Experiences of Black Adolescents With Depression in Rural Communities

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Literature does little to explore the perceptions of Black adolescents with depression or their perspective of treatment effectiveness. Studies are usually from urban areas and there is a dearth of research with Black adolescents from rural areas. This study explored the unique personal experiences of Black adolescents located in the rural southeastern United States, with the purpose of gaining a clearer understanding when working with this population. An interpretative qualitative method was used to explore 10 participants' interpretation of their experiences to gain insight in how they make meaning of those experiences. Five significant categories were found to capture participant themes: (a) definition of depression, (b) seeking treatment, (c) coping and problem solving strategies, (d) types of emotional support, and (e) contributing factors to depression. Specific recommendations and interventions are suggested for mental health clinicians to become more educated and aware when working with Black adolescents.

Keywords: **Black adolescents, depression, treatment effectiveness, rural, contributing factors**

Depression is a leading cause of disability worldwide (World Health Organization, 2020). The World Federation for Mental Health (2012) estimated that by 2030, more people will be impacted by depression than any other health problem. In the United States, approximately 13.3% of adolescents, or 3.2 million, had at least one major depressive episode and 9.5% were Black (National Institute of Mental Health [NIMH], 2013). Black people have experienced more severe forms of mental health conditions than individuals of other races because of unmet needs and other barriers (NIMH, 2013). In fact, Black people were reported to be 10% more likely to experience serious mental health problems than the general population (Shushansky, 2017), and Black children have a suicide rate that is almost two times higher than that of their White counterparts (Bridge et al., 2018).

Weaver et al. (2015) noted that although 90% of rural Black people live in the southeastern part of the United States, there are only two studies that specifically examined depression among rural Black people using national data (i.e., Probst et al., 2006; Willis et al., 2003). Most studies of depression that include Black youth are based on data from urban communities (Al-Khattab et al., 2016; Conner & Yeh, 2018; Ofonedu et al., 2013; Robinson et al., 2015). This suggests there is a dearth of research exploring Black adolescent experiences of depression in rural communities, and there is even less research focusing on Black youth who live in the rural southeastern United States (Smokowski et al., 2015: Weaver et al., 2015). The goal of this study was to explore the unique experiences of Black adolescents living in the rural southeastern United States who had been diagnosed with depression.

Contributing Factors to Depression in Black Adolescents

Adolescents who suffer from depression may experience substantial negative health and social consequences in late adolescence and adulthood (Lu, 2019). Black adolescents are particularly vulnerable

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to these consequences because they are more likely to live in low-resource neighborhoods and because they contend with the negative psychological impacts of racial discrimination (Robinson et al., 2015). Choi et al. (2006) found that ethnic minorities have higher scores on social stress and mental distress and lower scores on coping, self-esteem, and family cohesion. The depressive symptoms experienced by Black adolescents are often socially and culturally based (Lu et al., 2017). Therefore, it is essential for counselors, school personnel, and related professionals to remain abreast of the current research on depressive signs and symptoms, beliefs about treatment, and specific needs of Black adolescents.

Choi et al. (2006) discovered that Black, Hispanic, and Asian adolescents in the United States have consistently higher levels of social stress beginning in childhood compared to their White counterparts. Breland-Noble et al. (2010) found that relationship problems, academic problems, bereavement, and stress were primary triggers for depressive symptoms among Black adolescents. Ofonedu et al. (2013) determined in their study of Black adolescents that life events in the home, school, and community contributed to depressive symptoms. These factors included (a) a stressful home life, (b) stressful life circumstances and unique life experiences at school, and (c) the experience of high levels of violent crimes in neighborhoods. Stress is clearly a contributing factor to the depressive symptoms of Black adolescents.

Symptoms of Depression in Black Adolescents

Although understanding national trends and contributing factors can help practitioners identify adolescents suffering from depression, it is also important to understand potential racial and ethnic differences in the expression of adolescent depression (Lu, 2019). The manifestations of depressive symptoms vary in Black youth and affect all dimensions of physical, psychological, interpersonal, and social being (Ofonedu et al., 2013). In the Black community, mental health conditions have often been unacknowledged, misunderstood, and misdiagnosed (Shushansky, 2017; Vontress et al., 2007). According to Vontress et al. (2007), Black people often experience cultural dysthymia and mental health symptoms such as low-grade depression; feelings of sadness, hopelessness, and anger; aggression; and self-destructive behaviors. Vontress et al. (2007) characterized these symptoms as a "psychosocial condition" grounded in external societal experiences of discrimination and oppression that often go unrecognized (p. 131). Additional studies are needed to show how to better identify individuals suffering from depression and thereby increase the effectiveness of treatment for Black adolescents (Ofonedu et al., 2013).

