**Black Youths' Mental Health in Racialized Spaces: The Role of Structural Racism**

by

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## Dedication

To every Black, Palestinian, Latinx, Queer, Trans, Immigrant, Disabled, and oppressed child.
"…just wait and see, someday, we'll all be Free."

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## Abstract

Structural racism – the totality of ways power and privilege shape laws, policies, and historical contexts across reinforcing institutions and socioecological levels – drives racial inequities across social determinants of mental health and well-being among Black youth and their families (Bailey et al., 2017; Murry et al., 2018; Reskin, 2012). Black youth and their families encounter structural racism daily through interactions with racialized institutional contexts, including schools, neighborhoods, and workplaces (Iruka et al., 2022; Murry et al., 2018). As psychology evolves to include the study of racism across socioecological levels, it is essential for the field to 1) incorporate community perspectives (Neblett Jr., 2019) and 2) refine methodologies for measuring structural racism to understand its role as a determinant of mental health (Adkins-Jackson et al., 2022; Neblett & Neal, 2022). To address these goals, this dissertation synthesizes three studies.

The first two studies utilize secondary data from participatory research projects employing photovoice in Raleigh, NC, involving eight Black early adolescents (Study 1) and six Black maternal caregivers (Study 2). Secondary reflexive thematic analyses of each study's data revealed themes related to structural determinants, their effects on mental health, and the coping strategies and psychological processes used to mitigate or exacerbate mental health symptoms. The findings revealed that Black youth and Black maternal caregivers shared nuanced perspectives on internalizing symptoms, as evidenced by the themes *Anxiously Guarding* from the maternal caregivers and, for the youth, *Depression: Feeling Unwanted and Invalid*.

Study three developed a multidimensional measure of structural racism, focusing on inequities across racialized school and neighborhood contexts of Black youth. Using data from the Future of Families and Child Wellbeing Study ($N$=616), a second-order confirmatory factor model demonstrated modest fit, falling slightly short of conventional thresholds for model adequacy. The model included 12 structural racial inequity indicators across school and neighborhood contexts that loaded onto three latent variables: neighborhood advantages, neighborhood disadvantages, and school inequities. These three latent variables loaded onto a single latent variable: structural racism. The latent variable structural racism was associated with increased depressive symptoms in Black adolescents ($\beta$ = .136, $p$ = 0.007). Additional aims examined neighborhood social cohesion, caregiver depressive symptoms, and varying levels of structural racism exposure using latent profile analysis (Chantarat et al., 2021; Riley et al., 2024).

Findings from the three studies underscore the need for community perspectives on social determinants of health shaped by structural determinants, such as structural racism, as they shape Black communities' mental health. Findings also advance the field's operationalization and measurement of structural racism and its role in determining mental health of Black youth and families.

# Chapter 1 Introduction

Structural racism refers to the totality of ways that laws, policies, and institutional practices are shaped by power and privilege—producing racial inequities across interconnected systems such as housing, education, and community life (Z. D. Bailey et al., 2017; Bonilla-Silva, 1997; Gee & Ford, 2011; Krieger, 2014; Reskin, 2012). These inequities are rooted in discriminatory beliefs and an uneven distribution of resources, disproportionately burdening racially marginalized groups.

As a result, structural racism represents a significant threat to the mental health and well-being of Black youth, their families, and their communities (Iruka et al., 2022; Neblett, 2019). Yet, despite its pervasive and persistent effects, Black families and communities demonstrate resilience—finding ways to survive and even thrive (Denby, 2018; Iruka et al., 2022; Murry et al., 2018; Neblett et al., 2012).

Decades of research confirm that racism negatively affects mental health among racially marginalized populations (Neblett, 2019; Paradies et al., 2015; Pieterse et al., 2012; Williams & Williams-Morris, 2000). At the same time, a growing body of work has identified protective factors—such as racial identity, racial socialization, and neighborhood cohesion—that can buffer these effects (Benner et al., 2018; S. C. T. Jones & Neblett, 2017; Murry et al., 2018; Neblett et al., 2012). However, the field of psychology has only recently begun to explicitly examine the compounding effects of structural racism on the mental health of Black youth (Neblett, 2019; Trawalter et al., 2020). This dissertation extends that work by centering the voices of Black

youth and families through community-based projects that examine the structural forces shaping well-being.

Recent evidence underscores the importance of this approach. In a nationally representative sample of Black and white high school students (n = 41,258), state-level indicators of structural racism (e.g., bans on food assistance after drug convictions) were linked to a 1.37x greater likelihood of depressive symptoms among Black youth (Adkins-Jackson et al., 2025). Other indicators (e.g., racial disparities in incarceration and housing vacancy) were linked to greater loneliness (1.53x) and lower self-esteem (1.25x). Though effects were smaller for white youth, the findings underscore the idea that "racism makes us sick"—and that racism harms all of us (McGhee, 2022; D. Williams, 2016).

The AAKOMA Project's 2025 report found that 66% of Black youth and young adults reported moderate to severe depressive symptoms, 49% reported moderate to severe anxiety, and 28.4% reported suicidal ideation (A. Breland-Noble, 2025). These alarming statistics, alongside documented increases in suicide (Lindsey et al., 2019; Sheftall et al., 2022) and serious mental illness (Substance Abuse and Mental Health Services Administration, 2020), demand urgent attention to structural determinants of mental health.

Racism, defined here as differential treatment of racial groups across institutional, cultural, and interpersonal contexts based on power and historical domination (J. M. Jones, 1972; R. Williams & Williams-Morris, 2000), remains a major determinant of Black mental health. Studies consistently show that racism functions as a psychosocial stressor for Black youth (Benner et al., 2018; K. P. Jones et al., 2016; Paradies et al., 2015; Pieterse et al., 2012; Price et al., 2022), contributing to depressive symptoms and other mental health concerns through

individual (Bernard et al., 2022; Reck et al., 2022), institutional (Cavalhieri et al., 2024; Hope et al., 2021), and cultural pathways (S. M. Gibson et al., 2022).

While much research has examined each level of racism individually, few studies address how these levels operate together—particularly within psychology (Neblett & Neal, 2022; Trawalter et al., 2020). Moreover, most psychological measures rely on subjective perceptions of racism, with limited use of objective structural indicators (Bonilla-Silva, 1997; Krieger et al., 2005). This limits our ability to study structural racism as an integrated, measurable stressor.

Structural racism is a driving force behind racial inequities across the social determinants of mental health (SDoMH)—including education, community cohesion, neighborhood safety, and several other determinants (Neblett, 2019; Yearby, 2020). While these inequities are often attributed to poverty, scholars note that they are racialized by design, with poverty functioning as a conduit for structural racism's effects (Heard-Garris et al., 2021; McBride-Murry et al., 2011; McLoyd, 1998). The result is a compounded burden on Black youth across developmental domains (Berry et al., 2021; Compton & Shim, 2015; Cotton & Shim, 2022).

A small but growing number of studies (Adkins-Jackson et al., 2025; English et al., 2021, 2022a; Martz et al., 2024; Polos et al., 2022) are beginning to examine structural racism's effects on mental health using multidimensional or composite indicators. This work contributes to a broader effort to examine how racism across interpersonal, institutional, and cultural domains converge to affect well-being.

This dissertation joins that effort by:

1. Examining how structural racism shapes Black youths' and families' mental health across multiple determinants,

2. Centering their own conceptualizations of racism and health through community-based inquiry, and
3. Developing a multidimensional model of structural racism that integrates multiple indicators into a composite measure to predict depressive symptoms—a common outcome of racial stress (Brondolo et al., 2016; Hammack, 2003; Polos et al., 2022).

### 1.1 Structural Racism: Differing Definitions and Conceptualizations

Structural racism can be difficult to define precisely, and scholars have articulated it in numerous ways across disciplines. Frederick Douglass (1890) offered an early structural analysis of racism when he stated:

> "The true problem is not the negro, but the nation. Not the law-abiding Blacks of the South, but the white men of that section, who by fraud, violence, and persecution, are breaking the law, trampling on the Constitution, corrupting the ballot-box, and defeating the ends of justice."

In this address, Douglass called out both individual and institutional forces—such as political disenfranchisement and constitutional violations—as barriers to justice and equal rights for Black people. His framing reflects a foundational understanding of racism as embedded in the nation's structures.

Modern definitions of structural racism reflect Douglass's early insights. One of the most widely cited definitions in psychology comes from James M. Jones (1972), who defined institutional racism as "a system in which individuals or institutions intentionally or unintentionally exercise power against a racial group defined as inferior." Like Douglass, Jones acknowledged both individuals and institutions as sources of racialized power and harm.

In public health, early conceptualizations distinguished race as a social—not biological—construct, framing racism as a driver of poor health outcomes (Krieger et al., 1993; D. R. Williams, 1997). Building on this, Camara P. Jones (2000) introduced a multilevel framework—The Gardener's Tale—to conceptualize racism as personally mediated, institutionalized, and internalized. Personally mediated racism involves direct interpersonal discrimination; institutionalized racism reflects differential access to resources and power based on race; and internalized racism refers to the acceptance of negative societal messages about one's racial group. These frameworks (C. P. Jones, 2000; D. R. Williams, 1997) have become central in public health and sociological work and point to the structural nature of racism's effects.

