Black Boys Mental Health Help-Seeking:
Exploring Perceptions, Barriers and Social Processes

by

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Dedication

“Merciful Jesus, you are my guide, the joy of my heart, the author of my hope, and the object of my love. I come seeking refreshment and peace. Show me your mercy, relieve my fears and anxieties, and grant me a quiet mind and an expectant heart, that by the assurance of your presence I may learn to abide in you, who is my Lord and my God. Amen.”

- Author Unknown

This dissertation is dedicated first and foremost to the God that I serve. In all my questioning and confusion, my doubts, you have continued to shine light on me and fill me with strength that I never knew I had. Thank you for your blessings and favor. Nothing in this dissertation was completed alone. There are so many people in my life that have supported me, guided me, encouraged me, and lifted me up in times where I felt weak, felt like quitting, and doubted my ability to be anything more than I was at that moment

Mom, not only did you give me life, but you also have time after time spoken life into me. I have held on to the words that you said to me in 2013 when I was finishing my first degree, you said “you’re not done yet”. Since then, I have continued to pursue new heights and have reached places I never imagined. Thank you for instilling your strength and perseverance in me, never giving up on me, and making sure in every moment of doubt I knew how special I was.

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This dissertation is dedicated to my **grandparents** and the **ancestors** that survived so that I may thrive. As well as **my father-in-law** that has given me the gift of my wife and children.

Finally, I dedicate this dissertation to **Davis Street**, the street where I walked, ran, played, fought, cried, and the concrete in which I grew. May every rose that grew in concrete continue to reach for the sun, and in the words of Tupac Shakur, may we always celebrate their tenacity.

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Abstract

Though research on Black boys' mental health is expanding (Masuda et al., 2012; Schwartz & Blankenship, 2014; Watkins et al., 2006, 2015), it is still a largely understudied topic. In particular, research that considers the perspectives of Black boys makes up an even smaller subset of this research (Assari & Caldwell, 2017; Gaylord-Harden et al., 2017; Joe et al., 2018; Lindsey et al., 2010, 2017). It is the goal of this dissertation to elucidate the voices of Black boys in research on mental health and depression by unpacking their reported beliefs on mental health and depression, help-seeking preferences, and service utilization. This dissertation contributes to the growing scholarship on Black boys' mental health, by using the voices of Black boys to explore their beliefs and perceptions of mental health and depression, examine barriers and facilitators to their utilization of school-based mental health resources, and explore their mental health help-seeking process.

Chapter 2 explores Black boys' views and beliefs about mental health and depression. I found that though the boys had a high amount of knowledge about mental health and depression, they often did not relate their understanding of mental health and depression to their own experiences with depression and depressive symptoms. Furthermore, their hypothetical understanding of mental health service use did not translate to their actions related to addressing their mental health needs as the boys in the study preferred to address their mental health needs on their own.

Chapter 3 examines the effects of psychosocial barriers and access barriers on Black boys' use of school-based mental health resources. I found that Black boys that identified self-reliance as a barrier to mental health service use were significantly less likely to use school-based mental health resources. Furthermore, boys that identified stigma as a barrier to service use were significantly more likely to use mental health resources in their school. Findings speak to the effects of masculine norms around self-reliance as hindering Black boys' use of available mental health resources. However, they also speak to the potential benefits of having mental health resources in schools for boys that have stigmatized views of mental health and mental health services.

Chapter 4 explores the social processes related to mental health help-seeking for Black boys when experiencing depressive symptoms. I find that the boys navigate through several stages in their help-seeking process. Each stage is triggered by the progression or worsening of depressive symptoms. When the progression is triggered, the boys must make decisions about whether they are going to seek help rather it be formal or informal. With each decision, the boys are attempting to maintain a sense of independence in their decision to seek formal or informal help as well as in the actual act of how they are receiving mental health support. The boys in this study attempt to maintain independence by initially addressing their needs on their own, also having control over who they seek help from when they choose to seek help, and controlling how much they reveal to those they seek help from.

Chapter 1: Introduction

Rates of depression in adolescents have continuously increased over the past two decades. The National Institute of Mental Health (2017) reported that nearly 14% of adolescents in the United States between ages 13 and 17 years old had experienced at least one major depressive episode in the past 12 months. Of this 14% of adolescents, 70% reported experiencing some form of impairment related to the depressive episode (Quality, 2018). Adolescents who experience depression are at an increased risk for substance abuse, physical aggression, and suicide (Currie, 2005; Thapar et al., 2012).

Though the rates of adolescent depression are rising, few studies have specifically examined Black boys' experiences with depression. This is surprising given that existing scholarship has found that Black boys are at increased risk of experiencing stressful life events that would put them at increased risk of experiencing depression such as racism and discrimination, greater rates of poverty, and community violence (Caldwell et al., 2016). Furthermore, studies have reported that boys, in general, are less likely to express seek and receive mental health support as well often struggle with managing their depressive symptoms (Carlson & Grant, 2008; Hammond et al., 2010; McCusker & Galupo, 2011). Existing indicators suggest that Black boys have significant unmet mental health needs and are less likely to be referred for and utilize mental health services (A. M. Breland-Noble et al., 2012; Joe et al., 2018; Lindsey et al., 2017, 2018). For example, a recent study reported that Black boys over the past two decades

have had a significant linear increase in physical injuries from suicide attempts, while White boys had a significant decrease (Lindsey et al., 2019). Additionally, data shows that among Black adolescent boys account for more than 80% of suicide attempts (Joe, 2006). However, though Black boys have experienced this rise in suicide, their rates of formal depression diagnosis and their use of formal mental health services continue to be disproportionately low compared to their White counterparts (Lindsey et al., 2017; Perkins, 2014). When Black boys do receive a formal diagnosis, they tend to have more severe symptoms and have had a much more prolonged experience with depression prior to receiving the formal diagnosis (Lindsey et al., 2010, 2017). All indicators point to the under-diagnosis and under-treatment of Black boys for depression and depressive symptoms. Given such trends there is a critical need to understand why Black boys' mental health needs are not being identified at earlier stages, why they are not receiving adequate mental health care, and why Black boys are under-utilizing available resources to address depressive symptoms.

Current research has attempted to explain the unmet mental health needs of Black boys but has fallen short in exploring Black boys' perspectives on mental health and depression. For example, one line of research argues that Black boys fail to seek out necessary help due to negative perceptions of mental health services. A 2013 study found that Black adolescence identified negative perceptions of services and providers, stigma, and social norms (familial and community beliefs) as key reasons for avoiding n seeking formal mental health support when experiencing mental health challenges (Lindsey et al., 2013). An alternative line of research argues that Black boys' adherence to traditional gender norms of being "macho" and unemotional inhibits them from

seeking both formal and informal help for depressive symptoms (Khesht-Masjedi et al., 2017; Wisdom et al., 2007). Both areas of research give little attention to the boys' perspectives on mental health and depression that may influence their decisions. There is a critical need to understand their reasoning for their decisions regarding help-seeking. To do so greater research is needed that explores Black boys' beliefs about mental health and depression.

Along with individual beliefs on mental health and depression, that may influence help-seeking and the use of available services, there is a growing need for a greater understanding of factors that influence Black boys' use of available mental health services. The unmet mental health needs of Black boys are especially troubling given the rapid growth of available mental health services in K12 schools. The American Psychological Association reported that available school mental health centers have more than doubled over the past 10 years and are continuing to grow (Chamberlin, 2009; Wang et al., 2019). Though mental health services are increasingly available in the K12 school setting data shows that Black boys' participation in school-based mental health resources is disproportionately low relative to those of other racial/gender groups (Lindsey et al., 2013; Lindsey & Marcell, 2012). The disproportionately low use of available mental health resources calls for greater exploration of how Black boys seek help when experiencing depressive symptoms, as well as potential barriers to Black boys' use of school-based mental health services.

The Current Dissertation

This dissertation looks to contribute to the growing scholarship on Black boys' mental health by (1) exploring a group of Black boys' views and beliefs about

depression, (2) examining potential barriers to Black boys' school-based mental health resource use, and (3) exploring the mental health help-seeking process of a group of Black boys.

As a point of clarification throughout the dissertation, the term Black boy is used to describe adolescent Black males. Black is used in place of African American as a means of being inclusive of those that do not identify as African American such as individuals that identify as Afro-Latino, Afro-Caribbean, and bi- or multi-racial. Boy is used purposely to reflect the boyhood that Black adolescent males often are denied (see Nebbitt & Lombe, 2010) and to emphasize the participants' adolescent identities. Mental Health Resources are used in place of mental health services because of the wide variety of options to support adolescents experiencing mental health challenges. For example, support groups, school mental health centers, resource rooms (see Baroni et al., 2020), community centers, suicide, and mental health hotlines, and mental health literacy programs are mental health resources often available to adolescents that are not commonly included in scholarship that explores mental health service utilization.

Significance of Study

Adolescence being such a crucial time for successful long-term social and emotional development of young people makes Black boys low use of available mental health services concerning. Studies report that unaddressed mental health needs during adolescence are associated with long-term negative behaviors throughout the life-course such as substance abuse, domestic violence, (Watkins, 2012). Current research on help-seeking for mental health conditions suggests that an individual's beliefs about mental health conditions are associated with their help-seeking and coping behaviors

(Cairns et al., 2018; Jorm, 2015). In line with this argument, any future interventions, or strategies to improve mental health services in hopes of better attracting and treating Black boys must consider their beliefs and perceptions of mental health. Additionally, there is a growing need for greater research to explore potential barriers or facilitators to Black boys' engagement in available mental health services. Moreover, exploring the boys' views of the schools and their available mental health resources will lend itself to gaining a more complete understanding of factors they identify as affecting their use of school-based mental health resources, as well as their preferred methods of help-seeking when experiencing depressive symptoms.

Though research on Black males' mental health is expanding (Masuda et al., 2012; Schwartz & Blankenship, 2014; Watkins et al., 2006, 2015), it is still a largely understudied topic. Research that considers the perspectives of Black boys makes up an even smaller subset of this research (Assari & Caldwell, 2017; Gaylord-Harden, Pierre, Clark, Tolan, & Barbarin, 2017; Joe, Scott, & Banks, 2018; Lindsey et al., 2017, 2010). It is the goal of this dissertation to elevate the voices of Black boys in research on mental health and depression by unpacking their reported beliefs on mental health and depression, help-seeking preferences, and school-based mental health resource use.

Black Boys Voices and Strength-Based Approach.

A key aspect of this dissertation is elevating the voices of Black boys by ensuring that their views, opinions, and beliefs are well represented throughout this dissertation. Black boys are often discussed in scholarly literature but rarely are provided the opportunity to engage in the research process and have a say in the research that is

being conducted about them. Scholars have historically attempted to describe the experiences of Black boys without including their voices in their descriptions. This has led to scholarship that often portrays Black boys as a problem population in need of intervention and improved socialization. Recent work such as Bush and Bush (2018) argue that previous scholarship has failed to move beyond a deficit model of Black males that often contributes to greater negative societal views of this population. Furthermore, previous studies have failed to adequately examine Black boys' ecological context and therefore have provided limited views of Black boys' lived experiences. This dissertation intends to interrogate Black boys' context to provide an in-depth understanding of their views, beliefs, and experiences. Furthermore, it is the goal of this dissertation to move beyond the deficit model that places Black boys at the center of their plight and utilize a strength-based approach in examining Black boys' mental health needs that are often not being met. To do so, I will throughout this dissertation make use of the participants' own words to support findings. Furthermore, I look to highlight the boys' strengths that can be built upon to better improve mental health resources to fit their context.

Intersectional Approach

This dissertation uses an intersectional approach by considering the way that the intersecting social identities of Black boys including, race, gender and age impact their views, behaviors, and experiences. Intersectionality is an analytical approach that acts as a lens that calls for viewing individuals in their "whole context" meaning that the unique context of each social identity that is ascribed to a person should be considered when attempting to draw conclusions about their experiences (Crenshaw, 1989, 1991;

Hill Collins, 2019). The studies in this dissertation consider the unique roles of race, gender, and the developmental stage of the participants. With that said, it is worth noting that this study specifically focuses on Black boys and avoids making racial and gender comparisons beyond that of establishing existing racial/gender disparities that have been substantiated by existing scholarly literature. As such this dissertation specifically examines within-group similarities and differences.

Many of the studies that focus on Black boys' mental health use clinical samples of Black boys that have formal mental health diagnoses, meet criteria for a clinical diagnosis or are actively receiving mental health care (Breland-Noble, Burriss, & Kathy Poole, 2010). For example, Lindsey et. al (2006) in a study that looked to explore the help-seeking behaviors of Black boys, focused on boys who were actively experiencing depression and therefore sampled boys from a community-based mental health treatment center. However, in a subsequent study, Lindsey and Marcell underscored the importance of future research in using non-clinical, community samples of Black males to explore mental health beliefs and help-seeking behaviors more broadly among Black males (Lindsey & Marcell, 2012). This is important when considering the disproportionately low rates of Black boys who receive a formal diagnosis of depression. Sampling boys who are diagnosed or actively receiving treatment overlooks a significant portion of those who may be experiencing depressive symptoms but do not meet the criteria for a clinical diagnosis of depression. Furthermore, it overlooks the perspectives of Black boys who have had limited or no interaction with formal mental health services.

Moreover, when exploring mental health-related choices such as help-seeking and service utilization, scholars must move beyond clinical perspectives and consider

perspectives that are situated in the individual experience, perspectives that reflect contextual circumstances from the standpoint of individuals that is rooted in what individuals report. Clinical perspectives assume that standing clinical approaches to mental health care are adequate and to deviate from the clinical approach is a failure on the part of the individual that chooses not to partake in the formal clinical approach to mental health care. Conrad (1985) speaks to this in his study exploring medical patients' compliance with prescribed medication regimens. He argues that moving from a medical-centered perspective to a patient-centered perspective provides a nuanced way of exploring an individual's health decisions. In this perspective moving from dominant theories of health behaviors that focus strictly on doctor-patient interactions to a patient-centered approach provides more salient understandings of individuals' personal health-related choices. Conrad states, "When we examine 'noncompliance' beyond difficulties with 'side effects and drug efficacy…what appears to be noncompliance from a medical perspective may be a form of asserting control over one's disorder" (Conrad, 1985, p. 1). Though Conrad's work focuses on a patient-centered approach, and this study considers boys' outside of the patient role, the premise still stands. Moving away from medical-centered or clinical-centered perspectives and using an approach that puts the individual and their description of their experiences at the center of the study will provide a much richer understanding of mental health-related choices and the reasons for the choices.

This dissertation uses a non-clinical sample of Black boys to explore their mental health and depression beliefs as well as their help-seeking behaviors using both qualitative interviews and survey data. Non-clinical meaning that the participants were

not required to meet the criteria of a clinical diagnosis to participate in this study nor was it required for any of the boys to be actively receiving mental health care. The qualitative data consist of 15 semi-structured interviews with boys sampled from several high schools in Southeast Michigan, between ages 13 and 18 years old and two semi-structured interviews with key individuals identified by the participants as providing significant mental health support, including a teacher that specializes in social-emotional learning, and a community outreach coordinator that several participants identified.

Qualitative data collection methods

Interviews were audio-recorded lasting between 28 and 60 minutes long with a mean time of approximately 48 minutes. In these interviews, the participants were asked open-ended questions related to their beliefs, perceptions, and understandings of mental health and depression. They were also asked questions designed to explore how they view help-seeking, how they go about seeking help when experiencing depressive symptoms, their experiences with depression, and what factors they felt impacted their use of available services. The current interview protocol can be found in Appendix A.1. The eligibility criteria for the boys that participated in the study were as follows:

Eligibility Criteria:

- Identify as Black or African American
    - Bi- or Multi-racial students are included if they identify Black as one of their racial identities.
- Identify as a male
- Between the ages of 13 and 19 years old
- Currently enrolled in high school
- Speaks English

Those that did not meet these criteria were excluded from the study. Additionally, those that did not attend school within the state of Michigan were also excluded from the study.

Quantitative Survey Data

Quantitative data was provided by the Transforming Research into Action to Improve the Lives of Students (TRAILS) program from a needs survey collected in two large high schools in southeast Michigan. Data was collected via a collaboration with The University of Michigan Youth Policy Lab, and the county Intermediate School District (ISD). Studies in this dissertation used a subsample of the data consisting of participants that met the same criteria listed above giving a total of 172 participants in the survey data.

Dissertation papers and Research Questions

This dissertation follows the three-paper dissertation model whereas each paper addresses the established research question and focuses on specific aims related to the question. Each research question and subsequent paper build on one another to develop a thorough inquiry into Black boys' experiences with mental health, depression, and school-based mental health resources. Though the three papers build upon one another, they are written as three independent studies and therefore occasionally overlap in the background, findings, and works cited.

Paper 1:

Paper one makes use of the qualitative open-ended interviews to explore Black boys' perceptions, attitudes, and expectations of mental health and depression. It is guided by the ***research question****:* What beliefs about mental health and specifically depression do Black boys have?

- What formal and informal definitions of mental health and depression do the boys provide?
- How do they distinguish their formal definitions from their own mental health needs, if at all?
- What have black boys heard and internalized about mental health and how does that inform their approaches to addressing their own needs?

Paper 2:

Paper two examines the effects of external and psychosocial barriers on school-based mental health resource use for Black boys. This paper uses the previously described survey data collected by the Intermediate School District (ISD), the University of Michigan Youth Policy Lab, and the TRAILS to Wellness program. The major dependent variable is the use of a school mental health resource in the past 12 months. Using logistic regression, I examine the predictive power of external and psychosocial barriers on Black boys' use of school-based mental health resources. This paper is guided by the ***research question:*** What barriers predict Black boys' use of school mental health resources?

- What formal and informal resources do Black boys use for mental health support in their school setting?
- What are the most common barriers to mental health service use identified by Black boys?
- What is the association between perceived barriers and school mental health resource use?

Paper 3:

Paper three explores the social process of help-seeking by Black boys using a constructivist grounded theory approach informed by ecological developmental theory and the network episodic model. Using the 15 interviews and focusing on actions and

processes described in the interviews regarding help-seeking this study identified the boys use informal and formal mental health resources and the social process of help-seeking. This paper is guided by the ***research question:*** What processes do Black boys take part in when seeking support for depressive symptoms?

- Who do Black boys talk to and confide in about their own mental health needs?
- What factors do the boys identify as important to them when seeking help?
- What mental health resources, if any, do the boys use in their school? Why?

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Chapter 2:

Black Boys Views and Beliefs about Mental Health and Depression

Background

Rates of Black adolescents experiencing depression have increased over the past two decades. according to a recent report by the Congressional Black Caucus Emergency Taskforce on Black Youth Suicide and Mental Health (2020), Black adolescent suicide has risen by nearly 80 percent. Between 2015 and 2018 Black adolescents, between the ages of 12 and 17 years old, that reported experiencing major depressive episodes increased from 9 percent to 10.3 percent. Additionally, in 2018 suicide had become the second leading cause of death among Black boys between ages 15 and 24 years old (Heron, 2019). Given the rise in depression, self-harm, and suicide among Black boys there is a growing need to improve services and resources that will properly support Black boys and their mental health needs. However, only a few studies have addressed this growing need of improving mental health support for Black boys. Furthermore, they have provided a limited understanding of ways in which established mental health resources can better service Black boys. A first step in developing improved mental health resources for Black boys is exploring their views, beliefs, and understanding of mental health and depression.

Studies suggest that a person's sense of need regarding mental health support is largely based on their views and beliefs about depression. Additionally, a sense of need is a relative concept. To determine if a person feels that they need help or at least can recognize the need for help is strongly influenced by their beliefs and perceptions of the condition they may be experiencing. To properly support Black boys and their mental health needs, a deeper understanding of their views and particularly their beliefs related to mental health and depression must be properly explored.

Mental health and depression are complex concepts that at the very least are partly socially constructed and therefore must be understood within a group's specific social and cultural context. Freidson (1970) explained that illness is socially constructed due to the cultural variations in the experiences of illnesses as well as culturally influenced social norms in help-seeking that are often ignored by professional fields of medicine (Halpern & Anspach, 1993). Conrad and Barker (2010) build upon Freidson's perspective and argue that illness is not only socially constructed at the experiential level but also at the professional level. That is to say that medical knowledge about illnesses is constructed through the lens of "stakeholders and claims makers" and not simply given by nature (Conrad, 2007; Conrad & Barker, 2010). This is especially true when attempting to understand beliefs about mental health and depression. Variations in identities such as race, ethnicity, gender, and age must be considered when attempting to define and operationalize the concepts of mental health and depression. White and Marsella (1982b) argue that conceptualizations of mental health should move beyond a medical paradigm and give greater attention to the "interpretive enterprise" in which mental health and mental health conditions are constructed (White & Marsella,

1982b, 1982a). Subsequent studies have built on White and Marsella's call for greater cultural interpretations of mental health conditions by integrating an intersectional approach to mental health studies (Banks & Kohn-Wood, 2002; Fernando, 2014; Torres et al., 2018). Studies have found that mental health as a concept is often defined differently by multiple racial and ethnic groups (Hudson et al., 2018; Ward et al., 2013), gender groups (Johansson et al., 2007; Wisdom et al., 2007), and age groups including differences in adolescent developmental groups (Cairns et al., 2018).

Studies suggest that mental health beliefs are key aspects of understanding mental health-related choices such as help-seeking and preventative care. For example, a study by Jorm (2000) found that a greater amount of stigmatized beliefs about depression and lower mental health literacy in adolescents acted as an obstruction to positive help-seeking and coping behaviors. Subsequent studies have identified the importance of expanding individual's knowledge and understanding about mental health and particularly mental health conditions, such as depression, as a means of better addressing their mental health needs (Bhui & Dinos, 2008; Eckert et al., 2010; Goldney et al., 2002). For instance, Cairns et al. (2018) in a study of adolescent boys' and girls' beliefs about depression found that those with a greater comprehension of depression as an illness rather than a weakness were more likely to endorse positive views towards seeking professional help. However few studies have specifically examined Black boys' beliefs about mental health and depression as an important part of addressing many of their unmet mental health needs (Kataoka et al., 2002; Lindsey et al., 2017; Lindsey & Marcell, 2012).

Exploring Black boys' mental health beliefs is a fundamental part of identifying differences in symptom presentation, help-seeking behaviors, formal service use, preventative behaviors, and responses to others experiencing mental health challenges (Anglin et al., 2008; Ward et al., 2013). Studies have concluded that an individual's sense of need is relative to their intersecting identities and their environmental context, which influences their beliefs and views of mental health conditions. For example, Anglin, Alberti, Link, and Phelan (2008) using a sample of 653 adults in a vignette experiment about mental illness found that Black participants were more likely than White participants to believe that mental health problems would improve on their own and treatment was unnecessary. However, a study conducted by Waite and Killian (2008) specifically focusing on Black women found that the Black women in their study held a more favorable view of formal services than the Black male participants. Nonetheless, most of these same women felt they were not susceptible to depression and avoided formal mental health services. Such findings speak to the importance of considering intersectional identities when exploring mental health beliefs.

Race, Culture, and Mental Health Beliefs

Culture plays a key role in shaping mental health beliefs and views, as well as help-seeking behaviors, and coping strategies (Fabrega, 1989; Link & Phelan, 2001; Nagel, 1994). Shared cultural experiences are associated with many of the mental health beliefs endorsed by Black Americans. Williams and Williams-Morris (2000) argue that racism is deeply entrenched in the mental health field and that Black Americans throughout history have found themselves mistreated at the hands of health and mental health services. Furthermore, they argue that the experiences of racism have negatively

affected the mental health of Black Americans and that the combination of racism and mistreatment by the mental health field have left many Black Americans reluctant to participate in formal mental health services. Many cultural norms established within the Black community have developed from past traumas in the health and mental health fields. Burkett (2017) provides a “historically based and culturally candid” in-depth examination of Black Americans' mental health beliefs and low use of formal mental health services. Burkett argues that historical trauma, environmental toxicity, culturally bound economic insecurity, and cultural mistrust are aspects of historical and contemporary experiences that Black Americans have had with formal mental health services that have led to negative perceptions of mental health and mental health services.

Cultural beliefs about mental health and mental health services are often generationally transferred from adults to children. Studies have reported that Black adolescents often receive messages about mental health and depression from family members of previous generations such as parents and grandparents (Breland-Noble et al., 2015; Lindsey et al., 2010). Furthermore, studies have reported that Black adolescents often adhere to mental health beliefs and help-seeking behaviors similar to that of Black adults (Alegría et al., 2012; Assari & Caldwell, 2017; Cokley et al., 2014). For example, Lindsey and Marcell (2012) found that Black adolescent boys held unfavorable views of mental health services and preferred to cope with their mental health challenges on their own, similar to what other studies have reported about adult Black males in (Neighbors et al., 2007; Ward et al., 2013).

Socialized Gender Paradigms

Additionally, while exploring Black boys' mental health beliefs it is important to consider the role of gender and how adherence to particular gender norms can impact Black boys' views and beliefs about mental health and depression. Studies on males and depression have found that adherence to traditional masculine ideologies impacts males' views and experiences with depression (Berger et al., 2013; Brownhill et al., 2002). In particular, studies have found that many traditional masculine norms such as emotion suppression and self-reliance harm men's views and experiences with depression (Addis, 2008; Englar-Carlson, 2007). Men often partake in avoidance coping, using physical aggression to mask negative emotions, and prefer to address their needs independently rather than seek support from others (Addis & Mahalik, 2003; Brooks, 2010). Furthermore, studies have found that men with more traditional views of masculinity often associate symptoms of depression with "feminine characteristics" and have negative attitudes towards seeking formal mental health support (McCusker & Galupo, 2011; Seidler et al., 2016).

Studies that have examined adolescents' gendered behaviors have found that adolescent boys developing their understanding of masculinity often report some aspects of traditional masculine norms while also describing some nuanced understandings of masculinity. For example, recent studies have found that adolescent boys have less stigmatized views of depression than previous generations of men but continue to hold negative attitudes towards formal mental health services (Khesht-Masjedi et al., 2017; Wisdom et al., 2007). Furthermore, studies have reported that boys while having a less stigmatized view of depression are less likely to label themselves as

depressed and associate themselves with negative emotions such as sadness (Berger et al., 2013; Burns & Rapee, 2006; Moses, 2009)

Specifically, studies on Black males' views and beliefs about mental health and depression have found that Black males while also largely adhering to aspects of traditional masculine ideologies have somewhat different views on help-seeking. Studies have reported that Black males while having more negative attitudes towards formal mental health resources often have more positive attitudes towards seeking mental health support from family, peers, and community organizations. For example, Watkins et al. (2006) in a systematic review of scholarly literature on Black men and depression reported a shared finding that Black men relying on their community members, churches, and families for support when experiencing depressive symptoms. Additionally, Hudson et al. (2018) in a study of Black men's perceptions of mental health support for depression found that the Black men in his study largely supported the idea of participating in "non-judgmental Black male support groups". Studies on Black boys' views on mental health help-seeking have reported similar findings. Lindsey et al. (2010) reported that Black boys in his study overcame fears of stigma by relying significantly on their families for mental health support. Such findings speak to unique gender paradigms that are influenced by sociocultural norms as well.

Adolescence and mental health beliefs

Age and developmental stage impact views and behaviors of mental health and depression. Adolescence is a unique time in young people's lives in which they are transitioning between childhood and adulthood, often seeking a greater sense of independence, and are becoming more responsible for making their health-related

choices (Arnett, 1999; Nurmi, 2004). Furthermore, adolescence is a period for increased risk behaviors and mental health problems. Data from the National Institute of Mental Health report that nearly 14% of adolescents in the United States between ages 12 and 17 years old have experienced at least one major depressive episode (Center for Behavioral Health Statistics and Quality, 2020). The high likelihood of experiencing depression along with many of the characteristics of adolescence has been found to create unique views of mental health and unique experiences with depression.

Studies of adolescent's views and beliefs about mental health and depression have reported that though many of their views align with that of adults there are distinctive aspects of adolescence that influence this group of young people's understanding and experiences with mental health and depression. For example, recent studies have reported adolescents often have more mental health resources available to them due to the growing rates of mental health resources in schools but still are less likely to use them due to a desire for greater independence (Becker et al., 2015; Forman et al., 2009). Furthermore, studies report that adolescents are less likely to consider long-term outcomes when making health-related choices and therefore are less likely to seek formal mental health support when experiencing depressive symptoms (Sen, 2004; Sylwestrzak et al., 2015). Moreover, adolescence is a time of identity development meaning that adolescent's identities are relatively fragile. Studies of adolescent's mental health help-seeking have found that fears of stigma and potential ridicule by peers harm adolescent's help-seeking behaviors. Minkovitz (2006) found that adolescents begin reporting stigmatized views and fears of stigma related to mental health at a younger age than most studies assumed. In her study, she found that

adolescents in the 8th grade had already begun reporting stigmatized views of mental health and were reluctant to use formal mental health resources for fear of how their peers would view them.

Framework

This study uses aspects of the health belief model and mental health literacy framework in the questionnaire and in guiding the analysis for exploring and Black boys' mental health beliefs. The health belief model adopts a socio-cognitive approach to understanding individual service use decisions based on personal beliefs about particular mental health conditions (Rosenstock, 1977; Sakai et al., 2014). Mental health literacy is a domain-specific framework that examines an individual's knowledge and beliefs about mental health conditions which aid in the recognition, management, and prevention of mental health conditions (Jorm, 2000, 2015; Spiker & Hammer, 2019).

