

THE PROCESSES OF DISEASE MANAGEMENT IN AFRICAN AMERICAN  
ADOLESCENTS WITH DEPRESSION

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## DEDICATION

بسم الله الرحمن الرحيم

فما كان في من الصواب فمن الله، وما كان في من خطأ من نفسي ومن الشيطان

اعوذ بالله ان اقول غير الصواب، واستغفره من كل خطأ وهو الغفور التواب

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Halima Abdur-Rahman Al-Khattab

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Depression in African American (AA) adolescents is a prevalent mental health problem, can result in serious concurrent and long-term effects, and is associated with health disparities due to underutilization of mental health services. Initiatives to reduce disparities among depressed AA adolescents require a greater understanding of the experience of depression from their own point of view. The purpose of this dissertation was to generate a comprehensive theoretical framework that describes how AA adolescents experience depression throughout adolescence. The information gained about how AA adolescents understand and manage depressive symptoms, and in some cases seek and use mental health services will contribute to initiatives to reduce behavioral health disparities.

This dissertation project was composed of two components. The first component was an integrative review of studies that explored associations between adolescent coping responses and depression. The integrative review summarized and integrated research from the past ten years that examined coping techniques of depressed adolescents. It revealed that the use of active coping strategies plays an important role in recovery from depression.

The second component was a grounded theory study which included a sample of 22 community-based AA young adults (ages 18-21) and 5 clinic-based AA adolescents (ages 13-17). During semi-structured interviews, participants described their experiences with depression as adolescents. In addition, a timeline was constructed that included major events related to the unfolding of depression, including treatment seeking, which occurred during adolescence.

Data generated from the grounded theory study were analyzed and resulted in two qualitatively derived products. The first is a typology titled *Being With Others* that depicts interaction patterns of depressed AA adolescents with people in their lives. The five categories in the typology are *keeping others at bay*, *striking out at others*, *seeking help from others*, *joining in with others*, and *having others reach out*. The second product is a theoretical framework titled *Weathering through the Storm* that describes how depression in AA adolescents unfolds over time. The five phases of the framework are labeled *enduring stormy weather*, *braving the storm alone*, *struggling with the storm*, *finding shelter in the storm*, and *moving out of the storm*.

Claire Burke Draucker, Ph.D., RN, FAAN, Chair

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None.	
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None.	

## ABBREVIATIONS

Abbreviations	Term
AA	African American
ADAPT	Adolescent Depression and Psychotherapy Trial
BDI	Beck Depression Inventory
BISC	Behavioral Inventory of Strategic Control
BMMRS	Brief Multidimensional Measure of Religiousness/Spirituality
CBCL	Child Behavior Checklist
CBT	Cognitive-Behavioral Therapy
CCSC	Children's Coping Strategies Checklist
CD	Conduct Disorder
CDI	Children's Depression Inventory
CES-D	Center for Epidemiologic Study – Depression
C-NEM	Children's Network Episode Model
DD	Dysthymic Disorder
DDNOS	Depressive Disorder Not Otherwise Specified
DSM-IV-TR®	Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision
DSM-V-TR®	Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision
EA	European American
MDD	Major Depressive Disorder
ODD	Oppositional Defiant Disorder
RADS	Reynolds Adolescent Depression Scale
RSQ	Responses to Stress Questionnaire
RWCCL	Revised Ways of Coping Checklist
SAMHSA	Substance Abuse and Mental Health Service Administration
SI	Symbolic Interactionism
TADS	Treatment for Adolescents with Depression Study
TORDIA	Treatment of Resistant Depression in Adolescents
YRBSS	Youth Risk Surveillance System

## **CHAPTER ONE**

In this chapter, I will provide an introduction to the topic of depression in African American (AA) adolescents including the significant and long-term consequences of untreated depression, which is the focus of my dissertation work. The chapter will continue with an explanation of the purpose, the specific aims, and the substantive and methodological theoretical perspectives of my study. Next, the chapter will describe the study approach, including study design, sample, data collection, data management, and data analysis procedures. The chapter will conclude with descriptions of the three manuscripts that comprise the dissertation and a description of the fifth chapter.

### **Background and Significance**

#### **Significance**

Depression in African American (AA) adolescents is a serious mental health problem that if left untreated results in a number of negative health consequences and, frequently, recurrence later in life.<sup>4, 25, 35, 41, 46, 51-53, 59, 65, 66, 68, 74, 75, 77, 79, 81, 82, 89</sup> African American adolescents who are depressed often do not receive adequate mental health services for their depression and are faced with managing their symptoms alone or with informal supports.<sup>12, 26, 28, 53, 64, 80, 86</sup> The underutilization of mental health services by AA adolescents contributes to significant health disparities in this group.<sup>1, 2, 7, 8, 12, 18, 21, 26, 32, 35, 42, 43, 49, 51, 61, 64, 67, 76, 78, 82, 88-90</sup>

#### **Definition and Diagnostic Criteria for Depression**

Depression is a mood disorder in which feelings of sadness, loss, anger, or frustration interfere with everyday life.<sup>4, 84</sup> The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR®) defines a Major Depressive Episode as a period of at least two weeks during which individuals experience a depressed mood or a loss of interest in nearly all activities. There are three types of depressive disorders: Major Depressive Disorder, Dysthymic Disorder, and

Depressive Disorder Not Otherwise Specified. Major Depressive Disorder is characterized by one or more Major Depressive Episodes. Dysthymic Disorder is characterized by the presence of a depressed mood for a minimum of two years, accompanied by additional depressive symptoms that do not meet diagnostic criteria for Major Depressive Disorder. Depressive Disorder Not Otherwise Specified is characterized by depressive features that do not meet criteria of Major Depressive Disorder, Dysthymic Disorder, or other disorders with depressive features.<sup>4</sup>

### **Incidence and Prevalence of Depression Among Adolescents**

More than 25% of adolescents in the United States experience at least mild symptoms of depression.<sup>74, 75</sup> The estimated lifetime prevalence of Major Depressive Disorder or Dysthymic Disorder in adolescents ages 13 to 18 is 11.7%. Of this group, 74.4% experience severe symptoms. The average age of onset of Major Depressive Disorder and Dysthymic Disorder in the United States is between the ages of 11 and 14. The prevalence of depression among adolescents ages 13 to 14 is 8.4%, and this steadily increases to 15.4% among those ages 17 to 18 years.<sup>74, 75</sup> The estimated lifetime prevalence of Major Depressive Disorder or Dysthymic Disorder for female adolescents (15.9%) is approximately twice that of male adolescents (7.7%).<sup>62, 63</sup>

### **Correlates and Long-term Consequences of Depression in Adolescents**

Depression in adolescents is associated with a number of co-morbid health concerns, including high-risk sexual behavior, early pregnancy, substance abuse, poor academic performance, psychosocial functioning impairment, and increased risk for suicide.<sup>1, 2, 7, 8, 18, 21, 26, 32, 35, 42, 43, 49, 51, 61, 64, 67, 76, 78, 82, 88-90</sup> Suicide is the third most common cause of death in the United States among adolescents. Of adolescents who commit suicide, about 90 percent suffer from a psychological disorder, most commonly depression, at the time they ended their lives.<sup>22, 23, 38, 48, 56, 73, 75</sup> Depression in adolescence is also associated with recurrent depression in adulthood. Close to half

(45%) of adolescents who experience depression will also experience depression as young adults.<sup>1, 3, 12, 15, 64, 66, 70, 71, 82</sup>

### **How Adolescents Manage the Experience of Depression**

Adolescents manage depressive symptoms in a variety of ways. In this document, management refers to all the ways in which adolescents cope with or respond to their depressive symptoms. The most commonly employed coping strategies among adolescents who are depressed are denial, substance use, seeking emotional support, self-blame, and behavioral disengagement.<sup>41</sup> The use of drugs and alcohol, overeating, and engaging in risky social behaviors are other maladaptive coping methods associated with depression in adolescents.<sup>60</sup> Due to the stigma associated with mental health problems, adolescents often attempt to ignore, hide, or minimize their distress.<sup>29</sup> Important adults in the lives of adolescents, including parents, other relatives, and school personnel, may help them manage their depression but only if the adults are aware of the adolescents' distress and persist in their attempts to encourage the adolescents to seek treatment for their depression.<sup>28</sup>

### **Treatment Utilization for Adolescent Depression**

Adolescents with depressive disorders often do not receive adequate mental health treatment.<sup>26</sup> Among a nationally representative sample of adolescents ages 12-17 diagnosed with a Major Depressive Episode during the previous year, 17% had received prescription medication, 11% had received treatment from a medical provider, 30% had received treatment from a mental health specialist, and 62% had received no form of treatment.<sup>26</sup> Perception by parents or adolescents that an adolescent has a mental health problem is associated with utilization of mental health services, but socioeconomic status, possessing insurance, and having access to and/or knowledge of available services have little impact on utilization rates.<sup>2, 7, 18, 29, 89</sup> Research has shown that adolescents avoid using mental health services because they are afraid they will be

seen as mentally ill, the provider will not respect their privacy, or the provider will not understand their concerns.<sup>29</sup> AA adolescents who are depressed therefore often avoid mental health treatment altogether or fail to engage with counselors fully if they are forced to attend sessions.<sup>29</sup>

### **Available Treatments for Adolescent Depression**

The underutilization of treatments by adolescents who are depressed is particularly troublesome because effective treatments are available. The American Academy of Child and Adolescent Psychiatry recommends supportive psychotherapy for cases of mild depression and a combination of cognitive-behavioral therapy (CBT) or interpersonal therapy with pharmacological treatments for more severe cases of depression.<sup>9</sup> The Guidelines for Adolescent Depression in Primary Care include the use of evidence-based psychotherapy and pharmacological treatments for adolescents with depressive disorders.<sup>75</sup> Brief primary care interventions, psychotherapy, pharmacologic interventions such as selective serotonin reuptake inhibitors, and combinations of psychotherapy and pharmacotherapy are considered best treatment practices.<sup>66</sup> These treatment recommendations are based on overwhelming clinical consensus and empirical evidence from randomized controlled trials. Treatments meeting these best treatment practice requirements have been found to be effective more than 95% of the time.<sup>75</sup> Several large scale clinical trials that have demonstrated the effectiveness of treatments for adolescent depression include the Treatment for Adolescents with Depression Study (TADS),<sup>27, 58, 86</sup> the Adolescent Depression and Psychotherapy Trial (ADAPT),<sup>31, 86, 87</sup> and the Treatment of Resistant Depression in Adolescents Study (TORDIA).<sup>14, 33, 86</sup> Many adolescents, therefore, endure the distress of depression and its deleterious effects despite the fact that a variety of effective treatments have been developed and evaluated.

## **Depression in African American Adolescents**

Although the prevalence of depressive disorders among AA adolescents and their European American (EA) counterparts is similar (7.3% and 8.5%, respectively),<sup>26</sup> startling disparities exist in mental health treatment utilization<sup>12</sup>. The Substance Abuse and Mental Health Service Administration (SAMHSA) reported that 44.9% of EA adolescents who had experienced a Major Depressive Episode in the past year received mental health treatment for their depression compared to 28.9% of AA adolescents.<sup>12</sup> A comparison of service utilization rates across racial/ethnic groups of adolescents who experienced a Major Depressive Episode using the National Survey on Drug Use and Health data yielded similar results.<sup>26</sup> Several explanations for the underutilization of mental health services by AA adolescents have been proposed. Some research suggests AA adolescents are more stoic and tolerate greater distress than EA adolescents.<sup>2</sup> AA adolescents may also be more likely to consider depression a problem to be addressed through strong will and the support of God rather than a medical disease.<sup>2, 13, 60</sup> In addition, mental illness and the use of mental health services are associated with high levels of stigma within the AA community.<sup>18, 60</sup> The lack of minority mental health service providers adds to AA adolescents' fear of being misunderstood by clinicians.<sup>29, 60, 89</sup> Due to mistrust, AA adolescents may view treatments as ineffective, avoid medications, and believe clinicians will not look out for their best interest.<sup>29, 60, 89</sup>

Because depression in AA adolescents is a prevalent mental health problem, has serious concurrent and long-term effects, and is associated with health disparities due to underutilization of mental health services, strategies are needed to help AA adolescents manage their depression and engage in mental health services that are effective for them. A theoretical framework that focuses on self-management and service use and that describes how depression in AA adolescents unfolds throughout the adolescent years can provide a foundation for the development of such strategies.

## **Purpose and Specific Aims**

The overall goal of this dissertation project was to support initiatives to reduce behavioral health disparities among AA adolescents with depression by contributing a comprehensive framework that describes how AA adolescents experience depression throughout adolescence. In order to achieve this goal, two components were completed for the dissertation project. The first component was an integrative review of the literature on associations between adolescent coping responses and depression. The second component was a research study that resulted in two qualitatively derived products: a typology and a theoretical framework. The purpose of the research study was to describe how AA adolescents understand their depression and its effects, manage their symptoms, and, in some cases, seek and use mental health services over the course of their adolescent years. Interviews for the research study were conducted with two groups of participants: AA young adults (18-to-21-year-olds) who reported having experienced depression during adolescence (ages 13–17) and AA adolescents (13-17 year-olds) who were currently being treated for depression. Because I wanted to describe processes that change over time and are affected by social contextual factors, grounded theory methods<sup>19, 36</sup> were used.

The specific aims of the research study were to:

1. Describe how African American adolescents who are depressed understand their depression and its effect on them.
2. Describe how African American adolescents who are depressed manage their depressive symptoms.
3. Describe how African American adolescents who are depressed seek and utilize mental health services.
4. Generate an explanatory theoretical framework that depicts how depression in African American adolescents unfolds throughout their adolescent years.



## Theoretical Perspectives

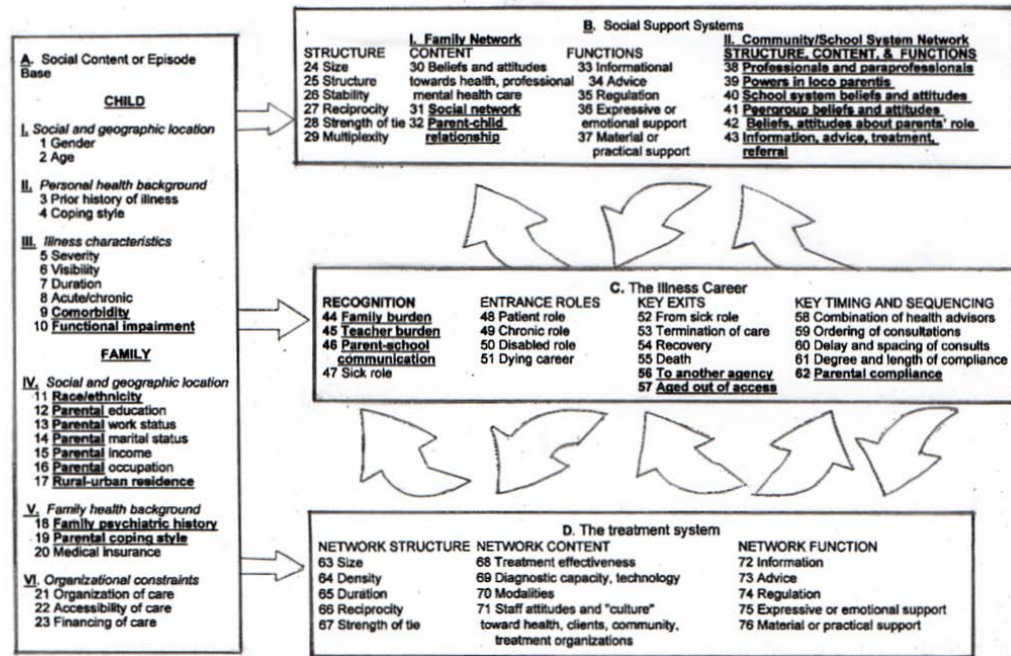
Two theories provide the foundation for this study. The Children's Network Episode Model (C-NEM)<sup>24</sup> provides the substantive theoretical perspective for this study and symbolic interactionism provides the methodological theoretical perspective.

### Children's Network Episode Model (C-NEM)

Depression management in AA adolescents has traditionally been examined by measuring mental health service utilization and treatment rates alone. The actions an adolescent takes in response to depression, however, include more than a one-time dichotomous decision to seek help or not. Management of depression in AA adolescents, which may include help-seeking, is a process that is influenced by the social environment.<sup>69</sup> The C-NEM<sup>24</sup> was adapted from the Network Episode Model,<sup>69</sup> which focuses on adults. The four concepts contained within the C-NEM are (1) the episode base, (2) social support systems, (3) the illness career, and (4) the treatment system<sup>24</sup> (see Figure 1 below). The complex and various components that make up the process of managing mental illness and mental health help-seeking and utilization are represented within these four areas. The C-NEM presents the organization of individual, family, school, and community factors that influence disease management.

The episode base includes characteristics of the adolescent such as gender, age, and coping style. Because adolescents typically do not make their healthcare decisions alone, characteristics of the family are also included in the episode base. These characteristics include the family's socioeconomic status or history of mental illness within the family. The social networks that influence the adolescents are included within the social support systems component of the model. The social support system includes family, community, and school networks. Social support variables include items that account for the structure (i.e., size or stability), content (i.e., beliefs or attitudes), and

**Figure 1-1.** Revised Network-Episode Model of Access to Care, Adapted for Children and Adolescents



**Note:** Items in **bold Underlined** are added to the original model, because of their relevance to youth

function (i.e., advice or regulation) of a particular network. The illness career includes variables related to the processes involved in healthcare utilization, namely problem recognition, entrance roles, exit roles, and variables related to timing and sequencing of care. Each time contact, be it entry or exit from a service, occurs, it has an impact on the adolescent and/or his or her family. Last is the treatment system, which is a variable that has influence on the individual, family, social system, and the illness career. The treatment system is similar to the social support system in that it includes network variables that describe structure, content, and function of the healthcare system and treatment providers.

The C-NEM views disease management as a dynamic process composed of a series of decisions made over time. These decisions form patterns of disease management and pathways into and out of care.<sup>24</sup> Social networks shape the beliefs,

attitudes, and perceptions an individual holds about a particular disease as well as healthcare institutions and providers. These beliefs, attitudes, and perceptions in turn influence an individual's illness management decisions.<sup>24</sup> Because the C-NEM views illness management as a process and places social relationships at the center of the framework, it supports the examination of depression management and help-seeking as processes from the perspective of AA adolescents.

The C-NEM was used to guide a study which measured the mental health service utilization among a nationally representative adolescent population.<sup>34</sup> The model was also used in a study that examined help-seeking behaviors of depressed AA adolescent boys.<sup>53</sup>

### **Symbolic Interactionism**

Symbolic interactionism<sup>10</sup> provides the theoretical foundation for the grounded theory methods to be used in this study. Symbolic Interactionism posits that human beings' actions towards an object in their environment are based on the meaning they ascribe to that object. Furthermore, that meaning is shaped by social interactions and refined or modified through interpretive processes. The three primary concepts of symbolic interactionism are the self, the world, and social action.<sup>20</sup> The self, or self-concept, is developed as a result of an individual's social interactions; first with those close to them (i.e. mother or father) and later by those in their increasingly expanding social networks. Social interactions also inform the development of an internal understanding of the communities' attitudes and beliefs. The world refers to the "object world" or a world of symbols.<sup>10</sup> An object can be physical (i.e. clothes), social (i.e. parents), or abstract (i.e. culture). An object only becomes a symbol if an individual assigns meaning to it. Meaning is assigned to an object based on the understanding an individual develops through their social interactions. Social action, also referred to as joint action, can be described as 'meaningful human interaction.'<sup>45</sup> During social or joint

action, individuals try to predict the actions of others as this allows them to determine the meaning that has been assigned to objects in the environment. Individuals need this knowledge so that they may choose an appropriate action and evaluate how others are interpreting their selected action.<sup>11</sup> Symbolic interactionism regards meanings as “social products that are created through the defining activities of people as they interact.”<sup>45</sup> An object’s meaning is unique to an individual and shaped by the manner in which those in their social network define the object.

According to Blumer,<sup>10</sup> exploration and inspection are required for the examination of social life. Exploration allows a researcher to become acquainted with the particular social phenomena being studied using a flexible process. This flexibility ensures the interpretations of the phenomenon will be based on empirical data. Inspection is a means of ensuring the analysis has validity. As conceptualizations are made, the researcher must continue to compare the conceptualizations to the data.

**Table 1-1. Methodology of Symbolic Interactionism and Grounded Theory<sup>45</sup>**

<b>Symbolic Interactionism</b>	<b>Grounded Theory</b>
Direct observation of empirical world	Participant observation; interviewing; document analysis; videotaping; etc.
Determination of data through disciplined observation	Observation; interviewing guidelines; theoretical sampling
Raising of abstract problems	Analytic, methodologic, personal memoing
Construction of categories	Open coding; axial coding; theoretical coding; properties, dimensions
Construction of theoretical scheme	Core category; categories; subcategories; properties, dimensions; memos; diagrams
Testing of categories	Theoretical sampling; theoretical saturation; literature review; group analysis; member checks

Symbolic interactionism provides the foundation for grounded theory methods, which focus on the psychosocial processes that change over time and that occur in a

sociocultural context.<sup>19, 37</sup> The table above displays the relationships between the basic tenets of symbolic interactionism as outlined by Blumer (1969) and the basic principles of grounded theory.<sup>36</sup>

### **Design**

Grounded theory methods were used to conduct this qualitative, community-based research study. Grounded theory methods consist of systematic yet flexible procedures for collecting and analyzing qualitative data to construct theories “grounded” in the data themselves.<sup>19, 37</sup> The intent of grounded theory methodology is to generate explanatory theoretical frameworks of psychosocial processes through the use of concurrent data acquisition, categorization, comparison, and formation of hypotheses.<sup>19, 37</sup> A completed grounded theory explains the investigated process using theoretical descriptors, illustrates the attributes of the theoretical categories, explicates causes and conditions under which the process manifests and varies, and identifies its ramifications. Additional attributes of a finished grounded theory include a close fit with the data, usefulness, conceptual density, durability over time, modifiability, and explanatory power.<sup>19</sup>

Despite an increase in racial/ethnic diversity in the United States, there are few explanatory theories addressing diversity-related problems.<sup>19</sup> The National Research Council (2002) recognizes that cultural contexts pertinent to race and ethnicity shape social and human science research. The development of theories that encompass and value diversity holds a high premium in the global knowledge marketplace.<sup>50</sup> Experts have argued that grounded theory is the “optimal methodological tool for examining new, emerging, and evolving issues pertaining to racial/ethnic diversity phenomena.”<sup>39</sup> Because how AA adolescents experience their depression, manage its symptoms, and use services are psychosocial processes shaped by social context and ethnicity, grounded theory methods are most appropriate to meet the proposed study aims.

## Definitions

The following are definitions of the major concepts of the dissertation study. They are divided into terms related to the substantive focus of the study (depression in AA adolescents) and terms related to the method of the study (grounded theory).

<b>Table 1-2: Definitions</b>	
<b>Substantive Terms</b>	
Adolescence	The period between puberty and adulthood roughly considered to be between 13 and 18 years of age. A time of physical, emotional, psychological, social, and mental change and growth <sup>85</sup>
African American (AA)	A person who has origins in any of the Black racial groups of Africa <sup>72</sup>
Children's Network Episode Model (C-NEM)	Theoretical framework that views illness management and help-seeking behavior as a dynamic process that is influenced by social networks <sup>24</sup>
Depression/depressive symptoms	Mood disorder in which feelings of sadness, loss, anger, or frustration interfere with everyday life <sup>4, 84</sup>
Depression management	All of the ways in which adolescents respond to their depressive symptoms. Responses may be internal, external, active, inactive, problem-focused, emotion-focused, or considered positive or negative in nature
DSM-IV-TR®	Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision. (Note: The DSM-V, the most recent version of the manual was not used in this study as it had not been published at the time the study was designed and funded.)
Episode base	A domain of the C-NEM that includes individual and family characteristics <sup>24</sup>
Help-seeking	A process that "begins with problem definition, moves to the decision to seek help, and ends with selection of a treatment service or service provider" <sup>16</sup>
Illness career	A domain of the C-NEM which includes variables related to the processes involved in healthcare utilization <sup>24</sup>
Mental illness	Refers collectively to all DSM-IV-TR® diagnosable mental disorders <sup>83</sup>

Social support system(s)	A domain of the C-NEM which includes family, community, and school networks <sup>24</sup>
Stigma	A designation of disgrace or disapproval that attempts to label a group of people as less worthy of respect than others and leads to discrimination <sup>17</sup>
Treatment system(s)	A domain of the C-NEM which includes network variables related to the healthcare systems and service providers <sup>24</sup>
Treatment utilization	Seeking out and participating in healthcare services for a particular disease process
<b>Methodological Terms</b>	
Adolescent participant	Study participant between the ages of 13-17
Axial coding	Development of subcategories that define attributes, characteristics, and dimension of previously generated categories <sup>19</sup>
Constant comparison	Simultaneous collection and analysis of data <sup>19</sup>
Credibility	Whether or not categories cover the breadth of collected data, whether systematic comparison between data and categories has occurred, and how well the data support the grounded theory <sup>19</sup>
Focused coding	Examination of initial codes for the presence of significant or recurrent codes <sup>19</sup>
Grounded theory	Qualitative research method that consists of systematic yet flexible procedures for collecting and analyzing qualitative data to construct theories “grounded” in the data <sup>19, 36</sup>
Initial coding	Line-by-line examination of transcripts and assignment of labels to empirical indicators <sup>19</sup>
Originality	The freshness of categories and the presence of new insights <sup>19</sup>
Resonance	Whether or not the theory makes sense to people experiencing the investigated process <sup>19</sup>
Symbolic interactionism	Human beings’ actions towards an object in their environment are based on the meaning they ascribe to that object. Meaning is shaped by social interactions and refined and modified through interpretive processes <sup>10</sup>
Theoretical coding	Determination of potential relationships among the categories constructed during focused coding <sup>19</sup>
Usefulness	Generalizability of the theory to practice <sup>19</sup>
Young adult participant	Study participant between the ages of 18-21

## Methods

**Sample.** Participants are initially chosen for grounded theory studies because they have knowledge of the phenomenon being studied.<sup>39</sup> Because I wished to recruit individuals who experienced a broad range of depressive symptoms and treatment experiences, participants were recruited from two populations.

The first population we recruited were young adults ages 18-21 who reported experiencing depression during adolescence (ages 13-17) and who were willing to participate in a retrospective interview. Community-based young adults were recruited to reflect back on their teen years for several reasons. First, they were able to provide information about their experiences with depression throughout adolescence and as they transitioned into young adulthood. Second, because research has shown that the majority of depressed adolescents hide their depression from their parents,<sup>40</sup> young adults could provide data on living through depression without the requirement of parental consent. Finally, recruiting community-based young adults yielded participants who did not receive treatment for their depression and who could thus provide data on managing depression without the benefit of mental health services. In addition, adolescents ages 13-17 who were receiving treatment for depression were recruited to participate in an interview about their current experiences. These adolescents were able to provide contemporaneous information about their experiences of depression, had a formal diagnosis of depression, and experienced symptoms that were severe enough to warrant mental health care.

**Young adults.** Twenty-two AA young adults ages 18-21 years old who had experienced depressive symptoms during adolescence (ages 13-17) were recruited by community-based sampling using public announcements and community networking. Recruitment was conducted within five postal areas in the Indianapolis metropolitan community, including three neighborhoods that were predominantly AA and two



neighborhoods that were racially mixed yet with a substantial AA population. I canvassed the five communities to assess locations frequented by young adults where recruitment flyers could be distributed, to identify publicly accessible yet private locations that could be used as interview sites, and to speak with community leaders about the study and enlist their support.

I distributed recruitment flyers in each community announcing the study on depression in AA adolescents. The flyers included a description of depressive symptoms taken from the DSM-IV-TR® criteria<sup>5</sup> but written in lay language. The flyers invited young adults ages 18-21 who experienced depression between ages 13-17 to contact me. Flyers were placed in a variety of locations including restaurants, gyms, postsecondary colleges, public libraries, grocery stores, and malls. The flyers indicated that interviews could be conducted in local community settings and that participants would receive a \$35 reimbursement for their time and travel after the interview was completed.

I screened potential participants over the phone for the following inclusion criteria: (a) self-identified as being AA; (b) aged 18 to 21; (c) could speak, read, and write the English language; and (d) reported having experienced depressive symptoms during adolescence or having been diagnosed with depression by a health professional. After receiving verbal consent, I used an adapted screening protocol<sup>30</sup> to screen for the following exclusion criteria: (a) experienced acute distress or a recent life crisis; (b) were recently hospitalized for mental health concerns; (c) had current suicidal ideation; and (d) had current homicidal ideation. No individuals who were screened were excluded from the study.

**Adolescents.** After obtaining approval from a large publicly funded medical center in Indianapolis, I recruited five 13-to-17 year old AA adolescent participants from an adolescent primary care clinic. Inclusion and exclusion criteria were identical to criteria for the young adults with the following exceptions: 1) Participants were to be

between 13-to-17 years of age and 2) were currently receiving treatment for depression from a health professional. Clinic staff were provided information about the study. With approval from the primary care provider, I approached eligible participants about the study.

**Sample Size.** An exact sample size cannot be determined a priori in grounded theory. Qualitative experts suggest that when using a grounded theory methodology to study a homogeneous group, 20-30 subjects is a sufficient number to identify shared psychosocial processes.<sup>19</sup> Because the sample was all AA youth who were depressed as adolescents, the assumption was that they shared psychosocial processes.

Therefore, 22 young adults and 5 adolescents provided sufficient data to meet the study aims.

