

EXPERIENCES AND PERCEPTIONS OF DEPRESSION IN YOUNG
BLACK MEN AFTER INCARCERATION

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by
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University of Missouri-Kansas City, 2013

ABSTRACT

One in three Black men in the U.S. faces difficulties obtaining employment, housing and maintaining self-sufficiency post incarceration. Felony records result in considerable social and economic vulnerability, which place many young Black men at risk for depression. However, very little is known about depression in young Black men or how depression is experienced and perceived by those with a felony record. Further, cultural and gender divergences from traditional clinical definitions and symptomatology of depression can complicate accurate and efficient identification of depression in these young men. Therefore, the purpose of this research was 1) to explore experiences and perceptions of depression in young Black men who have a history of incarceration and 2) to explore the social consequences of depression in this population. Semi-structured interviews were conducted with twenty Black men who have a history of incarceration to explore individual perceptions and experiences of depression. Data were analyzed using an inductive process

and thematic analysis. Emergent themes for individual experiences and perceptions of depression were a) anger and negativity, b) depression is weakness, c) invisible depression, d) being strong and going on and e) our depression is different. With regard to societal consequences, participants overwhelmingly reported that they believed that no one cared about the depression experiences of young Black men.

Findings from this study suggest the need for research to develop screening and assessment tools that accurately measure depression in this population. Findings also have implications for clinicians who identify and initiate ongoing therapeutic relationships with young Black men with depression. Mental health promotion programs that target the specific needs of this population are also warranted.

APPROVAL PAGE

The faculty listed below, appointed by the Dean of the School of Nursing have examined a dissertation titled "Experiences and Perception of Depression in Young Black Men after Incarceration" presented by Danielle Elizabeth Kristina Perkins, candidate for the Doctor of Philosophy degree, and hereby certify that in their opinion it is worthy of acceptance.

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CHAPTER 1

INTRODUCTION

Problem

Unidentified depression is associated with increased morbidity and mortality of individuals (Murphy et al., 2008; Sharp, & Lipsky, 2002). It is estimated that at least one-third of depression cases are unidentified (Hyman, 2000). Socioeconomically vulnerable and minority populations are at increased risk for depression (Turner, Wheaton, & Lloyd, 1995). Certain groups present challenges to recognition of depression; men are among these groups as they are less likely to expose emotional difficulties (Sharp & Lipsky, 2002). Reducing unidentified depression in young Black men requires increased understanding of unique variations of depression with appreciation for deviations from traditionally accepted definitions.

Young Black men experience higher rates of academic underachievement, unemployment, poverty, and incarceration when compared to their White counterparts (Boyd, 2007; Holzman, 2010; Sum, Khatiwada, McLaughlin, & Tobar, 2008). Such social inequalities predispose these young men to mental health disorders, including depression. Current data, based on existing depression screening measures, suggest that only one in fourteen Black men will develop depression in their lifetime (Community Voices, 2003). This figure is likely to be a serious underestimation as low levels of this population are screened due to lack of access and generalized distrust of medical professionals (Community Voices, 2003). Underestimation is further complicated by the insensitivity of commonly used depression screens in minority populations (Kim, Huang, DeCoster, & Chiriboga,

2011). Justification for the idea of an underestimation of depression incidence is also suggested by suicide rates for Black males in early adulthood, which have more than doubled since 1980 (Boyd, 2007). An estimated 90% of individuals who successfully commit suicide are likely to be depressed and of those, 30 to 50% are undiagnosed or receiving inadequate treatment (Hyman, 2000).

Findings from several large-scale investigations of depression that correlated socioeconomic status and environmental factors such as neighborhood safety and quality, and stability of housing consistently report non-significant levels of depression among Black men in the samples (Curry, Latkin, Davey-Rothwell, 2008; Silver, Mulvey, & Swandon, 2002; Latkin & Curry, 2003). In fact, several of these studies reported that male-gender is a protective mechanism against depressive disorder (Latkin & Curry, 2003; Silver et al., 2002). There is a general acceptance of the 2:1 ratio of incidence of depression in women and men, despite the fact that the American Psychiatric Association (APA) readily acknowledges that cultural and gender differences influence experience and communication of symptoms of depression (2000).

The Center for Epidemiological Studies Depression Scale (CES-D) and the Beck Depression Inventory (BDI) are widely utilized depression screening measures. Many of the previously cited studies used these tools to measure symptoms in their samples. However, the culture and experiences of young Black men impacts both their experience of depression symptoms and their verbal and nonverbal communication of these symptoms and thus may differ significantly from standardized measures and the medical definitions and descriptions of depression. A recent meta-analysis has found that the CES-D, an offshoot of the BDI, may not adequately reflect depression constructs relevant to race and ethnic variances and

further, mental health practitioners should appreciate these variances in relation to depression symptomatology and presentation (Kim et al., 2011). Interestingly, none of the studies included in the meta-analysis included Black men under the age of 40 years. To move toward culturally appropriate screening for depression in young Black men, it is integral to understand both the experiences and perceptions of depression and usefulness of current depression screening tools.

Failure of depression screening instruments to trigger further clinical assessment compromises the safety of many young Black men. For example, young Black males are at increased risk for suicide after confrontations with law enforcement, criminal justice systems, and housing authorities (Community Voices, 2003). Further, unemployment and poverty, both acknowledged contributors to depression (Aneshensel, 1992), disparately affect young Black men whom have documented unemployment rates as high as 75% in some major metropolitan areas of the United States (Holder, 2010). Such realities suggest that depression has a great impact on the mental health of young Black men. The inability of medical and mental healthcare providers to recognize these realities has a direct impact on the quality of mental healthcare provided to this population. Underestimation of depression incidence diminishes the social justification for increasing allocation of resources and accessibility to mental health care and social work services despite the dire needs of these men.

Approximately 30% of all young Black men ages 20 to 29 years have a history of incarceration and thus are especially vulnerable to depression and its implications (Community Voices, 2003; Tonry & Melewski, 2008). Social exclusion in the form of discrimination from housing and education opportunities and voter disenfranchisement are significant and potentially long-lasting restrictions to productivity, and mental health, in this

population (Alexander, 2010; State Felon Voting Laws, 2012). This study will target young Black men with a history of felony conviction. This population is at increased risk for depression as a result of widespread legal-justice involvement.

Specific Aims and Research Questions

The aims and research questions of this study were:

Specific Aim 1: To explore the experiences and perceptions of depression of young Black men, ages 18 to 35.

Research Question 1a: What are the experiences and perceptions of depression among young Black men after incarceration?

Research Question 1b: What are the perceived social consequences of exhibiting depression symptoms?

Specific Aim 2: Compare constructs of a standardized depression screening to depression themes in the interviews of young Black men.

Research Question 2a: How do depression themes from interviews with young Black men after incarceration compare to sub-constructs of the CES-D?

Significance and Innovation

The American Psychological Association and other research studies assert the premise that depression occurs more frequently in woman than men, at a rate of 2:1 respectively (2000). However, gender and cultural differences contribute to difficulties in diagnosing depression in diverse populations. In particular, experiences and communication of depression symptoms, lack of provider cultural sensitivity and knowledge of cultural norms impedes proper identification of depression (Community Voices, 2003; Sharp &

Lipsky, 2002). Given this, the true incidence of depression in populations such as young Black men is underestimated given the cultural differences of these men from the majority of mental healthcare providers. In fact, though Blacks represent nearly 12% of the general population, they represent only 2% of trained psychologist and psychiatrist (Community Voices, 2003). Although the utility of depression screens for multicultural populations has been widely studied no research has specifically examined perceptions of utility of depression screening measures in young Black men (Kim et al., 2011).

This study aimed to understand the experiences and perceptions of depression held by vulnerable young Black men and in addition the congruence of commonly used depression screening tools with these perceptions and descriptive language of this group. These findings would significantly contribute to the understanding of unique variances in perspective on depression experiences, expression and consequences of the illness, and thus the potential efficacy of commonly used depression screenings in a population that has not received widespread attention to depression outcomes, despite being at significant risk. Effective and sensitive depression screening of young Black men is integral to provision of mental health care that meets the psychological needs of these men. Findings relative to perceptions and consequences of depression are an essential foundation for further work that ultimately aids in development of more sensitive screens that measure relevant constructs of depression in young Black men. This study is the first in a program of research that seeks to extend understanding of unique experiences and perceptions of depression in young Black men. The ultimate goal is development and testing of culturally sensitive screening measures that increase accurate identification of depression in this population.

Evolution of the Study

Six years' nursing experience in mental health preceded the overdose and death of my beloved, and unfortunately, very troubled brother in March 2009. I saw it coming yet it wasn't any less shocking to hear the news. Three years later, his life and my loss continue to serve as the contextual forces that inspire my further inquiry, as a nurse researcher, into intersections of race, gender, and class and their impact on health.

My experiences in mental health nursing, in two cities located in Southeastern Louisiana, over the span of nine years color the lens through which I professionally interpret and process issues of mental health and mental illness. In contrast, it's my 32-years' experience growing up Black in the large, predominately White, Midwestern city of Indianapolis in the 1980s and 1990s that is the larger context that grounds and informs my current sense-of-self with regard to my own race, gender, and class. It wasn't until I left Indiana in 1998, at the age of 18, to go to a small private historically Black university in New Orleans, Louisiana that my true journey into my 'Blackness' really began. I grew up fully aware that I was Black and that Black was different from White. Fortunately, my parents had access to resources that shielded me from many of the social detriments of poverty and in fact my firmly rooted middle-class childhood upbringing afforded me many of the opportunities and successes that I enjoy today. Now, 14-years later, after having spent half of my entire life and all of my adulthood in the 'deep South' a more self-actualized, aware, and conscientious Black woman has evolved.

Mental health professional nursing practice in Southern Louisiana not only involved the provision, facilitation, and supervision of medical care, as is the responsibility of the Bachelor's prepared nurse, but also included the witnessing of human suffering,

disadvantage, and race-related disparities. Bearing witness to the practices of other health professionals throughout my nursing career, both good and bad, motivate the search for answers to the contexts and other influences that contribute to the successes and failures, in health, of the most vulnerable in our society.

The most significant loss I've ever experienced, that of my brother, has caused me to more carefully scrutinize the system for provision of mental healthcare and especially with regard to the implications of legal institutionalization. So many young Black men have negative interactions with American legal-justice institutions that I believe it to have negative consequences for their mental and physical health and longevity. This is because implications of felony status include significant social restrictions with regard to opportunities for employment, higher education, housing, and citizen involvement (Alexander, 2010). Further, widespread Black male membership in lower educational and socioeconomic categories (Boyd, 2007; Holzman, 2010) betrays general expectations for the experiences and lives of individuals that would potentially be characterized as 'mentally healthy.' Yet, worthy of debate are the disadvantaged young Black men that resist the inevitability of failure in the face of deprivation and social exclusion to become 'productive citizens' by tactics that remain evasive and poorly understood. However, to those who do not or are unable to 'make it' by not only surviving but thriving, we owe a debt of assistance and uplift. With so many young Black men suffering adverse psychological outcomes as a result of institutionalization, it is the duty of community and mental health professionals, and even professionals involved in the legal-justice institutions, to understand and value the intricacies of experiences of those that are socially excluded as a result. Further, we as

healthcare providers are all charged with work to reduce health disparities as a function of injustice.

Assumptions of the Research:

Assumptions that guided the conduct of this research included:

1. Depression experiences of young Black men differ from mainstream professional understanding of the illness.
2. Black men experience numerous stressors that predispose them to an increased risk for depression.
3. Depression is not well measured by traditional depression screening measures in populations of young Black men.

Definitions

Conceptual definitions for terms used in this study are included below to provide clarity.

Culture: The term culture has many vague conceptualizations commonly associated with race or groups who share various similarities (Kline & Huff, 2007). For this study, the term culture had multiple dimensions which combined to result in a valued and meaningful way of life that ensures the health and well-being of its members (Kline & Huff, 2007). For example, elements of lifestyle including diet, marriage rules, and means of livelihood are culturally dictated by groups sharing common beliefs and values (Kline & Huff, 2007).

Culture functions to provide individuals with purpose and meaning in life and a sense of identity. In addition culture dictates rules for behavior that ultimately support an individual's

sense of worth and thus maintaining the integrity and welfare of the group (Kline & Huff, 2007).

Young Black men: For this study, young Black men were identified as those who self-identified as of African descent and were age 18-35 years. Young Black men residing within the inner-city were of particular interest as the experiences of this group were historically and are currently unique with regard to socioeconomic vulnerability and culture (Hooks, 2004; Watkins, Green, Rivers, & Rowell, 2006; Willis, Coombs, Cockerham, & Frison, 2002). Young adulthood was defined as the period spanning from late teens to the mid to late 30s (Edelman & Mandle, 2010). The term inner-city was used in this study to refer to the center, usually older, interior of a city densely populated with poor minorities (Inner city, 2006).

Depression: Depression was conceptualized according to both mainstream public and professional psychological definitions and characteristics, both similar (American Psychiatric Association, 2000; Watkins et al., 2006). Depression is a mood disorder characterized by lack of interest or pleasure in most activities and may include any wide array of symptoms including but not limited to effects on appetite, complaints of pain, and feelings of hopelessness and/or helplessness (American Psychiatric Association, 2000). Causes for depression include genetic and hormone imbalances, situational crises, and/or environmental stressors (American Psychiatric Association, 2000; Matheson, Moineddin, Dunn, Creatore, Gozdyra & Glazier, 2006).

Mental health: Mental health pertains to the generalized psychological adjustment of individuals (Hackney & Sanders, 2003). Traits of mental health included negative functions such as depression and anxiety and positive functions of self-esteem and happiness (Hackney

& Sanders, 2003). Further, an individual's mental health encompasses 'growth-oriented' humanistic functions of identity integration and existential well-being (Hackney & Sanders, 2003).