Health Belief Model

The health belief model (HBM) is a socio-cognitive approach to understanding individuals' service use decisions based on their personal beliefs about a particular health condition. The HBM's primary goal is to predict how much an individuals' beliefs and understandings about a particular health condition significantly influence their likelihood of using preventative behaviors and formal health services. The HBM uses five constructs to identify health beliefs and predict preventative behaviors: (1) perceived susceptibility, (2) perceived severity, (3) perceived benefits, (4) perceived barriers, and (5) cues to action (Rosenstock, 1974, 1977). As a framework, HBM provides a basis to assess how a person ascribes to their understanding of mental health conditions. That is to say that their perceptions of how the mental health

condition will impact them and how they will address the condition can be assessed by using components of the health belief model.

The HBM's primary goal is to predict the likelihood of preventative behaviors and formal service use. However, several studies have used theoretical components of the HBM to explore mental health beliefs broadly quantitatively, and qualitatively (Conner et al., 2010; Nobiling & Maykrantz, 2017; Waite & Killian, 2008). Henshaw and Freedman-Doan (2009) point out that only the first three constructs of the HBM examine health beliefs. The fourth and fifth constructs, perceived barriers, and cues to action are acts that remind an individual of the severity of a health condition and motivate or discourage them to partake in preventative behaviors or seek necessary help. Therefore, using the first three constructs of perceived susceptibility, perceived severity, and perceived benefits can provide insight into a person's mental health beliefs without focusing on their help-seeking behaviors.

Mental Health Literacy

Mental health literacy (MHL) is a domain-specific derivative of the broader health literacy framework that looks to examine a person's beliefs and knowledge about particular mental health conditions as a means of assessing their mental health help-seeking behaviors (Jorm, 2000, 2012; Jorm et al., 1997). A benefit of mental health literacy is that is a multi-construct theory rather than a multidimensional construct. Meaning it consists of individual constructs that can be independently assessed and do not rely on any other aspect of the larger framework. MHL consists of five individual constructs that include (1) the ability to recognize specific mental health conditions; (2) knowledge and beliefs about risk factors and causes; (3) knowledge and beliefs about

self-help; (4) knowledge and beliefs about professional help; and (5) attitudes that facilitate recognition and help-seeking. However, though MHL consists of independent constructs it rightfully identifies interrelationships between each construct that lead to an in-depth understanding of a person's mental health beliefs and knowledge (Spiker & Hammer, 2019).

Using these frameworks with qualitative data collected from in-depth interviews with a group of high school-aged Black boys this study addresses the following **research question**: What beliefs about mental health and specifically depression do Black boys have? Additionally, this study addressed the following sub-questions:

1. What formal and informal definitions of mental health and depression do the boys provide?
2. How do they distinguish their formal definitions from their own mental health needs, if at all?
3. What have black boys heard and internalized about mental health and how does that inform their approaches to addressing their own needs?

The mental health literacy framework guides in examining knowledge and understanding of mental health and depression, while the mental health belief model guides in exploring how the boys in this study ascribe their knowledge and understanding of mental health and depression to their own experiences with depression and depressive symptoms. Aspects of both frameworks were used in developing the interview questionnaire as well as in the analysis of the interview data collected from the participants of this study. By exploring Black boys' perceptions, and formal and informal definitions of mental health and depression. This study was able to identify what the boys believed to be causes and symptoms of depression, their

perceived susceptibility to depression, views on the severity of depression, their views on help-seeking, and their views on care and support for depression. Additionally, this study also explored where and how the boys are gaining their information about depression and mental health broadly.

Methods

Few studies of adolescent mental health beliefs have employed the use of qualitative methods. Cairns et al. (2018) state that a majority of the studies that explore mental health beliefs in adolescents tend to use vignettes and surveys with scaled items to determine individual's causal beliefs about mental health conditions. They find that the rigid nature of close-ended survey questions and limitations of vignettes has not provided deep descriptive definitions of mental health and mental health conditions, specifically from the perspective of the adolescents. Employing qualitative strategies allows for in-depth exploration of these beliefs and definitions as well as greater exploration of the reasoning behind the adolescents' definitions.

This study utilizes reflexive thematic analysis as an inductive qualitative analytical approach to explore Black boys' views and beliefs about mental health and depression. Reflexive thematic analysis is identified by Braun, Clark, and Terry (2019) as a unique orientation of thematic analysis that utilizes a constructivist approach in its analysis of qualitative evidence. This orientation unlike others that tend to maintain some connection to the more quantitative (post) positivist approach does not look to simply describe or summarize the collected evidence, rather the goal is to "provide a coherent and compelling interpretation of the evidence" (Braun et al., 2019, p. 848).

Thematic analysis explores qualitative evidence intending to identify themes using a qualitative coding process that develops broad categories and eventually succinct themes. Though there are some discrepancies in how qualitative researchers operationalize the terms codes, categories, and themes. For this study, codes are considered short summative words or phrases attached to statements found in the individual transcripts (Saldaña, 2013). Categories are descriptive-level groups that organize themes based on their overall focus. Themes are shared or common meanings that are structured around a central concept, developed by comparing, contrasting, and combining the codes from individual transcripts (Braun et al., 2019; Saldaña, 2013). Categories are descriptive and developed most often before in-depth analysis and theme development as a way of classifying findings. Themes describe categories and are shared across interviews as a common experience or point of view (Braun et al., 2019; Vaismoradi et al., 2016)

Epistemology

This study uses a constructivist epistemology in exploring Black boys' views and beliefs about mental health and depression. Qualitative research in its essence intends to explore and illuminate lived experiences with in-depth perspective and context. In this vein, qualitative research moves beyond the positivist approach that often guides quantitative research and does not look to identify an objective reality or truth. Merriam and Tisdell (2016) state "qualitative researchers are interested in understanding how people interpret their experiences, how they construct their worlds and what meaning they attribute to their experiences" (Merriam & Tisdell, 2016, p. 6). Given the nature of

qualitative research, constructivism is a common perspective employed by qualitative researchers and is the philosophical perspective that I adopt in this study.

Constructivists argue that reality is not fixed, it is socially constructed and individualistic. That is to say, individuals construct subjective realities based on lived experiences, interactions, and cultural socialization. Exploring Black boys' mental health and depression beliefs means considering their subjective descriptions of their experiences with mental health and depression and interpreting their definitions of such ambiguous terms. Additionally, it means providing space for these boys to be open, vulnerable, and feel secure at the same time. Therefore, it would be imprudent to assume these boys' realities are concrete and stable. Charmaz (2008) in describing constructivism outlines the following assumptions of a constructivist researcher that are maintained throughout this study; "(1) reality is multiple, processual, and constructed under particular conditions; (2) the research process emerges from interactions; (3) it takes into account the researchers positionality, as well as that of the research participant; and (4) the researcher and research participants co-construct the data as a product of the research process"(Charmaz, 2008, p. 402).

Data Collection

To explore Black boys' mental health beliefs, I conducted individual semi-structured interviews with 15 Black boys between the ages of 13 and 19 years old currently enrolled in 1 of 5 high schools in Southeastern Michigan. The interviews ranged between 28 and 60 minutes long, with a mean time of 48 minutes. Interviews were initially conducted in the participants' school but eventually were moved to virtual interviews, due to school closures, as well as restrictions on in-person human subject

research caused by the COVID-19 pandemic. Interviews that took place in the participants' school were conducted in a private administrator's office or in an empty classroom where participant privacy and confidentiality could be maintained. Interviews completed virtually were conducted using Bluejeans or Zoom video conferencing program both of which allow for encrypted virtual meetings. Participants were given the option to call into the virtual interviews using a telephone or to connect using a computer. If connecting with a computer, cameras were turned off and only the audio was recorded. Bluejeans and Zoom are university-approved qualitative data collection programs due to their ability to encrypt online meetings.

Interviews were transcribed verbatim with the support of a university-approved transcription service. The audio recordings were uploaded to the program and a computer-generated transcription was produced. I then listened to the recordings while simultaneously reviewing the transcripts for accuracy, making edits as necessary. This also acted as an initial review of the transcripts whereas memos related to early potential themes were written to later aid in the analysis.

Sampling Strategy

A purposive snowball sampling strategy was utilized in recruiting this sample of Black boys. Purposive sampling is one most common sampling strategies in qualitative research (Merriam & Tisdell, 2016). It was chosen as the sampling strategy because purposive sampling assists in identifying a unique subset of a larger population that represent the group of interest being studied (Hsieh & Shannon, 2005). Inclusion criteria for this study included:

1. Must self-identify as Black or African American.

2. Must self-identify as a Male
3. Must be between the ages of 13 and 19 years old
4. Must be enrolled in high school
5. Must speak English

This study excluded anyone that did not meet all of the inclusion criteria as well as anyone that did not currently attend school in the state of Michigan.

A unique aspect of this study is though it focuses on mental health, it uses a non-clinical sample of Black boys. Many studies that explore adolescent views on mental health-related topics, particularly those of Black boys, use samples of boys that are currently receiving mental health services, have a history of receiving mental health services, or have a standing mental health diagnosis. For example, Lindsey et. al (2006) in a study that looked to explore the help-seeking behaviors of Black boys focused on boys who had been diagnosed with clinical depression, sampling boys from a community-based mental health treatment center. Although it makes some sense when studying mental health and depression of Black boys to seek input from boys who have received a formal clinical diagnosis and have at least moderate interactions with the mental health system. Studies have shown that Black boys are underdiagnosed with depression, less likely to express typical symptoms of depression, and are less likely to seek professional help when experiencing depressive symptoms. Therefore, it is important to consider samples of Black boys that do not have a formal clinical diagnosis and have not necessarily interacted with formal mental health services. Though I did not exclude boys that have a previous history of any mental health condition or a history of

receiving mental health services, I chose to avoid specifically sampling from clinical sites

Participants were recruited from local high schools in Southwest Michigan. Key contacts in each school helped me identify a small group of boys that met the previously described criteria. I met with the group of boys in their school, via email or over the phone and presented the study to them. During this time, they were given the opportunity to ask questions and raise any concerns about the study. They were provided consent forms either in person or via email that had to be read and signed by a parent or guardian. Consent forms were returned in person, or electronically from the parents' separate email account. All consent forms have been printed and stored for proper record keeping.

Participants

Participants consist of 15 Black boys enrolled in high school between the ages of 13 and 19 years old. The mean age of the participants was 16 years old. Six of the 15 reported experiencing depression, 11 reported knowing someone with depression 5 have known someone that committed suicide, and 2 reported having suicidal ideations. See participant descriptive in table 1.1.

Interview Questions

A pre-established questionnaire was used in the interviews with the participants. The questionnaire was developed using the health belief model and mental health literacy frameworks to assess the boys' views and beliefs about mental health and depression. See appendix A.1 for the established interview protocol.

Each interview was transcribed verbatim with the support of a university-approved transcription service. The service develops an initial computer-generated transcript from the recorded audio. I then reviewed each transcript while listening to the audio recordings. Necessary edits were made to ensure the accuracy of each transcript. These transcripts were next uploaded to Dedoose version 8.3.35, a web-based program used for qualitative and mixed methods data analysis. All aspects of this study were approved by the University of Michigan internal review board for human subject research (HUM00173387).

Additionally, as approved by the UM-IRB, adverse events such as expressed suicidal ideation were addressed in three ways. First, all participants were given a sheet with available mental health services, including services provided in their school at the end of each interview. Second, mental health professionals at each school were available in case any student expressed suicidal ideation or threatening behavior. All participants were made aware of my responsibility to contact mental health professionals if I felt they were at risk of harming themselves or others. Third, the parents of participants that completed virtual interviews agreed that they would be available in case of adverse events such as suicidal ideation or threatening behavior. Participants and their parents were made aware of my responsibility to report concerns about suicidal ideation of harmful behaviors. These measures were approved by the University of Michigan Institutional Review Board (IRB)

Analysis

Phase one

The first step in the analysis was familiarization with the transcripts. After the interviews were transcribed, I immersed myself in the evidence by reviewing the transcripts while simultaneously listening to the audio recordings. During this familiarization step, casual notes were taken and memos regarding potential themes were written. Analytic memos have an important role in thematic analysis as they provide a trail of thought as themes are constructed throughout the analytical process. Memos also provide an aspect of organization and clarity for defining categories early in the analysis. I used memos as an analytic technique as well as a quality control measure via reflective journaling (discussed in quality and rigor section). The goal of this initial phase was to aggregate each transcript as much as possible, before moving into the second phase of analysis, looking for reoccurring patterns across the transcripts.

The next step in this coding phase was to begin developing initial codes from each transcript. To develop these initial codes, I conducted line-by-line coding to break down the transcripts into smaller more manageable pieces. Line-by-line coding called for an additional in-depth review of each transcript to identify overt as well as discrete meanings described by the participants. In-vivo coding was employed in this coding phase as means of capturing the boys' voices and words in the coding process. In-vivo coding calls for using participants' actual words in the developed codes. Doing this allows for the participants' voices to come through in the results, which is an important aspect of uplifting participants' voices. It also is an important part of interpreting the meaning of participants' words, which is a significant focus of this study. Value coding was also used in this phase because of its use in coding values, attitudes, and beliefs

(Saldaña, 2013). One hundred and seventy-two codes were developed in the initial coding phase. Though not all of these codes necessarily characterized the boys' mental health and depression beliefs, they were found to represent important aspects of Black boys' experiences with mental health and depression. Value coding was an important first step in aggregating the responses into separate categories. Six categories were developed after the initial review (1) defining mental health and depression, (2) symptoms of depression, (3) causes of depression, (4) attitudes towards depression, (5) perceptions of mental health services and social support, and (6) Information gathering about mental health and depression.

Phase Two

In the second phase of analysis, codes were reorganized and condensed using patterned coding (Saldaña, 2013). This called for the combining of codes that shared common ideas or topics across the interviews. For example, codes attached to the boys' views on symptoms and causes were parented under the categories "symptoms of depression" and "causes of depression". Furthermore, the categories were separated into two groups based on if the boys stated they had personally experienced the identified symptoms or cause, or if the boys were speaking on what they assumed to be symptoms or causes of depression that they had not experienced see appendix A.2. As codes were combined and reorganized, codes were also evaluated for the necessity to the overall goal of identifying Black boys' mental health and depression beliefs. Unnecessary codes, that is codes that were deemed to not facilitate the aforementioned goal, were removed. A memo was developed to keep track of all codes removed in case the decision to restore the code was made later.

Phase Three

In the third phase parameters were established for the six developed categories (1) defining mental health and depression, (2) symptoms of depression, (3) causes of depression, (4) attitudes towards depression, (5) perceptions of mental health services and social support, and (6) Information gathering about mental health and depression. Defining parameters guided in organizing the codes under the correctly corresponding categories. For example, “being bullied” was a code and was identified as a shared experience by several participants. Being bullied was moved under the category “causes of depression” as the boys described it as a reason for their depressive symptoms.

Fourth Phase

The fourth phase of coding was “themeing” the evidence based on the established coded categories and the interpreted shared meanings of the developed codes. Saldana (2013) describes themeing as the “act of further defining specific coded categories with statements or phrases based on the coded categories shared meaning” (Saldaña, 2013, p. 175). A theme can describe at the manifest level, simple observable descriptive information, or the latent level a deeper interpretative meaning in the qualitative evidence (Boyatzis, 1998; Desantis & Ugarriza, 2000; Saldaña, 2013). In this phase, I looked to identify the interpretive meanings among the participants' shared experiences and views about mental health and depression. The codes have been reorganized and combined based on the interpretive meanings and renamed accordingly. The combined and renamed codes become themes developed and

therefore grounded in the qualitative evidence. The themes are organized under corresponding categories. See table 1.2 for categories and themes.

Ensuring Qualitative Rigor

Bracketing via constant memoing, and peer examination was utilized in this study to ensure consistency and rigor. Bracketing with a specific emphasis on reflexivity (Tufford & Newman, 2012) was done by constant memoing throughout the entire research process. I wrote notes before and after each interview that included preconceived expectations of the participants, emotional responses to the interviews, and thoughts on potential patterns between the interviews. Additionally, memos were written throughout the analysis as a trail of all decisions made regarding the coding process (Charmaz & Belgrave, 2012). Peer examination was conducted by sharing the transcripts and developed codes with colleagues that research similar topics (Merriam & Tisdell, 2016). I met with these colleagues bi-weekly throughout the analysis to ensure rigor and consistency.

Findings

Findings that emerged from the fifteen interviews with the participants fit within the framework of six categories, each with individually defined themes. The categories include (1) Defining mental health (2) Symptoms of depression, (3) Causes of depression, (4) Attitudes towards depression, (5) Perceptions of mental health services and social support, (6) Learned about mental health. Themes related to each category are outlined in table 1.2.

Defining mental health

Mental health was described by the participants as a spectrum of emotional responses linked to the way a person's mind processes things. In this definition, the participants described a person's emotional responses to daily experiences as being a product of the way their brain makes sense of the experience. How an individual feels daily, how they respond to good and bad events, and how much an individual has control over their response were the ways the participants defined mental health. For example, one of the participants stated, *"I think mental health is, it's like something about how your brain processes stuff in different situations, stuff like that and how it makes you act".* Another participant stated, *"Mental health is how stable someone can be and how they can process things in certain situations".* Among these definitions, the boys suggested that mental health is neither bad nor good rather it exist on a spectrum. That is to say that some individuals can have poor mental health, and some can have good mental health. Moreover, an individual can fluctuate between poor and strong mental health daily. In their definitions of mental health, the participants also identified specific conditions related to mental health including autism, bipolar disorder, and depression. The identifying of separate mental health conditions speaks to an understanding of a fundamental difference between mental health broadly and specific mental health conditions.

Defining Depression

Depression was defined as a constant feeling of sadness and a negative state of mind. The boys used phrases such as "feeling broken", "being mentally at a low point", and "thinking things won't get better". Though the boys described depression as a pervasive feeling of sadness, they also described depression as a temporary

experience associated with fleeing negative emotions. It was common for the participants to relate depression to their own experiences, often indirectly describing experiencing feelings of sadness and helplessness and how they were able to overcome those feelings with different coping strategies such as exercising, playing video games, drawing, and smoking marijuana. One of the boys stated,

> "Like when I was going through it [depression], I just didn't want to be around anyone. I knew I was depressed because people was telling me I was acting different but I had a lot going on. So, I think depression is when you got just a lot of negative stuff in your life, and you just feel mentally broken"

Additionally, some of the boys used hypothetical stories combined with the experiences of friends or family to describe depression. For example, one of the boys described depression as getting into a slump after a bad experience. This participant used the experiences of a close friend to describe his definition saying,

> "Depression is like a certain event happens and you get sad about it, like really sad. Like my friend had a lot going on at home and he was acting different, didn't want to talk and just look real depressed."

Symptoms of Depression

While defining depression participants were asked if they could describe what a depressed person may look like, or if they could explain how they knew someone was depressed. In their response's participants identified several clinical symptoms and behaviors associated with depression. The most identified clinical symptoms were cognitive including sadness, hopelessness, and anger. Behavioral symptoms included sudden changes in mood, changes in sleep patterns, angry outbursts, irritability, self-harm [cutting], and isolation. Additionally, three of the boys also identified

psychosomatic symptoms that they had personally experienced including nausea, headaches, and cold sweats. Although the boys identified multiple cognitive, behavioral, and physical symptoms of depression the boys did not ascribe many of these symptoms to their own experiences with depressive symptoms. Feeling lonely, angry and the psychosomatic experiences of headaches, nausea, and cold sweats were how the boys described their experiences. But terms for negative emotions such as sadness and hurt were often avoided when the boys discussed their own experiences with depression and depressive symptoms. Interestingly "weird" seemed to be a term the boys used as a proxy to describe more severe negative emotions, especially when describing feelings of sadness and hopelessness. For example, one of the boys when discussing a recent breakup with a young woman described having severe feelings of hurt and became physically bothered when trying to describe how he felt about their relationship ending. He stated,

> "I was messed up about it, it had me feeling like man I don't know, weird. Like I guess I was hurt but I was for real messed up about it. I text her and she didn't respond, and I had this weird feeling. Like man I don't even know..."

A linked memo from the interviewer written directly after the interview read,

> "He [interviewee] seemed very bothered when discussing the break-up with his girlfriend. It seemed to have been recent and he couldn't fully articulate his feelings about it, but he was clearly very sad and hurt"

The boys overwhelmingly described feelings of sadness as a symptom of depression. However, as the above excerpt shows, the boys had some difficulty attaching feelings of sadness to their own experiences. Similarly, the boys tended to avoid attaching feelings of hurt and despair to themselves though they would describe them as hypothetical

symptoms of depression. For example, one of the boys an 18-year-old senior disclosed experiencing sexual abuse as a young child. A peer in his school found out about the abuse and began spreading rumors about his sexuality. In describing his feelings about this situation. He stated,

> **Participant:** “People used to talk about me a lot because something that happened to me when I was younger, it had got out. People would be like "Oh you gay", they say stuff about me, but I don't really care.
>
> **Interviewer:** Okay, so it doesn’t bother you that other students know about what happened to you? Do you think that it really doesn’t bother you or do you not want it to bother you?
>
> **Participant:** I be depressed inside though, I don’t know I mean it don’t bother me, or I guess I be sad. I be trying to ignore it because I know myself, you feel me, so I don't be caring what people say.”

This participant repeatedly avoided using emotion-based language. Though he eventually identified feeling sad, he described feeling hurt and embarrassed without using the actual terms. This was a common practice for many of the participants when discussing their own experiences with depressive symptoms.

Causes of Depression: *Psychosocial Causes*

The participants were asked, what they believed caused depression. Several Psychosocial causes were identified by the participants such as relationship issues, experiencing loss, low social support, school-related stress, and racism. While psychosocial causes were identified, several of the participants, six of the fifteen, recognized the complexity of depression and its causes. For example, one of the participants stated *“I mean there’s a lot of things, do you want me to name all of them or*

just the ones that I've experienced? It's hard to really identify just one thing that causes it [depression]." The identification of multiple psychosocial causes as well as identifying the complexity of causes and symptoms of depression speaks to a reasonable understanding of depression by the participants.

Relationship Issues

The most common psychosocial causes identified were interpersonal causes related to relationship issues. This includes familial, romantic, and peer relationships. Boys discussed their own experiences with breakups with romantic partners, conflict with family members especially those in their homes, and the loss of family and friends as significant causes of depression. Five of the boys described having contentious relationships with at least one parent and that it was a significant cause of stress leading to depressive symptoms. One participant a 16-year-old sophomore stated, *"It makes me feel depressed sometimes. I don't really talk to my mom about stuff for real, we haven't really got the best relationship. But I love that woman to death though"*. This participants' response was similar to the other four boys that described troubling familial relationships that caused them a significant level of distress.

Additionally, losing a family member or peer was a significant interpersonal cause of depression that the participants identified. Though a majority of the boys described losing someone to death, two of the boys described losing fathers to incarceration as well. Interestingly these two boys described their feelings about their fathers' incarceration in a similar manner that other boys described losing family members to death. One of the boys said, *"Another thing that caused me to be depressed was not having my father around. He was in and out of jail my whole life. It's*

messed up not having him here though." The other participant said, *"man my dad locked up, so he aint here, you know he gone that [expletive] make me mad cause he gone"*. These participants' responses speak to the negative effects that loss other than death such as incarceration and absenteeism, especially from fathers can have on the mental health of Black boys. Previous literature has found that having an incarcerated parent for youth can have similar psychological effects as losing a parent to death (Turney et al., 2012; Turney & Wildeman, 2013). For Black boys, this is particularly important considering the high rates of incarcerated Black parents (Browning et al., 2018) and the increased risk for Black adolescents to experience losing a family member to death unexpectedly (Walker & Goings, 2017).

School-Related Stressors

Participants identified several school-related factors that they felt caused depression including bullying, gossiping, and falling behind or struggling with schoolwork. The participants reported bullying to be an issue that is common among adolescents that could cause depression. Several of the participants had experienced physical as well as cyberbullying at the hands of school peers. One participant stated, *"I think that me being bullied, and nobody helped me out...I think that's a part of depression, too".* Another participant stated that an experience with cyberbullying lead him to not want to return to school.

> *"Some people get depressed, or their mental health go down because people be shooting negative comments at them. Like I had someone saying negative stuff about me and commenting all kinds of stuff online, that had me feeling depressed. Like I didn't even want to come back to school."*

Additionally, related to their experiences with bullying participants described a lack of support in addressing the bullying that caused them to experience depressive symptoms. Three participants described being bullied and felt they did not receive proper support in addressing the bullying. All three of these participants described feelings of hopelessness, despair, and as if "*no one cared*" about them. The lack of support in addressing bullying speaks to a common issue identified by youth that often feels they lack key social support in addressing causes of depression. For Black boys, this is a significant issue given that previous literature has found that they often attempt to address their mental health needs on their own because they feel they do not have trusted support (Lindsey & Marcell, 2012). If Black boys feel unsupported in addressing issues such as bullying in their schools and online, then their risk of troubling responses such as physical aggression, isolation, and suicide becomes heightened.

Stress-related to schoolwork and school responsibilities was also a common issue that the participants felt led to many depressive feelings. However, the stress described by participants was not directly related to difficulties with schoolwork or responsibilities. Participants described concerns about their future, describing fears of what could happen if they did not do well in school or could not maintain their school responsibilities. For example, one of the participants played football for his school and felt overwhelmed with balancing football and his schoolwork and stressed about how failing to balance the two could translate into his future college career. He stated,

> "Like football is important to me and sometimes I just got too much to do and trying to keep up with schoolwork. That's something that really stresses me. Like I don't want to talk to no one or be around no one. If I can't keep up with all this now, how am I going to when I go to college...?"

Several other participants stressed about their life after school, questioning if they would be able to get a good job or get into the college they wanted. This was apparent only in older participants, those between ages 17 and 18 years old. The developmental stage of these older boys correlates with these concerns. Late adolescence is often marked with stress related to future endeavors and the transitioning from dependent child to independent adult (Steinberg, 2014). For boys, the stress of being able to properly care for themselves and a future family is tied to ideas of masculinity that often leads to high levels of distress in boys in late adolescents (Jackson & Elmore, 2017; Roberts-Douglass & Curtis-Boles, 2013). As the participants reach developmental stages that bring them closer to adulthood, it is not surprising that the stress of their future leads to significant depressive symptoms.

The participants also identified intrapersonal factors such as loneliness and feeling unsupported as causes of depression. Moreover, different than the way the participants described the symptoms of depression, many of the participants ascribed interpersonal and intrapersonal causes of depression to their own experiences, even when they began with describing them hypothetically. For example, loneliness and feeling isolated were common intrapersonal identified causes of depression. One of the participants stated, *"Being lonely…like feeling no one is there can make you depressed. Even if there really are people there for you sometimes you can feel like no one cares or your just alone."* This same participant eventually discussed his own experiences with the intrapersonal feeling of loneliness saying, "*feeling lonely has kind of been the thing that has triggered my depression. Like I know people want to be there, but I still feel lonely…"*

Many of the intrapersonal causes described by participants were associated with feeling a lack of social support. Participants identified internal feelings of loneliness, feeling unloved, and feeling unsupported as causes of depression. When describing these feelings participants often pointed out that they knew some people loved and cared for them but continued to struggle with feeling unloved and unsupported. In these descriptions, the participants struggled in fully articulating these feelings or why they continued to have them. Five participants specifically identified times in which they struggled with intrapersonal feelings of being unsupported, unloved, and lonely. However, all five throughout their interview identified several people in their lives that they received support from. These participants' responses speak to greater research that is needed to understand how Black boys identify and utilize social support.

Race and Racism

In this theme, participants identified racial factors as causes of depression that they felt uniquely impacted Black males. I asked the participants, "Do you think that some causes of depression are different for Black boys compared to other racial and gender groups?" In their responses, the participants identified racism, police brutality, media portrayals of Black males, and inequitable environmental factors associated with race, as causes of depression that is distinctive to Black males. For instance, one of the participants discussed viewing videos of Black men being killed by police on the internet and the effect it has had on his mental health. He stated,

> "I know like me, a lot of them [Black boys] are afraid of the police. They're afraid of them or their family member being killed or something. Seeing it [police

> shootings] just makes you mad and nervous and stressed. I don't really want to see it but like my mom and people aren't sheltering us from it anymore."

This participants' description reflects several other statements from participants concerned about their safety and potential experiences with police brutality. Additionally, they discussed racism as a significant cause of stress that could lead Black boys to experience depressive symptoms. One participant stated,

> "Living in the United States as a Black person, especially as a Black man, knowing the history of how this country was founded and the things that happen to us [Black men], that will have you mad all the time and can make you kind of depressed."

Similarly, the participants described the effects of seeing Black males portrayed negatively on television, as well as the effects of many Black people living in low-income communities as potentially causing Black boys to experience depression. In their descriptions of predominately Black communities, the boys identified high rates of community violence, poverty, and neighborhood blight (see Akers & Seymour, 2019) as causes of depression for Black boys in these communities. Though most of the participants, except one, did not ascribe racism as a cause of their own experiences with depression and depressive symptoms, they recognized that these factors were common among Black boys and have negative effects on their mental health. Previous studies have identified the impact that both direct and vicarious experiences with racism have on the health and mental health of Black adolescents (Williams & Williams-Morris, 2000).

Attitude towards depression: *Susceptibility*

Participants in this study attitudes about depression were explored by first asking "do you think anyone can become depressed? All the participants in the study believed anyone including themselves was susceptible to depression. Six of the participants in the study described themselves as specifically experiencing depression. Additionally, eleven of the participants stated they had someone close to them that had experienced depression. It is worth noting that none of these individuals had been formally diagnosed with depression. Their experiences with depression are based solely on their interpretation of depression and depressive symptoms. However, of the eleven boys that stated they knew someone with depression, six of them stated that the person they knew with depression, explicitly told them that they were depressed.