As in adults, unrecognized or undiagnosed dysthymia or symptoms of low-grade depression in adolescents can contribute to poor health and problematic behaviors (Saluja et al., 2004). Researchers discovered that untreated dysthymia elevates the risk of disruptive behaviors, anxiety, substance abuse, unsafe sexual practices, involvement in fights, lower achievement on tests, lower teacher-rated grades, and poorer peer relationships (Saluja et al., 2004). Auger (2005) discovered that the many signs and symptoms of adolescent depression were overlooked not only by parents but also by school systems, administrators, counselors, and teachers who daily were in a very unique position to identify those at risk of depression. Many cases of adolescent depression, particularly among minorities, have gone undiagnosed, misdiagnosed, and untreated (Cook et al., 2017; Shushansky, 2017). A better understanding of the unique experiences of Black adolescents diagnosed with depression would help improve symptom recognition, which may in turn reduce misdiagnosis and increase treatment effectiveness.

An understanding of the cultural implications and influence that oppression, prejudice, and various forms of discrimination have on Black people's mental health in the United States is helpful in contextualizing and normalizing symptoms of depression and reducing instances of misdiagnosis. Hope et al. (2017) posited that discrimination remains a common experience for Black adolescents

that can impact not only the onset of depression but also the quality of and access to mental health services. Furthermore, according to Liang et al. (2016), racial disparities exist, as Black youth are more likely to be misdiagnosed as having psychotic and disruptive behavior problems compared to mood (i.e., depression) and substance abuse disorders.

Lu et al. (2017) echoed these sentiments, stating that depression presents differently for Black adolescents. It is essential for Black adolescents to use their own language when describing their depressive symptoms. Additionally, it is important for clinical and school counseling professionals to be aware of gender differences in Black adolescents' expression of depression, specifically in terms of internalizing and externalizing symptoms. The findings of Breland-Noble et al. (2010) indicated that female Black adolescents seem to internalize behaviors (e.g., becoming withdrawn, exhibiting visible sadness), while male Black adolescents seem to externalize behaviors (e.g., becoming angry or acting out). Lu et al. (2017) further highlighted that "adolescents develop [symptoms] as a means of coping in response to environmental factors" (p. 614). More research is needed to understand how depressed Black adolescents describe their symptoms and assign meaning to their experiences of depression.

Coping Strategies of Black Adolescents

In addition to presenting different symptoms than individuals of other racial groups, Black adolescents have the lowest coping skills scores compared to their peers (Conner & Yeh, 2018). Recent studies suggest that adolescents who live in low-resourced neighborhoods feel like they have limited options in how to respond to stressful and anxiety-provoking situations because of limited or ineffective coping skills (Robinson et al., 2017; Robinson et al., 2015). There are indications that Black adolescents cope with depression in a variety of contexts. Some Black adolescents describe depression as a way of life, noting that everybody becomes depressed one way or another (Ofonedu et al., 2013). Researchers have shown that some Black adolescents conceal their feelings of depression because they are uncertain of how others would perceive them (Al-Khattab et al., 2016; Ofonedu et al., 2013). For instance, some Black adolescents reported trying to manage their depression independently and only going to an adult as a last resort (Breland-Noble et al., 2010). Black adolescents have been shown to manage their depression by strong will and spiritual beliefs (Ofonedu et al., 2013). Conner and Yeh (2018) highlighted how Black adolescents cope with depression in spiritual and creative ways such as listening to music, dancing, and writing.

In 2016, Al-Khattab et al. discovered that Black adolescents controlled their depression through their interactions with other people. Al-Khattab et al. identified five typology interaction models, which include hiding feelings of depression, lashing out verbally or physically toward others, seeking help from others to address emotional feelings, joining with others in social activities, and having others approach them about behavioral and mood changes. Therefore, it is critical for Black adolescents to better understand their experiences with depression and how interactions with others may influence their symptoms.

Treatment of Depression in Black Adolescents

Cook et al. (2017) noted that there are barriers to accessing mental health services and quality of care, which include stigma associated with mental illness, distrust of the health care system, lack of providers from diverse racial/ethnic backgrounds, lack of culturally competent providers, and lack of insurance or underinsurance. Often these barriers cause Black people to be unable or reluctant to seek help (Shushansky, 2017). Although Black adolescents may feel that treatment can be effective, many are reluctant to attend therapy because of the stigma and possible misdiagnosis of their symptoms, much of which has been influenced by their culture (Al-Khattab et al., 2016; Lindsey et al., 2010; Ofonedu et

al., 2013). Positive results have been seen when using family-centered prevention programs to address depressive symptoms in Black adolescents (Brody et al., 2012). Jacob et al. (2013) determined that behavioral activation was effective for decreasing depressive symptoms and impairments for the Black adolescents who participated in their study.

