J Child Fam Stud
DOI 10.1007/s10826-012-9583-3

ORIGINAL PAPER

Depression in Inner City African American Youth: A Phenomenological Study

Mirian E. Ofonedu · William H. Percy · April Harris-Britt · Harolyn M. E. Belcher

© Springer Science+Business Media, LLC 2012

Abstract Depression can at times be under-identified, and misdiagnosed, especially in youth from under-represented ethnic and racial groups who live in urban environments. This study employed a qualitative phenomenological methodology to examine the subjective experience of depression among clinically diagnosed inner city African American adolescents, aged 13–17 years. Five super-ordinate themes emerged from the study analysis including, (a) the depth of depression, (b) life events and experiences as "root base", (c) the emotional sense of self, (d) the survival self, and (e) the healing self. Findings also demonstrated the essence of the lived experience of being depressed as including both externalizing and internalizing strategies for coping. The adolescents described depression as a part of life and did not describe suicide as a solution, suggesting the need to consider that these constructs may lead to a more informed understanding and identification of depression among African American youths. Methodological limitations and recommendations for future research are addressed.

Keywords Depression · Adolescents · African American · Mental health · Phenomenological psychology

Introduction

The Substance Abuse and Mental Health Services Administration (SAMHSA 2011) reported that 8.1 % of 12–17 year olds met diagnostic criteria for a major depressive episode in the past year. It is believed that over half of the lifetime cases of anxiety, mood disorder, impulse-control disorder, and substance abuse begin before 14 years of age (Kessler et al. 2005). According to Breland-Noble et al. (2010), descriptions of the adolescent experience of depression most often times stems from data on White youth. Breland-Noble (2004) presented the idea that the burden of mental illness disproportionately impacts African American youth compared to their White counterparts, and that Black (the terms *African American* and *Black* was used interchangeably throughout the paper to reflect and respect the dual usage by the study participants) young people are underrepresented in both clinical care and research. Two years later, Breland-Noble et al. (2006), based on their interpretation of prior research, concluded that a lack of culturally sensitive treatments and provider bias in the delivery of care left African Americans with more unmet mental health needs than Whites. Joe et al. (2009) also suggested that African American youth often reported symptoms of depression and other mood disorders, that had not been previously been diagnosed. The lack of treatment may result in an escalation of symptoms, or the progression of depression into suicidal ideation and behavior. Research discussing the prevalence rates of depression stratified by race has been equivocal. For example, Allen-Meares et al. (2003) reported a higher prevalence of depression for African Americans, while Angold et al. (2002) reported a higher prevalence of depression for White youth (4.6 vs. 1.4 %). The Centers for Disease Control and Prevention (CDC 2006) reported that African American students make fewer reports of suicidal ideation and attempts when compared to students from other racial groups. The limited reporting of symptoms found in some studies of African American adolescents has raised concerns about the cultural validity of current depressive criteria (Delahanty et al. 2001).

M. E. Ofonedu (✉) · H. M. E. Belcher
The Family Center at Kennedy Krieger Institute,
1750 East Fairmount Avenue, Baltimore, MD 21231, USA
e-mail: ofonedu@kennedykrieger.org; mirianofonedu@aol.com

W. H. Percy · A. Harris-Britt
Capella University, Minneapolis, MN 55402, USA

Published online: 20 April 2012

Black youths' everyday experiences may differ from their White counterparts' experiences, even within the same geographic environment (Lindsey et al. 2006; USDHHS 2001). There seems to be a relationship between socio-economic status and race that significantly impacts differential outcomes related to both the diagnosis and experience of depression. African-American adolescents residing in inner city low-income environments have a higher risk of mental illness, including depression, than their counterparts possibly due to increased exposure to community violence, criminal and gang activity, drug use, and poverty (USDHHS 2001; Fitzpatrick et al. 2005). Living in the inner city can be characterized by minimal educational opportunities, high unemployment and crime rates, inadequate housing, and crowded neighborhoods. Inner city areas have been described as "islands of risk and despair" (Fitzpatrick and LaGory 2000 p. 121), where social detachment, crime, physical hazards, and stress abound (Ross and Mirowsky 2001; Ross et al. 2001). The Bureau of Justice Statistics (2000) reported that the average annual violent crime rate in inner-city areas is about 74 % higher than the rural rate and 37 % higher than the suburban rate.

Depression research and treatment have traditionally been approached utilizing a medical model conceptualization with a significant focus on the genetic and biological influences impacting the development and expression of the illness. Such an approach may miss the nuances associated with the expression of depression in people from diverse backgrounds, including persons from racially and socioeconomically diverse areas, like impoverished, inner city African American youth. Given the relatively limited focus of depression research on primarily White middle class youth, it is possible that current research and clinical measures that were developed to capture the clinical presentation of the disorder may be less relevant for under-resourced, African American youth (Summerville et al. 1992). Many researchers have argued for the development of new and more accurate measures of depression for African American youth and to support the development of a more inclusive nomenclature and description of the disorder in diverse populations (Breland-Noble et al. 2006). For example, Choi (2002) purports the "masked anger" hypothesis of depression in African American youth based on the premise that Black youth may show more anger, aggression, and irritability than sadness and decreased energy, symptoms which are typically associated with depression. While advances in the understanding of depressive phenomenology have occurred over the last decade, empirical investigations of depression in African American adolescents, including studies of Black adolescents' lived experience of depression and the effectiveness of treatment (Breland-Noble et al. 2010), their health-related perceptions of depression, anxiety, and suicidal ideation (Joe 2006; Molock et al. 2006; Lambert et al. 2004; Garcia and Saewyc 2007), and their help-seeking behaviors (Lindsey et al. 2006; Breland-Noble et al. 2006) continue to highlight the need for more research on the expression and presentation of depressive symptoms in African American youth, including the potential for symptom variability associated with the disease.