### **Data Collection**

Experts suggest that enhanced rapport and disclosure can be established and cultivated if the interviewer is of the same race/ethnicity as the participant.<sup>4, 6, 44, 57</sup> Both the study participants and I shared the same race/ethnicity. It was hoped that this shared trait would assist in the building of rapport between the participants and I to allow them to feel at ease and foster a willingness to share their rich stories during the interview.

**Young Adults.** I scheduled interviews in the participants' communities in a location that offered privacy for the interview (e.g. library meeting rooms, conference rooms in community centers) at a time that was convenient for the participants. The participants signed informed consent forms and completed a demographic data sheet. I screened participants for distress prior to, during, and after the interviews. Qualitative data was collected via semi-structured retrospective interviews or directed conversations<sup>54, 55</sup> with the participants. A funnel approach was utilized for each interview. The semi-structured interviews began with the following question: "You indicated that you experienced depression as a teenager. Would you tell me about that

experience?” This open-ended question allowed participants to lead the direction of the interview, thoughtfully reflect on their experiences, and tell their stories as experts (See Appendix K). As interviews progressed, questions became more structured to ensure that rich information was obtained to meet the study aims. Other questions were aimed at how the participants had managed their symptoms and how they used mental health services. Each participant was interviewed once and interviews lasted between 20 and 75 minutes. The interviews were digitally recorded and transcribed. Because discussing events related to depression during adolescence could be distressing, I was prepared to use the Research Interview Distress Protocol (See Appendix M) if, during the course of the interview, participants exhibited acute distress, safety issues, or imminent danger to themselves or others. I did not use the Interview Distress Protocol with any participant.

At the end of the interview, the participants and I reviewed and mapped the main events the participants discussed regarding management of their depression and treatment seeking/utilization (e.g., when they first noticed depressive symptoms; events that signified their depression was worsening; contacts with mental health providers; hospitalizations; major life events related to their depression, such as a move, the loss of a parent, or a break-up with a dating partner). The events were mapped on a timeline (See Appendix K) divided by grades in school, the most common way youth mark major happenings in their lives, with corresponding ages for those who were not in school. This allowed me to ensure the participant had covered major significant events and to validate the chronology of the events. Participants received a \$35 gift card at the completion of the interview to compensate them for time and travel.

**Adolescents.** Data collection procedures for the adolescent participants were identical to the procedures for the young adults with the following exceptions: 1) Written consent was obtained from the adolescents’ parent/guardian, and written assent was obtained from the adolescents; 2) Questions were about the participants’ current

experiences with depression rather than their retrospective experiences, and 3) Participants were asked about their experiences leading up to receiving mental health treatment as well as treatment itself. All interviews were conducted in an available patient exam room at the clinic. After informed consent and assent were obtained, the interview was conducted without the parent or guardian in the room. Adolescents were screened for acute distress before, during, and after the interview and no individuals who were screened were excluded from the study.

### **Data Management**

Participant names and phone numbers collected via voicemail (See Appendix C) were accessible only to the PhD committee chair and myself. Contact information was transcribed and the voicemail messages were deleted. Written consent forms and the contact information were stored in a locked file cabinet in the PhD committee chair's office. The interview data were labeled with identification numbers instead of participant names. A professional transcriptionist transcribed each recorded interview verbatim. Audio and transcription data were stored on a secure password-protected server. Only committee members and I had access to any of the written or digital data.

### **Data Analyses and Interpretation**

Two separate analyses were conducted on the participant narratives. Content analysis procedures as outlined by Krippendorff <sup>47</sup> were used to construct a typology of the ways in which being with others influenced the participants' depression (see manuscript 2). Standard constant comparison strategies Charmaz,<sup>19</sup> were used to develop the proposed theoretical framework (see manuscript 3). Detailed descriptions of data analysis and interpretation processes are provided in each manuscript.

### **Overview of Chapters Two to Four**

The 'Three Publishable Manuscripts Dissertation Format' was selected with input from my Research Advisory Committee. Chapters two through four of my dissertation,

therefore, consist of three dissertation manuscripts. The three manuscripts are full length, formatted, and each has been submitted to a peer-reviewed journal. Chapter Two is a scholarly review and integration of coping research related to adolescent depression. Chapter Three and Chapter Four are data-based and report the findings of the dissertation's four specific aims. Following are descriptions of each manuscript and the journals to which they have been submitted.

Chapter Two includes dissertation Manuscript 1. Manuscript 1 is a report of an integrative review that examined the associations between adolescent coping and depression over a span of ten years. Manuscript 1 has been submitted to *Archives of Psychiatric Nursing*. The mission of this journal is to support the international promotion of mental health care, literacy, and policy among advanced-practice psychiatric-mental health nurses. *Archives of Psychiatric Nursing* has an impact factor of 0.852 and publishes articles that address theory, practice, and research applications associated with a wide variety of ages, special populations, settings, and interdisciplinary collaborations in private and public sectors. *Archives of Psychiatric Nursing* was selected for Manuscript 1 because this journal publishes integrative reviews similar in structure and breadth to Manuscript 1 and reaches a wide audience of nurse researchers, practitioners, and policymakers.

Chapter Three includes dissertation Manuscript 2. Manuscript 2 is a report describing how AA adolescents manage depression through their interactions with people in their lives. Manuscript 2 has been submitted to the *Journal of the American Psychiatric Nurses Association*. This mission of this journal is to promote psychiatric nursing and improve mental health care for culturally diverse individuals, families, groups, and communities. The *Journal of the American Psychiatric Nurses Association* has an impact factor of 0.977 and publishes both clinical and research articles relevant to mental health nursing. The *Journal of the American Psychiatric Nurses Association*

was selected because the mission of the journal is congruent with the focus of Manuscript 2 and the findings will inform both researchers and clinicians.

Chapter Four includes dissertation Manuscript 3. Manuscript 3 presents an explanatory framework depicting how AA adolescents understand and manage depressive symptoms, and in some cases, use mental health services over the course of their adolescent years. Manuscript 3 has been submitted to *Qualitative Health Research*. *Qualitative Health Research* is international, interdisciplinary journal seeking to improve health care and advance the development and comprehension of qualitative research approaches. The journal has an impact factor of 1.441 and represents a wide array of perspectives including cross-cultural health, nursing, sociology, and public health. *Qualitative Health Research* publishes theory, methods, and research articles presenting the description and analysis of the illness experience, health and health-seeking behaviors, and sociocultural organization of healthcare. *Qualitative Health Research* was selected because Manuscript 3 is an excellent fit with the journal's mission and published content and the journal will allow for interdisciplinary dissemination.

#### **Overview of Chapter Five**

Chapter Five then synthesizes and integrates findings from all three manuscripts and describes how each manuscript builds upon the prior manuscript. The key findings generated during the completion of this dissertation study are highlighted. Chapter Five summarizes the limitations, clinical implications, and recommendations for future research from the three manuscripts.

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## CHAPTER TWO

This chapter presents the results of a comprehensive integrative review that examined coping techniques used by depressed adolescents titled, "An Integrative Review of the Associations Between Adolescent Coping Responses and Depression," which was submitted to the *Archives of Psychiatric Nursing*.

## **Abstract**

**Background:** Adolescent depression is a serious disorder resulting in negative health-related consequences if untreated.

**Purpose:** To systematically review the literature on the associations between coping responses and depression in adolescents.

**Design:** An integrative review of 36 articles, as described by Whitemore and Knaf<sup>19</sup> was conducted.

**Results:** Adolescents who actively confront stressors generally report fewer depressive symptoms, whereas those who avoid stressors tend to report more depressive symptoms. Adolescent coping research lacks consistency in the conceptualization and measurement of coping.

**Conclusions:** Despite limitations, findings suggest that mental health nurses should explore coping strategies used by depressed adolescents to determine how particular strategies affect their depression.

*Keywords:* Coping, Depression, Adolescent, Integrative Review

## **An Integrative Review of the Associations Between Adolescent Coping Responses and Depression**

Adolescent depression is a serious mental health problem that, if left untreated, results in a number of negative health consequences.<sup>22, 44, 67, 68</sup> Depression in adolescence often co-occurs with high-risk sexual behavior, early pregnancy, substance abuse, poor academic performance, psychosocial functioning impairment, and increased risk for suicide.<sup>3, 36, 39, 54</sup> Adolescents who are depressed are at higher risk for bipolar disorder and are more likely to experience depression as adults.<sup>12</sup>

Adolescents who are depressed often do not receive adequate mental health treatment.<sup>23</sup> Among a nationally representative sample of adolescents ages 12 to 17 diagnosed with a major depressive episode during the last year, 17% had received prescription medication, 11% had received treatment from a medical provider, 30% had received treatment from a mental health specialist, and 62% had received no form of treatment.<sup>23</sup> Perceptions by parents or adolescents that an adolescent had a mental health problem was associated with utilization of mental health services, but socioeconomic status, possessing insurance, and having access to and/or knowledge of available services were not consistently associated with utilization rates.<sup>3, 7, 18, 27, 79</sup> Research has shown that adolescents avoid using mental health services because of the hidden dangers or pitfalls they perceive.<sup>27</sup> They fear that if they seek services they will be seen as mentally ill, the provider will not respect their privacy, or the provider will not understand their concerns. Given these perceived pitfalls, adolescents engage in one of three paths: They avoid mental health services entirely to avoid the pitfalls, obtain treatment but do not fully engage in it to decrease their vulnerability to the pitfalls, or risk the pitfalls and let the treatment take hold by forming a meaningful relationship with a clinician.<sup>27</sup>

Because adolescents with depression frequently do not receive mental health treatment, they often cope with life stressors alone or with informal help Lazarus and Folkman<sup>47, 75</sup> defined coping as “a process in which cognitive or behavioral efforts are made to manage specific internal and/or external sources of psychological stress” (p.141). Compas, Connor-Smith<sup>19</sup> defined coping as “conscious volitional efforts to regulate emotions, cognition, behavior, physiology, and the environment in response to stressful events or circumstances” (p. 89.) Researchers have found that adolescents who are depressed may use maladaptive means of coping such as denial, substance use, self-blame, and behavioral disengagement<sup>36</sup> as well as adaptive means such as seeking assistance from important adults in their lives.<sup>26</sup>

Although a number of studies on coping and depression in adolescents have been conducted, the results of these studies have not been recently summarized and synthesized. Understanding the relationships between the use of specific coping responses and indices of depression could provide a better understanding of how adolescents with depression cope and what types of coping responses are helpful to them. The purpose of this integrative review is to systematically review the literature on the associations between coping responses and depression in adolescents. Documenting the nature of these associations will inform prevention and intervention initiatives for this population.

## **Methods**

### **Search Strategy**

The methodological strategies used in this integrated review were based on an approach outlined by Whitemore and Knaf<sup>77</sup> The scientific databases Psychinfo, CINAHL, and Medline were searched using a combination of the following search terms: adolescent(s), teen(s), depression, cope/coping, and manage(ment). The reference lists

of articles identified during the database searches were also examined to find additional relevant articles that did not surface during the database searches.

**Inclusion Criteria.** Criteria for inclusion of articles were as follows: a) reported on a research study conducted in the United States, (b) appeared in a peer-reviewed journal, (c) was published since 2005, (c) was written in English, (c) described a sample between the ages of 10 and 24, (d) included measures of both depression and coping, and (e) included a numerical index of the association between depression and coping. The search was limited to articles published since 2005 because stressors faced by adolescents in the last decade have changed dramatically, especially because of the proliferation of social media. The large age range (ages 10 to 24) chosen to signify adolescence was based on literature indicating that the developmental markers of adolescence have been extended in Western cultures.<sup>6</sup> Adolescence is usually considered to begin at puberty, which now often occurs as early as age 10, and milestones reflecting entry into adulthood (e.g., economic independence) are often delayed until the mid-20s.

Coping is often defined broadly and includes a wide variety of thoughts and behaviors. For the purpose of this review, studies were only included if coping was measured directly as a construct and included in the study aims. For example, a study examining the relationship between depressive symptoms and cigarette use among African American teens<sup>62</sup> was excluded because, although smoking could be considered a coping response, coping was not measured as a construct nor addressed in the aims of the study. Studies were excluded if both coping and depression were assessed but no associations between the two were examined or reported in the results. Studies were also excluded if the aim of the study was to understand coping with a specific disease. For example, a study examining coping in teens with cancer<sup>20</sup> was excluded because, although associations between coping and depression were reported, the manner in



which teens cope with cancer may be different from the manner in which teens cope with more common experiences such as academic, romantic, or family relationship stressors.

## Results

A total of 3,542 articles were retrieved using the search strategy outlined above. Review of published abstracts yielded 86 empirical articles that appeared to meet study criteria. The full-text articles were retrieved and examined more closely for inclusion. When the full-text articles were reviewed, it was determined that 36 articles met inclusion criteria (Table 1). The following information was extracted from each article: the citation, study purpose, sample, measures of depression and coping, and reported associations between coping and depression.

This information was displayed in a table format to facilitate cross-study examination and comparison (Table 1). When a particular coping response was reported to be associated with higher levels of depression, it is said to have a positive relationship with depression as displayed in the last column of Table 1. Conversely, when a particular coping response was reported to be associated with lower levels of depression, it was said to have a negative relationship with depression as displayed in the last column of Table 1.

As seen below in Table 1, over two-thirds ( $n=24$ ) of the studies used a cross-sectional design, six were longitudinal studies, and four were prospective studies. The majority of the studies ( $n=21$ ) had middle and high school samples, five studies had college samples, seven studies had community samples (e.g., homeless drop-in center), two had clinical samples (e.g. psychiatric outpatient clinic and hospital emergency department), and one did not provide sampling information. Though five of the studies had fewer than 100 participants, most ( $n=18$ ) had sample sizes between 100 and 300. Eight studies had between 300 and 1,000 participants, and the remaining five had sample sizes ranging from 1,000 to >12,000. Of studies that reported the racial/ethnic

composition of participants ( $n=34$ ), 15 were racially diverse. European American participants made up more than 70 percent of the sample in 12 studies, and six studies recruited only minority participants (e.g., African Americans, Southeast Asians, Latinos).

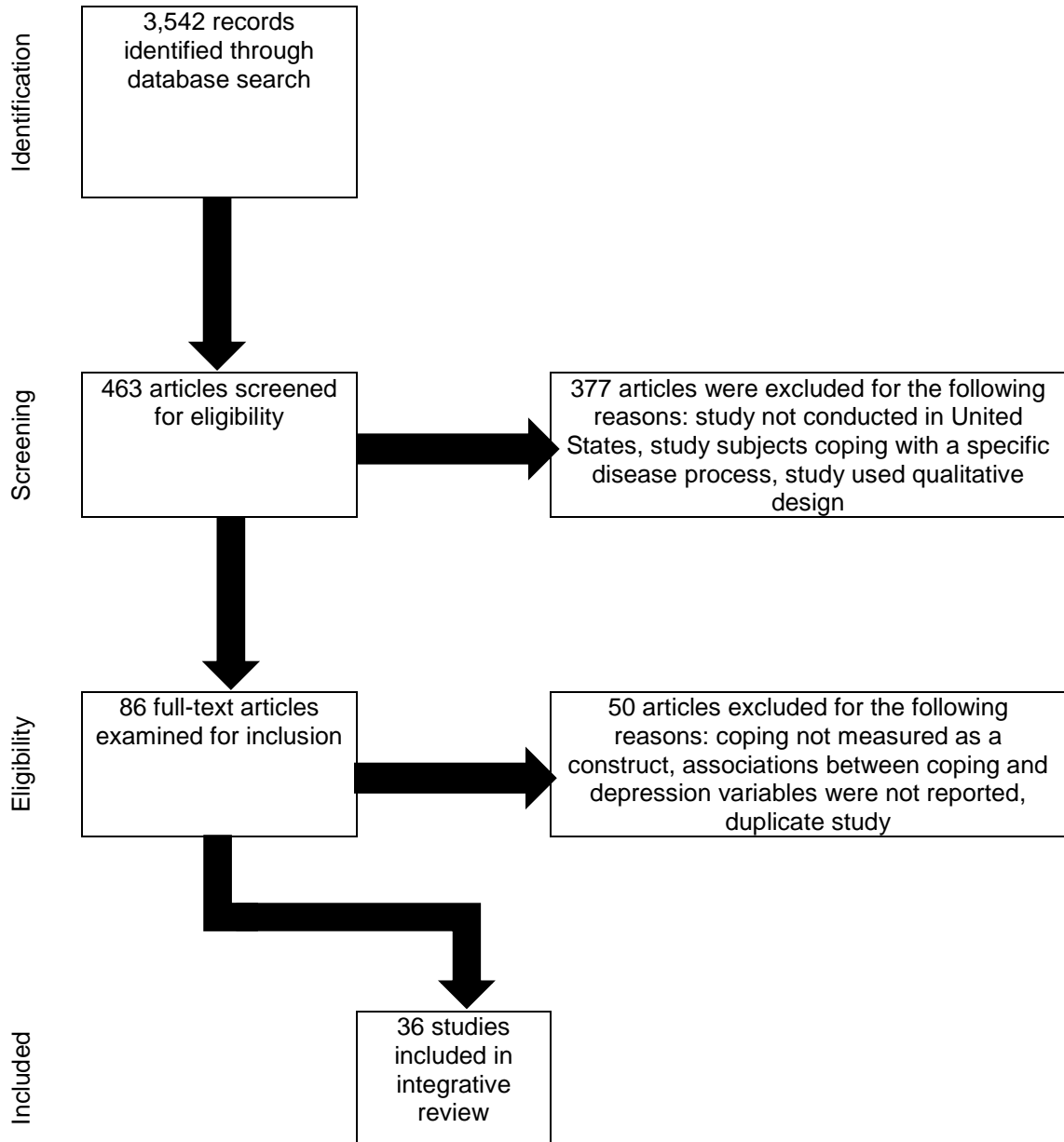


Figure 2-1. Flow of Search and Review Process

**Table 2-1.** Integrative Review Articles

	Author / Year	Design and Purpose	Sample/Setting	Depression Variables/Measures	Coping Variables /Measures	Associations between depression and coping variables
1	Aldridge & Roesch (2008)	Cross-sectional study using latent profile analysis to develop a coping typology of minority adolescents and explore the predictive ability of the typology with respect to depression and stress-related growth.	High school students from summer residential programs serving low-income students in San Diego. (ages=14–18) (N=354) (f=49%, m=51%)	Depressive symptoms (Children's Depression Inventory [CDI; Kovacs, 1981])	Dispositional coping styles (positive reinterpretation, instrumental social support, behavioral disengagement) (COPE [Carver et al., 1989]) Three coping profiles were determined: Class 1: Low generic copers (e.g. experimenting with various coping taxonomies but not employing these strategies to their fullest capacity), Class 2: Active copers (e.g., planning, instrumental social support), and Class 3: Avoidant copers (e.g., denial, behavioral disengagement, substance use, focusing and venting emotions)	The profiles were all positively associated with depression. Active copers experienced less depression than low generic copers. Low generic copers experienced less depression than avoidant copers.
2	Andreotti et al. (2013)	Correlational study to examine the relationships of cognitive reappraisal and secondary control coping to working memory, positive and negative affect, and symptoms of anxiety and depression.	Undergraduate students at a southeastern university (mean age=19.25) (N=124) (f=77.4%, m=22.6%)	Depressive symptoms (DSM Depression scale of the Adult Self Report [ASR; Achenbach & Rescorla, 2003])	Secondary control engagement coping (cognitive restructuring, positive thinking, acceptance, distraction). (Responses to Stress Questionnaire [RSQ; Connor-Smith et al., 2000])	Secondary control coping was negatively associated with depression.
3	Basanez et al. (2014)	Longitudinal study to examine the correlates of	Hispanic high school students in southern	Depressive symptoms	Avoidant and active coping Adolescent version of Kidcope Checklist (Spirito et al. 1988)	Avoidant coping in 11 <sup>th</sup> grade was positively associated with

		perceived ethnic in-group rejection.	California studied once in 10 <sup>th</sup> grade and again in 11 <sup>th</sup> grade. (ages=14–17) (N=2,214) (f=54%, m=46%)	(The Center for Epidemiologic Study-Depression Scale [CES-D; Radloff, 1977])		depressive symptoms in 11 <sup>th</sup> grade. Active coping in 11 <sup>th</sup> grade was negatively associated with depressive symptoms in 11 <sup>th</sup> grade.
4	Carleton et al. (2008)	Data drawn from correlational study to examine the protective role that religious coping serves against the development of depression.	Low income 6–8th grade students from seven Chicago public schools (mean age=12.7) (N=2,100) (f=46.9%, m=45.1%, not reported=8.0%)	Levels of depressive symptoms in children and adolescents (Children's Depression Inventory [CDI; Kovacs, 1992])	Three types of religious organizational resources (spiritual support, social support, and community involvement) (Congregational Development Questionnaire [CDQ; Pargament et al., 1991]) Extent to which adolescents use different coping strategies (Children's Coping Strategies Checklist – Ayers, Sandler, West, & Roosa, 1996)	Among females at low levels of stress only, religious coping resources were negatively associated with depression.
5	Carpenter et al. (2012)	Prospective correlational study to examine the relationships among positive and negative religious coping, stress, and depression.	9–12th graders in three private religious high schools in the Pacific Northwest (ages=14.1–19.3) (N=111) (f=72.1%, m=27.9%)	Depressive symptoms (short form of Children's Depression Inventory [CDI; Kovacs, 1985])	Positive religious coping (seven strategies including benevolent religious appraisals, collaborative religious coping, and seeking spiritual support) and negative religious coping (five strategies including spiritual discontent, punishing God reappraisal, and demonic reappraisal) (Brief RCOPE; Pargament et al., 1998)	In stressed youth, negative religious coping was positively associated with depression. In stressed youth, positive religious coping was not significantly associated with depression
6	Desrosiers & Miller (2007)	Correlational study to explore gender differences in the relationship between spirituality and depression.	Adolescents recruited from church groups, youth organizations, schools, and camps in New York City, New	Intensity of depression (Beck Depression Inventory [BDI; Beck, et al., 1961])	Positive religious coping subscale (the degree to which individuals use religion or spirituality to deal with adverse circumstances and to seek consolation and a sense of meaning). (Brief Multidimensional Measure of Religiousness/Spirituality [BMMRS; Fetzer Institute and the National	Positive religious coping in girls was negatively associated with depression.

			Jersey, Illinois, and San Francisco (ages 11–23) (N=615) (f=58.7%, m=41.0, not reported=0.3%)		Institute on Aging Working Group; 1999)	
7	Dew et al. (2009)	Longitudinal study to examine the relationships between depression and religious/spiritual characteristics in adolescent psychiatric outpatients.	Adolescent psychiatric outpatients from two clinics in North Carolina (ages=12-18) (N=145) (f=42%, m=58%)	Depressive symptoms (Beck Depression Inventory-II [BDI-II; Beck, Steer, & Brown, 1996])	Positive religious coping and negative religious coping (subscales of the Brief Multidimensional Measure of Religiousness/Spirituality [BMMRS; Fetzer Institute and the National Institute on Aging Working Group; 1999])	Negative religious coping was positively associated with depression. Positive religious coping was negatively associated with depression.
8	DuongTran (2011)	Cross-sectional study to investigate relationships among gender, ethnicity, stressful life events, coping-specific responses, and depression.	Southeast Asian American students in California and Washington (average age=15) (N=70) (f=42.9%, m=57.1%)	Depressive symptomatology (The Center for Epidemiologic Study-Depression Scale [CES-D; Radloff, 1977])	Preferred coping strategies (problem-focused, wishful thinking, detachment, seeking social support, focus on the positive, self-blame, tension reduction, and keeping to self)(Ways of Coping Checklist-Revised [WCCL-R; Folkman & Lazarus, 1985]) Total coping score frequency distribution divided into tripartites of copers (low, medium, and high).	Wishful thinking was positively associated with depression. Low, Medium, or High coping scores were not associated with depression.
9	Dyson & Renk (2006)	Correlational study examining the relationships among college freshmen's sex,	College freshmen at a southeastern university (ages=18–22)	Depressive symptoms (Beck Depression Inventory-II [BDI-II;	Coping strategies used during first year of college: Problem-focused coping (active coping, planning, suppression, restraint, and seeking instrumental support); Emotion-focused coping	Among females, avoidant coping was negatively associated with depression.

		gender role, stress level, coping strategies, and depression.	(N=74) (f=68.92%, m=31.08%)	Beck, Steer, & Brown, 1996)	(seeking emotional support, positive reinterpretation, acceptance, denial, and religion); Avoidant coping (behavioral disengagement, mental disengagement, drug use, humor) (Subscales of the COPE [Carver et al., 1989])	Among males, avoidant coping was not associated with depression. Problem-focused and emotion-focused coping were not associated with depression in males or females.
10	Epstein-Ngo et al. (2013)	Data drawn from a larger study on Latina families living in low-income, urban environments. Study to investigate the mediating and moderating capacity of stress responses and coping strategies in relation to community violence exposure, psychological wellbeing.	Latino youth from three high schools in two Northeastern cities. (mean age=14.5) (N=223) (f=61%, m=39%)	Depressive symptoms (Children's Depression Inventory [CDI]; Kovacs, 1981)	Coping strategies (religious coping, emotional support seeking, and denial) (Subscales of the COPE [Carver et al., 1989])	Religious, emotional support seeking, and denial coping were not associated with depression.
11	Erdem & Slesnick (2010)	Data drawn from randomized clinical trial testing substance abuse interventions. Correlational study exploring	Youth from runaway crisis center in Midwestern city. (ages=12-17) (N=140) (f=51.4%, m=48.6%)	Depressive symptoms (Beck Depression Inventory-II [BDI-II]; Beck, Steer, & Brown, 1996)	Task oriented coping subscale of the Coping Inventory for Stressful Situations – Adolescent version (CISS; Endler & Parker, 1990)	Task-oriented coping skills were not associated with depression.

		the risk and protective factors associated with runaway adolescents' depressive symptoms.				
12	Fear et al. (2009)	Correlational study to examine the role of perceptions of self-blame specific to interparental conflict and coping in the context of parental depressive symptoms as predictors of symptoms in youth of depressed parents.	Youth from mental health & general practice clinics, university, schools, and community center settings. (ages=9–15) (N=108) (f=53.7%, m=46.3%)	Depressive symptoms (The Child Behavior Checklist [CBCL; Achenbach & Rescorla, 2001])	Primary control engagement coping (problem solving, emotional expression, emotional modulation), secondary control engagement coping (cognitive restructuring, positive thinking, acceptance, distraction), and disengagement coping (avoidance, denial, wishful thinking) (Responses to Stress Questionnaire [RSQ; Connor-Smith et al., 2000])	Primary and secondary control engagement coping were negatively associated with depression. Disengagement coping was not associated with depression.
13	Garnett et al. (2015)	Cross-sectional study using latent profile analysis to develop a coping typology of ethnically diverse urban adolescents and explore associations of	Ethnically diverse youth in urban Boston. (mean age=16.29) (N=927) (f=58%, m=42%)	Depressive symptoms (adapted 5 item scale [26-item Modified Depression Scale; Dunn, Johnson, & Green, 2012])	Coping Latent Class Analysis indicators (avoidance, distraction, support, self-harm/substance abuse, other).	Avoidant and support-seeking latent classes were negatively associated with depressive symptoms. Distractive coping styles were negatively associated with depressive symptoms.

		the typology with discrimination, bullying, and depression.				
14	Gaylord-Harden et al. (2010)	Correlational study to demonstrate the replicability of statistical suppressor effects in coping research.	Low income African American sixth to eighth grade from five urban public schools (ages=M=12.90) (N=268) (f=56%, m=44%)	Depressive symptoms (Children's Depression Inventory [CDI; Kovacs, 1981])	Coping strategies (active, avoidant, support-seeking, and distraction) (How I Coped Under Pressure Scale – Revision 1 [HICUPS-R1; Program for Prevention Research, 1999])	No single coping strategy was associated with depression. Avoidant coping and support-seeking coping were positively associated with depression in the full structural equation model. Active coping was negatively associated with depression in the full structural equation model.
15	Horwitz et al. (2011)	Cross-sectional study to examine relationship of coping to depression and suicidal ideation.	Adolescents seeking services in a Midwestern university hospital emergency department (ages 13-17) (N=140) (f=59.3%, m=40.7%)	Frequency and severity of depressive symptoms (Reynolds Adolescent Depression Scale [RADS; Reynolds, 1987])	Emotion-focused coping (substance use, use of emotional support, venting, positive reframing, humor, acceptance, religion, & self-blame); Problem-focused coping (active coping, use of instrumental support, and planning); Avoidant coping (distraction, denial, and behavioral disengagement) (Brief COPE - Carver, 1997)	Emotion-focused and avoidant coping were positively associated with depression. Problem-focused coping was negatively associated with depression. Specific coping behaviors positively associated with depression were denial, substance abuse, emotional support, behavioral disengagement. Active coping was the only specific coping behavior negatively associated with depression.
16	Jaser et al. (2011)	Cross-sectional study to examine the relationships among coping,	Adolescents of staff at a large university medical center	DSM-Oriented affective problems indicated depressive symptoms (The	Voluntary coping strategies (primary control, secondary control, and disengagement coping) (parental depression version of Responses to	Disengagement coping was positively associated with depression.



		observed affect, and depression in adolescents of mothers with and without a history of depression	(ages 11–14) (N=72) (f=50%, m=50%)	Child Behavior Checklist [CBCL; Achenbach & Rescorla, 2001]) and (Youth Self Report [YSR; Achenbach, 1991])	Stress Questionnaire – RSQ; Conner-Smith et al., 2000; Langrock et al., 2002)	Primary control and secondary control coping were negatively associated with depression.
17	Kassel et al. (2006)	Prospective cross-sectional study to examine the association of negative mood regulation expectancies to symptoms of depression and anxiety.	Undergraduate students at Southeastern university (ages 18–24) (N=322) (f=81%, m=19%)	Depressive symptomology The Inventory to Diagnose Depression (IDD; Zimmerman, Coryell, Corenthal, & Wilson, 1986)	Strategies used in response to stressful situations. Five coping styles measured (avoidant, blaming, wishful thinking, problem focused, seeks social support) (Revised Ways of Coping Checklist [RWCCCL; Vitaliano, Russo, Carr, & Maiuro, & Becker, 1985])	Maladaptive coping was positively associated with increased depression. Adaptive coping was negatively associated with depressive symptoms.
18	Kort-Butler (2008)	Longitudinal study using data drawn from Add Health to examine how coping styles are gendered in ways that contribute to sex difference in depressive symptoms and delinquent behavior.	7–12 <sup>th</sup> graders from a representative U.S. sample (age=M=15.8) (N=12,270) (f=51.1%, m=48.5%)	Depressive symptoms (The Center for Epidemiologic Study-Depression Scale [CES-D; Radloff, 1977])	Coping styles (avoidant coping, approach coping, and action coping) (Questions from the National Longitudinal Study of Adolescent Health, 1995)	Avoidant and action coping were positively associated with depression. Approach coping was negatively associated with depression.
19	Li et al. (2006)	Cross-sectional study to investigate the roles of sex,	High school students (ages 14–18) (N=246)	Depressive symptoms (Reynolds Adolescent	Emotion-focused, problem-focused, ruminative, and distractive coping (Adolescent Coping Scale - ACS; Freydenberg & Lewis, 1993)	Ruminative coping was positively associated with depression.

		gender, and coping in adolescent depression.		Depression Scale [RADS; Reynolds, 1987])		Distractive and problem - focused coping were negatively associated with depression. No association between emotion-focused coping and depression and was reported.
20	Mahmoud et al. (2012)	Data drawn from a cross-sectional study to examine the relationship of depression, anxiety, and stress to life satisfaction and coping strategies.	Undergraduate students from psychology courses at a public university in Southeastern city. (ages 18–24) (N=508) (f=66%, m=34%)	Depression (Depression subscale of the Depression Anxiety Stress Scale-21 [DASS-21; Lovibond & Lovibond, 1995])	Adaptive coping (acceptance, planning, and positive reframing) and maladaptive coping (denial, self-blaming, and substance use) (Brief COPE Inventory [BCI; Carver, 1997])	Maladaptive coping was positively associated with higher levels of depression. Adaptive coping was not associated with depression.
21	Martyn-Nemeth et al. (2009)	Descriptive, correlational cross-sectional study to investigate relationships among self-esteem, stress, social support, and coping and to test a model of their effects on unhealthy eating behavior and depressive mood.	High school students in a suburban metropolitan Midwest area. (ages=14–18) (N=102) (f=79.4%, m=20.6%)	Depressive mood (Kandel Depressive Mood Scale for adolescents [Kandel & Davies, 1982])	Approach and avoidant coping (related to school, parents, peers, romantic interests, self, and future) (Coping Across Situations Questionnaire [CASQ; Seiffge-Krenke, 1995])	Approach and avoidant coping were not associated with depression.