Although the participants stated that they felt racism and the conditions of many predominately Black communities were causes of depression for Black people, a majority of participants felt that Black people were no more susceptible to depression than other racial groups. I asked the participants, "do you think depression is different for Black boys than for others". Eleven participants made statements that suggested that Black people were no more or less susceptible to depression than others. One of the participants a 17-year-old junior stated,

> "I think they can definitely be the same for white people, Mexican people, any type of any race, any gender. A black boy that goes through loss can be depressed and a white girl that goes through loss can be depressed."

However, four participants stated that the causes of depression could be different and that more attention should be given to the causes of depression for Black boys. For example, one participant also a 17-year-old junior stated,

> "I mean anyone can get depressed, but I don't think people really talk about how racism and stuff can make Black people depressed. Like no one really talks about how I feel as a Black male and seeing the stuff that happens to us [Black males]. So, I mean I think people should talk about it more because sometimes we don't even know we depressed from watching all this stuff."

This participant response echo's responses of the other participants that felt Black boys were uniquely susceptible to depression due to racism, and other race-associated factors such as poverty, and community violence.

Overall, the participants viewed depression as being relative to lived experiences. Connecting back to their identification of psychosocial causes, Black people experience racism which could lead to depressive symptoms. However, people of other racial groups experience things that also can lead to depressive symptoms, and therefore it is relative to their lived experiences and social context. These findings are supported by previous literature that has linked racism and race-specific factors to an increased risk of depression among Black people (Brondolo et al., 2011; Williams & Williams-Morris, 2000).

Stigma

Perceived stigma was a theme shared among the participants. Perceived stigma happens when an individual anticipates experiencing stigma from others (Link & Phelan, 2013). Fears of being stigmatized often lead to suppressing symptoms of mental health conditions, avoiding seeking support, and the internalization of stigmatized views of mental illness (Teh et al., 2014). When describing depression participants in the study commonly described it as a condition that should be addressed and in private. One participant, 17-year-old Junior stated, *"Depression is something that a lot of people*

keep to themselves, I keep mine to myself". Similarly, many of the participants that identified themselves as being depressed stated that they had not discussed their depressive symptoms with others. This was due to fear of how they would be viewed and treated bothers. Fear of what participants called "*being exposed*" was a shared reason identified by several of the participants as the cause of them not disclosing their depressive symptoms. Being exposed meant that the cause of the participants' depressive symptoms would become known by others. They were mostly concerned about peers that they did not trust finding out about their depressive symptoms. One of the participants stated, *"If I tell someone what I'm feeling and I don't really trust this person, they could put me out there in my social media or any other platform, I'm not trying to get exposed."* I asked this participant, what about being "exposed" concerned him, he responded, *"People try to pretend they care but really be all in your business. I just don't want people knowing what I'm going through you feel me."* The stigma that participants feared they may face if their depressive symptoms were exposed was also attached to their help-seeking behaviors and use of mental health resources such as school social workers, and mental health support groups. Participants reported that they did not know if they could trust others, especially social workers and counselors, and therefore were hesitant to utilize these resources in their schools.

Additionally, three of the participants reported that they felt their family members held stigmatized views of depression and depressive symptoms. One participant stated that if he went to his family and told them that he was feeling depressed that he wouldn't be taken seriously and that he would be told he was "acting like a little girl". His fear of being viewed this way led him to attempt to address his mental health needs on his

own. He went on to say, *“I use a fake smile often, I’ve actually gotten really good at it. Because people don’t really take depression and stuff serious. They just think you being dramatic”.* In this participant’s description, he points to the impact that perceived stigma has on help-seeking. The cloaking of his depressive symptoms was not associated with his stigmatized views of depression, but his fear of other's stigmatized views of depression and depressive symptoms which also has exacerbated some of his depressive symptoms such as, feeling lonely, isolation, and hopelessness.

Though some of the participants reported fear of other's stigmatized views as reasons they attempted to address their mental health needs on their own, three of the boys associated the same desire, with adhering to their idea of being a man. Self-reliance and independence are often attributed characteristics of manhood (Addis, 2008), which at least three participants attempted to adhere to by addressing their mental health needs on their own. I asked one participant “What do you think could help a Black boy take better care of his mental health?” he responded,

> “I think some boys don’t want anyone to help them. Like me, I like to handle things on my own. It’s important to be strong enough to handle things on your own, as a man I don’t always want to need someone to help me.”

Views on care and support

This section provides a brief overview of the participants' views on care and support for depression. An in-depth discussion of the participants' support preferences and the help-seeking process is the focus of the third paper of this dissertation. Participants were asked, “What kind of help would you recommend to someone that was depressed?” Though the participants overwhelmingly supported the notion that a

person with depression should talk with someone (i.e., friend, parent, counselor) when experiencing depressive symptoms, most of them preferred to address their mental health needs themselves, and as previously stated preferred keeping their experiences with depressive symptoms to themselves. Participants that did seek support for depressive symptoms often relied significantly on family for support and shied away from most types of formal mental health resources such as school social workers, therapists, and support groups, only using these resources as a last resort.

Self-Reliance and Avoidance Coping

All the boys when discussing mental health support for others reported that they felt going to a counselor or therapist was the best way to properly address depression. However, when the participants discussed how they would address their mental health needs most participants described avoiding formal resources, preferring to address their needs on their own. Doing so led the participants to partake in numerous avoidant coping behaviors. Avoidant coping consists of behaviors that are used to avoid stressors, and symptoms of depression while not addressing the cause (Herman-Stabl et al., 1995; Horwitz et al., 2011). The most common behaviors identified by the participants included smoking marijuana, listening, and making music, playing video games, exercising, and playing sports. Though the participants reported several different coping behaviors, they all had the same goal of allowing the boys to temporarily disconnect from their depressive symptoms and providing them with a greater sense of control over their emotions. For example, one participant that reported smoking marijuana to cope stated, *"When I smoke, it just takes my mind off stuff. It just brings me to another state of mind for a minute, I don't have to feel anything for a*

minute" Another participant discussing his use of marijuana stated, *"once I come down my head is all right, now I can think things through since the heat of the moment has cooled down."*

Addressing depressive symptoms on their own was the preferred choice for the participants. The act of managing depressive symptoms independently aligned with their perceptions of masculinity in that it provided them a sense of independence and allowed them to avoid relying on others for support. However, when participants reported seeking support from others it was most often a close family member.

Family for Support

The family was identified by participants as providing critical support when they were experiencing depressive symptoms. Though participants overwhelmingly preferred to address their mental health needs on their own. A majority of them described going to family members for support when their depressive symptoms became too severe to manage on their own. All of the participants in the study reported going to at least one family member for mental health support when experiencing depressive symptoms. They emphasized that the familiarity and trust they have with family members was key in deciding to seek support from their families. The most common family member was mothers, six participants reported that they would go to their mothers first for mental health support if they felt they needed it. Two of the boys stated they would go to their fathers but felt their moms would provide them with greater emotional support and provide better advice. Participants also reported going to siblings, grandparents, aunts, and uncles.

Families had an important role in supporting the participants with their depressive symptoms. Several participants reported that their families provided them emotional support and often encouraged them to seek formal support such as talking with their school counselor. For example, one of the participants stated he would go to his father first because he and his father had an open and honest relationship. Furthermore, he stated that he felt his father would encourage him to use mental health resources in his school. He stated,

> “My dad, he's very open. I know that I can go talk to him about something, pretty much anything. There wasn't a time where I'd ask him a question or tell him something that's going on my life where he was like, "Oh no, you can't talk about that." He's always been open to having a conversation and helping me with stuff…My dad would probably help me reach out to somebody, maybe my school counselor if he couldn’t help me with what was going on.”

Another participant stated that his mom encouraged him to see a therapist at the local community center. He stated,

> “I tried to once [go to therapy] for my mom, she said I should try to go up there [community center] and talk to the therapist there… I just went one day, I chopped it up with them it was cool, but I didn’t go back after.”

This finding is supported by previous research on Black boys help-seeking that has similarly found that they rely significantly on family for mental health support. This is especially for boys that fear being stigmatized (Lindsey et al., 2010). Furthermore, studies have found that families are key in directing adolescents into mental health services (Stiffman et al., 2004). The participants from this study found that family is more trustworthy and feel that they could be themselves with family members which led to their preference to use family for mental health support.

Peers and Teachers

Participants also described relying on both peers and teachers for mental health support, especially when experiencing depressive symptoms that were associated with school-related stressors. However, participants were very particular about which peers and teachers they would go to for support. There had to be an established sense of trust and familiarity with the person they went to for support. Thirteen of fifteen participants reported having at least one friend they would go to for support and five of the participants reported going to a teacher for support. However, most of the participants were not as open with their friends or teachers the same way they were with family. They described talking to peers about things that were bothering them but would avoid discussing their emotions and feelings in-depth. Furthermore, they constantly questioned how much they could "really trust" their friends with their personal information. Participants reported similar sentiments about teachers that they chose to go to for support. However, were more open in discussing their emotions with a teacher. One of the participants discussed a teacher that he would occasionally seek support from but admitted that he was not always as open with her. He attributed this to an uncertain sense of trust he had with her. He stated,

> "She's cool like I can talk to her sometimes but sometimes she acts a little funny and I don't know man like I can talk to her but sometimes I don't really want to, I will I guess if I really needed to… Like she just, like you know how sometimes you can trust someone but then other times you can't. Like she just not one of those people I think is 100 percent [honest] all the time. But she's cool to talk to most the time."

The role of teachers and peers were key options for participants that described limited or fractured familial relationships. Peers and teachers seemed to be a proxy for these participants, filling a void of support that they lacked in their families. For example, one participant stated,

> "I don't know… I don't really got a good relationship with my dad and my mom she work a lot so I don't really want to bother her with stuff. So, I'd probably talk to Ms. [name withheld; teacher] ... Like I'll go in her class sometimes and just sit and chill and she let me talk to her you know if I want to talk or if I need to talk."

Studies have similarly reported that peers and teachers can provide significant support for adolescents lacking familial support (Atkins et al., 2000). Ijadi-Maghsoodi et al. (2018) in a study of minority youth help-seeking barriers found that several of their participants with broken familial ties reported significantly relying on teachers and peers for mental health support. The participants' perceptions of mental health support showed that though they felt it was important to address mental health needs independently also felt support from others was important. Participants identified the important role that others that they are close with such as family, members, peers, and teachers can have in helping manage depressive symptoms.

Formal mental health services/resources as a last resort

The boys' stance on using formal mental health supports was somewhat contradictory. When asked, "what would you recommend to a depressed person to get better" most of the participants identified therapy and counseling as having an important role in addressing depression and depressive symptoms. For example, one participant a 17-year-old junior responding to the question stated, *"I would tell them to see a*

therapist. I know therapy isn't for everybody but try it and see if it works." However, when asked if he would go to a therapist or to his school counselor for help with a mental health challenge he stated,

> "Therapy isn't for everyone, I'd rather stick to talking to my friends, talking to my family, I don't want to just talk to this random person about what I've been through."

This type of response was common among the participants in this study. Many of them recommended formal mental health resources as a sensible option to address depression and depressive symptoms but also stated that they preferred not to use them for their own mental health needs preferring to rely on family and peers if necessary.

Though the participants recognized that using formal mental health resources had the benefit of receiving help from someone specifically trained in mental health, their preferences not to use formal mental health resources stemmed from a lack of trust and familiarity with the providers of the services and resources. For example, one of the boys a 16-year-old junior was asked, "what about a therapist makes you not want to go to them for help" he responded,

> "I doubt a trained therapist would tell your secrets and they know what they are doing but I just like to talk to people I know and trust. Like we got counselors here [school] but I don't really know them I just see them sometimes".

However, though most participants' preferences were to not use formal mental health resources, 10 participants reported that at some point they utilized a formal mental health resource to address depressive symptoms. However, all except one of these participants reported that they did so as a last resort. The primary source of

formal mental health support for participants were school counselors and social workers. One participant also reported seeing a therapist at a local community center. A participant discussed going to the school counselor after experiencing suicidal ideations saying,

> "It definitely was different I guess I hadn't really told many people how I was feeling, I told my friend [name withheld] but he was dealing with his own stuff and just wasn't really helping so the next day in school I went to her [counselor] office. To tell a counselor was kind of different, I think I definitely came out of it with a clearer head though"

The participants' overall stance on formal mental health resources speaks to the strength of their desire to address their mental health needs on their own. Participants were informed and aware of the resources available to them. However, they held a strong desire to address their needs on their own. Furthermore, their views of mental health resources such as therapists and social workers were favorable when referencing use by others. But regarding their own needs, they provided negative views of these resources. The contradiction in their perceptions and actions is clear in their descriptions.

Learning about mental health and depression

In this section, I discuss the ways that participants described learning about mental health and depression, including from where and who they have gained this information. Participants reported learning about mental health and depression from several sources. The most common were from their school and online sources such as social media sites and YouTube. Other sources included parents, peers, community centers, and television. Information about mental health and depression for the

participants was both intentionally and unintentionally solicited. In some instances, they reported learning about mental health and depression through hear-say or by way of witnessing a person discussing their own experiences with mental health challenges. In other instances, participants actively sought information about mental health and depression from different sources as a way of gaining a greater understanding of these concepts.

Learning from School

The school was the most common source of information about mental health and depression that participants identified. Eight participants stated that they had formally learned about mental health, mental health conditions, and specifically about depression in their school. Within schools, participants identified several different ways in which they learned about mental health and depression. Four participants reported that they had learned from organized events with guest speakers in their schools including, a mental health specialist from a local community center, a mental health scholar from a large university in the neighboring city, and a group of undergraduate psychology students that presented to students. Participants overall had positive views of the ways that that their schools provided information about mental health and depression. For example, one of the participants stated *"The guest speakers were informative. I learned some new information about mental health that I didn't know."*, The participants that identified the school as the location where they learned about depression and mental health described learning about symptoms and signs of depression, how to identify depression in others, how to access mental health support in their school, locations in their community where they can access mental health support,

and mental health first aid (see Kitchener & Jorm, 2002). Though participants often reported negative views of formal mental health resources, they provided positive views of the programs and presentations that provided them with greater mental health knowledge.

Two participants stated that they learned about mental health from the school social worker after meeting with them due to experiencing a mental health crisis. In these instances, participants independently sought support from the school's formal mental health resources and in their interactions with the social workers had gained new information about mental health and depression. I asked one of the participants an 18-year-old senior "Where have you heard about depression?" he responded,

> "… when I went and talked to the social worker here, they talk about how you got to take little breaks and calm yourself. She told me, a lot of times when you are feeling depressed sometimes you need a little one-on-one time to talk with someone. I felt like I knew more about depression after talking to her and stuff."

This participant's response is similar to the information that several other participants reported learning from the counselors and social workers in their school. These participants described an adequate understanding of causes, and symptoms, and were aware of multiple strategies to address ongoing mental health challenges such as counseling, mindfulness, and journaling. However, though participants identified such strategies they often did not identify them as the way they preferred to address their depressive symptoms. Even with this high level of knowledge on how to effectively address depression, the participants often described self-reliance via avoidant coping behaviors such as smoking marijuana, exercising, and playing video games, in addressing their depressive symptoms.

Online/Internet

The internet was also a common source of information about mental health and depression that participants identified. Information was received both intentionally and unintentionally. Six participants reported learning about mental health and depression online unintentionally through YouTube and Social Media sites including Facebook, Instagram, and Snapchat. This came from viewing videos and posts from celebrities, friends, and family about their own experiences with mental health challenges, depression being the most frequent. Participants reported that it was common to see their favorite YouTube star posts videos about their battles with depression before or after taking a temporary leave from the website. I asked one of the participants a 17-year-old junior, "Where have you heard about depression?" He responded,

> "Like Instagram and people talking about how depressed they are or on YouTube videos…. I would say it's like 50% people I know personally and 50% celebrities and stuff. Like sometimes a YouTuber will get depressed and then they'll make a video about why or what happened to them and it's usually the way I learn about it... I don't really be looking for stuff about depression but if I see a video, I will watch it and they will like say what they going through…"

The information shared in these instances provided participants with a vicarious understanding of depression, as well as other mental health conditions, by hearing about others' lived experiences with the condition. However, though these sources could provide useful information about symptoms, and treatment, conditions such as depression are socially experienced and therefore not always experienced the same by others based on their contextual circumstances (Karp, 1994). Research has shown that information about depression often fails to be culturally adaptive and can provide a

skewed understanding of depression for Black adolescents (Juhasz et al., 2012). However, a benefit of online sources is that adolescents can seek information that is relevant to them and specifically seek out culturally appropriate descriptions of depression.

Online sources were also used for intentional information seeking about depression. Three participants reported choosing to go online to seek more information about depression. Each of these participants looked for more information after finding out a family member or peer was experiencing depression and wanted to know more about it. One of the participants a 17-year-old senior stated,

> "Mostly I study it [depression] myself, like watch YouTube videos and look online because one person in my family was really depressed and tried to kill herself so I went through a whole mental health study thing for myself to better my family and see what was going on."

Information-seeking was a key strategy for these participants to gain a better understanding of what people in their lives were experiencing but also as a strategy to assess themselves for depression. I asked the same participant what he felt he learned from researching depression online? He responded,

> "I learned a lot like I found a lot of videos and articles and stuff that talked about what depression is and how people can feel like things will never get better. I feel like that sometimes, so I know I've been kind of depressed before, maybe not much as her [family member] but like maybe a little bit. Like I feel like the stuff I saw online taught me anyone can really get depressed, just some people do better with it."

This participant while acknowledging the new information he learned also was actively comparing his own experiences with this new information. Online resources are a

relatively new phenomenon given the expansion of social media and sites such as YouTube over the past 10 – 15 years. These findings support current research that shows adolescents are increasingly using the internet independently to seek mental health intervention to both assess their own experiences as well as to understand the experiences of others (Horgan & Sweeney, 2010; Kauer et al., 2014).

Family and Peers

Family and peers had an important role in the participants learning about mental health and depression. Six of the participants stated they learned about mental health from a family member or peer. However, the context in which they learned about mental health and depression from family and peers differed significantly. Half of the participants had direct conversations with their parents about mental health, depression, suicide, and substance abuse. Most of these conversations were prompted by a mental health crisis that happened to another student in the participants' schools. For example, one of the participants discussed his parents talking to him about depression after a younger student in his school committed suicide. This student a 15-year-old sophomore stated,

> "My mom and dad were really concerned after one of the freshmen killed himself. They talked to me and my sister about it [depression] and how it can cause some people to want to die… they were like telling us if we see anyone being bullied to like stand up for them and if we think someone is depressed, we can be there for them."

Interestingly a majority of the participants whose parents talked to them about mental health and depression stated their parents primarily focused on teaching them to identify depression in others and how to support them. None of the participants stated that the parents explicitly asked them if they were depressed or made any attempt to assess their child's mental health. Furthermore, two of the participants noted that their parents seemed uncomfortable talking about depression and suicide. One participant stated that his parents talked to him about depression after watching a movie in which one of the characters attempted suicide. He stated,

> "I don't really think parents know how to talk to their kids about this kind of stuff [depression and suicide]. Like my mom and dad tried to talk to me, after watching that movie, and my mom just looked nervous to even say the word suicide. We didn't know that dude was going to kill himself [movie character] so I think they felt like they had to talk to me since we just saw that but I don't really think they wanted to."

Though some parents appeared uncomfortable in having candid conversations about these topics, the students that reported that they learned about mental health and depression from their parents also reported feeling more comfortable going to their parents if they were experiencing a mental health challenge. Such findings speak to the important role that parents have in providing information but also the impact that such open conversations can have on parent and child relationships especially regarding their mental health needs and positive help-seeking. This is especially important for Black boys as studies show that family often helps them overcome stigma about mental health and provides emotional support (Lindsey et al., 2010).

Only one participant that described discussing mental health and depression with his parents provided a significantly different description. This participant described having a very positive and strong relationship with his parents, specifically with his father. In his description of discussing depression with his father, he described him as being open and encouraging of talking with his school counselors if he, the participant, ever felt that he was depressed. This case though different than the description of others provides insight into the ability of parents to provide positive guidance for mental health support. Furthermore, it speaks to the role of Black fathers and their influence on their sons.

Additionally, three of the participants shared that they learned about mental health from their peers that have experienced mental health challenges in the past. However, mental health-related conversations with peers were facilitated held at a local community center. These three participants all had taken part in a peer support group at a local community center in which they were able to share their experiences with mental health challenges as well as learn from others experiences. Additionally, the support group had two mental health specialists as facilitators that provided the participants with guidance and information about mental health and depression. This group provided the participants not only a space to learn more about mental health and depression but also to engage with other Black boys and gain mental and emotional support. One of the participants stated,

> “They had these little meetings, they call it group, and they were having it I think every Thursday. Then they'd come up with different topics to talk about, like mental health or depression would be one of them, and then they'd just have a

conversation about that for an hour… I used to go every day. It was coo to have other dudes to talk to about stuff you know."

Discussion

This study explored the views and beliefs about mental health and depression for a group of Black boys between the ages of 13 and 18 years old currently enrolled in high school. Exploring mental health and depression knowledge, beliefs, and attitudes provided insight into this group's perceptions of depression, the embodiment of symptoms, causes, and views on mental health help-seeking and service utilization. Furthermore, this study looked to gain an understanding of where this group of boys learned about mental health and depression and how it has shaped their views and beliefs. The findings from this study build on standing literature that finds Black boys while being generally well informed about mental health and depression often struggle with emotional expression (Joe et al., 2018), avoid openly expressing depressive symptoms (Breland-Noble, 2004), associate psychosocial stressors to causes of depression (Gaylord-Harden et al., 2017; Watkins et al., 2006), and rely significantly on their families for mental health support (Lindsey et al., 2010; Planey et al., 2019).

The participants' views and beliefs about mental health and depression developed from a combination of formal mental health education provided from their schools, vicarious experiences from online sources, and their adherence to socialized gender norms, which often resulted in a contradiction in what the participants knew versus what they did to address their mental health needs. Participants in this study displayed a high level of knowledge regarding the symptoms, causes, and outcomes related to depression. They were aware of the importance of formal mental health

counseling and therapy for persons experiencing depression. Additionally, they also identified the complexity of the term mental health often describing it as a spectrum of cognitive functioning and emotional responses to psychosocial stressors. However, many of the participants often avoided connecting their own experiences with depressive symptoms to many of the negative emotions they described as symptoms of depression such as sadness and hopelessness. Also, while identifying the importance of formal mental health resources such as therapy, support groups, and mental health social workers, participants reported a lack of trust in formal mental health resources and often preferred to rely on themselves to address their mental health needs or relying on close family members for mental health and emotional support.

The Important Role of Mental health education

The participants' ability to recognize mental health as a spectrum, as well as their identification of many clinical symptoms and psychosocial causes of depression, speaks to a well-informed understanding of depression and mental health that is likely associated with participants receiving most of their information about depression and mental health from formal presentations in their school setting. Studies have supported the expansion of mental health education in schools and community settings because of their centralized location and constant contact by adolescents. Though few studies have examined Black boys' mental health education and literacy, previous studies on Black adolescent mental health beliefs report that much of Black adolescents' mental health views come from family members such as parents and grandparents (Lindsey et al., 2006, 2010; Stewart et al., 2012). However, many of these studies do not consider the role that increased access to mental health information through school resources and

online resources has had on adolescent's views and beliefs on mental health and depression. Though the participants' views may largely be shaped by their family's perspectives on mental health, participants reported a high level of mental health knowledge and a more positive view of mental health challenges than previous studies have reported (Burns & Rapee, 2006; Rickwood et al., 2007).

The expansion of mental health education in school settings has likely led to less stigmatized views of mental illness and mental health services. Studies have described similar findings when examining mental health education and literacy (Jorm, 2012, 2015) programs in school settings. For example, Sharp, Hargrove, Johnson, and Deal (2006) assessed the impact of a psychoeducational intervention on a control and comparison group of adolescents' attitudes towards mental health and their help-seeking behavior. Their study found that the adolescents that were enrolled in the psychoeducational intervention showed significant improvements in overall attitudes towards mental health help-seeking and overall views on mental health challenges. Similarly, Milin et al. (2016) conducted a randomized control trial (RCT) to assess the effectiveness of a novel mental health curriculum placed in high schools. Their study found that youth that enrolled in the curriculum reported significant decreases in mental health stigma, more positive attitudes towards mental illness, and had a significant increase in their overall mental health knowledge. Findings from the current study agree with the standing literature that the expansion of mental health resources in the school setting provides an increased level of knowledge and understanding of mental health and mental health conditions. However, as demonstrated by participants in this study,

simply expanding mental health knowledge will not necessarily translate into changed behavior regarding improved help-seeking and service use.

Mental Health and Masculinity

Though the participants had a relatively high level of mental health knowledge, their views and understanding of mental health and depression did not translate into how they defined and addressed their own experiences with depression and depressive symptoms. Participants often avoided embodying negative emotions when describing their own experiences with depression. For example, some stated that they had experienced depression while avoiding saying they felt “sad or hurt”. Additionally, though the participants recommended the use of formal mental health resources for others, they preferred to address their mental health needs on their own and appeared to adhere to many traditional masculine behaviors when it came to assessing and addressing their own mental health needs such as self-reliance, guarded vulnerability, and suppressing negative emotions. This finding diverges from previous research models that treat mental health beliefs and knowledge as the foundation to understanding help-seeking behaviors. The mental health belief model, the behavioral model of health service use, and others while often providing an adequate framework for assessing mental health beliefs may not accurately predict service use for this population of boys because they fail to consider the effects of psychosocial and socio-cognitive factors such as adherence to traditional masculine behaviors, cultural norms, and adolescent irrationality.

Prior research has found that boys’ adherence to traditional masculine norms often inhibits them from openly expressing emotions related to depression such as

feeling sad, hurt, or hopeless (Addis & Mahalik, 2003; Yousaf et al., 2015). Studies suggest that males are often socially conditioned to suppress emotional pain (Brownhill et al., 2002), are more likely to report physical somatic pains as being associated with depression (Chuick et al., 2009), and avoid seeking support from formal mental health services (Addis, 2008). Moreover, studies of Black male's mental health help-seeking behaviors have found that they often adhere to these traditional masculine norms while also navigating socialized norms related to their racial identities. For example, Conner et. al. (2010) reported that Black men in their study on mental health beliefs viewed mental health and depression not only through the lens of masculinity but also through the lens of their Blackness. This intersectional lens contributed to a unique perspective on depression that the men held related to their experiences with depression as Black men. Moreover, a study by Lindsey et. al. (2006) found that Black boys described similar intersectional experiences with depression and addressed their needs in manners that were both gender and race-specific such as relying on family, community, and church for mental health support.

Though participants in the current study did not discuss in-depth where they received their messages about masculinity related to mental health, previous studies have shown that socialized masculine norms about mental health are often generationally reproduced. Boys receive messages about how a man should address their mental health needs from family members, peers, and others within their micro and meso networks (see Bronfenbrenner, 1979) as well as through media and socialized portrayals of Black masculinity (Chu et al., 2005; Goodwill et al., 2019; Way, 2011). Overall, the participant seems to be attempting to navigate what they know about

mental health and depression and how they have been socialized to address their own mental health needs as Black males.

Though not as apparent there were minor yet distinctive developmental differences in participants' responses. Specifically, regarding causes of depression and school-related stressors older participants, those between 17 and 18 years old described concerns about their futures and what they would do after they graduated. These concerns while minor speak to the boys' acknowledgment of their growing independence as important factors in their future. Furthermore, it calls for greater attention to the distinctive developmental stages in adolescence and the effects of these stages on Black boys' mental health beliefs and views. Participants described concerns about careers, college, and balancing their responsibilities currently and in the future.

Conclusion and Implications

This study is novel in that few studies have explored Black boys' views, beliefs, and knowledge about mental health and depression. The growing rates of suicide among Black boys and the growing call for addressing the unmet mental health needs of Black boys speak to the importance of greater research that examines this group's perspectives on mental health and depression while also considering where they are receiving their information about mental health and depression. This study is a step in addressing the call for greater research into Black boys' mental health needs and will benefit future research, policies, and practice that especially looks to address Black boys' mental health needs. Given the layered experiences illuminated in this study with Black boys regarding their mental health beliefs and behaviors, several implications can be drawn from this work to inform future research and practice.

First, this study demonstrates the benefits of mental health literacy programs with components that specifically target Black boys. Therefore, this study speaks directly to potential interventions that could continue to improve mental health literacy among Black boys by specifically targeting them and their unique contexts such as perspectives on Black masculinity, community collectivism, and cultural mistrust of health and mental health services. Participants in this study reported learning about mental health and depression from programs and presentations in their schools and their community. From these programs, the participants were able to gain a better comprehension of the causes, symptoms, and signs of depression. Similar mental health literacy and mental health education interventions that are specifically tailored to Black boys can provide them with a more thorough comprehension of mental health and mental health conditions, presented it in a manner that relates to the boys' racial and gender identity. For example, programs such as the African American Knowledge Optimized for Mindfully Healthy Adolescents (AAKOMA) project (Breland-Noble et al., 2012) and the Young Black Men Mental Health (YBMen) project (Watkins et al., 2020) leverage information and materials specific to Black adolescents and young adults to provide culturally specific mental health education in a manner that considers Black adolescent social context and preferences. The AAKOMA project is a program developed specifically for Black adolescents and their families to expand their mental health knowledge and increase Black adolescents' use of mental health services when experiencing depressive symptoms. The YBMen project is a mental health education program that provides mental health information and support for Black boys and men using a social media platform. The current study provides insight into the mental health

beliefs of Black boys that can be employed in such programs to better support Black boys' mental health knowledge. Such programs can also be adopted in school and community settings that serve large populations of Black boys.