Chapter 2

LITERATURE REVIEW

Young Black men, particularly those from inner-city communities, experience racism in a variety of forms, including stereotyping, profiling, and harassment from law enforcement (Kendrick et al., 2007; Tonry & Melewski, 2008). Their lives are further constricted by the minimal educational preparation provided at many inner-city primary and secondary schools, which limits their preparation for college and/or gainful employment (Holzman, 2010). For many, the ever-present financial and social lure of gangs, drugs and other illegal activities present in most inner-city environments undermine attempts at legitimate achievement (Tonry & Melewski, 2008). Young Black men are more likely to be incarcerated than those from any other racial or ethnic group (Alexander, 2010). Confounding the issues of race and class are the societal expectations for masculinity and manhood, in which Black men are expected to exhibit traditionally American functions of manhood, such as supporting their families, despite widespread exclusion from educational and occupational opportunities. For many in this population, the seemingly insurmountable gap between the societal barriers and expectations has a profound and lasting effect on their long and short-term mental health. Practitioners engaged in therapeutic relationships with young inner-city Black males should be aware of the historical nature of the social issues affecting this population, as well as the cultural and gender-specific differences that affect accurate identification of depression. The goals of this chapter are threefold. The first is to highlight the social, economic and historical context of the lives young Black men in America. The second is to discuss how the current

assessment of clinical depression may not appreciate this context. Finally, the validity of current depression measures is examined and called into question.

Socioeconomic Status: Intersections of the Past & Present

Emancipation from slavery in the 19th century did not provide young Black men with access to the industrial explosion of manufacturing jobs during the 20th century (Semmes, 1996). From the late 1800s and continuing until well into the twentieth century, many northern White employers for large industrial manufacturers believed that Blacks were suited for agricultural work only, making them unfit for well-paying industrial positions (Kusmar, 1976). In the 1930's and 40's, the exodus from rural Southern towns to northern industrial cities and the discriminatory practices in hiring limited opportunities for Black men to obtain jobs and wages comparable to those of the larger society during this period (Wilson, 1997). As late as 1987-1988, researchers conducted the Urban Poverty and Family Life Survey and found that almost 75% of manufacturing employers acknowledged that they avoided hiring Black males because of their lack of educational preparedness and professionalism, as well as their laziness, thievery, and aggression (Wilson, 1997). These decades of stereotyping and exclusion from well-paying jobs negatively affected the ability of many young Black men to become the economic heads of their households and adequately provide for their families, with a resultant negative impact on their self-sufficiency (Wilson, 1997).

The sub-standard and discriminatory education system present in many small and large cities forms a shaky foundation for young Black boys and begins a trajectory for negative economic consequences. Despite the social and educational gains of Brown vs. Board of Education of Topeka and the subsequent desegregation of schools in 1954,

substantial remnants of inequality continue to negatively impact the ability of inner-city schools to meet the academic needs of poor young Black students (Wraga, 2006). Many inner-city schools face challenges in relationship to concentrated poverty of its students, limited school budgets and large class sizes (Ahram, Stenbridge, Fergus, & Noguera, n.d.). These barriers lead to persistently low performance and expectations for minority students and poorly functioning school operations (Ahram et al., n.d.). For example, students attending schools with high concentrations of poor Black and Latino students are more likely to have inexperienced or unqualified teachers, decreased access to college preparatory courses, higher teacher turnover, and more remedial courses (Lee, 2004). Young Black boys, in particular, experience minimal opportunities for advancement in primary academic settings. They are often wrongly placed into special education classes as a result of discriminatory policies and receive much harsher penalties, such as expulsion, for similar classroom infractions when compared to their White counterparts (Holzman, 2010). In many Midwestern and southern states, Blacks males have high school graduation rates below 50% (Holzman, 2010). Black men over the age of 18 represent only 5% of all college students (Lewis, Simon, Uzzell, Horwitz, & Casserly, 2010); and more Black men acquire a high school equivalency diploma while in prison, than graduate from college each year (Boyd, 2007).

In addition to the historic employment disparities for Blacks, the United States maintained a culture of segregation for much of the first half of the 20th century (Alexander, 2010). Jim Crow laws enacted in 1876 legitimized the social disadvantages for Blacks in education, employment, housing, and legal/justice interactions today, leading to a proliferation of segregated urban ghettos in large cities across the Northeast and Midwest

United States (Alexander, 2010; Wilson, 1997). Confronted with discriminatory real estate sales and rental practices, Black families were cornered into and offered minimal opportunities out of poverty, urban ghettos and sub-standard housing. The high and continuous geographic concentrations of poverty and social restriction set the stage for marked increases in drug trafficking, substance abuse and intra-group violence in many inner-city neighborhoods in the 1970's and 80's (Wilson, 1997). These circumstances continue to be reflected in many large urban centers today.

The dynamics of urban life shape much of the current interactions between Black men and the larger society. Young Black men disproportionately experience suicide, homicide victimization and incarceration (Boyd, 2007; Rogers, Rosenblatt, Hummer, Krueger, 2001). Although historically having lower rates, the suicide rate among young adult Black men has increased two-fold since the 1980's (Boyd, 2007). Homicide is the leading cause of death for Black men aged 15 – 24, a rate three times higher than all other population sub-groups (Paxton, Robinson, Shah, & Schoeny, 2004). Black males 14 to 24 years of age are implicated in a quarter of homicides in the U.S. (Boyd, 2007). In fact, some theories suggest that many homicides are an alternative form of suicide. Rather than committing suicide by traditional means like firearm or suffocation, vulnerable and depressed young men may place themselves at increased risk for deadly force by law enforcement or deliberately provoke well-known violent individuals into an act of homicide against them (Willis et al., 2002). While perpetration of homicide increases the incidence of incarceration of young Black males, the national representation of this population in institutions is drastically disparate with regard to their relative proportion of the total society. Black men represent 40% of the more than 2 million men imprisoned in the U.S. despite comprising

little over 6% of the total population (McKinnon & Bennett, 2005; West, 2010). Black men age 18–24 are more likely to be incarcerated than all other men in this age group (Sum, et al., 2008). On any day in 2005, at least one-third of Black men age 20-29 were either imprisoned or jailed or on probation or parole (Tonry & Melewski, 2008). This is in spite of the facts that while crime rates may decrease, rates of incarceration unexpectedly and unexplainably increase (Alexander, 2010). In fact, despite recent national trends of bidirectional changes in the overall incidence of crime, the rate of incarceration of young Black men has consistently increased four-fold (Alexander, 2010). The source of the steady increase in conviction and imprisonment of young Black men is rooted in non-violent crimes related to drug offenses (Alexander, 2010). However, Blacks are no more likely to engage in drug use or distribution than Whites, a fact acknowledged by the Human Rights Watch (Alexander, 2010). A 2000 study conducted by the National Institute on Drug Abuse found that White students used crack-cocaine at a rate eight times that of their Black counterparts (as cited in Alexander, 2010). Further, White youth are three times more likely to be admitted to the emergency room for drug-related causes than Black youth (Alexander, 2010). Reasons for the disparity in incarceration of Black men for drug-related offenses are that they are more likely to perpetrate drug deals in public and semi-public environments and they are more likely to engage in drug sales with strangers. In contrast White men typically conduct their drug deals behind closed doors with people they know and trust (Tonry & Melewski, 2008). This increases the ease and likelihood of arrest and subsequent conviction of greater numbers of Black men than White (Tonry & Melewski, 2008). Finally, the increased severity of sentencing for drug-related offenses has also significantly contributed to disparities of imprisonment for Black men. For example, the 1986 federal law known as the “100-to-one

law” for crack and powder cocaine sentencing mandates a five-year prison sentence for possession of five grams of crack in contrast to possession of 500 grams of powder cocaine (NAACP, n.d.). The result of such a law is that small-scale crack cocaine users are punished more severely than the typical more affluent powder cocaine users and their suppliers (NAACP, n.d.); and thus Blacks are disparately affected by this law.

The penalties of conviction extend far beyond prison walls. The current Black male unemployment rate, 12.7%, is twice that of White males (U.S. Bureau of Labor Statistics, 2012; Apel & Sweeten, 2010). Unemployment is higher among men who have been incarcerated, as they are seldom able to return to the employment status and earnings that they had the year prior to incarceration (Boyd, 2007; Winnick & Bodkin, 2009; Waldfogel, 1994). Incarceration with a felony status results in permanent loss of voting privileges in 12 states and legally justified discrimination from future housing, education and professional licensing opportunities (Alexander, 2010; State Felon Voting Laws, 2012).

Whether Black men are the perpetrators or the victims of violence, both of these roles together with incarceration result in a disruption of family functioning (Rogers et al., 2001). This disruption is seen in the fact that in 2010 only about 13% of Black children lived with their married parents and 17% lived with their mothers only, a rate higher than all other race groups (Lofquist, Lugaila, O’Connell, & Feliz, 2012). Black single mothers living in inner-city areas experience much higher poverty rates than do their White counterparts (Snyder, McLaughlin, & Findeis, 2006). Additional struggles associated with food insecurity, crowded living conditions, and lack of medical care compound the lives of fully half of all Black families today (Sherman, 2006). Children in such economically limited, single-parent

families have an exponentially increased risk of having the poverty passed on to their children, or “generational poverty” (Hymowitz, 2005).

The 1965 report entitled *The Negro Family: The Case for National Action* presented by then Assistant Secretary of Labor Daniel Patrick Moynihan offered a critical analysis of a destabilizing Black family structure and community. Criminal deviance, matriarchy, and economic dependency of Black families served as statistical evidence of problematic outcomes in the report (Geismar & Gerhart 1986). The source of these problems were primarily attributed to the dysfunctional socialization processes of Black children rooted, first in slavery and subsequent inequality, discrimination, and oppression (*The Negro Family*, 1965). These controversial assertions about the determinants and outcomes of rapidly disintegrating Black nuclear families demonstrated tremendous cultural bias toward traditional nuclear families and ignorance about the strengths of the extended Black family (Goldberg, 1966). Black intellectuals, activists, and academics continue to criticize this report and its ignoring of any consideration of whether Black families’ “dysfunction” might be a functional adaptation in the larger societal context of exclusion and discrimination (Goldberg, 1966).

Depression

Depression is a mood disorder characterized by lack of interest or pleasure in most activities and may include any wide array of symptoms including but not limited to effects on appetite, complaints of pain, and feelings of hopelessness and/or helplessness (American Psychiatric Association 2000). Causes for depression include genetic and hormone imbalances, situational crises, and/or environmental stressors (American Psychiatric

Association, 2000; Matheson et al., 2006). The disorder has been found to be one of the top causes of disability and loss of productivity in developed countries like the U.S. (Smith & Bielecky, 2012). Variations in depression symptom expression exist across culture, ethnicity, and gender; inner-city areas of concentrated poverty possess characteristics of a psychologically hostile environment (American Psychiatric Association, 2000; Sharp & Lipsky, 2002; Latkin & Curry, 2003; Matheson et al., 2006; Paxton et al., 2004). Such an environment is the background for unemployment, poor education, violence, and limited housing opportunities that make up the daily realities for many young Black men. This essentially unrelenting variety of external sources of stress poses a threat to the psychological and the physiological health of young Black men. Stress-related mental and chronic diseases such as depression, anxiety, hypertension, and cardiovascular disease occur more frequently among minorities and individuals living in urban environments (Taylor & Turner, 2002; Gary, Stark, & LaVeist, 2007; Schulz et al., 2000; Galea, Ahern, Rudenstine, Wallace, & Vlahov, 2005).

While health care providers daily see the consequences of the physical impact of such stress, they might also expect to see a high rate of discouragement and depression among Black men and women, upon further examination. However research conducted using traditional screening tools for the assessment of depression in inner-city environments has not found this to be the case. The Center for Epidemiological Studies Depression Scale (CES-D) has been used in several large-scale studies to measure depression symptom severity in economically depressed inner-city environments. The findings from these studies highlight that the prevalence of depression is lower in men and also that overall risk for depression is considerably lower for men residing in inner-city environments (Curry et al.,

2008; Silver et al., 2002; Matheson et al., 2006; Latkin & Curry, 2003). Depression has long been associated with female gender (American Psychiatric Association, 2000) and because many of the above referenced studies that examine relationships between depression and inner-city environments confirm this well-established relationship between gender and depression, the results are reported without further scrutiny.

It is possible that traditionally constructed definitions and diagnostic criteria of depression may not adequately capture the experiences of young inner-city Black males. The findings from several studies seem to support the premise that depressive symptoms are perceived as a normal “part of life” for many young Black men and men with low socioeconomic status (Epstein et al., 2010; Kendrick et al., 2007). Interviews with young Black males in community settings reveal perceptions that traditional conceptualizations are incongruent with their own beliefs about how depression is experienced and expressed (Kendrick et al., 2007). In addition to gender, race has been found to confound the relationship between gender and depression. Studies of neighborhood effects on mental health found that, in addition to being female, Whites residing in high poverty urban neighborhoods reported higher psychological distress/depression and anxiety than Black residents in the same community (Gary et al., 2007; Schulz et al., 2000). The authors of these studies suggest several possible explanations for these results, the most concerning being Blacks’ alleged development of more effective psychological coping strategies due to earlier and more frequent exposure to hostile environments (Schulz et al., 2000). This suggestion disregards the impact of these environments on the long-term psychological, physiological, and socioeconomic success, or lack thereof, of young inner-city Black males. While scholars have long recognized the problems with these measures with regard to detection of

depression incidence in a culturally diverse society (Kim, 2010) the sensitivity of depression measurement in Blacks and men is seldom scrutinized in these large scale epidemiological urban-based studies.

A natural question arising from the contradiction between life in an oppressive environment and low rates of depression found when screening men and Blacks led to the questions: Do traditional screening tools accurately measure depression in young Black men? How do young Black men perceive depression and its consequences?