22	Merlo & Lakey (2007)	Longitudinal study to examine the trait and social influence components of attachment, depression, and coping.	9–12 <sup>th</sup> graders at a parochial school in Detroit, MI (ages 14–18) (N=150) (f=53%, m=47%)	Depressive symptoms (The Center for Epidemiologic Study-Depression Scale [CES-D; Radloff, 1977])	Coping strategies (problem solving, seeking social support, and avoidance) (Coping Strategy Indicator [Amirkhan, 1990])	Avoidant coping was positively associated with trait and social influence components of depression. Problem solving and support seeking were negatively associated with social influence components of depression.
23	Mosher & Prelow (2007)	Correlational study to examine relationships among maternal involvement, adolescent coping, coping efficacy, ethnicity, and depressive symptoms.	African American and European American students in northeastern United States (ages=13–19) (N=243) (f=56%, m=43.6%, not reported=0.4%)	Depressive symptomatology (Center for Epidemiological Studies Depression Scale-Brief Version [CESD-B; Roberts & Sobhan, 1992])	Active coping (positive cognitive restructuring [positive focus, optimism, and control]; problem focused coping [cognitive decision making, direct problem solving, and seeking understanding]) Avoidant coping (wishful thinking, repression, and avoidant actions) (Children's Coping Strategies Checklist – Ayers, Sandler, West & Roosa, 1996)	Among African Americans, active coping was negatively associated with depression and coping efficacy. Among African Americans, avoidant coping was not associated with depression. Among European Americans, avoidant coping was positively associated with depression. Among European Americans, active coping was not associated with depression.
24	Nyamathi et al. (2012)	Data drawn from larger study to conduct a cross-sectional study to explore coping style and depression among homeless young adults.	Homeless young adults recruited from a drop-in agency in Santa Monica, California (ages=15-25) (N=156) (f=26.3%, m=73.7%)	Depressive symptoms (The Center for Epidemiologic Study-Depression Scale [CES-D; Radloff, 1977])	Coping strategies (self-destructive escape, passive problem solving, positive action, spiritual hope, withdrawal, social support, and nondisclosure/problem avoidance) (Coping with Recent Stressful Events; [Murphy, Rotheram-Borus & Marelich, 2003])	Passive problem solving, withdrawal, and nondisclosure/problem avoidance were positively associated with depression. No associations between positive action, spiritual hope, or social support and depression were reported.

25	Peden et al. (2005)	Cross-sectional study to determine the prevalence, correlates, and predictors of depression in rural adolescents.	High school students from agricultural classes in Kentucky and Iowa (ages=14–18) (N=299) (f=40%, m=60%)	Depressive symptomatology (The Center for Epidemiologic Study-Depression Scale [CES-D; Radloff, 1977])	Active coping (John Henryism Scale for Active Coping [JHS; James et al., 1983])	Active coping was negatively associated with depression.
26	Perez et al. (2009)	Data drawn from a larger prospective longitudinal study to examine relationships of personal agency beliefs, direct coping, and spirituality to depressive symptoms.	6-9 <sup>th</sup> graders in a Northeastern public school system (ages=11-15) (N ≈ 1,096) (f=50%, m=50%)	Levels of depressive symptoms in children and adolescents (Children's Depression Inventory [CDI; Kovacs, 1992])	Direct coping (Behavioral Inventory of Strategic Control [BISC; Lopez & Little, 1996])	Among females, direct coping was negatively associated with depression.
27	Pina et al. (2008)	Correlational study to examine ability of social support, discrimination, and coping to predict post-disaster PTSD, anxiety, and depression in youth survivors of Hurricane Katrina.	Youth residing in the greater New Orleans area at the time of Hurricane Katrina. (mean age=11.43) (N=46) (f=39%, m=61%)	Depressive symptoms (Revised Child Anxiety and Depression Scale [RCAD; Chorpita, Yim, Moffitt, Umemoto, & Francis, 2000])	Active coping: positive cognitive restructuring (e.g., positivity, optimism,) and problem-focused coping (e.g., seeking understanding) Avoidant coping (e.g., repression, avoidant actions) (Children's Coping Strategies Checklist [CCSC; Program for Prevention Research, 1999])	Avoidant coping was positively associated with depression. Active coping was not significantly associated with depression.

28	Rohde et al. (2006)	Correlational study to identify demographic, psychopathology, and psychosocial factors predicting time to recovery from major depressive disorder (MDD) and moderators of cognitive behavioral therapy for MDD	Youth from a juvenile justice center in Oregon. (ages=13–17) ( <i>N</i> =114) ( <i>f</i> =48%, <i>m</i> =52%)	Depression severity (Beck Depression Inventory-II [BDI-II; Beck, Steer, & Brown, 1996])	Positive coping skills (cognitive or behavioral) and passive or ineffective coping (17-item tool; Rohde, Lewinsohn, Tilson, & Seeley, 1990)	Positive coping was associated with faster recovery from major depressive disorder. No treatment effect was associated with ineffective coping.
29	Rossi & Meber (2011)	Cross-sectional study to examine the existence of quarterlife crisis, an identity crisis that leaves recent college graduates depressed, anxious, and full of doubt.	4 groups of transitioning young adults High school-to-work (average age=18.7) ( <i>N</i> =23) ( <i>f</i> =61%, <i>m</i> =39%) High school-to-college (average age=18.63) ( <i>N</i> =75) ( <i>f</i> =73%, <i>m</i> =27%) College-to-work (average age=23.42) ( <i>N</i> =117) ( <i>f</i> =72%, <i>m</i> =28%) College-to-grad school	Depressive symptoms (The Center for Epidemiologic Study-Depression Scale [CES-D; Radloff, 1977])	Active-cognitive, active-behavioral, and avoidance coping (32-item questionnaire drawn from Health and Daily Living Form [HDL; Moos, Cronkite, Billings, & Finney, 1983]) Higher total scores of active and avoidance coping indicated greater use of positive coping.	Total coping was negatively associated with depression.

			(average age=23.26) (N=57) (f=79%, m=21%)			
30	Seaton et al. (2014)	Study to assess if the mediating capacity of coping strategies was contingent on specific levels of racial identity dimensions when examining the relation between perceived racial discrimination and depressive symptoms among Black youth.	High school students from Southeastern city. (ages=13–18) (N=314) (f=67%, m=22%)	Depressive episodes (The Center for Epidemiologic Study-Depression Scale [CES-D; Radloff, 1977])	Coping responses to problems or challenging situations (active, distraction, avoidant, support seeking coping) (Children's Coping Strategies Checklist – CCSC; Ayers, Sandler, West & Roosa, 1996)	Avoidant and distraction coping were associated with high levels of depression. Active coping was negatively associated with depression. Support-seeking coping was not significantly associated with depression.
31	Spann et al. (2006)	Data drawn from correlational study to examine relationships among suicidality, hopelessness, depression, locus of control, and religious coping.	African American high school students from a Washington DC suburb. (ages=13–19) (N=176) (f=65.3%, m=34.7%)	Depressive symptoms (Reynolds Adolescent Depression Scale [RADS; Reynolds, 1987])	Religious coping styles (self-directive, deferring, and collaborative) (Religious Coping Scale [RCS; Pargament et al., 1988])	Self-directive religious coping was positively associated with depression. Deferring and collaborative religious coping were not associated with depression.
32	Sung et al. (2006)	Cross-sectional study to examine the relationships among coping, gender, and	High school students in a farming community in	Depressive symptoms (Reynolds Adolescent Depression Scale	Approach coping (logical analysis, positive reappraisal, guidance and support, and problem solving) and Avoidance coping (cognitive avoidance, resignation or acceptance, seeking	Approach coping (logical analysis and problem solving) and avoidance coping (cognitive avoidance, acceptance or resignation,

		psychosocial factors.	southwestern Pennsylvania. (ages=14–18) (N=72) (f=66.7%, m=33.3%)	[RADS; Reynolds, 1987])	alternative rewards, and emotional discharge) (Coping Response Inventory-Youth [CRI-Y; Moos, 1993])	and emotional discharge) were positively associated with depression.
33	Thompson et al. (2010)	Correlational study to examine interactions of adaptive coping and maladaptive coping with depressive symptoms.	Girls with no prior history of a mental disorder. (ages=9–14) (N=149) (f=100%, m=0%)	Depressive symptoms (Children's Depression Inventory [CDI-S; Kovacs, 1985])	Maladaptive coping (involuntary engagement and involuntary disengagement) and adaptive coping (primary control and secondary control) (Responses to Stress Questionnaire [RSQ; Connor-Smith et al., 2000])	Maladaptive coping was positively associated with depression. Primary and secondary control coping were not associated with depression.
34	Van Voorhees et al. (2008)	Longitudinal correlational study using data drawn from a national study to examine relationships between depression and individual, family, school and community factors.	7–12 <sup>th</sup> graders from a representative U.S. sample (ages 11–18) (N [wave 1]=6,504) (N [wave 2]=4,791)	Depressive episodes (The Center for Epidemiologic Study-Depression Scale [CES-D; Radloff, 1977])	Active coping (problem-solving orientation and problem-solving strategies) (Questions from the National Longitudinal Study of Adolescent Health, 1995)	Active coping was negatively associated with new onset of depression.
35	Vanlede et al. (2007)	Longitudinal study to examine the relationships of action-control beliefs and behaviors to	6–7 <sup>th</sup> graders from an urban, residential, and commercial community on the East Coast.	Depressive symptoms (Children's Depression Inventory [CDI; Kovacs, 1985])	Coping strategies (direct, indirect, prosocial, and antisocial) (Behavioral Inventory of Strategic Control [BISC; Little, et al., 2001])	Direct coping was negatively associated with depression. No associations between indirect or prosocial coping and depression were reported.

		adjustment during the transition from elementary school to middle school.	(N=368)			
36	Wilson et al. (2005)	Correlational study to examine relationships among gender, coping, and physical and psychological health.	Middle and high school students (ages=10–19) (N=542) (f=58.9%, m=41.1%)	Depression (Profile of Mood States Short Form – Depression Subscale [POMS-SF; Shacham, 1983])	Coping strategies (emotion-focused, problem-focused, and avoidant) (Brief COPE - Carver, 1997)	Among females, avoidant coping and emotion-focused coping were positively associated with depression. Among females, problem-focused coping was negatively associated with depression. Among males, emotion-focused coping was positively associated with depression. Among males, problem-focused and avoidant coping were not associated with depression.



## Measures

The two major constructs of interest – coping and depression – were measured with a variety of instruments. Though depression was measured with a small number of commonly used standard instruments, coping was measured with a wide variety of tools.

**Depression.** Depression was measured in 29 of the studies with one of five depression measures. The Center for Epidemiologic Study – Depression scale (CES-D)<sup>61</sup> was used in 10 studies; the Children’s Depression Inventory (CDI)<sup>46</sup> was used in eight; the Beck Depression Inventory (BDI)<sup>10</sup> was used in five; the Reynolds Adolescent Depression Scale (RADs)<sup>63</sup> was used in four; and the Child Behavior Checklist (CBCL)<sup>1</sup> was used in two studies. Miscellaneous depression measures were used in the remaining eight studies.

**Coping.** Two instruments developed by Carver, the COPE<sup>16</sup> and the Brief COPE,<sup>15</sup> were used to measure coping in six studies. Two measures, the Children’s Coping Strategies Checklist (CCSC)<sup>8</sup> and the Responses to Stress Questionnaire (RSQ),<sup>21</sup> were each used to measure coping in four studies. Four other coping measures, the Behavioral Inventory of Strategic Control (BISC),<sup>49</sup> the Brief Multidimensional Measure of Religiousness/Spirituality (BMMRS),<sup>37</sup> the Revised Ways of Coping Checklist (RWCCCL),<sup>74</sup> and questions for the National Longitudinal Study of Adolescent Health,<sup>38</sup> were used twice in eight studies. Each of the remaining 15 studies assessed coping with a different measure. Authors of the studies included in the review used a variety of coping theories to guide their work, including Lazarus and Folkman’s transactional model of stress and coping;<sup>47</sup> Moos Model of Context, Coping, and Adaptation;<sup>11</sup> the Response Styles Theory;<sup>55</sup> and Conflict Theory.<sup>41</sup>

## Organization of Studies

Coping is a complex construct and several dimensions and subtypes of coping have been proposed.<sup>19</sup> The most commonly used dimensions of coping are problem-

and emotion-focused coping,<sup>47</sup> engagement (approach) and disengagement (avoidance) coping,<sup>30</sup> and primary and secondary control coping.<sup>66</sup> Problem-focused coping responses are actions used to alter the circumstances causing the stress, whereas emotion-focused coping responses are used to alter the negative emotions experienced in response to the stress.<sup>47</sup> Engagement coping responses are oriented towards the source of stress or emotions experienced in response to the stress, and disengagement coping responses are oriented away from the stressor and/or away from thoughts and emotions experienced in response to the stress.<sup>30</sup> Primary control coping responses are used to impact events by fixing the problem (i.e., problem-solving) or regulating emotions felt in response to the problem, whereas secondary control coping responses are used to adapt to the problem (i.e., acceptance).<sup>66</sup>

Researchers have explored and measured a variety of coping subtypes used by adolescents, including acceptance, avoidance, cognitive restructuring, denial, distraction, emotional modulation, emotional release, information seeking, problem solving, religion, rumination, social support seeking, social withdrawal, substance use, venting, and wishful thinking.<sup>19</sup> Though coping subtypes have been grouped into coping dimensions with the use of confirmatory factor analysis, there is no consensus on the best way to conceptualize coping subtypes because studies use different coping measures with diverse samples. For example, Ayers and Sandier<sup>8</sup> analyzed 10 coping scales and proposed a model with four factors: active coping, social support, distraction, and avoidance. Alternately, Walker and Smith<sup>76</sup> proposed a model with three factors: active coping, passive coping, and accommodative coping.

To organize the studies in this integrative review we chose four subtypes of coping that appeared most frequently in the sample of articles. The subtypes were problem-focused coping, emotion-focused coping, avoidant coping, and religious coping. Four tables were constructed for each subtype, and studies are displayed in each of the

four tables if they had a measure of coping consistent with that subtype of coping. Any study, for example, that included a measure of coping consistent with problem-focused coping was placed in Table 2.

Studies that did not fit into any of the four categories were added to the “Other Coping” Table (Table 6) and will be discussed separately. Some studies used the same term for a particular coping response; however, the descriptions of the response were different. As a result, the same term may appear on different tables. For example, the coping response “active coping” from the Van Voorhees and Panunesku<sup>72</sup> article is listed on the Problem-Focused Table (Table 2) because it is described in the article as “problem solving orientation and problem solving strategies,” whereas the term active coping from the Mosher and Prelow<sup>53</sup> article is listed on the Other Coping Table (Table 6) because it is described in the article as “positive cognitive restructuring and problem-focused coping.” Findings related to the coping subtypes are described below.

***Problem-focused Coping.*** Sixteen studies measured coping responses that could be considered problem-focused coping responses (Table 2). A commonly used definition of problem-focused coping is any coping response that “acts on the source of stress in the environment.”<sup>19</sup> In these 16 studies, problem-focused coping responses were referred to with a variety of terms including problem solving, active coping, and direct coping.

Five studies measured coping responses referred to broadly as problem-focused. These studies considered the construct of problem-focused coping to include any responses aimed at fixing a problem or reducing a source of stress. Of these studies, three revealed a negative association between problem-focused coping and Depression,<sup>39, 48, 52</sup> and one revealed a negative association between problem-focused coping and depression among females only.<sup>78</sup> However, one study did not find an

association between problem-focused coping and depression,<sup>29</sup> and one did not find an association between problem-focused coping and depression among males.<sup>78</sup>

**Table 2-2.** Problem-focused Coping Findings

Author/Year	Coping Responses	Association with Depression		
		Positive	Negative	None
Dyson & Renk (2006)	Problem-focused Coping			x
Horwitz et al. (2011)	Problem-focused Coping		x	
Li et al. (2006)	Problem-focused Coping		x	
Merlo & Lakey (2007)	Problem Solving		x <sup>A</sup>	
Wilson et al. (2005)	Problem-focused Coping		x <sup>B</sup>	x <sup>C</sup>
Gaylord-Harden et al. (2010)	Active Coping		x <sup>D</sup>	
Peden et al. (2005)	Active Coping		x	
Seaton et al. (2014)	Active Coping		x	
Van Voorhees et al. (2008)	Active Coping		x	
Kort-Bulter (2008)	Approach Coping		x	
Martyn-Nemeth et al. (2009)	Approach Coping		x	
Sung et al. (2006)	Approach Coping	x		
Perez et al. (2009)	Direct Coping		x	
Vanlede et al. (2007)	Direct Coping		x	
Erdem & Slesnick (2010)	Task Oriented Coping			x
Nyamathi et al. (2012)	Positive Action			x

Four studies measured coping responses referred to as “active coping.” These studies generally considered active coping to include responses aimed at solving a problem or improving a situation. All four studies provided evidence for a negative association between active coping and depression.<sup>35, 58, 69, 72</sup> Three studies measured coping responses referred to as “approach coping.” These studies considered approach coping to be responses that incorporated logical analysis, positive reappraisal, and problem solving. Two studies measured coping responses referred to as “direct Coping,”<sup>59, 73</sup> considered to be efforts to actively solve interpersonal problems. These studies provided evidence for a negative association between approach and direct

<sup>A</sup> Social influence variables of depression only

<sup>B</sup> Among females

<sup>C</sup> Among males

<sup>D</sup> In full structural equation model

coping and depression. Other types of problem-focused coping were referred to as “task-oriented coping,”<sup>32</sup> described as proactive coping responses to a particular stressor, and “positive action coping,” described as “thinking about what is important and getting life together.”<sup>56</sup> The studies revealed no association between these two types of coping and depression.

Overall, most studies ( $N=12$ ) measuring a form of problem-focused coping responses provided evidence that these forms of coping are beneficial and likely serve to prevent or decrease depressive symptoms. These findings suggest that it is typically advantageous if adolescents, when faced with life stressors, cope with these stressors by confronting them in some active or direct way.

**Emotion-focused Coping.** Eleven studies measured coping responses that could be considered “emotion-focused” (Table 3). A commonly used definition of emotion-focused coping is any coping response that “palliates negative emotions arising from a stressful encounter or event.”<sup>19</sup> In these studies, emotion-focused coping responses were referred to with several terms including “support seeking,” “emotional expression,” and “wishful thinking.”

**Table 2-3.** Emotion-focused Coping Findings

Author/Year	Coping Responses	Association with Depression		
		Positive	Negative	None
Epstein-Ngo et al. (2013)	Emotional Support Seeking			x
Garnett et al. (2015)	Support Seeking	x		
Merlo & Lakey (2007)	Seeking Social Support		x <sup>A</sup>	
Nyamathi et al. (2012)	Social Support			x
Seaton et al. (2014)	Support Seeking Coping			x
Vanlede et al. (2007)	Prosocial Coping			x
Dyson & Renk (2006)	Emotion-focused Coping			x
Horwitz et al. (2011)	Emotion-focused Coping	x		
Wilson et al. (2005)	Emotion-focused Coping	x		
Doungtran (2011)	Wishful thinking Coping	x		
Li et al. (2006)	Ruminate	x		

<sup>A</sup> Associated with the social influence variables of Depression

Six studies measured coping responses referred to as social support seeking. These studies considered social support seeking to be responses involving the pursuit of emotional support from others. Of these studies, four found no association between social support seeking and depression,<sup>31, 56, 69, 73</sup> one revealed a positive association between social support seeking and depression,<sup>34</sup> and one revealed a negative association between social support and depression.<sup>52</sup>

Three studies measured coping responses referred to broadly as emotion-focused coping. These studies generally considered the construct of emotion-focused coping to include any responses that minimize negative emotions resulting from a stressful encounter or event. Of these studies, two provided evidence for a positive association between emotion-focused coping and depression,<sup>39, 78</sup> and one study found no association between emotion-focused coping and depression.<sup>29</sup> Other types of emotion-focused coping were referred to as wishful thinking, described as wishing a “situation would go away,”<sup>28</sup> and rumination, described as continuous thinking about the negative emotions associated with a particular problem or stressful situation.<sup>48</sup> These studies revealed that both these types of coping were positively associated with depression.

Overall, there were mixed results regarding the associations between depression and responses within the emotion-focused coping subtype. The findings of the studies measuring the relationship between social support seeking and depression were inconsistent, and thus it is unclear if this coping response is beneficial to teens with depression. Most studies measuring other emotion-focused responses found positive associations with depression, suggesting that these forms of coping are disadvantageous to adolescents with depression. These findings suggest that it is either of no help or possibly damaging if adolescents, when dealing with a stressor, manage the stress by using emotion-focused coping responses.

**Avoidant Coping.** Nineteen studies measured coping responses that could be considered avoidant coping responses (Table 4). A commonly used definition of avoidant coping is any coping response that is “oriented away from the stressor or one’s thoughts and emotions.”<sup>19</sup> A variety of terms were used to refer to avoidant coping responses including problem avoidance, cognitive avoidance, and social withdrawal.

**Table 2-4.** Avoidant Coping Findings

Author/Year	Coping Responses	Association with Depression		
		Positive	Negative	None
Basanez et al. (2014)	Avoidant Coping	x		
Dyson & Renk (2006)	Avoidant Coping		x <sup>A</sup>	x <sup>B</sup>
Garnett et al. (2015)	Avoidance	x		
Horwitz et al. (2011)	Avoidant Coping	x		
Kort-Butler (2008)	Avoidant Coping	x		
Martyn-Nemeth et al. (2009)	Avoidant Coping		x	
Merlo & Lakey (2007)	Avoidance	x		
Mosher & Prelow (2007)	Avoidant Coping	x <sup>C</sup>		x <sup>D</sup>
Nyamathi et al. (2012)	Problem Avoidance	x		
Pina et al. (2008)	Avoidant Coping	x		
Seaton et al. (2014)	Avoidant	x		
Sung et al. (2006)	Avoidance Coping	x		
Wilson et al. (2005)	Avoidant	x <sup>A</sup>		x <sup>B</sup>
Garnett et al. (2015)	Distraction		x	
Seaton et al. (2014)	Distraction	x		
Li et al. (2006)	Distractive Coping		x	
Jaser et al. (2011)	Disengagement	x		
Fear et al. (2009)	Disengagement Coping			x
Epstein-Ngo et al. (2013)	Denial			x
Mahmoud et al. (2012)	Maladaptive Coping	x		
Nyamathi et al. (2012)	Withdrawal	x		

Thirteen studies measured coping responses referred to generally as avoidant coping. These studies considered avoidant coping to include responses that were focused away from a stressor or emotions experienced in response to a stressor. Of

<sup>A</sup> Among females

<sup>B</sup> Among males

<sup>C</sup> Among European American youth

<sup>D</sup> Among African American youth

these, 11 revealed a positive association between avoidant coping and depression, three studies did not reveal any associations between avoidant coping and depression,<sup>29, 53, 78</sup> and two studies revealed a negative association between avoidant coping and depression.<sup>29, 51</sup>

Three studies measured coping responses referred to as distractive coping. These studies considered distractive coping to include responses that distract one from thinking about the problem or stressor. Of these, two provided evidence for a negative association between distractive coping and depression,<sup>34, 48</sup> and one reported a positive association between distractive coping and depression.<sup>69</sup> Two studies measured coping responses referred to as disengagement coping. These studies considered disengagement coping to include responses that were a combination of avoidance and denial. One study found evidence for a positive association between disengagement coping and depression<sup>42</sup> and one study found no association between disengagement and depression.<sup>33</sup> Other types of avoidant coping were referred to as denial, described as refusing to believe a problem is real,<sup>31</sup> and maladaptive coping, described as a combination of denial, self-blame, and substance abuse.<sup>50</sup> One study found denial<sup>31</sup> had no association with depression,<sup>50</sup> and another study found a positive association between maladaptive coping and depression.

Overall, among the studies measuring a type of avoidant coping, the majority ( $N=11$ ) provided evidence that avoidant coping responses were commonly associated with depression. The findings suggests that avoidant coping responses are likely to be ineffective in ameliorating or preventing depression. No negative associations were found between distractive, disengagement, denial, maladaptive, and withdrawal coping responses and depression, suggesting that these types of responses are not likely to be beneficial for adolescents who are depressed.



**Religious Coping.** Seven studies measured coping responses that could be considered religious coping responses (Table 5). A commonly used definition of religious coping is any coping response that is “spiritually or religiously based cognitive, behavioral and interpersonal responses to stressors.”<sup>57</sup> Religious coping responses were referred to with a variety of terms including negative religious coping, positive religious coping, and self-directed religious coping.

**Table 2-5.** Religious Coping Findings

Author/Year	Coping Responses	Association with Depression		
		Positive	Negative	None
Carpenter et al. (2012)	Negative Religious Coping	x <sup>A</sup>		
Dew et al. (2009)	Negative Religious Coping	x		
Desrosiers & Miller (2007)	Positive Religious Coping		x <sup>B</sup>	
Dew et al. (2009)	Positive Religious Coping		x	
Carleton et al. (2008)	Religious Coping	x <sup>C</sup>	x <sup>D</sup>	
Epstein-Ngo et al. (2013)	Religious Coping			x
Spann et al. (2006)	Collaborative Coping			x
Spann et al. (2006)	Deferring			x
Spann et al. (2006)	Self-directive Religious Coping	x		
Nayamathi et al. (2012)	Spiritual Hope			x

Negative religious coping, positive religious coping, and religious coping (not otherwise specified) were each measured by two studies. The studies measuring negative religious coping, described as spiritual discontent or a belief that one is being punished for sins, found a positive association with depression.<sup>14, 25</sup> The studies measuring positive religious coping, defined this as “the degree to which individuals use religion or spirituality to deal with adverse circumstances and to seek consolation and a sense of meaning.”<sup>24, 25</sup> Two investigative teams found a negative association with depression.<sup>24, 25</sup> Religious coping (not otherwise specified), described as spiritual support or putting trust in God, were variably reported by different studies to have a positive

<sup>A</sup> Among stressed youth

<sup>B</sup> Among females

<sup>C</sup> Religious coping protective in low stress

<sup>D</sup> Religious coping in females with low stress

association,<sup>13</sup> a negative association,<sup>13</sup> and no association<sup>31</sup> with depression. Other types of religious coping were collaborative coping, described as the belief that both God and an individual possess the responsibility to control that individual's life;<sup>70</sup> deferring coping, described as a belief that solutions to problems come from God;<sup>70</sup> self-directive religious coping, described as a belief that the individual alone is responsible for controlling his or her life;<sup>70</sup> and spiritual hope, described as trusting/believing in God.<sup>56</sup> Aside from self-directive religious coping,<sup>70</sup> for which a positive association was found with depression, collaborative coping, deferring coping, and spiritual hope were not associated with depression.<sup>56, 70</sup>

Overall, the findings related to the association between a variety of forms of religious coping and depression are mixed. They suggest adolescents may fare better when confronting stressors if they obtain solace or a sense of meaning from their religious or spiritual beliefs or practices but may fare more poorly if they believe they are being punished for wrong-doing or responsible for their own misfortunes.