In contrast, the field of psychology has typically centered individuals' perceptions of racism at each level—whether personal or institutional—rather than examining how multiple levels of racism operate in tandem (Clark et al., 1999; S. P. Harrell, 2000). Eduardo Bonilla-Silva (1997) challenged this emphasis on perception, arguing that racism should be conceptualized structurally, with a focus on whiteness, dominance, and institutional power. He proposed a racialized social systems approach, emphasizing how economic, political, social, and ideological systems maintain racial stratification and inequity, largely independent of individual intent.

Public health scholars have also contributed to the field's structural lens. Gee and Ford (2011) describe how racism operates across socioecological levels, where institutional practices and structural forces interact to create and sustain health inequities. Although they later acknowledged the interplay of multiple forms of racism (individual and institutional), their framework helped clarify how racism manifests across systems. Still, some scholars have

conflated institutional and structural racism, treating the concepts as interchangeable and risking oversimplification (Dean & Thorpe Jr, 2022; Gee & Ford, 2011; D. R. Williams et al., 2019).

Other scholars, including Reskin (2012) and Krieger (2014), define structural racism as the totality of ways racial inequities are produced and sustained across institutions—including housing, education, employment, media, and the criminal legal system. These definitions emphasize how discriminatory beliefs and resource allocation become embedded across sectors. Bailey et al. (2017) also highlights the historical accumulation and ongoing reproduction of racial advantage through laws and institutional practices. Together, these frameworks offer a more comprehensive, multi-level understanding of how racism becomes woven into the fabric of society.

This evolving body of work provides a strong foundation for incorporating structural racism frameworks into psychological and developmental science (Beale Spencer et al., 2002; Iruka et al., 2022; Neblett Jr, 2019; Trawalter et al., 2020). Such integration is critical to understanding the multilevel effects of racism on health and mental health outcomes.

## 1.2 Conceptual and Theoretical Models of Structural Racism

Over the past two decades, multiple frameworks have been developed to understand how racism—especially structural forms—affects the health and development of Black communities (Bailey et al., 2017; Beale Spencer et al., 2002; Clark et al., 1999; Gee & Ford, 2011; Hammack, 2003; Harrell, 2000; Iruka et al., 2022a; R. Williams & Williams-Morris, 2000; Trent et al., 2019; D. R. Williams & Mohammed, 2013). While the frameworks vary in emphasis, they all suggest that racism operates across multiple levels and interacts with social determinants of health to shape mental health outcomes.

One foundational model by Williams and Williams-Morris (2000) posits that racism affects Black mental health through three pathways: (1) institutional discrimination, which lowers socioeconomic status and restricts access to healthcare and safe environments; (2) interpersonal discrimination, which serves as a chronic stressor; and (3) internalized racism, which leads to adverse psychological functioning. However, this model focuses more on additive pathways than on the compounding, structural nature of racism.

More recent frameworks take a broader ecological approach. Trent et al. (2019), building on Jones' (2000) "Gardener's Tale," describe how racism shapes children's health through material conditions—such as housing and education—and through internalized beliefs and interpersonal discrimination. Iruka et al. (2022) add further nuance, identifying four racialized determinants—economic stability, neighborhood conditions, birth outcomes, and education—and pointing to resilience factors such as racial identity, religious faith, and community assets.

Other frameworks explicitly connect structural racism to psychological processes in youth. Hammack (2003) theorizes that racism contributes to adolescent depression through three pathways: (1) alienation from U.S. culture, (2) chronic stress from racial discrimination, and (3) multigenerational disadvantage and financial strain. Spencer and colleagues (2002), drawing from PVEST, identify how structural, cultural, and individual racism contribute to differential stress appraisals among youth, shaping their coping strategies and identity formation. This framework emphasizes the interplay between systemic racism and youth development, while also highlighting potential sources of resilience, such as racial socialization and cultural pride.

Together, these conceptual models support a key premise of this dissertation: structural racism is not simply the sum of its parts. It is a patterned, compounding force that operates

across ecological contexts and shapes how Black youth understand themselves, their environments, and their mental health.

## 1.3 What We Know: The Impact of Structural Racism on Black Youth and Their Families

Although the examination of structural racism has gained renewed attention in recent years, it is not a newly examined phenomenon. For decades, researchers have documented the many ways racism – across structural, cultural, and individual levels – shapes the health and well-being of Black individuals (Beale Spencer et al., 2002; Bonilla-Silva, 1997; Clark et al., 1999; J. M. Jones, 1972). Much of this work has focused on discrete levels or forms of racism, but these dimensions do not operate in isolation. Instead, they accumulate and interact in ways that compound risk over time.

Understanding the mental health effects of structural racism on Black youth requires attention to how institutions—such as education, neighborhood environments, and the criminal legal system—work together to shape their lives and families' well-being. These intersecting structures influence racial identity, coping strategies, sociopolitical development, and mental health (Beale Spencer et al., 2002; Hammack, 2003; Watts et al., 2003; Watts & Guessous, 2013).

### *1.3.1 Black Families, Black Parents, and Structural Racism*

Structural racism affects Black families through multiple, interconnected systems. One stark example is the disproportionate incarceration of Black fathers, which has contributed to higher rates of single-parent households and socioeconomic strain (Giordano et al., 2019). This strain can impact youth mental health, leading to greater internalizing symptoms and intergenerational cycles of criminal legal contact (Assari, 2024). Parenting is also shaped by structural pressures. Some Black parents may engage in harsher discipline strategies—sometimes

attributed to internalized racial messaging or fear of systemic intervention by child welfare services (Briggs et al., 2022; Patton et al., 2021; Williams-Butler et al., 2023). Exposure to intimate partner violence within Black families, exacerbated by structural stressors, has also been linked to negative outcomes for youth (Willie et al., 2025). These dynamics reveal how racism indirectly shapes mental health through the family system.

### *1.3.2 Racialized Neighborhoods*

Neighborhood contexts, deeply shaped by historical and ongoing racial segregation, influence youth well-being in both direct and indirect ways. Perceived neighborhood safety has been associated with risk for major depressive disorder in Black boys (Assari & Caldwell, 2017), while youth in predominantly white neighborhoods may experience heightened depressive symptoms, particularly if they come from higher-income backgrounds (Assari et al., 2018). Other studies find indirect effects on mental health via pathways like social support and neighborhood cohesion (Hurd, Sellers, et al., 2013; Pachter et al., 2006). Yet few of these studies explicitly interrogate racism as a driving force behind these neighborhood disparities. Structural racism influences who lives where, the quality of services and cohesion in those neighborhoods, and in turn, the mental health of residents (Heard-Garris et al., 2021).

### *1.3.3 Racialized Criminal Legal Systems*

Black youth are nearly four times more likely than white peers to have contact with the criminal legal system—not because of higher crime rates, but due to systemic over-policing and criminalization (Kovera, 2019; Sickmund et al., 2011). This disproportionate contact reflects structural racism, evident in mass incarceration from unequal drug convictions (Alexander, 2011), over-policing of socioeconomically disadvantaged neighborhoods under policies like broken windows policing (Howell, 2015), and the school-to-prison pipeline driven by zero

tolerance policies that disproportionately suspend and expel Black youth (Heitzeg, 2009). These systems contribute to higher incarceration rates in Black communities, shaping social outcomes like education, employment, and mental health (Nowotny & Kuptsevych-Timmer, 2018).

The effects extend beyond youth to their families, impacting mental health across generations. Parental incarceration is associated with increased depressive symptoms and higher risk of incarceration in Black youth (Assari, 2024). In a mixed-methods study, Giordano et al. (2019) found that adolescents facing overlapping disadvantages—minority status, family conflict, parental incarceration—were more likely to become involved in the criminal legal system themselves. These findings highlight structural racism's reach across generations.

Exposure to police violence, whether direct or vicarious, further harms mental health. Studies show increased psychological distress, affective reactivity, and delinquency after police encounters or media exposure to brutality (Del Toro et al., 2019; Jackson et al., 2021; Sosoo et al., 2022). These experiences are linked to depressive symptoms and other forms of psychological distress (Galovski et al., 2018; Muscatell et al., 2022). Other studies of more context-specific variations in criminal legal contact, like the mental health of Black residents in proximal neighborhood contexts after a police involved killing (Bor et al., 2018), or other forms of police contact, are associated with an erosion of Black youths' mental health (Jindal et al., 2022). Taken together, this literature calls for deeper inquiry into how criminal legal systems operate as racialized institutions that affect the mental health of Black youth and their families.

#### *1.3.4 Racialized Educational Contexts*

Schools are another core context where Black youth regularly confront structural inequities. Many attend underfunded schools with limited access to quality instruction and resources (Logan et al., 2012; Merolla & Jackson, 2019). Youth report experiences of

discrimination, harsh discipline, stereotyping, and exclusion in these settings—experiences that both spark sociopolitical awareness and affect mental health (Hope et al., 2015; Hope & Bañales, 2019; C. D. Smith & Hope, 2020).

