).

## Cultural Consensus Modeling as a mixed-methods approach to identifying shared cultural beliefs

It is critical that theories of suicide-related thoughts and behaviors not be blindly applied to Black adolescents without consideration of their cultural relevance. The development of evidence-based treatments relies on accurate theoretical frameworks sensitive to the lived realities

of the populations from which they are derived. Cultural Consensus Modeling (CCM) can provide an evidence-based approach for developing a comprehensive, culturally informed understanding of suicide risk among Black youth. CCM is a rigorous, multi-method, bottom-up methodology to identify and measure shared cultural beliefs about a phenomenon of interest (Dressler et al., 2005; Fielding-Miller et al., 2016; Weller, 2007). CCM prioritizes giving direct voice to members of a target group to elucidate shared norms, beliefs, and cultural values. CCM has been used in prior research to examine contraception use in South African adolescent girls (Brown et al., 2018, 2020), the appraisal of microaggressions in undergraduate students (Michaels et al., 2018), transactional sex in Swaziland (Fielding-Miller et al., 2016), and cultural conceptualizations of *nervios*, a culture-bound syndrome, in Honduran adults (Stein, 2019). In the case of seeking to better understand reasons for and against suicide among Black youth, this entails amplifying the voices of Black youth as the foundation for understanding their experiences.

CCM utilizes a four-phase structure, combining qualitative and quantitative approaches to characterize cultural factors associated with a given outcome. The four phases include: (1) free listing; (2) rating survey; (3) in-depth qualitative interviews; and (4) quantitative survey methods (Brown et al., 2018, 2020). Each phase occurs sequentially, with the results of earlier phases informing subsequent work.

In Phase 1, individuals respond to questions about similar others in their cultural group rather than their individual behaviors, using a free-listing format. Utilizing these identified group beliefs, Phase 2 asks individuals to rate the extent to which factors identified in Phase 1 are valued by their peers. This process identifies unique clusters of individuals (termed *cultural consensus models*) who place greater importance on particular factors and can test if there is a single shared cultural model or whether there are multiple cultural models. Phase 3 utilizes qualitative interviews with key informants from Phase 2 to gather in-depth information regarding the identified factors. Phase 4 draws on the information obtained from Phases 1–3 and conducts a quantitative survey to determine the extent to which cultural consensus models are associated with individual behaviors, norms, or beliefs.

## Using Cultural Consensus Modeling to understand reasons for and against suicide for Black youth

Using the CCM approach to understand reasons for and against suicide in Black youth should result in a culturally informed model of suicide risk built upon the perspectives and voices of Black youth themselves. In turn, a culturally informed model of suicide risk in this minoritized population can inform theory development, help identify unique mechanisms or opportunities for preventive interventions, inform cultural adaptations for existing prevention programs, or lead to the development of novel suicide prevention approaches for Black youth. Below, we demonstrate how the CCM approach could be applied to develop a culturally informed model of suicide among Black youth. We then present preliminary data from Phase 1 of the CCM approach.

Phase 1 involves asking Black youth with a history of passive suicidal ideation to access their shared cultural knowledge about the risk of suicide. Participants are asked to respond to a series of prompts about suicide risk among similar peers, listing as many responses as they can. For example, participants might be asked, "What are the reasons why *other* Black youth like you may have thoughts about taking their own lives?" By asking youth to respond based not on their own experiences but on the experiences of similar peers, youth draw upon their cultural knowledge (i.e., shared beliefs, behaviors, or norms held by a group). The sample size for Phase 1 should be sufficient to achieve saturation of responses (i.e., a comprehensive list of factors Black adolescents consider when thinking about suicide; Brown et al., 2020; Dressler et al., 2005; Weller, 2007). The result of Phase 1 is a list of culturally relevant responses to each of the target prompts.