***Other Coping.*** Fifteen studies measured coping responses that did not fit into the problem-focused, emotion-focused, avoidant, or religious coping subtypes (Table 6). Most of the 15 studies measured coping subtypes that were a combination of problem-focused, emotion-focused, and/or avoidant coping responses.

Four studies measured coping responses referred to as primary and secondary control coping. These studies considered primary control coping as any coping response that acts on the source of the stress or one's emotions that arise from the stress and secondary control coping as any coping response that serves to adapt to the stressor. All four studies<sup>5, 33, 42, 71</sup> revealed a negative association between primary and secondary control coping responses and depression. However, one study<sup>71</sup> found no association between depression and primary or secondary control coping.

Four studies measured coping responses referred to generally as active coping. These studies considered active coping as any coping response aimed at fixing the problem or increasing positive emotions. One study revealed a positive association between active coping and depression,<sup>2</sup> two studies revealed a negative association between active coping and depression,<sup>9, 53</sup> and two studies reported no association between active coping and depression.<sup>53, 60</sup>

**Table 2-6. Other Coping Findings**

Author/Year	Coping Responses	Association with Depression		
		Positive	Negative	None
Fear et al. (2009)	1° Control Engagement Coping		x	
Jaser et al. (2011)	1° Control Coping		x	
Thompson et al. (2010)	1° Control Coping			x
Andreotti et al. (2103)	2° Control Coping		x	
Fear et al. (2009)	2° Control Engagement Coping		x	
Jaser et al. (2011)	2° Control Coping		x	
Thompson et al. (2010)	2° Control Coping			x
Aldridge & Roesch (2008)	Active Copers	x <sup>A</sup>		
Basanez et al. (2014)	Active Coping		x	
Mosher & Prelow (2007)	Active Coping		x <sup>B</sup>	x <sup>C</sup>
Pina et al. (2008)	Active Coping			x
Kassel et al. (2006)	Adaptive Coping		x	
Mahmoud et al. (2012)	Adaptive Coping		x	
Kassel et al. (2006)	Maladaptive Coping	x		
Thompson et al. (2010)	Maladaptive Coping	x		
Duongtran (2011)	Total Coping Score			x
Rossi & Meber (2011)	Total Coping Score		x	
Gaylord-Harden et al. (2010)	Avoidant & Support Seeking	x		
Kort-Bulter (2008)	Action Coping <sup>D</sup>	x		
Rohde et al. (2006)	Absence of Ineffective Coping			x
Rohde et al. (2006)	Positive Coping Skills		x	

Adaptive coping responses and maladaptive coping responses were each measured by two studies. These studies considered adaptive coping to include responses that focus on fixing the problem or decreasing negative emotions experienced

<sup>A</sup> Depression level of Active Copers < Low Generic Copers < Avoidant Copers

<sup>B</sup> Among African American youth

<sup>C</sup> Among European American youth

<sup>D</sup> Action coping=Make decisions without thinking too much. Go with “gut feeling”.

as a result of the problem. Both studies provided evidence for a negative association between adaptive coping and depression.<sup>43, 50</sup> Studies considered maladaptive coping to include responses such as ruminating or emotional numbing. Both studies reported a positive association between maladaptive coping responses and depression.<sup>43, 71</sup> Two studies combined measures of several types of coping responses into a single score. One study revealed a negative association between a total coping score and depression,<sup>65</sup> and the other revealed no association between the total coping score and depression.<sup>28</sup>

Other studies measured miscellaneous types of coping responses. One study measured action coping described as making decisions without thinking too much about it,<sup>45</sup> and another study measured a combination of avoidant and support seeking coping.<sup>35</sup> Both studies found a positive association between the measured coping response and depression.<sup>35, 45</sup> Another study measured the absence of ineffective coping,<sup>64</sup> described as the absence of behaviors that are ineffective in reducing stress, and found no association between the absence of ineffective coping and depression. One study<sup>64</sup> measured positive coping skills, described as cognitive or behavioral responses that effectively reduce stress, and reported a negative association between positive coping and depression.

Overall, all studies ( $n=6$ ) measuring primary control coping, secondary control coping, and adaptive coping responses provided evidence that these forms of coping may serve to prevent or decrease depressive symptoms. The findings of these studies taken together suggest that adolescents will benefit by focusing their efforts on directly addressing the source of their stress. On the other hand, studies measuring maladaptive coping responses, rumination, and attempting to numb emotions provided evidence that these types of coping are not beneficial and might cause or increase depressive symptoms. Studies that measured several seemingly disparate types of coping and

combined these scores into a general coping score or that measured a very general type of coping (i.e., absence of ineffective coping) either failed to find associations between these scores and indices of depression or showed inconsistency among studies. Few conclusions therefore can be drawn from these studies.

### **Discussion**

Studies included in this review provided evidence about coping responses that may serve to prevent or decrease depressive symptoms in adolescents as well as responses that may serve to trigger or increase their depressive symptoms. Adolescents in the studies who responded to stressors by actively and directly confronting the source of stressors tended to report fewer depressive symptoms, whereas adolescents who responded to the stressors by avoiding them or by focusing on the negative emotions provoked by the stressor tended to report more depressive symptoms. Drawing more specific conclusions about the association between coping and depression in adolescents, however, was impeded by several factors related to the state of the science in this area.

Most notably, this review reveals that there is a lack of consistency across studies in how coping was conceptualized and measured. As previously stated, authors used an assortment of coping theories to guide their work. Because each theory provides a different framework for categorizing and labeling types of coping responses, it is difficult to compare findings across studies based on these theories.

In some studies we reviewed, coping was operationalized differently even when based upon the same coping theory. For example, both DuongTran<sup>28</sup> and Mahmoud and Staten<sup>50</sup> viewed coping through the theoretical lens of Lazarus and Folkman's<sup>47</sup> transactional model of stress and coping. In DuongTran's<sup>28</sup> study, coping was operationalized to include eight subtypes: problem-focused, wishful thinking, detachment, seeking social support, focus on the positive, self-blame, tension reduction,

and keeping to self. In contrast, in Mahmoud et al.'s<sup>50</sup> study, coping was operationalized to include only two coping subtypes: adaptive and maladaptive coping. DuongTran<sup>28</sup> used the Ways of Coping Checklist-Revised to measure coping, while Mahmoud and Staten<sup>50</sup> used the Brief COPE Inventory as the coping instrument.

Furthermore, some studies measured coping responses that, by name, appeared to be similar, but upon closer inspection were conceptually different. One example can be seen in the measurement of “active coping” and “action coping” by VanVoorhees and Paunesku<sup>72</sup> and Kort-Butler,<sup>45</sup> respectively. VanVoorhees and Paunesku<sup>72</sup> measured active coping, described as problem solving, by assessing participants’ agreement with statements such as “Get as many facts as possible at first” and “Use a systematic method for comparing alternatives.”<sup>72</sup> In contrast, Kort-Butler<sup>45</sup> measured action coping, described as impulsive decision making, with statements such as “When making decisions, you usually go with your ‘gut feeling’ without thinking too much about the consequences of each alternative” and “you live your life without much thought for the future.”<sup>45</sup> Although both studies measured coping responses with a similar name, the operational definitions of these coping responses are at odds.

### **Limitations**

In addition to the conceptual inconsistencies, the review uncovered several methodological limitations to the group of studies that prohibit the drawing of strong conclusions. Because most studies in this review used cross-sectional designs, causality between the coping mechanisms and depression cannot be definitively determined. This is particularly problematic when studies focus on coping responses that could also be considered symptoms of depression. For example, Li and DiGiuseppe<sup>48</sup> used a cross-sectional study design to investigate the roles of sex, gender, and coping in adolescent depression. Although the authors found a positive association between ruminative coping and depression, it is impossible to ascertain if the ruminative coping contributed

to the depression, if the depression caused the adolescents to ruminate, or if the measures of depression and ruminative coping overlapped. The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-V-TR®), for example, includes “excessive or inappropriate guilt nearly every day” as one of the diagnostic symptoms for Major Depressive Disorder (MDD).<sup>4</sup> This diagnostic symptom of MDD is therefore very similar to rumination as measured by Li and DiGiuseppe.<sup>48</sup> In contrast, VanVoorhees and Paunesku<sup>72</sup> used a longitudinal study design to examine the relationships between active coping responses and depression over time, and thus they were able to provide evidence that adolescents who use active coping responses are protected against new onset of a depressive episode.<sup>72</sup>

Another limitation to the body of evidence on coping and depression in adolescents is that many studies do not address potential differences between genders and among racial/ethnic groups in regards to the association between coping and depression. Studies that explored gender and race reported findings which suggest that differences do exist, thus supporting the need for further examination. For example, although girls have higher rates of depression<sup>40</sup> and gender was reported in all 36 study reports, only five reported gender differences in adolescent coping.<sup>13, 24, 29, 59, 78</sup> One such study by Wilson et al.<sup>78</sup> examined the relationships among gender, coping, physical health, and psychological health and found a positive association between avoidant coping and depression among girls but not among boys. Similarly, though many of the studies in this review included racially diverse populations, out of those studies only one<sup>53</sup> reported findings according to racial/ethnic groups. Mosher and Prelow<sup>53</sup> examined the relationships among coping, ethnicity, and depressive symptoms with a sample of European and African American adolescents. These authors found a positive association between avoidant coping and depression among European American adolescents that was not present in African American adolescents.

Finally, integration of adolescent coping findings across studies is hindered because some studies measured coping generally whereas others measured coping in response to specific stressors. For example, many studies used a version of the COPE Inventory assessment tool<sup>17</sup> that asked questions about how participants “typically cope with stressful events,” whereas others used instruments that assessed how participants coped with specific stressors such as community violence exposure,<sup>31</sup> Hurricane Katrina,<sup>60</sup> racial discrimination,<sup>69</sup> and transitioning from elementary to middle school.<sup>73</sup>

### **Future Research**

In light of the findings of this review, we recommend that future researchers who study coping and depression in adolescents establish clarity and consistency about the conceptualization and measurement of coping. In addition, researchers should conduct longitudinal studies so that the complex relationships among coping and depression can be explicated. In particular, it is important that studies clarify what coping responses are most likely to prevent depressive symptoms or promote recovery from an episode of depression in adolescents. Gender and racial/ethnic differences in coping need to be considered so that findings will be culturally relevant, and strategies to prevent or facilitate recovery from depression can be tailored to specific populations. Lastly, future research should consider both situational and dispositional types of coping and make a clear distinction between the two.

### **Nursing Implications**

Despite the limitations of this body of literature, the findings of this review do suggest that psychiatric mental health nurses who work with adolescents can help youth develop coping strategies that actively and directly address stressors in order to help prevent or decrease depressive symptoms. In addition, psychiatric mental health nurses should be alert to coping responses that might render adolescents vulnerable to the onset or exacerbation of depressive symptoms, such as problem avoidance, distractive



coping, or disengagement. Even in light of the limitations of the studies on coping and depression in this population, psychiatric mental health nurses might draw on this literature to discuss with adolescents the many ways in which other adolescents cope with life stressors, help the adolescents identify and track their own use of coping strategies, explore with the adolescents whether those strategies seem to improve or worsen their depressive symptoms, and identify and test other ways of coping with their negative life experiences.

### **Conclusion**

Research on coping and depression in the adolescent population is limited by a lack of consistency in how coping is conceptualized and measured, a paucity of the longitudinal designs needed to establish causality, and the failure of most studies to address the impact of gender and ethnicity on coping and depression. Yet the studies considered as a whole do suggest that adolescents who actively address the source of their stressors as opposed to avoiding the source of their stressors or avoiding dealing with their negative emotions typically report fewer depressive symptoms. Studies that have revealed what types of coping responses are likely to prevent or ameliorate depressive symptoms do provide guidance for psychiatric mental health nurses and speak to the importance of exploring with adolescents how their coping strategies might be affecting the course of their depression.

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### CHAPTER THREE

This chapter presents the results of a qualitatively derived typology that classifies the interaction patterns of depressed AA adolescents with the people in their lives titled, “How African American Adolescents Manage Depression: Being With Others,” which was submitted to the *Journal of the American Psychiatric Nurses Association*.

## Abstract

**Background:** African American (AA) adolescents with depression face serious negative outcomes. Despite racial/ethnic disparities in treatment utilization, few studies have explored how AA adolescents manage their depression.

**Objective:** To describe common ways AA adolescents manage depressive symptoms through relationships with people in their lives.

**Design:** Qualitative descriptive methods were used to analyze the narratives of 22 AA young adults who had been depressed as adolescents and five AA adolescents in treatment for depression.

**Results:** A typology describing the varied ways AA adolescents manage their depressive symptoms through interactions with other people was constructed and labeled Being With Others. The five categories in the typology are *keeping others at bay*, *striking out at others*, *seeking help from others*, *joining in with others*, and *having others reach out*.

**Conclusions:** Clinicians might use the Being With Others typology to guide discussions related to detecting, assessing, and treating AA adolescents with depression.

*Keywords:* African American, adolescents, depression, social support, coping



## **How African American Adolescents Manage Depression: Being With Others**

Depression in African American (AA) adolescents is a serious mental health problem in which feelings of sadness, loss, anger, or frustration interfere with everyday life.<sup>4, 40</sup> According to the Diagnostic and Statistical Manual of Mental Disorders, (5<sup>th</sup> ed.; DSM-V-TR®), a Major Depressive Episode occurs when individuals experience a depressed mood or a marked loss of interest or pleasure in daily activities for a period of at least two weeks. These changes are accompanied by a variety of the following symptoms: a significant change in weight, appetite, or sleep habits; restlessness; fatigue; feelings of worthlessness or guilt; indecisiveness; and suicidal ideation.<sup>5</sup> There are three types of depressive disorders. Major Depressive Disorder is characterized by one or more Major Depressive Episodes. Dysthymic Disorder is characterized by the presence of a depressed mood for a minimum of two years, accompanied by additional depressive symptoms that do not meet diagnostic criteria for Major Depressive Disorder. Depressive Disorder Not Otherwise Specified is characterized by depressive features that do not meet criteria for Major Depressive Disorder, Dysthymic Disorder, or other disorders with depressive features.<sup>5</sup>

The Substance Abuse and Mental Health Administration reported that depression is experienced by an estimated 8.6% of 12- to 17-year-old AA adolescents, with more than 70% suffering from severe impairment.<sup>39</sup> In the 2013 Youth Risk Behavior Surveillance Survey (YRBSS), more than one in four (27.5%) AA high school students surveyed reported having had their usual activities impaired by prolonged feelings of sadness or hopelessness during the previous 12 months.<sup>8</sup>

Depression in adolescents is associated with a number of other health concerns, including high-risk sexual behavior, early pregnancy, substance abuse, poor academic performance, psychosocial functioning impairment, and increased risk for suicide.<sup>10, 36</sup> Suicide is the third most common cause of death in the United States among

adolescents. Of adolescents who commit suicide, 90 percent are experiencing a psychological disorder, most commonly depression, at the time they end their lives.<sup>13, 18</sup> Depression in adolescence is also associated with recurrent depression in adulthood. Approximately half of adolescents who experience depression will also experience depression as young adults.<sup>3, 14</sup>

Although rates of depressive disorders in AA adolescents and their European American (EA) peers are similar (8.6% and 10.9%, respectively),<sup>39</sup> startling disparities exist in mental health treatment utilization.<sup>6, 17</sup> One survey of a nationally representative sample of 13- to 17-year-old adolescents indicated that only 39% of respondents with depressive disorders had ever received mental health treatment. Moreover, AA adolescents with depressive disorders were 87% less likely than their EA counterparts to have ever receive mental health treatment.<sup>31</sup>

The underutilization of mental health services has serious consequences for AA adolescents. AA adolescents with social and emotional disorders are more likely than EA adolescents with similar problems to enter the juvenile justice system.<sup>1, 34</sup> High rates of substance abuse, academic failure, and high arrest and incarceration rates are problems disproportionately experienced by urban AA adolescents,<sup>1, 34</sup> and some experts suggest that unrecognized and untreated mental illness may underlie these problems.<sup>19</sup> Additionally, while overall rates of suicide attempts among adolescents have decreased recently, rates among AA adolescents, a group that has historically had a lower rate than other ethnicities, have increased.<sup>8</sup>

Despite a low rate of treatment utilization for AA adolescents, few studies have explored how they manage their depression in the absence of formal treatment. Depressed AA adolescents who do not receive adequate mental health services are faced with managing their symptoms either alone or with informal supports.<sup>15, 27</sup> Some

research suggests that they use religion and spirituality and rely on religious leaders, family, and friends to help them cope with their distress.<sup>7, 26, 29</sup>

Social support has been identified as a protective factor for adolescent psychological well-being in a variety of stressful life events<sup>12</sup> and specifically for adolescents who are depressed and suicidal.<sup>30</sup> Social support has been broadly defined as those perceived or actual interpersonal social resources that facilitate coping with life stressors.<sup>24</sup> Family support has been shown to promote healthy psychological adjustment<sup>23</sup> and to protect against suicidality<sup>20</sup> and depressive symptoms<sup>32</sup> in African American adolescents. Peer support has also been shown to influence mental health outcomes; poor quality interactions are associated with depressive symptoms and high quality peer interactions can protect against suicidality in depressed adolescents.<sup>28</sup> A recent study that examined the impact of family and peer support on depression and suicidality in a community-based sample of AA adolescents showed that family support protects AA adolescents from depressive symptoms and, at lower levels of depression, peer support has protective effects as well.<sup>28</sup>

Although research has shown that family and peer support can influence how AA adolescents experience depression, especially in light of low treatment utilization, few in-depth descriptions of how depressed AA adolescents interact with important others are available. Such information can provide the basis for a better understanding of how AA adolescents manage their depression. This understanding may provide a foundation to develop strategies to explore with AA adolescents how their relationships influence how they manage their depression and to support significant others who wish to help depressed AA adolescents. The purpose of this study was to describe common ways in which AA adolescents manage depressive symptoms through their relationships with other people in their lives.

## **Methods**

The data used for this report are drawn from an on-going larger study in which grounded theory methods<sup>11</sup> are being used to develop a theoretical framework that describes how AA adolescents understand their depression and its effects, manage their symptoms, and, in some cases, seek and use mental health services over the course of their adolescent years. The larger study, called the African American Adolescent Depression Study, will be first discussed because it provided the data for the findings reported here. Institutional review board approval was obtained from the first author's university for the larger study.

### **The African American Adolescent Depression Study**

**Sample.** Two participant populations of AAs were recruited in order to gather descriptions of a broad range of depressive experiences and treatment pathways. Young adults ages 18-21 who reported that they had experienced depression during adolescence (ages 13-17) were recruited to participate in a retrospective interview. Community-based young adults were recruited to reflect back on their teen years for several reasons. First, they were able to provide information about their experiences with depression throughout adolescence and as they transitioned into young adulthood. Second, because research has shown that the majority of depressed adolescents hide their depression from their parents, young adults could provide data on living through depression without the requirement of parental consent. Finally, recruiting community-based young adults yielded participants who had not necessarily received treatment for their depression and who could thus provide data on managing depression without the benefit of mental health services. In addition, adolescents ages 13-17 receiving treatment for depression were recruited to participate in an interview about their current experiences. These adolescents were able to provide contemporaneous information about their experiences of depression, had a formal diagnosis of depression, and

experienced symptoms that were severe enough to warrant mental health care.

Depression is a sensitive topic and participants may have been reluctant to discuss particularly painful experiences. Experts suggest that enhanced rapport and disclosure can be established and cultivated if the interviewer is of the same race/ethnicity as the participant.<sup>22</sup> Both the participants and interviewer in this study were AA, possibly limiting response bias.<sup>2</sup>

**Young adults.** Twenty-two AA young adults ages 18-21 years old who had experienced depressive symptoms during adolescence (ages 13-17) were recruited by community-based sampling using public announcements and community networking. Recruitment was conducted within five postal areas in the Indianapolis metropolitan community, including three neighborhoods that were predominantly AA and two neighborhoods that were racially mixed yet with a substantial AA population. The primary investigator canvassed the five communities to assess locations frequented by young adults where recruitment flyers could be distributed, identify publicly accessible yet private locations that could be used as interview sites, and speak with community leaders about the study and enlist their support.

The investigator distributed recruitment flyers in each community announcing the study on depression in AA adolescents. The flyers included a description of depressive symptoms taken from the Diagnostic and Statistical Manual of Mental Disorders (4<sup>th</sup> ed., text rev.; DSM-IV-TR®)<sup>4</sup> criteria but written in lay language. The flyers invited young adults ages 18-21 who had experienced depression between ages 13 and 17 to contact the investigator. Flyers were placed in a variety of locations including restaurants, gyms, postsecondary schools, public libraries, grocery stores, and malls. The flyers indicated that interviews could be conducted in local community settings and that participants would receive a \$35 gift card reimbursement for their time and travel after the interview was completed.

The investigator screened potential participants over the phone for the following inclusion criteria: (a) self-identify as being AA; (b) aged 18 to 21; (c) speak, read, and write the English language; and (d) report having experienced depressive symptoms during adolescence or having been diagnosed with depression by a health professional. After receiving verbal consent, the investigator used an adapted screening protocol,<sup>16</sup> to screen for the following exclusion criteria: (a) experiencing acute distress or a recent life crisis; (b) recent hospitalization for mental health concerns; (c) current suicidal ideation; and (d) current homicidal ideation. No individuals who were screened were excluded from the study.

**Adolescents.** After obtaining approval from a large publicly funded medical center in Indianapolis, the investigator recruited five 13-to-17-year-old AA participants from an adolescent primary care clinic. Inclusion and exclusion criteria were identical to criteria for the young adults with the following exceptions: 1) Participants were between 13 and 17 years of age and 2) currently receiving treatment for depression from a health professional. Clinic staff were provided information about the study and identified potentially eligible participants using clinical records. With approval from the primary care provider, the investigator approached eligible participants about the study.

### **Data Collection**

**Young Adults.** The investigator scheduled interviews in the participants' communities in a location that offered privacy for the interview (e.g., library meeting rooms, conference rooms in community centers) at a time that was convenient for the participant. The participants signed informed consent forms and completed a demographic data sheet. The investigator screened participants for distress prior to, during, and after the interviews. The interviews were semi-structured and began with the following question: "You indicated that you experienced depression as a teenager. Would you tell me about that experience?" Other questions were aimed at how the

participants had managed their symptoms and how they had used mental health services. The interviews were digitally recorded and professionally transcribed.

**Adolescents.** Data collection procedures for the adolescent participants were identical to the procedures for the young adults with the following exceptions: 1) Written consent was obtained from the adolescents' parent/guardian and written assent was obtained from the adolescents; 2) questions were about the participants' current experiences with depression rather than their retrospective experiences; and 3) participants were asked about their experiences leading up to receiving mental health treatment as well as with the treatment itself. All interviews were conducted in an available patient exam room at the clinic. After informed consent and assent were obtained, the interview was conducted without the parent or guardian in the room. Adolescents were screened for acute distress before, during, and after the interview and no individuals who were screened were excluded from the study.

### **Data Analysis**

The research team members read the 27 transcribed interviews in their entirety to get an overall understanding of the salient issues discussed by the participants. This initial review revealed that participants' interactions with others were clearly a major focus of the narratives. The team therefore decided to explore this phenomenon in greater depth. The team sought to develop a typology since it was evident that there were several different ways in which the participants interacted with others, and the interactions seemed to reflect attempts to manage depression.

To develop this typology, content analytic procedures according to Krippendorff<sup>21</sup> were used. Each transcript was reread and any text unit (e.g., phrase, sentence, complete story) about interacting with others was extracted and coded. The first and last authors compared and contrasted the text units ( $n= 302$ ) and through dialogue and consensus determined there were five categories of ways participants interacted with

others. All of the text units could be classified into one of the five categories within the typology. With feedback from the second and third authors, the first and last authors refined the labels and definitions for the five categories. All authors independently verified that each text unit was appropriately categorized. The first author collated the text units for each category into a separate data matrix for further comparisons. Each text unit was organized by participant gender and specific features of the interactions, including people involved with the interactions, places where the interactions took place, types of interactions, and outcomes of the interactions. The data matrices were used to write narrative summaries for each category. All authors reviewed the category summaries.

## **Results**

### **Sample**

All 27 participants from the parent study described ways in which they had managed their depressive symptoms through their relationships with other people in their lives. The entire study sample is therefore described below.

**Young Adults.** The young adult sample included 22 young adults ages 18 to 21. Twelve were females, and 10 were males. All identified as African American, although four also identified as more than one race. Eleven were employed, 11 were unemployed, and of the 22, seven were students. Twelve of the young adults had no children, seven had one child, one had two children, and two did not provide information about children. Nine were Christian, two were Muslim, two reported having no religious affiliation, and 11 did not report religious affiliation. Six participants reported their annual household income as less than \$19,999, two as \$20,000 to \$39,999, three as \$40,000 to \$99,999, four were unsure, and seven did not report an annual household income.

**Adolescents.** The adolescent sample included five individuals ages 13 to 17. Three were female, and two were male. All identified as African American; however, two



also identified as more than one race. All five were students, and one was employed. Three were Christian, and two did not report a religious affiliation. None of the adolescents provided data on annual household income.

### **The Being With Others Typology**

We labeled the typology as “Being With Others” to reflect that the participants’ interactions with others were best understood as relationship patterns that were embedded in their day-to-day lives rather than as discrete interactions that the participants viewed as ways of coping. The participants’ ways of interacting ranged from withdrawing from all others to avoid rejection or judgment to being fully engaged with others as a way of getting help with depression. The five categories of Being With Others included *keeping others at bay*, *striking out at others*, *seeking help from others*, *joining in with others*, and *having others reach out*. Participants often used more than one way of Being With Others to manage their depressive symptoms.

Category Name	Category Definition	Number of Participants	Number of Text Units
Keeping Others At Bay	Preventing people from knowing about feelings of depression, withdrawing from interacting with others, or spending time alone	22	63
Striking Out At Others	Lashing out verbally or physically at others	19	81
Seeking Help From Others	Seeking help from others	21	44
Joining In With Others	Seeking and participating in activities	19	30
Having Others Reach Out	Being approached or helped by someone who notices something is wrong	23	84

Table 1 displays the five categories, the definition for each category, the number of participants who contributed to each category, and the number of text units that contributed to each category. The categories within the Being With Others typology are described and discussed below. Participants are referred to only by their gender and their age at the time of the interview to protect their identities. Although some

participants were between 18 and 21 years of age at the time of the interview, all examples refer to events that occurred while participants were between the ages of 13 and 17.

**Keeping Others At Bay.** One way that the participants experienced Being With Others was by keeping them at bay. By keeping others at bay we mean instances in which the participants had prevented people from knowing about, acknowledging, or trying to help with the participants' depression. The ways participants kept others at bay, the people they kept at bay, and the reasons they kept others at bay are described below.

Many participants kept others at bay by hiding feelings of depression. One 19-year-old female participant felt she could not talk to her family about being depressed and thus "kept it all bottled up." When the participants had been asked how they "were doing," they often denied they were distressed and instead replied everything was "fine" or "okay." Participants also hid their feelings of sadness by pretending to be happy. A 21-year-old female participant stated,

I would put on a smile for my parents and my siblings. Whenever somebody would leave and I knew I was going to be alone, they would ask me, "Are you going to be alright?" And I would say "Yes, of course," because I didn't want them to know what I was dealing with. But, it was a living hell. I put up a really good façade for them, like all cheery and happy, nothing's wrong. They didn't suspect anything.

Similarly, during therapy or counselling sessions, participants had often chosen to tell their counselors "what they wanted to hear" instead of disclosing their true feelings.

Many participants had kept others at bay by avoiding them. Female participants were particularly likely to stop spending time with their friends. One 21-year-old female participant said, "I had a best friend at the time, I wasn't hanging out with her as much." Participants also often stopped participating in activities they had previously enjoyed or failed to fully engage in the activities. A 19-year-old female participant who had been a

performer since the age of two revealed, “I was in show choir and throughout that year I just didn’t really enjoy it. I was fine with standing in the back, which really wasn’t like me. My wanting to be in the back just wasn’t normal.” Some participants avoided others by spending time in their rooms or going for walks alone. One 19-year-old female participant said, “I just kind of wanted to be by myself.”

Participants kept a variety of people at bay. Participants were most likely to keep their family members at bay for fear these persons would try to intervene with their depression. One 19-year-old female participant explained, “I would come home from school and just sleep and then I would eat dinner and go back to sleep.” Participants also kept friends and romantic partners at bay so peers would not view them as depressed and therefore different. As mentioned above, many participants had kept therapists or counselors at bay especially if the participants had not chosen to be in therapy. Other participants did not have one particular group of people they kept at bay but rather isolated themselves “from everyone.”

Participants kept others at bay for a number of reasons. Most participants were ashamed that they were depressed and afraid of what others might think. A 20-year-old female participant said, “I didn’t want people to talk about me. I didn’t want them to say I was weak.” Some participants believed they should deal with their problems alone. An 18-year-old male participant shared, “I don’t like talking about how I feel with people I’m close to because it affects them. It’s better to keep things to myself. I feel like, when you have a problem internally, you deal with it yourself.” Participants had kept others at bay fearing that if they “opened up” they would be ridiculed or shunned. A few participants feared being removed from their parents’ custody if they “said too much” to an untrustworthy counselor or teacher.