As highlighted by a study of Black adults from a rural faith community, Black people living in rural communities suffering from depression face additional barriers to treatment such as (a) a lack of medical resources, (b) insufficient education about depression, and (c) stigma (Bryant et al., 2013). Sullivan et al. (2017) learned that terminology was crucial when discussing treatment with rural Black adults on a stigmatized topic such as mental illness. Parental concerns about marginalization because of having a child with a mental health diagnosis and some primary care providers' characterization of mental health symptoms as a "phase" have been found to be barriers to treatment for Black children living in rural communities (Murry et al., 2011). Working with Black children who live in poverty, Graves (2017) identified cultural and macro-level barriers that influence the process of seeking treatment.

Treatment of mental health disorders extends from diagnoses. Considering the differences in symptoms and frequency of misdiagnosis, it is not surprising that treatment options for Black adolescents have shown varied outcomes across the literature. Additionally, some researchers suggested that new measures need to be developed for accurately identifying depression in diverse populations, which would then inform modifications in treatment (Ofonedu et al., 2013). Having a better understanding of the unique and complex experiences of Black adolescents may help parents, therapists, schools, and counseling professionals understand and identify those most at risk for depression. Planey et al. (2019) discovered that Black youth viewed seeking mental health treatment as a contextual and relational process rather than an event. What is clear is that more culturally diverse training for therapists, schools, and counseling professionals is needed to prevent, detect, and implement interventions for minorities experiencing depression during the disease's earlier stages. Likewise, research exploring Black adolescents' unique experiences of symptoms, environmental factors, and coping strategies remains necessary in order to inform effective treatment.

Purpose of the Present Study

The review of the literature captured symptoms and coping strategies unique to Black adolescents. Studies highlight that environmental factors contribute to depressive symptoms in this population. Furthermore, disparities exist in mental health care for adolescents, specifically for minorities (Alegria et al., 2010; Brenner, 2019; Lake & Turner, 2017). This clear gap in the literature indicates insufficient knowledge regarding the personal experiences of Black adolescents with depression. Most of the studies in the extant literature took place in urban areas; little is known about rural experiences and even less is known about experiences in the southeastern United States. This qualitative study was designed to help fill that gap. It posed an overarching research question to Black adolescents living in the rural southeastern United States: "What is your experience with depression?" This study was designed to offer human services professionals a clearer understanding of the unique experiences of Black adolescents in this geographical region who had been diagnosed with depression, with the hope of informing clinical practices.

Method

The goal of this study was to explore the unique experiences of Black adolescents living in the rural southeastern United States who had been diagnosed with depression. The research design for

the study was a basic interpretive qualitative method, as described by Merriam (2009). The purpose of this method is to understand the perspectives of the participants involved by uncovering and interpreting their meanings (Everall et al., 2006). This purpose was well-suited to the overall objective of this study, which was to gain a clearer understanding of the unique personal experiences of Black adolescents living with depression in the rural southeastern United States.

According to Merriam (2009), interpretive qualitative research is founded on the idea that people and their interactions with their world, or reality, socially construct meaning. Researchers using this method are interested in how individuals "interpret" their experiences, "construct their worlds," and assign "meanings" to their experiences (Merriam, 2009, p. 38). Moreover, Merriam asserted that interpretive qualitative research has multiple meanings and is a complex phenomenon ideal for attempting to understand and treat Black adolescents with depression. Using Merriam's (2009) model, researchers "strive to understand the meanings individuals construct regarding their world and their experiences" in a natural setting (p. 4). Another characteristic is that the researcher serves as the primary instrument for both collecting and analyzing data. The research process is inductive rather than deductive, which means that the researcher gathers data in an effort to "build concepts, hypotheses, or theories" in the forms of themes and categories (Merriam, 2009, p. 5). A final characteristic of this model is that interpretive qualitative research is richly descriptive and includes details about the context, the participants involved, and quotations and interview excerpts (Merriam, 2009).

Merriam (2009) noted that certain elements of the basic interpretive qualitative design may overlap with other designs, particularly when concepts of cultural values are discussed and explored. Merriam's design does not require researchers to give a full sociocultural interpretation of the data, as is done in ethnography. Indeed, this study does not provide a full sociocultural interpretation. However, the data were analyzed using Patton's (1987) content analysis model because the model provides a rigorous, systemic, and ethical procedure for analyzing data. Merriam's model for collecting data and Patton's model for analyzing data form a rich methodological combination that enhances the trustworthiness of the research study and improves the transferability of its findings.