In Phase 2 of CCM, responses from Phase 1 are reviewed, duplicates are condensed, and the items are placed into a rating survey. A new sample is then asked to rate the extent to which factors identified in Phase 1 are valued by peers. For example, participants might be asked, "When *other* Black adolescents consider hurting or killing themselves, how much do they consider [Phase 1 response]?" Data are then examined to identify unique clusters of individuals, termed cultural consensus models, who place greater importance on particular factors. Phase 2 also evaluates whether there is a single shared cultural model or whether multiple cultural models are present (i.e., clusters of individuals who share their pattern of responses). While CCM does not make a priori hypotheses regarding the number of cultural models that may emerge, evaluating multiple models acknowledges the heterogeneity present within a cultural group and does not assume cultural groups will hold homogeneous belief systems. While prior literature emphasizes the importance of cultural factors in understanding suicide among Black youth (e.g., Joe et al., 2008; Opara et al., 2020), the "ground-up" approach of CCM precludes specific hypotheses regarding the emergence of cultural models. In prior research, the emergence of

2–4 cultural models is typical (e.g., Brown et al., 2018; Fielding-Miller et al., 2016; Stein, 2019). At the conclusion of Phase 2, cultural consensus models representing shared beliefs about the importance of various reasons for and against suicide have been identified.

Phase 3 utilizes qualitative interviews with key informants from Phase 2 to gather in-depth information regarding the identified factors. Respondents for Phase 3 are selected based on high cultural competence (i.e., a pattern of responses highly congruent with the cultural consensus models) for each of the identified models from Phase 2. Results from Phase 2 indicative of minimal within-group heterogeneity (i.e., a consistent pattern of responses across participants) would likely result in a single cultural model. Greater within-group heterogeneity would result in more than one cultural model. The Cultural Consensus Analyses conducted in Phase 2 also allow for an examination of the extent to which an individual participant is consistent in their responses with the identified cultural model(s). Thus, the aim of Phase 3 is to select participants who are most closely aligned with each of the cultural model(s) identified in Phase 2. Phase 3 leverages the depth of qualitative interviews to gather greater insight into the identified reasons for and against suicide, to help understand how the identified cultural consensus models differ, and to expand on findings from the free listing and rating phases.

Finally, Phase 4 of the CCM approach includes a quantitative survey with a new sample of participants to determine the extent to which cultural consensus models are associated with *individual* reasons for suicide rather than those of peers. Cultural models developed are also validated in relation to extant theories of STBs. In addition to the identified cultural consensus models, the CCM process also produces a new measurement tool that can be scrutinized for its psychometric properties in future studies using traditional classical test theory or item response theory approaches.

## The present study

In an effort to address the lack of inclusion of Black voices in youth suicide prevention research, the present study includes data from Phase 1 of a CCM study of suicide in Black youth. The purpose of the study is to elucidate reasons for and against suicide as identified by Black youth, elevating the voices of these youth as a foundation for building a culturally informed understanding of suicide risk in this population. We hypothesize that Black youth will generate IPTS-related motivations for suicide as well as motivations related to minority stress and discrimination (Opara et al., 2020). While this study represents only the first phase of CCM, the results of this study may illustrate the CCM process and its utility for generating a culturally sensitive understanding of suicide.

# METHOD

## Participants

Participants were $N = 50$ Black adolescents recruited via Research Match and via referral by their clinician at a local mental health clinic in the Houston metropolitan area. Inclusion criteria were: (1) 12–17 years of age; (2) self-identify as Black and/or multiracial (including Black); and (3) at-risk for suicide as determined by a PHQ-9 depressive symptom score ≥5 (indicating mild depressive symptoms; Kroenke et al., 2001) or endorsement of item 9 on the PHQ-9, which pertains to the presence of passive suicidal ideation. Participants' scores on the PHQ-9 ranged from 5 to 26, with a mean of 15.93 ($SD = 5.61$), falling in the "moderate/severe" symptom severity range (Kroenke et al., 2001). On item 9 of the PHQ-9, concerning passive suicidal thoughts, 86% endorsed passive suicidal ideation in the previous 2 weeks. Broad inclusion criteria to denote elevated risk for suicide-related thoughts and behaviors were selected to ensure an inclusive selection of participants. Given known barriers to mental health help-seeking in Black youth (Planey et al., 2019), a low bar for inclusion was intended to include those who may under-report symptoms or purposefully omit self-report of suicidal ideation. Exclusion criteria included: (1) the inability to complete study procedures in English; and (2) the presence of either intellectual disability or psychosis, assessed verbally during the consent/assent process. Participants' mean age was 16.20 years (SD = 1.18, range 12–17). Participants self-identified as male (76.0%, $n = 38$), female (22.0%, $n = 11$), and other (2.0%, $n = 1$). Participants also self-identified as heterosexual (92.0%, $n = 46$) and bisexual (8.0%, $n = 4$). Forty-seven participants (94.0%) identified as non-Hispanic Black, one (2.0%) identified as Hispanic Black, one (2.0%) identified as non-Hispanic Black and White, and one (2.0%) identified as Hispanic, Black, and White.