Depression and Gender

Increasing attention is being devoted to the often neglected area of emotionality in males with regard to their unique experiences, expression, and perceptions of depression (Brownhill, Wilhelm, Barclay, & Schmied, 2005; Kendrick et al., 2007). There is widespread acceptance of significant differences among men and women with regard to symptomatology of depression (Emslie, Ridge, Ziebland, & Hunt, 2006). Specifically, women are more likely recognize and thus communicate emotional and psychosomatic symptoms that are commonly associated with depression (Rochlen et al., 2010). Men, however, are thought to exhibit depression in ways that are not reflected in diagnostic criteria including anger, risk taking, help-seeking avoidance, and drug and alcohol abuse (Brownhill et al., 2005; Rochlen et al., 2012). Findings from several qualitative studies provide direction for future inquiry of depression in men.

Findings from a focus group composed of young Black men residing in the community showed that “stress”, associated with being treated differently due to ethnicity, was a common term used to denote depression and that these experiences, regardless of the

implications, were perceived as an inalienable fact of life (Kendrick et al., 2007). In order to cope with the daily barrage of stressors, participants described attempts to “chill” in spite of insults. Attempts to mitigate stressors by means of social-interaction based distraction, engagement in sports activities, and smoking and alcohol use were commonly identified as ways in which young Black men tried to “chill” (Kendrick et al., 2007). “Chilling” proved to be particularly important as the need to prevent various stressors from having a significant impact was found to be a high priority among the groups. Another significant emergent theme pertained to interactions with the police. Participants agreed that police targeting and profiling, based on race, contributed to their experiences of stress (Kendrick et al., 2007). The findings from this qualitative study, the only of its kind, contributes unique knowledge to the state of the science as it is the only study with a sample composed entirely of young community-based Black men (Kendrick et al., 2007).

Qualitatively derived depression data from focus groups and individual interviews conducted primarily with European male samples resulted in somewhat differently ‘situated’ themes for understanding depression in men (Emslie et al., 2006). Ethnically oriented perceptions of being treated differently or unfairly did not emerge as contributing factors for depression in these groups. Instead, interviews with European White men, diagnosed with depression, yielded themes relating to feeling different—not particularly being attributed to any specific cause or reason. The feelings of difference communicated by the men included general perceptions of not fitting into social situations and not being able to articulate their experiences effectively (Emslie et al., 2006). However, a focus group study that aimed to explore hidden depression in a sample of European born men found that constructs of avoidance, escapism, and ‘numbing pain’ emerged as themes (Brownhill et al., 2005).

Participants described drinking alcohol and smoking pot to escape from and numb the pain associated with depression. In addition, efforts to avoid depressive feelings by distractions with work or attempting to forget about problems were believed to negatively impact social interactions (Brownhill et al., 2005). This is similar to the tactics of the young men in the Kendrick et al. (2007) study with regard to attempts to diminish the effects of daily encounters with stressors by “chilling”. However, significant feelings of anger and subsequent violent outbursts emerged as a theme among the men in this same focus group and not among the group of young Black men. Particularly, reckless and self-endangering behaviors and violence towards others rooted in anger and disregard for one’s self and others was recognized by many of the men in the sample as externalized symptoms of depression (Brownhill et al., 2005).

Unique manifestations of depression among European and Black men highlight the importance of continuing to explore the differences of depression perception, experiences, and expression generally among men and specifically young Black men. The manner in which depression manifested and expressed is especially significant because increased mortality is associated with undiagnosed and untreated depression (Probst, Laditka, Moore, Harun, & Powell, 2007). Particularly as it relates to risk for suicide, major depression serves as the underlying cause for more than one-half of all attempts of individuals to take their own life (Emslie et al., 2006). Early adulthood is a significant risk factor for depression as well as suicide (Watkins et al., 2006). Adults in their mid-20s are most likely to experience their first depression episode and this may be further complicated by increased mortality associated with suicide, the third leading cause of death among all young Americans age 15-24 (National Institute of Mental Health, n.d.). Finally, researchers found experiences of

depressed mood to be more prevalent among young Black adults, when compared to Whites and Asian Americans (Gore & Aseltine, 2003). The increase in symptomatology is associated with the transition from high school into early adulthood and is the result of intersections of race and class disparities for young Blacks (Gore & Aseltine, 2003). Particularly, diminished prospects for gainful employment and/or education, for Blacks, were found to contribute to depressed mood thereby highlighting the significance of social structures and their impacts on mental health (Gore & Aseltine, 2003).

It may be that conscious and unconscious rejection of depression symptom experiences by Black men contributes to the underreporting of symptoms in epidemiological studies on depression. With the exception of very few studies, most literature indicates that Black men are at no greater risk for depression or other clinical psychiatric disorders (Watkins et al., 2006) yet they are disproportionately exposed to the environmental and social hazards that have been consistently found to contribute to psychological distress and depression outcomes in other ethnic groups (Graham & Gracia, 2012). To date, there have been no psychometric studies of the CES-D or BDI in young Black men. There is a need to examine the limitations of these depression measures with regard to the inclusion of language that captures relevant expressions of depression symptomatology in this vulnerable group. Understanding the convergence of depression symptom screening and the unique expression and perceptions of depression in young Black men is integral to understanding the complexities of this mental illness as well as advancing the efficacy of screening in this population.

Depression Screening

The most recently published version of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) identifies that gender and cultural variations may contribute to the under and misdiagnosis of depression across populations. However, the manual lacks discussion of cultural variations in depression symptomatology for Blacks and/or males despite inclusion of Asian, Latino, and Middle Eastern cultural differences in depression experiences (American Psychiatric Association [DSM-IV-TR], 2000). Risks associated with female gender receive considerable attention in the manual. However, there is no acknowledgement of the influence of socioeconomic status, despite its well-established inverse relationship with depression (Schulz et al., 2000; Latkin & Curry, 2003; Gary et al., 2007). Many large-scale investigations of depression and related social variables in inner-city environments utilize measures of depression based on the diagnostic criteria included in the DSM (Silver et al., 2002; Matheson et al., 2006; Latkin & Curry, 2003; Curry et al., 2008). The lack of acknowledgement of the critical influences of socioeconomic status, on depression, by institutions responsible for setting the criteria for diagnosis suggests a need for increased scrutiny for cultural sensitivity of the instruments used to screen for depression in economically challenged communities.

The Center for Epidemiologic Studies-Depression Scale (CES-D) and the Beck Depression Inventory (BDI) are self-report surveys widely used to measure depression symptom severity in community populations for epidemiological reporting. The following provides a psychometric evaluation of reliability and validity of these measures for depression in diverse populations and with regard to gender.

Centers for Epidemiologic Studies Depression Scale

Epidemiological studies of depression over the past ten years have increased public health and clinical knowledge about the prevalence of illness and the effectiveness of therapeutic modalities (Patten, Bilsker, & Goldner, 2008). The Diagnostic and Statistical Manual of Mental Disorders—Fourth Edition (DSM-IV) has been the primary force in driving diagnosis based on symptomatology for depression (Patten et al., 2008). Previous editions of the DSM have served as a guide for development of several of the most widely used depression screening measures used in epidemiological studies of the subject.

Radloff (1977) developed the CES-D for use in epidemiological studies of depressive symptomatology in the general public. The measure places particular emphasis on the assessment of depressed mood. The CES-D is based on common symptoms used to clinically diagnose depression in healthcare settings (Radloff, 1977); symptomatology that is explicitly included in the DSM (American Psychiatric Association [DSM-IV-TR], 2000). For example, questions about depressed mood, diminished interest or pleasure, psychomotor agitation, insomnia, and appetite disturbance are all contained on the CES-D and within the criteria for major depression, as described by the DSM (American Psychiatric Association [DSM-IV-TR], 2000; Radloff, 1977). The instrument contains 20 items with scores greater than 16 indicative of mild to moderate depression (Radloff & Locke, 1986). Initial studies of the validity of the measure employed content, criterion, and construct validity methods; examination of reliability of the CES-D was based on test-retest performance and replication (Radloff, 1977). Early field tests of the CES-D, which included both quantitative survey methods and qualitative one-to-one interview techniques, utilized a sample obtained by using random sampling techniques. However, it was acknowledged that men and those with less

education were underrepresented in these initial tests. Revisions of the CES-D, based on field test results, were further tested in two additional separate follow-up surveys in the same geographic regions (Radloff, 1977). In addition to the three aforementioned preliminary tests with participants from non-clinical settings, samples from both in-patient and out-patient psychiatric setting were given the CES-D on 3 separate occasions. The findings from these initial tests of construction were reported with regard to the White members from each of the samples. Presentation of Whites only findings from the field tests was rationalized according to the need to make the samples comparable across each of the periods of data collection (Radloff, 1977). In order to assess for generalizability of findings across gender, age, race, and education the small percentage of nonwhite participants, included in the first two field tests, were combined and compared to the clinical patient group.

The findings from the initial test results from the Whites only sample showed that the items were acceptable among the participants and that internal consistency was .85 in the community and .90 in the patient samples; the test-retest correlations were moderate at .70 in the Whites only sample (Radloff, 1977). With regard to validity, correlation of CES-D scores and nurse-clinician assessment findings were .56, a moderate relationship. In addition, 70% of the clinical sample and only 21% of the community sample scored above the cut-off. The findings of reliability across subgroups of varying gender, race, age, and education level resulted in coefficient alphas of .80 or above all the subgroups; however, test-retest reliability were low, less than .40 for Blacks, and individuals under age 25 (Radloff, 1977). These findings highlight an inconsistent performance of this screening measure in young Blacks; those of whom are particularly socioeconomically vulnerable.

There are numerous concerns regarding the selection of participants included in the initial tests of reliability and validity of this measure. First, the diversity of the sample is not reported in the original report published by Radloff (1977). The author refers the reader to an additional report by Comstock and Helsing (1976) for information regarding the demographical representativeness of the sample; the final sample from this large epidemiological study was approximately 7% Black and 93% White. Also, the final sample was 58% females (58%). The techniques used to assess for generalizability across diverse subpopulations involved the comparison of community and clinical samples, which are presumed similar on the basis of diversity with regard to race, age, gender, and education but not with regard to the influences of the social context of their residences and disease states, both significant variables. These differences severely limit the transferability of findings.

Since the development of Radloff's (1977) original work with the CES-D it has widely used in numerous studies of depression and its correlates, all over the world. Many epidemiological studies that use the CES-D to measure community depressive symptomatology in economically disadvantaged and dangerous neighborhoods find a significant incidence among women/girls in the sample (Curry et al., 2008; Fitzpatrick, Wright, Piko, & LaGory, 2005; Menke & Flynn, 2009; Silver et al., 2002; Latkin & Curry, 2003). This finding is fairly consistent as well as expected by researchers and as such is usually not further explained.

Variance in ethnic diversity, in addition to gender, affects responses and overall performance of the CES-D for groups participating in neighborhood depression epidemiological studies. The effectiveness of depression measurement across cultures has been discussed extensively. Reliability and validity of the CES-D has been examined in

various community dwelling Asian and Black cultures. Korean and Japanese translations of the CES-D have been developed and tested (Demura & Sato, 2003; Noh, Kaspar, & Chen, 1998). Findings from the assessment of a translated CES-D in a sample of Japanese adults highlight inconsistent performance of factor structures and subscale reliability (Demura & Sato, 2003). The reliability of each of the four CES-D subscales was assessed using Cronbach's alpha. The physical symptoms subscale had the highest reliability, although a moderate score (0.74) (Demura & Sato, 2003). The remaining scales depressive affect, positive affect, and interpersonal all had reliability < 0.64, reflecting poor reliability (Demura & Sato, 2003). These reliability scores indicate that the questions reflecting each of these factors do not consistently measure the corresponding attribute of depression (Polit & Beck, 2008). However, the CES-D in its entirety had an acceptable coefficient alpha of 0.81 (Demura & Sato, 2003). While the findings from this psychometrics study are promising, inconsistent performance of the stand-alone sub-constructs of depression highlight cultural differences in interpretations of depressive symptomatology that veer from the original work conducted by Radloff and Locke (1986).

Another study examined a Korean translated CES-D in a random sample of 1,039 Korean adults, age 18 or older. Overall performance of the depressive subscales in the Korean sample was mostly similar to previous studies with Americans samples; the internal consistency alpha of .89 was acceptable (Noh et al., 1992). However, it is worthy to note that the Positive Affect subscale correlated poorly with the CES-D, in its entirety; correlation scores ranged from 0.10 to 0.47 (Noh et al., 1992). The sample was less likely to endorse experiences of positive affect and as such resulted in increased CES-D scores for group. These ethnic differences in subscription to depressive sub-constructs contained on the CES-D

indicate that other groups may experience similar alterations in reporting of symptom severity.

Finally, one recent study assessed psychometric performance of the depression measure in a clinical and community sample of 723 Black men in their 60's (Love & Love, 2006). Depressive Affect and Somatic symptoms merged into one factor for the group, instead of two. This suggests that physiological and emotional symptomatology resulting from stressors is enmeshed and expression of either is may be associated with depression. Further, crying responses a component of the Depressive Affect factor was found to attribute to Interpersonal Distress (Love & Love, 2006). For many men, attributes of crying as a perception of interpersonal distress is likely reflective of restrictive emotionality (Love & Love, 2006). In this sample, crying was perceived most disruptive to social functioning of relationships, and less an emotional or somatic expression of sadness associated with Depressive Affect. Overall, the findings from this psychometrics study highlight the uniqueness of experience, perception, and expression of depression in Black males, albeit an elderly sample. Evidence of psychometric inconsistencies of the CES-D with Asian populations and older Black men indicate possibilities that such inconsistencies exists in other cultures. Differences in perception and recognition of common symptoms, according to cultural membership, can seriously impact reporting of depressive severity and ultimately affects incidence estimation. The sensitivity of this measure warrants further investigation as the questions are patterned primarily according to DSM criteria, as are the questions contained on the Beck Depression Inventory (BDI) another widely used depression scale.