Furthermore, the role of teachers and school personnel may be key to implementing such interventions and programs in the school setting. This study found that though participants had an overall negative view of formal mental health services and personnel such as therapists and social workers, participants identified teachers as being individuals they often would go to for mental health support, specifically for depression and depressive symptoms. Teachers are often in an intermediate position because they are not formal mental health professionals but have the ability to provide specialized support and can guide students into formal mental health services. Additionally, teachers are able to establish strong relationships with students given the frequency in which they interact. This makes them key in providing mental health support and mental health education to students. Particularly for Black boys, I find that teachers can be trained in greater cultural competence that is specific to Black boys' context. Such training would improve teachers' recognition of depressive symptoms among their Black male students. Furthermore, Interventions that provide such skills training would be key. For example, I have found that technology-based interventions such as virtual reality and simulation interventions can provide training that mimics classroom settings and realistic scenarios with Black male students experiencing depressive symptoms (Smith, Mitchell, et al., 2020). Such interventions are innovative and have the distinct ability to be tailored to different communities, backgrounds, and scenarios (Smith, Pinto, et al., 2020).

Also, several theoretical frameworks that have argued that mental health beliefs and knowledge are components of mental health service utilization such as the health belief model and the mental literacy framework would benefit from greater consideration of racial, ethnic, and cultural contextual factors. Many of these models have failed to consider culturally specific contextual factors that are associated with help-seeking and service utilization such as racial identity, cultural norms, gender norms, as well as socialized views of mental health and mental health conditions. Furthermore, a thorough search of the literature found few studies that made use of the mental health literacy and mental health belief frameworks with Black adolescents, none that specifically sampled Black boys. Because they have not been examined thoroughly with Black boys, there is potential for such models to be biased when attempting to examine Black boys' mental health beliefs and knowledge. Additionally, these models would benefit from adaptations using a critical-interactionist lens (see Martins & Burbank, 2011) which would call for greater consideration of social context, environment, and structural factors in examining mental health knowledge and beliefs. The combining of macro and micro theoretical approaches such as interactionism and critical perspectives can lead to the development of theoretical models that provide a more in-depth understanding of Black adolescent's development and perspectives. Furthermore, such theories will lead to both upstream and downstream approaches in examining and improving help-seeking and service use among Black boys by addressing their behaviors while also improving services and access to such services.

Limitations

This study has some limitations that should be considered along with the findings. First, as in all qualitative analyses, there was not 100% consensus, there were those that diverged from the larger shared experiences (negative cases). These cases were considered within the context of the larger shared descriptions. They provided insight into potential different directions of the findings and are discussed based on their apparent divergence from the primary findings following the possibility principle guidelines (see Mahoney & Goertz, 2004). Additionally, although the goal of qualitative research is not to provide generalizable results across differing populations, findings from this study are limited in scope and by the sample demographic. This study uses a sample of 15 participants that self-identify as Black and male and are between ages 13 and 18 years old. Adolescent developmental stages could impact young people's views and beliefs about mental health and depression. This study speaks to some minor developmental differences however, a greater sample of participants from any age within the adolescent age range could potentially provide greater insight into specific views or beliefs associated with earlier or later adolescent developmental stages. Furthermore, specific demographic and contextual information such as income, the number of parents in the household, diagnosed mental health conditions, sexuality, and so on was not intentionally collected, though some of this information became aware through the course of an interview. Each of these factors could potentially influence the participants' views and subsequent behaviors. Future studies should look to make use of a demographic questionnaire prior to conducting individual interviews. Finally, all interviews were collected from boys in two counties in Southeastern Michigan. Factors associated with the location such as school mental health resources, community mental

health resources, among many other factors associated with the specific location limit the finding from this study beyond the participants. Overall, though this study has limitations the findings are significant and speak to an important issue facing Black boys and therefore is a significant contribution to current literature on Black boys' mental health, help-seeking, and service utilization.

Table 1. 1: Interview Participant Demographics

Participant ID	Age	Grade	Self-assigned Depression	Time Enrolled in Current School	Knows someone with Depression
00425	17	Junior		0.5	Yes
00225	17	Senior		0.5	No
00325	17	Senior		3	Yes
00125	16	Sophomore	Yes	1.5	Yes
00525	18	Senior	Yes	1.5	Yes
00625	18	Senior	Yes	4	Yes
00121	15	Freshmen		1	Yes
00221	16	Sophomore	No	1	Yes
00115	14	Freshmen	No	0.5	No
00120	18	Senior	Yes	4	Yes
00112	14	Freshmen	No	1	Yes
00122	14	Freshmen		1	
00124	16	Junior		3	
00126	15	Sophomore	Yes	2	
00117	14	Freshmen		3	

Table 1. 2: Participant Mental Health and Depression Beliefs Category and Themes

Categories	Themes
Defining Mental Health	Cognitive processing Emotional Reactions Mental Health is a Spectrum
Symptoms of Depression	Clinical Symptoms Psychosomatic symptoms
Causes of Depression	Psychosocial causes (Inter- and Intrapersonal) School related stress Racism
Attitudes towards depression	Susceptibility Stigma
Perceptions of mental health services and social support	Self-reliance and Avoidance Coping Support from Family Peers, Teachers, and Community center staff Formal mental health resources as last resort
Learned about mental health and depression	School Online/Internet Family and Peers Community Centers

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Chapter 3:

Barriers to School-Based Mental Health Resource Use among Black Boys

Introduction

Current research suggests that Black boys disproportionately underutilize mental health resources, are more likely to suffer from untreated mental health challenges and are more likely to have unmet mental health needs (Assari & Caldwell, 2017; Barksdale et al., 2010; Lindsey & Marcell, 2012). This is surprising given the growth of rates in which schools are implementing mental health resources for student use and the potential impact it could have on Black male students (Dowdy et al., 2010, 2015; Husky et al., 2011). However, data trends show that Black adolescents are one of the least likely groups to use available mental health resources in their school setting and are less likely than their White peers to receive sufficient mental health support (Coker et al., 2009; Locke et al., 2017). The low use of mental health resources by Black boys is particularly important given the growing rates of mental health challenges plaguing Black boys. The Emergency Task Force on Black Youth Suicide and Mental Health, formed by the Congressional Black Caucus, reported data trends that show suicide attempts for Black adolescence rose by nearly 75% since 1991 and injury from suicide attempts by Black boys rose by 122% (Lindsey et al., 2019; The Congressional Black Caucus Emergency Taskforce on Black Youth Suicide and Mental Health, 2020). Furthermore, Black boys' rates of depression have steadily increased, rising at a rate

higher than that of their White peers, though their rates of formal depression diagnosis still lag.

Despite these troubling trends Black boys experiencing pervasive mental health challenges are 87% less likely to have ever received mental health services and are less likely to openly seek formal mental health support (Lindsey et al., 2006, 2017). Furthermore, additional studies have reported a less than 35% treatment completion rate for Black boys that choose to utilize mental health resources (Alegria et al., 2015; Alegría et al., 2012; Caldwell et al., 2016). Underdiagnosing and misdiagnosing are both common for Black boys experiencing mental health challenges as well. Lindsey et.al. (2017) states that boys are more likely to partake in externalizing behaviors when experiencing mental health challenges, particularly when experiencing depression, leading to higher rates of discipline for conduct problems. Black boys specifically are more likely to have their externalized behaviors linked to misdiagnosis of behavioral disorders such as Conduct and Oppositional Defiant Disorder (Alegría et al., 2012; Clark, 2007; Fabrega et al., 1993).

The underutilization of mental health resources has been found to lead to disparaging outcomes for Black boys. For example, studies have found that adolescents with untreated mental health conditions are at an increased risk of experiencing long-term substance abuse issues, are more prone to violent physical aggression, have significantly higher rates of exclusionary school discipline (detention, suspension, expulsion), juvenile justice detainment, and are more likely to partake in self-harm and have suicidal ideation (Joe et al., 2018; Molock et al., 2007; Thapar et al., 2012). Furthermore, studies suggest that individuals that receive necessary mental health

support during early adolescence have improved long-term mental health outcomes throughout the life course (Löwe et al., 2004; Watkins, 2012; Watkins et al., 2020). This speaks to the importance of examining barriers that deter and facilitate Black boys' use of school-based mental health resources.

School-based mental health resources

More public K12 schools in the U.S. are providing mental health resources to their students than ever before. Data from the 2019 Indicators of School Crime and Safety reported that as of 2018, 51% of public schools in the United States provided diagnostic mental health assessments, 38% provided full mental health treatment services, and 80% of schools with mental health services had provided at least 1000 students with diagnostic assessments (Wang et al., 2019). Though the growth of mental health services in schools is still behind what many scholars would consider adequate (Marryat et al., 2017; Ramey, 2016), the increased range of services and mental health resources in schools is promising. Furthermore, there is strong evidence that the expansion of these resources will continue to rapidly increase. In fact, the United States House of Representatives recently passed bill H.R.1109 titled “Mental Health Services for Students Act of 2020” which would fund on-site mental health services in public schools and increase the number of mental health specialists in each school in the United States.

Providing mental health resources in K12 schools helps eliminate many barriers associated with the underutilization of community-based mental health resources. For example, Staudt (1999) conducted a study of perceived barriers to mental health services and found that most parents that were attempting to access mental health

services for their children, identified agency and community factors as the most disabling barriers. Specifically, agency hours, location, and waiting lists were among the most identified barriers to accessing mental health services. Furthermore, additional studies have identified, lack of insurance, transportation issues, and low mental health literacy as key barriers that impede the use of mental health services and resources (Bulanda et al., 2008; Juszczak et al., 2003; Thompson et al., 2015). Some researchers have speculated that removing access barriers to mental health resources will significantly improve young people's use of available mental health resources, especially Black youth that often has limited access due to the many physical barriers (Bains et al., 2017; K. D. Becker et al., 2015; Green, 2017; Ijadi-Maghsoodi et al., 2018). By integrating mental health resources into the school setting many of the physical barriers can be overcome.

Additionally, schools often act as avenues to ongoing formal mental health services beyond the school setting. Frequently school staff is the first point of contact for students experiencing mental health challenges. Repeated interactions with students allow school staff to recognize sudden changes in their behaviors, changes in school performance, and other indicators that the student may be experiencing a mental health challenge (Roorda et al., 2011). In fact, studies on school-based mental health resources have shown an increase in programs designed to train teachers and other school staff as mental health gatekeepers (Mo et al., 2018; Robinson-Link et al., 2020). Acting as gatekeepers, teachers and school staff have become instrumental in providing mental health support to students as well as guiding students into necessary mental health resources both in the school as well as in their communities.

With the vast amount of mental health resources in K12 schools, it is surprising that few studies have specifically examined the use of school-based mental health resources. Especially for groups uniquely vulnerable to mental health challenges such as Black boys. Very few studies examine school-based mental health resource use and a thorough search of scholarly literature discovered only one article none specifically report rates for Black boys. Brown and Grumet (2009) in an evaluation of a school-based suicide prevention program reported that only 14% of the Black youth that was selected to participate in the initial screening were able to receive consent from their parents while also choosing themselves to participate in the screening. Brown and Grumet further reported that the female to male ratio of Black youth that participated was 2:1 respectively but do not discuss potential reasons for the lack of Black boys' participation. Additionally, a majority of studies that examine school-based mental health resource use examine a specific mental health program or only consider counseling and social work services in their mental health resources (Day et al., 2015; Langley et al., 2010). The lack of considering a broader range of mental health resources in schools risks underestimating and misunderstanding student's use of the available mental health resources.

Barriers to accessing and using mental health resources

Given the disparaging outcomes associated with the underutilization of mental health resources, it is imperative that scholars examine barriers that particularly affect Black boys' use of available mental health resources as a means of improving access and utilization. Barriers have been defined as reasons or obstacles that prevent individuals from seeking, obtaining, or completing mental health services and support

(Planey et al., 2019). Most barriers can be categorized as psychosocial or access barriers. A psychosocial barrier includes views and attitudes related to mental health, a mental health condition, or towards mental health services that impact a person's help-seeking behavior (A. M. Breland-Noble, 2004). For example, studies commonly identify stigmatized views of mental health and mental health services (Bulanda et al., 2008; Conner et al., 2010), treatment fears (Vogel et al., 2007), self-reliance (Planey et al., 2019), and cultural/social norms (Lindsey et al., 2006; Whaley, 2001) as internalized barriers that have impeded mental health help-seeking. Access barriers are barriers that are most often beyond the control of the individual. These are physical and system-level barriers that obstruct access to resources, such as the location of services (Platell et al., 2017), transportation issues (Bulanda et al., 2008), insurance status, and time (Thompson et al., 2015).

However, though there is a vast amount of scholarly literature on barriers to mental health service use, few studies have examined barriers in Black boys' service utilization. The few studies that have, report that Black boys rely significantly on family and close friends for support more than they do on formal systems of support (A. Breland-Noble et al., 2006; Lindsey et al., 2010; Lindsey & Marcell, 2012). In addition, studies have identified a sense of mistrust in formal services, a lack of knowledge of where to go, and adherence to masculine norms as reasons Black boys avoided using formal mental health services (Lindsey et al., 2006; Powell et al., 2016; Congressional Black Caucus, 2020). Though some studies examine barriers to Black boys' use of mental health resources, no current studies could be identified that specifically examine

barriers to Black boys' use of school-based mental health resources, where a majority of adolescent tailored mental health resources are concentrated and are most accessible.

Sociocultural factors

Factors such as high rates of conservative religious views, high levels of stigma and shame associated with mental illness, and a general mistrust of formal health services have been identified as sociocultural barriers associated with Black Americans underutilization of available mental health resources (Burkett, 2017; Davis & Ford, 2004; Planey et al., 2019). Historical abuse and mistreatment towards Black Americans by formal mental health services are likely associated with many of these socio-cultural factors (A. Breland-Noble et al., 2006; Lasser et al., 2002). Though few studies have been conducted specifically on barriers to Black adolescents' use of mental health resources, studies have found that many of the socio-cultural barriers are shared generationally and therefore often instilled in Black adolescents (Lindsey et al., 2006, 2013). Such generational transitions are associated with Black youths' underuse of mental health resources.

Though some sociocultural factors act as barriers to formal mental health resource use, there also persists a lack of sociocultural relevant mental health resources for Black youth. Lateef, et al. (2021) in a systematic review of African-centered interventions and mental health practices found African-centered interventions that specifically targeted Black students were positively associated with increases in Black students' academic achievement, self-concept, cultural identity, and behaviors. However, they also found that there is only a small amount of recognized mental health interventions that use an African-centered approach in K12 schools.

Masculinity

Adherence and internalization of traditional masculine ideologies and norms have been contributed to Black boys' underutilization of available mental health resources as well (Addis & Mahalik, 2003; Cheatham et al., 2008). Studies of masculinity and socialized gender paradigms have noted that males throughout the life-course are less likely to seek support for mental health challenges even though they are more likely to experience mental distress and substance abuse compared to females (Berger et al., 2013; Hudson et al., 2018; McCusker & Galupo, 2011). Research suggests that males' adherence to socialized masculine norms such as emotion suppression, self-reliance, acting as a provider, and bravado attitudes often act as barriers to males' mental health resource use and lead to negative attitudes towards seeking formal support for mental health challenges (Addis & Mahalik, 2003; Vogel et al., 2007). Studies of boys' adherence to socialized masculinity have found that boys begin to partake in many troubling masculine norms at a very young age and partake in socialized masculine behaviors as a way of proving their manhood (Brooks, 2010; Vogel et al., 2011).

Black boys are seated at the unique intersection of being Black, male, and adolescent and therefore are likely to experience barriers related to each unique identity. For example, Hunter and Davis (1992) conceptualized a specific form of masculinity that focused on the ways Black males defined masculinity and manhood. Black masculinity according to Hunter and Davis though it largely overlapped with White middle-class views of masculinity also endorsed less stereotypical attributes of masculinity such as humanism, spirituality, and Afrocentrism as key aspects of Black men's perceptions of masculinity. Subsequent studies on Black masculinity have found

that Black boys often adhere to many of these socialized norms at a young age and often wrestle with this ideology throughout their adolescent development (Ferguson, 2000; Pelzer, 2016).

Stigma

Furthermore, studies suggest that boys often report stigmatized views of mental health and mental health services as a barrier to using available mental health resources. Though associated with multiple potential psychosocial barriers, self-stigma and perceived stigma specifically have been found to be associated with disparities in mental health service utilization. Link and Phelan (2001, 2013) argue that stigma is an aspect of socialization that is based on how others believe they will be perceived for using mental health services or being associated with a mental illness. Studies have found stigma among adolescents to be particularly debilitating due to adolescent's desire to build peer relationships and the fragile state of their identity development (Chandra & Minkovitz, 2006; Steinberg, 2014). For example, multiple studies have stated that boys often report feelings of discomfort, embarrassment, fear, and shame when asking for help to address mental health challenges, due to stigmatized views of depression and other mental health challenges (Gonzalez et al., 2005; Gulliver et al., 2010; Lynch et al., 2018).

Mental health stigma among Black adolescents, in particular, has been found to impact how they exhibit symptoms of mental health challenges, define mental health and mental health challenges, as well as how they seek help, and who they seek help from (A. Breland-Noble et al., 2006; Moses, 2009a, 2009b). Though there is limited literature, studies have reported that Black adolescents tend to hold more stigmatized

views of mental illness and mental health services than their White counterparts. For example, Moses (2009a) reported that Black adolescents were less likely to identify their mental health problems as being pathological and were less likely to label their emotional problems as a mental health challenge as compared to White participants. Additionally, Barksdale, Azur, and Leaf (2010) found that Black adolescents held more negative views of mental health services and were less likely to have reported using school-based mental health services compared to their White counterparts.

Given the importance of school-based mental health resources on addressing the mental health needs of Black boys and the lack of studies that examine barriers specific to Black boys use of these available resources, this study looks to address the following **research question:** What barriers predict Black boys use of school-based mental health resources? Additional aims to identify:

- What resources do Black boys use for mental health support in their school setting?
- What are the most common barriers to mental health service use identified by Black boys?
- What is the association between perceived barriers and school mental health resource use?

Methods

Data

This study consists of a secondary analysis of cross-sectional survey data from a need assessment conducted during the academic year of 2018-2019 at two large local high schools and two large middle schools in Southeastern Michigan. Inclusion criteria for participants were between ages 11 and 19 years old, could read and write in

English, and were enrolled in one of the four schools sampled. Those that did not meet the above criteria or whose parents did not provide permission were excluded from the survey. The needs assessment was conducted via a collaboration with the intermediate school district of a large Southeastern County in Michigan and the Transforming Research into Action to Improve Lives of Students (TRAILS) program. TRAILS is a professional development program for school-based mental health specialists that provides training on evidence-based mental health practices for school counselors and other mental health professionals. TRAILS is supported by the University of Michigan Depression Center, and partners with the University of Michigan Youth Policy Lab for data collection. The needs assessment was a self-administered online survey completed by students in their schools over two days. The survey used a population sample, looking to survey the entire student body of each school. No individual incentives were provided to participants. Schools that reached an 80% completion rate received a $2500 donation from TRAILS to be put towards a student-centered event. Informed consent forms were sent to parents of all students, where parents were given the option to opt out of their child being sampled in the need assessment. Students also were given the option to opt-out of participation. Students that chose to opt-in were provided a time slot to use computers in their school to complete the online survey. The median completion time for the surveys was approximately 15 minutes. Trained site coordinators stationed at each school oversaw the survey completion. Additionally, volunteers were not matched to the demographic characteristics of the study population.

For this study, only data from participants that identified as male and Black and between the ages of 13 and 19 years old were included in the analysis. Due to the age

range, only high school students were included in the sample. Of note, gender was based on self-identification as male, and Black identity also included those that identified as having biracial or multiracial identities inclusive of Black racial identity. The University of Michigan institutional review board provided approval for this secondary analysis [HUM00183896].

Sample

Responses from 168 Black boys were included in the analysis. As seen in table 2.1 the mean age of participants in the analysis was 15 years old (SD=1.01) with a majority of them being between 9th and 10th grade (n=108; 63.9%; SD=.867). Additionally, 51 boys (29.65%) were identified as being of mixed race.

Dependent Variable

The dependent variable for this study was “school-based mental health resource utilization”. Participants’ resource utilization was assessed with the question, *“Which school resources have you used in the past year to help with stress or related concerns?”* Response options were “teacher”, “school psychologist”, “school social worker”, “school nurse”, “school counselor”, “resource room teacher”, “school principal”, “support group” or “none of these”. Each school sampled has each of the resources available to its students. Since this study examines the overall utilization of any school-based mental health resource, and to avoid issues with multicollinearity a dichotomous outcome variable was developed. The resources were combined and given the response option, 1 or 0 with 1 indicating yes, a participant had used a school mental health resource in the past 12 months and 0, indicating a participant had not used a

school mental health resource in the past 12 months. The resources were combined to a dichotomous dummy variable to allow for a single regression model to explore the overall use of school-based mental health resources. The number of responses to each resource is included in table 2.2.

Independent Variables

Barriers in this study included both access and psychosocial barriers. Barriers were assessed by asking participants, *"Which of the following things might stop you from seeking mental health services of any kind?"* Access barriers included in the analysis were, "transportation", "time constraint", "insurance status", and "parents forbid". Psychosocial barriers included barriers that were specific to the participants' perceptions of mental health and mental health services as well as their preferences for mental health support. Psychosocial barriers included "self-reliance", "stigma", "negative perception", "fear of treatment", and "past negative experience". Each barrier was included in the model as a single item.

Controlled Variables

Age and depression were treated as control variables in the models. Age was treated as a control variable to assess potential developmental differences, measured as a continuous variable ranging between 13 and 19 years old. Depression was included as a control variable to examine potential differences between boys meeting criteria for clinical depression and those that were not. Depression was measured using the Patient Health Questionnaire (PHQ-9) modified for adolescents (PHQ9-A). The PHQ9-A is a depression module, which evaluates the severity of depression using the 9

DSM criteria as “0” (not at all) to “3” (nearly every day). The PHQ9-A has been used by many other studies to assess adolescent levels of depression and has been found to be valid and reliable (Kroenke et al., 2001; Richardson et al., 2010). The PHQ9-A for this subsample of boys was found to be highly reliable (9 items: α=.87).

Data Analysis

Given this study was exploratory in nature no hypotheses were specified prior to analysis. Using Littles missing completely at random (MCAR) test missing data are assumed to be randomly distributed, therefore item non-response was addressed using list-wise deletion an appropriate method of addressing missing data that is randomly distributed. Descriptive analyses were performed with frequency distributions on each relevant variable to develop a demographic profile for this sample of Black boys. Bivariate analysis with cross-tabulations and chi-square tests of significance were performed to identify associations between the use of school-based mental health services and socio-demographic variables, barriers, and depression. Multiple logistic regression models were fitted using variables associated with barriers while controlling for age and depression to identify the barriers that significantly influence the odds of Black boys in the sample using school-based mental health resources.

Logistic regression was chosen as the analytical approach in this study due to its ability to properly predict outcomes for binary variables (0,1 variables) such as the binary dependent variable for this study, school-based mental health resource utilization. The logistic regression analysis was conducted using the logit command weighted for analysis of a subpopulation from complex survey data in Stata version 16. Two separate models were conducted. The first model examined the effect of access

barriers on the school mental health resource use. A second model was conducted to examine the effects of psychosocial barriers. Adjusted odds ratio (OR), standard error (SE), 95% confidence interval (CI), and p-value are reported. A p-value of less than 0.05 was considered statistically significant.

Results

Descriptive Data

Cross tabulations were first conducted to identify early relationships between Black boys and reported barriers. Additionally, the descriptive analysis reported in table 2.2 was completed to identify the proportion of Black boys that used school-based mental health resources as well as which resource, the most used. Ninety-Five (56%) of the Black boys in the study reported using at least one school-based mental health resource in the past 12 months. From the options provided teachers were the most used resource by Black boys in the study with 26 boys reporting (28.8%) going to a teacher for emotional or mental health support. School social workers/counselors were the next most used school-based resource with 22 boys (23.1%) reporting going to a school social worker or counselor for emotional or mental health support. The mean PHQ9-A score reported in table 2.1 for Black boys in the study was 5.87, meeting the criteria for mild depression. Additionally, 84 (49.12%) Black boys in the study reported moderate to severe levels of depression with 36 (21%) meeting criteria for clinical depression (PHQ-A ≥ 10).

The relationship between predictor variables and control variables was examined using bivariate analysis, cross-tabulations, and chi-square. For example, the

relationship between depression and school mental health resource use for Black boys in the sample was examined using chi-square. The bivariate analysis showed no significant relationship between Black boys experiencing depressive symptoms and their use of school-based mental health resources (P=.096). Outcomes from the bivariate analysis are included in table 2.3 and table 2.4.

Access Barriers and School Mental Health Resource Use

The multiple logistic regression model that examined the association of access barriers on school mental health resource use included the four previously discussed access barriers, “transportation”, “time constraint”, “insurance status”, and “parents forbid”. Both age and depression were controlled for in this model and showed no significant relationship. A test of the full model compared to the null model, using log likelihood ratio test was not statistically significant χ^2=6.0, P=.429. No coefficients were found to be significantly associated with school mental health resource use. Table 2.5 reports the odds ratios, t-statistics, and p-values from this model.

Psychosocial barriers and School Mental Health Resource Use

For the multiple logistic models predicting the association of psychosocial barriers on school mental health resources use the five previously discussed psychosocial barriers, “self-reliance”, “stigma”, “negative perception”, “fear of treatment”, and “past negative experience” were used. A test of the full model compared to the null model was statistically significant χ^2=20.06, P<.05. In this model, two of the five independent variables were found to be significantly associated with school mental health resource use. Self-reliance (OR=.23; P=.005; CI; .07-.63) and stigma (OR=3.58;

P=.038; CI: 1.07-11.98) were both statistically significant. The three remaining psychosocial barriers were found not to be significantly associated with school-based mental health resource utilization. Additionally, age as a control variable was not significant nor was depression. Table 2.6 reports the significant contributions of each predictor variable to school mental health resource use. The strength of association between the predictors was fairly weak based on the pseudo R^2 (Cox and Snell R^2 = .094; Nagelkerke's R^2 = .127).

Discussion and Implications

This study examined how access and psychosocial barriers impact the use of school-based mental health resources by a group of 168 Black boys enrolled in two local high schools in Southeastern Michigan. The study centered around three primary areas of inquiry: (1) identifying the school-based mental health resources Black boys used for mental health support, (2) identifying the most common barriers to mental health resource use among boys in this study, and (3) investigating the barriers that predict Black boys use of school mental health resources. School-based mental health resource use was measured using a dichotomized variable that consisted of any use of eight mental health resources in either of the two high schools within the past 12 months. Age and depression using PHQ9-A scores were included as control variables to examine the effects of the potential barriers on the use of mental health resources.

Findings from this study suggest that though school-based mental health resources are often considered to be formal resources in most research, the continuous interaction the boys have with their schools, along with the often informal relationships students develop with school staff (see Decker et al., 2007) could place schools in a

more intermediate role regarding mental health support which would give the boys a greater sense of comfort, similar to that of what they receive from family and peers.

School Mental Health Resource Use

Findings from this analysis suggest that the majority of Black boys in the current study are making use of the available mental health resources in their school. More than half of the boys in this study (56%) reported using at least one mental health resource in their school. Of those that reported using a resource, 27% reported a teacher as the school mental health resource of choice, followed by a social worker or school counselor (23%). While specific evidence on Black boys' school-based mental health resource utilization is limited, studies have reported that generally, between 30% and 60% of Black adolescents in K-12 schools use school-based mental health resources when they are available (D. M. Anglin et al., 2008; T. M. Anglin et al., 1996; Bains et al., 2017; Barksdale et al., 2010). Similarly, studies report that teachers play an important role in facilitating more formal mental health resources as they often are the first point of contact for students experiencing mental health challenges (Boldero & Fallon, 1995; Decker et al., 2007; Milatz et al., 2015). These findings speak to the importance of expanding mental health resources in schools and the benefits such an expansion can have on Black boys' mental health needs. More than half the boys in this study used a resource in school to address their mental health needs. Nearly a quarter of these boys went to their school counselor or social worker and another quarter relied on support from a teacher to address a mental health concern. This speaks to the important role that these types of resources have in addressing Black boys' mental health needs. Though studies have shown that over the past two decades school-based mental health

resources have grown overall, data also has shown that social workers and school staff trained in mental health support, specifically in schools with a majority Black student population has been stagnant and even shrunk in some districts (Bean, 2011; Ramey, 2015). Expanding the availability of social workers, counselors, and teachers with mental health training in predominately Black schools could provide Black boys greater support to address many of their unmet mental health needs.

Black Boys and Depression

Black boys in this study had a mean PHQ9-A score of 5.87, meeting the criteria for mild depression. Nearly half the boys were determined to have moderate or higher levels of depression with over 20% meeting criteria for clinical depression based on their PHQ9-A scores. The rates of depression observed in this study are nearly double the national rate of 9.5% for Black adolescents between ages 12 to 17 and more than three times the national rate of 6.8% for adolescent males in general, according to the National Substance Abuse and Mental Health Administration (Quality, 2018). These findings align with previous studies that have demonstrated that Black boys often have unmet mental health needs. Specifically, evidence suggests that Black boys are under-assessed for mood disorders such as depression and anxiety (Barksdale et al., 2010; Feisthamel & Schwartz, 2009; Schwartz & Blankenship, 2014; Stewart et al., 2012).