## Procedure

All procedures were reviewed and approved by the appropriate Institutional Review Board prior to the start of the study. Participants were identified via ResearchMatch or were referred by their clinician at a

local mental health clinic. ResearchMatch is a national health volunteer registry that was created by several academic institutions and supported by the U.S. National Institutes of Health as part of the Clinical Translational Science Award (CTSA) program. ResearchMatch has a large population of volunteers who have consented to be contacted by researchers about health studies for which they may be eligible. The consent process and study procedures were conducted over a secure videoconference. A member of the research team reviewed the study protocol, obtained informed parental consent and youth assent, and provided a link through which the participant could complete the study questionnaire, which consisted of demographic information and free-response questions. The consent process and study procedures combined required approximately 45 min and the adolescents were compensated with a $30 USD Amazon gift card. In the event an adolescent endorsed suicidal ideation during the study procedures, a suicide risk assessment was conducted and a safety plan was discussed with the adolescent and parent.

## Measures

### Demographics

Participant demographics were assessed via adolescent self-report and included gender, age, sexual orientation, race, and ethnicity. For each item, participants were instructed to select from several categories, with the option to select multiple responses and to provide a response of "other" and specify a different response. Racial categories included Black, White, Asian, American Indian/Alaskan Native, Hawaiian Native/Pacific Islander, and others. For the purpose of study inclusion, an individual met inclusion criteria if they self-identified as Black irrespective of any other racial/ethnic identities endorsed.

### Patient Health Questionnaire—9

The Patient Health Questionnaire—9 (PHQ-9; Kroenke et al., 2001) was used to assess the severity of depressive symptoms in the previous 2 weeks as part of the study inclusion criteria. The PHQ-9 has been extensively validated for use as a brief depressive symptom screener among youth and adults and has demonstrated strong psychometric properties (Levis et al., 2019). Each of the nine items is scored from 0 *"not at all"* to 3 "*nearly every day"* with total scores ranging from 0 to 27. Symptom ranges include mild (scores ranging from 5 to 9), moderate (10–14), moderate/severe (15–19), and severe (20–27). In the present study, internal consistency (Cronbach's alpha) was good ($\alpha = 0.85$).

### Cultural Consensus Modeling

For phase one of the CCM approach, two items were used to generate free-listing responses. The instruction read, "We are interested in learning more about why Black teens and preteens may think about ending their own lives. We are NOT asking about your individual thoughts and behaviors." The first item accessed cultural knowledge about suicide risk, "What are the reasons why Black youth may have thoughts about taking their own lives? Please name as many reasons as you can think of and number your responses." The second item accessed cultural knowledge about resilience, "For Black youth who are having thoughts about ending their own lives, what are some reasons for living? Please name as many reasons as you can think of and number your responses." Respondents were provided a large text box to accommodate responses of varying lengths.

## Data analysis

Qualitative data analysis was conducted in accordance with the principles of CCM. First, free-listing responses were first reviewed by a member of the study team (RH). The purpose of reviewing and grouping responses was to synthesize the free-listing responses and then identify the frequency with which each response was generated. As is typical in CCM, participants provided a variety of responses, ranging from single-words answers to longer explanations. In the first step, identical or syntactically equivalent responses were identified and grouped together (e.g., grouping "bullying" and "being bullied;" grouping "family," "family situations," and "family problems"). The purpose of this first step was to organize responses and identify clear overlap/repetition. In the second step, conceptually equivalent responses were grouped together (e.g., grouping "bullying" and "bullied in streets and in school"; grouping "low self-esteem," "lack of self-confidence," and "self-doubt"). All grouped responses from these steps were then reviewed by a second member of the study team (DB). Any disagreements were discussed between the two raters until mutually agreed upon. Upon completion of the CCM analysis, while not typical of CCM, an abbreviated content analysis was conducted for the purpose of identifying common domains of responding. Responses were then organized into a series of preliminary overarching themes based on the expression of shared

ideas and constructs (RH). Each response was assigned to only one theme, and themes were considered mutually exclusive. A second member of the authorship team (DB) then reviewed the identified themes. Each theme was then discussed between the two authors, with adjustments made by mutual agreement, and theme labels were generated. Finally, the resulting themes and free-listing responses were reviewed by two additional members of the authorship team (CS, JB) for additional input and clarification. No further adjustments to the identified themes were identified at this step.