Beck Depression Inventory

The Beck Depression Inventory, developed in 1979, has been widely used to detect the presence and severity of depression in clinical and non-clinical samples of adult and adolescent populations (Beck, Steer, Ball, & Ranieri, 1996). It has recently been revised to make it more consistent with the diagnostic criteria of the DSM. Specifically, with regard to the time frame for measurement of symptoms, the period has been expanded from one week of symptoms to two weeks (Beck et al., 1996). In addition, symptomatology included on the survey has been altered to reflect bidirectional fluctuations of depressive symptoms including increases and decreases in appetite, weight, and sleep (Beck et al., 1996). The second edition of the BDI was published in 1996 and contains 21 items; each item is rated on a 4-point scale ranging from 0 to 3 with a score of 20 considered moderate depression (Beck et al., 1996).

The instrument was initially tested in clinical and non-clinical samples. The psychometric analysis yielded Somatic-Affective and Cognitive factors results for the clinical sample and Cognitive-Affective and Somatic factors in the non-clinical student-based sample. A Somatic-Affective factor is represented by retarded physiological effects associated with depression including fatigue, decreased energy, irritability, decreased libido, and changes in appetite (Dozois, Dobson, & Ahnberg, 1998). The Cognitive-Affective factor is represented by both individual perceptions and emotions commonly attributed to individuals with depression. These include feelings of self-dislike, pessimism, indecisiveness, sadness, suicidality, self-dissatisfaction, guilt, work difficulty, and social withdrawal (Dozois et al., 1998). The original psychometric analytic results for the BDI-II are detailed in the Beck Depression Inventory Manual (2nd ed.). The results from these tests established content and factorial validity and showed high reliability of the measure with a

coefficient alpha of .93 in college students and .92 in outpatient (Dozois et al., 1998). Subsequent exploratory and confirmatory factor analyses of the BDI and BDI-II have been conducted to validate the original factor structure and its generalizability across gender groups (Dozois et al., 1998). A predominantly female (67%) and Caucasian (79%) sample of 1,022 psychology students was used to conduct the psychometric validation study (Dozois et al., 1998). Upon initial assessment, high internal consistency was noted for the entire score of participants; coefficient alphas of .89 and .91 for the BDI and BDI-II were obtained respectively. To examine the factor structure of the BDI and BDI-II, the sample was randomly divided into two groups that were found to have no statistically significant differences; the first group provided the factor structure results and the second group was used to cross-validate the results (Dozois et al., 1998). The factor structure results for the BDI-II were highly congruent with the factor structure of the BDI. The Cognitive-Affective and Somatic factors accounted for 41% of the variance in the BDI responses while Cognitive-Affective and Somatic-Vegetative factors accounted for 46% of the variance in BDI-II responses (Dozois et al., 1998). Confirmatory factor analysis was used to confirm the two-factor structure identified in the exploratory factor analysis. The two-factor structure was found to be an adequate fit for the data based on the results of the goodness-of-fit index (GFI = .91) and adjusted goodness-of-fit index (AGFI = .88); with desirable results being greater than .90 (Dozois et al., 1998). With regard to generalizability, no significant differences were found between male and female mean scores for the BDI-II. Further, the two-factor structure was confirmed in both gender groups (Dozois et al., 1998). However, these findings are restricted to non-clinical academic samples of undergraduate students.

Thus, a predominantly White female college-student sample significantly limits generalizability to the broad population.

Grothe et al. (2005) conducted a validation study of the BDI-II in a clinical sample of low-income Black adults. A well-balanced sample of men and women ranging in ages from 20 to 81 years were recruited from the waiting rooms of a medical clinic. Factorial validity, reliability, and criterion validity analyses were conducted in order to examine the validity of the BDI-II. The internal consistency of the total score was high, with a coefficient alpha equal to .90 (Grothe et al., 2005). The Cognitive and Somatic Factors were also found to demonstrate high internal consistency in the sample, with alphas equal to .81 and .87 respectively (Grothe et al., 2005). The factorial validity findings echoed those of the previous analysis of White clinical samples (Beck et al., 1996); Cognitive, Somatic, and Depression factor structures emerged from the sample data (Grothe et al., 2005). Criterion validity was established by comparing BDI-II scores of clinically diagnosed patients with major depression to BDI-II scores of patients without major depression. The scores of patients with major depression were significantly higher ($p < .01$) than those of patients without depression (Grothe et al., 2005). The BDI-II has been found to be a reliable and valid screen for depression in clinical sample of Blacks with low socioeconomic status. However, the mean participant age of 49 years and absence of discussion with regard to gender differences in scores restricts generalization of findings to middle age Black patients seeking medical attention.

Clinical Implications of Depression Screening

Research into the intricacies of how young Black men interact with the dominant society and depressive outcomes are warranted in response to the staggering social disparities experienced by this population. However, the methods currently employed to identify depression in large samples mostly indicate that this debilitating illness is a non-issue. Unfortunately, social influences of racism, discrimination, profiling, and harassment continue to impact young Black men today. Further, variant experiences of under-education, unemployment, and poverty further impair the self-efficacy of these young men; and these experiences are not without consequence. There are psychological, physiological, and sociological manifestations of depression that are unique to this population. While intersections of race, gender, and class impact experiences as well as expressions of depression in this group, the current DSM provides no specific guidelines or diagnostic criteria for this group. This deficit serves as a springboard for future research. Practitioners should carefully consider the assessment, history, and diagnostic measures used for identifying depression in urban young Black men. Specifically, with regard to past legal/justice experiences, employment status, and substance abuse a current and detailed history may provide better insight into the emotional health of these young men. This is especially important as depressive affect and somatic symptoms may be masked by restrictive emotionality, common among Black male subpopulations (Hammond, 2012; Majors & Billson, 1992). Culturally appropriate understandings and subsequent enhanced screening based on these understandings will uncover the true incidence of depression and depressive symptoms within this population. As a result, more attention can be directed toward the development of effective intervention(s) and increase scrutiny of the larger

socioeconomic and political structures that continue to oppress and largely impair this population.

Chapter 3

METHODOLOGY

This chapter describes the approach that was used to answer the three research questions:

1. What are the experiences and perceptions of depression among young Black men who have a history of felony conviction?
2. What are the perceived social consequences of exhibiting depression symptoms?
3. How do depression themes from interviews with young Black men with history of felony conviction compare to constructs of the CES-D?

A description and rationale for the selected research approach is presented first. Sampling methods and procedures are then discussed, followed by a description of data generation, analysis, and interpretation techniques and processes. Finally, validity and rigor and the fashion in which it will be demonstrated throughout the conduct of this research is discussed.

Research Design

Qualitative research has, at its core, the purpose of “intimately connecting context with explanation” (Mason, 2002, p. 1). The qualitative researcher is afforded the opportunity to capture the stories and life experiences of individuals (Creswell, 2007). Qualitative research is defined or associated with postmodern approaches to inquiry that are grounded in discourse and content analysis (Mason, 2002). It differs from quantitative or scientific methodologies in that a naturalistic paradigmatic perspective provides a context for understanding human problems and experiences (Polit & Beck, 2008). A naturalistic paradigm emphasizes a close relationship between the inquirer and the participant because it

is believed that the ability to generate knowledge is optimized when there is less distance between the researcher and that which is being studied; this is in opposition to the positivist paradigm associated with quantitative research methods (Polit & Beck, 2008). Further, a naturalistic paradigm also connotes a constructivist perspective. Constructivism values disassembly of old ideas and structures and reconstruction of new ideas, structures, and interpretations (Polit & Beck, 2008). A qualitative approach to querying the experiences and perceptions of depression in young Black men affords for an appreciation of historical and current societal structures that may impact the lives of these young men. It further allows for communication and construction of unique and yet significant elements of perceptions of mental illness that create a picture for interpretation that ultimately contributes to better understanding of individual struggles, barriers, and aspirations.

Qualitative researchers make key decisions concerning research strategies with regard to experience and contextual forces (Mason, 2002; Braun & Clarke, 2006). Ongoing analysis of data and flexibility in design are characteristics common to most qualitative strategies (Polit & Beck, 2008). This study used a thematic analytic strategy to arrive at answers to the research questions. Thematic analysis is further described in the analysis section. During data collection, concurrent analyses of experiences and perceptions of depression among participants may necessitate any number of adjustments to the interviewing strategy and lines of questioning during the conduct of the study. Finally, intense involvement of the researcher that “requires the researcher to become the research instrument” is readily applicable to this study (Polit & Beck, 2008, p. 219). Particularly, with regards to interviewing young men and patterns of self-presentation that may echo hegemonic masculinity necessitates meaningful and significant efforts on the part of the researcher and

participant to establish a rapport and trust that is capable of circumventing potential problems during interviews (Gubrium & Holstein, 2001).

Rationale

Thematic analysis was chosen as the most fitting method for this study for the following reasons:

1. Little research has been done to understand unique perspectives about depression held by vulnerable Black men. Conceptualization and organization of themes pertaining to depression perception can be generated via a qualitative interview approach.
2. Uncovering what depression is and its consequences as perceived by young Black men is invaluable knowledge for clinical practitioners and provides insight for more accurate assessment of atypical depression in this population.
3. Thematic analysis can serve as a useful first-step in research trajectories that have ultimately focused on instrument development and development and testing of interventions to improve mental health outcomes.
4. The product of thematic analysis is a minimally organized and yet richly descriptive and interpretive summary of the data (Braun & Clarke, 2006). The results contribute to the knowledge base of perceptions of depression from this vulnerable population. Ultimately, knowledge of emotionality and depression in this population can inform interventions aimed at enhancing the mental health of this population with considerations for relevant variances in contextual influences and definitions of depression.

Sampling Methods and Procedures

Twenty participants were recruited from a Midwestern agency and invited to volunteer to participate in this study. The agency serves a 'community bridge' program for formerly incarcerated men, providing social resources and job training. The Principle Investigator (PI) discussed her professional background and the study details during the daily morning assembly. Individuals who were interested in participating in the study submitted a signed notecard (Appendix A) declaring interest to a designated agency employee. The agency employee worked with the PI to schedule the interview date and time.

Sample size in qualitative research depends on a number of factors related to data collection and analysis. One primary goal in qualitative sampling is to achieve redundancy in the concepts that emerge inductively from the data however the purpose of the study, methods, and resources also impact the final sample size decision (Sandelowski, 1995). In addition, sampling that is purposeful with regard to demographic homogeneity and phenomenal variation permits a lone researcher to reduce the minimal number of participants and still achieve credible results (Sandelowski, 1995). The scope of the study is a final consideration for determination of sample size (Morse, 2000). Because the research questions were narrowly focused on perceptions of depression, and this is easily obtained in interviews, fewer participants were needed (Morse, 2000). In a recent review of 560 qualitative PhD studies Mason (2010) found a mean sample size of 31 participants. For this study, participant interviews were conducted until redundancy of themes was reached. Thus, a sample size of 20 to 30 participants was anticipated to reach repetition of themes. Inclusion criteria for participants were: a) self-identifying Black males; b) age 18 to 35 years, and who; c) have been incarcerated, and released, within the previous 12 months. The

vulnerability associated with felony status made young Black men with this history an appropriate population to recruit for this study of how depression is experienced, communicated, and lived.

Data Generation

Individual face-to-face semi-structured interviews were used to elicit responses to the research questions. Interview methodology is a popular means of gathering qualitative data in research. Specifically, semi-structured interview guides are commonly used for interviewing in qualitative studies and include predetermined open-ended questions and possible probes (DiClicco-Bloom & Crabtree, 2006). The interview questions (Appendix B), typically 5 to 10 in number, should be specific enough to delve deeply into the aspects of the phenomena under investigation and yet should remain flexible and amenable to the spontaneity of unplanned follow-up questions that may further clarify the conversation (DiClicco-Bloom & Crabtree, 2006). Individual interviews necessitate that the selection of interview participants be homogenous with regard to certain characteristics as it relates to the research question. Rapport should be established at the outset of the interview process because it is essential to the development of a safe and comfortable environment for sharing of the interviewee's experiences and perceptions (DiClicco-Bloom & Crabtree, 2006).

It is necessary that the interviewer remain sensitive to their influence and power over the interviewee and the bias that this may impose on the collection of data. Whenever possible, integration of reciprocity in the relationships via sharing of information in response to the questions of participants is desired as it may serve to balance power and reduce the hierarchal nature of the interviewer over the interviewee (DiClicco-Bloom & Crabtree,

2006). The nurse, as an investigator, is thought to be compromised with regard to objectivity and thus the establishment of trust may be achieved by an interactive process of listening, learning, testing, sharing, and sense of bonding (DiClicco-Bloom & Crabtree, 2006).

Methodological techniques that require consideration when using individual interview data collection methods include strategies for putting the participant at ease and establishing trust. Logistical considerations such as planning ice-breakers and up-front “small talk” and placing voice-recording equipment out of sight of the participant can help to establish rapport (Polit & Beck, 2008). Other concerns include anticipatory planning for the possibility of strong emotions such as fear, anger, and grief from the participant that could be elicited by discussing sensitive and emotional topics. Providing a calm environment for the interview can place these emotions in a cathartic light rather than a stressful one. Other potential problems include equipment failures or interruptions from outside sources. Problems such as these can be mitigated by note taking during and immediately post interview and preplanning for a quiet and distraction free environment (Polit & Beck, 2008). The experience and ability of the transcriber is an additional concern and thus care should be taken to ensure that important details such as participant tone, spelling, and interview flow are appropriately captured in the transcripts (Polit & Beck, 2008). Further, the maintenance of anonymity by the PI is priority to the ethical integrity of the study (DiCicco-Bloom & Crabtree, 2006).

Procedures

Audio-tape recorded interview sessions were held in a private and distraction-free room within the recruiting agency. At the start of the interview session a script reviewing the purpose of the study and informing the participant of his rights as a research subject was read

(Appendix C); verbal consent was obtained at this time. Continued participation in the interview implied ongoing consent; however, the participant was informed that he may stop the interview and terminate participation in the study at any time. After consent, demographical but non-identifiable questions were asked (Appendix D). The interview proceeded and upon its conclusion the participants received fifty dollars cash compensation for their travel, time, and any inconveniences imposed as a result of participating in the study; a receipt was signed by participants as evidence of compensation (Appendix E). Cash was provided due to the ease of use for participants and it prevented incurring extra fees and endorsing any establishment associated with purchasing of merchant gift cards. All interview recordings were transcribed into written reports by a professional transcription agency (Appendix F).