However, schools are an ideal placement to improve the identification of Black boys experiencing mood disorders. This study shows that needs assessments and mental health screenings in the school setting can act as a net to capture students experiencing depression that may not have otherwise been identified. This would be key in identifying and providing the necessary mental health support that is needed for Black

boys. Furthermore, expanding mental health screenings in schools could address disparities in Black boys being disciplined for behaviors that are associated with mood disorders (Bosk, 2013; Ramey, 2014, 2015). For example, a study by Lindsey et al. (2017) found that Black boys were underdiagnosed for depression due to the misrecognition of many of their depressive symptoms and bias in societal perceptions of Black boys. Furthermore, they argue that the misidentification of their depressive symptoms as behavioral issues often removes Black boys from their school setting, due to exclusionary discipline, (see Rocque, 2010) where they are more likely to be assessed and access mental health support. By expanding mental health screenings in schools there becomes greater potential to identify Black boys experiencing mood disorders such as depression and guiding them into the necessary supports.

Additionally, this study found that Black boys that met the criteria for clinical depression were no more likely than boys that did not meet the criteria to use their school-based mental health resources. This finding is particularly surprising giving the assumed need for mental health support for boys that are experiencing such severe levels of depression. Moreover, given that more than half of the boys in this study reported using a mental health resource in their school, it is even more surprising that that meeting criteria for clinical depression were not significantly associated with using school-based mental health resources. It is possible that Black boys experiencing clinical levels of depression have a more difficult time openly discussing their feelings than those with less severe depressive symptoms and therefore were no more likely to seek support than those with less severe symptoms.

Access Barriers

As hypothesized, this study revealed no external barriers that were significantly associated with Black boys' use of school mental health resources. Recent work on school-based mental health resources has found that by integrating mental health resources with increased mental health awareness in the K-12 school settings, many external access factors that act as barriers to mental health resource utilization such as, financial and physical access issues could be eliminated (Guo et al., 2017; Stormshak et al., 2010; Williams, 2013). Studies continue to suggest that schools act as a central location where adolescents have physical access, do not have to worry about insurance or other financial barriers, and can discretely use the mental health resources (Dowdy et al., 2010, 2015; O'Connor et al., 2017). The findings from this study show that access barriers may not significantly deter mental health resource use for Black boys. However, this cannot be substantiated because this study cannot determine causal relationships (see limitations).

Self-Reliance

Boys in this study that identified self-reliance as a barrier to using mental health resources were nearly 80% less likely to use a school-based mental health resource. This finding is somewhat expected. Previous research has found that preferences for self-reliance is a significant barrier to using available mental health resources for adolescents broadly (S. J. Becker et al., 2014; Gulliver et al., 2010; Sakai et al., 2014). However, studies also suggest that for boys' self-reliance may be particularly challenging to overcome given its association with traditional masculine ideologies. For example, Lynch, Long, and Moorhead (2018) in a study of late adolescent boys mental health help-seeking found that the boys in their study were reluctant to seek help,

preferring to address their mental health needs on their own, often leading to avoidance coping behaviors (see Horwitz et al., 2011). Moreover, a study conducted by Lindsey and Marcell (2012) found that Black boys' preference for addressing their mental health needs on their own was attributed to their perceptions of manhood and masculinity. Traditional masculine traits such as independence, leadership, assertiveness, and guarded vulnerability have been identified as discouraging boys from using mental health resources (Addis, 2008; Addis & Mahalik, 2003).

When considering Black boys' self-reliance as an outcome of adherence to traditional masculinity the intersection of their racial and gender identity must be considered as well. Powell et. al. (Powell et al., 2016) in exploring Black men's help-seeking behaviors found that the men's diminished help-seeking behaviors were attributed to their sense of autonomy, freedom, and sense of control. Similarly, Black masculinity scholars have identified comparable factors that Black men categorize as being important aspects of masculinity that differ from that of traditional masculine ideologies (Hunter & Davis, 1992; Jackson & Elmore, 2017; Pelzer, 2016). For example, Mincey et. al. (2014) found that Black men put a greater emphasis on engaging with family and community as a characteristic of masculinity compared to traditional masculine ideology. This behavior is mimicked by many Black boys as studies report that Black boys prefer to rely on family and peers for mental health support over formal mental health resources (Lindsey et al., 2006, 2010; McCracken et al., 2001).

Stigma

Boys in the study that reported stigma as a barrier to using mental health services were nearly four times more likely to use a school-based mental health

resource. This finding was surprising given that an abundance of research has reported stigma to be a significant barrier to mental health resource utilization (Henshaw & Freedman-Doan, 2009; Johnson et al., 2012; Planey et al., 2019). For example, studies such as that of Vogel et. al. (2011), and Masuda, Anderson, and Edmonds (2012) found stigma to be associated with males' avoidance of formal mental health resources and their preference to address their mental health needs on their own. However, findings from the current study could point to protective factors that schools and the mental health resources within them provide for Black boys experiencing mental health challenges, especially those with stigmatized views of mental health and mental health services. Studies conducted by Lindsey et. al. (2010, 2013) found that Black boys that reported stigmatized views of mental health and mental health services benefited from positive social support from family and peers and were more likely to seek out support from informal resources due to a greater sense of comfort and trust. In their studies, they found social support had a positive interactive effect between service utilization and mental health stigma. Results from the current study could speak to a similar relationship for Black boys and school-based mental health resources.

Schools and school staff have a unique role in adolescent's lives. Schools though traditionally viewed as formal institutions are spaces where young people spend a majority of their time and often take part in informal activities such as socializing with peers, fostering romantic relationships, and often developing casual relationships with school staff (Crosnoe et al., 2003; Decker et al., 2007; Shaunessy & McHatton, 2009). The less formal aspects of the school setting potentially provide students with a sense of comfort and nurturing that is similar to what they receive in their homes and from

family and peers. In this case, students may not view their school setting as being as formal as scholars have previously treated school settings to be. Perceiving schools as an informal setting could facilitate Black boys' use of mental health resources in their school setting, especially for boys with stigmatized views of mental health and mental health services.

Recent school-based mental health interventions have capitalized on the social location of schools in adolescent lives by providing mental health resources and training to teachers and key school staff. For example, Baroni et al. (2016) evaluated a trauma-informed socio-emotional learning (SEL) intervention in an alternative high school for girls. In their evaluation they found that teachers were a significant source of support for girls in their study and the school acted as a central location where students felt comfortable enough to ask for and receive mental health support. Similarly, Stormshak et al. (2011) in an evaluation of a school-based family-centered mental health intervention reported that schools held a similar social location as a student's home regarding adolescent social development. This allowed them to leverage students' comfort and the pre-established relationships the schools had with student's families in addressing their mental health needs. Moreover, studies on students' school attachment have found that students with positive school attachment are more likely to be open and seek support from teachers and school staff (Oldfield et al., 2016; Wolters, 2003). Studies that call for greater implementation of mental health resources in schools often specify schools as being closely associated with students' families, peers, and overall home life, providing a similar sense of comfort (Atkins et al., 1998; Dishion & Kavanagh, 2003; Theron & Engelbrecht, 2012). The totality of these studies and the findings from

the current study speaks to the need for greater consideration of ways to provide mental health resources in the school setting while framing them as informal to leverage Black boys' comfort in their schools overcome barriers such as stigma and self-reliance. Based on the finding's teachers play a key role in providing mental health support to Black boys. Schools professionals should consider developing toolkits that can provide specialized training and resources to teachers and other key school personnel that can provide mental health support to Black boys within the school setting while also integrating their families and communities. The training along with the integration can likely address Black boys' concerns with stigma as well as overcome Black boys' desire for self-reliance.

Limitations and Future Directions

Some limitations to this study should be noted and can likely be addressed in future studies. This study used a sample of Black boys in Southeastern Michigan and findings may not be generalizable to Black boys from other regions in the U.S. or globally. Furthermore, because these schools were close in location the results may not accurately represent the region as well. This study also utilizes cross-sectional data which does not account for changes over time or confounding variables, and therefore cannot establish a causal relationship. Future studies would benefit from a nationally representative sample that would allow for more generalizable results regarding barriers and facilitators to Black boys' use of school-based mental health resources. Furthermore, longitudinal data would allow for the examination of changes in mental health resource use over time and potentially establish a causal relationship. An additional limitation is that this study was conducted as secondary analysis and

therefore was limited by the items included in the dataset. Many of the independent variables included in the analysis are single-measure items, the full constructs of each of these may not be fully captured by the single items. Future studies should look to examine the effects of these barriers using valid and reliable scales. Finally, data collected via self-report in the study may potentially be subject to recall bias.

Despite these limitations, this study addresses a significant gap in the literature on Black boys' mental health and service utilization and provides insight into ways to better attract Black boys into using mental health resources in their schools. Additionally, this study benefits from a large sample size of Black high school-aged boys, a population often difficult to sample, in schools with a large variety of mental health resources available. Additionally, future studies should consider exploring the context of school mental health resources that could benefit Black boys when using the resources, such as race and gender identifies of counselors, social workers, and teachers. Also, student's perceptions of ease of access to school resources and Black boys' school attachment.

Conclusion

While data shows that mental health resources are rapidly increasing in schools little research has been conducted to examine if Black boys, a population uniquely vulnerable to depression given their disproportionately higher rate of incarceration, experiences with police brutality, poverty, and exclusionary school punishment, are accessing and utilizing these available resources. This study serves as an early step in exploring how school-based mental health resources can better serve the needs of Black boys. Identifying potential barriers to Black boys' use of school-based mental

health resources provides mental health and educational scholars, interventionists, social workers, and mental health professionals with insight on how to improve these resources and better attract Black boys into utilizing them.

Table 2. 1: Participant Demographics

	Freq.	Percent	Mean	Stand. Dev.	95% CI
Age:	--	--	15.73	1.01	15.58 - 15.88
14	23	13.53 %	--		
15	43	25.29 %	--		
16	64	37.65 %	--		
17	36	21.18 %	--		
18	4	2.35 %	--		
Grade:	--	--	10.06	.867	9.93 - 10.19
9th	54	31.95 %	--		
10th	54	31.95 %	--		
11th	57	33.73 %	--		
12th	4	2.37 %	--		
Depression Severity (PHQ9-A score**):**	--	--	5.87	5.83	4.99 - 6.75
None (0-4)	86	50.88 %	--		
Mild (5-9)	47	28.07 %	--		
Moderate (10-14)	20	11.70 %	--		
Mod. - Sev (15-19)	8	4.68 %	--		
Severe (20-27)	8	4.68 %	--		
Clinical Depression: (PHQ9-A score)	--	--			
No (0-9)	135	78.95 %	--		
Yes (10-27)	36	21.05 %	--		

Table 2. 2: School-Based Mental Health Resources (SBMHR) Frequency Table

	Freq.	Percent	Cum.
Used a SBMHR			
No (0)	75	44.11 %	44.11 %
Yes (1)	95	55.88 %	100.00 %
SBMHR			
School Teacher	26	28.82 %	--
School Psychologist	9	5.29 %	--
School Social Worker	22	12.94 %	--
School Nurse	7	4.12 %	--
School Counselor	22	12.94 %	--
Resource Room Teacher	7	4.12 %	--
School principal	10	5.88 %	--
Support group	11	6.47 %	--

School-Based Mental Resource Frequencies include multiple responses from participants

Table 2. 3: Access Barriers Correlations

Variables	(1)	(2)	(3)	(4)	(5)	(6)	(7)
(1) SBMHR	1.000						
(2) Transportation	0.017	1.000					
	(0.832)						
(3) Time	0.102	0.066	1.000				
	(0.188)	(0.398)					
(4) Insurance	0.083	0.420	0.144	1.000			
	(0.284)	(0.000)	(0.062)				
(5) ParentsForbid	0.019	0.088	0.101	-0.035	1.000		
	(0.810)	(0.257)	(0.193)	(0.653)			
(6) Age	0.084	-0.101	0.013	0.061	0.004	1.000	
	(0.280)	(0.193)	(0.869)	(0.431)	(0.960)		
(7) Depression	0.061	0.193	0.175	0.224	-0.082	-0.137	1.000
	(0.426)	(0.012)	(0.024)	(0.004)	(0.293)	(0.076)	

Table 2. 4: Psychosocial Barriers Correlations

Variables	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
(1) SBMHR	1.000							
(2) Self-Reliance	-0.149	1.000						
	(0.055)							
(3) Stigma	0.175	0.194	1.000					
	(0.023)	(0.012)						
(4) Neg. Perception	0.011	0.200	0.140	1.000				
	(0.887)	(0.009)	(0.070)					
(5) Trust	0.101	0.258	0.415	0.188	1.000			
	(0.194)	(0.001)	(0.000)	(0.015)				
(6) Neg. Experience	0.055	0.275	-0.001	0.299	0.018	1.000		
	(0.478)	(0.000)	(0.985)	(0.000)	(0.815)			
(7) Age	0.084	0.005	0.098	0.142	0.044	-0.040	1.000	
	(0.280)	(0.945)	(0.208)	(0.068)	(0.569)	(0.607)		
(8) Depression	0.061	0.279	0.226	0.141	0.243	0.262	-0.137	1.000
	(0.426)	(0.000)	(0.003)	(0.068)	(0.001)	(0.001)	(0.076)	

Table 2. 5**: Access Barriers to SBMHR Use Logistic Regression Output**

School Resource Use (SBMHR)	Coef.	St.Err.	t-value	p-value	[95% Conf	Interval]	Sig
Transportation	.886	.56	-0.19	.848	.256	3.061	
Time	1.905	1.172	1.05	.295	.57	6.36	
Insurance	1.845	1.608	0.70	.482	.335	10.177	
Parent Forbid	1.299	1.371	0.25	.805	.164	10.281	
Age	1.222	.197	1.24	.213	.891	1.677	
Depression	1.317	.535	0.68	.497	.594	2.919	
Constant	.029	.074	-1.38	.166	0	4.37	

Mean dependent var	0.437	SD dependent var	0.498
Pseudo r-squared	0.020	Number of obs	167.000
Chi-square	4.592	Prob > chi2	0.597
Akaike crit. (AIC)	238.271	Bayesian crit. (BIC)	260.097

**** p<.01, ** p<.05, * p<.1*

Table 2. 6: Psychosocial Barriers to SBMHR Use Logistic Regression Output

School Resource Utilization (SBMHR)	Coef.	St.Err.	t-value	p-value	[95% Conf	Interval]	Sig
Self-Reliance	.224	.119	-2.81	.005	.079	.637	***
Stigma	3.589	2.208	2.08	.038	1.075	11.988	**
Neg. Perception	.764	.422	-0.49	.626	.259	2.253	
Trust	2.04	1.427	1.02	.308	.518	8.036	
Neg. Experience	3.557	3.009	1.50	.134	.678	18.672	
Age	1.238	.211	1.26	.209	.887	1.728	
Depression	1.412	.635	0.77	.443	.585	3.41	
Constant	.026	.07	-1.36	.174	0	5.028	

Mean dependent var	0.437	SD dependent var	0.498
Pseudo r-squared	0.075	Number of obs	167.000
Chi-square	17.119	Prob > chi2	0.017
Akaike crit. (AIC)	227.744	Bayesian crit. (BIC)	252.688

**** p<.01, ** p<.05, * p<.1*

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Chapter 4:

Help-Seeking for Depressive Symptoms: A Social process

Background

Adolescents experiencing depression is a growing concern as the rates of depression and suicide associated with depressive symptoms continue to exponentially grow for young people. Current data reports that nearly 14% of adolescents, between the ages of 13 and 17 years old, have experienced at least one major depressive episode in a 12-month period, and nearly 20% reported suicidal ideations (National Institute of Mental health, 2017). Although research has found that adolescents have a high likelihood of overcoming depression with proper mental health support and care, data from the Center for Behavioral Health Statistics and Quality (2020) show that only about a fifth of adolescents in need of mental health care receive it.

Black boys are especially susceptible to many of the negative long-term effects of unaddressed depression and depressive symptoms such as substance abuse, violent behavior, incarceration, and suicide (Joe, 2006; Thapar et al., 2012) due to their low rates of service utilization and high rates of depressive symptoms (Perkins, 2014). Studies have reported that Black boys often experience depressive symptoms at higher rates than their counterparts of other racial/ethnic groups given their increased likelihood of experiencing harsh social conditions such as high rates of poverty and community violence (Harding, 2010; Hooper et al., 2017), as well as disparate social

treatment such as racism, discrimination, and police brutality (Lindsey et al., 2017; Skiba et al., 2002). Though Black boys are at increased risk of experiencing depressive symptoms, studies report that Black boys are often underserved by mental health services, they underutilize available mental health resources and are more likely to experience punishment when exhibiting symptoms of depression rather than to receive a referral for mental health treatment (Assari & Caldwell, 2017; Lindsey et al., 2018; Ramey, 2018).

Given these troubling trends for Black boys, it is surprising that few studies have looked to examine Black boys' mental health help-seeking behaviors. The few studies that have examined Black boys help-seeking have found that boys in their study often relied on family and peers for mental health support, held negative views of formal mental health resources, and have identified stigma as a significant barrier to openly seeking external mental health support (Assari & Caldwell, 2017; Joe et al., 2018; Lindsey et al., 2013). However, many of these studies do not provide an in-depth understanding of Black boys' help-seeking decisions. Lindsey et al. (2006) reported that Black boys in their study preferred to receive support from family members and often received diverging messages about using formal mental health services to address mental health challenges. Ali et al. (2019) found that Black boys in their study were more likely to utilize mental health resources in their school setting than in the community. However, Barksdale, Azur, and Leaf (2010) in their study found that Black adolescents were less likely to utilize school mental health resources as compared to their White adolescents. Though each of these studies reports on some aspect of Black boys' help-seeking behaviors and service utilization, they fail to adequately explain the

help-seeking process and the pathways that lead boys into utilizing mental health services and resources. Cauce et al. (2002a) while developing a framework that better considers the cultural context in help-seeking research, called for greater research that "specifically focuses on the pathways in which minority adolescents seek help for mental health problems" (Cauce et al., 2002a, p. 2). In this call for greater attention to help-seeking pathways, scholars are encouraged to consider help-seeking beyond that of service utilization. It calls for a clear distinction between help-seeking as a process and service utilization as a potential outcome of the help-seeking process, rather than as a proxy for help-seeking which many previous studies have done (Pescosolido & Boyer, 2010).

Help-seeking and service utilization

In understanding help-seeking and service utilization as separate acts, we have to clarify the differences between help-seeking and service utilization. Service utilization is the act of using available mental health services and resources such as psychiatrists, outpatient psychologists, and mental health social workers, either by choice or by force (Barksdale et al., 2010; Draucker, 2005; Stefl & Prosperi, 1985). Help-seeking is the process that often leads to service utilization but not always. Many scholars that examine mental health help-seeking have failed to adequately examine help-seeking behaviors beyond that of service utilization and in doing so have ignored the role that other forms of mental health support can provide to individuals experiencing mental health challenges. Scholars must view help-seeking as a process that can move in multiple directions and can take multiple forms. The distinction between help-seeking

and service utilization is especially salient when we consider the research on Black American help-seeking decisions and their low use of mental health services.

Black males and help-seeking

Studies on Black male's help-seeking and service utilization have reported that Black males often hold negative views of mental health services and prefer to manage their mental health needs on their own (Lindsey & Marcell, 2012; E. Ward & Mengesha, 2013; Watkins et al., 2006). Distinctive to Black males is the role that manhood and masculinity have in impacting their help-seeking behaviors. Studies have reported that behaviors associated with traditional masculine norms encourage men to address their mental health needs independently and suppress their negative emotions (Addis, 2008; McCusker & Galupo, 2011). Such behaviors have been found to negatively impact men's attitudes about mental illness and mental health services, their symptom management, and help-seeking behaviors (Hammond et al., 2010; Seidler et al., 2016). Moreover, scholars such as Cheatham et al. (2008) and Powell et al. (2016) have found that Black males while adhering to many aspects of traditional masculinity also have identified the impact of racism, their sense of control, influence from family and community, and racial identity as impacting their help-seeking decisions and service utilization.

Black boys are in a unique position as Black, male, adolescents in that they belong to three groups that underutilize available mental health services while also being at increased risk for experiencing depressive symptoms. Studies on Black boys' help-seeking behaviors and subsequent service use have provided mixed results. While studies find that Black boys often underutilize available mental health resources

(Samuel, 2014), studies have also reported that Black boys often seek support from family and peers when experiencing high levels of mental distress (Lindsey et al., 2010; M. Te Wang & Sheikh-Khalil, 2014). Furthermore, while data shows that the social circumstances that Black boys often face are associated with a heightened risk of mood disorders such as depression and anxiety (Brondolo et al., 2011; Caldwell et al., 2016), Black boys remain disproportionately underdiagnosed for these conditions (Alegría et al., 2012; Bell et al., 2015; Mizock & Harkins, 2011). Lindsey, Brown, and Cunningham (2017) stated “many Black boys have serious problems connecting to mental health treatment to address their depression and other precursor issues often leading to suicide” (Lindsey et al., 2017, p. 377). Studies have reported that suicidal behaviors among Black boys have increased by nearly 125% over the past two decades (Bridge et al., 2018; Joe, 2006; Lindsey et al., 2019) yet few studies have thoroughly examined Black boys help-seeking process as an attempt to improve services to better identify Black boys in need and provide improved care.

Growing access to mental health resources

Studies have shown that access to mental health resources for adolescents has increased exponentially. Adolescents have greater access to mental health resources such as mental health social workers, counselors, mental health support groups, and virtual support networks in their schools, communities, and online. For example, the 2019 Indicators of School Crime and Safety reported that as of 2018, diagnostic mental health assessments were being conducted by 51% of public schools in the United States, 38% provided full mental health treatment services, and 80% of public schools with mental health services had provided at least 1000 students with diagnostic

assessments (K. Wang et al., 2019). Furthermore, studies have reported that community health centers and youth-oriented community programs have also rapidly increased their mental health resources (Druss & Goldman, 2018; Weist et al., 2006). A benefit to adolescents is that many of these resources are free to access and they often do not need parental permission to utilize these services. For example, Bains, et al. (2014) in a study of Black and Latino boys' use of school-based mental health centers found that boys that utilized the mental health centers reported that ease of access was a key factor that contributed to their use of the mental health center. Additionally, Grumet (2009) in assessing the effectiveness of a school-based suicide prevention screening tool, found that students were more inclined to take part in the suicide screening due to its accessibility in the school setting. Furthermore, the suicide screening found that twenty percent of the students screened reported current or past suicidal ideations.

Black boys in theory would benefit from the expansion of the school and community mental health services given their heightened risk for depression and the ease of access to the resources. Studies have called for greater ecological approaches to mental health care for Black boys that incorporate their families, communities, and schools to better serve them (Dishion & Kavanagh, 2003; Livingston & Nahimana, 2006; Mason et al., 1994). However, these newly developed programs and interventions often lack a thorough understanding of Black boys' help-seeking process and therefore often fail to adequately address Black boys' mental health needs.

Help-Seeking a Social Process

Though most current research supports the notion that help-seeking is a social process, previous studies on help-seeking behaviors have mistakenly ignored the social process aspects, instead, relying on health beliefs and individualistic decision making when attempting to understand help-seeking decisions (Ruwindu Attygalle et al., 2017; Sakai et al., 2014b). However, studies by Pescosolido (1991), and more recently Stiffman et. al (2004) and Pescosolido and Boyer (2010) have pushed to understand help-seeking as a dynamic social process that takes place over time and is impacted by social interactions, socialized norms, and cultural beliefs. Glaser (2005) states that a social process is "something that occurs over time and involves change over time. These changes over time usually have discernable breaking points to the extent that stages in the process can be identified" (Glaser, 2005, p. 6). In understanding help-seeking as a social process scholars can look to identify the stages in the help-seeking process in which decisions regarding how, where, and when to seek help are being made. Identifying such stages would provide greater insight into what role contextual factors such as a person's social network, cultural norms, physical environment, and social environment have on the person's help-seeking decisions. Furthermore, the notion of help-seeking as a social process insinuates that help-seeking decisions while intentional may not always be rational because the decision is likely influenced by external contextual factors.

This study looks to explore the social process of help-seeking for Black boys using a grounded theory approach. This study is guided by the **research question**: What processes do Black boys take part in when seeking support for depressive symptoms? In exploring this social process, I looked to identify:

1. Who do Black boys talk to and confide in about their own mental health needs?
2. What factors do the boys identify as important to them when seeking help?
3. What mental health resources, if any, do the boys use in their school and why?

Theoretical Frameworks

This study uses aspects of the network episode model and ecological systems theory in its exploration of Black boys' help-seeking process. The network episode model is a framework that identifies help-seeking as a social process that is embedded in social networks and is processual in that there are multiple stages and decisions made over time that make up a more in-depth and complex process in addressing mental health conditions see appendix B.1. The ecological systems theory attests that young people's development takes place within a context of multiple social systems that interact to make up a young person's social environment see appendix B.2. Both these theories place an individual at the center of large and complex social networks that influence the individuals' perspectives, beliefs, and behaviors. These theoretical frameworks were used in developing the interview questionnaire as well as in guiding the analysis of the qualitative interviews.

Network Episode Model

The network episode model (NEM) was developed to move beyond previous concepts of help-seeking as simply a cognitive process. Previous help-seeking models have primarily focused on individuals' perceptions and views of mental health conditions as the principal influencer of their help-seeking behavior (Henshaw & Freedman-Doan, 2009; Pescosolido & Boyer, 1999). However, studies later reported that while many previous help-seeking theories adequately identify mental health beliefs, views, and

even experiences they have often fallen short in accurately predicting and explaining help-seeking behaviors and subsequent service utilization. For example, the health belief model (HBM) identifies the primary determinant of service utilization as beliefs and attitudes about particular mental health conditions (Green & Murphy, 2014; Rosenstock, 1977). However, Carpenter (2010) conducted a meta-analysis exploring the predictive power of the components in the mental health belief model and reported that though the HBM adequately predicted preventative behavior, it did not adequately predict service utilization. Other models such as the Socio-Behavioral Model (Andersen, 1995) have been found to have similar limitations (Babitsch et al., 2012; Bradley et al., 2002).

The NEM begins with the foundation that addressing an illness is a social process influenced by “the social networks that individuals have in their homes, community, the treatment system, and social service agencies” (Pescosolido & Boyer, 2010, p. 435). The model links interactions with family and peers, the community, formal mental health systems, and the social experiences of an illness referred to as the illness career, all within the social process of help-seeking. Additionally, the assumptions made by NEM allow for greater emphasis to be put on sociocultural and environmental influences on help-seeking by considering the socialized experience of an illness. That is to say that illness, and in particular mental health conditions are at least partially socially constructed in that the experience of illness is influenced by environmental and cultural context. If we think of culture as a toolkit of skills, habits, styles, preferences, and perspectives (Swidler, 1986) we have to consider that socialized cultural norms provide individuals with particular ways of making sense of illnesses and symptoms. A

final aspect of the NEM is that it argues that help-seeking as a social process is made up of multiple decisions over time and therefore there are distinct stages in which decisions about how and where to seek help are being made. These stages are based on the illness career, the social experience of the illness (Aneshensel, 2013; Karp, 1994).

Ecological Systems Theory

Ecological systems theory conceptualizes child development as a system of complex interactions taking part within multiple environmental systems (Bronfenbrenner, 1979). The interactions within these environments range from direct interpersonal interactions with surroundings and individuals to larger systems that have little to no direct contact with an individual but influence their development from a systemic and policy level. Ecological systems as a conceptual model organize the structure of an adolescent's environments based on their social location to the adolescent. Bronfenbrenner describes five nested systems of interaction that start with a child's most intimate influential settings and expands to broader settings made up of policy and cultural norms that impact their experiences, the way they are viewed by society, and the opportunities they have (Bronfenbrenner, 1979; Stokols, 1996; Swick & Williams, 2006). Bronfenbrenner stated, "the capacity of a setting such as the home, school, or workplace to function effectively as a context for development is seen to depend on the existence and nature of social interconnections between settings, including joint participation, communication, and the existence of information in each setting about the other." (Bronfenbrenner, 1979, p. 6). In other words, the multiple settings that an adolescent navigates through such as their home, school, community, and workplace

work collaboratively in the overall development of the adolescent. There are four environmental systems included in ecological systems theory, (1) microsystem, (2) mesosystem, (3) exosystem, (4) macrosystem, and (5) chronosystem. For this study, I focus on the microsystem, mesosystem, and exosystem.

The microsystem is the environment closest to a child, which most often has the strongest impact on their early development. Immediate family, close peers, and school environments are the most common structures at this level. Interactions in the microsystem influence a child's sense of trust, belonging, and mutuality as well as influences much of their understanding of society and its social systems (Bronfenbrenner, 1979; Swick & Williams, 2006; Velez & Spencer, 2007). The mesosystem accounts for the interrelations of the multiple settings and structures within the microsystem. For example, the way a child's parents interact with teachers in the child's school, or changes in the home and immediate family are likely to affect a child's interactions in school. Most important at the mesosystem level is that consideration must be given the norms, standards, and realities of the multiple structures in the microsystems. The exosystem includes "mid-level" structures that surround a child. They are impacted directly as well as indirectly by the structures in the exosystem. At the exosystem level, community context, economic opportunity, and out-of-school activities makeup opportunities that give a child a sense of purpose and direction as well as help them begin to develop a particular worldview, shaped by the context of their surrounding community (Ettekal & Mahoney, 2017; Swick & Williams, 2006).

The ecological systems theory identifies social interactions throughout each of the embedded systems as being at the center of child development (Cauce et al.,

2002b). Therefore, to understand behaviors such as Black boys' help-seeking and service use, the social interactions that take place throughout the ecological systems and the ways that Black boys are influenced by the structures within them must be examined. Relatedly, studies show that ecological systems theory has become a more common aspect of adolescent mental health interventions (Cappella et al., 2008; Dishion & Stormshak, 2007; Mason et al., 1994) given its attention to the influence of multiple environmental settings, policy, culture, and social norms.