Participants and Procedure

The university IRB granted approval for this study. Purposive sampling was used to identify 10 Black adolescents living in the rural southeastern United States who were being treated for depression. The southeastern part of the United States was selected because it contains fewer metropolitan areas that have been studied specifically. Each of the participants met the following criteria: (a) self-identified as Black, (b) was between the ages of 13 and 17, (c) was willing to participate, (d) had secured a signed informed consent form from their parents, (e) had signed a participant assent form, and (f) was currently under the care of a counselor either in or out of school for depression. The participants ranged in age from 13 to 17 years old and were in grades seven through 12. Six participants were female and four were male.

Approval was obtained in advance from a public school system located in the rural southeastern United States. The public school system administrator agreed to send the letter of invitation along with the consent and assent forms to the parents and potential participants. In addition, the first author sent a packet of information to a counseling agency; school professionals, including professional school counselors and school psychologists; and social workers. The packet contained an invitation letter requesting that the packet be shared with potential participants and their parents; it also contained consent and assent forms. The informed consent form described the study and the efforts that would be

taken to protect the confidentiality of the participants' information. The informed consent form stated that the risk of participating was the normal discomfort of sharing one's experiences with depression and that if a participant felt uncomfortable, they could withdraw from the study at any time.

Parents and participants signed the consent and assent forms, respectively, and returned them to either the local counseling agency or school professionals, who forwarded the forms to the first author. The first author then contacted the parents, with the participants present, to schedule a 45- to 90-minute, face-to-face interview with the participant. The informed consent form was verbally reviewed, ensuring that the parents and participants understood that a second interview to review and correct the interpretation would be optional. Interviews took place either during the day in a private room at the school or outside of school hours in the first author's office. Because adolescent depression is considered a sensitive topic, participants were instructed to follow up with their counselor if they experienced adverse feelings as a result of participating in the study.

Data Collection and Analysis

The first author met with each of the 10 participants for a single semi-structured interview that lasted between 45 and 90 minutes. In phenomenological research, the researcher follows the essence of participants' responses (van Manen, 1997). The first author spent time establishing rapport with the participants. Once the first author believed a participant was comfortable, she asked the participant the overarching question, "What is your experience with depression?" Follow-up questions specific to each participant were used to probe the participants' responses regarding their experience as Black adolescents living with depression in the rural southeastern United States. Several participants expressed a reluctance to fully disclose or discuss their experiences with depression; however, no participants withdrew from the study, and all participants completed the first interview. At the end of the first interview, the participants were notified that they would be contacted for a second interview to review the transcript of the first interview and verify its accuracy and trustworthiness.

Interviews were recorded and transcribed verbatim by both the first author and a professional transcriber. The transcripts were coded and analyzed for themes related to the research question of this study. The first author utilized Patton's (1987) content analysis model as a process of bringing order to the data by organizing the data into major themes, categories, and case examples. The first author consulted with two experts in qualitative research in the human services field and used three levels of coding: open, axial, and selective. Open coding included reading the transcribed interviews several times and coding phrases, from one word to portions of paragraphs. Based on input from the consultants, the first author enhanced the coding process by entering the data into the NVivo QSR software program, which facilitated organization and analysis. The first author then condensed the data into five categories. Axial coding enabled the first author to organize, link, and cluster codes, while selective coding allowed the first author to analyze the words, sentences, and themes from the interviews. Data analysis via coding was a back and forth process, and staying close to the transcripts was essential. The labeling and coding allowed the first author to interpret and classify the data and themes into five categories that were supported with direct quotations from the participants.

Trustworthiness

Trustworthiness is an important aspect of qualitative research (Hays & Singh, 2012). The generally candid nature of each participant in relating even the most difficult experiences, such as rape, would suggest a high degree of trustworthiness in their responses. Member checking was offered to all participants in the form of a follow-up interview. When contacted by the first author to schedule this interview, however, none of the participants felt that it was necessary. Rather, all of the participants

stated they were satisfied with their responses in the first interview. In addition to offering member checking, the first author used rich data, prolonged engagement, respondent validation, a search for discrepant data, and peer review to ensure trustworthiness. A peer review of the method was conducted by doctoral-level professors in human services who specialized in qualitative research in order to enhance internal validity (Lincoln & Guba, 1985; Merriam, 2009). The first author used an audit trail by engaging in memo-writing to express thoughts, perspectives, observations, and reactions to interviews, transcriptions, and coding. An *audit trail* is a strategy in which a researcher explains as best as possible how they arrived at the results of the study by documenting how the data were collected, how categories were developed, and how findings were interpreted throughout the study (Lincoln & Guba, 1985). An audit trail thus improves the quality of a study. The information and details from this study may be generalizable to other groups and may contribute to the knowledge base of best practices when working with this population in counseling.