Analysis

Analysis of interview data occurred while data was being collected in order to support an emergent understanding of the first three research questions (DiCicco-Bloom & Crabtree, 2006). This approach allowed for the recognition of recurrent themes in the data, or the point at which no new categories were gleaned from the interviews (DiCicco-Bloom & Crabtree, 2006). Interview transcripts were checked against the original audio recordings to ensure accuracy. Reflexive notes were made in the margins of the data transcripts. Structural descriptions of stories captured in interviews were chronologically organized according to the shared experiences of participants. Common themes and structural similarities relative to context, history, and experiential similarities were gleaned manually, at first, and then subsequently verified by the use of qualitative data organization software Nvivo 10.

Thematic analysis necessitates that the researcher give credence to the inductive versus deductive approach to coding and analysis of data (Braun & Clarke, 2012). Often however, both approaches are used as the researcher is unable to remain completely uninfluenced by a priori theoretical notions, as in deductive approach, nor the semantic content of the data, as in an inductive approach (Braun & Clarke, 2012). A primarily inductive-oriented thematic content analysis style was used to answer the first 2 research questions. This style of data analysis begins at the level of the raw data generated from individual interviews and then progresses toward broadened interpretations of common themes and overall structure shared by research participants (Creswell, 2007). However in order to answer research question three, constructs of the CES-D offered a deductive-oriented perspective as emergent codes were assigned and organized into thematic statements that both supported and contradicted CES-D constructs.

Lastly, interpretations of the overall meaning gleaned from the aggregate interview data was used to inform the discussion of the overall perceptions of depression held among the group. Interpretation of data was guided by the perspective that ‘understanding’ is subject to the values, experiences, and background of individuals (Koch, 1999). Awareness of the influence of individual experience presents an opportunity for interpretative processes that welcome and account for the backgrounds of the interpreter and participant (Koch, 1999).

Rigor

Generating understanding of situations that would otherwise be considered perplexing and confusing is the purpose of qualitative research (Golafshani, 2003). Ensuring that the

methods used produce quality and worthwhile results are as of priority importance for qualitative researchers as they are quantitative. Strategies to ensure rigor in qualitative research are much debated with regard to reliability and validity of results, as these are commonly desired attributes of quantitative research (Golafshani, 2003). However, elements of credibility, transferability, dependability, and confirmability of qualitative research, attributes of trustworthiness, serve as an alternative to reliability and validity and are a paradigmatic-appropriate means of ensuring rigor in qualitative research.

Credibility has been an established priority goal and consideration when developing qualitative research studies (Polit & Beck, 2008; Lincoln & Guba, 1985). An element of trustworthiness, “credibility refers to confidence in the truth of the data and interpretations of them” (Polit & Beck, 2008, p. 539). Several strategies to increase the credibility of study findings include prolonged engagement, persistent observation, and triangulation (Lincoln & Guba, 1985).

The stability of qualitative data over time and conditions, or dependability, is another criterion for assessment of trustworthiness of qualitative inquiry (Lincoln & Guba, 1985). One approach for ensuring dependability of findings is that of the inquiry audit (Lincoln & Guba, 1985). The tasks of inquiry audit, conducted by the chair of this dissertation committee, included an examination and corroboration of the *process* as well as the *product* of the inquiry (Lincoln & Guba, 1985). Specifically, aspects of the data collection procedures and in addition the findings, interpretations, and recommendations made from the data were the concern of the dissertation chair and committee. Their support, review, and guidance serves as a testament to the dependability of findings.

Confirmability or the degree to which there is congruence between different individuals regarding the accuracy of the data, its meaning, and its relevance is another consideration (Polit & Beck, 2008). Confirmability of findings, like dependability, can be determined via auditing elements of the inquiry (Lincoln & Guba, 1985). In addition, the priority concern of the PI was that the interview findings “reflect the participants’ voice and the conditions of the inquiry, and not the biases, motivations or perspectives of the researcher” (Polit & Beck, 2008, p. 539). In order to achieve this goal, the researcher conducted periodic member-checks. According to Lincoln & Guba (1985) “The member check, whereby data, analytic categories, interpretations, and conclusions are tested with members of those stakeholding groups from whom the data were originally collected, is the most crucial technique for establishing credibility” (p. 314). This strategy was used to assess the correctness of interpretation and meaning of verbal and nonverbal communications during the interview (Lincoln & Guba, 1985). For example, data from one interview was recounted, by the PI, for a different participant who was then asked to comment (Lincoln & Guba, 1985).

Transferability of qualitative study findings is a final concern and attribute of trustworthiness to be considered by the researcher (Lincoln & Guba, 1985). Comparable to generalizability of quantitative findings, transferability represents the extent to which findings generated from qualitative study is applicable in other settings or groups (Polit & Beck, 2008). The strategy to aid in transferability of findings originates in data collection techniques and the richness of description of the context in which participants communicate their story (Lincoln & Guba, 1985). The PI made a substantial effort to elicit considerable contextual details and elements from participants, during the interview, in order to aid in

future decisions of transferability of findings. It was the goal that, upon dissemination of findings from this study, readers would be able to determine whether or not a transfer of findings is appropriate.

Reflexivity

Another consideration that is an important and alternative strategy for validation of findings gleaned from qualitative methods is the reflexive actions taken by the researcher prior to and during data collection (Lincoln & Guba, 1985). Reflexivity and its corresponding activities provide insight into the baseline stance of the researcher. The reflexive journal that might include the daily schedule and logistics of the study, a personal diary, and a methodological log are a record available for auditing that reflect the degree to which the inquirer's biases influenced the outcomes, more or less (Lincoln & Guba, 1985). The PI maintained a reflexive journal for the purposes described above; this journal was shared with committee members.

Limitations

Several limitations and challenges are posed when implementing a qualitative approach in a research study. For example, willingness of participants to engage with and trust the researcher is a priority concern. Rapport was supported by providing participants with the background and experience of the PI as a mental health nurse during the daily morning assembly. Another significant limitation is that transferability of findings will be limited to young Black men with felony record. However, this population was selected because, although unfortunate, it is representative of a large proportion all Black men. Thus, the findings and the implication of findings are useful for a substantive subpopulation of

Black men that are likely to be negatively impacted emotionally by the consequences of felony status.

Further challenges to qualitative approaches concern the need to collect extensive information from participants and the interpretation of those accounts by the researcher (Creswell, 2007). The need for the researcher to actively work both collaboratively and reflexively with the participant aids in capturing the readily apparent as well as underlying story and context of the phenomenon. In addition, the analysis should be conducted with careful consideration for reflexive influences in interpretation.

Human Subjects Protections

The study devoted appropriate attention to the protection of human subjects. Institutional approval from the University of Missouri-Kansas City was obtained prior to any data collection (Appendix G). Further, expressed permission was obtained from the agency that agreed to assist the PI by referral of potential participants (Appendix H).

Twenty participants that were employed in a community 'bridge' program were interviewed. These individuals possessed the characteristics for inclusion including being a self-identified Black male, age 18 to 35 years, and recently released from jail within the past year. As these individuals were considered vulnerable, the appropriate precautions were taken as to minimize the risk incurred from participating in this study.

Data collected from participants was recorded in the form of digital recordings of interviews and field notes collected of these interactions. This data reflected the experiences and perceptions of depression as well as perceptions about the social consequences of depression. Demographic data collected included but was not limited to age, income,

education, employment, and duration of incarceration. Only the PI had access to data collected from participants. All computer files, including uploaded digital recordings and depression screening data, was stored on a password-protected computer and accessible only by the PI. Digital media used by the recorder was erased following each upload. Participants were assigned pseudonyms for any reference to individuals in publication.

Potential risks to participants included psychological distress as a result of discussion of depression. In the event that participants became visibly emotional or display behaviors associated with suicidal ideation during the interview, the PI further assessed these risks and provided an immediate referral for mental health care services. Potential benefits to individual research participants were minimal, but may have included a greater sense of mental wellness derived through their reflection on past experiences during interviews. Participants may have also derived satisfaction in contributing to a knowledge base that has the potential to benefit other Black men who have been adversely affected by incarceration. Benefits to the practice of nursing were expected through the advancement of knowledge about the language of depression used by young Black men and the utility of commonly used depression screens.

CHAPTER 4
STUDY MANUSCRIPT¹

Abstract

One in three Black men in the U.S. faces difficulties obtaining employment, housing and maintaining self-sufficiency post incarceration. Felony records result in considerable social and economic vulnerability, placing many young Black men at risk for depression. Little is known about depression in Black men with felony records. Twenty Black men with a history of incarceration were interviewed to explore perceptions and experiences of depression. Emergent themes were anger and negativity, depression is weakness, invisible depression, being strong and going on, and our depression is different. Findings have implications for clinicians who initiate ongoing therapeutic relationships with young Black men.

Introduction

Despite widespread poverty, poor education opportunities, high unemployment rates, and widespread incarceration among young Black men in major cities across America, little is known about their mental health (Kendrick, Anderson, & Moore, 2007). Available research indicates that among Black men residing in some of the largest and harshest inner-city environments in the United States (US) depression is uncommon (Curry, Latkin, & Davey-Rothwell, 2008; Silver, Mulvey, & Swandon, 2002; Latkin & Curry, 2003). A well-established inverse relationship exists between low socio-economic status and depression that is contradicted by research findings about Black men (Aneshensel, 1992). Several studies

¹ This chapter was prepared in partial fulfillment of the requirements for a manuscript-format dissertation submitted for publication in 2013.

reported low rates of depression among community samples of young Black men living in poverty in disadvantaged neighborhoods (Curry et al.; Silver et al.; Latkin & Curry).

Depression measurement has typically been based on traditional clinical definitions and symptomatology of depression (Kim, 2010). Measures such as the Center for Epidemiologic Studies Depression Scale (CES-D) were developed for use in community settings to assess frequency and severity of classic depression symptoms such as crying, loneliness, sadness, feelings of fear, and difficulty completing daily tasks (Radloff, 1977). However, this measure and others like it were “initially developed and tested for European Americans” (Kim, p. 28).

Researchers who have recently conducted studies focusing on the uniqueness of depression expressions have noted that men’s experiences of depression often differ from traditional clinical symptoms (Branney & White, 2008; Brownhill et al., 2005; Rochlen et al., 2010). For example, risk-taking behavior, including deliberate self-harm, anger, sexual indiscretions, and drug and alcohol abuse, are much more common among men than women (Brownhill et al., 2005). Risk taking behaviors are a more acceptable manifestation of depression among men when compared to women who more commonly display depression through expressing emotion, feeling powerlessness, crying, and feeling lack of control (Emslie et al., 2006). Furthermore, diagnostic criteria for depression on traditional depression screening tools such as the Center for Epidemiologic Studies-Depression Scale (CES-D) do not include items that reflect risky behaviors that are common for men (Branney & White, 2008; Brownhill et al., 2005).

Background

Scant literature exists to aid in understanding of depression among young Black men. Further, little is known about how the symptomatology included on depression screening measures substantiates the realities of this population. Most depression studies have examined epidemiologic and predictive variables, including self-esteem, racial-identity, racism, parenting style and gender-role conflict (Kogen & Brody, 2010; Mahalik, Pierre, & Wan 2006; Pierre & Mahalik 2005; Pieterse & Carter, 2007; Wester, Vogel, Wei, & McLain, 2006). Epidemiological studies that have examined prevalence of depression in residents of economically depressed areas, primarily inner-city communities in the U.S., compared depression among subgroups residing in the area. Gary, Stark and LaVeist (2007) and Schulz et al. (2000) reported higher psychological distress, depression, and anxiety in White people who reside in high poverty inner-city neighborhood than Black inhabitants in the same area. Similarly, Curry, Latkin, and Davey-Rothwell, (2008) and Silver, Mulvey, and Swanson, (2002), and Matheson et al., (2006) examined the prevalence of depression in large poor inner-city communities. In these studies, researchers found that women experienced depression at statistically significant higher rates than men and that, overall, men were at a lower risk for depression. However, the instruments used to measure depression symptom severity in the aforementioned studies were based on traditional depressive symptomatology. Moreover, the researchers did not address the cultural validity of instruments used to screen for depression when they discussed limitations of findings. As a result of this oversight, a low incidence of depression for men reported in epidemiological studies negatively impacts further research and intervention for this group.

Despite the findings from epidemiologic depression research, a reality for men and specifically young inner-city Black men, is that there are psychological consequences for their social and economic situations (Hooks, 2004). Findings from Kendrick et al. (2007) ethnographic study of perceptions of depression in 28 community-dwelling young Black men 18 to 25 years of age suggests that epidemiologists may be missing something in assuming that young Black men are at low risk for depression. Participants often used the word “stress” rather than “depression” when describing their response to various situations or experiences. Many of the young men described their stress as normal and mostly tolerable, but for some “being Black in this society is always a stress that eats away at your soul” (Kendrick et al., p. 68). Participants shared experiences of being stereotyped as athletically talented but academically unintelligent, which contributed to feelings of depression or stress, by the young men (Kendrick et al.). The young men also identified the constant threat of harassment by law enforcement as a source of stress; most participants shared experiences of profiling, targeting, and negative interactions with police (Kendrick et al.). Ultimately, the young men in the study were clear that depression was unique for Black men and that a traditional medical definition of depression was not applicable to their experiences. The constant battles associated with being young, Black, and male and the resultant psychological distress were a reality that, to them, necessitated coping rather than an acknowledgement of depression. In other words, depression was a ‘fact of life’. This study provided insight into the unique impact of gender, race, and culture, on depression. However, few additional studies validate or expound on these findings.

Incarceration of young Black men in America has steadily increased over the previous 30 years despite bidirectional fluctuations in crime statistics (Alexander, 2010).