Clinicians and researchers can support the early diagnosis and treatment of depression by better understanding the various symptom presentations associated with the disease (Breland-Noble et al. 2010). Currently, only 34.7 % of adolescents diagnosed with depression receive treatment (SAMHSA 2011). Further, studies indicate that it is unclear whether or not conventional treatments are as effective for black adolescents compared to their white peers (Breland-Noble 2004; Breland-Noble et al. 2006; Lindsey et al. 2006). According to Joe (2006), many African American youth may be at greater risk for depression and suicide due to discrimination and institutional racism. Another culturally based concern can be perceived stigma. Rose et al. (2011) explored this issue and suggest that more severe depression may be significantly related to greater perceived stigma in ethnic minority adolescents. Further examination of how African American youth experience depression, including the impact of stigma and socio-economic factors, may offer insights that will inform effective identification and treatment models.

Recent studies on the subjective experience of depression and treatment concerns in African American youth have employed qualitative methods to explore the phenomenon (for example, see Breland-Noble et al. 2010; Lindsey et al. 2006). According to Breland-Noble et al. (2010), if research on depression is to lead to effective treatment of African American youth, first we need to know how these youths describe their experience with the disorder. Qualitative analysis can provides such descriptions.

Heppner et al. (1999) claimed that knowledge of the human experience is actively constructed, evolving from an interpersonal exploration of people's internal constructions. Their view is consistent with the constructivist-interpretivist paradigm, which holds that subjective experience from the individual's perspective is needed to fully understand a human phenomenon (Schwandt 2000). Therefore, learning how depressed Black adolescents describe and assign meaning to their experiences of depression may be an important step in the recognition and treatment of depression in these young people. The purpose of the present study was to elicit qualitative descriptions of the subjective experience of living with depression from inner city Black adolescents. Their descriptions were analyzed to find the essential structures and meanings of the youths' experience.

Method

Methodological Background

This study employed a qualitative phenomenological method to examine the intrapsychic quality of the lived experience of the participants. Phenomenology, an approach within qualitative methodology, was used to answer the research question. Wertz (2005), described phenomenology as allowing individuals experiencing a phenomenon to describe their experience exactly as it appears in their consciousness. As a methodological approach, phenomenology offers access to human subjective experience from the perspective of those who experience it.

Theoretical Foundation of the Methodology

The constructivist (or interpretivist) paradigm (Schwandt 1994, 2000) provides the foundation for qualitative research methods. The phenomenological researcher studies individuals as subjects who construct the meaning of their experience and not as objects of the investigation. Phenomenological reduction is the scientific process in which a researcher suspends or holds in abeyance his or her presuppositions, biases, assumptions, theories, or previous experiences to see and describe the phenomenon (Gearing 2004). *Epoché*, a Greek word meaning to refrain from judgment, is the first step in the core process of phenomenology and the first step of the phenomenological reduction process (Moustakas 1994). To help reduce researcher bias associated with prior knowledge, preconceptions, and bias, the authors adopted a phenomenological attitude and set aside prejudgments from the beginning of the study in order to focus on those views reported by the participants.

Data Collection

Participants

Participants for this study included 10 African American adolescents, ages 13–17 years, living in a large inner city in the eastern United States. Of these adolescents, 40 % were male (N = 4) and 60 % were female (N = 6). All were currently enrolled in and attending public school. Approximately 60 % of the youths reported that they were below their expected grade level in school. Participants met the following criteria, they (a) had a DSM-IV-TR (APA 2000) diagnosis of depression, confirmed by licensed clinicians at the study recruitment site, (b) had been receiving mental health treatment for depression for at least 1 month; (c) self-identified as Black or African American; (d) understood the study and voluntarily agreed to participate and cooperate in the interview; and (e) provided their assent via a signed form while their parents provided consent via signed form. Adolescents were excluded if they (a) had any chronic medical illness or disorder, based on their clinician assessment (including intellectual disability, pervasive developmental disorder, psychotic symptoms, or active suicidal intent) that might have interfered with the adolescent's ability to understand the interview questions or provide meaningful information during the interview, and (b) did not speak English.

Recruitment and Consent Procedures

The study participants were recruited from an outpatient mental health clinic in an inner city area in Maryland. The study was approved by the Capella University Institutional Review Board (IRB), as well as by the IRB for the larger medical institution in the eastern United States, which houses the site where the study participants were recruited. Upon IRB approval, the lead author (MO) met with the clinicians from the recruitment site and explained the study including its inclusion and exclusion criteria. The clinicians were provided with the study advertisement flyers to share with potential participants and their families. The lead author was the sole contact for persons interested in the study and was reachable via phone. When families called to inquire about study participation, the lead author instructed them on the process and set up initial consent meeting. The parental consent and assent forms were discussed and signed during these meetings. The individual interviews were conducted in the lead author's professional office. Each participant received a $20 Wal-Mart gift certificate for participation.

The Research Topic

The research topic for this qualitative study was to understand "How inner city African American youth describe their experience of living with depression." The research question was asked to provide the opportunity to investigate the participants' internal, conscious, cognitive, and affective experience of living with depression. Each participant met with the lead author for a 60-min audiotaped interview. The interview opened with this statement: "Please tell me all you can about your experience with feeling depressed." Non-directive questions were asked in order to deepen the information or clarify the participants' descriptions. "I really would like you to say more about that," or "Can we go into that last point a bit more?" or "Tell me what you mean?" are examples of the generic follow up questions asked. No new subjects were introduced by the interviewer, and follow up questions were carefully worded to avoid leading the participant.

Data Analysis

Giorgi and Giorgi's (2003) descriptive phenomenological method guided the data analysis. The aim was to describe the structures of the Black adolescents' conscious experience of living with depression. The first three steps of Giorgi and Giorgi's method supported the analysis of each participant's interview, and the fourth step supported the composite analysis that yielded the findings of the essential structures of the experience.

Step 1: Getting a Sense of the Whole

The lead author transcribed the interviews and checked the transcripts for accuracy against the actual tapes. Each transcript was read and reread as many times as needed in order to get a sense of the whole (Giorgi and Giorgi 2003). The objective was to get a clear understanding of what the participants said, before attempting any analysis or interpretation.