While developing awareness of racism may foster critical consciousness, it can also carry psychological costs. Studies show that perceptions of school-wide discrimination are associated with depressive symptoms, decreased school belonging, and lower academic engagement (Boyd et al., 2024; Butler-Barnes et al., 2022; S. M. Cooper et al., 2022). Beyond perceived disadvantage, observed factors that racialize educational context like racial composition and contextual disadvantage within schools also influence outcomes. For example, Walsemann et al. (2011) found that Black students experienced more depressive symptoms in predominantly white schools. Polos et al. (2022) observed that contextual disadvantage amplified the relationship between exposure to structural racism and depression. Other forms of school contextual disadvantage, such as a school's proximity to high-poverty areas, have been associated with worsened mental health for adolescents, particularly for racially marginalized youth (Coley et al., 2018).

#### *1.3.5 Structural Racism Shaping Individual-Level Health Outcomes*

Structural racism influences health not only through institutions like schools and neighborhoods, but also through broader state-level and systemic processes that shape individual experiences and outcomes. For example, studies have shown that Black adolescents living in states with higher levels of structural racism are more likely to report loneliness—often a precursor to depressive symptoms—as well as behavioral health indicators like sleep disturbances (Zhang et al., 2025). These are not isolated effects; they form part of a broader

pattern where racism embedded in societal structures manifests in mental and physical health disparities.

While the field is still evolving, growing evidence links structural racism to adverse mental health outcomes beyond depression, including trauma exposure, suicidal behaviors, toxic stress, and even biological aging (Bradford et al., 2024; English et al., 2022a; Martz et al., 2024; Merolla & Jackson, 2019). Quantitative approaches that attempt to measure structural racism often draw from indices that aggregate disadvantage across systems—educational access, housing segregation, economic inequality—and examine their downstream effects on youth development.

Still, metrics for assessing structural racism remain a work in progress. This makes qualitative data—particularly voices and experiences of Black youth and families—especially critical for illuminating how structural racism is perceived and felt across daily life contexts. This dissertation contributes to that understanding by incorporating participant narratives and lived experience to explore how structural forces shape racialized determinants of mental health. Further, individual, familial, and community-level variables may moderate the relationship between structural racism and mental health. For instance, Black parents experiencing structural disadvantage may also suffer from depressive symptoms, which in turn impact their children's mental health (Holmes et al., 2020; Pachter et al., 2006). Neighborhood and school environments influence not only immediate well-being but also racial identity formation—a critical protective factor against racism (Byrd & Legette, 2022; Witherspoon et al., 2016).

Ultimately, structural racism impacts health through a complex interplay of systemic inequities and interpersonal experiences. Racial identity, parenting, social cohesion, and institutional resources all operate within these systems, shaping whether Black youth experience

risk or resilience in the face of racialized adversity. Understanding these interlocking factors is essential to identifying pathways to healthier futures for Black youth and their families.

### *1.3.6 Sociopolitical Development and Awareness of Racism*

Black youth and their families' mental health is shaped by racism, whether they are consciously aware of it or not (Gibson et al., 2022; Salter et al., 2018). However, awareness of racism may influence how youth experience and respond to its effects. Sociopolitical development (SPD)—defined as the process of developing critical awareness of social inequities and building the skills to resist them—offers one framework for understanding how marginalized youth make meaning of racism and its impacts (Watts et al., 2003; Watts & Guessous, 2013). SPD is shaped by discriminatory experiences, family and peer socialization, and opportunities to critically reflect and take action against systemic injustice.

Importantly, adolescence is a developmental period when cognitive skills expand and youth become capable of understanding abstract systems, including structural racism (Kurtz-Costes & Rowley, 2012). Early adolescence, in particular, has been identified as a key period for developing awareness of racism (Hope & Bañales, 2019; Johnson et al., 2024). Yet while this awareness may enhance youths' ability to name inequality and take action, it also brings psychological risks, especially when youth lack supportive environments or coping resources (Solmi et al., 2022).

Although growing research explores SPD and critical consciousness in older adolescents and young adults, relatively few studies examine how these processes unfold in early adolescence—and even fewer focus on the mental health implications. This dissertation seeks to address that gap by qualitatively exploring how early adolescents make meaning of structural racism and its effects on their well-being. In doing so, it aims to build a more developmentally

informed understanding of how sociopolitical development interacts with structural forces to shape the mental health of Black youth.

### 1.4 Gaps in Literature

Psychological research has long documented the mental health impacts of racism on Black adolescents. However, much of this work has focused narrowly on interpersonal experiences of racism, such as direct discrimination or microaggressions (Trawalter et al., 2020). Far less attention has been paid to structural racism as a compounding, system-level phenomenon—especially from the perspectives of the youth and families most affected.

Community members, including Black adolescents and caregivers, experience and make meaning of racism daily. Yet their insights are often excluded from theoretical and empirical efforts to define or measure structural racism. Integrating their voices could fill key conceptual gaps—illuminating how racism operates across systems and how it shapes mental health outcomes in ways that researchers may overlook.

Youth perspectives are especially critical. Adolescence is a sensitive developmental period marked by increasing awareness of societal structures and the onset of most psychiatric conditions (Solmi et al., 2022). It is also a time when youth begin encountering racialized institutions firsthand—such as schools, policing, and employment—and forming identities in relation to these experiences (Johnson et al., 2024; S. C. Jones et al., 2020; Kurtz-Costes & Rowley, 2012; Nordberg et al., 2016; Seider et al., 2022). Early adolescence is a critical period to study, especially given the limited research on how youth at this age understand racism and how their ecological context shapes their mental health and development. (Blum et al., 2014; Johnson et al., 2024).

Quantitative efforts to measure structural racism are also relatively new. Although public health scholars have begun to use composite indicators and policy-based measures (Adkins-Jackson et al., 2022; T. Brown & Homan, 2024; Chantarat et al., 2021; Hardeman et al., 2022; Neblett & Neal, 2022), psychology has lagged behind in developing robust quantitative models that capture how structural forces shape mental health across ecological levels (Neblett, 2019). Moreover, studies often prioritize researcher-defined variables and constructs, rather than grounding measurement in community-defined determinants of health—highlighting the need for a shift toward research that centers lived experience, leverages participatory methods, and bridges qualitative and quantitative approaches to structural racism.

### 1.5 Positionality

As this dissertation speaks to the racialization of Black youth and the structural forces shaping their lives, I recognize that I—a Black man—have also moved through many of the same systems. I have been racialized, marginalized, and privileged in ways that give me both proximity to, and critical distance from, the youth and families whose voices are centered in this work.

My interpretations are informed by personal experience but also shaped by my training as a psychologist. I have been trained in statistical analysis, psychopathology, and experimental research—tools often rooted in reductionist, positivist approaches to knowledge production. At the same time, I have been mentored in Black, feminist, liberatory, and community-based methodologies that have reshaped how I engage in research. These frameworks remind me that the data are not just numbers or quotes, but snapshots of people's lived experiences—each with ethical and emotional weight.

This dissertation is grounded in a belief that rigorous, empirical analysis and structural critique are not incompatible. I aim to hold both commitments: to conduct precise, theory-informed research while remaining accountable to the communities whose realities I seek to illuminate. In doing so, I acknowledge a tension: that the very tools used to analyze structural racism are themselves products of the structures being critiqued. Holding this tension, I leverage findings of community-attuned research to engage in critical quantitative methodologies that affirm what many in Black communities have long known: that structural racism is bad for our mental health, and that change begins with listening.

### 1.6 Specific Aims

This dissertation seeks to advance conceptualization and empirical examination of racialized determinants of mental health for Black adolescents. Specifically, it aims to understand how these determinants coalesce into structural racism, and how that structure impacts Black youth and their families. To address these goals, the dissertation includes three studies guided by the following aims:

1. **Elucidate Black youths' awareness of racism** across ecological levels (e.g., interpersonal, institutional, cultural) and explore how that awareness relates to their sociopolitical development and mental health.
2. **Examine the contextual factors shaped by structural racism** that Black youth and their caregivers identify as determinants of mental health.
3. **Investigate how multiple forms and levels of racism combine** to produce a unique, overarching structural stressor—and assess how this multidimensional form of racism predicts depressive symptoms in adolescence.

Studies 1 and 2 employ **community-based participatory research (CBPR)** and **photovoice** methodology (Israel et al., 2012; Wang & Burris, 1997) to center youth and caregiver perspectives. Study 1 explores adolescents' awareness of racism and its links to their mental health and sociopolitical development. Study 2 investigates caregivers' conceptualizations of structural factors that shape Black youths' mental health. Study 3 uses **quantitative secondary data** from the Future of Families and Child Wellbeing Study (FFCWS)—a nationally representative birth cohort—to develop a multidimensional model of structural racism and examine its associations with depression across adolescence and early adulthood. Together, these studies aim to enrich how we **define, measure, and respond** to structural racism as a determinant of Black youth mental health.