## RESULTS

### Reasons for suicide

Frequencies of endorsed risk factors for suicide are shown in Table 1. The most commonly identified responses were racism (40%), depression (32%), poverty (26%), bullying (22%), lack of self-confidence (18%), discrimination (16%), and marginalization (16%). Several overarching themes were identified, including: racism and social justice issues, family/peer relationships and belongingness, health and mental health issues, stress and emotion-related concerns, socioeconomic and neighborhood factors, trauma, abuse, and neglect, limited self-expression and visibility, and lack of hope for improvement.

Within the domain of *racism and justice issues*, the most common responses were "racism" (40%), "discrimination" (16%), and marginalization (16%; e.g., "rejection in society," "lack of acceptance in society"). For the purpose of grouping responses, the term racism referred specifically to responses that included "racism" or "racial conflict." Discrimination included responses indicating actions against an individual or group due to race (e.g., "they are harassed for the color of their skin") and marginalization included general rejection, isolation, or otherness in society (e.g., "lack of acceptance from society" and "lack of compassion and care for young Black lives"). One participant responded, "Black people no matter what age have it worse than white people in society. They are harassed for the color of their skin. This treatment maybe has been died down with generations, but that doesn't mean it has stopped. Some black teens may have been groomed to think they aren't worth much because of this." Another participant described "The thought that the society is against them," while another noted a "Lack of love from the community due to skin color." This section also noted discrimination specifically from law enforcement, with one participant writing "I think racism to begin with is a factor, how the police treat us African Americans

**TABLE 1** Frequencies for free listing of reasons for suicide ($N = 50$).

| | *n* | % |
|---|---|---|
| *Racism and social justice issues* | | |
| Racism | 20 | 40 |
| Discrimination | 8 | 16 |
| Marginalization | 8 | 16 |
| Discrimination by police | 3 | 6 |
| Inequality | 2 | 4 |
| The pressure from white people | 1 | 2 |
| Because of prejudice, youth could believe they may be "stupid" or "inferior" to other people | 1 | 2 |
| *Family/peer relationships and belongingness* | | |
| Bullying | 11 | 22 |
| Family | 7 | 14 |
| Lack of parental support | 3 | 6 |
| Un-accepting parents | 2 | 4 |
| Peer pressure | 2 | 4 |
| Lack of feeling of belonging | 2 | 4 |
| "Fake friends" | 1 | 2 |
| Name calling | 1 | 2 |
| Difficulty finding a romantic partner | 1 | 2 |
| *Health and mental health issues* | | |
| Depression | 16 | 32 |
| Bereavement | 4 | 8 |
| Anxiety | 3 | 6 |
| Mental health issues | 3 | 6 |
| Drug abuse | 2 | 4 |
| Illness | 1 | 2 |
| *Stress and emotion-related concerns* | | |
| Lack of self-confidence | 9 | 18 |
| Stress and pressure | 6 | 12 |
| Failure | 3 | 6 |
| Emotional pain | 2 | 4 |
| Lack of purpose | 1 | 2 |
| Not having a reason to live | 1 | 2 |
| Tired of staying afloat | 1 | 2 |
| Not trying to burden | 1 | 2 |
| *Socioeconomic and neighborhood factors* | | |
| Poverty | 13 | 26 |
| Gangs | 3 | 6 |
| Not able to have mental health facilities in the neighborhood | 1 | 2 |
| Community violence | 1 | 2 |
| *Trauma, abuse, and neglect* | | |