The merging of the network episode model and ecological systems theory is a key merger given the nature of these frameworks. NEM utilizes an interactionist approach (see Aksan et al., 2009; Blumer, 1986) in explaining help-seeking and service utilization. Considering social interactions within an individual's vast social networks aids in exploring the social process of help-seeking. Furthermore, exploring social networks within particular settings and environments is key in understanding how environments that provide mental health resources, such as the school setting, can better attract and service Black boys. Additionally, the NEM and EST frameworks assist in identifying which members of Black boys' social networks are most salient in their mental health help-seeking decisions as well as other factors that influence Black boys help-seeking decisions.

Methods

This study uses 15 semi-structured qualitative interviews with Black boys from four high schools in Southeast Michigan to explore their help-seeking behaviors and service use as social processes. Interviews were collected from March 2020 through January 2021. The initial six interviews were conducted with boys in their schools in a

private office or classroom during the first two weeks of March. On March 13 all public schools in the State of Michigan were closed due to the coronavirus pandemic. On this same day, the University of Michigan restricted all person-to-person human subject research from being conducted. Due to the school closures and restrictions on human subject research, it was required that all in-person interviews were changed to virtual interviews. The necessary changes were made, and this study was approved via the University of Michigan Institutional Review Board as a tier-1 non-regulated study (HUM00173387).

Additionally, as approved by the UM-IRB, adverse events such as expressed suicidal ideation were addressed in three ways. First, all participants were given a sheet with available mental health services, including services provided in their school at the end of each interview. Second, mental health professionals at each school were available in case any student expressed suicidal ideation or threatening behavior. All participants were made aware of my responsibility to contact mental health professionals if I felt they were at risk of harming themselves or others. Third, the parents of participants that completed virtual interviews agreed that they would be available in case of adverse events such as suicidal ideation or threatening behavior. Participants and their parents were made aware of my responsibility to report concerns about suicidal ideation of harmful behaviors.

Virtual interviews were conducted via BlueJeans or Zoom video conferencing platform. The mean length of the interviews was 48 minutes, with the longest interview lasting a total of 63 minutes, the shortest lasting a total of 28 minutes. Each interview was recorded and stored in an encrypted online cloud under my secured university-

licensed account. The interviews were transcribed via an online transcription service that provided a computer-generated transcript. I then reviewed the computer-generated transcripts, while listening to the audio recordings, to check for accuracy.

The mean age of the participants was 16 years old. Each participant was enrolled in high school (grades 9-12) with a majority of them being between sophomore and junior year (10-11th grade). All the participants self-identified as Black or African American as well as self-identified as a boy (male gender). None of the participants disclosed having a Trans or non-binary gender identity, see table 3.1 for participant demographics.

This study uses a constructivist grounded theory approach to explore Black boys help-seeking behavior and school-based mental health service use. Grounded theory (GT) was chosen as the analytical method for this study because of its unique ability in identifying social processes via its systematic approach to data analysis. GT is a structured systematic qualitative method for exploring social processes and developing theory supported and grounded in the data (Charmaz & Liska-Belgrave, 2015; Glaser, 2005; Glaser & Strauss, 1973). GT uses an iterative process to develop conceptual understandings from qualitative data. It emphasizes the constant comparison of data as well as simultaneous data collection and data analysis, allowing for theoretical changes in data collection based on early findings. GT is an acceptable methodology for this study size given that previous GT studies have successfully been conducted and reached saturation with sample sizes between 13 and 30 participants (Hassett et al., 2018; Sakai et al., 2014a; Westberg et al., 2020).

Specifically, this study uses constructivist grounded theory (CGT) a permutation of traditional grounded theory that follows an epistemological and ontological perspective of a non-fixed reality. Constructivism is inherently anti-positivist; it views reality as collaboratively constructed between a participant and researcher. Specifically, a constructivist scholar views "the built environment, social institutions, language, culture, belief systems, and so on" as constructing individual realities (Constantino, 2012, p. 2). In studying the lived experiences and perspectives of Black boys regarding mental health, it is key to consider their realities as unique and constructed through social, institutional interactions, and individual experiences. In particular, I approach this study with a social constructionist and interactionist epistemology.

CGT was developed as a way of maintaining the systematic approach of traditional GT while accounting for constructivist epistemology that many qualitative scholars approach their research with (Charmaz, 2000; Mills et al., 2006). Kathy Charmaz, a pioneer in CGT among many others, states "a social constructionist approach allows scholars to address "why" questions while preserving the complexity of social life" (Charmaz, 2008, p. 397). Under the CGT there are four primary assumptions (1) reality is multiple, processual, and constructed under particular conditions; (2) the research process emerges from interactions; (3) it takes into account the researcher's positionality, as well as that of the research participant; and (4) the researcher and researched co-construct the data as a product of the research process. Additionally, though traditional grounded theory developed by Strauss and Corbin (Corbin & Strauss, 1990; Glaser & Strauss, 1973) opposed pre-engagement with literature related to the research topic, CGT encourages engagement with literature and previous knowledge.

Such engagement acts as a means of providing the researcher with an additional “voice to contribute to the researcher's theoretical reconstruction” (Mills et al., 2006, p. 29). Strauss and Corbin (1998) argue that though theoretical sensitivity is important in GT it can be maintained by other means. Constructivist grounded theorists insist that engaging the literature can provide insight that is important in examining the data. Furthermore, Charmaz (2015) contends that it would be impossible for a researcher with a specific research interest to avoid at least some broad familiarity with the literature on their research topic. This aspect of CGT is important to this study given that established theoretical frameworks were used in the development of the interview protocol as well as in the analysis.

Analysis

Transcripts were reviewed and analyzed using Dedoose 8.3.45 a qualitative and mixed methods analysis application (Salmona et al., 2020). Each interview transcript was uploaded to Dedoose and electronically linked with the participants’ demographic information. Demographic information included participant age, grade, school, if they self-reported experiencing depression, and personal experience with suicide, see table 3.1. A three-cycle coding process was used to explore the participants’ help-seeking process. The first cycle uses in-vivo and process coding to reduce the data into discrete parts called codes that are open to all potential theoretical directions. The second cycle uses focused coding and axial coding to reorganize and analyze data by comparing codes across transcripts to develop more succinct descriptions of similarities between transcripts called categories. The third cycle uses theoretical coding to identify what in grounded theory is called a “core/central category”, a category that links the overall

findings of the study to one or two explanatory outcomes. Additionally, following the analytic standards of constructivist grounded theory (Charmaz & Liska-Belgrave, 2015), I analyzed completed interviews while simultaneously collecting new data.

First Cycle. The first cycle of coding utilized an initial open coding process. Open coding is the first step in data reduction. The goal of initial coding is to begin identifying early emerging themes from each interview and attempting to develop early emerging categories that can later be examined and compared between transcripts (Chun Tie, Birks, & Francis, 2019; Saldaña, 2013). Using an open-ended process I conducted open coding line-by-line for each interview transcript, this is an essential first step in CGT to begin deconstructing the data (Charmaz, 2000; Charmaz & Belgrave, 2012). I specifically looked to identify actions and behaviors related to help-seeking and the use of any mental health resources. Using line-by-line coding I was able to keep the analysis open to potential "theoretical directions" that may have emerged (Charmaz & Belgrave, 2012; Saldaña, 2013). Moreover, I was able to identify actions and behaviors while also maintaining the integrity of the participants' own words using process coding. In addition to process coding, commonly associated with GT, in-vivo coding was also used in the initial coding phase.

In-vivo coding uses the actual language found in the interview transcripts. By using the participants' own words in the initial codes, it assured first that the findings were sensitive to the unique colloquial used by the participants. Secondly, in-vivo coding allowed for the amplification of the Black boys' voices, which often is lost in the research on this population. Though in-vivo coding is not a traditional aspect of grounded theory, it was essential in data reduction. It ensured that the boys' voices

were fully considered throughout the analysis both before and after analytical interpretations began. For example, one of the boys described concern with the way school counselors misrepresented his words. He used the term “rennarrate”, which was captured as a code and was found to be a significant barrier in using formal mental health supports.

“Don’t tell me what I’m thinking, especially after I just told you what I was thinking…[interviewer spoke]. Right, like don’t rennarate my story that I’m telling you, it’s my story.”	*Don’t tell me what I’m thinking* *Rennarrate my story*

Process coding was key in identifying processes and actions in the transcripts. Codes were developed using gerund (-ing) words to identify action in the data. For example, one of the early codes developed identified the action of self-blaming.

“It had me look at myself like I was the bad person like I was the person always in the wrong.”	*Blaming self*
“I have conversations about a general topic and see what people's thoughts are and how other people think and then process that in my own head and consider that every time I make a decision, I got to think like everybody not going to think the same as me so I can't just go ahead and shoot for it with decisions all the time.”	*Seeking information* *Making informed decisions*

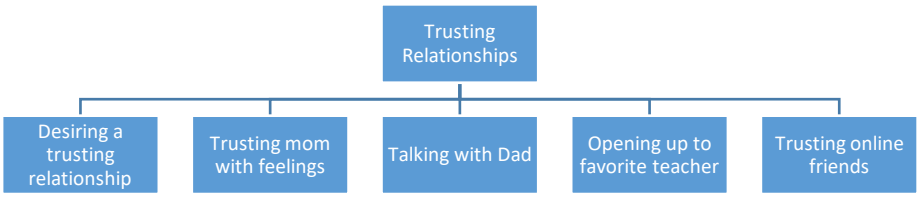
Using process coding allowed me to describe observable activities that the participants identified as well as more conceptual actions that they describe in the interviews. Additionally, process coding aids in identifying social interactions, a key aspect of NEM. The codes developed during the open coding phase were used to identify early patterns. Each transcript was thoroughly analyzed, and more codes were developed using both in-vivo and process coding.

Second Cycle*.* In the second cycle of coding, relationships between codes begun being identified. The goal in this cycle was to develop broad categories by merging similar codes as well as removing codes that were irrelevant to the topic of Black boys' help-seeking processes. Categories are descriptive-level texts of participants' explicit accounts (Hallberg, 2006; Vaismoradi et al., 2016). In merging the codes, I was able to develop broad categories related to help-seeking behaviors, identify key supports in the boys' help-seeking decisions, as well as identify barriers identified by the boys. For this cycle, I employed focused coding and axial coding to assist in identifying the most analytically relevant categories and removing irrelevant ones. Focused Coding calls for the most frequent codes to be merged without yet developing too much constraint from category properties or dimensions, the codes are merged merely on similarity and broad degrees of belonging (Dey, 1999; Saldaña, 2013). Categories developed for each transcript were compared and merged across multiple transcripts into broader tentative categories. Though there were no dimensional constraints on the merging of codes, each decision to merge codes was documented in corresponding memos, an important aspect of GT to maintain transparency and rigor. For example, memo 41 was an analytical memo that documented the reasons all codes related to the importance of trust in their interpersonal relationships were combined under the categorical code of "trusting relationships". Written *memo 41 from Dedoose:*

> "When the boys describe people that they open up to or receive support from they described very strong relationships and intense feelings for the person they open up to. This is interesting, it seems like it takes a lot of trust and relationship-building to get these boys to open up. I am going to make a tentative category for

trusting relationships and move these to this category. I may need to consider the level of trust the boys describe before being open with the person"

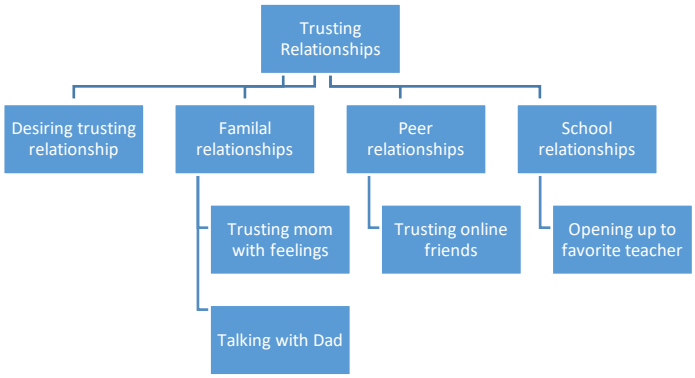
A benefit of using Dedoose in the analysis is that it is effective data management and visualization tool that aids in efficiently developing codes and merging them into analytical categories. Dedoose provides tools to visually connect codes and categories in a structured hierarchal order. For instance, using the same example from above regarding trusting relationships, during phase two, trusting relationships became a category built from combing several individual codes.



Once these tentative categories were developed, I transitioned from focused coding to axial coding. Axial coding calls for refining categories with clearly defined properties and dimensions. I used axial coding to work through each tentative category and determine the categories that continue to be salient and then defined the categories based on their relevance to the topic of study and the codes that were merged to develop them. In this step, I reviewed tentative categories shifting them into core subcategories for their importance throughout the social process being identified. Following the basic tenets of grounded theory, each category was given a detailed description that describes its contexts, conditions, interactions as well as processes within the category. Previously written memos were used throughout this categorization process to be sure that the defined properties and dimensions of the categories are

grounded in the data. Furthermore, each decision made in refining the categories was recorded via memos.

As categories were defined and redefined, they were also organized using the aspects of the ecological system and network episode model frameworks. Relationships and supports were organized based on their proximity to the participant. Broader environmental categories were defined, such as the school setting, the community setting, in the home, and online/social media. Each interaction the boys described as part of their help-seeking process was moved into the corresponding environment in which it happened. The person which the participant describes as being part of their help-seeking process was also placed into a corresponding category based on their relationship with the participant. This allowed each broad category to have more defined branches.



Interviews were ongoing while data analysis was being conducted immediately. Furthermore, ongoing analysis informed the data collection process as interviews were modified in accordance with emerging categories. Doing this allowed me to partake in the iterative process, developing concepts throughout the data collection and analytic process. For example, the topic of feeling like a burden was a reoccurring theme in the first few interviews. Starting with interview eight I began asking explicitly about the

feeling of being a burden using the question, “Are you ever concerned asking others for help or support will bother them?” and then following up with the probing question, “

Quality and Rigor

To maintain quality and rigor in data collection and analysis I first continued to collect interviews until I felt I reached a point of theoretical saturation. A sufficient saturation point is difficult to identify. However, at the time of the final interview, several themes had become repetitive, and a limited amount of new evidence was emerging. Additionally, to assure rigor I used constant memoing throughout the entire study, including during data collection, analysis, and in writing the current manuscript. During data collection, two forms of constant memoing were used, personal journaling, and structured interview debriefing. Personal journaling is similar to reflexive bracketing (Tufford & Newman, 2012) in that allowed me to reflect on my values, preconceived notions, and biases before conducting interviews. Using interview debriefing forms (Collins et al., 2013) I made notes of personal reactions to interviews, my initial thoughts, and any concerns regarding the participant, the interview protocol, or any other aspect of the interviews. Throughout the analysis, I used analytic memos (Charmaz & Belgrave, 2012) that acted as a document trail to keep track of all analytical decisions being made. These memos were used in developing the current manuscript often leading to important quotes and organizing findings. Finally, I used peer examination (Merriam & Tisdell, 2016) by allowing colleagues in similar areas of research including education, mental health, and adolescent development review drafts of the findings, de-identified transcripts, and analytic memos to provide feedback on overall findings.

Findings

This study looked to identify the help-seeking process for a group of Black boys as a product of social interactions and socio-cognitive decision-making. In doing so, this study identifies unique pathways that participants in the study navigate in their help-seeking process. A model is presented to illustrate the participants' help-seeking process modified from Pescosolido's network episode model and revised illness career model, see appendices B.1, B.3. The boys in this study that described experiencing depressive symptoms discussed several stages they navigate in their help-seeking process. Each stage of the help-seeking process is triggered by the progression of the depressive symptoms, see appendix B.4 for the modified model.

At the onset of the depressive symptoms, that is when the participants first notice the symptoms, they begin with (1) attempting to manage the symptoms on their own, often relying on several avoidant coping strategies such as smoking marijuana, playing video games, and exercising. However, as the participants' depressive symptoms continue to progress many of them describe experiencing a crisis point where they feel incapable of managing the symptoms on their own. At this point, the participants are pressed to make decisions of whether they are going to seek external help and from who they are going to seek help, whether it be (2) informal or (3) formal supports.

Following Pescosolido and Boyer's (1999) previous study on help-seeking and service use, informal mental health supports are defined as those within a person's social network that provide some aspects of mental health support and guidance but are not formally associated with mental health care such as family, peers, teachers, principals, and community center staff (Murry et al., 2011a; Nguyen Thai & Nguyen, 2018; Srebnik et al., 1996). Pescosolido and Boyer (1999) separate the informal support

network into two systems, the lay system including family and peers, and the human/social service system including teachers, principals, and community center staff. They describe formal mental health supports as inclusive of individuals that are specifically designed to provide mental health support. These include “psychiatrists, psychologists, social workers, and psychiatric nurses” (Pescosolido & Boyer, 1999, p. 421). However, their definition of formal support does not include the numerous mental health resources that have been developed over the past two decades that specifically target adolescents experiencing mental health challenges such as school social workers and counselors, support groups, and call-in services (Forman et al., 2009). Scholars must consider the increased options specifically developed for adolescents to address their mental health needs in our definitions of formal mental health resources. Therefore, it is worth updating this list with the increasingly available mental health resources. Mental health resources that are often freely available and within reach to adolescents including school social workers, school counselors, formal support groups, call-in services, virtual support groups, and community counselors are also examples of mental health resources that are considered formal in this study (Anglin et al., 1996; Bains & Diallo, 2016; Duong et al., 2021).

Throughout their help-seeking process independence was identified as a core category that is integrated throughout the majority of the participants’ help-seeking decisions. The participants look to maintain a sense of independence in their decision-making as well as in the act of how they are receiving mental health support. In their description’s independence is discussed as both physical independence and as independent decision-making.

Physical Independence and Independent Decision-Making

Physical independence refers to the participants' desire to address their mental health needs on their own with no help from others. They initially attempt to be physically independent in addressing their mental health needs by using avoidance coping behaviors, that can be done independently and allow them to avoid physically relying on anyone else such as smoking marijuana, exercising, and playing video games. Independent decision-making is the socio-cognitive process of making, what they believe to be, informed decisions on their own regarding how they address their mental health needs. Though several of the participants stated they made help-seeking throughout the help-seeking process, the participants are making independent choices about seeking external support for their depressive symptoms, who to seek support from, and how much to reveal based on their criteria and sense of need. Independent decision-making is the act of forming opinions and decisions based on their understanding of depression and how they should manage the depressive symptoms. The desire for physical independence and independent decision-making that is demonstrated by the participants is a characteristic of masculinity and adolescence. The desire for greater independence is connected to traditional masculine ideology (Addis & Mahalik, 2003; Smith et al., 2007). The desire for independence is also a central feature of adolescence as a developmental stage (Geuzaine et al., 2000; Hassett et al., 2018). When considering boys' adherence to traditional masculinity and their developmental stage it makes sense that independence is such an important aspect of their help-seeking process.

Independence: masculinity and adolescence

Studies suggest that adolescent boys largely adhere to aspects of traditional masculine ideology when considering ways to address mental health challenges (Johnson et al., 2012; McCusker & Galupo, 2011; Vogel et al., 2011). Studies report that males prefer to rely on themselves to address their mental health needs and are less likely than females to seek out support for formal mental health services (Addis, 2008; Englar-Carlson, 2007). For example, Seidler et. al. (2016) reported that physical independence and independence as a cognitive act was a characteristic of traditional masculine ideology that negatively affected the way men in their study expressed depressive symptoms, managed their symptoms, and lead to a lack of overall help-seeking for depression.

Studies also report that adolescence is a time in which young people are striving for greater independence and autonomy in their decision-making (Steinberg, 2014). During adolescence, friends and peer groups become more important and separation from parents and formal systems of control become frequent. Due to adolescents looking for greater physical independence as well as independence in their decision-making they often avoid seeking parental and formal support for emotional challenges, instead preferring to address their needs on their own, or turning to peers for support (Hassett et al., 2018; Sylwestrzak et al., 2015). The boys in the current study make decisions with the intention of maintaining independence associated with their intersecting identities as boys and adolescence, while also addressing their depressive symptoms.

Stages of Help-Seeking

Three stages were identified in the participants' help-seeking process that the participants maneuver through. During the onset of depressive symptoms (1), the participants described a preference for addressing their mental health needs on their own. As the depressive symptoms progressed the participants (2) began seeking support from informal supports such as family, peers, and teachers, and eventually became more likely to (3) utilize formal mental health supports such as school social workers, counselors, and community therapists. Within each stage, the participants make multiple decisions regarding their level of need, who they will seek support from, how much information they will reveal about their mental health struggles, and when they need to seek further support. Furthermore, the participants move through each stage differently. For example, it was common for boys to attempt to manage their depressive symptoms on their own, then choose to seek informal support, and then return to attempting to manage symptoms on their own again before deciding to seek formal support. Therefore, though the process is described linearly in this study, the process for the participants was somewhat more sporadic. Finally, though many of their help-seeking decisions were made independently, as their depressive symptoms progressed, they became more accepting of guidance and mental health support from others. The following sections describe each stage of the help-seeking process and discuss the context of the help-seeking stage.

The onset of depressive symptoms

Participants in this study described a myriad of depressive symptoms. Six of the fifteen participants stated they had experienced depression, though none of them had been formally diagnosed with depression. Thirteen of fifteen participants reported that

they had experienced pervasive depressive symptoms. Common symptoms described by participants included pervasive feelings of sadness, hurt, loneliness, agitation, anger, and fear. The reasons for these feelings were as diverse as the symptoms themselves including issues with romantic relationships, father's incarceration, sexual abuse, and bullying. Additionally, familial, and domestic issues in the participants' homes, school-related stressors, and issues with peer relationships also caused their depressive symptoms identified by the participants.

During the onset of the depressive symptoms, a majority of the participants described not being able to fully identify the oncoming feelings associated with depression. Six participants stated that they had begun to notice that they were not feeling like themselves but were not able to adequately describe what they were feeling. Moreover, when they were able to begin to identify some of their feelings, they reported difficulty with classifying those feelings as depression. For example, one of the participants, a 15-year-old sophomore stated,

> "It was like last year I was kind of feeling sad and had a lot going on but didn't really know that it was like depression or anything. You know how sometimes you just have a bad day, so I didn't think I needed to tell anybody… Like I just felt weird and stuff but eventually I just kept feeling off and then my teacher told me she was worried about me and stuff."

Research has shown that it is common for individuals to struggle with recognizing symptoms of depression during their onset (Aneshensel, 2013; Eberhart & Hammen, 2006). This is especially the case for adolescents as they are expected to experience persistent mood swings as a characteristic of adolescence (Rice et al., 2019; Thapar et al., 2012).

As the depressive symptoms progressed the participants reported a greater level of disturbance. Two of them reported having trouble sleeping. Four others described isolating themselves and wanting to avoid being around others to the point that they would often go truant from school. A shared experience by a majority of the participants was experiencing these symptoms alone and not opening up to others about the looming feelings. No participant reported opening up to anyone during the onset of depressive symptoms. All of them attempted to address their depressive symptoms on their own. One of the participants a 16-year-old sophomore stated,

> "I never really thought I be going through these feelings. Like I knew, something was kind of off but I didn't really want to admit it because it made me feel weird. But I mean after a while you have to get it out you know what I mean, it gets to be too much."

Only two participants reported that they reached out to friends before attempting to address the symptoms on their own. However, after talking with a friend about the early signs of their depressive symptoms both of them attempted to manage the depressive symptoms independently.

Self-reliance

Managing their depressive symptoms on their own was an important aspect of independence for the participants. I asked one of the participants, a 17-year-old senior why he didn't want anyone to help when he first started having the depressive feelings that he described. He responded, *"Handling things on my own makes it a whole lot easier, I've learned to work by myself, it's a one-man job you know, I take care of myself".* Another participant, a 14-year-old freshman when asked the same question stated, "*I feel like I could ask someone for help, but I probably wouldn't, I would try and*

to do things on my own at least at first". The boys' preference to rely on themselves to address their mental health needs was deeply entrenched with their perceptions of independence as a characteristic of manhood. The participants repeatedly stated that it was their responsibility and an expectation to get better on their own. This finding is substantiated in several lines of research on Black boys' help-seeking. Previous studies have reported that Black boys often associate addressing their mental health needs on their own, with what they believe is expected of them as "men" (A. M. Breland-Noble et al., 2010; Lindsey & Marcell, 2012; Mincey et al., 2014).

Avoidance Coping

At this stage, in attempting to address the depressive symptoms the participants relied on multiple coping behaviors that they felt gave them the ability to manage their depressive symptoms on their own. All the participants described coping behaviors that provided them with relief, albeit temporary, from the depressive symptoms. The most common coping behaviors included smoking marijuana, listening, and making music, playing video games, physical activity [i.e., sports and exercise], and sleeping. Previous studies have identified such coping behaviors as avoidance coping (Herman-Stabl et al., 1995). Avoidance coping behaviors are those that avoid seeking solutions for psychological distress, instead focusing on regulating emotion often leading to withdrawing from potential social support in hopes of individually addressing symptoms rather than causes (Chao, 2011; Herman-Stabl et al., 1995; Horwitz et al., 2011). Though avoidance coping can provide some sense of relief from psychological stress it fails to address the root cause of the distress and therefore only provides temporary relief. Additionally, a key aspect of avoidance coping behaviors is that most of them can

be done in isolation and consist of problematic behaviors such as substance abuse, isolation, and physical aggression. This is demonstrated by some of the participants' chosen coping behaviors. For example, three of the boys stated that they would smoke marijuana when they were experiencing depressive symptoms. For these boys, smoking marijuana was not a deviant act, rather a necessary behavior to independently address their depressive symptoms. However, the boys recognized that being caught smoking marijuana could lead them to get into significant trouble.

On the other hand, some coping strategies consisted of a more positive approach where participants took part in behaviors that are socially acceptable and often expected of boys such as exercising and playing video games, Additionally, two of the participants discussed coping strategies that are often associated with cultural norms (see Adjapong & Levy, 2020). One of the participants reported writing music and rapping as a strategy that helped him cope with his depressive symptoms. He stated, *"I'm a rapper, so I'd go to the studio a lot. So, I be basically venting on beats. I like going in there and being alone, I like being by myself."* Such coping behaviors for the participants provided relief and did not threaten their desire for independence, and therefore were preferred coping options.

Though the different coping behaviors have different implications, they shared the common trait of being done independently. Ten of the participants specifically stated that they preferred to be alone when coping with their depressive symptoms. Furthermore, they described their coping behaviors as attempts to detach from their depressive symptoms and to feel as if they were back in control of their emotions. One

of the participants a 16-year-old junior indicated that his coping behaviors were about feeling balanced and regulated. He stated,

> "I just figured out that rapping and sometimes smoking [marijuana] is like a path for me to just like balance everything out. Like I feel evened out you know, that's what I be trying to get, like to keep myself calm and balanced."

Though participants often described their coping behaviors in a positive light, as helping them overcome the negative depressive symptoms, avoidance coping can have troubling long-term outcomes. Studies have reported that consequences of addressing mental health needs by avoiding the emotions are associated with long-term unaddressed mental distress (Herman-Stabl et al., 1995; Horwitz et al., 2011; Seiffge-Krenke & Klessinger, 2000). For males, this is a common issue in which they often struggle with unaddressed mental distress that leads to problems such as substance abuse, physical aggression, and high rates of suicide and suicidal ideations (McCusker & Galupo, 2011). As we see with the boys in this study, the use of marijuana to independently cope with depressive symptoms is a precursor to more long-term issues associated with avoidance coping such as substance abuse. Additionally, addressing feelings of vulnerability and negative emotions such as sadness with physicality is potentially harmful in that it reinforces problematic traditional masculine behaviors of being physical and aggressive when experiencing negative emotions. Furthermore, the growing rates of suicide among Black boys (Joe et al., 2018; Lindsey et al., 2019) is potentially associated with Black boys' avoidant coping behaviors and their preference for self-reliance to address depressive symptoms.

Crisis and Emotional vulnerability

Although the participants identified self-reliance and avoidance coping as their initial step in addressing their depressive symptoms, most that reported experiencing symptoms, stated that as symptoms continued to progress, they chose to move beyond independently coping and began to seek external support to help them manage their depressive symptoms. The act of externally seeking support most often came after the boys reached a crisis point in which their depressive symptoms became overwhelming, and participants acted in a way that is best defined as emotionally vulnerable. For example, one of the boys a 17-year-old senior discussed seeking support from his mother after experiencing what he described as a “mental breakdown”. He stated,

> “I would probably go to my mom, she always checks up on me and asks how I’m feeling. I finally went to her when for the first time in my life I went through a mental breakdown, I just started bawling my eyes out and we talked for like two hours.”

This participant’s response is similar to six other participants that describe moments of emotional vulnerability stemming from a feeling of overwhelming distress. Emotional vulnerability, in this case, was moments in which the participants acted in a way that externally expressed negative emotions such as feelings of sadness, hopelessness, and anger. The participants described moments in which they would cry, or have a physical, or verbal outburst. In these instances, the boys became acutely aware and acknowledged the severity of the depressive symptoms that they had often avoided or attempted to cope with on their own.

The emotional vulnerability was particularly challenging for participants, as guarded vulnerability is a trait of traditional masculine ideology that boys often ascribe to. Johnson et al. (2012) describes guarded vulnerability as a paradoxical frame that

adolescent males often adopt. They point out that men, while acknowledging that they are not coping well with depressive symptoms, simultaneously mask negative emotions, avoid seeking external support, and hide any real sense of need as a way of guarding any sense of emotional vulnerability. The participants in this study similarly felt that by asking for external support they were violating a basic principle of manhood which is independence. However, the progression of depressive symptoms led the participants to experience moments in which they struggled to balance their desire for physical independence with their need to be emotionally vulnerable. Emotional vulnerability acted as a junction point for many of the participants in their experiences with depressive symptoms. In these moments they often chose to seek external support. For instance, I asked one of the participants a 16-year-old junior what made him decide to talk with his teacher about his depressive symptoms. He stated,

> "I was just having a lot on my mind and got into my feelings, and I don't know. Like I even cried, I just got mad and felt like for real sad and bust out in tears. That's when I went to Ms. [name withheld] classroom and she let me sit in there and chill. I talked to her and later I talked to my sister about it. Sometimes you just got to get stuff out."