## Chapter 2 Study I

Racism is a major threat to Black youths' psychological development, health, and well-being (Iruka et al., 2022; S. C. T. Jones & Neblett, 2017; Trent et al., 2019). Defined as the discriminatory treatment of racial groups across socioecological levels—including institutional, cultural, interpersonal, and intrapersonal domains—racism operates through historical and systemic power imbalances. It has been described as the "determinant of determinants" for Black mental health (J. M. Jones, 1972; Williams & Williams-Morris, 2000). Black youth are exposed to disproportionate stressors across key determinants of mental health—such as education, social and built environments, and community contexts—at every level of the socioecological model. These impacts begin as early as the prenatal period and extend through the life course, contributing to premature morbidity and mortality (Seaton, 2020). Adolescence is a particularly critical developmental period for examining the impact of racism, as youth become increasingly aware of racial inequality and structural oppression during this time (Barnes & Motz, 2018; Johnson et al., 2024; Prins et al., 2023; Wittig, 2017).

Over the past several decades, research has documented the harmful effects of racism on Black youths' mental health and development. More recently, the field of psychology has begun shifting beyond documenting harm to exploring how Black youth make meaning of and resist racism—particularly through the lens of Sociopolitical Development (SPD) (Hope et al., 2023; Watts et al., 1999, 2003; Watts & Guessous, 2013). Rooted in Freire's (1970) theory of critical consciousness, SPD refers to the psychological processes that support critical reflection, agency,

and action against oppression. It offers a framework for understanding how youth develop awareness of systemic inequality and engage in resistance. Emerging research suggests that SPD can shape life course trajectories and adolescent mental health, sometimes serving a protective role, but at other times posing risks depending on context (Hope et al., 2024; Maker Castro et al., 2022; Mosley et al., 2021). Thus, examining how SPD intersects with experiences of racism, mental health, and resilience is critical to understanding the impact of racism on Black adolescents' mental health.

While a substantial body of research explores SPD, racism, and Black youth mental health as separate constructs, few studies examine how these intersect—particularly during early adolescence (Johnson et al., 2024). Existing work in this area has primarily relied on quantitative methods, often focusing on associations between critical consciousness and mental health outcomes (Heberle et al., 2020; Maker Castro et al., 2022). However, to understand how Black adolescents experience and make meaning of racism—and how these processes shape their sociopolitical development and psychological well-being—qualitative approaches are essential. This study addresses that gap through a secondary analysis of a photovoice project with eight Black youth. The analysis focuses on how participants describe their sociopolitical development, perceptions of racism across socioecological levels, racialized identities, coping strategies, and implications for mental health.

### 2.1 Theoretical and Conceptual Frameworks

Black youth contend with racism, whether or not they have the language or conceptual understanding to name it (Salter et al., 2018). Thus, theoretical frameworks that capture their awareness and engagement with racism are essential for understanding its impact on their health and well-being. Sociopolitical Development (SPD) theory, developed by Watts and colleagues

(2003), describes how individuals become aware of and respond to social and political forces, including oppression. This theory highlights Black youths' growing awareness of structural racism and their resistance to it.

In contrast, other models focus less on awareness or resistance and more on the developmental consequences of racism itself. One such framework is García-Coll and colleagues' (1996) Integrative Model of Developmental Competencies in Minority Children, which posits that minority children's social position is shaped by racism, influencing their exposure to and navigation of key social determinants of health (e.g., education, social contexts, built environments). These interactions, in turn, shape the mental health of Black youth, families, and communities. In both models, racism is conceptualized as a psychosocial stressor and key determinant of health that operates across multiple ecological levels, each with distinct effects on Black youths' mental health (Iruka et al., 2022; S. C. T. Jones & Neblett, 2017; Seaton, 2020).

Several additional theoretical and conceptual models examine the role of identity, coping, and psychological outcomes in shaping Black adolescents' development, particularly as they relate to mental health. For example, Hammack's (2003) framework on depression posits that racial oppression can isolate Black youth from dominant cultural narratives, contribute to internalized racism, distort self-concept, and foster feelings of hopelessness—factors that collectively increase vulnerability to depression. Beale-Spencer and colleagues (2002) argue that structural racism racializes the environments Black youth inhabit, influencing both mental health and identity development. For instance, exposure to cultural racism—such as persistent stereotypes that question Black intellectual capacity—combined with institutional barriers (e.g., neighborhoods lacking job training or access to professional employment) can lead to negative self-appraisal (private regard) or negative perceptions of one's group (public regard). These

identity processes are critical, as beliefs about one's racial group—such as nationalist ideology or internalized racism—can either buffer or exacerbate mental health risks (K. O. Cokley, 2005; W. E. Cross Jr., 1995; Sellers et al., 1998; Umaña-Taylor et al., 2014).

Other frameworks focus on strengths-based approaches to resilience. For example, J. L. White's (1984) *The Psychology of Blacks* highlights seven core psychological assets—improvisation, resilience, social connectedness, spirituality, emotional expressiveness, humor, and healthy skepticism—that collectively support effective coping and help safeguard Black individuals' mental health.

### 2.1.1 Developmental Context: Early Adolescence

It is also essential to situate these theoretical frameworks within the context of adolescent development. Early adolescence, between the ages of 10 and 14 (Blum et al., 2014), is a critical period during which Black youth begin to acquire the cognitive, emotional, and behavioral capacities necessary to recognize and interpret systemic oppression (Umaña-Taylor et al., 2014). This stage marks the emergence of racial identity development and an increased understanding of group membership and social stratification (Cross Jr & Cross, 2007; Kurtz-Costes & Rowley, 2012). As Black youth engage in more cross-cultural interactions, they may also begin to experience and recognize racial discrimination experiences (Banerjee et al., 2018; Seaton & Douglass, 2014). These cognitive and emotional shifts support the development of sociopolitical awareness and inform how youth understand and respond to racism (Blum et al., 2014; Watts & Guessous, 2013). The same developmental capacities also shape youths' coping strategies, which in turn influence their mental health (Spencer et al., 2002).

These processes unfold within a broader socioecological context, as youth interact with key socializing agents—such as schools, neighborhoods, peers, and communities—whose

structures and practices are shaped by racialized laws, policies, and sociopolitical forces. During early adolescence, family, school, and neighborhood contexts often involve reduced supervision, particularly for youth facing structural disadvantage, which can increase the risk of delinquent behavior and related mental health concerns (Beyers et al., 2003; Witherspoon & Hughes, 2014). Early adolescence is thus a particularly sensitive developmental window, during which Black youth simultaneously face normative developmental stressors, racism-related challenges, and the evolving construction of racialized identities. Given this convergence, further research is needed to examine how racism—both perceived and structural—affects the mental health of Black youth during this formative period.

### 2.1.2 Multiple Levels of Racism and Their Impacts on Mental Health for Black

Black youths' mental health is shaped by racism across ecological levels—individual, cultural, institutional, and internalized. These levels, collectively understood as structural racism, exert cumulative effects that cannot be understood in isolation (Z. D. Bailey et al., 2017; Iruka et al., 2022; Trent et al., 2019). Although structural racism is increasingly acknowledged in the literature (Adkins-Jackson et al., 2025; Polos et al., 2022), psychological research often focuses on discrete forms of racism—such as interpersonal discrimination—without fully accounting for the broader systems in which these interactions occur.

#### *2.1.2.1 Institutional Racism*

Racialized school and neighborhood contexts are social determinants of Black youths' mental health. For instance, Seaton and Douglass (2014) found that Black youth in predominantly Black or white schools showed increased depressive symptoms related to discrimination, whereas those in racially diverse schools did not. Other studies have linked school racial composition, teacher and peer discrimination, and disparate discipline practices to

worse mental health outcomes (S. M. Cooper et al., 2022; Polos et al., 2022; Prins et al., 2023). Similarly, racially segregated neighborhoods are associated with higher discrimination and worse mental health (English et al., 2014; K. White & Lawrence, 2019), though neighborhood cohesion may buffer these effects (Hurd, Stoddard, et al., 2013)

#### *2.1.2.2 Cultural Racism*

Cultural racism reinforces white supremacy by asserting dominant group superiority through stereotypes and everyday racism (Essed, 1991). These narratives negatively shape how Black youth view themselves and are viewed by others. Youth exposed to cultural racism may experience stereotype threat, internalized racism, and worsened self-concept (James, 2020; Nadal et al., 2021). In one photovoice study, Black boys described pressure to counter stereotypes of criminality and athleticism (C. D. Smith & Hope, 2020).

#### *2.1.2.3 Individual Racism*

Racial discrimination—including direct, vicarious, and online forms—is the most studied level of racism. Meta-analyses consistently show associations between discrimination and internalizing symptoms, stress reactivity, and poor academic outcomes (Benner et al., 2018; Kim et al., 2025). Vicarious exposure to police violence and family-based racism also (Durham, 2018; Loyd et al., 2022) predicts poorer outcomes for children (Heard-Garris, Ekwueme, et al., 2021; Sosoo et al., 2022). Microaggressions—subtle acts of exclusion or invalidation—also negatively impact youth mental health (Durham, 2018; Loyd et al., 2022)

### 2.1.3 Sociopolitical Development, the Awareness of Racism, and Black Youths' Mental Health.

Whether or not youth perceive racism, its effects still shape well-being (Salter et al., 2018). SPD theory helps us understand how youth develop awareness and resistance to

oppression through cognitive, emotional, and social skills (Watts et al., 2003). Watts and colleagues proposed a stage-based model of SPD. The *acritical stage* is characterized by minimal awareness of structural oppression and little or no resistance to it. In the *adaptive stage*, youth recognize oppression but attempt to navigate or benefit from existing systems without challenging them. During the *precritical stage*, youth are aware of structural inequities but remain unengaged or unsure of how to act; and in the *critical* and *liberatory* stages, youth integrate structural awareness with identity development and collective action. These stages may map onto mental health trajectories. For example, youth in early SPD stages may report less distress, while youth with greater awareness but little opportunity for action may experience more symptoms of stress or depression (S. M. Gibson et al., 2022; Godfrey et al., 2019).