Results

Through data analysis, the researcher identified five significant thematic categories: (a) definitions of depression, (b) seeking treatment, (c) coping and problem-solving strategies, (d) types of emotional support, and (e) contributing factors to depression. These five thematic categories were broken down into their constituent contents. Each thematic category was addressed with the invariant constituents that make up that category, including elaboration on any significant constituent patterns (such as high and low frequency of occurrence). Quotations from the participants are included in the text as examples to elucidate the invariant constituents and thematic categories. For reasons of confidentiality, some identifying information was excluded. All participants identified as Black and lived in the rural southeastern United States.

At the time of the study, the participants were living in a southeastern U.S. community in one of the lowest socioeconomic brackets of the country. In the participants' community, the majority of the population was Black and participated in the school's free or reduced-fee lunch program. Because of the homogeneous nature of the community, the participants did not speak of any adverse social or political circumstances, and the researcher avoided broaching the topic in an effort to do no harm. The researcher believed that overlooking the social and political climate of the community increased the trustworthiness of the participants' responses, as the participants were not influenced by the discussion of the climate nor did they voluntarily express its relevance to their experience. As a Black adult, the researcher, who is first author, was aware of how the social and political climate played into their experience. However, because the participants were adolescents experiencing emotional pain, the first researcher attempted to instill hope in them as part of their experiences of this study. To maintain confidentiality, specific details about the contextual factors in the participants' community have been omitted.

Definitions of Depression
Data analysis identified 18 codes that were relevant to the category regarding how participants defined depression. Of these codes, three emerged with significantly higher prevalence than the others: (a) *sadness*; (b) *isolation, social withdrawal, or loneliness*; and (c) *permanent or persistent*. Nine out of the 10 participants (90%) indicated that they experienced the feelings associated with these three codes. For example, in response to how he defined depression, Participant 5 noted that he became "sad, mad, and very frustrated." Participant 1 defined depression in terms of social withdrawal, saying, "Usually I stay in my room and I don't talk to anybody, I just stay in there, and that is about it." Participant 4 provided an example of the theme of permanent or persistent experiences by stating, "I don't think it could just

go away, especially when it's very serious." Participant 3 provided an example that captured the overall essence of this category when he stated:

> I have been sad a whole lot, without reason; and so, I think that is why I was depressed . . . when I am around people for too long, I get sad; but when I am alone, I am happier. I feel safe when I am by myself. When it [depression] comes on, it comes on strong. It is really bad. Because I feel really, really sad, and my thoughts aren't, you know, normal. Sometimes they are violent . . . like I don't have any hope at all. I don't think like I normally would. Sometimes I don't think at all. Sometimes when I get really sad or angry, I think about hurting people. So, I have to withdraw further. I have to push it further down into my mind so that I won't act on it.

It is interesting to note that the next most frequently found codes were *stress-related* and *frustration*, each with a prevalence of 60%, and *more common in young Black girls*, which had a prevalence of 50%. Alternatively, only one participant mentioned each of the following codes with regard to defining depression: *suicidal thoughts or attempts*, *more common in young Black boys*, and *feeling sick*.

Seeking Treatment

The category of seeking treatment contained 10 codes. Participants expressed contradictory feelings about the effectiveness of treatment and the barriers to seeking treatment. For example, 90% of participants expressed that they felt that *therapeutic treatment was effective* in mitigating or curing depression, including Participant 7: "To me, to talk to my therapist was like a relief to me, because he was the only person that I can be able to tell my thoughts, get my thoughts together why I was in there." Simultaneously, 30% of participants noted that they felt that *therapy was not effective* as a treatment. This overlap and apparent incompatibility in the data helped reveal the full breadth of Black adolescents' opinions and feelings about depression and seeking treatment, as participants expressed both positive and negative experiences.

This overlapping trend was seen elsewhere in this thematic category. For example, there were codes of *medication is effective* (50%) and *medication is not effective* (30%). This apparent contradiction was highlighted not only between participants but also within a single participant. Participant 10 directly stated she believed medication to be effective; she then revealed that she had been given medication that sent her into a coma. She reported taking her medication as prescribed but "after that I passed out, and I didn't remember nothing, all I knew I woke up in the hospital." Three codes were identified as directly related to seeking treatment. Significant barriers to therapeutic treatment were *negative connotation of mental illness* (80%), *uncomfortable issues brought up in treatment* (80%), and *lack of trust* (70%). The code *negative connotation of mental illness* was grounded in external perceptions, as many participants indicated that they did not want other people to know that they were in treatment.

For example, Participant 2 stated, "I don't tell them. I don't want them to know," when referring to his friends. Participant 3 provided an example of the code of uncomfortable issues, noting, "I don't like to talk about it much. You know, it is kind of aggravating. It makes me feel weak when I talk to people about my problems." Regarding the code *lack of trust,* Participant 6 noted, "I have very weak trust issues. Sometimes they can be strong but mostly weak."