Step 2: Identifying Meaning Units and Themes

First, meaning units were identified. Meaning units are non-repetitive, non-overlapping statements that convey a single idea regarding the research question. Each meaning unit then is given a code, which is simply a shorter term that captures the meaning carried by the participants' words (the meaning units). Next, the transcripts were re-read from a psychological viewpoint, that is, re-stating the participants' original words in psychological terms. Finally, codes (that is, meaning units expressed in the code) that recurred across the interview were clustered together, and each resulting cluster of meaning units was restated as a theme. The lead author completed the initial coding, with assistance from the second author (WP). Consensus in emerged themes were reached by the research team.

Step 3: Structural Descriptions

Here, the aim was to transform the meaning units into psychologically relevant structures. Each meaning unit was re-read in a spirit of contemplative dwelling, and *imaginative variation* (Giorgi and Giorgi 2003) used to identify the essence or core structures of each participant's experience. This means that the researcher's imagination was used to vary elements of a theme to see if the underlying meaning remains invariant. Those features that cannot be changed without changing the meaning are considered the core structures of the individual participant's lived experience (Giorgi and Giorgi 2003).

Step 4: Composite Description or Essence of the Experience

Once the essential or core structures of each individual's lived experiences had been analyzed, the composite structures of the phenomenon in general (Giorgi and Giorgi 2003) were sought. Once again using imaginative variation, the invariant elements of the individual core structures were found, leading to a statement of the composite structure, or essence, of the experiences. This captured the meaning of the experience, as interpreted by the researcher. In accordance with Giorgi's model the researchers did not go back to the participants to elicit their feedback on the conclusions. This is because in phenomenological psychological research, member checking is not done (Giorgi 2006), for a number of both practical and methodological reasons. If the essential structures of the everyday experience of being depressed described in this study are, in fact, essential, then further research will confirm them. If they turn out to be unique to this small sample, further research will show that. Phenomenological findings derive their credibility from the clarity of and the fit between the relationship of the essential structures described and the illustrative data–the words of the participants.

To ensure that information revealed are kept strictly confidential, the following steps were taken: (a) the participants were assigned numbers, (b) all instances of the participants' names were replaced by numbers and all written documents labeled with the numbers rather than with the participants' names, and (c) data was stored electronically in a password protected computer during data analysis.

Results

The study analysis resulted in the emergence of five superordinate themes that relates to the experiences of African American adolescents. Each adolescent's experience of living with depression was unique but associated to the other adolescents' experiences of living with depression. The five themes that formed the essence of the adolescents' experience of living with depression are (a) the depth of depression, (b) life events and experiences as root base, (c) the emotional sense of self, (d) the survival self, and (e) the healing self. It is important to note that in phenomenological psychological analysis, the goal is to develop theme statements that closely capture the psychological structures of the experience being investigated (Giorgi 2009, p. 145). For that reason, all the invariant psychological structures are considered of equal relevance and none is held as more important. Other methods of qualitative analysis, such as thematic analysis (Braun and Clark 2006), do estimate the relative importance–by counts

of incidence and prevalence, for instance–of individual themes, but phenomenological analysis does not aims for the core structures of the lived-through cognitive/affective experience, no theme or structure is considered primary to others. Thus, the lead researcher developed the psychological descriptions of the core structures and the second researcher reviewed the data to corroborate or critique them. In that way, the final set of super-ordinate themes (core structures) was developed.

The super-ordinate themes accompanied by few illustrative statements from the interview transcript is also given in Table 1 (Fig. 1).

Theme 1: The Depth of Depression

In their attempt to clearly describe the depth of their experiences with living with depression, the adolescents used metaphors and other descriptive language. For example, being depressed is "being dead while still alive." It is characterized by both emotional and bodily pains. Living with depression is like a "storm," like "lightning," like a "flash" (how fast mood changes), like "thunder" (headaches). Being depressed is like being in the "dark," it is like a "sexual transmitted disease (STD) tattooed to the heart" (never ending). The feelings are like a "clicking bomb" (anger), a "rollercoaster," and a "gorilla," (rage), a "heart ripping apart," a "heart not beating" (dead), a "heart broken," "the wind smacking you," and "rain" (crying). It is falling into a "down stage" (sadness), like a "dart feeling," and being "driven with a motor" (restless). It is "losing self," and "energy absorbing" (weariness). Being depressed is being "invisible," "erased," and "taken over" (defeated). It is being "trapped" (no escape). It is like a "circle" (back and forth), like being "scrambled up in a bubble" (extreme pain). Feeling depressed is like having drops of pains in one's body, emotions, and thoughts. The youth did mention that there are periods of "happy" feelings when depression is under control. However, there is reluctance to experience "happy" feelings for fear of the "pain" returning. For the depressed, to have "happy" feelings forces the realization of the negative effects that depression has or has had on one's life. This realization drives a search for the meaning of one's depression and for ways to survive and heal.

Theme 2: Life Events and Experiences as Root Base

This theme established the root base for the emergence of the participants' emotional stagnation and important events

Table 1 Emerged super-ordinate themes and illustrative statements

Super-ordinate themes	Illustrative statements
The depth of depression	P3: Depression, it's nothing but a thunder storm that will not go away. You hear the thunder. You hear the rain, which is the crying that you are having over and over again. The rain is your crying. Rain is me crying so much. The thunder is my headache, the pain I'm feeling. The lighting is all the stress, the confusion and everything and the mood swings. How fast my mood swings, how fast my mood changes and everything. Like a flash. Like the lighting. Depression is like being death while still alive
Life events and experiences as root base	P3: I'll be too scared to go outside because they're shooting and everything. We moved so much. It hurts too. Is like I start making friends and next thing you know, I have to move
	P4: My real father chose crack over me when I was 2 days old
	P5: I have lot of hate in my heart about everything that happened. I had to grow up quicker than the rest of the kids because my mom was acting like a child, smoking and drinking and taking drugs and not really been there for us
Emotional sense of self	P1: You can't control how you feel and what your feelings are
	P2: It's just like the wind, sadness, and its just smacking you and smacking you. And trying to go against that wind, you just can't and so you just gave up and you just flow with it
	P3: It hurts. It is painful. It absorbs your energy
	P5: Like your heart is just not even beating anymore
	P10: Like. I feel invisible and rejected and lone and like erase
The survival self	P3: I have to watch my back all the time. I've gotten into fights. I had to defend myself. Before I usually show my fears and everything. I use to cry so much. I have programmed myself not to show any sadness at that school because they will take it and eat it up. That's why it's hard for me to open up to my boyfriend. It's hard for me to tell him how I'm feeling like. I don't want to do any thing. I just want to lay my head and go to sleep
	P8: I don't wanna be mess with. I don't always seek out people to talk to because some things cannot be resolved by words. I want to be alone all the time
The healing self	P3: When I'm with somebody that is positive, I feel like I'm shielded. I feel like I'm protected
	P5: I gotta learn how to deal with it. Without venting to anybody or hurting anybody else because I was hurt