**Striking Out At Others.** One way that the participants experienced Being With Others was by striking out at them. By striking out at others we mean instances in which

the participants had lashed out verbally or physically. The types of behaviors they exhibited, the people they struck out against, and the events that surrounded their striking out are described below.

Several participants indicated that they experienced their depression as anger rather than sadness, and because they “bottled up” their feelings, their anger was easily triggered by others. Nearly all of the participants at some point struck out at others to express or release their feelings of anger. Several had confrontations with others that included angry outbursts of yelling or cursing. Female participants in particular often used insulting, rude, or intentionally hurtful language when feeling angry. One 16-year-old participant described how she had verbally attacked a classmate: “I actually used lyrics of a song that I knew very well to verbally abuse her.” Both male and female participants released built-up anger by throwing objects like cell phones or chairs or by engaging in physical altercations.

The participants struck out at a variety of people. Some participants exhibited a rude or hostile attitude to most everyone with whom they interacted. A 16-year-old female, for example, “took out” her feelings on “any and everyone.” Some participants who felt picked on by others at school had retaliated with verbal outbursts and physical attacks on their classmates. One 21-year-old female talked about her response to being teased at school: “I would just go around the classroom, or in the hallway, be mean to them. They talked about me being pregnant, I’d be ready to fight.” Other participants were aggressive toward siblings or other family members, and several had “flipped out” against those close to them. A few participants hit or kicked random strangers. One 21-year-old male described an assortment of people his anger had been directed toward: “I might be arguing with my brother, or I might get into it with somebody at the gas station, or I might be driving and somebody might cut me off and I’m heated.”

Striking out at others transpired in a number of ways. Some participants intentionally provoked confrontations at school or home in response to a perceived slight from peers or family members. When describing how altercations with classmates who “brushed her a certain way” typically occurred, one 13-year-old female participant stated, “Usually they make me angry, I cuss them out or I try to fight them.” Other participants had unexpected outbursts during interactions that they realized did not warrant such an intense angry response. One 21-year-old male found himself “blowing up and not knowing why” despite not wanting to argue with others. He was confused by his own behavior and stated, “Why is it even making me upset, this upset?” Several participants were unaware that their behavior had been perceived as hostile and were surprised to learn they had offended others and were seen as rude and mean. One 21-year-old female said, “I didn’t even know when I was being mean.” A few participants hit, kicked, or verbally attacked others with no provocation. A 20-year-old female who had been depressed after the death of her father talked about how she dealt with her emotional pain while at school:

If someone walked up to me, I would kick them or punch them, and it made me feel better. I’d say something to them to the point where we’re about to fight, and it would be like a relief. It sounds weird, but I noticed when I act out, I feel better.

**Seeking Help From Others.** One way that the participants experienced Being With Others was by seeking help from them. By seeking help from others we mean instances in which participants had sought help from someone in response to their feelings of depression. The ways participants sought help, the people they sought help from, and the outcomes of seeking help are described below.

Participants had sought help from others in a number of ways. Most participants who sought help did so by revealing their feelings to or discussing their problems with others. Some participants “let it out” by venting their frustrations to others, and other

participants talked out their problems with others to get help in finding a solution to them. A 20-year-old female participant sought help from her godmother so they could figure out together how to “deal with” the participant’s problems.

Some participants asked others to do activities with them as a distraction from their negative feelings. One 21-year-old female participant asked her mother to go to the mall even if they did not have money to purchase anything. She told her mother, “We’ll just go window shopping, it doesn’t matter, let’s just get out and do something.” Other participants engaged others with “cries for help.” A 21-year-old female participant described how she had called her best friend to say goodbye moments before attempting suicide: “I was crying while I was talking to her. I could barely get the words out of my mouth, but I said ‘[Friend] I’m calling you to say goodbye.’ And I hung up.”

Participants were likely to seek help from people they knew well, especially family members. They sought help from parents, siblings, aunts, grandmothers, and foster or god-parents. Participants most commonly sought help with their feelings of depression from their mothers. One 22-year-old male participant talked to his mother when he was upset because she would help him to “calm down.” Participants also had sought help from professionals such as counselors, teachers, and clergy. One 21-year-old female said, “I talked to a lot of my high school teachers. I would talk to them whenever I was feeling down or something was wrong.” Several participants had sought help from people they identified as mentors. One 19-year-old male participant described why he felt comfortable seeking help from his mentor: “She watched me grow up since I was young, up until I was in the ninth grade. She had been there and she used to mentor my sister, so I felt I could talk to her.”

Seeking help from others commonly resulted in positive outcomes for the participants. Most participants experienced a decrease in feelings of sadness, anger, and loneliness after seeking help from others. One 21-year-old female participant felt

that simply talking to her grandmother helped “heal a lot.” Participants typically felt understood, loved, or supported after talking about their feelings or problems and felt particularly connected to their confidants. One 21-year-old female participant who talked about her feelings with a close friend felt the friend “was really listening.” One 19-year-old male participant found talking to peers in group counseling sessions to be helpful because he felt he was “not the only one out there” dealing with depression. Seeking help also enabled participants to receive advice or help in solving their problems. A few participants had been connected to formal mental health services as a result of seeking help from others. One 21-year-old female participant said, “I told my friend about everything that was going on. She was concerned and suggested that I talk to one of the counselors at the school.”

Seeking help from others, however, did not always result in positive outcomes. A few participants were rejected by those from whom they sought help. One 21-year-old female participant who had tried seeking help from her twin sister said:

It would basically go in one ear and out the other. [My sister] would be like, “Oh girl, just shut up. Everything is going to be alright.” And then she’d go on her merry little way. Like she [wouldn’t] take me seriously. I’d be like, “I’m dead serious.” I’d be sitting there bawling in front of her face and she’d be like “Oh, okay, you’re alright.” Like it was a little game. It was not a game.

Some participants grew discouraged when they had attempted to contact others when feeling down but could not “reach” them. A few participants were devastated when their pleas for help were ignored.

**Joining In With Others.** One way that the participants experienced Being With Others was by joining in with them. By joining in with others we mean instances in which the participants sought out and participated in social activities as a response to their feelings of depression. The types of activities they engaged in, the people with whom they joined, and the benefits they gained from joining in with others are described below.

The participants had joined in with others by participating in a number of activities as a way of avoiding or ameliorating the distressing feelings they were having. These activities were either planned and structured or casual and unstructured. Structured activities included organized team sports, student clubs or groups, and church-related events. When depressed, the male participants were particularly likely to play sports including basketball, football, and soccer to join with others. Other participants, both male and female, had responded to their feelings of depression by joining school-based clubs like student government, choir, or special interest groups. One 21-year-old male participant stated, "I joined a group called Pride Out, they teach kids to be drug free. That helped me a lot during depression." A few female participants had joined in with others by attending religious services. Other participants joined with others by participating in unstructured leisure activities such as shopping, eating at a restaurant, traveling, "hanging out" at a friend's home, going to a barbecue, seeing a movie, attending a dance, or going camping. A few participants joined in by providing emotional support to friends who were also struggling with depression as a form of distraction from the participants' own depressive symptoms.

Joining in with others involved a variety of people. Most participants had joined in with peers for school-based and sports activities. Many participants, however, joined in with family members for leisure and church-related activities. Some participants were strategic about who they joined in with as a way to feel better. One 20-year-old male participant described the people he joined in with:

When I felt bad I would go out and hang out with friends that were in my outer circle. When I felt more pensive and more reflective I'd hang out with people who were in my inner circle. The difference in the activities would be going out or hanging out with [outer circle] friends...like at a party or at a movie, and inner circle would be going over somebody's house or going to the park and talking.



Although most adolescents join in with others by participating in activities, the participants in this study joined in with others specifically as a way of combatting their depression. Joining in with others served a variety of purposes for them. Some activities distracted participants from their distress and the circumstances that had led to their depression, at least temporarily. Being with others took their minds off feelings of sadness, thoughts of self-harm, or a chaotic home life. One 19-year-old female participant who attributed her depression to overwhelming expectations and responsibilities at home participated in the high school choir as “a way to get out.” When describing how church attendance helped with depression, one 21-year-old female participant stated that “it would help, just take my mind off of that stuff when I went to church.” In addition, some participants, especially those who played sports, experienced a release of pent-up emotions. One 21-year-old male participant stated, “I used to play basketball, and go hard at playing basketball, like tired, tired... just to burn off all of the extra energy and built up stress.” For several of the participants, joining in with others had allowed them to connect with, rather than withdraw from, others. One 21-year-old female participant reported “not being lonely anymore” when she joined a club in high school. Another 18-year-old male participant who joined in by providing emotional support to depressed peers said he believed that being a support to others had made him feel better. He said, “I had a handle on the way I felt and if I could help somebody else going through the same thing, then I probably didn’t need the same help from somebody else.”

**Having Others Reach Out.** One way that the participants experienced Being With Others was by having others reach out to them. By having others reach out we mean instances in which participants had been approached or helped by someone who noticed something was wrong. The participants were invited to open up and talk or receive help for their depression. The participant behaviors that triggered others to reach

out, the types of people who reached out to the participants, the ways in which others reached out, and the outcomes of their reaching out are described below.

Others typically had reached out to the participants after noticing behaviors that signaled something was wrong. The behaviors of male and female participants that drew the attention of others differed. Others typically noticed male participants who appeared overtly upset. Their facial expressions and body language often signaled their distress. One 15-year-old male participant said his mother knew something was wrong because he would “have a mad face.” Other male participants had others reach out to them in response to harmful behaviors. For example, a 19-year-old male who purposely injured himself with a knife and a 21-year-old male who committed robberies were offered help by others who cared about them. Occasionally, male participants had someone reach out to them in the absence of noticeable signs of depression. A 21-year-old male participant described the circumstances in which his mother had reached out: “She would always come to me whenever a problem was going on. I don’t know how. I wouldn’t even tell her anything was going on. She would just know something was not right.” Female participants who drew the attention of others were likely to show subtle behavioral changes. Several people had reached out to female participants after noticing that they had withdrawn from normal activities or had become less “talkative.” When describing the changes that caused her mother to reach out, one 21-year-old female participant stated, “I shut down, I didn’t talk anymore. I really didn’t say anything.”

Those people who reached out to the participants knew them either formally or informally. People who knew participants in a formal capacity included personnel within the school and legal systems. Teachers, coaches, school therapists, and criminal justice personnel had noticed a problem with some of the participants and offered to help. For example, a judge offered help to a 20-year-old male participant who as a teenager had a long history in the foster care system. The participant said, “The judge saw how I was in

pain because I wasn't able to talk to anyone in my [foster] family, and he granted me the rights for me to talk to my [biological] mom." Most of the people who had reached out to the participants, however, were family members including parents, grandparents, great-grandparents, and siblings. Mothers were most likely to reach out to the participants when they were distressed. An 18-year-old male participant said, "She [his mother] is the only person who would touch that nerve. Nobody else would confront me about depression or about the way I am or the way I act. Or ask me why am I a certain way." Some participants had mentors or family friends who had reached out to them, and other participants were approached about their depression by close friends or romantic partners. A 14-year-old female participant identified her boyfriend as a person who regularly "tried to see what was wrong" with her when she was depressed.

Participants had experienced having others reach out in a variety of ways. Most commonly others reached out by talking to participants about their problems or feelings. These conversations often ensued when the other noticed a change in a participant's mood or behavior and asked "what's wrong?" or "are you okay?" One 13-year-old male participant described a typical interaction with his mother: "Sometimes I get off the bus upset and she asks me, 'What's wrong?' And that's how our conversations start most of the time." Some others persisted in their inquiries if the participant did not initially "open up." One 15-year-old male participant who denied having a problem eventually opened up to his father who "just kept asking." Participants were most likely to share their distress if others had reached out to them with empathy, kindness, and respect. One 21-year-old female participant had had a previous negative counseling experience with a therapist whom the participant perceived as rude and disrespectful. She described her encounter with a subsequent school therapist:

I could talk to her. She didn't look at you like you're just faking, this is another kid trying to get a check or something, no. She looked at me like a human being. She talked to me like a person's supposed to talk to, and

she didn't make my mom feel uncomfortable when she came. She wasn't rude to me or my mother.

Participants had also received advice, suggestions for coping with their feelings of depression, and words of comfort or encouragement. A 21-year-old male participant received daily encouragement from his girlfriend when she told him "how proud she was" that he was maintaining a steady job and staying out of trouble. Some people had reached out to participants by trying to connect them to a mental health care professional for help with their depression. Female participants were more likely to be encouraged to attend therapy than male participants. One 16-year-old female with depression had been enrolled into therapy in the community by her mother and received a separate referral at school for in-school therapy. In contrast, people more commonly reached out to male participants by engaging them in constructive activities as an alternative to their destructive behaviors. A 21-year-old male participant described how a family friend reached out to him: "She found stuff that I could do so I wouldn't have too much free time to get into trouble."

Having others reach out often benefitted the participants. Female participants were particularly likely to feel better because they felt more connected to or loved and supported by those who reached out to them. A 16-year-old female participant described a two-week "happiness extension" that was powered by her knowledge that she could talk to her boyfriend "no matter what." Several female participants had improved after being connected to formal mental health care as a result of someone reaching out to them. Male participants were likely to feel better after having others reach out to them because they felt calmer and less angry and began to engage in more productive and fewer risky behaviors. One 21-year-old male described the impact of having someone reach out to him: "I started to calm down, started to open up, and started seeing positive [things] there were to do."

Having others reach out, however, was not always beneficial. Some participants, especially females, did not feel comfortable opening up to those who reached out to them. These participants did not believe the other person would understand what they were going through, believed their problems were “no one else’s business,” or doubted the person’s motives for reaching out. Some participants feared negative consequences from discussing their situations with others. A teacher reached out to a 21-year-old female who was having declining grades in high school when the participant became homeless. The participant said, “I talked to her about it. She wanted to bring the law into it and all of that, so I just stopped talking to her.”

### **Discussion**

The Being With Others typology presents the multiple ways one sample of AA adolescents managed their depressive symptoms through interactions with other people in their everyday lives. Although participants in this study were asked general questions about how they had managed their depressive symptoms, all discussed interactions they had with other people that influenced their depression. At times, these interactions exacerbated or prolonged the participants’ distress, such as when they verbally and physically attacked others or hid their pain from loved ones, whereas at other times the interactions ameliorated their symptoms, such as when the participants got involved in group activities or when they asked for or accepted help from others for their problems.

Although the narratives of young adult and adolescent participant groups were similar, there were some notable differences between male and female participants. Female participants, for example, responded to depression more often by withdrawing from others, while male participants responded more often with overt signs of distress. Whereas female participants became less talkative or stopped doing things they had previously enjoyed, such as spending time with their friends, male participants were more likely to become angry and engage in behaviors that were harmful to themselves

or others. Female participants were more likely to be offered formal mental health treatment in response to signs of depression, whereas male participants were more often connected to structured activities like sports or clubs. For female participants, the positive outcomes of Being With Others typically included feeling supported and loved, whereas for male participants, positive outcomes often included feeling calmer and less angry.

Our construct of Being With Others supports the findings of prior studies in which social support was shown to lessen symptoms of depression in AA adolescents.<sup>9, 25, 26, 28</sup> Just as our participants identified a variety of others who had provided help, Chandra and Batada<sup>9</sup> reported that AA youth who are depressed get support from family members, friends, and school personnel such as counselors, teachers, and coaches. Similarly, just as our participants who received help from others often experienced a decrease in feelings of sadness, anger, and loneliness and felt understood, loved, and supported, Matlin, Molock, and Tebes<sup>28</sup> reported that peer and family support decreased depression in AA adolescents.

Our findings can be understood through the lens of theories of coping.<sup>37, 38</sup> For example, Roth and Cohen<sup>37</sup> proposed that there are two types of coping: engagement coping and disengagement coping. Engagement coping includes responses that are focused on dealing with the stressor proactively or addressing the emotions stemming from it and consists of activities that include problem solving or seeking social support.<sup>38</sup> The participants in our study who sought help or joined in with others evidenced engagement coping. Disengagement coping, on the other hand, includes responses that are focused on escaping the stressor or emotions stemming from them such as withdrawal or denial.<sup>38</sup> The participants in our study who kept others at bay evidenced disengagement coping.

The gender differences suggested in our findings had been reported by other researchers.<sup>7, 9, 35</sup> Perkins et al.<sup>35</sup> found that AA males commonly experienced anger while depressed. Breland-Noble et al.,<sup>7</sup> for example, also found that males were more likely than females to lash out with anger in response to feelings of depression. Chandra and Batada<sup>9</sup> found that males were more likely than females to engage in sports in response to feelings of depression, and the current study extends these findings by specifying that participants struck out at others and engaged in sports as a way to release pent-up emotions and “burn off” built-up stress.

Findings from our study most strongly resonate with findings from a phenomenological study of AA adolescents’ experience of depression conducted by Ofonedu, Percy, Harris-Britt, and Belcher.<sup>33</sup> These researchers described their participants’ experiences in ways that closely resembled our findings. Ofonedu et al.<sup>33</sup> compared youths’ experiences of living with depression to a storm with lightning (sudden changes in mood) or a “clicking bomb” (anger and rage), whereas our participants described “bottling up” their feelings and experiencing intense anger that was easily triggered by others. Ofonedu et al.’s<sup>33</sup> finding that adolescents concealed their feelings because they were uncertain of how others would respond is similar to our finding that adolescents kept others at bay and “put on a smile” because they feared being ridiculed or shunned if they “opened up.” Just as many of our participants eventually reached out to others for help, Ofonedu et al.’s<sup>33</sup> participants also eventually sought or accepted emotional support from family, friends, and others in order to gradually heal from the pain of depression. Findings from our study are also similar to findings from a qualitative study describing means of engaging AA adolescents in treatment for depression conducted by Breland-Noble et al.<sup>7</sup> These researchers described their participants’ desire for one of two extremes: to either be left completely alone or for loved ones to reach out to them in very specific ways, whereas our participants described isolating

themselves “from everyone” or wanting others to reach out with empathy, kindness, and respect. Breland-Noble et al.’s<sup>7</sup> finding that adolescents experienced significant distrust of peers, adults, and clinicians is similar to our finding that adolescents often did not feel comfortable opening up to those who had reached out to them because their problems were “no one else’s business.”

### **Limitations**

Our findings should be understood in the context of the limitations of this study. First, all participants were asked about how they had managed their depression but not asked directly about their interactions and relationships with others. As a result, some participants may not have discussed important interactions that influenced their depression. Second, although the use of retrospective interviews with young adult participants allowed them to reflect upon their experiences with depression during adolescence in its entirety, their memories of the events might have been compromised by the passage of time. We do believe, however, that all participants gave in-depth accounts of events that were meaningful in their lives, and these accounts provided rich data that met the study goals.

Another limitation is that a formal retrospective diagnostic interview was not conducted to determine if the young adult participants would meet DSM-IV-TR® criteria for depression.<sup>5</sup> Some participants therefore may not have met diagnostic criteria, and others may have had co-morbid disorders that could account for some findings. For example, some participants may have had Oppositional Defiant Disorder, the main features of which include losing one’s temper, arguing with adults, and showing anger, and this diagnosis could account for participants’ behaviors in the category of striking out at others. Despite the lack of a formal diagnosis, however, the participants provided robust descriptions of depression as they had experienced it. In addition, the narratives



of the adolescents who had been diagnosed with and were in treatment for depression and the young adults who self-reported depression were not notably different.

Finally, our sample was comprised of all AA participants because of our intent to examine how AA adolescents manage depressive symptoms in the face of treatment disparities. However, we cannot claim that any of these findings are specific to AA adolescents. A study comparing how adolescents from different racial/ethnic groups manage depressive symptoms through their interactions with other people would be necessary to draw these conclusions.

### **Future Research**

Future research might include a longitudinal study that explores how each of the five categories of the Being With Others typology unfolds over time. Some of the categories might be sequential, and the ways of Being With Others likely change as the depression progresses or as adolescents receive help. Investigators might also develop a tool to measure the extent to which adolescents engage in the five ways of Being With Others, thus enabling researchers to explore associations between these categories and important outcome measures such as depressive symptomatology and quality of life.

### **Clinical Implications**

Despite the identified limitations, the findings from this study contribute to a better understanding of how AA adolescents manage their depressive symptoms through their relationships with other people in their lives. The typology of Being With Others could be used by psychiatric mental health nurses and other clinicians to assess the variety of ways adolescents engage with or withdraw from people as a way of managing their depression. The typology can alert clinicians to patterns of interactions associated with depression in AA adolescents that are not often considered indices of depression, such as putting on a happy face or joining rather than avoiding activities. Using knowledge of the typology, clinicians can determine whether or not an adolescent's interactions with

others have changed since the onset of depressive symptoms and how these interactions might serve to help manage depressive symptoms.

**Table 3-2.** Discussion Guide for Depression in African American Adolescents

Depression Management Category	Description	Question
Keeping Others At Bay	Preventing people from knowing about feelings of depression, withdrawing from interacting with others, or spending time alone	Some teens report that they deal with feelings of depression by keeping others at bay. They keep their feelings bottled up or hide them from others by putting on a happy face. Sometimes they feel like they can't be completely honest about how they feel. Is that something that you do? If so, tell me about some times you have done this.
Striking Out At Others	Lashing out verbally or physically at others	Some teens report that they deal with feelings of depression by striking out at others. They release built up anger by yelling, cursing, or physically fighting; are viewed at home or school as being in a bad mood; or have times when they 'flip out' on people around them. Is that something that you do? If so, tell me about some times you have done this.
Seeking Help From Others	Seeking help from others	Some teens report that they deal with feelings of depression by seeking help from others. They have people they feel comfortable talking to when they are upset or ask for help with their problems. Is that something that you do? If so, tell me about some times you have done this.
Joining In With Others	Seeking and participating in activities	Some teens report that they deal with feelings of depression by participating in extracurricular sports, school-based clubs like government, choir, band, or orchestra, or do things with people outside of school like going to the movies, shopping, or hanging out at someone's home. Is that something that you do? If so, tell me about some times you have done this.
Having Others Reach Out	Being approached or helped by someone who notices something is wrong	Some teens report that when they are upset or sad, people in their lives notice. These teens have people who ask how they're doing or if they're okay or people who get them to talk about their feelings. Do you have people in your life who do that? If so, tell me more about those people

The typology can also serve as a springboard that clinicians can use to initiate discussions with adolescents about their relationships with important others and to encourage adolescents to consider ways in which important others can better help adolescents manage their depression. Table 2 displays example questions developed from the study findings that might guide a discussion with AA adolescents who are suffering with depression.

## **Conclusion**

Although previous research has identified social support as a protective factor for adolescents with depression, the Being With Others typology expands these findings by looking at social support in a multifaceted way. The “real life” stories provided by our participants reflect the significance of important others in the everyday lives of depressed AA teens. Longitudinal exploration of the five categories of the Being With Others typology could provide insight into relationships between and among the five categories and depression outcomes. Clinicians can use the Being With Others typology to guide important conversations about depression with AA adolescents.

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## CHAPTER FOUR

This chapter presents an explanatory theoretical framework depicting how AA adolescents understand and manage depressive symptoms, and in some cases, use mental health services over the course of their adolescent years. The theoretical framework, labeled Weathering through the Storm, is presented in a report titled, “Processes of Understanding and Managing Depressive Symptoms by African American Adolescents” and was submitted to *Qualitative Health Research*.

## Abstract

**Background:** Depression in African American (AA) adolescents is a significant health concern that frequently is untreated and results in serious, negative long-term health and social outcomes.

**Objective:** To describe AA adolescents' experiences of depression and processes of managing symptoms over the course of their adolescent years.

**Design:** Grounded theory methods were used to collect and analyze narrative data from 22 AA community-based young adults (ages 18-21) and five AA clinic-based adolescents (ages 13-17).

**Results:** A theoretical framework titled *Weathering through the Storm* was developed that describes how AA adolescents understand their depression and its effects, manage their symptoms, and, in some cases, seek and use mental health services over the course of their adolescent years. The five phases of the framework are labeled *enduring stormy weather*, *braving the storm alone*, *struggling with the storm*, *finding shelter in the storm*, and *moving out of the storm*.

**Conclusion:** The framework can be used to guide discussions with depressed AA adolescents and explore strategies for management of the disease.

**Keywords:** African American, adolescent(s), depression, management, social support, coping, Grounded Theory, qualitative, community-based, mental health, treatment use



## **Processes of Understanding and Managing Depressive Symptoms by African American Adolescents**

### **Background**

Depression in African American (AA) adolescents is a prevalent, significant, and frequently untreated mental health concern that is often associated with serious health and social problems. A Major Depressive Episode is defined by the American Psychiatric Association<sup>5</sup> as a period lasting at least two weeks during which an individual experiences a depressed mood or noticeable loss of interest or pleasure in usual activities as well as other symptoms such as significant changes in appetite, weight, or sleep habits; fatigue; restlessness; indecisiveness; an inability to concentrate; feelings of guilt or worthlessness; and suicidal ideation. The American Psychiatric Association<sup>5</sup> includes three depressive mood disorders in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-V-TR®)*: Major Depressive Disorder (MDD), Dysthymic Disorder (DD), and Depressive Disorder not otherwise specified (DDNOS). Individuals with MDD experience one or more Major Depressive Episodes. Individuals with DD experience a depressed mood for at least two years along with additional depressive symptoms that do not meet diagnostic standards for MDD. Individuals with DDNOS experience depressive symptoms that do not meet diagnostic criteria for MDD, DD, or other disorders with depressive symptoms.<sup>5</sup>

The Centers for Disease Control and Prevention<sup>11</sup> reported that 27.5% of AA high school adolescent students who completed the 2013 Youth Risk Behavior Surveillance Survey (YRBSS) had experienced sadness or hopelessness that interfered with their usual activities during the previous year. The Substance Abuse and Mental Health Administration<sup>46</sup> reported that in 2014 depression among 12- to 17-year-old AA adolescents occurred at a rate of 9.1%. According to the Center for Behavioral Health Statistics and Quality,<sup>10</sup> the majority of youth who are depressed suffer severe

impairment because the depression interferes with or limits their ability to carry out major life activities at home, school or work.

Depression in adolescents is associated with many co-morbid health concerns including impairment of psychosocial functioning, poor academic performance, high-risk sexual behavior, early pregnancy, substance abuse, and an increased risk of suicide.<sup>12, 43</sup> Suicide is the second leading cause of death in the United States among adolescents.<sup>28</sup> Ninety percent of adolescents who commit suicide sufferer from a psychological disorder, most commonly depression, when they end their lives.<sup>14, 24</sup> Adolescent depression is also tied to depression during adulthood since half of depressed adolescents will have recurrent depression as young adults.<sup>3, 19</sup>

Although rates of depression among AA and European American (EA) adolescents do not differ, disparities in formal mental health treatment utilization by AA and EA adolescents are striking.<sup>46</sup> Despite the fact that there are several evidence-based treatments for adolescent depression, including cognitive-behavioral therapy<sup>6</sup> or a combination of psychotherapy with pharmacological treatments,<sup>45</sup> AA adolescents often do not receive these treatments. The Substance Abuse and Mental Health Services Administration reported that 41.6% of EA adolescents experiencing a Major Depressive Episode in the previous year received formal treatment compared to only 28.6% of AA adolescents.<sup>46</sup> The National Survey on Drug Use and Health reported similar results after comparing service utilization rates across racial/ethnic groups of adolescents who had experienced a Major Depressive Episode.<sup>18</sup> Several explanations for the underutilization of mental health services by African American adolescents have been proposed. Researchers have found that depressed AA adolescents may be more stoic and tolerate greater distress than EA adolescents,<sup>2</sup> may be more likely to consider depression a problem to be addressed through strong will and the support of God rather than as a medical disease,<sup>2, 9, 34</sup> and may experience a high level of stigma within their

communities.<sup>12, 34</sup> AA adolescents may fear being misunderstood by clinicians since there are limited numbers of minority providers, and they may believe that clinicians will not look out for their best interest.<sup>21, 34, 47</sup>

AA adolescents with depression can face serious consequences when they do not receive adequate treatment. AA adolescents with social and emotional disorders are arrested at more than twice the rate of their EA counterparts.<sup>41</sup> Disproportionately high rates of academic failure, substance abuse, arrest, and incarceration are experienced by urban AA adolescents,<sup>1, 37</sup> and some researchers have suggested that unrecognized and untreated mental health problems may underlie these disparities.<sup>29</sup> Furthermore, while overall rates of suicide attempts among adolescents in the US have declined, attempted suicide rates of AA adolescents, especially under the age of 12, have risen.<sup>11</sup>

Despite the prevalence of depression in AA adolescents and its serious consequences, few researchers have described how AA adolescents experience depression throughout adolescence, especially from their own perspectives. Also, few studies have explored how AA adolescents use mental health services or manage their depression without formal mental health care.<sup>9, 20, 33, 34</sup> Despite an increase in racial/ethnic diversity in the United States, there are few explanatory frameworks addressing diversity-related problems.<sup>13</sup> The National Research Council<sup>17</sup> recognizes that social and human science research is shaped by cultural contexts pertinent to race and ethnicity. The development of theories that encompass and value diversity holds a high premium in the global knowledge marketplace.<sup>31</sup> The purpose of this study therefore is to develop a theoretical framework that describes how AA adolescents understand their depression and its effects, manage their symptoms, and, in some cases, seek and use mental health services over the course of their adolescent years.