**TABLE 1** (Continued)

| | *n* | % |
|---|---|---|
| Traumatic experiences | 3 | 6 |
| Abuse/Neglect | 3 | 6 |
| Sexual harassment | 2 | 4 |
| Neglect by family and community | 1 | 2 |
| *Limited self-expression and visibility* | | |
| Not feeing safe to be able to express their true emotions | 1 | 2 |
| Having suppressed emotions that leads to emotional build-up | 1 | 2 |
| Feeling rejected | 1 | 2 |
| Tired of being overlooked | 1 | 2 |
| Feeling less of oneself | 1 | 2 |
| *Lack of hope for improvement* | | |
| Lack of hope for a better tomorrow | 1 | 2 |
| The thought that they should work a way out for themselves, yet the factors are not working for them | 1 | 2 |

really unjustified." Another wrote, "Discrimination by policemen in the streets."

Within the domain of *family/peer relationships and belongingness*, the most common responses were "bullying" (22%) and family issues (14%; e.g., "family problems," "lack of parental support"). One participant noted that, "bullying can include many things, such as the way they dress, talk, look, and/or the conditions they've had to grow up in." Within the domain of *health and mental health issues*, "depression" (32%) was overwhelmingly the most common response, though multiple participants referred to bereavement (e.g., "loss of a close friend or relative"), "anxiety," and generic "mental health issues" as well. Within the domain of *stress and emotion related concerns*, several participants referred to a "lack of self-confidence" or "low self-esteem" (18%), or general stress and "pressure to succeed" (12%).

Within the domain of *socioeconomic and neighborhood factors*, the most common response was "poverty" or "being broke" (26%). In addition to general income-related concerns, participants noted a racial component to socioeconomic concerns, such as "poverty among Black families" and "a lot of black parents are not well to do and it takes a toll on their kids." One participant noted, "The violent nature of most black neighborhoods guarantees one that it's not like to have a normal life..." and another wrote that "not [being] able to have mental health facilities in the neighborhood" contributed to suicide risk.

Within the domain of *trauma*, *abuse*, *and neglect*, participants identified "abuse", "neglect", and "sexual harassment" as being associated with suicide risk. Finally, the domains of *limited self-expression and visibility* and *lack of hope for improvement* consist of unique responses offered by only a single individual each, such as "not feeling safe to be able to express their true emotions" and "lack of hope for a better tomorrow," respectively.

## Reasons against suicide

Frequencies of endorsed reasons against suicide are shown in Table 2. The most commonly identified individual responses were family (58%), having a purpose or goals (36%), friends (30%), and hope for a better future (26%). Several overarching themes were identified, including: relationships, hope and living for the future, supporting Black empowerment, finding solutions in the face of challenges, and religious beliefs.

Within the domain of *relationships*, the most common responses were "family" (58%), "friends" (30%), and "loved ones" (10%). With respect to family, one participant wrote, "Family. I think family is everything and to some it's the thought of family that keeps them moving." Of note, responses indicated the reciprocal nature of these relationships. Some wrote about not wanting to hurt family members, indicating that caring for their family is protective against suicidal thoughts. For example, one participant wrote, "Family: A lot of us are holding back because we love our families and wouldn't want them to feel hurt" while another wrote about the "pain and agony of seeing loved ones sad." Others indicated that family caring about them is protective, with another participant writing, "Your family. Your family are people care as much, if not more, about you than you do."

Within the domain of *hope and living for the future*, the most common responses were "having a purpose/goals" (36%), "hope for a better future" (26%), and that "there's still something to live for" (14%). Several participants expressed the importance of finding your purpose, with one writing, "Realizing your purpose in the world because you weren't created to just exist but were brought here for a purpose." Another participant noted, "Anyone and everyone, Black or not, has the possibility to achieve greatness and have happiness in their life. It just takes time and dedication." Other responses indicated a sense of hope that things will get better, with another participant writing "I guess the main reason is hope of one day the pain might go away. We expect that at each moment the universe can align to our destiny." Others noted specific life experiences they live for, such as vacations, good food, or particular hobbies and interests that bring a sense of happiness.