Random bouts of crying were the most common act of emotional vulnerability that the participants described. Three boys specifically described crying and feeling overwhelmed after attempting to address their depressive symptoms on their own. After each act of crying the participants next described choosing to seek external support to help manage their depressive symptoms.

However, although crying was the most common expression of emotional vulnerability, participants also described physical and verbal outbursts of anger, as well

as other psychosomatic symptoms of depression such as headaches and nausea associated with emotional vulnerability. The different ways that the boys experienced their moments of vulnerability have different implications that many of them were acutely aware of. For example, one of the participants discussed his concern that if he was not able to better manage his depressive symptoms that he would have a physical outburst that would get him in trouble. He stated,

> "I be getting mad sometimes and I know when I feel like I am going to lose control you know. Like those feelings sometimes can be like too much and I don't want to be breaking stuff or getting into fights because then I'm just going to get into more trouble so when I feel like that, I try to find a way to calm myself down and if I can't I'll probably go talk to somebody."

This participant's awareness of the effects that an outward expression of anger could have, led him to attempt to better regulate his feelings and emotions. At this point, this participant is forced to decide to either continue in attempting to manage his depressive symptoms on his own or seek external support. Even boys that did not describe experiencing a physical moment of emotional vulnerability often described feeling that they were in crisis which led them to external help-seeking. For example, participants reported experiencing suicidal ideations and desires to hurt themselves and others as moments when they decided to seek out support to help manage their depressive symptoms.

Although verbal and physical aggression as an emotional response may be socially acceptable behavior for males that adhere to traditional masculine ideologies, surprisingly the boys spoke about these outbursts shamefully while describing their crying outbursts with pride. Such descriptions speak to potential nuances of masculinity

that the boys are retaining. Studies on positive masculinity have found that while adolescent boys still adhere to some problematic traits of traditional masculine ideologies they also have adopted some positive masculine traits such as being open to greater emotional expression in spaces where they feel supported (Lomas, 2013; Roberts-Douglass & Curtis-Boles, 2013). Furthermore, studies have suggested that when boys feel emotionally supported, they are more likely to openly express negative emotions such as sadness and hurt. This is exhibited by one of the boys' responses when I asked him, "what made you feel comfortable enough to cry?" He responded,

> "I had people around me that cared about me, it was basically that. They [school teacher] was basically telling me if I needed to let it out, let it out. I think it's okay for a man to cry sometimes, I needed to get it out."

Additionally, this stage of crisis and subsequent emotional vulnerability led many of the participants to move beyond their desire for physical independence. At this point, independent decision-making became more significant than physical independence due to the growing severity of the participants' depressive symptoms. Their increased need for help led them to seek support that they felt would help them manage their depressive symptoms while also allowing them to maintain independence in their decision-making.

Informal Support

In seeking external support to help the participants address their depressive symptoms and continue to maintain independent decision-making, participants described a strong preference for informal support from those in their social network. Participants in the current study receive both direct support as well as informal referrals

to seek formal support. In this section, I will discuss the participants' use of informal supports including, family, peers, teachers, and community outreach staff, and the factors that the participants identify as being important to them when seeking informal support.

Accessing Informal Supports

Accessing support from those within their informal network played an important role for the participants in addressing their depressive symptoms. The participants spent a majority of their experience with depressive symptoms navigating back and forth between attempting to address their depressive symptoms on their own and utilizing informal support. The use of informal supports provided the participants with a high sense of independence in their decision-making when addressing their depressive symptoms. Participants were able to choose who they went to for support, how much information they provided to others about their needs, and could also choose to opt-out of using these external supports at any time. This high level of physical independence and independent decision-making made the use of informal supports a significant preference for the participants when they felt the need to seek external support. Furthermore, the boys were able to seek support from individuals that they trusted and with who they had established relationships.

The participants described accessing support from their informal network in two ways. First, they chose to seek support on their own in hopes of being able to better address their depressive symptoms. Second someone from their social network recognized their need and offered them support to address their depressive symptoms. Several of the participants reported that they had been approached by family, peers,

and school staff that were concerned about their behavior. However, all of the participants that reported utilizing informal resources emphasized that they only did so when they sought the support of their own accord. Deciding to seek support independently was an important part of accepting external support. In addition, when I asked the participants, *"When you feel like you can't handle things going on in your life do you ever want someone to ask you what is wrong?"* All except one of them responded "no". Most responded, that if they felt they needed help that they would seek it on their own. Moreover, several of the participants highlighted that they would feel "annoyed" if someone insisted something was wrong when they felt there was not, or they felt it was something they could manage on their independently.

Family and Peers

Participants largely relied on family and peers for mental health support when seeking support beyond themselves. They reported a preference for receiving support from their close family and peers over any other mental health resource, both formal and informal. Using a criterion of trust and familiarity, the participants established small networks of close family and peers from their larger social networks. The smaller established network provided them a sense of comfort while not infringing on their desire for independence. Participants described their small network as being inclusive of close family and peers that they felt they could trust, and that they could relate to. In their descriptions, they emphasized that openness and autonomy were important factors in these relationships. For instance, I asked one of the participants, a 15-year-old sophomore, whether he would talk to his school counselor when he felt sad. He responded,

> “I feel like family knows you better than going to a school counselor or something like that. Somebody you know and somebody you look up to and trust. That’s somebody who I’d listen to and talk to. Like I know my family, I don’t know them [school counselor] and I can go to my family whenever I want or feel like I really need to.”

Participants also reported that the people they were most comfortable seeking mental health support from were individuals that provided them time and space to be open in their own way and on their own terms. When the same participant from above was asked who he would go to for help first, he responded;

> “I'd really just say my mom or maybe my dad. I just feel like she [mom] probably just, she'd give more... how do I put this? I feel like she'd give more advice on it [feeling depressed] to be honest. But she let me talk about what I’m feeling my way, you know she just let me talk and say what I need to say”

Another participant, an 18-year-old, responded to the same question,

> “Sometimes I go to my little sister. She helps me out with certain things when I’m stressed or dealing with a lot. But mostly my mom because she knows more, and she actually knows what I go through. They both know how I deal with stuff so I can talk to them about things the way I feel is best to talk about it.”

Though mothers and siblings were the most common initial choices for support in addressing depressive symptoms, the participants also described seeking support from fathers, brothers, uncles, and grandparents. One of the participants identified his father as a first choice. This participant described his father as being open, understanding, and supportive of him expressing his feelings. This participant stated,

> “I would first go to my dad probably. I know he's very open. I know that I can go talk to him about something, pretty much anything. He might be disappointed in

> me if I tell him maybe I did something wrong. But I know I can go and talk to him about it and he'll be disappointed in me maybe, but he'll still help me deal with whatever's happening. I've pretty much talked to him about everything, and there wasn't a time where I'd ask him a question or tell him something that's going on my life where he was like, "Oh no, you can't talk about that." He's always been open to having a conversation and helping me with stuff."

In his description, this participant confirms the importance of being open and a sense of autonomy provided by his father, as part of the reason he feels comfortable in seeking support from him.

Additionally, participants emphasized the importance of having a trusting relationship with family and peers they sought support from. They regularly reassessed the level of trust that they had with individuals within their social network. This was particularly important for participants when they sought support from peers. They often similarly spoke about family and peers in regards to seeking informal support, but emphasized the importance of assessing how much they could trust non-familial peers with their "personal business". For example, I asked one of the participants "what is it about talking to a friend that you feel is better than talking with the counselor?" He responded,

> "Like you look for somebody you can trust. Like I got friends that are like family like I can trust them 100 percent. I got others that are cool, but I wouldn't really go to them with too much personal stuff. But the friends that are like my family they always there and I know they won't tell no one what we talk about. I don't think you can get that [trust] from like a counselor or a therapist…"

In this participant's description, he speaks to the importance of privacy as an aspect of trust, which he is assessing before choosing to share his depressive symptoms with his

peers. Therefore, although family and peers are often discussed together by the participants, there appears to be a difference in what they feel they can share with peers and what they can share with family.

This difference became more apparent when several of the participants described what they had shared with family members versus what they shared with friends. Nine of the fifteen participants in the study reported they would seek support from a family member first. These participants described sharing overwhelming feelings and emotions with family members and sought emotional support. For example, one of the participants, a 14-year-old freshman stated,

> "I told my mom that I was angry, I was feeling weird you know. Like I was at a point where I felt like I was going to just break down. I started crying and she was there to listen to how I was feeling."

This participant's response was similar to the descriptions of the others of expressing their feelings to their family members.

On the other hand, participants that sought support from peers described explaining to them the situations that led to depressive symptoms while avoiding revealing their feelings, especially negative feelings such as sadness. For example, when discussing the importance of getting support from his close friends one of the participants stated,

> "Like I can talk to him [friend] about anything for real. Like we got similar experiences. So when I'm having a hard time I'll call him and we can talk about the situation he helps me think about it in a different way or you know can just relate to what I'm dealing with.

As a follow up to this statement I asked, *"You mentioned, you talked with him about the situation, did you tell him how you were feeling about it?"* he responded,

> "… Kind of, like I don't really tell him if I was crying or something, but I mean I think he gets it because we got a lot of similar experiences. But I'll tell him what happened and like he knows if I was mad and stuff, but I don't really tell him if I was like getting too emotional about stuff.

This participant's response characterizes the way that participants restricted how much information they shared with others. It was a common practice for participants to limit how much information they would willingly provide to others about their experiences with depressive symptoms and how severe the symptoms had become. The participants most often shared their feelings and emotions with family while not discussing the causes of the feelings in-depth. In contrast, many of the participants described often sharing their experiences with peers while avoiding discussing many of the negative feelings associated with the experiences.

Previous studies that have examined Black boys' mental health help-seeking behaviors and service utilization have similarly found that Black boys prefer to utilize family and peers for mental health support over formal mental health resources (Ali et al., 2019; Hassett et al., 2018; Lindsey et al., 2013, 2017). However, few studies have provided insight into the reasons the boys prefer support from family and peers and how the two groups differ regarding providing support. For example, Lindsey et al. (2010) found that Black boys' in their study preferred to seek support from family members, primarily mothers when they were experiencing depressive symptoms, and identified trust as a key reason. However, limited understanding, beyond that of trust, is provided about the boys' preferences to receive mental health support from family. In the current

study, the participants describe the family as providing emotional support while peers provided a sense of relatability and validation. Furthermore, while trust has an important role in the boys' preference for family and peers for mental health support, the ability to independently make decisions regarding external mental health support is a substantial factor that contributes to the participants' preferences for family and peers for support. The participants can control how much information they provide, choose who they want to receive support from, and end their use of external support when they would like.

Additionally, studies have identified that differences in race/ethnicity and cultural norms can impact the way adolescents' desire for independence affects their behaviors related to mental health and emotional support. Specifically, studies have found that some adolescents such as those of native indigenous groups are more likely to increase their physical dependence on their families as they advance into later adolescence (Cauce et al., 2002b), while others such as White American adolescents are more likely to decrease their physical dependence from their families (Geuzaine et al., 2000). Studies of Black masculinity have reported that connection to family and community is a unique aspect of Black manhood and therefore could lead Black males, especially young boys developing into men, to physically rely on their families and community more when experiencing mental health challenges while attempting to maintain their independent decision-making by controlling the decision of who to seek support from.

Role of teachers and intermediary supports

In addition to peers and family, the participants also described seeking support from members of their school staff, as well as a community outreach employee. Pescosolido and Boyer (1999, 2010) indicate that these members of the human/social

service system are in an interesting position. Although they are not considered formal mental health resources; however, they have a significant, if not direct link, to formal services and so are key figures in guiding adolescents into formal mental health resources. In this study, I refer to these individuals as intermediate informal support due to their distinctive position between formal and informal supports. These individuals were especially important for participants that reported having weak familial ties. Five participants reported receiving support from intermediate informal support, a teacher being the most common. Four of the participants discussed seeking mental health support from a teacher they were close with and two reported receiving mental health supports from a community outreach coordinator at a local community center. One of the participants reported support from both a teacher and the community coordinator. Of these five participants, four of them also described contentious relationships in their homes and broken familial ties. Establishing strong relationships with a teacher or a community coordinator seemed to fill the void in mental health and emotional support that the boys desired. For example, one of the participants an 18-year-old senior stated,

> "I'll talk with my mom sometimes, but we don't always get along. We don't have the best relationship and I don't really got no one else to talk to. Like I don't really got close friends, feel me. So I'll talk to Ms. [name withheld; teacher] sometimes or I'll talk to Ms. [name withheld; coordinator at community center]. They are coo and they got my back usually."

Additionally, I asked another participant "who would you go to if you felt overwhelmed or couldn't handle things going on in your life". He responded,

> "I don't know… I don't really got a good relationship with my dad and my mom she work a lot so I don't really want to bother her with stuff. So I'd probably talk to

> Ms. [name withheld; teacher]... Like I'll go in her class sometimes and just sit and chill and she lets me talk to her you know if I want to talk or if I need to talk."

The participants that sought support from these intermediate resources described being open about their feelings like the way other participants described relying on their families for support; often sharing their feelings and seeking emotional support. However, similar to the way that the participants described their relationship with peers, these participants described consistently assessing their level of trust with the intermediate support. For example, one of the participants that reported going to a teacher when experiencing depressive symptoms stated,

> "She's cool, like I can talk to her sometimes but sometimes she acts a little funny and I don't know man like I can talk to her but sometimes… like you know how sometimes you can trust someone but then other times you can't. Like she just not one of those people I think is 100 percent [trustworthy] all the time. But she's cool to talk to most the time."

I followed up this statement with the question "what do you feel like you can talk to her about" and he responded,

> "Like I talk more about what I am feeling at the time, like if I'm mad or sad I'll tell her, and she tries to help me feel better… I don't tell her too much of the stuff that's going on in my personal life but at least I have someone I can talk to when I am having a hard time you know."

The role of teachers, school staff, and community members in providing support for adolescent mental health has been well documented in previous literature (Baroni et al., 2020; Ijadi-Maghsoodi et al., 2018; Lagana-Riordan et al., 2011). Studies such as that of Shelemy, Harvey, and Waite (2019) have found that teachers play a key role in addressing students' mental health, especially for those with strained familial

relationships. Students can often establish strong relationships with teachers and are more inclined to be open with them when seeking support for mental health challenges. Similar relationships have been documented with community center staff and others that engage with youth in their schools and communities regularly (Mahoney & Stattin, 2000). Specifically related to Black adolescents' studies have found that spaces that allow for candid conversations about race and are culturally responsive such as community centers (see Gay, 2002) tend to attract Black adolescents that are experiencing mental health challenges. These spaces and their staff can often bridge the gap for students with a lack of familial support (Brown & Grumet, 2009; Chen et al., 2014). However, few studies have thoroughly examined these relationships with Black boys. Though students can establish strong emotion-based relationships with teachers and other intermediate supports there also can be concerns from students about the positionality of these individuals as agents of their school or community center (Rios, 2009, 2011). This could explain why though the participants described these individuals as being emotional supports they also felt they had to assess their level of trust with them. Two cases uniquely spoke about having a high level of trust in a particular teacher. However, in these cases, a high level of trust had been established over a long period and after a tremendous amount of emotional support had been provided by this teacher.

The participants in this study described the importance of family, peers, teachers, and community staff in aiding them in addressing their depressive symptoms. Each of these actors in the participants' network has a distinctive role that the participants describe in supporting them when experiencing depressive symptoms. Family members

and teachers play a key role in providing emotional support, while peers provided the understanding and relatability that participants desired. The role of masculinity and stigma seems to also impact these relationships. Research on adolescent males and masculinity report that stigma often impacts their help-seeking behaviors, leading to them restricting the amount of information they share with others regarding depressive symptoms, especially the negative feelings associated with them (Addis, 2008; Englar-Carlson, 2007). The participants in the current study, while being open about their feelings with family members and teachers, described avoiding emotion-based language with peers. This is likely associated with perceived stigma in which a person expects to experience mistreatment due to their belief that others hold stigmatized views of mental illness (Link & Phelan, 2001); this is especially salient for males. Studies have reported that boys' fear that they will be viewed as non-masculine leads them to cloak negative emotions in the presence of others (Vogel et al., 2007, 2011). However, several lines of evidence have found that family can provide support for adolescents that helps them overcome perceived stigma as well as self-stigma (Fallon & Bowles, 2001; Lindsey et al., 2010; Moses, 2010).

The emotional support that Black boys seek from teachers could be leveraged in developing toolkits that provide specific training and resources to teachers to aid them in being a go-to resource for Black boys experiencing depressive symptoms. Furthermore, the findings show that Black boys while having specific roles for family, peers, and teachers can receive similar support and therefore I find it important to consider ways in which these groups can be integrated to provide mental health support to Black boys.

Although participants described a strong preference for addressing their depressive symptoms independently or with aid from informal supports, and despite many negative views of formal mental health supports, as their depressive symptoms grew in severity several participants described utilizing formal mental health resources as a last resort.

Formal Mental Health Support and Independent Decision Making

In this section, I discuss the participants' use of formal mental health supports and the pathways that led them to these supports. I found that the pathways described by the participants and whether or not they felt they were able to make an independent decision in utilizing the formal supports were connected with their reported experiences, preferences, and perceptions of formal supports. The participants only turned to these supports as a last resort. Ten participants reported using formal mental health support, the most common was a school social worker and counselor. Six participants reported going to a counselor or social worker in their school. Additionally, two utilized a mental health support group at a local community center, facilitated by a mental health specialist. One participant utilized a counselor at the same community center, and one participant reported that he had contacted the national suicide hotline for support with suicidal ideations.

Pathways to Formal Support

The participants that utilized formal mental health supports did so via three pathways. They (1) chose to seek support from a formal resource because they felt they were in crisis, (2) a person or persons from the participants' support network recognized the severity of their need and guided them by recommending they seek formal support,

or (3) they were mandated to formal support due to a behavioral issue. When speaking about their preferences for support to address their depressive symptoms, most of the participants in this study reported that they preferred not to use formal mental health supports. Overall, when referring to their utilization, the participants described a negative view of these types of supports. They stated that they felt counselors and social workers could not be trusted, they could not relate to them, and that they preferred to receive support from trusted family or peers. However, ten of the fifteen participants in this study reported that they utilized a formal mental health resource for mental health and emotional support at least once.

Pathway: Choice

Choice consisted of participants that sought support for their depressive symptoms on their own. Each participant that chose to seek formal support reported doing so after experiencing a mental health crisis associated with their depressive symptoms. This was the case for three of the participants in the study. A unique case was from one participant that reported experiencing suicidal ideations and chose to seek support from the national suicide hotline instead of seeking support from the support that he was familiar with. Though this participant's choice was different than others, it still maintains the importance of making an independent personal choice of how and when to seek mental health support. The other two participants sought help from a school counselor after describing a mental health crisis that triggered moments of emotional vulnerability. During these crises, the participants felt the informal supports no longer provided what they needed, and therefore chose to seek support from a counselor in their school. In these instances, the participants described themselves as

assessing their needs and making an independent choice about seeking formal support. One of the participants that pursued support from their school counselor stated,

> "I was like at a breaking point. I talked to my mom about it but she didn't really know what to say. So, I just went and knocked on her door [school counselor] and asked if I could talk to her... it was cool, I felt a little better after talking to her."

When I asked what it was that made him feel like he could go to his counselor, the participant responded,

> "I mean I know they're [counselors] here and I remember her talking to our class once about mental health and stuff. She's cool too like I've seen her talk to other students, and I mean I was really at that point where I was like going to lose it, so I figured maybe she could help me, and I decided to go."

Similarly, the other participant that chose to seek support from his school counselor stated that he was familiar with the counselor from witnessing their interactions with other students. Recognizing their school counselors from previous interactions aided in the participants assessing their counselors to be safe support to utilize, speaking to the importance of familiarity for the participants when considering formal support. Moreover, the severity of depressive symptoms persuaded the participants to seek formal support. This speaks to the impact that the pervasive experience of depression and depressive symptoms can have given that in these moments of crisis the participants gave less thought to their sense of comfort and independence that they receive from informal supports, in hopes of receiving the support needed to overcome or manage the depressive symptoms.

Although some aspects of physical independence were sacrificed in the use of formal supports, independent decision-making was maintained by this pathway. Participants that chose to seek formal support reported feeling proud of their decision and described actively participating in the care they were receiving. For example, the participant that contacted the national suicide hotline stated,

> "I called them because I didn't really know what else to do and I wanted help... I talked to the guy on the phone [crisis counselor] for a while, he was really helpful, and I just listened to him, well he listened to me first, but we talked back and forth and he was really helpful. I still have some days where I have a hard time, but I don't think I would ever take my life for real… If I felt like I would call them again."

However, though these participants described their pathway as an independent choice to seek formal support, in their descriptions they also identified the role of previous interactions with the counselors that made them feel comfortable enough to seek their support. Previous social interactions rather direct or indirect played an important role in these participants' choices, even when participants reported making the choice independently.

Pathway: Guided

Being guided to formal mental health support came by way of recommendation to seek formal support from a trusted member of the participants' informal support network. Five of the ten participants that utilized a formal mental health resource reported that someone within their informal support network identified changes in their behaviors that caused concern about the participants' well-being. This concern often led to a recommendation to seek formal support. For example, I asked a participant, "what led you to talk with the school counselor", he responded,

> “Ms. [name withheld; teacher] was concerned about me. I had talked to her before because I wasn’t feeling like myself and she let me talk it out. But I still was like coming to school, head was down all the time, always had my headphones in. I wasn't talking. It was like I just wasn't acting myself; I wasn't being normal. So, she one day just said I should go talk to the counselor… so I went.

The guidance to formal mental health support reported by participants came from family, friends, or teachers that recognized the participants' need for formal mental health intervention and recommended the participants seek formal support. The participants only accepted the recommendation from people they had previously sought mental health support from and therefore someone they trusted and were comfortable with. Another participant stated that he met with a therapist at a local community center after it was recommended by his mom. He stated,

> “I tried to once for my mom. She was concerned because I guess I was acting weird. Her and I had talked before when I was going through stuff, but I guess she thought I needed more help. I just went one day, I chopped it up with them…I went because I know my mom wants the best for me and she really only wants to help me”

This participant’s response speaks to the importance of receiving a recommendation from a trusted person, while also allowing participants to make independent decisions regarding utilizing formal supports.

Guided pathways overlap with the choice pathway in that the boys still made the choice to utilize formal support, but after someone, they trusted advised them to do so. Therefore, independent decision-making was still maintained in this pathway. Providing the participants with guidance while securing their independent decision-making led to

similar responses about their experience as the participants that chose to seek formal support on their own. For example, the same participant that sought support from the therapist at the community center, under recommendation from his mom stated,

> "I didn't really want to go at first, because I don't really like talking, I like keeping everything to myself, but I went because my mom asked me to. It was cool though. It was something new that I tried, and we talked for a minute, and I was able to kind of get out things that were bothering me.

I asked the follow-up question, "What would you say to a Black boy about therapy?" he responded*, "I think Black boys should try therapy, it can be a new experience for them, don't pressure them to, but it was a cool little experience for me."*

Pathway: Mandate

The third pathway through which participants came to utilize formal mental health support was by mandate due to behavioral issues. Two of the participants described being required by their school to meet with a school counselor for this reason. One of the participants skipped school several times and was required to meet with a school counselor to address his truancy and issues that he was having in his home. The second participant was required to meet with the school counselor after getting into a fight. Both these participants stated that they faced suspension and possibly expulsion if they refused to meet. They described their interactions with the counselors as forced. Because they felt forced into the formal support they chose to participate as little as possible. Furthermore, these participants reported more negative views of their interactions with the formal supports. For example, the participant that was mandated due to fighting stated,

> "I had to meet with her [school counselor] because I got into a fight, and they were going to kick me out of school… She was making me mad though like she kept telling me I was always angry and everything, and I'm just thinking like lady you don't know nothing about me, I'm not angry… I don't think she really understood me… I didn't really talk I prefer to deal with stuff on my own but just that one day I kind of exploded."

Additionally, the participant that was required to meet with a school counselor due to truancy stated,

> "I had to meet with her twice and then they decide if we have to meet again, I guess depending on how the other two meetings go. I mean I don't really say anything when I'm in her office, I don't really want to cause I didn't want to be there in the first place... Like I'm not about to talk to you just because you making me sit here, that's how I felt about it… I probably talked just enough to not have to do another meeting."

Being mandated to use formal mental health support led the participants to feel that their independence was being violated and therefore resulted in greater reluctance to participate, as well as negative views of the formal resources. Studies by Cauce et al. (2002a) and Pescosolido et al. (1998) reported similar findings for participants that were forced into formal mental services in their study. Pescosolido states "the chord running through all accounts of coercion [forced service use] is active resistance to using services" (Pescosolido et al., 1998, p. 280).

Discussion of Formal Supports

Previous research of formal mental health resource utilization has reported similar pathways into mental health resources as this current study. Pescosolido, Gardner, and Lubell (1998) identified three pathways in which individuals came into

contact with formal mental health services, choice, coercion, and muddling. In their description choice happened in two ways, a person made an “individual choice” in which they independently decided to seek support from formal mental health service, and “supported choice” in which a person independently seeks formal support after their need is recognized by others. Furthermore, Cauce et al. (2002a) identify coercive pathways and voluntary pathways for youth that often lead them into formal mental health resources. In both these studies, coercion is described as ordered treatment and care such as legal or court-mandated mental health treatment. These studies among others (Espinosa et al., 2013; MacDonald et al., 2018; Morgan et al., 2004) have identified that particular pathways to formal mental health resource use have profound effects on an individual's experiences with receiving support and their subsequent views of the resource they use.

Coercive pathways are often found to be associated with negative experiences in formal mental health care and lead to greater avoidance by participants. Those that make independent choices, even when those choices are guided by others are more likely to report a favorable view of the service and actively participate in their treatment. This is reflected by the participants in the current study. Participants that were mandated to interact with formal mental health supports held a more negative view of their interactions with these formal supports. Participants that made their choice independently reported more positive experiences and were likely to recommend the resource to other Black boys. This is particularly important when considering the high rates of Black participants experiencing punishment in their schools for behaviors associated with mental health challenges (Bosk, 2013; Ramey, 2015; Rios, 2006).

School counselors when perceived as an agent of discipline rather than mental health support could be associated with Black boys' negative views of the formal mental health resources in their schools. For example, Bosk (2013) finds that there are often competing paradigms of “badness” and “sickness” in school mental health resources in which the resources can act in a healing manner, or a disciplinary manner based on the context in which a student enters the resource. If a significant pathway into formal mental health resources for Black boys is through mandate then the likelihood of these boys participating and using formal mental health resources by choice in the future becomes put in jeopardy.

Guided pathways into formal mental health support uniquely allowed for intervening with participants that were showing troubling behaviors while also allowing them freedom in their decision-making. Participants held a strong preference to rely on informal supports when experiencing depressive symptoms due to a desire for physical independence and independent decision-making. Furthermore, the participants had a high level of trust and comfort with their informal supports. The trust and comfort that they have with these informal supports seemed to play a role in the participants accepting their guidance into formal mental health resources. Stiffman, Pescosolido, and Cabassa (2004) refer to those that guide adolescents into formal services as gateway providers and state that these individuals in an adolescent’s informal network are key figures in guiding them into formal resources, as well as positively framing these resources. A key characteristic of a gateway provider is that they have a strong enough relationship established with the person they are guiding or hold enough social influence that their perspective positively impacts the other's view of formal services. Additionally,

the gateway provider's influence can help address issues with stigma related to mental health and mental health resources. Participants in the current study that reported receiving guidance into formal mental health resources only accepted the guidance of those they had previously sought support from. This illustrates that the relationship between the participants and their informal support network is an important relationship that can be utilized to guide Black boys into formal support without making them feel forced. Furthermore, it illustrates the role that social interactions with key members of the participants' social network have on influencing the participants' help-seeking decisions.

Participants reported that their families were often the individuals that encouraged their formal resource use. Previous studies have found that families play an important role in deterring or encouraging Black adolescents' use of formal mental health resources (A. Breland-Noble et al., 2006; Lindsey et al., 2010; Lindsey & Marcell, 2012). However, in this study, there were no reports of family or peers directly discouraging the participants from utilizing formal resources. In fact, family, parents, in particular, encouraged formal mental health resource use and were instrumental in getting the participants to seek formal support. Stiffman et al. (2004) argue that gateway providers are key in helping adolescents overcome stigma when seeking mental health support. Similarly, Lindsey et al (2010) similarly reported that families can positively mediate the relationship between stigma and formal mental health resource use for Black boys because of the comfort and trust they provide. Findings from the current study build on these arguments and find that families and others in the informal support network can provide guidance that allows Black boys to overcome their negative views

of formal mental health resources, especially when they are reaching a point of crisis and require formal intervention.

Overall Discussion

In this study, I explored the help-seeking process of a group of Black boys between the ages of 13 and 18 years old enrolled in several high schools in Southeastern Michigan. The goal in exploring this process was to identify who the boys talk to and confide in about their mental health needs, key factors that the boys identified as being important to them when seeking help for depressive symptoms, and which resources the boy prefer to use when seeking help for depressive symptoms.