## Methods

**Theoretical Perspective.** The Children's Network Episode Model (C-NEM)<sup>16</sup> provided the theoretical perspective for this study. Depression management in AA adolescents has traditionally been examined with consideration of mental health service utilization and treatment rates alone, but it is actually a complex process influenced by the social environment.<sup>40</sup> The C-NEM views disease management as a dynamic process composed of a series of decisions made over time. These decisions form patterns of disease management and pathways into and out of care.<sup>16</sup> Social networks shape the beliefs, attitudes, and perceptions an individual holds about a particular disease as well as healthcare institutions and providers. These beliefs, attitudes, and perceptions in turn influence an individual's illness management decisions.<sup>16</sup> Because the C-NEM views illness management as a process and focuses on social relationships, it supports the examination of depression management and help-seeking in AA adolescents as unfolding processes set in the context of the adolescents' families and communities.

**Design.** Grounded theory methods consist of systematic yet flexible procedures for collecting and analyzing qualitative data to construct theories "grounded" in the data themselves.<sup>13, 23</sup> Symbolic Interactionism (SI) provides a theoretical basis for grounded theory methods. SI, the foundation of grounded theory, posits that human beings' actions towards an object in their environment are based on the meaning they ascribe to that object. Furthermore, that meaning is shaped by social interactions and refined or modified through interpretive processes. Behaviors of an individual are guided by the meaning an object has for each individual. According to Blumer,<sup>7</sup> exploration and inspection are required for the examination of social life.

The intent of grounded theory methodology is to generate explanatory theoretical frameworks of psychosocial processes through the use of concurrent data acquisition, categorization, comparison, and formation of hypotheses.<sup>13, 23</sup> A completed grounded

theory explains the investigated process using theoretical descriptors, illustrates the attributes of the theoretical categories, explicates causes and conditions under which the process manifests and varies, and identifies its ramifications. Additional attributes of a finished grounded theory include a close fit with the data, usefulness, conceptual density, durability over time, modifiability, and explanatory power.<sup>13</sup> Experts have argued that grounded theory is the “optimal methodological tool for examining new, emerging, and evolving issues pertaining to racial/ethnic diversity phenomena.”<sup>26</sup> Because the ways in which AA adolescents experience their depression, manage its symptoms, and use services are psychosocial processes shaped by social context, grounded theory methods<sup>13</sup> were used to conduct this study. The authors received approval from their university’s institutional review board.

**Sample.** Participants are initially chosen for grounded theory studies because they have knowledge of the phenomenon being studied.<sup>26</sup> Because we wished to recruit individuals who had experienced a broad range of depressive symptoms and treatment experiences, data were collected from two AA participant populations. The first population was young adults ages 18-21 living in the community who had experienced depression as adolescents (ages 13-17) and who could provide retrospective information about their experiences living with depression. This population was chosen for several reasons. First, it enabled us to include individuals for whom we did not need parental consent. Because research showed that most adolescents hide their depression from their parents,<sup>27</sup> including only adolescents would have resulted in a sample that excluded all individuals who chose not to disclose their depression to their parents or legal guardians. Second, this population allowed us to obtain narratives about experiences with depression throughout adolescence and into young adulthood. Finally, we were able to obtain narratives from individuals who had not sought or utilized formal mental health services, a perspective that may have been missed had we only recruited

participants from clinic-based settings. The second population in our sample was adolescents ages 13-17 who were being treated for depression. These individuals could provide contemporary information about their present-day experiences and had exhibited symptoms severe enough to merit a diagnosis of depression and formal treatment from a health professional.

**Sample Size.** An exact sample size cannot be determined a priori in grounded theory. Qualitative experts suggest that when using this method to study a homogeneous group, 20 to 30 subjects is a sufficient number to identify shared psychosocial processes.<sup>13</sup> We assumed the study sample was fairly homogeneous since they were all AA adolescents or young adults from the same geographical area and they shared a psychosocial process that would constitute the theoretical framework. A total of 27 participants (22 young adults [ages 18-21] and 5 adolescents [ages 13-17]) were recruited for the study, and they provided sufficient data to meet the aims of the study.

**Young Adults.** We used community networking and public announcements to recruit 22 AA young adult participants (ages 18-21) who had experienced depressive symptoms as adolescents (ages 13-17.) Five postal areas within the Indianapolis metropolitan community were selected for participant recruitment. Three neighborhoods had populations that were predominantly AA, and the remaining two had populations that were racially mixed but with a sizable AA population. The investigator canvassed the five communities to (a) identify locations where AA young adults spent time in order to determine where best to distribute recruitment flyers, (b) locate sites that could be used to conduct interviews that were both publicly accessible and offered privacy, and (c) enlist recruitment support from community leaders by speaking with them about the study.

The investigator distributed recruitment flyers, which contained lay descriptions of depressive symptoms from the DSM-IV-TR® criteria,<sup>5</sup> in each of the five selected

communities. The investigator placed flyers in locations such as grocery stores, gyms, malls, postsecondary colleges, public libraries, and restaurants. The flyer invited African American young adults ages 18-21 to contact the investigator if they had experienced depression between the ages of 13-17. Potential participants were informed by the flyer that interviews could be conducted at a community location convenient to them and that they would be reimbursed for their time and travel with a \$35 gift card after completing the interview.

The investigator conducted a phone screening to determine if potential participants met the following inclusion criteria: (a) self-identified as being AA; (b) aged 18 to 21; (c) could speak, read, and write the English language; and (d) reported having experienced depressive symptoms during adolescence or having been diagnosed with depression by a health professional. The exclusion criteria were as follows: (a) had recently experienced acute distress or a life crisis; (b) had a recent hospitalization for mental health concerns; (c) had current suicidal ideation; or (d) had current homicidal ideation. None of the individuals were screened out of the study for these reasons.

**Adolescents.** The investigator received authorization from a large publicly funded medical center to recruit 13 to 17-year-old AA adolescent participants from an adolescent primary care clinic in Indianapolis. Five participants were recruited using inclusion and exclusion criteria identical to those used for the young adult (ages 18-21) participants with the exception of the age requirement. The investigator informed clinic staff about the study and approached eligible participants about the study after a primary care provider confirmed the participants met study criteria.

### **Data Collection**

Because experts have found that rapport and open disclosure are facilitated that in interview studies if the participant and interviewer are of the same race/ethnicity,<sup>30</sup> all interviews were conducted by the first author, an AA nurse researcher. The data

collection procedures varied slightly in the two populations because of the need for parental consent in the second group.

**Young Adults.** After the investigator determined a potential participant was eligible to participate in the study, an interview was scheduled at a location in the participant's community such as at a community center or library. After the investigator obtained written consent, the participant completed a demographic data sheet. Because discussing events related to depression during adolescence could cause distress, participants were screened for acute distress, safety issues, or imminent danger to themselves or others prior to, during, and after the interviews based on a standard screening and interview distress protocol.<sup>22</sup> None of the participants exhibited distress that precluded or interrupted the interviews.

A semi-structured interview guide was developed to guide the conversations. The interview began with the following question: "You indicated that you experienced depression as a teenager; would you tell me about that experience?" More structured questions were then asked about how participants understood and managed their depressive symptoms as well as if and how they used mental health services. Finally, participants were asked if and how their experiences with depression were affected by their race. At the end of the interview, the participants and investigator reviewed and mapped the main events related to the participants' depression on a timeline to validate the chronology of the events and to ensure that all important events had been discussed. Participants received a \$35 gift card at the completion of the interview to compensate them for time and travel. The interviews were digitally recorded and professionally transcribed.

**Adolescents.** The investigator collected data from clinic-based adolescent participants using procedures identical to those used with young adults, with a few exceptions: 1) Written assent and consent were obtained from the adolescents and their



parent/guardian, respectively; 2) the semi-structured interview questions solicited data on the participants' current experiences with depression as opposed to their retrospective experiences; and 3) all clinic-based participants were questioned about how they were currently connected to mental health services as well as about the treatment they were receiving.

### **Data Analysis**

Data collection and analysis occurred simultaneously. Data were analyzed using grounded theory procedures as outlined by Charmaz.<sup>13</sup> Grounded theory analysis is based on a concept-indicator model of analysis. Empirical indicators (relevant facts or incidents) are identified in the transcripts and compared for similarities and differences. Uniformities in the indicators are identified to determine categories, which are compared to additional indicators to determine the properties of the category. Theoretical propositions are developed about the relationships among the categories and explored by further examination of the data. Propositions with empirical support form the bases of the theoretical framework.

Four coding processes were used to analyze the data.<sup>13</sup> Initial coding, a line-by-line examination of transcripts and assignment of labels to empirical indicators related to the study aims, was performed on all transcripts by the first author and verified by the last author. Focused coding, an examination of initial codes for the presence of significant or recurrent codes and the grouping of these into categories, was then conducted by the first author and verified by the last author. Categories were developed related to how the participants understood their depression and its effects, how they managed their symptoms, and if or how they sought and utilized mental health services throughout their adolescent years. Subcategories that defined the attributes, characteristics, and dimensions of the categories were generated during axial coding. The categories and subcategories were labeled through discussion and consensus by

the first and last authors and verified by the second and third author. Theoretical coding, in which the potential relationships among the categories were determined and integrated to develop a theoretical framework, constituted the final stage of data analysis. The framework was presented to the research team by the first author and suggested modifications were incorporated. Several strategies were used to increase the trustworthiness and credibility of the study and framework. A structured audit trail was kept to provide a written record of each methodological and analytic decision. Methodologic and analytic decisions were discussed with a committee made up of members possessing both qualitative research and adolescent mental health expertise. As categories were developed during data analysis, the first author also appraised how the emerging categories resonated with subsequent participants.

## **Results**

### **Sample**

**Young Adults.** The sample included 22 AA young adults ages 18 to 21. Ten were males and 12 were females. Although four participants identified as more than one race, all 22 identified as African American. Seven participants were students. Half were employed and half were unemployed. One young adult had two children, seven had one child, twelve had no children, and two did not indicate how many children they had. Two reported having no religious affiliation, two were Muslim, nine were Christian, and 11 did not provide information about religious affiliation. Annual household income was reported as less than \$19,999 for six participants, between \$20,000 and \$39,999 for two, and between \$40,000 and \$99,999 for three. Four participants were unsure about their annual household income and seven did not provide data for this question.

**Adolescents.** The sample included five AA adolescents ages 13 to 17. Two were male, and three were female. Although two participants identified as being more than one race, all identified as African American. All were students and one was

employed. Two did not provide information about religious affiliation, and three were Christian. None of the adolescent participants provided data about annual household income.

### **Weathering through the Storm**

Most participants were forthcoming and gave in-depth accounts of events that had been meaningful in their lives. A few participants required more probing but still provided rich data for analysis. A few participants became tearful at times but all wanted to continue the interview. Some smiled, laughed, or spoke enthusiastically about their experiences. The interviews lasted between 20 and 60 minutes with an average of 35 minutes. There were no appreciable differences between the young adult and adolescent participant interviews or data.

The participants described their experiences of adolescent depression primarily in the form of life stories about the turmoil they had lived through rather than as a mental illness with specific symptoms. This turmoil took the form of poverty, homelessness, foster care placement, juvenile justice system involvement, and family dysfunction. Many had experienced traumatic events such as a serious physical injury, parental divorce, the unexpected or violent death of a loved one, and abandonment by a parent. The participants' narratives often focused on how they had managed to get through these turbulent times and, for some, to achieve stability. We chose the common idiom of *weathering through the storm* as the core category to summarize the participants' narratives. Weathering means to experience, bear up against, or "withstand a difficulty or danger,"<sup>38</sup> and the term storm reflects violent weather, heavy rain or snow, or strong wind. The word *through* indicates movement from one phase to another within the framework. The idiom thus captures the turbulence of the experiences the participants discussed as well as, for some, having made it through turbulent times. The participants described five phases of weathering through the storm: (a) enduring stormy weather, (b)

braving the storm alone, (c) struggling with the storm, (d) finding shelter in the storm, and (e) moving out of the storm.

The five stages described below represent a conceptual rendering of a progressive process of how depression commonly unfolds over adolescence. All participants did not necessarily experience all the phases in the orderly fashion suggested by the model. Some participants experienced some aspects of two phases simultaneously, reverted back to prior phases because of a setback, or lingered mainly in one phase. The five phases of weathering through the storm, as described below, however, represent a theoretical framework depicting the dynamic process of Weathering through the Storm.

***Enduring stormy weather.*** Because all the participants had withstood some turbulence in their lives before they experienced, recognized, or acknowledged their depression, we labeled this phase *enduring stormy weather*. The participants experienced this phase in one of two circumstances: *living in a stormy climate* and *experiencing the storm blow in*.

*Living in a stormy climate.* We refer to the first circumstance as *living in a stormy climate* to reflect circumstances in which participants had lived with turbulence for many years, often for most of their lives. Many participants described growing up in family environments marked with adversity. Some lived with a single parent, several of whom were often absent because they worked long hours. Other participants had parents who struggled with substance abuse or mental illness. The mother of one 18-year-old male participant, for example, was frequently hospitalized for drug overdoses and alcohol poisoning. Some participants lived in the midst of criminal, drug, and gang-related activities, either in their homes or in their neighborhoods. Several experienced many disruptions while trying to meet their school obligations because they did not have stable housing. A 21-year-old female participant almost failed to graduate from high school

because she had moved from “house to house.” The helplessness participants felt regarding the adverse circumstances they faced often led to feelings of hopelessness. One 21-year-old male was “hit” by the reality of his situation when the electricity in his home was disconnected for non-payment. He said, “Coming home to no lights and no heat...it’s really depressing. [Mom] was going to school and working two jobs at the same time, and for that to happen, it’s just like wow. It really hurt me.”

A few participants were involved in the criminal justice system themselves and spent extended periods of time in and out of juvenile facilities. One 19-year-old male participant saw his mother’s addiction to pills and alcohol and claimed this led him to sell drugs, which resulted in his getting “locked up” multiple times between the ages of 13 and 17. Some participants lived in foster care after enduring neglect or abuse at the hands of their parent(s). A 20-year-old male participant who was a “ward of the state” from the age of six had been placed with different foster families in multiple states and was not allowed to have contact with his relatives for many years.

Some participants attributed the difficulties they faced to racial discrimination. One 21-year-old male said, “It’s like they see African Americans like everybody is a drug dealer...so it’s very hard to get a job.” Other participants were teased or bullied because of their race. A 21-year-old female who attended a school that was not racially diverse said, “People started making fun of me, the way that I look, the way I talk, all of that. I just got depressed.”

*Experiencing the storm blow in.* We refer to the second circumstance as *experiencing the storm blow in* because some participants had lived “normal” or “happy” lives only to experience a sudden disruptive or traumatic event. Unlike the participants who had *lived in a stormy climate*, the lives of participants who *experienced the storm blow in* were struck by sudden misfortune. The events included the separation or divorce of their parents, the violent or unexpected death of a loved one, finding out they were

adopted, or suffering severe physical trauma. One 21-year-old female participant, for example, described a carefree life until she was severely injured in a motor vehicle accident. She stated,

My life changed drastically [because of the accident] and I didn't know how to deal with it. Since I was in a wheelchair, things were different. I didn't get to go outside as much, not nearly as much. I never got to play. I was always in the house watching a movie in front of the TV, just by myself a lot.

These participants thus were more likely to attribute their depression to a single event and its repercussions than to growing up with adversity.

***Braving the storm alone.*** Because most participants initially attempted to face their depression alone while giving the impression to others that “everything was fine,” we labeled this phase *braving the storm alone*. In many cases, participants felt distraught but did not acknowledge or label their emotional state as depression and tried to hide their feelings by trying to appear to be happy. These participants described “putting on a smile” to mask their suffering. Others hid their feelings by appearing to be indifferent to their problems. One participant, a 21-year-old male, stated that he “painted [on] an ‘I don’t care’ face.” Others covered up their feelings by denying that they were unhappy. When the family of one 21-year-old female participant asked if anything was wrong, she said, “What’s wrong? Nothing. I’m fine, see, I’m smiling. Then, when they left, I would go back to my normal self.” Some participants ignored their feelings of distress by directing their time and energy into their “regular” activities such as schoolwork or sports. An 18-year-old male participant said, “The time my depression was the worst was also the time I was really focused on soccer.”

Participants braved the storm alone for several reasons. Many felt they should “keep their problems to themselves” or should be able handle their problems on their own. Some participants feared they would be viewed as weak if others learned of their distress. Others chose not to talk about their depression because they felt “people

wouldn't understand." Some participants hid their emotions during difficult times because they wanted to be strong for friends and family members who were also struggling emotionally. One 21-year-old female participant hid her depression during her parents' separation. She said, "I had to put the grown-up face on and help my siblings." Some participants chose to deal with their depression alone because they believed this was the norm in African-American culture. One 21-year-old female claimed that instead of talking about feelings of depression, African American females find "different ways to cope." Another 21-year-old female participant emphasized that because she was African American asking for help was not an option. She said, "That's not something we or anybody we knew did. We always thought, like, therapists or something were for crazy people."

***Struggling with the storm.*** Because all the participants had a difficult time managing their depression and other life stressors, we labeled this phase *struggling with the storm*. The participants struggled in two ways during this phase: *retreating from the storm* and *battling the storm*.

*Retreating from the storm.* Because many participants dealt with their distress by withdrawing from people or activities or by avoiding painful feelings, we labeled this way of struggling with the storm as *retreating from the storm*. Some participants retreated from the storm by isolating themselves from people, whereas others retreated from the storm by using banned substances.

Several participants went from being "talkative" and "social people" to people who were quiet and "preferred to be alone." One 21-year-old female "shut down" while struggling with depression and stopped talking to people. Many participants isolated themselves by avoiding their peers. One 18-year-old female described herself during this time as being "antisocial." Some participants tried to avoid their peers by not attending school. One 20-year-old male who dropped out of high school during his junior year said,

“I quit going to school. I stopped getting up, stopped waking up.” Others went to school but withdrew from usual activities. One 21-year-old female participant described her activities before and after she was depressed:

[Before depression] I was always social. I would always go to the skating rink or to the [movies], but [after depression] I just sat in the house. I sat in my room, I didn't do anything. I went to school and I went home.”

Participants also tried to avoid family members. Some secluded themselves in their bedrooms, avoided interacting with their families by sleeping often or refused to attend family gatherings.

Participants withdrew from others for a variety of reasons. Some withdrew from friends and family because interacting with others drained the little energy they had or they “did not want to be bothered.” Some withdrew from people so others would not hurt them. One 21-year-old female participant, for example, said, “I shut myself off so I wouldn't get hurt.” Others simply wanted to be alone. One 21-year-old female claimed “being happier” when she was by herself.

Some participants tried to escape their distress by using banned substances. Several smoked marijuana because it made them feel calm. One 19-year-old male participant who started “smoking weed” at the age of 12 said, “It [marijuana] would bring me down... soothe me, and then everything was good.” Others used alcohol or took prescription pain pills to distract them from their emotional pain. A 21-year-old female began taking her mother's prescription pain pills because they allowed her to sleep, which meant she didn't have to “worry about anything” or deal with her problems. She preferred being “stuck in [her] dreams” to “being in the real world.”

*Battling the storm.* Because many participants responded to their feelings of depression with expressions of anger and aggressive behavior, we labeled this manner of struggling with the storm as *battling the storm*. When feeling bad, participants often lashed out at other people. Some screamed at others, and a few treated others cruelly.



A 16-year-old female, for example, had publicly humiliated a friend at school when she “verbally exploded.” In some instances, the participants provoked physical altercations that included kicking and punching. Some threw objects at others or destroyed their own property. One 21-year-old male said, “I ran through a lot of cell phones just throwing them.” One 21-year-old female said she was “angry, bitter, and mean” while depressed.

Participants acted aggressively toward a variety of people in their lives. Much of the aggression was directed toward peers at school. One 21-year-old female said, “I would go through the hallways hitting on kids and talking bad about them in front of the teachers.” Participants were often “rebellious” toward teachers, sometimes walking out of class. Others were “hostile at home” and argued with family members. One 14-year-old female participant frequently “got into it” with her brother. In a few instances participants had been antagonistic toward strangers. One 21-year-old male participant, for example, acted aggressively toward other drivers when he was upset. A few participants directed feelings of aggression against themselves by self-cutting or engaging in other self-injurious behaviors when they could no longer tolerate their feelings.

Many participants suggested it was easier for them to express anger than to experience their sadness. They claimed they “bottled up” their depressive emotions which later “erupted” as aggression. One 21-year-old male said,

It’s just like you’re hurting inside, but you don’t even show it anymore because your hurt turns into anger and now you’re mad at everybody else and just any little thing... It’s like you don’t even cry anymore; you’re just mad at the world.

Many participants recognized that their reactions were not warranted, but they lashed out nonetheless. One 21-year-old male said, “At the end (of a fight) I always (felt) like I didn’t have to go there, like really I did but I didn’t have to. So I always felt bad afterwards.” Another 19-year-old male suggested that African Americans are more likely

than others to express depression as anger. He said, "When we get depressed, we get mad."

***Finding shelter in the storm.*** Because many participants had eventually experienced some form of protection or refuge from the turbulence of depression, we labeled this phase *finding shelter in the storm*. The participants found shelter in activities that offered them a sense of relaxation or security, important others who offered support, and professional services that provided safety and guidance.

Participants found refuge in a variety of activities that distracted them from their distress or offered a way to release pent-up emotions or physical tension. Many participants had listened to music to improve their mood. Some participants listened to soothing Reggae-like music to calm themselves down when angry, and others, when feeling down, chose upbeat or "crunk" music to boost their mood and feel "hyped." One 16-year-old female participant, who frequently listened to music to manage her feelings of depression, said,

Music [gives] me this feeling, this unconditional love that I need. Words to a song that describe my situation so perfectly, it's like, yes! This is exactly what I've been needing for the entire day. Why didn't I listen to this earlier? Music has always been my salvation to get away from anything that's bitterness, anger, any emotion that I have that I do not want. Music just, it's like, oh, you're mad? Listen to this song. If you're sad, listen to this song. They will help you get by and it has so much.

Some participants found refuge in journaling or writing poetry and songs because these activities allowed them to "pour out their feelings" and be completely "honest." A few participants watched funny videos or created artistic drawings to improve their mood or distracted themselves by cleaning at home. One 21-year-old female would boost her mood by reading about African American culture when she felt people around her were denigrating her for being African American. Other participants released physical tension by exercising. One 21-year-old female, for example, danced, walked, and stretched in order to "release stress, relax (her) muscles, stretch them out, instead of being so tense

and tightened up.” Many participants found a safe haven by playing sports such as basketball, football, or soccer that counteracted, at least temporarily, their despondency or allowed them to release aggressive feelings. Some responded to their low mood by choosing to spend time with close friends rather than avoid them. A few participants joined extra-curricular school clubs like theatre, band, or student council at school or community-based support groups to feel better and distract themselves from their troubles. Others secured jobs that anchored them. One 21-year-old male participant worked at a steady job as a way of staying “out of trouble.”

Some participants found shelter in the storm through the support of others. Although many hid their depression from those close to them, some eventually reached out to others when the depression became unbearable. In some instances, other people had noticed the participants’ distress and reached out to them. In either case, important others would offer support, a listening ear, advice, and comfort or reassurance, thus providing the participants a sense of protection from the turbulence of their lives. Participants generally felt “heard” by others after talking about feelings of sadness, loneliness, or anger. Most also felt supported, comforted, and “loved” when they were able to open up to someone about their feelings. One 21-year-old female said, “Once you do get it out it feels a lot better. I didn’t feel as empty inside. I didn’t feel lonely anymore.”

The participants were most likely to get support from family members, especially their mothers. One 20-year-old male identified his mother as being the one person who “looked out for” him. Another 20-year-old male who had been in foster care for a number of years received “inspirational advice, motivation, and encouragement” from his birth family when he reconnected with them. He said, “[My family] let me know, hey, I got somebody in my corner. It’s not time to give up. I’ve got to keep fighting.” Some participants identified close family friends, other trusted adults, or “mentors” whom they

knew in an informal capacity as being people who had helped them. One 21-year-old female found talking to her friend about her feelings to be therapeutic because she “felt like [her friend] was really listening.” Some were supported by friends or romantic partners. One 20-year-old male participant credited his girlfriend as being the person who had been there for him as he struggled with his depression.

Participants were also sheltered from the storm by formal support services, however it was not a common occurrence. Some had been connected to a mental health, social service, or school-based services that provided help. Several participants worked with counselors or attended support groups. One 21-year-old female revealed that she was depressed to a friend, and it was her friend who encouraged her to talk to the school therapist. Another participant, a 19-year-old male, was connected to an outpatient group counseling program after talking to a mentor about his problems. Many participants were offered assistance from teachers or school counselors who observed their distress. A high school teacher of a 21-year-old female, for example, had reached out to help her when her grades dropped. A few participants received help from law enforcement personnel. For example, one 20-year-old male who had witnessed the murder of his best friend received help from the homicide detectives assigned to the case.

***Moving out of the storm.*** Because some participants escaped the turmoil they dealt with and no longer felt depressed, we labeled this phase *moving out of the storm*. Some of the participants, although not all, reached a point where they felt better and had gained a sense of satisfaction, contentment, or stability. Even some participants who had endured longstanding turmoil felt like they had moved out of the storm. One 21-year-old male had grown to feel “calm” and had developed a positive outlook as opposed to being “negative all the time.” He no longer spent his time “selling drugs” and “robbing people” but enrolled in school and obtained a job. Participants’ lives had

become disrupted when they became depressed, and thus moving out of the storm entailed becoming reengaged in “normal” activities. One 21-year-old female became firmly engaged in activities such as student council, school talent shows, and an early childhood development program. She said, “I was doing things that a teenager my age should do.” A 19-year-old female described her behavior during and after depression:

[During depression] I was in show choir and throughout that year I just didn't really enjoy it. I was fine with standing in the back, which really isn't like me because I have danced since I was two, so me wanting to be in the back just wasn't normal. [After depression] I got my spot back in the front. I definitely did change. I went back to the normal me and it was very clear to people.

Some participants who moved out of the storm had become firmly reconnected with others from whom they had been estranged. A 19-year-old female who had become depressed during her parents' tumultuous divorce found a way to spend “quality time” with each parent when she began to feel better. Following her depression, she was able to “[look] forward to something exciting.” Some participants noted a change in their mood and a sense of well-being. A 21-year-old female, who had been severely injured in a motor vehicle accident and had attended a support group to deal with her physical disability, said, “Through the group I found peace with myself and acceptance of myself. I realized that life does go on. It doesn't have to be sad or bad or boring.”

## Discussion

The purpose of this study was to develop a theoretical framework that describes how AA adolescents understand their depression and its effects, manage their symptoms, and, in some cases, seek and use mental health services over the course of their adolescent years. Using grounded theory methods,<sup>13</sup> we analyzed 27 interviews of persons who had experienced depression in adolescence and developed a theoretical framework we labeled *Weathering through the Storm*. The framework includes five phases that we labeled *enduring stormy weather*, *braving the storm alone*, *struggling*

*with the storm, finding shelter in the storm, and moving out of the storm.* The framework reflects the major finding that adolescents experience depression not as a cluster of symptoms but rather as a period of turbulence during which they must overcome a number of life challenges.

Our construct of Weathering through the Storm resonates with the findings of several prior studies.<sup>9, 25, 44</sup> Our participants, for example, described depression in ways consistent with descriptions reported by participants in a study by Breland-Noble et al.<sup>9</sup> In their qualitative descriptive study exploring strategies for engaging AA adolescents in mental health treatment, these researchers found that AA adolescents who are depressed talk about having “issues” or times they are “just going through a lot” (p. 10) as opposed to being depressed.<sup>9</sup> Ofonedu, Percy, Harris-Britt, and Belcher<sup>36</sup> similarly reported that clinically depressed AA youth identified life events and experiences as the cause of their depression. Ofonedu et al.<sup>36</sup> reported that participants in their study described being depressed with metaphors reflecting turbulence such as “being scrambled up in a bubble,” being on a “rollercoaster,” and “the wind smacking you” (pg.100). The current study’s findings are also consistent with prior research that has revealed associations between adverse life events and depression among AA adolescents.<sup>25, 44</sup> Just as our participants associated hardships related to racial discrimination and financial stressors with their depression, Sanchez, Lambert, and Cooley-Strickland<sup>44</sup> reported that AA youth who had experienced discrimination and economic stress within the previous six months reported more depressive symptoms. Similarly, Grant et al.<sup>25</sup> reported that AA youth with more depressive symptoms had experienced neglectful/distant parenting, inconsistent discipline, and exposure to violence within the previous six months. The current study extends these findings by providing robust examples of how adverse life circumstances are perceived by AA adolescents as central to the unfolding of their depression.

Our finding that AA adolescents initially attempt to hide their depression and manage their feelings alone is similar to a finding in a study conducted by Lindsey, Chambers, Pohle, Beall, and Lucksted<sup>32</sup> These researchers explored behavioral determinants of mental health service use among urban AA youth and found that adolescent participants who experienced mental health problems instinctively kept to themselves and hid their need for help. However, whereas the participants in the Lindsey et al.<sup>32</sup> study concealed their problems by engaging in solitary activities<sup>32</sup> many participants in our study masked their pain by pretending to be happy. Our finding that participants avoided thinking about their distress by engaging frenetically in activities is supported by findings reported by Randall and Bohnert.<sup>42</sup> These researchers explored relationships among organized activity involvement, depressive symptoms, and social adjustment in adolescents and found that adolescents who were over-involved in organized activities (i.e., more than 10 hours per week) had high rates of depressive symptoms.<sup>42</sup> In addition, just as our participants were afraid to talk to others about their feelings of depression, Breland-Noble et al.<sup>9</sup> found that AA adolescents had difficulty trusting people enough to talk about their problems.