#### *2.1.3.1 Protective Factors and Socialization*

SPD unfolds in the context of socializing agents—parents, peers, schools, media, and organizations—who influence youth's identity and coping strategies (Watts & Guessous, 2013). Coping strategies vary by level of racism and are learned through racial socialization messages, peer modeling, and cultural norms (Anyiwo et al., 2023; Volpe et al., 2021). Some messages foster pride and resistance; others may encourage silence or adaptation (e.g., code-switching). These messages shape not only youths' capacity to resist oppression but also their mental health outcomes.

### 2.1.4 Gaps in Literature and Study Aims

Although there is extensive research on how Black youth perceive and cope with interpersonal forms of racism, less is known about their awareness of racism at the institutional, cultural, and structural levels. This is especially true during early adolescence, a critical developmental window in which youth begin to develop the cognitive, emotional, and social

capacities to understand and navigate complex systems of oppression (Johnson et al., 2024; Kurtz-Costes & Rowley, 2012).

In addition, despite increasing scholarly attention to sociopolitical development (SPD), relatively little research has examined how SPD unfolds during early adolescence or how it is shaped by youths' lived experiences with racism. Most SPD research relies on survey-based methods and adolescent samples, with few studies capturing how early adolescents in specific racialized communities articulate and navigate their developing awareness of structural oppression. Finally, although Black youth experience racism whether or not they can name it, few studies use participatory qualitative methods to capture how youth in specific communities make sense of racism and its effects. Without the voices of youth themselves, we risk missing how racism operates beneath the surface—like toxins in the water that fish cannot see but still harm them (Salter et al., 2018).

### 2.1.5 Current Study

This study addresses these gaps through a secondary qualitative analysis of a photovoice project conducted with Black early adolescents in a racially segregated urban Midwestern community. Using a sociopolitical development framework, the analysis explores how youth make meaning of racism across ecological levels, the coping strategies they employ, the socialization messages they receive, and the connections between these experiences and their mental health.

To guide this analysis, the study is organized around two primary research questions:

1. How do Black early adolescents understand and experience racism across individual, cultural, and institutional levels?
2. How do these experiences shape their sociopolitical development, coping strategies, identity, and mental health?

## 2.2 Method

Participants ($N = 8$) in the original photovoice project were Black middle school students between the ages of 13 and 15. Two participants self-identified as boys and six participants as girls. Participants' exact ages were not recorded. All participants were affiliated with Strengthening the Black Family, a community-based organization in Raleigh, NC. Other socioecological and demographic data were not available in the dataset. Youth were encouraged to select pseudonyms that reflected their identities; the chosen names were: Beyoncé, Juicy Qel, Candy Girl, The Plug, A, Brandon, Kid, and Apple Head.

The project was a collaboration between graduate students enrolled in a photovoice course at the University of North Carolina at Chapel Hill and community partners from Strengthening the Black Family. The study was conducted under the supervision of co-principal investigators Dr. Enrique Neblett and Dr. Alex Lightfoot. Community partners played a key role in participant recruitment, study design, and implementation.

The original goal of the photovoice project was to explore how Black youth understood and experienced race, racism, and health in their daily lives and communities. Youth participants collaboratively developed three guiding research questions for the project:

- Why does racism still live, and why are people racist?
- How do we feel/see racial stereotypes day-to-day?
- How do races come together vs. what keeps them apart?

The current study is a secondary analysis of that project's data. It seeks to address the following research questions:

1. How do Black early adolescents understand and experience racism across individual, cultural, and institutional levels?
2. How do these experiences shape their sociopolitical development, identity, coping strategies, and mental health?

### 2.2.1 Photovoice and Community-Based Participatory Research (CBPR) Approach

Photovoice is a participatory method that uses photography and group dialogue to center community members' experiences, voices, and solutions. (Wang & Burris, 1997). Grounded in Paulo Freire's (1970) theory of critical pedagogy and feminist participatory inquiry, photovoice was developed as a tool for community empowerment and health promotion. It encourages participants to identify and document challenges and strengths in their environments and to advocate for change.

The approach is embedded in the principles of CBPR (Israel et al., 1998, 2012) which emphasize shared power, co-learning, and action-oriented research. In this study, community members helped co-construct the research questions, select and discuss photographs, and identify key themes through the SHOWED process (Wang & Burris, 1997):

- **S**ee: What do you see?
- **H**appening: What's really happening?
- **O**ur lives: How does this relate to our lives or community?
- **W**hy: Why does this problem or strength exist?
- **E**mpowerment: How does it empower or affect you?
- **D**o: What can we do about it?

Photovoice has been used effectively with Black youth to promote critical reflection and enhance sociopolitical development (Jahn et al., 2021; C. D. Smith & Hope, 2020). Photovoice data were collected in 2017, prior to the current data analysis. The researcher's role in this project was primarily secondary analysis of already collected data, though he did engage the original research data collection team, including the Principal Investigators, graduate research assistants, and lead community partner. Additionally, Beck's (2019) ethical guidelines for secondary analysis of CBPR were followed, including additional measures to protect participants' data (de-identification), consulting with members of the original research team regarding the accuracy of data, and acknowledging the original data source when reporting on data.

### 2.2.2 Data Collection Procedures

Participants met for five photovoice sessions. The first session involved informed consent procedures, group introductions, norm setting, and an initial photography assignment. Sessions two through four were each organized around one of the youth-developed research questions listed earlier. In each session, participants shared photographs they had taken in response to the prompts, engaged in discussion using the SHOWED method, and identified photos that most resonated with the group's shared perspectives. Discussions were audio-recorded and transcribed verbatim.

In the final session, participants synthesized insights from the photo discussions and brainstormed actions to address the challenges they had identified. Products from the primary data collection included participant photos, audio recordings, meeting transcripts, youth- and RA-generated memos, a collaboratively developed codebook, and planning materials such as agendas and flyers.

### 2.2.3 Analytic Approach and Epistemological Framing

Data were analyzed using critical reflexive thematic analysis, a method that emphasizes both pattern identification and interpretive meaning-making grounded in theoretical frameworks and researcher reflexivity (Braun & Clarke, 2006; Byrne, 2022; Castleberry & Nolen, 2018). This approach supports theoretical flexibility while maintaining a structured analytic process that allows for both deductive and inductive interpretation of participant narratives. Secondary data analyses were conducted using NVivo 12 (Welsh, 2002) software and included the following stages:

- Familiarization with the data
- Generation of initial codes
- Identification of cross-cutting themes
- Review and refinement of themes
- Consultation with members of the original research team
- Development of written interpretations of the themes

Both inductive (data-driven) and deductive (theory driven) coding strategies were used (Clarke et al., 2015). Deductive codes were developed a priori based on established theories and frameworks, including Watts and colleagues' (1999, 2013) models of SPD, which outline stages (i.e., acritical, adaptive, precritical, critical, liberatory) and socializing processes (i.e., parental influence, organizational involvement, exposure to historical events). Definitions from Neblett's (2019) conceptualization of different forms of racism were used to identify different forms of racism across socioecological levels. J. L. White's (1984) strengths-based cultural framework was used to identify coping strategies such as humor and collectivity. Other codes were based on

common conceptual definitions for cognitive, affective, and behavioral processes. (**See Appendix.)**

Inductive codes emerged through iterative categorization during the coding process (Neale, 2016). Inductive codes (e.g., "It's Lit", Unity in the Community, Give Respect to Get Respect) were reflective of common sentiments expressed by the participants that were not represented in the theory-driven deductive codes. Themes were derived through NVivo matrix coding queries to explore code co-occurrence (e.g., SPD × levels of racism, coping strategies × mental health outcomes; see **Study 1 Table 2.1 and Table 2.2)**. Final themes were reviewed in collaboration with one of the original principal investigators to ensure alignment with project goals and contextual fidelity. A complete list of the codes and definitions used in this analysis is available in the **Study 1 Appendix**. Member checking was not available due to the extended duration since data were collected. All coding was conducted by the lead author in consultation with a principal investigator to ensure data integrity.

Finally, the study was grounded in a critical constructivist epistemology (Phillips, 2023), which posits that knowledge is socially constructed through human interaction, shaped by prior knowledge, historical context, and critical interpretation. This approach aligns with the participatory nature of photovoice, as youth participants were positioned as co-constructors of knowledge, challenging dominant paradigms and adding new perspectives to existing academic frameworks.