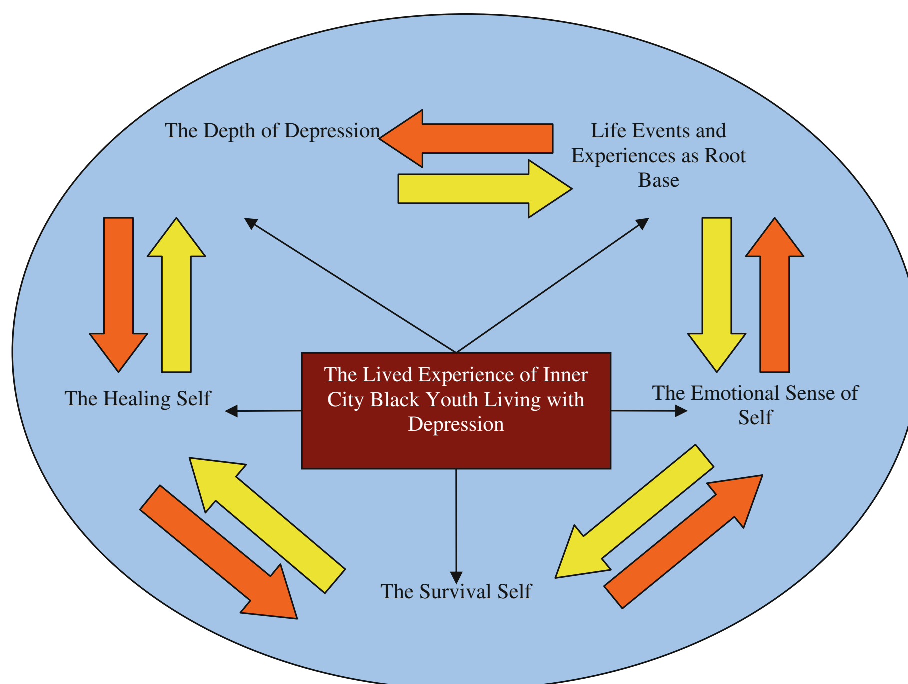

Fig. 1 The essence of inner city Black youth experience with depression. The *five themes* formed the essence of the adolescents' experience of living with depression. The bi-directional *arrows* suggest an interactional relationship between and among all the themes

that they saw as causes of their depression onset and degree of their emotional struggles. The adolescents reported that negative life events and experiences typically led to the "kick off" of their depressions. Depression is inevitable following life events and experiences that seem particularly difficult, threatening, distressing, and unmanageable. Depression is often located in the places of people's lives. Comments made by the adolescents reflected that they experienced negative life events in the context of the home, school, and community environment that resulted in them feeling depressed. The perceptions of the level of stress in the environments can affect the degree of depression.

The Home Experience

Stressful home life and experiences heighten the adolescents' emotional distresses, causing their depression. Their burden with depression becomes deeper when other members of the family are suffering from depression. A personal struggle to come to terms with losing important relationships through deaths, separation, and frequent moves also deepens one's depression. Increased family conflicts and criticism, regardless of hearing positive comments from others, cause one's feelings of worthlessness, inadequacy, and, ultimately, emotional stagnations. Interpersonal relationships become threatening and demanding and family support is uncertain. There is a loss of trust and a sense of being unconnected to others at home. There is also an increased need to provide support to others at the expense of oneself, which leads to emotional parentification.

The School Experience

Existing stressful life circumstances and unique life experiences and influences, deepens the youth's depression at school. For them, being depressed means suffering low academic performance, losing academic self-esteem, and lacking self-reliant school performance. The experience of depression results in poor concentration at school and inability to complete schoolwork. Difficulties at school hinder the adolescent's recovery and investment in academics in a way previously experienced. The adolescents experienced feelings of disappointment and hurt when their depressive symptoms are not recognized as legitimate by teachers and peers but seen as acting-out behaviors. They tended to strive for high standards of achievement before their depression and have the tendency to experience some self-doubt and distrust despite achievements. Negative affects are concealed for uncertainty of how peers and teachers would respond if revealed. For them, being depressed is suffering peers' criticism and intimidations at school. It is not having social responsibilities and a sense of connectedness to others. Being depressed means difficulty investing hope in sources of help and feeling unsafe where safety is expected.

The Community Experience

For the adolescents, being depressed means experiencing high levels of violent crimes in neighborhoods. It is losing neighborhood trust and a sense of connectedness to the

physical environment. It is living under stress, without support, and resources. It is not being able to go outside and play, visit friends, and enjoy activities of interest. It is feeling unsafe and without protection where protection is expected. It is being unable to relocate to a safer environment and living daily in constant fear, worry, isolation, and suspicion. There is the zeal to find means of escape (positive or negative) from the 'pain' of the negative community experiences.