Three minor codes emerged relating to seeking treatment. Two were *trouble expressing self in therapy* (40%) and *treatment was not necessary* (40%). Participant 3 stated, "I have a lot of trouble expressing myself. You know, when I get into the office, I just forget what to say." Three of the 10

participants openly discussed *lack of Black people's knowledge or education about depression* as a specific barrier to treatment. They shared their perceptions of the lack of education and discussion about depression within their own community, which they felt presented a specific barrier to treatment for them. Participant 6 stated, "I can't overly generalize it, but some people need to know more, 'cause they don't understand, because sometimes you just need that time and people they don't understand that you need it." However, taking these and the other barriers in this thematic category into account, the prevalence of participants who reported that treatment was effective was three times greater than the prevalence of participants who thought that treatment was ineffective.

Coping and Problem-Solving Strategies

The third thematic category contained 29 different codes related to problem-solving strategies and behaviors or activities the participants used to cope with depressive symptoms. The participants described various strategies to cope with depression, but the most prevalent was *suppressing/hiding thoughts/feelings*. There were seven strategies that more than half of the participants reported using as problem-solving strategies and strategies to cope with depression. The positive problem-solving strategies were *listening to music*, *turning to religion/going to church/praying*, and *talking/spending time with family*. The problematic coping strategies reported were *using illegal drugs*, *engaging in self-harm*, *having sex*, and *isolating*. See Table 1 for codes and results.

It is encouraging that 18 out of the 29 codes could be characterized as neutral or positive coping strategies. The other 11 are areas of concern, even if only one participant reported engaging in the behavior. Participant responses overlapped and participants reported coping and problem-solving strategies that might be characterized as both positive and negative. In addition to contrasts in the specific codes and types of behaviors, contrasts in the percentages of participants who reported negative behaviors compared to positive behaviors were noted. For example, participants reporting the negative problem-solving strategy of *engaging in self-harm* as a way to cope often went into detailed narrative descriptions. This strategy was more frequently reported than any of the positive or neutral coping and problem-solving strategies.

Types of Emotional Support

This thematic category addressed the types of emotional support that the participants received during their experiences with depression. Four distinct subthemes of codes were identified: *peers*; *family*; *school* (teachers); and *helping professionals* such as hospitals, managed care facilities, and therapists. Each of the four subthemes contained codes that were sorted as either positive or negative. A lack of support or refusal of support was considered a negative, and similar to other categories, participants shared multiple overlapping experiences. Negative support from peers was the only theme to have 100% prevalence; every participant mentioned that peers had negatively affected them through a lack of emotional support during their experience with depression, including Participant 2: "They didn't believe me at first, but later they just seem like they don't care." Half of the participants expressed that they had also received positive emotional support from their peers during their experience with depression. In the family group, equal percentages of participants (60%) reported receiving positive support from family and experiencing a lack of support from family. The participants were similarly split regarding their perceptions of receiving positive (50%) and negative (50%) emotional support from teachers at school. The greatest proportional difference in negative and positive emotional support was within the category of helping professionals. In this subtheme, four times as many participants (40%) reported that they had had positive emotional support from mental health care providers in a hospital, halfway house, or therapeutic community than participants reporting negative emotional support from mental health care providers (10%).

Table 1

Coping and Problem-Solving Strategies

Strategy		Percent of Respondents (*N* = 10)
Positive or Neutral Coping Strategies	Listening to music	70%
	Turning to religion / going to church / praying	70%
	Talking / spending time with family	60%
	Attending therapy	40%
	Writing	40%
	Creating art	30%
	Playing video games	30%
	Watching TV	30%
	Crying	30%
	Taking prescription drugs	20%
	Eating food	20%
	Reading	20%
	Talking / spending time with friends	20%
	Distracting self	20%
	Laughing	20%
	Joining clubs	10%
	Working out	10%
	Researching	10%
Problematic Coping Strategies	Suppressing / hiding thoughts / feelings	90%
	Using illegal drugs	70%
	Engaging in self-harm	60%
	Having sex	60%
	Isolating	60%
	Attempting suicide	40%
	Engaging in violence	40%
	Running away	30%
	Yelling / shouting	10%
	Having violent thoughts	10%
	Avoiding responsibilities / rebelling	10%

Contributing Factors to Depression

This theme of contributing factors to depression appeared to be the most salient to the central research question of how Black adolescents living in the rural southeastern United States described their experiences with depression. The previous themes captured definitions of depression, seeking treatment, coping and problem-solving strategies, and types of emotional support. This theme provided a description of the participants' lives in terms of their context and environment, which the participants identified as contributing factors to their experiences of depression. When asked about contributing factors to their depression, the three most noted by the participants were *verbal abuse* (70%), *differences from other people and being bullied* (70%), and *parental or family problems* (70%). Participants also reported *sexual abuse* (40%) and *physical abuse* (30%) as contributing factors. Participant 6 made the following statement, which captures the essence of this theme:

> My depression started really kicking in when I was around 13 . . . it runs in my family.
> My mom has it and when I was little, I was sexually abused . . . and I've been made
> fun of all my life . . . my weight . . . a scalp infection. People make fun of stuff like that.
> And that's been going on since I was little.