The various ways AA adolescents struggled to manage their depression in our study has been reported by other researchers.<sup>15, 36, 39</sup> For example, just as some of our participants withdrew from being with others, Ofonedu et al.<sup>36</sup> reported that social withdrawal and self-isolation were common responses among depressed AA adolescents. In addition, just as some of our participants used marijuana, alcohol, or prescription pain pills to numb or escape their emotional pain, Costello, Swendsen, Rose, and Dierker<sup>15</sup> reported associations between depression and the use of alcohol, tobacco, marijuana and other. Our findings most closely resonate, however, with those of Perkins et al.<sup>39</sup> who conducted a qualitative study examining depression in young AA male ex-offenders. These researchers found that their participants commonly expressed

their feelings of depression as anger and aggression. Our study supports these findings and contributes evidence that AA females as well as males exhibit angry and aggressive behaviors when depressed.

In a longitudinal study examining associations between music preferences and depression in adolescence, Miranda and Claes<sup>35</sup> found that listening to Soul music (e.g., hip hop, R&B, reggae) was a predictor of decreased depression among girls. Our study extends these findings with evidence from both male and female participants who listened to particular musical selections to modulate their emotions, such as listening to upbeat hip-hop when they felt sad or calming reggae when they were angry. Consistent with our findings that engaging in structured activities could help with depressive symptoms, Bohnert, Richards, Kolmodin, and Lakin<sup>8</sup> found that such activities were associated with increased motivation and decreased alienation in urban AA adolescents. In relation to mental health service use, our participants described being connected to formal services in ways consistent with those described by Lindsey et al.<sup>33</sup> in that most were connected to services through encouragement by a loved one or receiving a recommendation from a teacher.

Although recovery from depression was not achieved by all participants in the current study, the experiences of adolescents who felt recovered were similar to findings from prior studies.<sup>4, 36</sup> For example, Alim et al.<sup>4</sup> reported that optimism and a sense of purpose were significantly related to resilience and recovery among AA adolescents. Similarly, our participants who had recovered from depression became engaged in school or work and developed a positive outlook on life. Our finding that social reengagement was a common feature of recovery has also been reported by others.<sup>4, 36</sup>

All participants in the current study were asked if being African American had an impact on their experience or management of depression. Some articulated that they believed their ethnicity influenced their depressive experiences whereas others did not



believe that ethnicity mattered. Although studies have found race, poverty, and discrimination to be associated with depression,<sup>15, 32, 36, 39</sup> to our knowledge our study is one of the only ones that posed a question about race and depression directly to participants. Some participants stated that racial discrimination and oppression were associated with their depression, that they were more likely to express depression as anger than other ethnicities because they were AA, and that they were reluctant to get formal treatment from counselors of a different race who would not understand them.

### **Limitations**

Our conclusions should be interpreted in light of certain study limitations. First, we did not administer a formal retrospective diagnostic interview to assess whether young adult participants would meet DSM-IV-TR® criteria for depression.<sup>5</sup> As a result, some participants may not have met the diagnostic threshold for depression and some of the experiences shared by participants might have related to normal adolescent challenges rather than depression. However, the participants' narratives described experiences that would meet several diagnostic criteria of depression and most described depressive experiences that seemed quite severe. Furthermore, the narratives of young adults who had not been formally diagnosed with depression did not differ notably from the narratives of the clinic-based adolescents who had received a formal diagnosis of depression. In addition, it is likely that some participants had a co-morbid disorder that may have influenced experiences they attributed to depression. For example, some participants might have had a diagnosis of Disruptive Behavior Disorder, such as Oppositional Defiant Disorder (ODD) or Conduct Disorder (CD),<sup>5</sup> which could have accounted for the frequent references they made regarding incidents of aggression. However, the participants themselves clearly associated their aggressive behaviors with feelings of depression.

Second, the use of interviews asking participants to discuss incidents that had occurred in the past may have resulted in retrospective recall biases, and some experiences might not have been discussed in full detail. However, most participants gave comprehensive accounts of past events that had been particularly meaningful to them and thus provided robust data that met the study goals.

Lastly, all of the participants in our sample were AA so we could not ascertain which experiences discussed by the participants were influenced by ethnicity per se, and we do not claim that our findings are unique to AA adolescents alone. When we asked participants directly about connections between race and depression, most gave examples of how race mattered, and others spontaneously shared examples about how race had some bearing on their experience of depression. Thus, our findings do contribute a beginning understanding about AA adolescents' perceptions of the influence race has on their depression.

### **Future Research**

Based on the limitations of the current study, we recommend that future research include a longitudinal study that follows a large group of AA adolescents throughout their adolescent years and, for those who become depressed at some point, includes interviews with important others in their lives. Such a design would allow for identifying the processes of depression management and explicating multiple treatment pathways as they unfold in real time and include multiple perspectives that could result in a more nuanced understanding of how depression unfolds throughout adolescence. In addition, recruiting a larger, multi-ethnic sample of adolescents would allow for group comparisons so that researchers could determine specific ways in which ethnicity influences depression in adolescents.

Investigators might also develop a tool that measures the extent to which adolescents with depression successfully navigate each of the five phases of the

framework. Studies could then determine if the degree to which adolescents successfully navigate through the phases predicts outcomes such as amelioration of depressive symptom severity and intervention effectiveness.

### **Practice Recommendations**

Although there are several limitations to the study and the framework would need further development and validation, the Weathering through the Storm framework could be used by mental health treatment providers to open a dialogue with depressed AA adolescents about the course of their depression. Providers might share the framework as a whole with adolescents and ask if the processes laid out resonate with their own experiences, and if so, where they see themselves in the process of Weathering through the Storm and what would help them move through the process.

The Weathering through the Storm framework could also be used with AA adolescents to explore aspects of depression that may be affected by race/ethnicity. Treatment providers can directly ask about how experiences of racial discrimination influence the adolescents' lives since racial issues are often not the focus of treatments for depression. In addition, the findings suggest that professionals who work with youth, such as teachers, coaches, and law enforcement personnel, should be particularly aware of the possibility that AA adolescents may have an increased likelihood of expressing depression as anger.

### **Conclusion**

The Weathering through the Storm framework was developed to depict the processes involved in AA adolescents' management of depression. The framework adds to current literature with a depiction of chronic and acute challenges that can lead to depression and of common ways in which depression unfolds in this population. Our findings suggest that depression among AA adolescents may be expressed differently than in other groups and that specific challenges associated with race may contribute to

the mental health disparities experienced by AA adolescents. Further development of the framework with a larger and more diverse sample and a longitudinal design is recommended. Despite limitations, clinicians can use the Weathering through the Storm framework to guide discussions with AA adolescents and explore pathways to successfully managing their depression.

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## CHAPTER FIVE

### Summary of Dissertation Project

Depression in AA adolescents is a prevalent mental health problem, can result in serious concurrent and long-term effects, and is associated with health disparities due to underutilization of mental health services. The overall goal of this dissertation project was to generate a comprehensive framework that describes how AA adolescents experience depression throughout adolescence. The information gained in this project will contribute to initiatives to reduce health disparities in this population. This dissertation project was composed of two components. The first component was an integrative review of studies that explored the relationship between coping responses and adolescent depression, and the second component was a grounded theory study that resulted in two qualitatively derived products. The first is a typology that classifies the interaction patterns of depressed AA adolescents. The second a theoretical framework that depicts how depression in AA adolescents unfolds over time. Three different but related manuscripts were developed from this work and are presented as Chapter 2, Chapter 3, and Chapter 4 of this dissertation.

Manuscript 1 is a report of an integrative review that investigated associations between adolescent coping responses and depression. This integrative review summarized and integrates research from the past ten years that examined coping techniques used by depressed adolescents. The review yielded conclusions regarding the state of the science on adolescent coping and depression and provided a foundation for the grounded theory research study.

Manuscript 2 builds upon Manuscript 1 (the integrative review) by examining how AA adolescents manage depression through their interactions with important others in their lives. Manuscript 2 is a report of a typology that we labeled Being With Others and that describes five common interaction patterns of depressed AA adolescents with other



people in their lives. The five categories in the typology are *keeping others at bay, striking out at others, seeking help from others, joining in with others, and having others reach out.*

Manuscript 3 builds upon Manuscript 2 (the Being With Others typology) by explaining how AA adolescents experience depression over time. While Manuscript 2 presents a typology that provides a comprehensive categorization of interpersonal interactions, Manuscript 3 presents an explanatory theoretical framework that describes more generally how depression in AA adolescents unfolds over time. This theoretical framework, labeled Weathering through the Storm, depicts how AA adolescents understand and manage depressive symptoms, and in some cases, use mental health services over the course of their adolescent years. The five phases of the framework are labeled *enduring stormy weather, braving the storm alone, struggling with the storm, finding shelter in the storm, and moving out of the storm.*

### **Synthesis of Key Findings**

Although the findings of the dissertation project are detailed in the three manuscripts, several key findings that cut across the manuscripts are discussed below. A synthesis of these findings is presented in terms of the four aims of the research study.

#### **Aim 1: Describe how African American adolescents who are depressed understand their depression and its effect on them.**

Manuscript 2 (the Being With Others typology) and Manuscript 3 (the Weathering through the Storm theoretical framework) describe how AA adolescents understand or view depression not as a disorder or as a collection of symptoms but rather as the turmoil they feel in response to life challenges. Manuscript 2 (the Being With Others typology) revealed that depressed AA adolescents often describe their depressive experiences in terms how they interact with others. These interactions can range from

pushing others away in response to distressing feelings to engaging others as a way of healing. Manuscript 3 (the Weathering through the Storm theoretical framework) also highlights that AA adolescents understand their depression not as a disease but as turbulence in their lives that they must manage. I conclude that the common idiom of Weathering the Storm best describes how AA adolescents understand their depression and its effect on them.

**Aim 2: Describe how African American adolescents who are depressed manage their depressive symptoms.**

The findings described in Manuscript 1 (the integrative review) highlight that adolescents manage their depressive symptoms with a variety of coping strategies. The review revealed that research generally supports that adolescents who actively or directly address their problems fare better than adolescents who avoid them. The findings described in Manuscript 2 (the Being With Others typology) reveal that while depressed adolescents may push others away when feeling depressed, many will eventually use the support of others to manage their depressive symptoms by seeking help or advice from people close to them, talking to someone about their problems, or joining others in group activities. The findings presented in Manuscript 3 (the Weathering through the Storm theoretical framework) reveal that adolescents manage their depression through a complex process that involves moving through a time of turbulence due to on-going adversity or an acute life crisis to a time in which they experience stability and fulfillment. I conclude that adolescents who successfully manage their depression do so through a series of phases in which move from avoiding their problems and disengaging from or lashing out against others to confronting their problems directly and engaging with others who can help and support them.

**Aim 3: Describe how African American adolescents who are depressed seek and utilize mental health services.**

The findings of Manuscript 2 (the Being With Others typology) reveal that AA adolescents who are depressed seek and utilize mental health services in variety of venues (e.g., mental health center, school counseling) and are connected to services either voluntarily, often at the urging of other important adults, or involuntarily, such as required by juvenile detention or foster care placement. The findings of Manuscript 3 (the Weathering through the Storm theoretical framework) highlight that for some AA adolescents, mental health treatment plays a key role in how they manage the turbulence in their lives. While some AA adolescents avoid formal mental health services as they are fearful that the services could be deleterious or irrelevant to them as African Americans, some found mental health treatment to be stabilizing amidst the turbulence they were experiencing. I conclude that AA adolescents seek and utilize mental health services through a variety of pathways, that they typically get treatment only if an important other persistently encourages it, and that mental health services can facilitate recovery if the adolescents do not feel forced into treatment and if they feel the treatment meets their unique needs, especially as African Americans.

**Aim 4: Generate an explanatory theoretical framework that depicts how depression in African American adolescents unfolds throughout their adolescent years.**

Manuscript 3 (the Weathering through the Storm theoretical framework) presents an explanatory theoretical framework that describes how AA adolescents understand their depression and its effects, manage their symptoms, and in some cases, seek and use mental health services over the course of their adolescent years. This framework is the culmination of the dissertation project. I acknowledge that theoretical framework is dynamic rendering of how depression in AA adolescents commonly unfolds over the

course of the adolescent years, and that AA adolescents do not always experience the five phases (*keeping others at bay, striking out at others, seeking help from others, joining in with others, and having others reach out*) in a linear or orderly process. However, the framework depicts common ways in which AA adolescents experience depression, either in response to on-going life adversity or an unexpected traumatic event. Although much of the framework might well apply to all racial or ethnic groups, it is specific to AA adolescents as it is based on descriptions of life challenges particular to them (e.g., discrimination they encounter in society), their beliefs about how their race influenced how they managed their depression (e.g., best to manage the depression within the family structure), and their perceptions of systemic mental health disparities (e.g., untrustworthy providers).

### **Strengths of Dissertation**

This dissertation project has several strengths. The integrative review of research on coping in adolescents who are depressed is the first such review to be done in 15 years.<sup>2</sup> and revealed some significant gaps in this body of literature. The grounded theory research study is one of few studies to conduct in-depth interviews about AA depression from those who experienced it and one of the only studies to directly ask AAs about the impact of race on their experiences of depression. The findings of the study are based on a sample that represented a broad range of depressive experiences due to the recruitment of two groups of participants: young adults ages 18-to-21 and adolescents ages 13-to-17. The sampling strategy allowed for inclusion of AA adolescents' who had formal mental health treatment as well as those who relied on self-management strategies. The study was strengthened by the community assessments conducted prior to recruitment that fostered support from local community leaders and was particularly important in recruiting young AA males, a traditionally difficult to recruit population. As a result of these strengths, this dissertation project resulted in findings

that will have clinical relevance in the development of initiatives to combat mental health disparities in this population.

### **Limitations of Dissertation**

The findings from this project should be understood in the context of several limitations. The findings presented in Manuscript 1 (the integrative review) represent a comprehensive integrative review, but because a quantitative integration of the findings, such as a meta-analysis, was not conducted, conclusions about the strength of the associations between the coping and depression variables could not be made. In addition, studies measuring adolescent coping responses for a particular disease process (e.g. cancer, diabetes, etc.) were excluded, thus limiting the scope of the review.

In the grounded theory research study, the use of retrospective interviews for the young adults (ages 18-to-21) could have resulted in inaccurate recall of information as in some cases the events they described happened several years prior to the interview. Yet because the young adults were discussing experiences from their lives that were particularly meaningful, they were able to provide a robust description of most events. In addition, the narratives provided during retrospective interviews did not seem to differ in any significant way from narratives given by adolescents reporting on their current experiences. Another limitation of the grounded theory study is the young adult participants were not given a formal diagnostic interview to verify their depression. However, many of the symptoms that they discussed are consistent with symptoms of depression as outlined in the DSM-V manual.<sup>1</sup> In addition, without a complete diagnostic interview, it is impossible to ascertain if comorbid disorders might not account for some of the findings. For example, it might be that some of the aggressive behaviors discussed might be due to Disruptive Behavior Disorders rather than depression.

Finally, all the participants were AA and, without comparison groups from other ethnicities, it is impossible to determine which findings are specific to AAs.

### **Summary of Recommendations for Future Research**

The limitations of this dissertation project provide direction for future research. A meta-analysis that determines the strength of associations between a variety of coping strategies and depression in a variety of sub-populations of depressed adolescents (e.g., those with cancer, childhood obesity) is needed. Future qualitative studies of adolescent depression could include a retrospective diagnostic interview of participants to confirm a diagnosis of depression and assess for comorbid disorders. A longitudinal study that follows groups of high-risk youth of varying ethnicities throughout adolescence, and that includes important others in the adolescents lives, could refine the framework. If the framework were more fully developed, variables drawn from the framework (e.g., receiving the support of others) could be measured to determine how certain processes are related to outcomes (e.g., duration of depression).

### **Summary of Practice Implications**

Despite the limitations, the findings of have practice implications for mental health treatment providers and other professionals who work with AA adolescents. Both the typology and the theoretical framework could provide springboards by which providers could facilitate discussion of how important others influence experiences of depression in adolescent clients and how their depression is unfolding. The findings suggest that providers should be alert to a wide variety behaviors that signal depression (e.g., lashing out) beyond behaviors commonly associated with the disorder. Finally, the findings support that providers should be particularly sensitive to aspects of adolescent depression that might be unique to the AA population.

## **Conclusion**

This dissertation project produced a comprehensive integrative review, a typology of interaction patterns of depressed AA adolescents with other people, and an explanatory theoretical framework depicting how depression unfolds in AA adolescents over time. All three contribute to a comprehensive understanding of how AA adolescents experience depression throughout adolescence and provide information that can contribute to the development of strategies to reduce mental health disparities in this population. Further development and testing of the framework with larger and more diverse samples is recommended. Depression in this population is not best understood as a cluster of symptoms to be treated but rather as a complex and arduous process of Weathering through the Storm.

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## APPENDICES

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**Appendix A**  
**Inclusion/Exclusion Criteria**

Young Adult Inclusion Criteria:

- A. Self-identifies as African American or Black
- B. Between the ages of 18 and 21
- C. Speaks, reads, and writes the English language
- D. Self-reports having been depressed or experiencing many of the symptoms of depression listed on recruitment fliers **during adolescence** (ages 13 to 17) or reports having received a formal diagnosis of depression **during adolescence** (ages 13 to 17).

Adolescent Inclusion Criteria:

- A. Self-identifies as African American or Black
- B. Between the ages of 13 and 17
- C. Speaks, reads, and writes the English language
- D. Currently receives mental health treatment for depression at Midtown Mental Health Center

Young Adult and Adolescent Exclusion Criteria:

- A. Is currently experiencing a high level of stress or emotional distress that (a) interferes with school, work, or family obligations; (b) interferes with self-care activities; and/or (c) has required a recent hospitalization.
- B. Has thoughts of harming themselves (suicidal ideation)
- C. Has thoughts of harming someone else (homicidal ideation)

## Appendix B

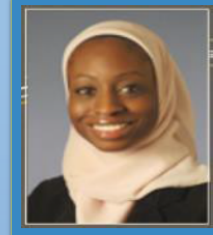
### Recruitment Flyer

Indiana University School of Nursing Research Study on the Experience of African American Teenagers who have Depression

## Were you **DEPRESSED** as a **TEEN**?

A study is being conducted by Halima Al-Khattab RN, a doctoral student in the Indiana University School of Nursing. She is looking to interview teenagers about how they manage depression. You are eligible if you are:

- African American
- 18 – 21 years old
- Experienced depression as a teenager (ages 13 – 17)



If you experienced these symptoms **AS A TEENAGER** you may be eligible to participate:

- A depressed mood for at least 2 weeks
- A loss of interest in usual activities for at least 2 weeks



Other symptoms you may have experienced include:

- Feelings of worthlessness
- Excessive guilt
- Thoughts of suicide
- Disturbed physical functioning
- Loss of appetite or overeating
- Significant weight-loss or weight gain
- Insomnia (inability to sleep)
- Hypersomnia (sleeping too much)
- Fatigue or loss of energy
- Difficulty concentrating or making decisions

The topic of adolescent depression can be sensitive and might bring up tough feelings. As a result we are advising individuals who are currently experiencing a high level of stress or emotional distress not to participate at this time. This includes individuals who:

- Have recently been *hospitalized for an emotional problem*
- Are currently *having thoughts of harming him or herself*
- Are currently *having thoughts of harming someone else*

You will receive a \$35 a Wal-Mart gift card after completing the interview.

Taking part in this study is voluntary.  
Interviews will be held at a location convenient to you.  
Please call \_\_\_\_\_ to hear more about the study.

## **Appendix C**

### **Voicemail Message Script**

Hello, you have reached the information line for a research study about how African American adolescents manage depression. This study is being conducted by Halima Al-Khattab, a nursing graduate student, under the supervision of her advisor, Dr. Claire Draucker from Indiana University School of Nursing. She is currently recruiting 18-21 year-old young adults for interviews about the depression they experienced when they were between 13 and 17 years old.

An official diagnosis of depression from a doctor or mental health specialist when you were a teenager is not required for you to participate in this study.

If you agree to be in the study, you will need to:

- Review the details of the study
- Read and sign a consent form
- Complete a Demographic Data Sheet
- Participate in a digitally recorded interview for approximately 60 minutes in which you will be asked questions about your experiences with depression as a teenager.

After completing the interview, you will receive a \$35 Wal-Mart gift card.

If you would like to volunteer for this study or have questions about this study, please leave a message with your name and a phone number where you can be contacted.

Thank you for calling.

## Appendix D

### Young Adult Acute Distress Screening Interview Protocol

#### Young Adult (Ages 18-21) Acute Distress Screening Interview Protocol

This is Halima Al-Khattab from Indiana University School of Nursing. Thank you for your interest in our study. Do you have any questions about the study? [If yes, answer questions. If no, proceed.]

Please verify your name and phone number?

Because the topic of adolescent depression can be sensitive and might bring up tough feelings, we are advising individuals who are experiencing a high level of stress or emotional distress not to participate at this time. Is it all right if I ask you some questions to determine if there is any reason you should not participate? [If no, thank you for your time and interest. If yes, read confidentiality statement and conduct screening interview.]

**CONFIDENTIALITY STATEMENT:** All answers that you give will be kept private. However, under law, if you tell us you are planning to cause serious harm to yourself or others, we must report that information to local law authorities.

Screening Questions	NO	YES	Follow-up Questions  If YES, ask questions	Participant's Responses	Acute Emotional Distress or Safety Concern? (Y or N)	Imminent Danger? (Y or N)
1. Are you experiencing a high level of stress or any emotional distress?			<ol style="list-style-type: none"> <li>1. Tell me what you are experiencing.</li> <li>2. Is it getting in the way of you doing things you need to do (school, work, family obligations)?</li> <li>3. Is it getting in the way of you taking care of yourself?</li> <li>4. Have you been in the hospital recently for the problem?</li> </ol>			
2. Are you currently having thoughts of harming yourself?			<ol style="list-style-type: none"> <li>1. Tell me what thoughts you are having.</li> <li>2. Do you intend to harm yourself?</li> <li>3. How do you intend to harm yourself?</li> <li>4. When do you intend to harm yourself?</li> <li>5. Do you have the means to</li> </ol>			

			harm yourself?			
3. Are you currently having thoughts of harming someone else?			<ol style="list-style-type: none"> <li>1. Tell me what thoughts you are having.</li> <li>2. Do you intend to harm someone else? Who?</li> <li>3. How do you intend to harm him/her/them?</li> <li>4. When do you intend to harm him/her/them?</li> <li>5. Do you have the means to harm him/her/them?</li> </ol>			

Actions for screener:

1. If answers to screening questions are all NO, inform the participant that they are eligible to participate and schedule interview.
2. If a participant's responses reflect **acute distress or safety concerns but NOT imminent danger**, take the following actions:
  - a. Do not schedule an interview.
  - b. Recommend that the volunteer contact his/her mental health care provider or provide counseling resources if needed.
  - c. Indicate that, with the participant's permission, Dr. Draucker (study psychologist / Principal Investigator) will call him/her the next day to see if he/she is okay.
  - d. Notify Dr. Draucker (study psychologist / Principal Investigator) of the results of the screening.
3. If a participant's responses to additional screening questions reflect **imminent danger**:
  - a. Contact local law authorities.
  - b. Indicate that, with the participant's permission, Dr. Draucker (study psychologist / Principal Investigator) will contact him/her the next day to see if he/she is okay.
  - c. Notify Dr. Draucker (study psychologist / Principal Investigator) of the results of the screening immediately.

## Appendix E

### Adolescent Acute Distress Screening Interview Protocol

Study #1307011805

#### Adolescent (Ages 13-17) Acute Distress Screening Interview Protocol

This is Halima Al-Khattab from Indiana University School of Nursing. Thank you for your interest in our study. Do you have any questions about the study? [If yes, answer questions. If no, proceed.]

Please verify your name and phone number?

Because the topic of adolescent depression can be sensitive and might bring up tough feelings, we are advising individuals who are experiencing a high level of stress or emotional distress right now not to participate at this time. Is it all right if I ask you some questions to determine if there is any reason you should not participate? [If no, thank you for your time and interest. If yes, read confidentiality statement and conduct screening interview.]

**CONFIDENTIALITY STATEMENT:** All answers that you give will be kept private. However, under law, if you tell us you are planning to cause serious harm to yourself or others, we must report that information to local law authorities. If you tell me that you are experiencing a great deal of distress and need help, I will share this information with you therapist or counselor.

Screening Questions			Follow-up Questions  If YES, ask questions	Participant's Responses	Acute Emotional Distress or Safety Concern? (Y or N)	Imminent Danger? (Y or N)
	NO	YES				
1. Are you experiencing a high level of stress or any emotional distress?			<ol style="list-style-type: none"> <li>1. Tell me what you are experiencing.</li> <li>2. Is it getting in the way of you doing things you need to do (school, work, family obligations)?</li> <li>3. Is it getting in the way of you taking care of yourself?</li> <li>4. Have you been in the hospital recently for the problem?</li> </ol>			
2. Are you currently having thoughts of harming yourself?			<ol style="list-style-type: none"> <li>1. Tell me what thoughts you are having.</li> <li>2. Do you intend to harm yourself?</li> <li>3. How do you intend to harm yourself?</li> <li>4. When do you intend to harm yourself?</li> <li>5. Do you have the means to harm yourself?</li> </ol>			

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<p>3. Are you currently having thoughts of harming someone else?</p>			<p>1. Tell me what thoughts you are having.</p> <p>2. Do you intend to harm someone else? Who?</p> <p>3. How do you intend to harm him/her/them?</p> <p>4. When do you intend to harm him/her/them?</p> <p>5. Do you have the means to harm him/her/them?</p>			
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Actions for screener:

1. If answers to screening questions are all NO, inform the participant that they are eligible to participate and schedule interview.
2. If a participant's responses reflect **acute distress or safety concerns but NOT imminent danger**, take the following actions:
  - a. Do not schedule an interview.
  - b. Recommend that the volunteer contact his/her mental health care provider at Midtown Community Health Center.
  - c. Notify the adolescent's mental health care provider of the results of the screening.
  - d. Notify Dr. Draucker (study psychologist / Principal Investigator) of the results of the screening.
3. If a participant's responses to additional screening questions reflect **imminent danger**:
  - a. Notify the adolescent's parent or guardian (who will be present).
  - b. While keeping adolescent on the phone, contact local law authorities.
  - c. Notify the adolescent's mental healthcare provider of the results of the screening immediately.
  - d. Notify Dr. Draucker (study psychologist / Principal Investigator) of the results of the screening immediately.



## Appendix F Indiana University Young Adult Informed Consent Form

Study #1307011805

### ▲ Indiana University Young Adult Informed Consent Statement for

#### **Processes of Disease Management and Treatment Use in Adolescent Depression**

You are invited to participate in a research study of how African American adolescents manage depression. You were selected as a possible participant because you indicated you are interested by leaving a voicemail message with your contact information. We are interviewing young adults who believe they experienced depression as teens and asking them to reflect back on those experiences. Please read this form and ask any questions you may have before agreeing to be in the study.

The study is being conducted by Halima Al-Khattab, RN, a graduate student under the supervision of her advisor, Claire Draucker, RN, PhD, from Indiana University School of Nursing. It is funded by a Ruth L. Kirschstein National Research Service Award For Individual ~~Predoctoral~~ Fellowships To Promote Diversity In Health-Related Research (Parent F31 - Diversity).

#### **STUDY PURPOSE**

The purpose of this study is to interview 18–21-year-old African Americans about their experience with depression as a teenager (ages 13 to 17). Specific topics that will be explored are:

1. How you managed depression as a teenager
2. What you found helpful or unhelpful in managing depression
3. How relationships with family and friends influenced your management of the depression
4. If, when, and how you sought mental health treatment
5. How you obtained mental health treatment
6. Any experiences you had with mental health treatment

#### **NUMBER OF PEOPLE TAKING PART IN THE STUDY:**

If you agree to participate, you will be one of approximately 20 young adults who will be participating in this research.

#### **PROCEDURES FOR THE STUDY:**

If you agree to be in the study, you will need to:

- Review the details of the study
- Read and sign this consent form
- Complete a Demographic Data Sheet
- Participate in a digitally-recorded interview for approximately 60 minutes in which you will be asked questions about your experiences with depression as a teenager.

#### **RISKS OF TAKING PART IN THE STUDY:**

While in the study, the risks are:

- being uncomfortable answering the questions
- thinking about unpleasant memories associated with dealing with depression as a teenager
- feeling psychological stress as a result of thinking about unpleasant memories

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You can ask questions at any time during the interview. You do not have to answer any question that you feel uncomfortable with. You can choose to immediately end the interview at any time.

#### **BENEFITS OF TAKING PART IN THE STUDY:**

The benefits to participation that are reasonable to expect are having the chance to talk about your experiences of living with symptoms of depression as a teenager. Talking about these events may allow you to think about the events you experienced from a different perspective and to gain a new understanding of these experiences. However, it is possible that you may not benefit from participating in this study.

#### **ALTERNATIVES TO TAKING PART IN THE STUDY:**

You have the option to not participate in the study.

#### **CONFIDENTIALITY**

Efforts will be made to keep your personal information confidential. We cannot guarantee absolute confidentiality. Your personal information may be disclosed if required by law. For example, if you reveal the abuse of a child or current intent to hurt yourself or someone else, we would need to report that to authorities. Your identity will be held in confidence in reports in which the study may be published and databases in which results may be stored. Only the interviewer, her advisor Dr. Draucker, and the research team will have access to the digital recordings and/or typed transcripts. Both the recordings and transcripts will be stored on a password-protected computer. The information collected will not have your name attached to it.

Organizations that may inspect and/or copy your research records for quality assurance and data analysis include groups such as the study investigator and her research associates, the Indiana University Institutional Review Board or its designees, study sponsor the National Institutes of Health (NIH), and (as allowed by law) state and/or federal agencies such as the Office for Human Research Protections (OHRP), which may need to access your research records.