Approximately 30% of all young Black men ages 20 to 29 years have a history of incarceration (Community Voices, 2003; Tonry & Melewski, 2008). Post-incarceration social exclusion, in the form of discrimination from housing, education, and employment opportunities and voter disenfranchisement, pose significant and lasting threats to individual productivity and mental health, as well as community cohesion (Alexander; State Felon Voting Laws, 2012). Discrepancies between life in an oppressive environment and low rates of depression found when screening Black men leads to several questions: What are indications that young Black men experience depression? How do young Black men experience and manifest depression (Perkins, 2013)? To begin to address these gaps in the literature, the aim of this study was to explore the experiences and perceptions of depression among young Black men with a history of incarceration; a population who are at risk for mental illness due to their social and economic vulnerability.

Method

A semi-structured interview with thematic content analysis was chosen for this study because minimal research was available to aid in understanding the unique perspectives about depression held by the target population. The product of thematic analysis is a minimally organized and yet richly descriptive and interpretive summary of the data (Braun & Clarke, 2006).

Sample

A convenience sample of young Black men with a history of incarceration was recruited from a community program that aids ex-offenders in their transition to the community after incarceration. The program employs approximately 50 to 60 ex-offenders,

and includes both men and women. Inclusion criteria for participants were a) self-identifying Black males, b) age 18 to 35 years, and c) a history of incarceration within the previous 12 months. Thirty men volunteered to participate in the study, 20 met the inclusion criteria and were subsequently enrolled as study participants, verbally consented, and completed the study. Men older than age 35 were not enrolled and difficulties coordinating interview times with volunteers, during their work hours, inhibited some volunteers from enrolling.

Data Collection

Approval to conduct the study was obtained from the University Institutional Review Board. Informational study flyers were placed in the break area of the recruitment facility. Interested participants were instructed to fill out a card in order to schedule an appointment with the investigator who answered their questions about the study and read them an information sheet providing details about the study and their rights as subjects. To maintain their anonymity, participants provided verbal consent to participate. The primary investigator conducted all the interviews which lasted from 20 to 60 minutes and were audio recorded. An interview guide was used to ensure that the aims of the study were addressed.

Data Analysis

All audio files were transcribed verbatim into typed-written reports with professional transcription services. Transcribed interviews were verified against the audio file for accuracy. Interview transcripts were imported into QSR NVivo 10 for data organization and ease of coding. Data were analyzed using an inductive-oriented, thematic content analysis (Boyatzis, 1998). Data analysis began at the level of raw data and progressed toward broadened interpretations of common themes and overall structure (Boyatzis). After

completing an initial coding of data and based on the question posed and the context provided by the participant, codes were grouped into categories of depression experiences or depression perceptions. All coding tasks were independently performed by the primary investigator and a co-investigator with qualitative methods experience. Coding tasks and resultant categories were compared and in cases of discrepancy the data were discussed until a consensus was reached. These tasks were performed in order to ensure credibility and confirmability of findings.

Findings

Participant ages ranged from 20 to 35 years old; 95% were single and 90% had a high school diploma, GED, or higher. Criminal offenses included robbery, assault, traffic violations, and drug possession and distribution. Only one participant had a medically recognized history of depression. Sample characteristics are shown in Table 1. Five themes emerged during the analysis of the interview transcripts: (a) anger and negativity, (b) depression equals weakness, (c) invisible depression, (d) being strong and going on, and (e) our depression is different. Data coded and referred to as an ‘experience’ reflected self-described experiences of depression reported by the participant. Likewise, data coded and discussed as a ‘perception’ reflects the participants’ interpretation of depression in young Black men other than themselves.

Table 1

Characteristics of Sample

Variable	N/%
Total Age	20
Mean (SD)	27.7 (4.79)
Range	20—35
<hr/>	
Marital Status	
Single	19/95%
Married	1/5%
<hr/>	
Education	
Less than High School	2/10%
High School/GED	9/45%
Some College	7/35%
College Graduate or greater	2/10%
<hr/>	
Parental Upbringing	
Both Parents	5/25%
Mom Only	13/65%
Other Relatives	2/10%
<hr/>	
Medical History of Depression	
No	19/95%
<hr/>	
Lifetime Number of Months Incarcerated	
Mean (SD)	59.7 (41.32)
Range	11—180

Anger and Negativity

Participants reported negative feelings and emotions that they personally experienced or perceived in others that they associated with depression. Negative emotions included suicidal ideation (SI) and anger that were used to characterize depression experiences and

perceptions. Well over half of the participants (16) stated that “anger” and “frustration” was commonly experienced emotions and that they witnessed anger in others whom they believed were depressed. One 20-year-old man who described growing up poor in the inner-city acknowledged feeling depressed while incarcerated. He said, “I just wanted to die. I was just tired of it. But when I get those feelings...I will cast it out by my anger...I will use my anger to just kill it. I will switch it. I will switch it over to anger.” Other young men revealed similar feelings of anger. In recounting a past incidence of incarceration, a 31-year-old participant with a history of alcohol abuse described feeling “fear, anger, real sad...Sometimes, I didn’t want to get out of my bunk...It was a lot of pain. It was a lot of pain...It was a lot of anger. All I needed was just a reason...” One participant believed that manifestations of anger emotions were a more acceptable than feelings of sadness or helplessness. The 34-year-old participant said, “Most times, most people don’t know how to deal with their depression, and it comes out as anger, resentment, and it’s like the whole world is against me.”

Half of the young men described negative emotions associated with experiences of depression as being “in a slum” and “feeling down.” Feeling “beat down” was common for three participants. Negative emotions in others were perceived to be a sign of depression that could be recognized. When asked “how would you recognize if another young Black man was depressed” and “what are signs that someone is depressed”, five participants responded that depressed individuals would be “sad”, “gloomy” and have their “head down” and experience “self-pity” and “worry.”

Suicidal ideation (SI) was both experienced and perceived to be signs of depression among the young men in the study. One young man detailed a previous experience of depression as a teenager, one in which he had come close to committing suicide:

I really was depressed at 16...The first time and the only time I ever thought about blowing my own brains out...my little sister happened to catch me right before I pulled the trigger. I tucked it and I had to really think about it. I was really tripping. I was drinking, whatever, unhappy...I had to really think about it...I was about to go out like somebody weak.

Two other young men acknowledged similar experiences of SI during prior experiences of depression. Four of the young men tied experiences and beliefs about suicide to depression. Two men recounted seeing what appeared to be others considering and sometimes actually taking their lives. For example, a 28-year-old participant described witnessing his brother's contemplation of suicide by drowning when faced with the dissolution of his family by divorce. He stated, "I've been walking with him going fishing and I've seen him on the bridge look down and like really see the wheels turning in his head contemplating."

Seven of the participants also felt that during these self-described episodes of depression, they did not feel, behave, or think as they normally would. Participants stated that they experienced changes in their attitudes, "messed up thinking," and that they had unusual thoughts and behaviors. For example, one young man described a previous experience in which he noticed a change in his behavior that he attributed to being depressed. He stated, "I stopped working out. I ate one meal a day and not even the whole thing and I would sleep." Similarly, eight participants perceived that depressed young men would commonly show signs of depression by not acting in ways that they normally would. One

participant stated, “If I’m around you and usually you happy and then on this day no matter what I say, you give a short statement...little fake laughs and all that, something wrong. There’s something wrong.”

Depression Equals Weakness

Weakness, perceived as a lack of personal strength or an inability to endure the situation, was acknowledged by participants who had self-described experiences of depression. In addition to the experience, the perception that depressed young Black men are weak also emerged. A gender association of femininity was intermingled in many of the discussions of depression and weakness in men. Five participants that had previous experiences of depression discussed attempts to “stay strong” and to fight their feelings in an attempt to not “go out like somebody weak.” While discussing what others might think about depressed young Black men, a 32-year-old participant with a history of SI equated a previous experience of weakness to depression stating, “Some people might see them [black men] as weak. Everybody has falls and weakness sometimes. I’ve been there a few times. But when I found myself being weak or whatever I try to snap out of it.”

The experiences of depression and weakness were described as a feminine trait. Nearly half the sample shared this perception that other young Black men who act depressed are weak and, as a result, feminine. For example, a 28-year-old participant said, “Certain emotions are deemed female emotions. Certain sickness, depression, high anxiety, these are, so to cry or to cut your wrists, or to be depressed, I feel like that’s what females do. You’re weak to me.” The perception that depressed Black men are weak closely mirrored personal accounts of weakness by participants with self-described depression. While giving his

opinion about a family member who he felt had suicidal ideations and a friend who he witnessed cutting his wrists, one young man said, “You know, I look at that as a weakness. I feel like he’s weak for that. So, I mean, yes, it’s depression, you’ve got to deal with it.” Other men echoed these attitudes, stating, “A man is supposed to be strong so if you come off looking depressed and sad then you’re weak.” The 32-year-old participant with the history of SI offered his thoughts about young men who display or talk about their feelings: “Sitting around and talking about your feelings and we’ll sit up there and tell you straight up stop lying like you some little bitch...Take your panties off, be a man, you know what I mean, you got to handle your stuff.”

Invisible Depression

The young men both experienced and perceived a varying and dynamic impact of depression on interpersonal relationships and relationships with others. Whether participants experienced depression themselves or perceived depression in others, when asked by the investigator “What others thought of depressed young Black men,” 15 participants responded that “no one cares” or that there is a negative perception of depressed Black men in society. One 30-year-old participant stated, “When I was depressed it wasn’t just a suicidal thing or whatever...[You] feel like nobody gives a fuck about you.” Similarly, when asked what other people think about young Black men who might be depressed, one 24 year-old participant who had spent nine years incarcerated, after a long pause stated that “At first, you got to find somebody that even gives a fuck; that even cares. If you find somebody that cares like I don’t know how they feel.”

Though the general perception was that “nobody cares” about depression in young Black men, some participants did communicate that someone close to them, such as a family member or a friend, knew about their depression. A 24 year-old participant who acknowledged episodic depression feelings stated that it was his grandmother who recognized his depression when no one else had.

I stay with my grandma right now. She just asked me from out of nowhere, I’d just be sitting in the room and she can tell then I’m not doing all right or something or something is on my mind. She just comes and ask me are you all right, everything okay?

Similarly, eight young men stated, “You have to know someone to know if they’re depressed.” The young men often identified family members as those who would most likely recognize their depression; however, one 30 year-old participant stated that mental healthcare professionals brought his problems with depression to his attention while he was incarcerated. He said, “I’ve been to all of the little grief and loss, anger management classes, and I went and got in that grief and loss class that’s how I knew that something wasn’t right.”

Another nuance of the interpersonal impact of depression communicated by participants was the perception of hidden depression symptoms and the “need to open up.” The young men largely agreed that it is socially not okay to be depressed or to show signs of depression and that depressed young men try to “cover it up” and “hide emotions” that are deemed unacceptable by others. One young man who shared his experience of a friendship with another young man who committed suicide remembered that, in the days before his death, the young man behaved in a way that would not seem unusual.

Among some of the men there was a perception that “depressed people need help” and that Black men with depression need to “talk about it with someone.” However, some of

the men perceived that there was a lack of acknowledgement by society that Black men suffer from depression. One young man stated, “A lot of people don’t look at young Black men as being depressed, you know what I’m saying. You don’t hear that too much ...us being depressed...”

Being Strong and Going On

Many of the young men that described their emotional experiences tied to depression simultaneously placed emphasis on moving forward in their lives despite their experiences. In fact, when asked to expound upon depression experiences, seven of the men immediately pivoted toward discussing coping strategies that allowed them to carry on despite their mental burdens. A “nothing is going to defeat me” attitude echoed in the interviews. When recounting a particularly difficult time during his previous incarceration, a young man who was 20 years of age described feeling “tired” and “ready to die.” Instead of continuing to feel sad, he acknowledged using anger to redirect these emotions. He stated:

[I] will use my anger to go work out or whatever and probably write a letter, draw. I will draw, clean up, sleep, eat, something. I would just do something else instead of just keep focusing on that [depression]. I would just try to switch everything. So I would try to control myself, control my thinking.

Other young men mentioned using similar sorts of coping strategies.

I try to snap out of it, you know what I mean, or sit up there and try to find another angle, you know what I mean, how I could get something done, you know what I mean. I’m always trying to find a solution, you know what I mean, for something else.

In an attempt to go on with life, despite experiences of depression, several young men described playing basketball, working out, and listening to music. Five young men described

similar efforts to control or redirect their thoughts when depressed. For example, one 22 year-old participant said “I don’t put myself in the position to where I’m just sad all the time, I’m angry all the time, I’m lonely all the time. I don’t want to go through that no more.” Similarly, a 30 year-old with a baby due in the coming months said, “I don’t worry about stuff that’s out of my control. So if it’s out of my control I pretty much tell them like, hey look, I’m not going to be able to help you with that. There’s nothing I can do.” In addition, participants discussed using exercise, prayer, cleaning, and marijuana to distract themselves from feelings of depression.

Our Depression is Different

One young man stated “no two Black men are the same” with regard to depression experiences. Several participants agreed that each young Black man experiences depression in a personal and unique way and that depression experiences of Black men are different from the experiences of White men. Racism and discrimination experiences and beliefs about White privilege were cited as the main reasons they felt that depression in Black was different from that of White men. They also perceived that Black men had to be stronger in order to survive everyday challenges. While talking about social differences between Black and White male racial experiences, one participant stated:

I’m thinking at the back of my head if you went half through the stuff I went through you would have killed yourself a long time ago, you know what I mean. That’s the way I feel... You know, it’s totally different when most White folks are handed stuff.

Similarly, one participant discussed the need for a different diagnosis associated with mental anguish when comparing Black male and White male experiences, he stated:

I think the diagnosis will be the same as they would prescribe for white guys that are depressed, and it can't be the same. We live separate lives. We, for a white male, same age group, never been arrested, never been locked up, to study him and to study us and give us the same diagnosis is wrong. You can't do that. You've got two totally separate lives. Even a white male that's been locked up, same age group, you can't, you can't, you can't study us, you can't give us the same outcome.