## 2.3 Results

Eight themes emerged from the secondary thematic analysis of youth photovoice data, organized into three analytic domains aligned with the core research questions. These domains

reflect key aspects of Black adolescents' racialized experiences: (1) awareness of racism across ecological levels and stages of sociopolitical development (SPD); (2) coping strategies for navigating racism; and (3) the mental health consequences of racism and racialized development. Table 2.1 and Table 2.2 illustrate the analytic process. Table 2.1 maps code co-occurrence across ecological levels of racism and SPD stages, providing the foundation for themes in Domain 1. **Table 2.2** displays youth-generated research questions and photo discussion patterns that informed themes in Domains 2 and 3. Through this iterative analytic process, I identified the following themes within each domain:

- **Domain 1: Awareness of Racism and SPD**

  • Theme 1: *The everydayness of internalized racism arrests Black youth in the acritical stages of SPD*

  • Theme 2: *"The schools, neighborhoods, and police still allow it": Black youths' precritical reflections on institutional racism*

- **Domain 2: Coping with Racism**

  • Theme 3: *"...Stick together if you actually want to get free": Collective coping to combat racism*

  • Theme 4: *"That's so funny": Distancing, avoidance, and humor as coping mechanisms*

  • Theme 5: *"Does it have to be about race?": Adaptive and acritical stages of SPD as barriers to race-based conversations.*

  • Theme 6: *"Imma show you": Counter-narratives and fulfilled stereotypes*

- **Domain 3: Mental Health Consequences**

  • Theme 7: *Depression—feeling unwanted, invalidated, and hopeless in the face of racism*

• Theme 8: *"All stereotypes contain truth": Grappling with racial stereotypes and emotional health*

### *2.3.1* Domain 1: Awareness of Racism Across Multiple Ecological Levels and Adolescent Sociopolitical Development

The first two themes describe how youth named and reflected on racism across contexts and how these reflections mapped onto stages of Sociopolitical Development (SPD). Analyses revealed the following themes: (1) The schools, neighborhoods, and police still allow it: Black youths' precritical reflections on institutional racism and (2) The everydayness of internalized racism arrests Black youth in the acritical stages of SPD.

Together, these themes provide insight into how Black early adolescents understand racism across ecological levels and how their cognitive, emotional, and behavioral responses align with different stages of SPD.

#### *Theme 1: The schools, neighborhoods, and police still allow it: Black youths' precritical reflections on institutional racism*

Youth described experiencing racism in both school and neighborhood settings. While some reflections aligned with the critical stage of SPD, most revealed adaptive or precritical awareness without direct action.

In schools, youth highlighted systemic inequities in curriculum content, access to extracurricular activities, racial representation, and classroom demographics. Beyoncé and The Plug, for example, challenged curriculum content related to race and policing:

Beyoncé: “There’s a higher percentage of Black people killing Black people than police officers... I learned that in my Global Conflicts class.”
The Plug: “Statistics are gonna show that Black people do more stuff than white people, but that doesn’t mean it’s true… back in Reconstruction… they started putting Black people in jail for dumb stuff… so it just keeps going on and on in history.”

Beyoncé's repetition of classroom statistics reflects an acritical stage of SPD. The Plug offers historical context and critique, demonstrating a more critical reflection that challenges systemic misrepresentations of Black criminality.

Youth also noted inequities in extracurricular access, particularly in sports like lacrosse, and described being among the only Black students in gifted classes despite their school being majority Black. These experiences led to feelings of isolation and exclusion. Several noted frustrations over their school’s public image, which included disproportionately white students in promotional materials. These examples represent precritical awareness—recognizing injustice but without associated action.

While some youth reported attending protests or challenging peers (indicating potential critical action), others expressed a sense of futility. As A remarked, “I don’t know what to do,” highlighting the perceived barriers to change even when racism is recognized.

Beyond schools, youth described institutional racism in their neighborhoods. Apple Head drew an analogy between piano keys and hiring practices:

“If it’s a Black person who wants a professional job, people will say no… you'd have to pull different strings to get the job… but if you’re with the white people, they’d just be like, yeah.”

The Plug reflected on racially segregated housing:

"Mostly Black people live in public housing... maybe some of them think we're like bougie Black people because we live in… the White section."

These narratives reflect an adaptive stage of SPD, where youth observe inequality and occasionally attempt to benefit from existing structures without engaging in systemic critique or change.

***Theme 2: The everydayness of internalized racism arrests Black youth in the acritical stages of SPD***

Youth repeatedly described internalized racial stereotypes as part of daily life—what some scholars describe as internalized appropriated oppression. These beliefs often kept them in the acritical or adaptive stages of SPD.

Participants were aware that others viewed Black youth as dangerous, criminal, or unintelligent. At times, they rejected these beliefs; and other times, they internalized them:

Brandon: "If I see a bunch of Black boys walking toward me, I won't keep walking. I'll get out the way… If I see a group of white boys, I'll just keep going."

Here, Brandon mirrors the racialized surveillance he experiences—both identifying systemic bias and replicating it in his own behavior. His awareness lacks structural critique, consistent with the acritical stage of SPD.

Youth also described stereotyped media portrayals and assumptions about Black behavior. Brandon remarked:

"Now it seems like [Black people] stick together through negative energy… if someone gets killed, all of a sudden, they want to get together."

Kid added, regarding social media:

"The things that attract white people are like… panda bears and stuff like that."

These comments reveal an internalization of deficit narratives about Black communities and preferences, even when couched in humor or sarcasm.

Gendered stereotypes were also evident. Several youth expressed the belief that Black girls are "fast" or "act grown," and suggested that white girls only behave similarly when influenced by Black peers. When one participant challenged this view, the belief was restated more emphatically, ending the conversation. These reflections demonstrate how misogynoir can operate within peer discourse and inhibit critical growth.

Overall, these findings highlight the frequency with which youth encounter, internalize, and perpetuate racial stereotypes. While some awareness is present, these reflections often remain at the acritical or adaptive stages of SPD, limiting opportunities for resistance or structural critique.

### 2.3.2 Secondary Data Analysis

Although photovoice is typically used for primary data collection, it can be leveraged for secondary analysis to explore new questions from existing rich, contextualized data (Fleming et al., 2009; Heaton, 2004; Panazzola & Leipert, 2013). This study follows Beck's (2019) three-step framework for secondary qualitative analysis:

1. Clarify new research questions and assess whether the original data can address them.

2. Determine analytic purpose, which in this case was analytic expansion using Thorne's (1994) typologies.
3. Consult with original researchers to ensure contextual integrity and alignment between the original study and new questions.

The current study re-engages with the original data corpus—including photos, four session transcripts, codebooks, and memos—through the lens of sociopolitical development and mental health. This allows for a deeper understanding of how Black early adolescents understand racism across ecological levels and its impact on their mental health. Original codebooks and memos were used to guide researchers' development of interpretive codes as well as to assist in the meaning-making of current data. Images were used to better interpret transcripts, and transcripts were used as the primary data source for analysis.

### 2.3.3 Domain 2: Black Adolescents' Coping Strategies

In addition to naming multiple levels of racism, Black youth engaged in a range of coping strategies to support their mental and emotional well-being. Four prominent approaches emerged: (1) using humor to diffuse or deflect emotional pain, (2) avoiding conversations about race and racism, (3) crafting counternarratives to challenge stereotypes, and (4) seeking collectivity within and across racial lines to resist racism.

#### *Theme 3: "That's so funny": Using Humor to Connect and Deflect for Black Adolescents' Racial Coping*

Laughter was a near-constant feature of the group's interactions—directed at one another, at themselves, and even at serious topics. Humor emerged as a primary coping tool. It was used

both to (1) disarm peers and deflect difficult conversations, and (2) build cultural connection and affirmation within the group.

For instance, in one discussion, Kid described a racist incident in which a Black student had a tampon thrown at them by white students on a bus. While recounting the story, the group interrupted with jokes, offering mock reactions and imagined responses. The humor built momentum—until Kid grew quiet and disengaged. Similarly, when JQ recounted a racially discriminatory encounter with peers and a teacher, the group initially laughed, but quickly shifted to expressions of care and solidarity when they saw JQ's distress: "That's not funny" and "They should've went to the office."

These moments illustrate how humor was often deployed to create emotional distance from painful experiences. Yet its effectiveness varied depending on context, relationship dynamics, and the severity of the racism described.

Humor was also a deliberate strategy for connection. The youth reflected on its racial and cultural specificity:

A: "I think it [humor] is about race because… it depends on, like, where you come from… If you come from the hood, you make a joke about the hood, you're gonna understand it… If you come from a well-put-together environment, you're gonna be like, 'What are you talking about?'"

Their comments show that humor functioned as a form of Black cultural capital—rooted in shared experience, environment, and identity. It helped them mark intragroup boundaries, form cultural bonds, and navigate racialized differences in what was considered funny or offensive.

For example, in one exchange, the group jokingly debated whether enjoying "fried chicken" or "Kool-Aid" was a marker of Blackness:

Brandon: "That's a stereotype. I don't think you can actually act White."
Candy Girl: "People call people 'oreos' and stuff…"
JQ: "If somebody say like… you like fried chicken… and somebody say, 'I don't like fried chicken or I don't like Kool-Aid,' then you be like…"
(Several youth at once): "You not Black!" (laughter)
The Plug: "Kool-Aid is nasssty!"