Within the domain of supporting Black empowerment, participants described inspiration from seeing Black people succeed (e.g., "seeing people like Barack

**TABLE 2** Frequencies for free listing of reasons against suicide ($N = 50$).

| | *n* | % |
|---|---|---|
| *Relationships* | | |
| Family | 29 | 58 |
| Friends | 15 | 30 |
| Loved ones | 5 | 10 |
| Love | 2 | 4 |
| Pets | 2 | 4 |
| Hurting people that care about you | 2 | 4 |
| Boyfriend/girlfriend | 1 | 2 |
| Advice from parents and elders | 1 | 2 |
| *Hope and living for the future* | | |
| Having a purpose/goals | 18 | 36 |
| Hope for a better future | 13 | 26 |
| There's still something to live for | 7 | 14 |
| Hobbies and interests | 4 | 8 |
| Having passions | 3 | 6 |
| Vacations or experiences | 3 | 6 |
| Finding fulfillment and content | 1 | 2 |
| *Supporting Black empowerment* | | |
| Black empowerment | 6 | 12 |
| Proving you are not what others think | 2 | 4 |
| *Findings solutions in the face of challenges* | | |
| There's always another way | 2 | 4 |
| Fixing problems we face | 1 | 2 |
| Doing everything possible to earn a living | 1 | 2 |
| Innovative minds where a person may find a way of surviving | 1 | 2 |
| Improved self-esteem | 1 | 2 |
| Online platform where there is easy access to speak to someone about challenges | 1 | 2 |
| *Religious beliefs* | | |
| Religious beliefs | 5 | 10 |
| *Other* | | |
| Fear of criticism in case suicide fails | 1 | 2 |
| Able to control suicidal thoughts | 1 | 2 |
| The unknown | 1 | 2 |
| They have to find the will to live on their own. | 1 | 2 |

Obama succeed") and a desire to contribute to "Black empowerment" (e.g., "the continued struggle for Black lives" and "to show the world that Black is king"). Within the domain of *finding solutions in the face of challenges*, participants described efforts to fix problems or to find options other than suicide (e.g., "fixing problems we face"). Finally, several people noted *religious beliefs* (10%) as supporting resilience, such as "Religion. Serving God because at the end of the day, we exist because of Him."

## DISCUSSION

This study sought to address the lack of inclusion of Black youth in suicide prevention research through the first phase of CCM. CCM is a rigorous, multi-method, bottom-up approach to amplify the voices of the community and to elucidate culturally driven shared norms and values. Phase 1 of the CCM approach, presented here, involves collecting free-listing responses from a sample of Black youth at elevated risk for suicide-related thoughts and behaviors. One benefit of the CCM free-listing approach is that youth are prompted to respond about how *similar others* may think about suicide, drawing on a larger cultural understanding of the phenomenon rather than their own individual reasons for suicide and reasons for living. The most common reasons for suicide were racism, depression, poverty, and bullying. The most common reasons for living were family, having a purpose or goals, friends, and hope for a better future.

As hypothesized, youth generated reasons for and against suicide consistent with the IPTS constructs of perceived burdensomeness and thwarted belongingness. With regard to thwarted belongingness, family and peer relationship issues were frequently identified, with bullying and family as two of the most common concerns. This is consistent with empirical data indicating that the frequency of fighting with parents is associated with increased odds of suicidal ideation in black adolescents (Goodwill, 2021). Bereavement, as a mental health concern, may also be related to thwarted belongingness, as previously identified in the literature (Hill, Kaplow et al., 2019). Critically, youth identified both caring for others and others caring for them as reasons for living, indicating the reciprocal nature of belongingness in the IPTS (Van Orden et al., 2010). Perceived burdensomeness-related elements (i.e., "others would be better off without me") were less commonly generated by youth, with only one participant directly identifying being a burden as a risk factor. Themes of Black empowerment as a reason for living may indicate a desire to benefit society or improve their own lives or the lives of others, which may also be related to perceived burdensomeness. In a prior qualitative study of perceived burdensomeness among adolescents, relying on others and letting others down were the most frequently described

examples of burdensomeness (Hill, Hunt et al., 2019). Thus, to the extent that contribution to or support for others may serve to counteract perceptions of burdensomeness, resilience factors like family, loved ones, and pets may also reference perceived burdensomeness, albeit indirectly. Responses related to trauma, abuse, and neglect may also be indicative of the acquired capability for suicide, which is hypothesized to result from repeated exposure to painful and provocative events (Van Orden et al., 2010), though such a connection was not explicitly stated by youth.