The least prevalent factors mentioned by participants were *foster care* (20%), *stress of schoolwork* (20%), and *a scary book* (10%). *Verbal abuse* was reported 30% more frequently than *sexual abuse* and 40% more frequently than *physical abuse*. However, it is interesting to note that Participant 2 considered foster care to be a cause of depression and not a solution. Most participants identified a combination of these factors as contributing to the onset of their depressive symptoms.

Discussion and Implications

This study sought to examine the unique experiences of Black adolescents diagnosed with depression living in a rural community located in the southeastern part of the United States. Five themes emerged when examining the participants' narratives with depression. These themes included definitions of depression, seeking treatment, coping and problem-solving strategies, types of emotional support, and contributing factors to depression. In defining depression, 90% of the participants in this study cited sadness, isolation, and depression's ongoing nature. This is not surprising, as these codes fit within the diagnostic criteria for depression. It was surprising, however, that participants defined depression as stress-related, as stress is not one of the diagnostic criteria. At the same time, the idea of depression as stress-related is supported in other studies (Breland-Noble et al., 2010; Bryant et al., 2013; Choi et al., 2006; Ofonedu et al., 2013; Robinson et al., 2015). The mental health community would do well to acknowledge the differences in how Black adolescents from rural U.S. communities may define depression. When working with Black adolescent clients, practitioners may wish to inquire about stressors and consider their relation to depression in order to inform treatment plans and interventions.

Most participants who sought treatment for depression indicated that treatment was effective; however, 30% of participants expressed that therapy was ineffective. Additionally, only 50% of participants indicated that medication was an effective form of treatment. Participants also identified barriers to seeking treatment, which included negative connotations associated with mental illness and discomfort discussing issues in treatment. Barriers identified included a lack of trust, problems with self-expression, the belief that therapy was not needed, and a lack of knowledge about depression in the Black culture. These results are consistent with prior research (Al-Khattab et al., 2016; Bryant et al., 2013; Lindsey et al., 2010; Ofonedu et al., 2013; Sullivan et al., 2017), indicating that mental health

conditions are often misunderstood, misdiagnosed, or unacknowledged within the Black community (Graves, 2017; Murry et al., 2011; Shushansky, 2017).

Prior research has also highlighted the stigma of mental illness in the Black community (Cook et al., 2017). This stigma helps to explain previous research showing that Black people often seek help as a last resort (Al-Khattab et al., 2016; Breland-Noble et al., 2010; Ofonedu et al., 2013; Vontress et al., 2007). It is essential that counselors acknowledge the stigma associated with mental illness and reluctance to seek treatment within the Black community. More practitioners who are aware of and sensitive to the mental health needs of Black communities are needed. It is imperative that clinicians take it upon themselves to become competent when working with this population. To address the stigma, practitioners might offer training in evidence-based practices related to Black adolescents' mental health at churches, schools, and various community organizations in the Black community. These types of trainings could be particularly effective in rural communities where participants are likely to communicate to others about the trainings, thereby validating the information and possibly reducing the stigma. One of the codes from this study was related to the effectiveness of medication for reducing depressive symptoms. More research is needed to explore factors that may contribute to this experience. Additionally, more research is needed to understand the unique traits of Black adolescents seeking treatment in other regions of the United States.

There were a few positive strategies for coping with depression that the participants identified, including listening to music, engaging in spiritual practices, and spending time with family. These positive coping strategies supported the constructs of spiritual beliefs and relationships with others, which were established in prior studies (Al-Khattab et al., 2016; Conner & Yeh, 2018; Ofonedu et al., 2013). The theme of coping and problem-solving strategies was dominated by the most common strategy: participants hiding their thoughts and feelings as a way of managing their depressive symptoms. This result corroborates the findings of prior studies that show Black adolescents conceal their feelings and symptoms of depression (Al-Khattab et al., 2016; Breland-Noble et al., 2010; Ofonedu et al., 2013; Vontress et al., 2007). As previous studies have suggested, hiding thoughts and feelings may be due to the stigma associated with mental illness and limited options in how to respond to stressful and anxiety-provoking situations (Robinson et al., 2017; Robinson et al., 2015). The finding that the participants hide thoughts and feelings also supports previous research that Black adolescents may be fearful of how others will react to them and isolate themselves as a result (Al-Khattab et al., 2016; Breland-Noble et al., 2010; Ofonedu et al., 2013). Participants also reported engaging in unhealthy coping behaviors such as self-harm, sexual intercourse, and isolation. These harmful strategies may be due to the limited coping skills of Black adolescents that have been identified in prior research studies (Robinson et al., 2017; Robinson et al., 2015). Again, these findings highlight the need for culturally specific training regarding mental health in Black communities.