Theme 3: Emotional Sense of Self

This theme defined the awareness of the changes to one's sense of self, including how the youth described the emotions they felt while living with depression. The adolescents described depression as "endless body and emotional pains" that affect a person's whole being, thoughts, emotions, and body. Having depression elicits different feelings for the adolescents that include unremitting sadness, extreme weariness and boredom, loss of hope, power, self-worth, and self-affection, erratic emotional states, confusion, feeling helpless, self-blame, anger, and guilt. The adolescents perceived their interpersonal relationships as over-demanding, threatening, and non-supportive. For these African American youths, depression was characterized as an array of feelings unlike those previously experienced. Being depressed is feeling like a non-human, being afraid, and being separated from the world around. It is enduring an overpowering weariness that defeats one's ability to perform the tasks of daily living. It is feeling extreme exhaustion, "weak," and having "less energy." It is living with feelings of helplessness, hopelessness, emptiness, and feeling a void within. Depression was discussed as feeling overwhelmed and powerless, like one is different from others. It is feeling rejected and invisible, like you are not really yourself. Being depressed means feeling unremitting sadness, hurt, restless, and irritable. It is weeping for no discernable reason, crying self to sleep, and feeling unwanted, unloved, ashamed, and guilty. It is feeling like an outsider from everyone else, frustrated, and mad all the time. It is feeling inadequate and worthless. It is feeling confused, losing control, and blaming self for everything. It is losing a sense of connectedness, trust, and self-affection. It is feeling stupid, ugly, weird, crazy, and with memory problems. Being depressed means feeling bored all the time and unmotivated to complete required tasks. It is having unpredictable out-of-context mood changes, being happy for a moment, sad and mad the next. It is having negative thoughts about self. It is feeling like one has no desire to maintain positive, interpersonal relationships and interest in social conventions and activities. It is being fearful of ultimately losing self.

Theme 4: The Survival Self

This theme emerged out of the adolescents' struggles to protect and preserve their sense of self and others from the negative emotions and pains associated with depression. For them, to be depressed is also to cope with being depressed. Being depressed is to search for the best ways to protect self from its 'pain' and to preserve a sense of self. The youths described their attempts to remediate and protect themselves from the physical and emotional pains of depression, in different and sometimes similar ways. The adolescents found anger, self-initiated withdrawal, isolation, and aggressive identity helpful in coping with the depression. They also discussed concealing emotions to protect themselves from possible negative outcome of revealing. Anger was experienced as a power emotion that feeds off of the emotional and bodily pains of depression and is used to pass unwanted feelings onto others. This was done by self-isolating, pushing people away by being bad, moving away from everyone, and talking too much or not talking at all to contain fears and inner struggles. Being depressed also means feeling weak and fearing being seen as weak. Subsequently, these was a tendency to adopt an aggressive identity, through fighting, engaging in risk taking behaviors, intimidating peers, and criticizing others to shield oneself. Being depressed means that what is strong in self is perceived by oneself as weak and hidden away. Covering up one's inner struggles from others is believed to be necessary in order to have the strength to get through the negative periods of depression. The fear of being rejected and being seen as a failure deepens the hiding away of the emotional pains. The survival self means programming oneself not to show any sadness, even at the expense of losing out in life and neglecting self-needs. It means revealing only when revealing does not require engagement in complex processes.

Theme 5: The Healing Self

This theme describes what the adolescents have done or are doing to heal from their depression. The adolescents' reports show that they want to heal from their depression but fear relapsing. The "happy" feelings that they experience when their depression is under control inspire them to search for ways to heal from it. The healing journey was described as a gradual process and involving emotional and mental hard work. The adolescents admitted their increased need for emotional support from family, friends, and teachers. There is a back and forth in the healing process. To heal from depression is to stay outside the "bubble" and the "rain," and to go through the sunny part, shielded by family and friends. It is like having an "umbrella" (friends and family support) for the 'rain' and 'storm' (depression

pains). Sometimes, the "umbrella" (support) disappears, leaving one standing in the "rain, all wet again" or back inside the "bubble" and suffering all over again (pain from depression). But then again, someone comes and pulls one out of the "bubble" (sadness) or gives one another "umbrella" (support) to cover self up again (heal). Although the adolescents described the relationship with professional helpers as positive and supportive, they also described the need for autonomy, to feel in charge of their depression and its treatment. Adolescents discussed "taking 1 day at a time" and being responsible for one's recovery. To heal is to be committed to doing what is needed to heal from the depression. It is searching for and learning the meaning of depression, decoding the reasons for depression, and understanding the causes of depression.

Despite the unremitting emotional distresses, the adolescents were optimistic about the future and want to work hard to heal from the "storm" of the depression. For them, to heal from depression is to know that different healing strategies work for different people. It is deciding how to treat it. It is staying positive, feeling hopeful, and doing what feels good. It is having a sense of getting better. It is not letting it "take over" oneself or "mess up" oneself. It is having a deeper level of family, teachers, and friends' support. It is not being seen as weak, different, or as attention seekers but as human beings with genuine feelings. It is having a message of hope and encouragement in the support received and being cared for by important family members, friends, teachers, or professional helpers. To heal from depression is to know that everyone gets depressed in one way or the other, that depression is never ending and that it goes away for a while but it always comes back and one has to learn to live with it.

Discussion

The present study, drawing upon the constructivist-interpretivist framework, examined the subjective experience of inner city African American youths with a diagnosis of depression. The findings revealed that the description of depression varied in this population and that depression affects all dimensions of the participants' being physical, psychological, interpersonal, and social. These findings are consistent with previous investigations that reported ethnic differences in the expression and report of depressive symptoms (Molock et al. 1994; CDC 2006). Many studies suggest the need to consider cultural variances and psychosocial influences on the presentation of depression in African American youth during diagnosis and treatment (Breland-Noble 2004; Breland-Noble et al. 2006; Lindsey et al. 2006; Choi 2002; USDHHS 2001; Summerville et al. 1992).

In line with prior research, the present study suggests that negative life events and experiences are significantly associated with depressive symptoms (Fitzpatrick et al. 2005; Lindsey et al. 2006). Other studies indicate that external stressors constitute risk factors that interact with personal predispositions (primarily psychological stressors, environmental stressors, or a combination of these two) to produce psychological distress (USDHHS 2001; Grant et al. 2004; Fitzpatrick and LaGory 2000; Fitzpatrick et al. 2005; Saunders 2003), which is the case for the participants in this study. They describe how negative life events directly affect their cognition and lead to changes in their self-perceived competences, in line with the suggestion of Tram and Cole (2000). While the biopsychosocial etiology of depression is widely accepted, these findings provide information about the subjective experience of these psychosocial stressors in the everyday lives and neighborhoods of urban, African American youth.