Discussion

Previous studies on the subject of young Black men and depression posit that there is a lack of connection between experiences of symptoms and identification of depression among Black men rather than a difference in symptom manifestation (Kendrick et al.). The findings from this study lend additional credibility to this assertion, given the similarities of the depression experiences described when compared to traditional depression symptoms. Depressive affect is a key construct of traditional depression symptomatology. Negativity, a nuance of depressive affect emerged as a theme in this study. However, there were notable differences in male depression symptomatology that are reflected in the findings. These included the emergence of 'anger', 'weakness' and 'being strong and going on' themes. While these differences may not be consistent with traditional symptomatology, they are receiving increasing attention in Black masculinity literature (Hooks, 2004).

Depressive affect, a construct of the CES-D, is characterized by having the 'blues', feeling depressed, sad, lonely and crying (Radloff, 1977). The young men in this study used traditional and non-traditional descriptors to report their experiences and perceptions of negative emotions associated with classic depressive symptomatology. For example, the men never used the term "blue" when describing their feelings or when sharing their perceptions; alternative, synonymous terms including feeling "sad", "down", "low", "beat down" and "in a slum" were used. Negative emotions associated with depression are a

hallmark of depression symptomatology and measurement. However, an awareness of cultural verbiage that is commonly used is integral not only to identifying negative emotions but other aspects of depression experiences in young Black men.

The varying shared experiences and perceptions related to suicidal ideation, six out of 20 participants, lend credibility to increased suicide rates among young Black men. While the risk for suicide remains higher in young White men, suicide rates increased more rapidly among young Black men from 1980 to 1995 (Kendrick et al.). Further, not feeling your usual self and feeling consumed by depression are appreciable nuances of depression and depressed affect. Although suicidal ideation and not feeling one's usual self are not considered traditional depression symptoms by themselves these experiences may be discussed in conversations with depressed young Black men.

Anger emerged as a major emotional experience and perception related to depression among these young men. Some participants found this emotion to be more acceptable than depressive affect and stated that they switched their emotional response to anger instead of sadness in order to feel as though they could move on with their lives, both while in jail and in the community. One participant stated "I just wanted to die. I was just tired of it. But when I get those feelings...I will cast it out by my anger...I will use my anger to just kill it...I will switch it over to anger." While some of the emotional experiences shared by the participants align with depressive affect, anger is not an emotion included in traditional depression symptomatology, nor is it included on depression measures. However, literature does exist which supports the inclusion of anger symptoms among depressed men (Rochlen et al., 2010). The preference for anger and dominance rather than sadness, by young Black men, is thought to be rooted in the masculine-oriented American culture of domination

(Hooks, 2004). Anger and aggression are the easiest way for men to assert their manhood and thus is perceived to be more acceptable in the context of experiencing emotions and behaviors considered to be effeminate such as crying, sadness and loneliness (Brownhill et al.; Hooks).

The perception that individuals would need to know someone, personally, in order to know if they are depressed is considered a nuance of the interpersonal domain of depression. Interpersonal distress, a construct of traditional symptomatology of depression, emphasizes the social dynamics of depression. Interpersonal distress is an individual's beliefs about the friendliness of others and their perception that others dislike them (Radloff). Both the experience and perception that "nobody cares" about depression in young Black men was perhaps the most notable and poignant example of the interpersonal domain. This perception was extended to healthcare providers, in addition to society. Several of the young men recounted feeling as though they were nothing in the eyes of healthcare providers. One young man recalled his interactions with healthcare providers while incarcerated. He stated, "Every nurse I ever talked to, every dentist, every dental assistant, I was worse, I was nothing, nothing to them."

Some participants found it difficult to find the words to communicate perceptions and feelings associated with depression. Some found it difficult to define what depression was to them. This sort of impaired communication, whether due to lack of understanding of depression or difficulties finding the correct words that describe depression feelings, may make it difficult to seek help and may impede meaningful relationships, particularly when emotions such as anger may mask more traditional feelings such as sadness and 'blues'. Many of the men stated that "you would have to know someone in order to know if they are

depressed.” Indeed, this validates the experiences of depression shared by some of the men. In a few cases, recognition of depression symptoms in these young men by family members and healthcare professionals were described. It was this recognition of depression in them, by others that were close to them, that prompted the young men to open up. The closed nature of depression experiences and the perception that nobody cares is further confounded by poor knowledge of depression and difficulty communicating symptoms with others. These interpersonal impacts are significant in that they may prevent help-seeking behaviors and recognition of depression in young Black men.

When describing previous experiences of depression, many of the young men described feeling that they were weak as a result of it. Further, the perception among the participants that other depressed Black men are weak mirrored the reported experience. Femininity, as a facet of weakness, also played a role in the experience and perception of weakness associated with depression. Weakness has received attention in the literature concerning male depression (Rochlen et al.; Waite & Calamaro, 2009). Cultural expectations of masculinity that are rooted in an aversion to femininity help to shed light on weakness as theme of male depression (as cited in Kilmartin, 2005). Any semblance of being weak or vulnerable is attributed to being feminine or less than masculine (as cited in Kilmartin) and hence, undesirable. This perceived vulnerability can be especially precarious for the physical safety of young Black men residing in urban environments (Rich, 2000). For example one young man stated, “A Black male in the extremes that we come from, we’re not really, we’re raised to not show weakness.” The “extremes” including prison and inner-city neighborhood environments are inhospitable toward individuals who show signs of weakness. Thus, this young man and the others that acknowledged depression tended to immediately pivot the

discussion toward describing their efforts to remain mentally strong despite feeling depressed. As a group, Black men perceive greater stigma associated with depression and are less likely to seek treatment for depression symptoms than White men (Menke & Flynn, 2009). The perception of weakness and femininity does pose a significant barrier to help seeking for many young Black men.

The perception that young Black men are unique in their experiences of depression has been cited in the literature (Kendrick et al., 2007; Watkins, Green, Rivers, & Rowell, 2007). In this study, the participants felt that depression for young Black men were distinct from depression among White men because of experiences pertaining to racism, profiling, and harassment. According to one young man, the increased intensity of depression symptoms was perceived to be due in part to having “a lot on our table to be depressed about.” Another participant voiced similar beliefs about differences in depression among Black and White young men. He stated,

So if you're going to study us, if you're going to put us into our own group, [we've] got to have our own diagnosis that's different from theirs. You've got to pinpoint what it is exactly that makes us the way we are.

Being strong and going on was typically in response to the negative emotions associated with depression described by the men. This study and other literature supports the assertion that young men are more likely to engage in various activities to distract themselves from depression rather than dwell on the situation or their feelings (Scott & Davis, 2006). This sort of emotional separation and restriction in the face of perception and experiences of racism, discrimination, and constant threats to social and economic stability is well documented among Black intellectuals (Majors & Billson, 1992).

Overall, the emergent themes from this study validate the limited but ever-growing body of literature on the subject of depression in men. This study advances knowledge of depression in a large albeit vulnerable and often overlooked population in the U.S., young Black men with felony records. The life circumstances and legal-justice experiences of these young men places them at increased risk for depression and yet the literature indicates that young Black men, as a group, are unlikely to reach out for help due to distrust and stigma (Waite & Calamaro, 2009). Barriers such as the uniqueness of Black experiences of manhood in America and the difference in culture between provider and patient may serve to further hinder help-seeking behaviors. Further, the experience and perception that nobody cares is particularly troubling and immediate efforts to display compassion and acceptance to those at-risk would likely prove beneficial. Many of the young men in this study were thankful for providing them time to tell their stories and for doing something to help other young men in need—because, according to these young men, “depression is a problem in Black men.”

Strengths and Limitations

The primary investigator, a Black female, is of similar ethnic background as the participants. As a result, there was potential for bias due to these similarities. For example, during discussions about weakness the investigator may have missed opportunities to further explore the concept due to her perceived understanding of what the participant was describing. However, participants were found to be forthcoming in their discussions about depression and this may have been due to the gender and race of the interviewer. Many participants disclosed their surprise at research being conducted on their mental health and were appreciative of the attention to their struggles. A Black male investigator may not have

received such explicit depictions of depression as there may have been a preconceived expectation that another Black man would have already understood.

Conclusion

Findings from this study validate several aspects of male depression that have been previously identified such as anger, suicidality, and aversion to displays of weakness (Brownhill et al., 2005; Hooks, 2004; Kendrick et al., 2007). While not all young Black men have an incarceration history or felony record, a sizable 11% of young men ages 20 to 35 were institutionalized in 2006 and that number continues to increase (Alexander, 2010). These young men often return to their communities with minimal opportunities for employment, housing, and healthcare (Alexander, 2010). These constraints not only threaten the mental and physical health of young Black men but they also increase the odds of re-offense and re-institutionalization (Alexander, 2010). Community and institutional primary and mental healthcare providers are likely to encounter disadvantaged young Black men with a history of legal-justice involvement. Insights from these young men may be helpful in initiating discussions about depression as they may not want to talk about it or don't know how to talk about it. Further, increasing community awareness and education about psychological distress, depression and emotionality in young men and available mental health resources may also prove beneficial.

Replication of this research in diverse subgroups of young Black people such as those without a history of incarceration or among those who have been clinically diagnosed with depression will further enhance understanding of depression in this vulnerable population. Replicated findings from this and similar studies can provide cultural context for the

evaluation of the validity of current depression screening and measurement tools. For example, anger is not included on any of the traditional depression screens nor is it discussed in the DSM-IV despite recognition that it is often a trait of depressed men. Research that explores experiences and beliefs about depression and mental illness in young Black men is uniquely positioned to inform screening measure enhancement and development of interventions that appropriately and adequately address mental health and depression.

APPENDIX A
PARTICIPANT INTEREST NOTECARD

I would like to join the
study on depression in
men

Print Name _____

A RecycleForce staff member will contact you for
details.

I would like to join the
study on depression
in men

Print Name _____

A RecycleForce staff member will contact you for
details.

APPENDIX B
INTERVIEW FORM

Depression Study Interview Guide (*probes in italics*)

INTRODUCTION AND ICE BREAKER:

1. Introduction of myself and the research study
2. Read the informed consent in its entirety
3. Time permitted for questions
4. Obtain verbal consent for interview
5. Read and complete demographic data sheet

SCRIPT (begin recording):

Tell me about the one, or two, experiences that have most influenced your getting into trouble with the law.

What was life like for you in jail?

- *What was the daily routine?*
- *Did you have communication with family/friends?*
- *How did all of this make you feel?*

What was life like for you after jail?

- *What is your daily routine like now that you are out?*
- *How does that make you feel?*

What does depression mean to you?

- *I'm curious about how depression may play a role in the lives of young Black men. Have you experienced it? If not, have you witnessed it and what did it look like?*
- *What do you think about young Black men who act like they are depressed?*
- *How do you think other people view men who are depressed? (i.e. like family, friends and etc.)*

In what ways do you think people might display depression?

- *How do you recognize depression?*
- *What's the difference between stress and depression?*

There are a lot of symptoms that are believed to be related to depression. In your opinion, what does _____ have to do with depression?

Feeling bothered by things that usually didn't bother you

Having problems with appetite

Persistent feelings of the blues that no-one could help with

Trouble concentrating

Feeling depressed

Feeling that every action required effort

Feelings of failure

Feelings of fear

Poor sleep

Less talkative

Feeling lonely

People were unfriendly

Crying

Feeling sad

Feeling that people disliked you

Difficulty getting "going"

(feeling just as good as others; hopefulness; happiness; enjoying life)

Is there anything else that I have not asked that might help me understand the experiences of depression by young Black men?

- *What is the most important thing that you would want nurses to know about depression in young Black men who have been in jail?*
- *Do you think that depression is important, why or why not?*

APPENDIX C
DEPRESSIONS STUDY INFORMATION FORM

Information Sheet for Participation in a Research Study: Perceptions and Experiences of Depression in Young Black Men after Incarceration

Dr. Patricia Kelly and Danielle EK Perkins, RN

Request to Participate

You are being asked to take part in a research study being conducted at RecycleForce. The researcher in charge of this study is Dr. Patricia Kelly but the study will be run by Danielle Perkins, a Registered Nurse and student researcher at the University of Missouri Kansas City, who will interview subjects for the study.

The study team is asking you to take part in this research study because you have a history of incarceration, are Black and between 18 years and 35 years of age. Research studies only include people who choose to take part. This document is an informational form about this depression study. Please read this form carefully and take your time making your decision. The researcher will go over this form with you. Ask her to explain anything that you do not understand. Think about it and talk it over with your family and friends before you decide if you want to take part in this research study. This information forms explains what to expect: the risks, discomforts, and benefits, if any, if you agree to be in the study.

Background

Young Black men experience many stressors that increase their risk for depression. However, depression in young Black men is poorly understood. The researcher will hold private interviews with young Black men who are considered to be at risk for depression. You will be one of about 20 to 30 subjects in the study at RecycleForce.

Purpose

The purpose of this study is to understand the beliefs and experiences of depression, according to the views of young Black men. The study is being done because little is known about depression and young Black men. The results of this study will be used to better understand depression and emotions in Black men.

Procedures

If you decide to join the study, the interview day, time, and location will be set with help from a RecycleForce staff member. The interview will take place in a quiet and private room at RecycleForce. You will meet alone with Danielle Perkins, RN on the day and time of the interview. You will take part in 1 audio-taped interview that will last about 1 to 2 hours.

You must agree to be audio-taped to be part of the study. No personal identifying information will be audio-taped. Only the researchers and the transcriber will have access to the audio-tapes. A transcriber is a person who will listen and make a written record of the audio-tape. After the written record is checked against the audio-tape, all electronic files of the recording will be completely erased.

If you agree to take part in this study, you will be involved in this study for the length of the interview. You do not have to be in this study, you should join of your own free will. If you do decide to join the study, you may at any time refuse to answer certain questions and or stop the interview.

Risks and Inconvenience

If you join the study there is a small risk that you may become emotionally upset. For example, you may feel sad or angry when talking about your experiences in jail. If the researcher thinks you need more help she will refer you to RecycleForce staff member.