The theme of emotional support resonated with all participants in this study, suggesting the significance of relationships (Breland-Noble et al., 2010). When examining emotional support, positive and negative experiences emerged. Positive emotional supports were found in family members (60%), teachers (50%), and mental health professionals (40%). Yet all participants indicated being negatively impacted by a lack of support among their peers. Participants reported feeling invalidated or not believed by their peers. They also reported that their peers did not seem to show concern. These experiences may have exacerbated the participants' symptoms. Only half of the participants indicated receiving positive peer support when seeking help for depressive symptoms. These findings are concerning because of the heavy emphasis placed on relationships within Black communities (Breland-Noble et al., 2010).

Relationships were identified as significant to all participants in this study, indicating that healthy relationships may be a protective factor and may increase emotional and mental health. Counseling professionals in private practice and in schools are thus encouraged to inquire about a wide range of relationships when working with their Black adolescent clients. For example, a counseling professional might ask a client to complete a detailed relationship profile for each significant person in their life. This would help to uncover significant relationships that could support the client's current challenges and to identify those individuals who might not be providing support. Counseling professionals might also conceptualize client symptoms as connected to these relationships. Family or systemic interventions may be incorporated into treatment planning to decrease depressive symptoms.

The theme of contributing factors encompassed a surprisingly high number of significant adverse and traumatic experiences. When examining the factors contributing to the development of depression in Black adolescents, most participants in this study cited verbal abuse, differences from others/bullying, and family-related issues as salient factors. Other contributing factors included sexual and physical abuse. Participants reported verbal abuse (70%), sexual abuse (40%), and physical abuse (30%) as contributing factors of depression. However, participants did not identify one single factor but rather described multiple and overlapping factors that contributed to their depressive symptoms. The connection between adverse and traumatic experiences and depressive symptoms specifically within the Black adolescent population appears to be underreported in the literature.

It is important to note the high prevalence of abuse indicated within the study. The lack of existing studies exploring the relationship among Black adolescents, depression, and adverse childhood experiences indicates that additional research is needed. An implication of this study is that when working with Black adolescent clients who are presenting with symptoms of depression, counseling professionals might incorporate an adverse childhood experience screening tool. Assessing clients for adverse childhood experiences as a matter of regular practice may better inform preventative measures and treatment. As this study highlights, it is essential for clinical and school professionals working with Black adolescents to understand that abuse can contribute to depressive symptoms.

Overall, many of the symptoms described by participants could be associated with a diagnosis of dysthymia as a result of oppression, supporting the work of Vontress et al. (2007). However, the participants did not use the word "oppression" and may not have recognized the systemic aspects of their experiences (Vontress et al., 2007). It may be that the participants' adverse experiences of abuse overshadowed any cultural or historical factors that may also have been present. The current study highlighted the overlooked and undertreated experiences of Black adolescents with depression. Counseling professionals may choose to gain a preliminary understanding of Black adolescent depression and dysthymia symptoms "within the context of their legacy of discrimination and oppression" (Vontress et al., 2007, p. 132).

Limitations

Overall, these findings need to be considered in light of some specific limitations. First, the interview questions were semi-structured. This means that the researcher used open-ended questions followed by discussion. As a result, the interviewer may not have covered the exact same content with each participant. Furthermore, because of the nature of the study, some participants may have been more forthcoming about their personal experiences. Thirdly, although the participants were asked about past events, the memories of those events may have been compromised because of

the passage of time or because of received or ongoing treatment. Lastly, given the limited number of participants interviewed, more research is needed to understand the mental health needs and experiences of Black adolescents who are experiencing depression.

Conclusion

In this qualitative study of 10 Black adolescents living in a rural community, the authors provided space for the participants to use their own terms and language to define depression. It is clear through this and other research that contextual factors are often involved in the onset of depression in Black adolescents, and there is not enough active therapeutic and medical treatment for Black adolescents living with depression. There is a stigma associated with mental illness and reluctance to seek treatment within the Black community, particularly in rural areas. As a result, counselors and mental health providers need to become more educated and aware when working with Black adolescents who live in rural communities.

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