These lighthearted moments show how the group used humor to affirm in-group cultural knowledge—even while negotiating racial stereotypes. They also described joking about their "white phase"—periods when they identified more with white peers or cultural content—which sparked further laughter and reflection.

While humor served as a coping mechanism for everyday racism and racial identity negotiation, it broke down in the face of more direct, painful discrimination. In such moments, humor gave way to silence or more serious support. As a coping strategy, humor had clear trade-offs: it fostered connection and emotional release, but could also mask pain or create interpersonal tension when it misaligned with the severity of a situation.

### ***Theme 4: "Black people should sometimes stick together if you actually want to get free" — Collective Coping and Cross-Racial Solidarity as Resistance***

In response to the "Empowered" and "Do" components of the photovoice SHOWED method, participants reflected on what would create change in their communities. Two

interconnected strategies emerged: (1) strengthening unity within the Black community, and (2) fostering solidarity across racial groups. These collective coping approaches were framed as both necessary and hopeful ways to combat racism.

Several youth described a desire for greater intra-racial solidarity, often naming historical examples to illustrate a time when Black people acted more collectively. They evoked periods such as slavery and the civil rights movement as moments when collective action was essential for survival and liberation. Referencing a photo of a shirt that read "Unity in the community," one youth offered it as a visual answer to their research question: "What brings races together vs. what keeps them apart?" Another participant connected this desire to history:

"It looks like the white people don't trust the Black people being so close together so they're making a barrier in between each one." (Image 2.1)

The piano metaphor surfaced multiple times in the discussion, symbolizing the necessity of racial harmony. One youth shared:

Br: "To play the piano you need all the keys. And Dr. Martin Luther King Jr. said that he wanted us to play together."

This imagery reflected both the importance of cross-racial collaboration and the youth's belief that racism persists in part due to ongoing social separation: "But that's why racism lives—because we're separated, and we want to be together."

The youth described cross-cultural exchanges as important tools for challenging stereotypes and building mutual understanding. For example, they recommended sharing music

playlists across racial groups, believing that this could spark empathy and dialogue. One youth commented on segregated church communities:

"We are still segregated in the church. I don't understand why… if we're all having the same goal, why can't we just be doing it together?"

These cross-racial interactions were viewed as practical and symbolic efforts to dismantle barriers and humanize one another's experiences.

At the same time, the youth expressed a desire for more frequent collective action within the Black community. They voiced frustration that people only came together after tragedies, such as police killings, rather than celebrating positive milestones:

"People should come together when someone's going to college… not just when something bad happens."

They also expressed nostalgia for tighter neighborhood bonds, recalling times when families gathered more regularly: "Everybody used to go to that one person's house." These comments revealed a longing for consistent connection and preventative community-building—rather than reactive responses to crisis.

While most reflections about cross-racial exchange were aspirational, the youth also named tensions with white peers at school. They described being subject to inappropriate or stereotype-reinforcing questions, and expressed interest in more opportunities for open dialogue—both to share their own experiences and to better understand others. Social media was mentioned as a tool with dual potential: it could either reinforce harmful images or uplift positive portrayals of Blackness. As one youth put it:

"There is positive stuff, but the negative stuff gets more attention… it spreads, it goes viral."

Despite these tensions, youth held onto the idea that collective coping—both within the Black community and across racial lines—was key to liberation. One participant returned to the piano metaphor:

"Dr. Martin Luther King said we should play together, and to play the piano you need to play both white and Black keys."

An accompanying photo (Image 2.2) of a white community member with a homemade Black Lives Matter sign further illustrated this vision of racial harmony and solidarity.

In sum, participants identified unity—both racial solidarity and cross-cultural collaboration—as essential to coping with and ultimately transforming racism. As one youth concluded:

"Black people should sometimes stick together if you actually want to get free."

**Theme 5: "Does it have to be about race?": Adaptive and acritical stages of SPD as barriers to race-based conversations.**

While the purpose of the project was to explore Black youth's experiences of racism and its impact on health, participants frequently resisted sustained conversations about race. Across sessions, the youth expressed fatigue and discomfort with the topic, describing it as "negative" and emotionally taxing. Their tendency to avoid discussions of racism, despite its daily relevance, suggested a pattern of adaptive and acritical sociopolitical development (SPD). These

early SPD stages often involve either a lack of critical analysis or efforts to protect oneself emotionally by steering away from race-related discourse.

This avoidance surfaced early. After the first photo session—during which a Black man was fatally shot by police in their neighborhood—the facilitators invited participants to reflect on the event. Although this was a significant and timely issue, youth largely bypassed direct engagement with the incident. Instead, they gravitated toward historical examples of racism or other less emotionally charged topics. One participant commented on Black Lives Matter protests, stating:

"It seems like they stick together through negative energy, like if someone gets killed, they suddenly wanna get together."

This statement, combined with the group's focus on "Black-on-Black crime" over police violence, reflected a mix of lived experience and school-based misinformation. These rationalizations align with the adaptive and acritical SPD phases, where youth may internalize dominant narratives or downplay structural racism as a coping mechanism.

Avoidance was also evident in group dynamics and topic selection. When Kid proposed attending a local protest in response to the police killing, the group unanimously rejected the idea:

Kid: "What are we going to do with this project?"

*(Suggests going to the protest)*

Group: "Nooooo!"

This strong, collective dismissal highlighted their discomfort with engaging in direct racial justice action, echoing a broader reluctance to confront racism explicitly. The same pattern repeated when youth selected their research questions for the second and third photovoice prompts. They frequently asked to change the topic altogether, saying:

"Can we talk about a different topic?"
"I'm tired of talking about races, it's so negative."

Even when nudged toward a more positive lens—such as focusing on "racial leaders" or "making racial amends"—their engagement remained limited. These alternative topics were less about solving problems within their own communities and more about abstract or historical ideals, further illustrating an acritical lens.

This discomfort grew across sessions, with increasing off-topic conversations and attempts to shift focus away from race. In one exchange near the end of photo prompt 2, the pattern became explicit:

TP: "Oooh like what races do together like…"

A: "Nooo! No races!"

Moderator: "Well, what do you…"

A: "I don't wanna do races. I'm tired of doing that. It's so negative!" *(background laughter)*

This moment underscored their collective impulse to retreat from emotionally difficult topics. Rather than indicating apathy or disengagement, their avoidance may be a form of psychological self-protection. In contexts where race is inescapably present but rarely addressed in supportive ways, not talking about racism becomes an adaptive coping strategy.

These findings suggest that while the youth are deeply aware of racism in their lives, they are not always ready—or do not always feel safe enough—to confront it critically. Their responses reflect the tension between their lived experience and their developmental stage, where critical consciousness may still be forming, and emotional safety remains a priority.

### Theme 6: "Imma show you" — Black Youth Use Both Defiance and Resistance to Respond to Stereotypes

Stereotypes were a central concern for the youth as they reflected on their racialized experiences. They described feeling angry, confused, saddened, or shocked in response to being stereotyped. In coping with those emotions, they tended to respond in one of two ways: (1) fulfilling the stereotype, allowing external expectations to shape their behavior; or (2) rejecting the stereotype through counternarratives that asserted alternative visions of Black identity. Though seemingly opposite, both responses served a common function: "teaching a lesson" to those who stereotyped them—whether by showing the harm of biased assumptions or challenging them with strength and success.

In some cases, youth fulfilled stereotypes in ways that reflected internalized beliefs or protective strategies. Apple Head, for example, shared that teachers assumed they would misbehave:

"… oh just because I'm Black, people think I'm gonna act bad so I'm just gonna decide like ok since I am Black and I'm in this class, I'm gonna act bad and I'm not gonna do my work and I'm not gonna try and stuff like that."

Others described how negative assumptions by adults—including teachers, parents, and pastors—could become self-fulfilling. One youth commented that "old people and the adults think that the kids are like the worst people in the world," reinforcing messages of suspicion and criminality. In a related exchange, JQ explained why he and his friends traveled in large groups: "No matter what… if we at another game or something, I always go with like a bunch of people, cause like I might get jumped."

Although this behavior may fulfill stereotypes about Black youth in groups being threatening, JQ clarified that the motivation was safety, not aggression. Similarly, Candy Girl described peers saying "watch your bag" when Black students were nearby—a stereotype rooted in suspicion and surveillance. While she found the comment discriminatory, she and others acknowledged that safety concerns at their school were real, further complicating the boundary between stereotype and survival.

Some youth strategically "played into" stereotypes to make a point. JQ recounted a white peer who assumed that seeing a group of Black teens meant someone would be jumped. JQ and his friends would respond, "You!"—a mocking reversal that highlighted the absurdity of the stereotype while subverting it.

At the same time, youth described defying these expectations through counternarratives. A reflected:

“I’m my own individual person, and you can’t… think that just because my generation is like that, that I’m gonna grow up and be like a trash bag cause I’m not, I’m gonna be successful. And I’ll show you, and that gives me empowerment.”