In their everyday lives, the young people in this study used both externalizing (blaming others) and internalizing (blaming self) strategies for coping to remediate and protect self from the physical and emotional pains of depression. This finding is consistent with prior studies, which indicate that depressed youth tend to withdraw and blame more than those who were not depressed (Spirito et al. 1996). Scott and House (2005) suggested that depressed Black youth may use avoidant coping strategies because of the distress of experiencing discrimination. The youth in this study described themselves experiencing psychological stress because they perceived others as viewing their emotional struggles as acting out. This aligns with Harrell (2000), who suggested that such responses influence African American youths' coping strategies. Specifically, their anger at perceived discrimination may lead to reactive behavior and their fear of rejection may promote an avoidant response.

The subjective description of feeling weak and fearing being seen as weak by the adolescents in the present study is consistent with previous studies that suggest that instead of expressing depression as sadness, which culturally may be viewed as a sign of weakness, African Americans with depression may demonstrate irritability and anger (Baker 2001). The tendency to hide inner struggles by adopting an aggressive identity, and using anger to pass unwanted feelings onto others to shield self, is consistent with Choi's (2002) suggestion that Black youths who use passive withdrawal as a coping strategy may exhibit anger, aggression, and irritability rather than classic symptoms of sadness and decreased energy often associated with depression. According to Iwata et al. (2002), depressed African Americans are less likely to endorse sadness than Caucasians.

Suicide has been discussed in the literature about mental health concerns in African American adolescents (Molock

et al. 2006; Joe 2006; Gibbs 1997; Walker et al. 2006; Spirito et al. 1996). Interestingly, adolescents in the present study rejected suicide and homicide as escapes from their psychological distress. This finding supports previous research on African Americans' lay beliefs about suicide (Walker et al. 2006; Gibbs 1997). Molock et al. (2006) and Gibbs (1997) have argued that African American suicide rates are low because long-standing cultural values and beliefs resist suicide as a problem-solving alternative. In a college undergraduate sample, Walker et al. (2006) found that religious or spiritual deference, resilience against overwhelming strain, and resistance to stigmatization contributed to African Americans being less likely to attribute suicide to interpersonal causes.

The adolescents' descriptions show that different healing strategies work for different people. The adolescents in this study described depression as a part of life—that on has to learn to live with it because everyone gets depressed in one way or another. This finding concurs with previous indications that African American adolescents view depression not as a medical illness but as a concern that can be controlled through strong will and spiritual beliefs (Lindsey et al. 2006; Molock et al. 2007; Kendrick et al. 2007). The adolescents interviewed for this study also described a conflict—wanting to be close to their family, friends, and peers but believing rejection is inevitable and support would not be genuine—which they resolve by maintaining emotional distance from others and from the world around them. This finding aligns with Breland-Noble's work, which suggests that depressed African American adolescents demonstrate ambivalence about seeking support from adults in their lives, opting instead to manage alone and only turning to adults as a last resort (Breland-Noble et al. 2010), and adds to it the description of motivation—not trusting that emotional support will be available or sincere.

On the other hand, when the adolescents receive genuine support from their family and social system, they experience a buffer from depression's "pains". This finding add qualitative depth to previous research findings among African American adolescents that indicate that higher levels of social support predict lower levels of depressive symptoms for this group (Lindsey et al. 2010; Zimmerman et al. 2000). Gibbs (1997) indicated that social support, cultural cohesion, and the extended family are factors mitigating depression and suicidal behaviors among African Americans. McMahon et al. (2011) also indicated the importance of extended family networks as the types of social support that youth rely upon in African American impoverished communities, making an adequate support system much more crucial for this population. Breland-Noble et al. (2006) suggested improving strategies for including African American youths and their families in prevention and intervention studies. This study serves as a basis for reexamination of the way in which depression is defined in this population. Given the uniqueness of inner city Black adolescents' experiences, it is hypothesized that stressful life events interact to produce different symptoms of depression than commonly reported. Results suggest that self-perceived social experiences may be influential in the expression of depressive symptoms among this population.

The small sample size, the restriction to a specific geographic location, and the socioeconomic status of the participants limit the generalizability of findings. Another limitation is that the research team did not confirm the participants' diagnosis empirically and did not use multiple informants to verify study participants' depression. Given that a depressed individual's perceptions of him or herself and others are unrealistically negative, future research warrants the inclusion of multiple informants to address this concerns.

Implications for Future Research

While the findings of this study supported many of the findings in previous literature, they also led to more questions for future research. Do the present findings extend to the larger population of African American adolescents? Do depressed Black youths in other geographical locations or on different socioeconomic levels experience their depressions in similar ways? Do they have similar attitudes towards suicide? This study did not explore factors in the rejection of suicide as a solution nor the benefit of using anger as a coping mechanism when life circumstances are threatening, but investigating those issues may inform culturally appropriate treatment for this and other populations. The positive and negative health outcomes of anger expression and suppression in young inner city Blacks would be an important area of investigation. Also warranted is a mixed-method research approach, including quantitative measures with qualitative data from both depressed Black youths and those who work with them is warranted in order to investigate more fully the actual experience and presentation of depression in this populations.

The present study's findings also yield implications for prevention and intervention efforts. For example, if further study confirms the findings that depressed African American adolescents view depression as a non-medical concern, suicide as not a solution to the pains of depression, and depression as being a part of life, families and clinicians would have valuable information about the importance of these cultural beliefs. Further research on these themes could provide new support for Breland-Noble et al. (2010) proposal that communities be engaged through culturally relevant psycho-education on adolescent depression and its impact on African American youth. If these themes are

discovered to be credible descriptions of the unique experiences of this group of depressed young people, then new information may be useful to clinicians and educators. If confirmed, the results of the present study could suggest that intervention strategies should assess the psychological impact of depression on Black youth using contextual level psychosocial effects and individual coping styles when developing treatment plans. Also, further investigation on the benefit of acknowledging and addressing resilience as part of the treatment with this population is necessary. Lindsey et al. (2010) suggest that clinicians be open and willing to explore perceptual barriers held by African American youth concerning depression and formal service use. In addition, encouraging a stronger sense of connectedness to healthy family members, peers, and community, during treatment may forestall depressed Black youths' reactive and avoidance behaviors. To better understand depression in this population, it important to allow youth to label their depression using their terminology (Breland-Noble et al. 2010). Clinicians should, rather than focusing on a narrowly defined set of clinical symptoms, acknowledge and support the youth's self-description of depression, their individual strengths and healing process while promoting positive and safe outlets for anger and externalizing behaviors.