Benefits

An indirect benefit of being a part of this study is that by reflecting on your own experiences you may gain a better understanding of yourself. Another indirect benefit is that other people may benefit in the future from the information about depression that comes from this study.

Fees and Expenses

It is free to join this study.

Compensation

If you join the study you will receive \$50.00 cash for your time.

Alternatives to Study Participation

The alternative is not to take part in the study.

Confidentiality

While we will do our best to keep the information you share with us confidential, it cannot be absolutely guaranteed. Individuals from the University of Missouri-Kansas City Institutional Review Board (a committee that reviews and approves research studies), Research Protections Program, and Federal regulatory agencies may look at records related to this study to make sure we are doing proper, safe research and protecting human subjects. The results of this research may be published or presented to others. You will not be named in any reports of the results.

All audio-taped interviews will be completely anonymous. Your name will not be recorded or linked to the audio-tape or written record. If you stop the interview, the tape-recording will be kept and used in the study.

Contacts for Questions about the Study

The University of Missouri-Kansas City appreciates people who help it gain knowledge by being in research studies. It is not the University's policy to pay for or provide medical treatment for persons who are in studies. If you think you have been harmed because you were in this study, please call the researcher, Dr. Patricia Kelly at 816-235-2617. You should contact the Office of UMKC's Social Sciences Institutional Review Board at 816-235-5927 if you have any questions, concerns or complaints about your rights as a research subject. At any time and in the future you may call the researcher **Danielle Perkins, RN at 317-278-2010** if you have any questions about this study. You may also call **Dr. Patricia Kelly at 816-235-2617** if any problems come up.

Voluntary Participation

Taking part in this research study is voluntary. If you choose to be in the study, you are free to stop participating at any time and for any reason. If you choose not to be in the study or decide to stop participating, your decision will not affect your employment at RecycleForce. The researchers or sponsors may stop the study or take you out of the study at any time if they decide that it is in your best interest to do so. They may do this for health or administrative reasons or if you no longer meet the study criteria. You will be told of any important findings developed during the course of this research.

You have read this information sheet or it has been read to you. You have been told why this research is being done and what will happen if you take part in the study, including the risks and benefits. Participation in the interview is proof of your consent to be in the study.

APPENDIX D
DEMOGRAPHIC FORM

Demographic Questionnaire

1. Which of the following best describes you?
 - a. African-American (Black)
 - b. African
 - c. West-Indian
 - d. Caribbean
 - e. OtherAre you Hispanic?
 - f. Yes
 - g. No
2. Age _____
3. Who raised you as a child?
 - a. Both Parents
 - b. Mom only
 - c. Dad only
 - d. Other relatives
 - e. Adopted/Foster parents
4. Highest level of school completed?
 - a. Less than high school
 - b. High school/GED
 - c. Some college
 - d. College degree
 - e. Graduate degree or higher
5. Marital Status
 - a. Single/Never Married
 - b. Married
 - c. Separated
 - d. Divorced
 - e. Widowed
6. Lifetime number of months incarcerated _____
7. Have you been told by a doctor or nurse that you have depression and/or anxiety disorder?
 - a. Yes
 - b. No

APPENDIX E
RECEIPTS

RECEIPT		No.: 1
Paid by:		Paid to:
DESCRIPTION		AMOUNT
		SUBTOTAL
		DISCOUNT(S)
		TAX
		TOTAL
Date:	Received by:	

RECEIPT		No.: 2
Paid by:		Paid to:
DESCRIPTION		AMOUNT
		SUBTOTAL
		DISCOUNT(S)
		TAX
		TOTAL
Date:	Received by:	

APPENDIX F
TRANSCRIPTION CONFIDENTIALITY FORM

This AGREEMENT is made as of this 7th day of March 2013, by and between Absolute Marketing & Research, hereinafter referred to as "Contractor", and the Trustees of University of Missouri-Kansas, School of Nursing, hereinafter referred to as "University".

WHEREAS Contractor is engaged in the business of providing transcription services and University desires to contract for said services.

NOW, therefore in consideration of the mutual covenants and premises herein set forth, the parties agree as follows:

1. RELATIONSHIP OF THE PARTIES

For the purposes of this Agreement and the performance of all duties, responsibilities and obligations hereunder, Contractor shall, at all times, be considered an independent contractor and neither it nor any of its directors, officers, employees or agents shall be considered an employee or agent of University for any purpose. Contractor shall have control of its work and the manner in which it is performed. Contractor shall be free to contract for similar services to be performed for other companies and individuals while under contract with University. Contractor reserves the right to subcontract with established transcription services should the need arise. Contractor shall be solely responsible for the payment of any and all taxes and benefits associated with employment, as applicable. Contractor's responsibility for taxes shall include employment taxes and worker's compensation, as applicable.

2. EQUIPMENT, SUPPLIES AND SERVICES

2.1 General Description. Contractor will provide University with transcribed reports of non-medical and medical dictation, oral histories, interviews, focus groups, meetings and seminars within the established turnaround time guideline or upon written agreement dictated by department researcher. Contractor and University agree that University is responsible for assuring that the final transcript is accurate. Contractor will provide to University all transcription services as stated in all of the Contractor's written offers or clarifications as attached hereto and incorporated herein by this reference.

2.2 Corrections and Edits. University will make stylistic and content edits to reports accurately transcribed by Contractor. Consistent with the provisions as found in Section 2.1, if errors, are attributable to Contractor, then Contractor shall make the corrections at no charge to University, provided University notifies Contractor of said errors within seventy

two (72) hours of receipt of transcription. Contractor shall also note unintelligible dictation in its transcribed materials. Any changes that University requests to transcribed materials, other than for corrections attributable to Contractor's error, shall be subject to a charge, as specified in the Order for services. Such changes shall be processed at the applicable price per hour of \$25/hour.

3. MISCELLANEOUS

3.1 Solicitation of Employees. Either party and its affiliates shall not, and either party will use reasonable best efforts to prevent any other party with whom either party has a business relationship, from directly or indirectly soliciting the employment of any of either party's current or former employees during the term of this Agreement and for a period of one (1) year after termination of this Agreement.

3.2 Force Majeure. Neither party shall be liable or deemed to be in default for any delay or failure to performance under this Agreement or any interruption of service resulting, directly or indirectly, from acts of God, civil or military authority, acts of public enemy, or accidents, fires, explosions, earthquakes, floods, failure of transportation, strikes or other work interruptions by either party's service providers, employees or agents, or any similar or dissimilar cause beyond the reasonable control by either party.

3.3 Ownership of Papers, Products and Equipment. During this Agreement and upon its termination. University shall have complete, unrestricted ownership of all final papers, databases and products produced by the efforts of Contractor specifically under this Agreement. Contractor shall not use or permit others to use University's name, logos, trade or service marks in any fashion without the express written permission of University. All equipment purchased by University shall remain the property of University. Archiving of such property is available from Contractor, free of charge, if requested. If requested, all final papers, databases and products produced by the efforts of Contractor may also be destroyed in behalf of client once client is in receipt of property.

3.4 Proprietary Information and Confidentiality. Both Contractor and University agree that all data and information gathered, compiled or reviewed by either party shall be considered proprietary and confidential information. Both parties shall, at all time, keep proprietary information strictly confidential and shall in no way use such information for advancement of interests of any person or entity other than the other party, nor in any way

that is detrimental to the other party without advance written consent of the other party. No reports, information or data (whether oral or written) about the other party or its employees or patients shall be divulged, disseminated, published or otherwise made available to anyone other than authorized employees or agents of either party without advance written consent of the other party. Both parties are cognizant of the fact that all information pertaining to patients of University is extremely confidential information and is protected from disclosure by federal and state law. Every Contractor employee will sign an agreement of confidentiality when hired and these will be kept on file by Contractor.

3.5 HIPAA Compliance. Contractor will meet and abide by all applicable state and federal regulations, including the Health Insurance Portability and Accountability Act (HIPAA), including those requirements related to the use and disclosure of protected information as applicable. Contractor shall not retain patient or university names on any database after completion or termination agreement.

Additionally, AMR holds certifications and continuing education for the following:

- A) NIH (National Institute of Health) Office of Extramural Research for Protecting Human Research Participants.
- B) Ethics Certifications for Standards of Conduct
- C) Certifications for Information Security

3.6 Indemnification. Each party thereto agrees to indemnify and hold the other party, its employees, agents and officers, harmless from and against any and all demands, claims, judgments, losses and damages, and any related costs or expenses (including reasonable attorney's fees) arising from any injury or damage to person or property caused by the negligence or misconduct of its employees, agents, or officers.

3.7 Amendments. No amendment or modification of the terms of this Agreement shall be binding on either party unless reduced to writing and signed by an authorized representative of the party to be bound.

3.8 Entire Agreement. This writing expresses the parties' complete agreement and understanding. No other terms or conditions, whether oral or in writing, shall be considered part of this Agreement unless this Agreement is amended pursuant to Section 3.7, Amendments.

3.9 Governing Law and Enforcement. This agreement shall be construed, enforced, arbitrated and otherwise governed by the laws of the State of Indiana. Contractor agrees to abide by all applicable state, federal and local laws pertaining to confidentiality, medical records and reports and employment/public accommodations.

3.10 Benefit. This Agreement shall be binding upon and inure to the benefit of the parties hereto and their respective heirs, assignees, successors, and legal representatives.

3.11 Severability. Each provision of this Agreement shall be valid and enforced to the fullest extent permitted by law. The invalidity or unenforceability of any provision of this Agreement shall not affect the validity or enforceability of any other provision.

3.12 Signature Authorization. University and Contractor each acknowledge and represent to the other that execution, delivery and performance of this Agreement have been duly authorized by all necessary corporate actions and that their duly authorized officers are signing this Agreement.


3.13 Assignment. This Agreement is not assignable, in whole or in part, by either party without the prior written consent of the other party and with the exception of the assignment after any merger or acquisition or business combination involving Contractor or University. In the event of any merger or acquisition or business combination involving either Contractor or University, this Agreement will remain in full force and effect.

3.14 Notices. All notices to either party shall be in writing and be delivered by certified United States mail or by overnight delivery and delivered to the person and address set forth on the signature page of this Agreement.

3.15 Waiver. Waiver by either party of a breach or failure to perform any provision of this Agreement shall not constitute a waiver of any subsequent breach of the same of a different provision hereof.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement as of the day and year first above written.

Date: March 7, 2013

By:  _____

Signature

Sandra L. Keller

Owner/Project Manager

Address: Absolute Marketing & Research

804 N. College, STE 102

Bloomington, IN 47404

P 812-330-0066

F 812-335-6620

C 812-369-6582

skeller@absoluteresearch.net

www.absoluteresearch.net

Trustees of University of University of Missouri-Kansas, City School of Nursing

By: _____

Signature

Name: _____

Title: Director of Purchasing

APPENDIX G
UMKC IRB AUTHORIZATION

From: umkcirb@umkc.edu

Sent Date: Thursday, March 07, 2013 14:16:01 PM

To: kellypj@umkc.edu, Depkf5@mail.umkc.edu, lasiters@iupui.edu, semnesc@umkc.edu

Cc:

Bcc:

Subject: IRB Protocol Approved: 13-459, Patricia J. Kelly

Message:

The SSIRB has approved the protocol with the following details.

Protocol ID: 13-459

Principal Investigator: Patricia J. Kelly

Protocol Title: Perceptions and experiences of depression in young Black men after incarceration

Review Type: Administrative Review

Department: School of Nursing

Approval Date: 03/07/2013

The formal approval letter and stamped consent forms, if applicable, can be found by accessing the protocol in the eProtocol system. Please contact the Research Compliance Office (email: umkcirb@umkc.edu; phone: (816)235-5927) if you have questions or require further information.

APPENDIX H
LETTER OF SUPPORT



A cleaner
environment.
A stronger
workforce.

January 14, 2013

Ms. Danielle Perkins
809 Jefferson Ave.
Indianapolis, IN 46201

Dear Ms. Perkins,

This letter is in support of your dissertation study entitled *Experiences and Perceptions of Depression in Young Black Men after Incarceration*. The not for profit Workforce, Inc. dba RecycleForce assists formerly incarcerated men and women with their re-entry into society, providing wage paying employment and a wide range of social support services. There is sufficient participation in the organization for you to achieve the desired sample size indicated in your research proposal. The RecycleForce team looks forward to assisting you in the collection of data in fulfillment of the requirements for your dissertation research.

Sincerely,

Gregg Keesling
President, Recycle Force
1125 Brookside Avenue
Suite D12
Indianapolis, IN 46202
317-532-1367 (Office)
317-532-1369 (Fax)
gkeesling@recycleforce.org

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VITA

Danielle E. K. Perkins was born and raised in Indianapolis, Indiana. She received her primary education from Lawrence Township schools in Indianapolis and earned her Bachelor's Degree in Nursing in 2002 from Dillard University in New Orleans, Louisiana. After a year of working in New Orleans on a telemetry unit at the Veterans Affairs hospital, she relocated to Baton Rouge, Louisiana to begin her Master's Degree in Nursing which she completed in 2005. Her Master's Degree focus was nursing education and thus she began a fulltime teaching appointment at the University of Louisiana at Lafayette; she later relocated to Lafayette in 2007. Danielle maintained clinical practice, primarily in the areas of telemetry and mental health, prior to and throughout her graduate studies and into her teaching career.

In 2009 her brother passed away from an accidental overdose. It was at this time that Danielle realized that her brother and many other young Black men close to her suffered in silence with mental health problems, at one time or another. This was the catalyst for Danielle completing her Doctoral education, to bring attention to the needs of young men suffering with mental health issues in silence due to a lack of education, stigma, and poverty.

Danielle continues to work as a faculty member at Indiana University School of Nursing in Indianapolis. She received a scholarship from the Jonas Center for Nursing Excellence for the 2012-2013 school years. She has two prior publications and a manuscript in her area of expertise currently under review. She looks forward to becoming re-engaged in numerous professional organizations including the American Nurses Association and the American Psychiatric Nurses Association post-graduation.