Participants in this study transition through three stages in their help-seeking process; self-reliance in which they took part in multiple avoidance coping behaviors such as substance use, playing video games, and exercising; using informal resources where they relied significantly on family members and close peers, as well as teachers, and staff at their local community center for mental health support; and the use of formal resources which often was the last resort for participants and included seeking support from school social workers, counselors, and community therapists. Each stage of the help-seeking process was triggered by what participants described as a mental health crisis that often led to acts of emotional vulnerability such as bouts of crying, angry outbursts, as well as suicidal ideation, and self-harm. Throughout the participants' help-seeking process their desire for both physical independence and independent decision-making was embedded in each help-seeking decision. Participants looked to address their depressive symptoms independently and where they could not maintain physical

independence, they looked to maintain independence in their decision-making related to seeking support for their depressive symptoms.

Findings from this study build on previous literature that views help-seeking as a dynamic interaction between social interactions and cognitive decision-making as part of a larger complex social process. Participants made independent cognitive decisions that were influenced by their interactions within their social networks. Furthermore, the participants describe making key decisions at critical points in their experience with depressive symptoms. An important aspect of identifying help-seeking as a social process calls for an understanding of mental illness as a social experience, or what medical sociologists have described as an illness career. Strauss (1992) and Karp (1994) point out that pivotal decisions related to help-seeking throughout an illness career are marked by “critical turning points”. These critical turning points are changes or transformations in identity in which a person steps outside of their norm due to growing levels in the severity of the illness. In this case, the boys go through several critical stages in their experiences with depressive symptoms that cause them to separate from their initial goal of independence and actively seek, and in most cases, accept external support.

The crisis points and subsequent moments of vulnerability that led to, bouts of crying, angry outburst, suicidal ideation, and desires to harm themselves or others, acted as critical points through the help-seeking process, in which the boys made crucial decisions about seeking help. These acted as key moments throughout participants' experiences with depressive symptoms in which their help-seeking behaviors transitioned into a greater acceptance of external support, beginning with

informal support, and eventually leading to formal forms of support. These findings are supported by previous studies of Black boys' help-seeking behaviors. Lindsey and Marcell (2012) in a study of Black males' help-seeking behaviors identify what they refer to as "tipping points" that led to external help-seeking by the participants to avoid a "greater crisis". Scott and Davis (2006) in a study of young Black males' help-seeking, reported that participants in their study would choose to seek professional help, even with negative views of professional help, if they felt they were experiencing an "emotional crisis". Though these previous studies identify these critical points, they provide a limited view of the larger social process of help-seeking for Black males that are provided in the current study. Understanding the larger dynamic social process that Black boys maneuver through when attempting to address depressive symptoms is key in identifying where to intervene to best attract Black boys into services and better support their mental health needs.

Though Pescosolido's network episode model identifies social interaction and the social experiences of illness as key aspects of help-seeking as a social process, her model does not specifically examine stages throughout the help-seeking process. Furthermore, her model inadvertently describes the social process as linear without specifically speaking to the deviations and divergent behavior that individuals take in seeking mental health support. Findings from this study show that there are discernable stages in the help-seeking process and that an individual's movement through the stages changes based on multiple factors. Furthermore, I find that by integrating aspects of the ecological model with the network episode model, the stages and movement in the help-seeking process become more apparent.

An especially important finding from this study is the role that physical independence and independent decision-making have on the participants' help-seeking process. I discovered independence as a characteristic of masculinity and adolescence, was a key factor in the participants' help-seeking decisions. The desire for physical independence and independent decision-making led many of the participants away from relying on others for support, especially support from formal resources that they felt provided them with limited control and therefore limited independence. Additionally, the participants looked to have autonomy in their decision-making regarding how they addressed their depressive symptoms. This desire for independence led to many avoidant coping behaviors as well as, distrust of others that allowed the participants to reach critically severe levels of their depressive symptoms before they chose to seek help beyond themselves. Previous studies have similarly found that Black boys do not often access mental health services for depression until they've reached severe levels. For example, Stein et al. (2010) in their study of ethnic adolescent depression treatment found that Black boys demonstrated greater severity levels of depressive symptoms at entry into depression treatment. Though participants in the current study, during these crisis points, chose to seek external support, previous studies have reported that boys at these crisis points can often turn to troubling behaviors with detrimental outcomes such as suicide, or incarceration (Joe, 2006; Okonofua & Eberhardt, 2015). These crisis points are key periods to guide Black boys into resources that can help them adequately address their depressive symptoms safely and productively.

Participants in this study relied significantly on family, peers, and teachers for support in addressing their depressive symptoms. The reliance on others for mental

health support created an interesting juxtaposition in which the participants looked to maintain independence while also being physically dependent on others for mental health support. At these points, the divergence of physical independence and independent decision-making becomes most apparent. In maintaining their independent decision-making, participants cognitively evaluated their trust and familiarity with family members, peers, teachers, and others in their informal network to decide who they would seek support from and how much information they would share. In making these decisions we can see where social interactions and cognitive decision-making intersect in the participants' help-seeking process. Their perceptions of trust and familiarity are based on their continued interactions with those in their social network, which influences their decisions on who to seek support from and how much they should reveal.

Previous studies have demonstrated the important role of social interactions within a person's social network that influences their perceptions of mental health conditions and ultimately their help-seeking decisions (Lindsey et al., 2013; Link & Phelan, 2013). Particularly studies have found that family and peers can contribute to greater or less stigmatized views of mental health conditions and services and therefore influence cognitive decisions even when an individual believes they are making the decision independently (Murry et al., 2011b; Nobiling & Maykrantz, 2017). Pescosolido et al. (1998) found that even when participants in their study reported choosing to utilize formal mental health services independently, they often described their decision as being influenced by close family members and peers that they previously sought support from. Intriguingly, though studies report that family and peers can often deter adolescents from seeking formal support, participants in this study reported that their

family and peers often encouraged their use of formal mental health supports and acted as guides into these supports. This speaks to the important role that families play in Black boys' use of formal mental health resources. Families and peers can be leveraged in future interventions and programs that hope to specifically address the mental health needs of Black boys.

In accessing formal mental health supports three pathways were uncovered from the participants' descriptions, choice, guided, and mandated. Each pathway impacted the participants' experience with formal mental health supports and seemed to influence their perceptions of the available mental health resources in their schools. Choice and guided pathways allowed participants to maintain at the least some sense of independence in their help-seeking decision-making. However, the mandated pathway mimicked what previous studies have identified as coercion into formal mental health services (Cauce et al., 2002b; Pescosolido et al., 1998) which often leads to negative views of mental health services and resistance to service use. The act of resisting particular mental health services is associated with individuals attempting to maintain or redeem a sense of control and independence. Participants in this study described losing physical independence as their depressive symptoms progressed due to their need for greater support. In losing physical independence, participants sought to at least maintain independence in their decision-making. Though participants identified trust and familiarity as key factors in who they chose to seek help from, their desire for independence had a larger influence on their help-seeking decisions as well as on their views of the resources that they utilized. The act of forcing a participant to use formal services violated the participants' desire to make independent service-use decisions

and therefore lead to greater resistance and negative views of the resources. These findings are supported by previous studies in both health and mental health research that report patients often choose not to adhere to medical advice, not utilize formal health resources, or alter prescription regimens, as a way of testing the progression of an illness, destigmatizing an illness, and reclaiming a sense of independence that is lost from experiencing a particular illness (Conrad, 1985; Vermeire et al., 2001).

Conclusion and Implications

This study is novel given that few studies have examined Black boys' help-seeking and service utilization as a social process that involves social interactions and cognitive decision-making through multiple stages. Black boys' movement through stages in the help-seeking process is important to consider when attempting to attract them into services and provide them adequate mental health support. This is especially important given the growing rates of suicide and suicidal ideation among Black boys. This study is a step in addressing Cauce et al. (2002) call for greater research that specifically focuses on the "pathways and processes by which ethnic minority adolescents seek help for mental health problems" (Cauce et al., 2002b, p. 44). Several implications can be drawn from this work to inform future research and practice regarding Black boys' mental health needs and care.

First, this study brings together research on service utilization and help-seeking in understanding Black boys help-seeking decisions by emphasizing that formal service utilization is only one potential outcome of help-seeking. Studies have previously focused on help-seeking, or service utilization, or treated the two as interchangeable. By doing so, studies often fail to consider other forms of mental health support beyond

formal service use. This study finds that by exploring help-seeking as a social process and considering other forms of support such as the use of family, peers, teachers, and resources in the community a more thorough understanding of how Black boys address their needs regarding depressive symptoms can be identified. Future research would benefit from using a social interactionist approach in conducting an in-depth analysis of how alternate forms of mental health support are utilized by Black boys experiencing depressive symptoms, as well as other mental health challenges and conditions.

Furthermore, future studies on Black boys' help-seeking would benefit from a critical interactionist approach. Critical interactionism combines critical social theory and interactionism to address complex social problems using both an upstream and downstream approach (Martins & Burbank, 2011). The current study focuses on micro-level interactions and movements; however, studies have shown that Black boys' perceptions of mental health and mental health services are also the product of macro-level structures and inequalities. Focusing on their interactions while also considering the role of power and social inequalities is a logical next step in gaining an in-depth understanding of Black boys' help-seeking and subsequent service utilization (M. Burbank & Martins, 2019).

Second, this study provides a map of the participants' help-seeking process that can help guide mental health specialists, interventionists, and other key stakeholders in identifying strategic points to intervene and better attract Black boys experiencing depressive symptoms into services. For example, this study found that as the boys' depressive symptoms progressed, they often experienced a crisis that led them to be more open to accepting external support. Helping Black boys become more aware of

these crisis points and encouraging them to utilize available mental health supports in their schools and communities during those moments could improve their use during their most vulnerable times.

Furthermore, improving mental health resources to provide a greater sense of autonomy and independence to Black boys experiencing depressive symptoms would also potentially attract Black boys to utilize these resources. Overall, continuing to map the help-seeking process and conducting an in-depth analysis of Black boys' social networks will benefit in identifying crucial points for intervention. Participants identified teachers as playing an important role in providing emotional support when they were experiencing depressive symptoms. Expanding teachers' capacity to support students' mental health would significantly benefit Black boys that find comfort and support from their teachers. Schools can develop toolkits, provide resources, and training that would help teachers and other key school personnel in identifying Black boys' moments of vulnerability and stepping in to provide support or guide them into the necessary supports. As a policy implication, increased funding to schools from a federal and state policy level to provide such training and resources is needed and will be key to combat the rising rates of suicide and self-harm among Black boys.

This study also revealed the importance of families and peers in addressing Black boys' mental health. Expanding mental health resources that incorporate family, peers, and community is vital in guiding Black boys into available resources. A 2006 study by Livingston and Nahimana argued that structural and ecological factors that impact the mental health of Black children have not been adequately considered in mental health services. They argued that any service that wants to positively impact the

lives of Black children has to be connected to their families and communities to assure that their social context is thoroughly integrated (Livingston & Nahimana, 2006). Interventions such as the EcoFIT model use an ecological approach to provide care that is family-centered and integrates mental health resources in the school setting along with the family and community (Stormshak et al., 2011). Though this model has not been specifically tested on Black boys, other interventions have built upon this model to specifically target Black adolescents. The African American Knowledge Optimized for Mindfully Healthy Adolescents (AAKOMA) project integrates school-based and community-based mental health resources with adolescents' families to expand Black adolescents' knowledge about mental health conditions while also encouraging their use of formal mental health resources (A. M. Breland-Noble et al., 2010). Findings from the current study speak to the importance of expanding interventions such as these to better attract and support Black boys that are experiencing depressive symptoms. As previously stated this implies a greater need for federal, state, and private funding for interventions and programs tailored to Black boys' mental health needs.

This study also acts as a springboard for future research. This study provides an overview of the help-seeking process of this group of Black boys. Future studies should look to explore the context of specific social networks on Black boys' help-seeking decisions and provide a deeper analysis of the individual stages within the help-seeking process. This study begins an early discussion into the roles of family and peers, as well as school staff but could not provide in-depth descriptions of how messages about mental health care are communicated and the influence this has on help-seeking. Furthermore, future studies using techniques such as social network mapping or

phenomenological studies could provide in-depth insight into how Black boys navigate specific aspects of their social network.

Limitations

This study has some important limitations that should be considered. First, as in all qualitative analyses, there was not 100% consensus, there were those that diverged from the larger shared experiences (negative cases). These cases were considered within the context of the larger shared descriptions. They provided insight into potential different directions of the findings and are discussed based on their apparent divergence from the primary findings following the possibility principle guidelines (see Mahoney & Goertz, 2004). Additionally, although the goal of qualitative research is not to provide generalizable results across differing populations findings from this study are limited in scope and the sample demographic. This study uses a sample of 15 participants that self-identify as Black and male and are between ages 13 and 18 years old. Adolescent developmental stages could impact the help-seeking behaviors of young people. A greater sample of participants from any age within the adolescent age range could potentially provide greater insight into specific help-seeking behaviors associated with earlier or later adolescent developmental stages. Furthermore, specific demographic and contextual information such as income, the number of parents in the household, diagnosed mental health conditions, sexuality, and so on was not intentionally collected, though some of this information became aware through the course of an interview. Each of these factors could potentially influence the participants' help-seeking options and subsequent behaviors. Future studies should look to make use of a demographic questionnaire prior to conducting individual interviews. Finally, all

interviews were collected from boys in two counties in Southeastern Michigan. Factors associated with the location such as school mental health resources, community mental health resources, among many other factors associated with the specific location limit the finding from this study beyond the participants. Overall, though this study has limitations the findings are significant and speak to an important issue facing Black boys and therefore is a significant contribution to current literature on Black boys' mental health, help-seeking, and service utilization.

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Appendices

Appendix A

A. 1: Interview Questionnaire

Demographic Questions

A. What is your name or nickname?

B. How old are you?

C. What grade are you in?

D. How long have you been at your school?

Belief and Perception

1. What do you think mental health is?
- Can you tell me what have you heard about mental health?
- Where have you heard about it?

2. What do you think depression is?
- Can you tell me a story about someone you may know that has experienced depression?
- How did/would you know this person was depressed?
- What else does a depressed person do?

3. Do you know anyone that has experienced depression or any other mental health challenge?

4. What have you heard in the media (social media, music, TV, etc) about mental health and depression?
- Where do you remember hearing it?

5. What do you think causes a Black boy to become depressed?
- Do you think this could be different for boys in other racial groups?

Help-seeking

6. What kind of things do you think could help someone take better care of their mental health?
- Do you think that this would be different for young Black men, such as you? If so, why?

7. What kind of help would you recommend to a friend that was depressed?
- How well do you think that (*their response*) would work for a young Black man?

8. If you felt you couldn't handle things going on in your life, where would you go for help? Why?
- Who would you go to first? Why?
- Could you tell me about a time that you wanted to tell someone how you were feeling, but didn't?
  - Why didn't you?
  - Did you ever want someone to ask you what was wrong?
- What would keep you from getting help if you felt like you needed it?

School Factors

9. What is available in your school for students who may need help for their mental health?
- Where would you go in your school if you felt like you were stressed out?
- How about outside of school, where would you go if you were stressed out?

10. Could you tell me about a space in your school where you think students could go to talk about how they feel?
- Would you use this space? Why or why not?

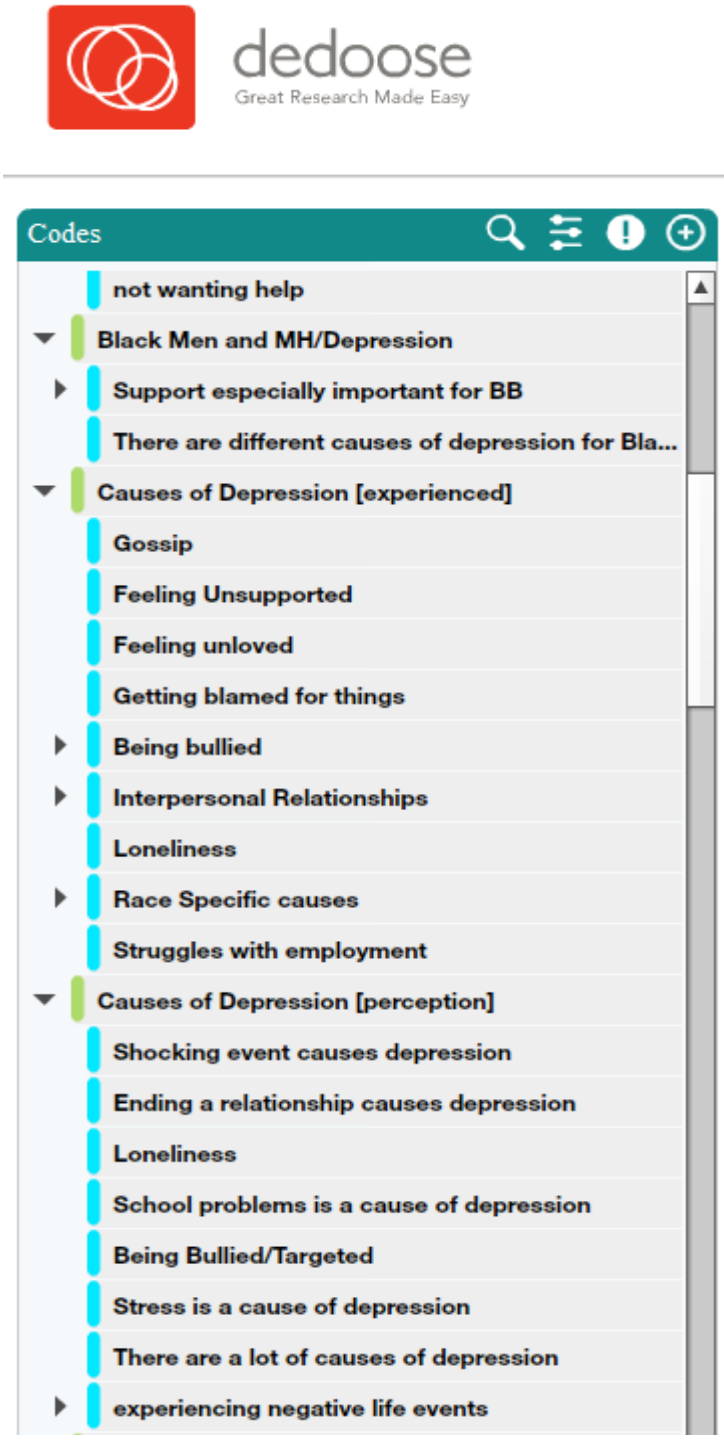
11. Do you think students feel comfortable asking for help in your school when they are going through things? Why or why not?
- Do you feel comfortable asking for help in your school when you're going through things? Why or why not?

Wrap-up

Given everything that we have talked about, is there anything else that you feel that I should know or that you want to say?

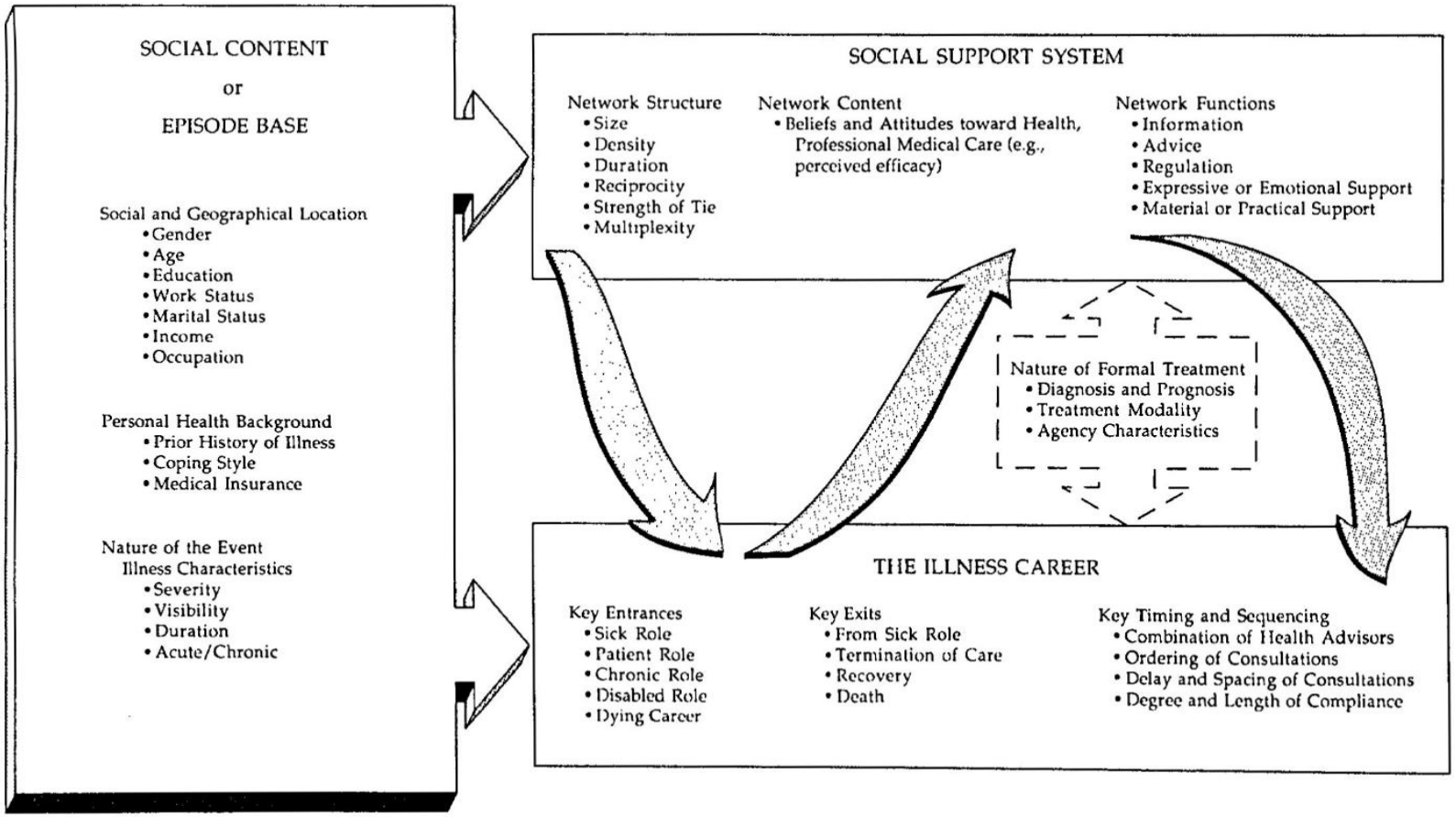
Do you have any final questions for me or about the study?

Figure A. 2: Dedoose Coding Screenshot



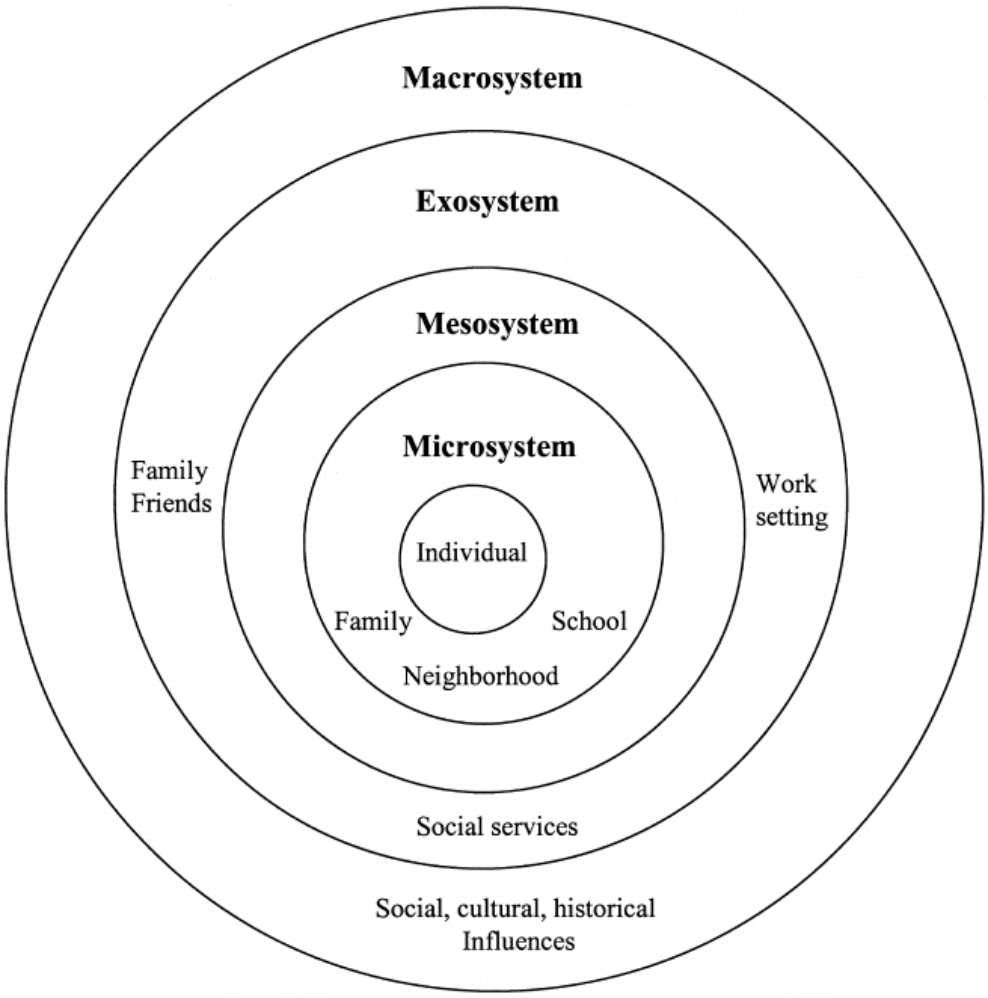
Appendix B

Figure B. 1: Network Episode Model



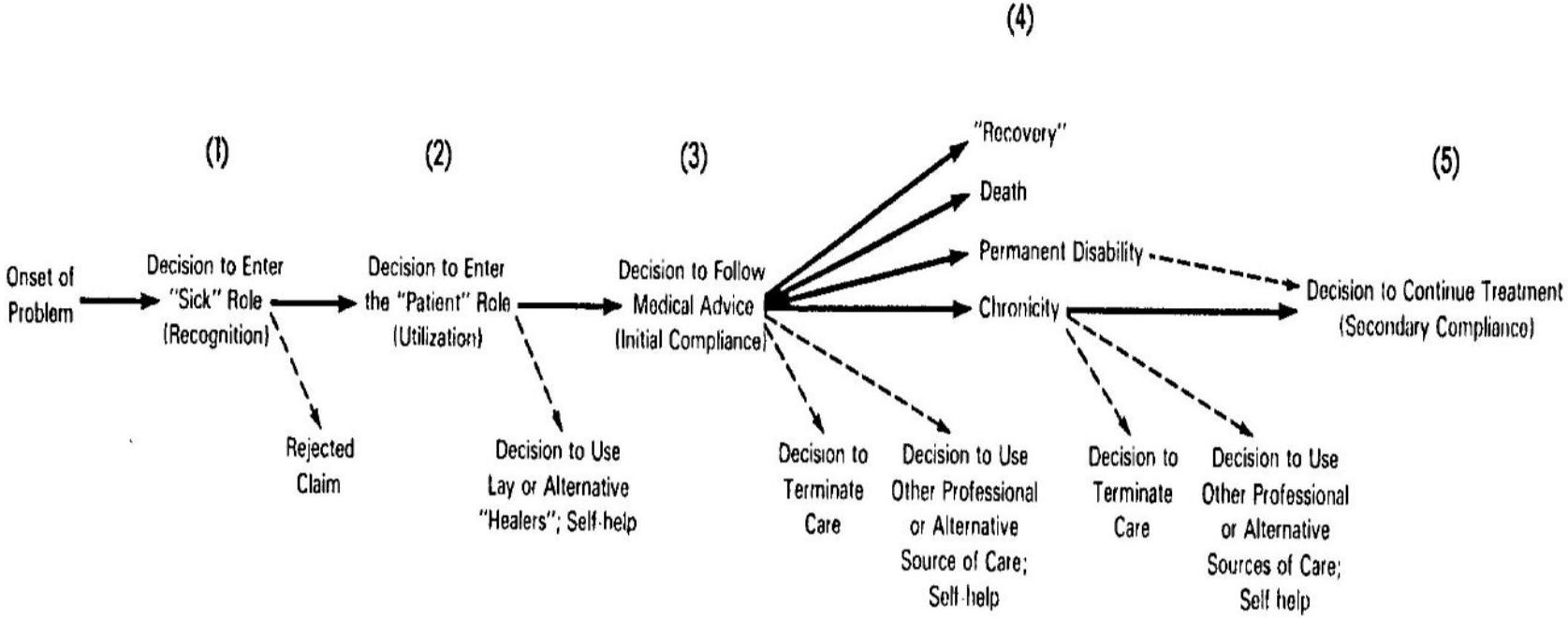
Note: Network Episode Model. Retrieved from Pescosolido, B. A. (1991). Illness Careers and Network Ties: A Conceptual Model of Utilization and Compliance. In *Advances in Medical Sociology* (Volume 2, pp. 161–184). JAI Press Inc.

Figure B. 2: Ecological Systems Theory Model



Note: Bronfenbrenner's Ecological Systems Theory. Retrieved from Swanson, D. P., Spencer, M. B., Harpalani, V., Dupree, D., Noll, E., Ginzburg, S., & Seaton, G. (2003). Psychosocial development in racially and ethnically diverse youth: Conceptual and methodological challenges in the 21st century. *Development and Psychopathology*, *15*(3), 743–771.

Figure B. 3: Revised Illness Career



Note: Revised Illness Career. Retrieved from Pescosolido, B. A. (1991). Illness Careers and Network Ties: A Conceptual Model of Utilization and Compliance. In *Advances in Medical Sociology* (Volume 2, pp. 161–184). JAI Press Inc.

Figure B. 4: Participants Help-Seeking Process