References

Allen-Meares, P., Oyserman, D., DeRoos, Y., & Colarossi, L. (2003). Assessing depression in childhood and adolescence: A Guide for social work practice. *Child and Adolescent Social Work Journal, 20*(1), 5–20. doi:10.1023/A:1021411318609.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., Text Rev.). Washington, DC: Author.

Angold, A., Erkanli, A., Farmer, E. M., Fairbank, J. A., Burns, B. J., Keeler, G., et al. (2002). Psychiatric disorder, impairment, and service use in rural African American and white youth. *Archives of General Psychiatry, 59*, 893–901. doi:10.1001/archpsyc.59.10.893.

Baker, F. M. (2001). Diagnosing depression in African Americans. *Community Mental Health Journal, 37*, 31–38. doi:10.1023/A:1026540321366.

Braun, V., & Clark, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77–101. doi:10.1191/1478088706qp063oa.

Breland-Noble, A. M. (2004). Mental healthcare disparities affect treatment of Black adolescents. *Psychiatric Annals, 34*(7), 535–538.

Breland-Noble, A. M., Bell, C., & Nicolas, G. (2006). Family first: The development of an evidence-based family intervention for increasing participation in psychiatric clinical care and research in depressed African American adolescents. *Family Process, 45*(2), 153–169. doi:10.1111/j.1545-5300.2006.00088.x.

Breland-Noble, A. M., Burriss, A., & Poole, H. (2010). Engaging depressed African American adolescents in treatment: Lessons from the AAKOMA PROJECT. *Journal of Clinical Psychology, 66*, 868–879. doi:10.1002/jclp.20708.

Bureau of Justice Statistics. (2000). *Criminal victimization*. Retrieved from http://www.ojp.usdoj.gov/bjs/cvictgen.htm.

Centers for Disease Control and Prevention. (2006). Youth risk behavior surveillance—United States, 2005. *MMWR [Morbidity and Mortality Weekly Report] Surveillance Summary, 55*(SS-5), 1–108.

Choi, H. (2002). Understanding adolescent depression in ethnocultural context. *Advances in Nursing Science, 25*, 71–85. Retrieved from http://journals.lww.com/advancesinnursingscience/pages/default.aspx.

Delahanty, J., Ram, R., Postrado, L., Balis, T., Green-Paden, L., & Dixon, L. (2001). Differences in rates of depression in schizophrenia by race. *Schizophrenia Bulletin, 27*(1), 29–37. Retrieved from http://www.nimh.nih.gov/index.shtml.

Fitzpatrick, K. M., & LaGory, M. (2000). *Unhealthy places: The ecology of risk in the urban landscape*. New York, NY: Routledge.

Fitzpatrick, K., Piko, B., Wright, D., & LaGory, M. (2005). Depressive symptomatology, exposure to violence, and the role of social capital among African American adolescents. *American Journal of Orthopsychiatry, 75*(2), 262–274. doi:10.1037/0002-9432.75.2.262.

Garcia, C., & Saewyc, E. (2007). Perceptions of mental health among recently immigrated Mexican adolescents. *Issues in Mental Health Nursing, 28*(1), 37–54. doi:10.1080/01612840600996257.

Gearing, R. E. (2004). Bracketing in research: A typology. *Qualitative Health Research, 14*, 1429–1452. doi:10.1177/1049732304270394.

Gibbs, J. (1997). African-American suicide: A cultural paradox. *Suicide and Life-Threatening Behavior, 27*, 68–79.

Giorgi, A. (2006). Concerning variations in the application of the phenomenological method. *The Humanistic Psychologist, 34*, 305–319. doi:10.1207/s15473333thp3404_2.

Giorgi, A. (2009). *The descriptive phenomenological method in psychology*. Pittsburgh, PA: Duquesne University Press.

Giorgi, A., & Giorgi, B. (2003). The descriptive phenomenological psychological method. In P. M. Camic, J. E. Rhodes & L. Yardley (Eds.), *Qualitative research in psychology. Expanding perspectives in methodology and design* (pp. 243–273). Washington, DC: American Psychological Association.

Grant, K. E., Lyons, A. L., Finkelstein, J. S., Conway, K. M., Reynolds, L. K., O'Koon, J. H., et al. (2004). Gender differences in rates of depressive symptoms among low income, urban, African American youth: A test of two mediational hypotheses. *Journal of Youth and Adolescence, 33*, 523–533. doi:10.1023/B:JOYO.0000048066.90949.be.

Harrell, S. P. (2000). A multidimensional conceptualization of racism-related stress: Implications for the well-being of people of color. *American Journal of Orthopsychiatry, 70*(1), 42–57. doi:10.1037/h0087722.

Heppner, P. P., Kivlighan, D. M., & Wampold, B. E. (1999). *Research design in counseling* (2nd ed.). Pacific Grove, CA: Brooks/Cole.

Iwata, N., Turner, R. J., & Lloyd, D. A. (2002). Race/ethnicity and depressive symptoms in community-dwelling young adults: A differential item functioning analysis. *Psychiatry Research, 110*, 281–289. doi:10.1016/S0165-1781(02)00102-6.

Joe, S. (2006). Explaining changes in the patterns of Black suicide in the United States from 1981 to 2002: An age, cohort, and period analysis. *Journal of Black Psychology, 32*, 262–284. doi:10.1177/0095798406290465.

Joe, S., Baser, R., Neighbors, H., Caldwell, C., & Jackson, J. (2009). 12-Month and lifetime prevalence of suicide attempts among black adolescents in the National Survey of American Life. *Journal of the American Academy of Child and Adolescent Psychiatry, 48*(3), 271–282. doi:10.1097/CHI.0b013e318195bccf.

Kendrick, L., Anderson, N. L., & Moore, B. (2007). Perceptions of depression among young African American men. *Family & Community Health, 30*(1), 63–73. Retrieved from http://journals.lww.com/familyandcommunityhealth/pages/default.aspx.