As hypothesized, themes related to minority stress and discrimination were also highly prominent. The most common reason for suicide was racism, with discrimination and marginalization also commonly reported. Discrimination took many forms, with youth reporting harassment, bullying due to their race, and negative interactions with law enforcement. Out of 160 total responses regarding risk factors, 43 (26.9%) were related to themes of racism and social justice. Consistent with Opara and colleagues' model (2020), themes of racism and intersectionality were woven throughout youths' responses, placing a range of reasons for and against suicide within a larger framework of racism and discriminatory experiences. For example, multiple youth placed poverty into the larger context of racial differences in wealth. Black empowerment and the desire to contribute to the Black community also arose as reasons for living. Addressing racism and justice issues beyond more traditional IPTS targets would appear to be critical for suicide prevention efforts for Black youth, but it may also provide youth with reasons for living upon which to build strengths-based prevention approaches. Additionally, these themes indicate that integrating across models of intersectionality (Opara et al., 2020), minority stress (Forrester et al., 2019; Meyer, 2015), and socioecological perspectives on suicide risk (Cramer & Kapusta, 2017) may contribute to a more nuanced understanding of suicide risk in the population.

Several other factors emerged, which may point to additional theoretical orientations or risk factors that should be considered in a culturally relevant conceptualization of suicide. For example, mental health-related concerns were noted, aligning with psychiatric models of suicide (Bertolote et al., 2004). Concerns regarding stress, feeling under pressure, lacking confidence, and being in emotional pain may align with Shneidman's conceptualization of suicide as being primarily driven by psychological pain (termed *psychache*) (Shneidman, 1996). Several youths noted religion as a reason for living, consistent with prior literature on protective factors for suicide among Black youth (Anglin et al., 2005; Kaslow et al., 2004). Recent data from the National Survey on Drug Use and Health also indicate that 40% of Black youth with a history of suicide attempts strongly agreed that their religion was important to them, nearly double that of other racial/ethnic groups, indicating the importance of considering religion and spirituality in the context of Black youth suicide prevention (Goodwill & Yasui, 2022). Finally, broader environmental factors, including socioeconomic concerns, were noted, specifically the impacts of poverty, a factor not directly included in most theories of suicide. Cramer and Kapusta (2017) highlighted the role of poverty as a risk factor in their socioecological model of suicide, but research on poverty as a risk factor is scarce. The frequency with which Black youth identified poverty as a risk factor (26% of respondents) may indicate a highly proximal role of poverty in the development of suicide-related thoughts and behaviors. An emerging research design that uses geographic indicators such as ZIP codes or census tracts to examine how neighborhood-level risk and protective factors map onto the prevalence of suicide-related thoughts and behaviors may help explore the role of poverty as a risk factor for suicide (Hill et al., 2021).

## Implications for treatment development research

Even as these preliminary results inform possible modifications to or extensions of theoretical models of suicide, they may also begin to inform development and treatment adaptation for the prevention of suicide in Black youth. As ideation-to-action theories gather increasing empirical support, researchers have begun to incorporate elements of these theories into novel suicide prevention approaches (Allan et al., 2018; Buitron et al., 2022; Hill & Pettit, 2019; King et al., 2021; Webb et al., 2022). Failure to account for culturally relevant elements, such as the effects of racism, discrimination, and poverty, could result in interventions that are less relevant (and less efficacious) for Black youth (Griner & Smith, 2006). Interventions may benefit from leveraging culturally relevant protective factors, such as building a sense of purpose and supporting Black empowerment, through engaging in activities related to Black pride, and social justice. Prior research indicates there may be both benefits and costs to political and social engagement (Oosterhoff et al., 2021), so further research is needed to identify the best methods of engagement for deriving mental health benefits. Interventions deemed personally relevant may be more efficacious and engaging for patients, and personal relevance may be based, at least in part, on cultural differences (Hall et al., 2021). Integrating culturally relevant protective factors to help

create engagement and improve treatment efficacy may be critical for reducing mental health disparities (Lau, 2006; Parra Cardoa et al., 2012).