#### **PAYMENT**

You will receive payment for taking part in this study. At the conclusion of the interview, you will receive a \$35.00 Wal-Mart gift card. If you decide to stop the interview early, he or she will still receive the \$35.00 gift card.

#### **CONTACTS FOR QUESTIONS OR PROBLEMS**

For questions about the study or a research-related injury, contact the researcher, Halima Al-Khattab, at [redacted]. If you cannot reach the researcher during regular business hours (Mon-Fri, 8:00AM-5:00PM), please call the IU Human Subjects Office at (317) 278-3458 or (800) 696-2949. After business hours, please call the researcher, Halima Al-Khattab, at [redacted].

In the event of an emergency, you may contact the 24-Hour Crisis & Suicide Hotline at 317-251-7575.

For questions about your rights as a research participant, to discuss problems, complaints, or concerns about the research study, or to obtain information or offer input, contact the IU Human Subjects Office at (317) 278-3458 or (800) 696-2949.

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**VOLUNTARY NATURE OF STUDY**

Taking part in this study is voluntary. You may choose not to take part or may leave the study at any time. Leaving the study will not result in any penalty or loss of benefits to which you are entitled. Your decision whether or not to participate in this study will not affect your current or future relationship with Indiana University School of Nursing.

Your participation may be terminated by the investigator without regard to your consent if you show evidence of acute distress, if there are safety concerns, or if you indicate that you are an imminent danger to yourself or others.

**PARTICIPANT'S CONSENT**

In consideration of all of the above, I give my consent to participate in this research study.

I will be given a copy of this informed consent document to keep for my records. I agree to take part in this study.

**Subject's Printed Name:** \_\_\_\_\_

**Subject's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
(must be dated by the subject)

**Printed Name of Person Obtaining Consent:** \_\_\_\_\_

**Signature of Person Obtaining Consent:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## **Appendix G**

### **Indiana University Adolescent Informed Assent Form**

Study #1307011805

#### **Indiana University Assent to Participate in Research**

#### **Processes of Disease Management and Treatment Use in Adolescent Depression**

We are doing a research study. A research study is a special way to learn about something. We are doing this research study because we are trying to find out more about how African American teenagers manage their depression. We would like to ask you to be in this research study.

#### **Why am I being asked to be in this research study?**

You are being asked to be in this research study because you currently see a counselor or therapist Midtown Community Mental Health for depression.

#### **What will happen during this research study?**

We want to tell you about some things that might happen if you are in the study. This study will take place at Midtown Community Mental Health. We think it will last for one to two months.

If you want to be in this study, here are the things that we will ask you to do.

- Review the details of the study
- Read and sign this assent form
- Complete a Demographic Data Sheet
- Participate in a digitally recorded interview for approximately 60 minutes in which you will be asked questions about your experiences with depression as a teenager.

#### **Are there any bad things that might happen during the research study?**

Sometimes bad things happen to people who are in research studies. These bad things are called “risks.” The risks of being in this study might be that you may:

- be uncomfortable answering the questions
- think about unpleasant memories associated with dealing with your depression
- feel psychological stress as a result of thinking about unpleasant memories

Not all of these things may happen to you. None of them may happen. Things may happen that the doctors (**or researchers**) don't know about yet. If they do, we will make sure that you get help to deal with anything bad that might happen. You can ask questions at any time during the interview. You do not have to answer any questions that you feel uncomfortable with. You can choose to immediately end the interview at any time.

#### **Are there any good things that might happen during the research study?**

Sometimes good things happen to people who are in research studies. These good things are called “benefits.” The benefits of being in this study might be that having the chance to talk about your experience of living with symptoms of depression as a teenager. Talking about these events may allow you to think about the events you have experienced from a different perspective and to gain a new understanding of these experiences.

We don't know for sure if you will have any benefits. We hope to learn something that will help other teenagers with depression.

Study #1307011805

**Will I get money or payment for being in this research study?**

You will get a \$35.00 Wal-Mart gift card at the conclusion of the interview. If you decide you want to stop the interview early, you will still receive the \$35.00 gift card.

**Who can I ask if I have any questions?**

If you have any questions about this study, you can ask your parent or guardian, or your doctor, or the researcher, Halima Al-Khattab. Also, if you have any questions that you didn't think of now, you can ask later. If you cannot reach the researcher during regular business hours (Mon-Fri, 8:00AM-5:00PM), please call the IU Human Subjects Office at (317) 278-3458 or (800) 696-2949. After business hours, please call the researcher, Halima Al-Khattab, at .

**What if I don't want to be in the study?**

If you don't want to be in this study, you don't have to. It's up to you. If you say you want to be in it and then change your mind, that's OK. All you have to do is tell us that you don't want to be in it anymore. No one will be mad at you or upset with you if you don't want to be in it. Deciding not to participate will not effect your relationship with anyone at Midtown Community Health Center.

The researcher may decide that you can not participate if you become very distressed, if there are concerns for your safety, or you say that you are a danger to yourself or others.

**My choice:**

If I write my name on the line below, it means that I agree to be in this research study.

I will be given a copy of this assent document to keep.

\_\_\_\_\_  
Subject's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Subject's Name

\_\_\_\_\_  
Signature of person obtaining assent

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of person obtaining assent

<p><i>For IRB Office Use ONLY</i></p> <p><b>IRB Approval Date: June 30, 2014</b></p> <p><b>Expiration Date: June 29, 2015</b></p>
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## Appendix H

### Indiana University Parent or Guardian Informed Consent Form

Study #1307011805

#### Indiana University Parent or Guardian Informed Consent Statement for

#### **Processes of Disease Management and Treatment Use in Adolescents Depression**

Your teenager is invited to participate in a research study of how African American adolescents manage depression. Your teen was selected as a possible participant because he or she is a client at Midtown Community Health Center. We are interviewing teenagers about their experience with depression. Please read this form and ask any questions you may have before agreeing to allow your teen to be in the study.

The study is being conducted by Halima Al-Khattab, RN, a graduate student under the supervision of her advisor, Claire Draucker, RN, PhD, from Indiana University School of Nursing. It is funded by a Ruth L. Kirschstein National Research Service Award For Individual Predoctoral Fellowships To Promote Diversity In Health-Related Research (Parent F31 - Diversity).

#### **STUDY PURPOSE**

The purpose of this study is to interview 13-17-year-old African Americans about their experience with depression. Specific topics that will be explored are:

1. How they manage depression as a teenager
2. What they find helpful or unhelpful in managing depression
3. How relationships with family and friends have influenced their management of the depression
4. When and how they sought mental health treatment
5. How they obtained mental health treatment
6. Any experiences they have had with mental health treatment

#### **NUMBER OF PEOPLE TAKING PART IN THE STUDY:**

If you agree to allow your teen to participate, he or she will be one of approximately six (6) teenagers who will be participating in this research.

#### **PROCEDURES FOR THE STUDY:**

If you give consent and your teen agrees to be in the study, he or she will need to:

- Review the details of the study
- Read and sign an assent form
- Complete a Demographic Data Sheet
- Participate in a digitally recorded interview for approximately 60 minutes in which he or she will be asked questions about his/her experiences with depression as a teenager.

#### **RISKS OF TAKING PART IN THE STUDY:**

While in the study, the risks are:

- loss of confidentiality
- being uncomfortable answering the questions
- thinking about unpleasant memories associated with dealing with depression as a teenager
- feeling psychological stress as a result of thinking about unpleasant memories
- compounding current psychological or emotional problems by reliving stressful memories.

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Your teen can ask questions at any time during the interview. He or she does not have to answer any question he or she feels uncomfortable with. Your teen can choose to immediately end the interview at any time.

#### **BENEFITS OF TAKING PART IN THE STUDY:**

The benefit to participation that is reasonable to expect is your teen having the chance to talk about his or her experiences of living with symptoms of depression as a teenager. Talking about these events may allow him or her to think about the events from a different perspective and to gain a new understanding of these experiences. However, it is possible your teen may not benefit from participating in this study.

#### **ALTERNATIVES TO TAKING PART IN THE STUDY:**

You have the option to not allow your teen to participate in the study.

#### **CONFIDENTIALITY**

Efforts will be made to keep your teen's personal information confidential. We cannot guarantee absolute confidentiality. Your teen's personal information may be disclosed if required by law. For example, if your teen reveals the abuse of a child or current intent to hurt him or herself or someone else, we would need to report that to authorities. Your teen's identity will be held in confidence in reports in which the study may be published and databases in which results may be stored. Only the interviewer, her advisor Dr. Draucker, and the research team will have access to the digital recordings and/or typed transcripts. Both the recordings and transcripts will be stored on a password-protected computer. The information collected will not have your teen's name attached to it.

Organizations that may inspect and/or copy your research records for quality assurance and data analysis include groups such as the study investigator and her research associates, the Indiana University Institutional Review Board or its designees, study sponsor, the National Institutes of Health and (as allowed by law) state and/or federal agencies such as the Office for Human Research Protections (OHRP) etc., who may need to access your medical and/or research records.

#### **PAYMENT**

Your teen will receive payment for taking part in this study. At the conclusion of the interview, your teen will receive a \$35.00 Wal-Mart gift card. If your teen decides to stop the interview early, he or she will still receive the \$35.00 gift card.

#### **CONTACTS FOR QUESTIONS OR PROBLEMS**

For questions about the study or a research-related injury, contact the researcher, Halima Al-Khattab, at  
If you cannot reach the researcher during regular business hours (Mon-Fri, 8:00AM-5:00PM), please call the IU Human Subjects Office at (317) 278-3458 or (800) 696-2949. After business hours, please call the researcher, Halima Al-Khattab, at

In the event of an emergency, you may contact the 24-Hour Crisis & Suicide Hotline at 317-251-7575.

For questions about your rights as a research participant or to discuss problems, complaints, or concerns about the research study, or to obtain information or offer input, contact the IU Human Subjects Office at (317) 278-3458 or (800) 696-2949.

**VOLUNTARY NATURE OF STUDY**

Taking part in this study is voluntary. You may choose not to allow your teen to take part or to leave the study at any time. Leaving the study will not result in any penalty or loss of benefits to which your teen is entitled. Your decision whether or not to allow your teen to participate in this study will not affect his or her current or future relationship with Midtown Community Health Center.

Your teen's participation may be terminated by the investigator without regard to your consent if your teen shows evidence of acute distress, if there are safety concerns, or if your teen indicates that he or she is an imminent danger to him or herself or others.

**GUARDIAN'S CONSENT**

In consideration of all of the above, I give my consent for my teen to participate in this research study.

I and my teen will be given a copy of this informed consent document to keep for our records. I agree to allow \_\_\_\_\_ take part in this study.

**Teenager's Name:** \_\_\_\_\_

**Parent or Guardian's Printed Name:** \_\_\_\_\_

**Parent or Guardian's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
(must be dated by parent/guardian)

**Printed Name of Person Obtaining Consent:** \_\_\_\_\_

**Signature of Person Obtaining Consent:** \_\_\_\_\_ **Date:** \_\_\_\_\_



## Appendix I

### Young Adult Demographic Data Sheet

#### Young Adult (ages 18-21) Demographic Data Sheet

Participant # \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Gender: MALE / FEMALE

Do you identify yourself as African American? YES / NO

Do you identify with any other ethnic group? YES / NO

If yes, which group(s) do you identify with?

- \_\_\_\_\_ American Indian or Alaska Native
- \_\_\_\_\_ Asian
- \_\_\_\_\_ Native Hawaiian or other Pacific Islander
- \_\_\_\_\_ Black
- \_\_\_\_\_ White
- \_\_\_\_\_ More than one race
- \_\_\_\_\_ Other

Occupation:

If student, year in school: \_\_\_\_\_

Marital status:

Number of children:

Religious affiliation:

Number in household:

Annual household income in the family you grew up in: ENTER LETTER \_\_\_\_\_

- A. Less than \$19,999/year
- B. \$20,000-\$39,999/year
- C. \$40,000 - \$99,999/year
- D. \$100,000 or more/year
- E. Unsure

Are you currently employed? YES / NO

List mental health treatment you received between the ages of 13 and 17

Type of Provider	Approximate Dates

## Appendix J

### Adolescent Demographic Data Sheet

#### Adolescent (ages 13-17) Demographic Data Sheet

Participant # \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Gender: MALE  FEMALE

Do you identify yourself as African American? YES  NO

Do you identify with any other ethnic group? YES  NO

If yes, which group(s) do you identify with?

- American Indian or Alaska Native
- Asian
- Native Hawaiian or other Pacific Islander
- Black
- White
- More than one race
- Other

If student, year in school: \_\_\_\_\_

Religious affiliation:

Number in household:

Are you currently employed? YES  NO

List mental health treatment you have received between the ages of 13 – 17

Type of Provider	Approximate Dates

## Appendix K

### Young Adult Interview Guide

#### Young Adult (ages 18-21) Interview Guide

Participant # \_\_\_\_\_

A funnel approach will be utilized for the interview. The questions will start broadly and give the participant the opportunity to lead the direction of the interview. The following are the questions included in the interview guide.

1. You indicated that you experienced depression as a teenager. Tell me about that.
2. Tell me about the first time you knew you were depressed.
3. Tell me how you managed your experience of depression.
4. Tell me about the worst experience you had related to your depression when you were a teenager.
5. Tell me about a good experience you had managing your depression when you were a teenager.
6. Did you ever get help for your depression from others? For example, family, friends, teachers, clergy, healthcare providers, etc.
  - a. If so, tell me about the help that you got.  
(Note: repeat this question for each individual from whom the participant received help.)
7. Did you ever go to a mental health professional, like a therapist, counselor, psychologist, or psychiatrist, for your depression?
  - a. If so, tell me how you decided to go to a therapist (counselor, etc.).
  - b. Tell me how it was arranged for you to see a therapist (counselor, etc.).
  - c. What did the therapist (counselor, etc.) do that was helpful?
  - d. What did the therapist (counselor, etc.) do that was not helpful?  
(Note: repeat these questions for any mental health professional seen.)
8. Is there anything else you would like to tell me about your experience with depression as a teenager?
9. Now, I would like to construct a timeline to include any major events you experienced in regard to your depression as a teen. For example, when you first noticed you were depressed, times when the depression got better or worse, experiences that made your depression better or worse.  
(Note: discuss each age/year of school)

#### Timeline

Grade in School	Middle School	Freshman	Sophomore	Junior	Senior	After High School
Age	12-13	13-14	14-15	15-16	16-17	17+

## Appendix L

### Adolescent Interview Guide

#### Adolescent (ages 13-17) Interview Guide

Participant # \_\_\_\_\_

A funnel approach will be utilized for the interview. The questions will start broadly and give the participant the opportunity to lead the direction of the interview. The following are the questions included in the interview guide.

1. You indicated that you are currently experiencing depression. Tell me about that.
2. Tell me about the first time you knew you were depressed.
3. Tell me how you have been managing your experience of depression.
4. Tell me about the worst experience you have had related to your depression.
5. Tell me about a good experience you have had managing your depression.
6. Have you received help for your depression from others? For example, family, friends, teachers, clergy, healthcare providers, etc.
  - a. If so, tell me about the help that you got.  
(Note: repeat this question for each individual from whom the participant received help.)
7. You indicated you are currently receiving treatment for depression at Midtown Mental Health Center?
  - a. Tell me how you decided to go to a therapist (counselor, etc.).
  - b. Tell me how it was arranged for you to see a therapist (counselor, etc.).
  - c. What has the therapist (counselor, etc.) done that has been helpful?
  - d. What has the therapist (counselor, etc.) done that has not been helpful?  
(Note: repeat these questions for any mental health professional seen.)
8. Is there anything else you would like to tell me about your experience with depression?
9. Now, I would like to construct a timeline to include any major events you have experienced in regards to your depression. For example, when you first noticed you were depressed, times when the depression got better or worse, experiences that have made your depression better or worse.  
(Note: discuss each age/year of school)

#### Timeline

Grade in School	Middle School	Freshman	Sophomore	Junior	Senior	After High School
Age	12-13	13-14	14-15	15-16	16-17	17+

## Appendix M

### Young Adult Research Interview Distress Protocol

#### Young Adult (ages 18-21) Research Interview Distress Protocol

The following protocol outlines the actions of the interviewer if, during the course of the interview, a participant exhibits acute distress, if there are safety concerns, or if there appears to be imminent danger to self or others

Indications of Distress During Interview	Follow-up Questions	Participant Behaviors/Responses	Acute Emotional Distress/ Safety Concern? (Y or N)	Imminent Danger (Y or N)
Indicate they are experiencing a high level of stress or emotional distress, OR exhibit behaviors suggestive that the interview is too stressful such as uncontrolled crying, incoherent speech, indications of flashbacks, etc.	<ol style="list-style-type: none"> <li>1. Stop the interview.</li> <li>2. Offer support and allow the participant time to regroup.</li> <li>3. Assess mental status.               <ol style="list-style-type: none"> <li>a. Tell me what thoughts you are having.</li> <li>b. Tell me what you are feeling right now.</li> <li>c. Do you feel you are able to go on about your day?</li> <li>d. Do you feel safe? (if NO, ask questions below)</li> <li>e. Determine if the person is experiencing <b>acute emotional distress beyond what would be normally expected in an interview about a sensitive topic.</b></li> </ol> </li> </ol>			
Indicate they are thinking of hurting themselves	<ol style="list-style-type: none"> <li>1. Stop the interview.</li> <li>2. Express concern and conduct a safety assessment.               <ol style="list-style-type: none"> <li>a. Tell me what thoughts you are having.</li> <li>b. Do you intend to harm yourself?</li> <li>c. How do you intend to harm yourself?</li> <li>d. When do you intend to harm yourself?</li> <li>e. Do you have the means to harm</li> </ol> </li> </ol>			

	yourself? 3. Determine if the person is an <b>imminent danger to self.</b>			
Indicate they are thinking of hurting others	1. Stop the interview. 2. Express concern and conduct a safety assessment. a. Tell me what thoughts you are having. b. Do you intend to harm someone else? Who? c. How do you intend to harm him/her/them? d. When do you intend to harm him/her/them? e. Do you have the means to harm him/her/them? 3. Determine if the person is an <b>imminent danger to others.</b>			

Actions for interviewer:

1. If a participant's distress reflects an emotional response reflective of what would be expected in an interview about a sensitive topic, offer support and extend the opportunity to: (a) stop the interview; (b) regroup; (c) continue.
2. If a participant's distress reflects **acute emotional distress or a safety concern beyond what would be expected in an interview about a sensitive topic but NOT imminent danger**, take the following actions:
  - a. Encourage the participant to contact his/her mental health provider OR the 24-hour crisis line at (317) 251-7575 or 1-800-273-TALK (8255).
  - b. Provide the participant with contact information for the 24-hour Crisis & Suicide Intervention Line, offered by the Mental Health America of Greater Indianapolis at (317) 251-7575 or 1-800-273 (TALK), and encourage the participant to call either number if he/she experiences increased distress in the hours/days following the interview.
  - c. Indicate that, with the participant's permission, Dr. Draucker (study psychologist / Principal Investigator) will contact him/her the next day to see if he/she is okay.
  - d. Notify Dr. Draucker (study psychologist / Principal Investigator) of the recommendations given to participant.
3. If a participant's distress reflects **imminent danger**, take the following actions:
  - a. Contact local law authorities unless arrangements can be made for the participant to be transported to the emergency room by a family member.
  - b. Indicate that, with the participant's permission, Dr. Draucker (study psychologist / Principal Investigator) will contact him/her the next day to see if he/she is okay.
  - c. Immediately notify Dr. Draucker (study psychologist / Principal Investigator) of actions taken.

## Appendix N

### Adolescent Research Interview Distress Protocol

#### Adolescent (ages 13-17) Research Interview Distress Protocol

The following protocol outlines the actions of the interviewer if, during the course of the interview, a participant exhibits acute distress, if there are safety concerns, or if there appears to be imminent danger to self or others

Indications of Distress During Interview	Follow-up Questions	Participant Behaviors/Responses	Acute Emotional Distress/ Safety Concern? (Y or N)	Imminent Danger (Y or N)
Indicate they are experiencing a high level of stress or emotional distress, OR exhibit behaviors suggestive that the interview is too stressful such as uncontrolled crying, incoherent speech, indications of flashbacks, etc.	<ol style="list-style-type: none"> <li>1. Stop the interview.</li> <li>2. Offer support and allow the participant time to regroup.</li> <li>3. Assess mental status.               <ol style="list-style-type: none"> <li>a. Tell me what thoughts you are having</li> <li>b. Tell me what you are feeling right now.</li> <li>c. Do you feel you are able to go on about your day?</li> <li>d. Do you feel safe? (if NO, ask questions below)</li> <li>e. Determine if the person is experiencing <b>acute emotional distress beyond what would be normally expected in an interview about a sensitive topic.</b></li> </ol> </li> </ol>			
Indicate they are thinking of hurting themselves	<ol style="list-style-type: none"> <li>1. Stop the interview.</li> <li>2. Express concern and conduct a safety assessment.               <ol style="list-style-type: none"> <li>a. Tell me what thoughts you are having.</li> <li>b. Do you intend to harm yourself?</li> <li>c. How do you intend to harm yourself?</li> <li>d. When do you intend to harm yourself?</li> <li>e. Do you have the means to harm yourself?</li> </ol> </li> <li>3. Determine if the person is</li> </ol>			

Study #1307011805

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	<b>an imminent danger to self.</b>			
Indicate they are thinking of hurting others	<ol style="list-style-type: none"> <li>1. Stop the interview.</li> <li>2. Express concern and conduct a safety assessment. <ol style="list-style-type: none"> <li>a. Tell me what thoughts you are having.</li> <li>b. Do you intend to harm someone else? Who?</li> <li>c. How do you intend to harm him/her/them?</li> <li>d. When do you intend to harm him/her/them?</li> <li>e. Do you have the means to harm him/her/them?</li> </ol> </li> <li>3. Determine if the person is an <b>imminent danger to others.</b></li> </ol>			

Actions for interviewer:

1. If a participant's distress reflects an emotional response reflective of what would be expected in an interview about a sensitive topic, offer support and extend the opportunity to: (a) stop the interview; (b) regroup; (c) continue.
2. If a participant's distress reflects **acute emotional distress or a safety concern beyond what would be expected in an interview about a sensitive topic but NOT imminent danger**, take the following actions:
  - a. Encourage the participant to contact his/her mental health provider at Midtown Community Health Center OR the 24-hour crisis line at (317) 251-7575 or 1-800-273-TALK (8255).
  - b. Notify the adolescent's mental health care provider of the participant's distress.
  - c. Notify Dr. Draucker (study psychologist / Principal Investigator) of the participant's distress.
3. If a participant's distress reflects **imminent danger**, take the following actions:
  - a. Contact local law authorities unless arrangements can be made for the participant to be transported to the emergency room by a family member.
  - b. Notify the adolescent's mental healthcare provider of the results of the distress immediately.
  - c. Notify Dr. Draucker (study psychologist / Principal Investigator) of the participant's distress immediately.



## CURRICULUM VITAE

Halima Abdur-Rahman Al-Khattab

### Education

<b>Institution</b>	<b>Dates</b>	<b>Degree</b>	<b>Major</b>
Indiana University	05/2009 – 08/2016	Doctor of Philosophy	Clinical Nursing Science
Indiana University	08/2006 – 05/2009	Bachelor of Science	Nursing
Indiana University	08/1999 – 08/2003	Bachelor of Science	Cytotechnology

### Positions Held

<b>Position</b>	<b>Institution</b>	<b>Dates</b>
Research Assistant	Indiana University School of Nursing	08/2012 – present
Registered Nurse	Indiana University Health	05/2009 – present
Co-Facilitator	Leadership Education in Adolescent Health	08/2012 – 05/2013
Teaching Assistant	Indiana University School of Nursing	08/2011 – 05/2012
Research Assistant	Indiana University School of Nursing	08/2009 – 12/2009
Student Nurse	Indiana University Health	05/2007 – 05/2009
Cytotechnologist	Cytology Pathology Services	05/2005 – 05/2007
Cytotechnologist	Quest Diagnostics	10/2004 – 04/2005
Cytotechnologist	MD Anderson Cancer Center	02/2004 – 10/2004
Cytotechnologist	L. Roudebush Veterans Medical Center	07/2003 – 02/2004

### Publications

**Al-Khattab, H.,** Oruche, U. M., Perkins, D., Draucker, C. B., (2016). How African American Adolescents Manage Depression: Being With Others. (in press).

### **Publications Continued**

- Draucker, C. B., **Al-Khattab, H.**, Hines, D. D., Mazurczyk, J., Russell, A. C., Stephenson, P. S., & Draucker, S., (2014). Racial and Ethnic Diversity in Grounded Theory Research, *The Qualitative Report*, 19(34).
- Oruche, U. M., Draucker, C. B., **Al-Khattab, H.**, Cravens, H., Lowry, B., & Lindsey, L. (2014). The Challenges for Primary Caregivers of Adolescents with Disruptive Behavior Disorders. *Journal of Family Nursing*, 21(1).
- Oruche, U. M., Draucker, C. B., **Al-Khattab, H.**, Knopf, A., & Mazurczyk, J., (2014). Interventions for Family Members of Adolescents with Disruptive Behavior Disorders. *Journal of Child and Adolescent Psychiatric Nursing*, 27(3).

### **Presentations**

- Al-Khattab, H.**, Oruche, U. M., Perkins, D., & Draucker, C. B., How African American Adolescents Manage Depression: Being With Others. Podium presentation, Midwest Nursing Research Society's 40<sup>th</sup> Annual Research Conference, Milwaukee, WI, March 2016.
- Al-Khattab, H.**, African-American Adolescent Depression. Invited webinar presentation, Certificate in Culturally Competent Mental Health Care 2015-1016: Addressing Indiana's Mental Health in Urban and Rural Populations. <http://go.iu.edu/15kx>, Indiana University School of Nursing, December 2015.
- Al-Khattab, H.**, Hines, D. D., Draucker, C. B., Mazurczyk, J., Russell, A. C., Stephenson, P. S., & Draucker, S., Racial and Ethnic Diversity in Grounded Theory Research. Invited podium presentation, The Qualitative Report Sixth Annual Conference, Fort Lauderdale, FL, January 2015.

### **Presentations Continued**

- Al-Khattab, H.** & Draucker, C. B., Processes of Disease Management and Treatment Use in Adolescent Depression. Podium presentation, American Psychiatric Nurses Association 28<sup>th</sup> Annual Research Conference, Indianapolis, IN, October 2014.
- Al-Khattab, H.** & Draucker, C. B., Community-Based Strategies for Recruiting African American Young Adults for a Qualitative Study on Depression Management. Podium presentation, Midwest Nursing Society's 27<sup>th</sup> Annual Research Conference, Chicago, IL, March 2013.
- Al-Khattab, H.**, Broome, M.E., & Weaver, M. T. The Influence of Contextual Factors on the Mental Health Help-Seeking Behaviors of African American Adolescents. Podium presentation, From Disparities Research to Disparities Interventions: Lessons Learned and Opportunities for the Future of Behavioral Health Services Conference, Arlington, VA, April 5-8, 2011
- Al-Khattab, H.**, Broome, M.E., & Weaver, M.T. Influence of Contextual Factors on the Mental Health Help-Seeking Behaviors of African American Adolescents. Poster, Midwest Nursing Research Society, Columbus, OH, March 24–27, 2011
- Al-Khattab, H.**, Broome, M.E., & Weaver, M.T. The Relationship Between Contextual Factors and Mental Health Help-Seeking Practices of African-American Adolescents and their Parents. Poster, International Society of Psychiatric-Mental Health Nurses Annual Conference, Tucson, Arizona, March 30 – April 1, 2011
- Gerkenmeyer, J. E., Oruche, U., Stephan, L., Wheeler, C., & **Al-Khattab, H.** The Lived Experience of Primary Caregivers of Children with Mental Health Needs. Podium presentation, A System of Care for Children's Mental Health: Expanding the Research Base, Tampa, Florida, March 2009

### **Presentations Continued**

**Al-Khattab, H.** & Broome, M.E. Migraine Pain Comparison in Undergraduate versus Graduate Students & Science Versus Non-Science Majors. Poster, Committee on Institutional Cooperation Conference, Michigan State University, July 2008

**Al-Khattab, H.** & Broome, M.E. Migraine Pain in College Students. Poster, Midwest Nursing Research Society Conference, Indianapolis, IN, December 2007

### **Honors and Awards**

Ruth L. Kirschstein National Research Service Award for Individual Predoctoral Fellowship to Promote Diversity in Health-Related Research (Parent F31 – Diversity)	2013 - 2015
Lee D. Fuller Award for Clinical Excellence in Care of the Mentally Ill Recipient	2014
Indiana University School of Nursing 100 <sup>th</sup> Anniversary Scholars Fellowship Recipient	2013
Leadership Education in Adolescent Health Fellow	2012 – 2015
Spotlight on Nursing Graduate Scholarship Recipient	2012 – 2014
T32 Health Behavior Research Pre-Doctoral Fellow	2010 – 2013
Research Incentive Fellowship Recipient	2010 – 2015
Southern Regional Education Board Doctoral Scholar	2011 & 2012
Irene and Nathaniel Aycock Scholarship Recipient	2011 & 2012
Student Travel Stipend Awardee – Disparities Research Conference	2011
Nursing 2000 Scholarship for Graduate Education in Nursing	2010
Fairbanks Fellowship Recipient	2009 & 2010

### **Honors & Awards Continued**

Indiana University School of Nursing Alumni Association Elected Board Member	2009
Florence Nightingale Nursing Scholarship Recipient	2009
Frances Lehman Nursing Scholarship Recipient	2009
Lavern V Sutton Leadership Award Recipient	2009
National Beta Image Award Recipient	2009
Regional Beta Image Award Recipient	2008