Kessler, R., Berglund, P., & Demler, O. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry, 62*, 593–602. Retrieved from http://archpsyc.amaassn.org/cgi/content/full/archpsyc;62/6/593.

Lambert, S. F., McCreary, B. T., Joiner, T. E., Schmidt, N. B., & Ialongo, N. S. (2004). Structure of anxiety and depression in urban youth: An examination of the tripartite model. *Journal of Consulting and Clinical Psychology, 72*(5), 904–908. doi:10.1037/0022-006X.72.5.904.

Lindsey, M., Joe, S., & Nebbitt, V. (2010). Family matters: The role of mental health stigma and social support on depressive symptoms and subsequent help seeking among African American Boys. *Journal of Black Psychology, 36*, 458–482. doi:10.1177/0095798409355796.

Lindsey, M., Korr, W., Broitman, M., Green, A., Leaf, P., & Bone, L. (2006). Help-seeking behaviors and depression among African American adolescent boys. *Social Work*, *51*(1), 49–58. Retrieved from http://miranda.naswpressonline.org/vl=5011393/cl=14/nw=1/rpsv/cw/nasw/00378046/v51n1/s6/p49.

McMahon, S., Felix, E., & Nagarajan, T. (2011). Social support and neighborhood stressors among African American Youth: Networks and relations to self-worth. *Journal of Child and Family Studies, 20*(3), 255–262. doi:10.1007/s10826-010-9386-3.

Molock, S. D., Barksdale, C., Matlin, S., Puri, R., Cammack, N., & Spann, M. (2007). Qualitative study of suicidality and help-seeking behaviors in African American adolescents. *American Journal of Community Psychology, 40*(1), 52–63. doi:10.1007/s10464-007-9122-3.

Molock, S., Kimbrough, R., Lacy, M. B., McClure, K., & Williams, S. (1994). Suicidal behavior among African American college students: A preliminary study. *Journal of Black Psychology, 20*, 234–251. doi:10.1177/00957984940202009.

Molock, S., Puri, R., Matlin, S., & Barksdale, C. (2006). Relationship between religious coping and suicidal behaviors among African American adolescents. *Journal of Black Psychology, 32*, 366–389. doi:10.1177/0095798406290466.

Moustakas, C. (1994). *Phenomenological research methods*. Thousand Oaks, CA: Sage.

Rose, T., Joe, S., & Lindsey, M. (2011). Perceived stigma and depression among black adolescents in outpatient treatment. *Children and Youth Services Review, 33*(1), 161–166. doi:10.1016/j.childyouth.2010.08.029.

Ross, C., & Mirowsky, J. (2001). Neighborhood disadvantage, disorder, and health. *Journal of Health and Social Behavior, 42*, 258–276. doi:10.2307/3090214.

Ross, C., Mirowsky, J., & Pribesh, S. (2001). Powerlessness and the amplification of threat: Neighborhood disadvantage, disorder, and mistrust. *American Sociological Review, 66*, 568–591. doi:10.2307/3088923.

Saunders, B. E. (2003). Understanding children exposed to violence: Toward an integration of overlapping fields. *Journal of Interpersonal Violence, 18*, 356–376. doi:10.1177/0886260502250840.

Schwandt, T. A. (1994). Constructivist, interpretivist approaches to human inquiry. In N. K. Denzin & Y. S.Lincoln (Eds.), *Handbook of qualitative research* (pp. 118–137). Thousand Oaks, CA: Sage.

Schwandt, T. A. (2000). Three epistemological stances for qualitative inquiry: Interpretivism, hermeneutics, and social constructionism. In N. K. Denzin & Y. S.Lincoln (Eds.), *Handbook of qualitative research* (2nd ed., pp. 189–213). Thousand Oaks, CA: Sage.

Scott, L. D., & House, L. E. (2005). Relationship of distress and perceived control to coping with perceived racial discrimination among Black youth. *Journal of Black Psychology, 31*, 254–272. doi:10.1177/0095798405278494.

Spirito, A., Francis, G., Overholser, J., & Frank, N. (1996). Coping, depression, and adolescent suicide attempts. *Journal of Clinical Child Psychology, 25*, 147–155. doi:10.1207/s15374424jccp2502_3.

Substance Abuse and Mental Health Services Administration [SAMHSA], Center for Behavioral Health Statistics and Quality. (2011). *The NSDUH Report: Major depressive episode and treatment among adolescents: 2009*. Rockville, MD. Retrieved from http://oas.samhsa.gov/2k11/009/AdolescentDepression.htm.

Summerville, M., Abbate, M., Siegel, A., & Serravezza, J. (1992). Psychopathology in urban female minority adolescents with suicide attempts. *Journal of the American Academy of Child and Adolescent Psychiatry, 31*, 663–668. doi:10.1097/00004583-199207000-00013.

Tram, J. M., & Cole, D. A. (2000). Self-perceived competence and the relation between life events and depressive symptoms in adolescence: Mediator or moderator? *Journal of Abnormal Psychology, 109*, 753–760. doi:10.1037/0021843X.109.4.753.

U.S. Department of Health and Human Services [USDHHS]. (2001). *Mental health: Culture, race, and ethnicity—A supplement to mental health: A report of the surgeon general*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.

Walker, R. L., Lester, D., & Joe, S. (2006). Lay theories of suicide: An examination of culturally relevant suicide beliefs and attributions among African Americans and European Americans. *Journal of Black Psychology, 32*, 320–334. doi:10.1177/0095798406290467.

Wertz, F. (2005). Phenomenological research methods for counseling psychology. *Journal of Counseling Psychology, 52*, 167–177. doi:10.1037/0022-0167.52.2.167.

Zimmerman, M. A., Ramirez-Valles, J., Zapert, K. M., & Maton, K. I. (2000). A longitudinal study of stress-buffering effects for urban African American male adolescent problem behaviors and mental health. *Journal of Community Psychology, 28*, 17–33. doi:10.1002/(SICI)1520-6629(200001)28:1<17:AID-JCOP4>3.3.CO;2-9.