## Strengths, limitations, and future directions

CCM is a rigorous, mixed-methods approach that champions the voices of members of a target population. A primary limitation of the Phase 1 methodology is its reliance on free-listing among a relatively small number of participants. While the sample size of 50 participants should produce saturation of responses (Dressler et al., 2005; Weller, 2007), any systematic selection bias may be reflected in the free-listing responses provided. For example, our sample drew from both a local clinic as well as a national sample, two groups that may have unique perspectives. The sample was predominantly male, heterosexual, and had a mean age of 16.20 years. As such, the results may not be broadly generalizable to Black youth. In the 2019 Youth Risk Behavior Survey, 84.4% of high school students (91.2% of males) identified as heterosexual (Underwood et al., 2020). Thus, while the present sample roughly aligns with population rates of sexual minority youth, the results certainly cannot represent reasons for and against suicide in the Black sexual and gender minority community. Sexual and gender minority youth likely experience different risk and protective factors associated with intersectional identities. Future research examining suicide risk among Black sexual and gender minority youth is needed. Of note, the current sample was predominantly made up of boys, despite adolescent girls reporting suicidal ideation at greater rates among Black high school youth in the Youth Risk Behavior Survey (16.9% of girls vs. 10.7% of boys; Ivey-Stephenson et al., 2020). Prior research on suicide-related thoughts and behaviors in youth has frequently included more girls than boys (e.g., Hill & Pettit, 2019; King et al., 2019), despite Black adolescent boys being more likely to die by suicide compared with Black adolescent girls (Centers for Disease Control and Prevention, 2022). Perhaps as a result, even well-supported risk factors appear more predictive of suicide attempts in girls than boys (King et al., 2014), and others have called for increased attention to suicide among Black adolescent boys (Marraccini et al., 2021). Consequently, the high rate of Black boys in the present study, while limiting the generalizability of the data, fills an identified need in the extant literature. The inclusion of an older adolescent sample, with a mean age of 16.20 years, also limits the representation of, and generalizability for, younger pre-adolescent Black youth, for whom suicide risk is particularly disproportionate (Bridge et al., 2015). Future research must include a greater focus on early adolescent and pre-adolescent Black youth. A single-item indicator of passive suicidal ideation was used as part of the inclusion criteria, but it was not able to provide an assessment of suicide risk or ideation severity and should not be interpreted as such (Millner et al., 2015). Historical effects may also impact the responses, with this research taking place in the context of the national Black Lives Matter movement and the global COVID-19 pandemic. Responses endorsed less frequently may also be of limited cultural relevance, which highlights the need to pursue the second phase of CCM, applying quantitative analysis to identify shared cultural models. Additional phases of CCM are needed to examine the free-listing responses reported here, generate cultural consensus models, and test those models in relation to extant theories of suicidal behavior. It is critical that future CCM phases include a broader representation of Black youth, including larger numbers of girls, sexual and gender minority youth, and younger adolescents, to allow for different cultural models to emerge. Additionally, the strong presence of themes related to racism and social justice in these responses highlights the need to examine the influence of systemic and policy-level factors on suicide risk among Black youth. This requires moving beyond individual and interpersonal psychological models to evaluate the larger societal context in which suicidal thoughts and behaviors occur.

## CONCLUSION

Despite increasing rates of suicide-related thoughts and behaviors in Black youth, the perspectives of Black youth are vastly underrepresented in extant theories of suicidal behavior and in suicide prevention treatment development. This study sought to address the lack of inclusion of Black youth in suicide prevention research via the first phase of CCM. CCM is a rigorous, multi-method, bottom-up approach to amplify the voices of the community and elucidate culturally driven shared norms and values. Phase 1 of the CCM approach involved asking a sample of Black youth to generate perceived reasons for and against suicide for other Black youth. Responses highlighted issues of racism and social justice, depression, and poverty, as well as the protective role of relationships, living for the future, and contributing to Black empowerment. Future research should utilize the CCM model among minoritized populations. The results of CCM research can help inform extant theories of suicidal behavior and identify unique mechanisms or opportunities for preventive interventions.

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## CONFLICT OF INTEREST STATEMENT

The authors state that they have no conflicts of interest to disclose.

## DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

## ETHICS STATEMENT

The study was approved by the Institutional Review Board of the University of Houston.

## CONSENT STATEMENT

All participants provided informed consent/assent prior to enrollment in the study.

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