Counternarratives also surfaced in response to messages from parents and teachers about phones and social media. Youth reported making good grades despite frequent adult assumptions that technology was to blame for poor performance. These stories conveyed resistance not only to racial stereotypes but to adults’ narratives about adolescent behavior.

Participants also pushed back against the idea that a person can "act white"—a stereotype that was especially salient in peer dynamics. They challenged the “Oreo” label and emphasized that behavior does not equate to racial identity. This came up in playful exchanges:

Br: “That’s a stereotype. I don’t think you can actually act White.”

CG: “People call people ‘oreos’ and stuff…”

Br: “You can’t ACT a race. You can BE a race but you can’t ACT a race.”

They reflected on how friendships across racial lines were sometimes difficult due to intra-group policing of behavior. Still, some expressed longing for the ease of childhood, when cross-racial friendships felt more natural and less subject to judgment. These reflections offered a powerful counternarrative—one that resisted the idea that racial boundaries must define social connections.

Across contexts, youth used both stereotype fulfillment and resistance as active strategies to confront racism. Whether through defiance or irony, their message was clear: “Imma show you”—what it means to be Black on their own terms.

### 2.3.4 Domain 3: Mental Health Outcomes

In addition to exploring how Black youth perceive and cope with racism, the data also illuminated how these experiences affect their emotional well-being and mental health. Across the photovoice sessions, participants described a variety of emotional responses—ranging from sadness and anger to confusion and resignation—as they reflected on stereotypes, internalized messages, and racialized encounters. These affective responses revealed important insights into how racism shapes the mental health of Black adolescents and how youth navigate these impacts in both personal and communal ways.

***Theme 7: Grappling with Stereotypes: Emotional Toll and Racialized Identity Development***

Youth in the study reported a wide range of affective responses to the racism and stereotypes they encounter, including sadness, anger, confusion, defensiveness, and emotional indifference. Their narratives revealed that stereotypes—whether societal, interpersonal, or internalized—shaped how they felt about themselves, their racial group, and their place in the world. These emotional reactions contributed to their broader mental health experiences and racialized self-concept.

One participant offered a visual metaphor using a t-shirt with colored circles—red, blue, and green—to represent the complex and sometimes contradictory feelings that accompany Black identity. “Blue is like neutral... red is like, we feel bad about some of the stuff that people stereotype about us. And then green is like… good, because sometimes I feel like I’m glad to be Black.” This articulation captured how stereotypes could be affirming, emotionally neutral, or deeply damaging.

Youth frequently described sadness and anger in response to societal stereotypes. For example, one participant expressed dismay about racial profiling in policing:

"I think it's sad that if somebody gets pulled over and if a Black person goes for their cell phone, then the police officer will think it's a gun, but if a white person does it, they might think that they're trying to get their license."

This sentiment extended to other contexts, including school and church, where youth reported being perceived as "bad" or "likely to commit a crime." In response to being mischaracterized, one participant said simply, "Oh, it makes me mad, because I'm not a bad person."

Interpersonal experiences with stereotypes—particularly from white or non-Black peers—often left youth feeling confused or excluded. They recounted instances of peers assuming they were violent or unintelligent, or questioning their authenticity if they liked activities or items deemed "white," such as lacrosse or Starbucks. These moments triggered both frustration and self-reflection as youth attempted to reconcile external judgments with their lived experiences.

Internalized stereotypes, which youth expressed about themselves or other Black youth, also provoked negative emotional reactions. During group discussions, participants sometimes endorsed anti-Black narratives—for instance, that Black girls are "fast" or that Black kids are inherently "bad and mean." These moments often led to push back from peers and evoked visible discomfort or defensiveness. In one exchange:

TP: I think cause those kids are just bad and mean

AH: We bad and mean

A: I'm not bad. And I'm not mean.

JQ: [A,] come on now.

TP: Everybody's like mean whether they know it or not.

Though some resisted these narratives, others expressed a sense of resignation. One participant remarked, “I said no different. Cause I’m used to things.” These statements reflect the complex emotional negotiations Black youth must make when confronting internalized racism and managing its effects on self-worth.

***Theme 8: Depression – Feeling Unwanted and Invalid***

The youth in this research study shared nuanced perspectives on how racism is associated with depressive symptoms for themselves and other similar-aged Black peers. When asked to reflect on how racism impacts health, Brandon suggested a research question about the statement “Depression: feeling unwanted and invalid.” When asked what research question he would develop from that topic, he shared:

“…I don’t really have a question. I just know that people feel that way, so I mean my question would be why does racism still live?”

While they did not ultimately frame their research around that phrase, there was a strong response to the topic, and a continued reflection on depression and its associations with racism. Examining commonly associated affective, cognitive, and behavioral experiences of depression, the data revealed further nuance into exactly how racism shapes their mental health, specifically with respect to depressive symptomatology.

Youth researchers’ reflections on feeling unwanted were particularly salient and occurred in the context of interpersonal racism. On several occasions, the youth described feeling rejected by peers, their schools, and their broader communities. These experiences often led to social withdrawal, fitting the youth’s own descriptions of depression as “feeling unwanted and invalid.” For example, Juicy Qel shared:

black

This young person's report of overt racism and disengagement from the learning activity reflects a behavioral response to interpersonal distress. His choice to withdraw appears to stem from feeling unwanted in his learning environment, a sentiment deepened by his observation that he was the only African American student in the class.

Relatedly, other participants discussed their experiences in similarly unwelcoming academic settings. For instance, CG described her experience:

"…in my 7th period, there's on like, three Black people in there and then like, the rest are Indians so like, when she says we can work in groups, ALLLL of them go to like one corner… and then, when they put [me] in a group with them, they be like ok… nobody wanna talk, and I be like ok, so y'all can talk to y'all friends but y'all can't talk to me…"

In both CG and Juicy Qel's classroom experiences, being one of the only Black students in advanced academic settings led to overt or everyday racism and social exclusion. These emotional and behavioral responses align with depressive symptoms, especially feelings of isolation and invalidation.

In addition to feeling unwanted, participants also described **feeling invalidated**. This included situations in which their thoughts, feelings, or identities were dismissed or diminished. When reflecting on stereotypes, participants often said they were "not true," implicitly rejecting their validity. In one exchange, The Plug shared:

"…It can make people feel depressed. It can put them in like, serious…mental health states."

This was in reference to stereotypes that exclude Black youth from participating in certain sports, like lacrosse. Participants also described feeling invalidated when their community or teachers didn't believe them, or when they were mischaracterized. These

experiences often elicited anger, sadness, and doubt—closely related to the affective and cognitive symptoms of depression.

Together, the youth's descriptions of feeling unwanted and invalid provide insight into how everyday racism becomes internalized and experienced not just as interpersonal harm, but as a psychological burden tied to depressive symptomology.

## 2.4 Discussion

The results from this secondary analysis of the racial equity photovoice project yielded eight themes that deepen our understanding of how Black early adolescents experience and respond to racism. Specifically, the findings highlight (1) how sociopolitical development (SPD) shapes youth awareness of racism, (2) the coping strategies Black adolescents use to navigate racism and other forms of oppression, and (3) the mental health consequences of these experiences. The themes also underscore early adolescence as a pivotal period for sociopolitical development, marked by increasing exposure to and engagement with systems of oppression—and emerging capacities to interpret, resist, or internalize them.

### 2.4.1 Awareness of Racism and Sociopolitical Development (SPD)

Black early adolescents in this study demonstrated varying degrees of awareness of racism across ecological levels, as well as emerging capacities for sociopolitical development (SPD). Their ability to identify inequities in schools and neighborhoods—and in some cases, their participation in protests—reflects moments of critical reflection and insight aligned with the critical stage of SPD. As Watts and Guessous (2013) proposed in their shift from a stage to a process model of SPD, youth development must be understood in the context of the socializing agents that shape their cognitive, emotional, and behavioral responses to oppression—including connections to mental health.

For these youth, the murder of Akiel Denkins by local police and a related Black Lives Matter protest—events occurring during the photo assignment period—functioned as significant socializing experiences (Joseph, 2021). These moments could have supported critical consciousness development and community connection. However, for some, they also elicited frustration and disengagement. Several youth noted that their communities only seemed to come together in response to violence, not for affirming events like college send-offs. This reaction may reflect an adaptive stage of SPD response shaped by chronic exposure to violence, reduced neighborhood cohesion, and limited access to health-promoting community structures (Hobson-Prater & Leech, 2012; Walker & Brisson, 2017).

Additionally, youth critiques of inaccurate curriculum—particularly the claim that "Black-on-Black crime" exceeds police violence—highlight how institutional racism shaped their perspectives. Some participants challenged these narratives, suggesting a form of critical resistance. These findings align with research by Dukes and Gaither (2017), who found that exposure to negative racial stereotypes is linked with increased victim-blaming and greater empathy for police. In this study, youth were not only targets of harmful stereotypes but also resisted and questioned institutional messaging.

Ultimately, youth expressed complex, sometimes contradictory perspectives that reflected both critical insight and internalized racism. Their limited sociopolitical engagement may stem from a combination of reduced opportunities for action, internalized negative beliefs, and structural barriers. While photovoice offered a space for reflection and storytelling, time constraints and the lack of follow-through on action steps may have constrained their growth. Still, consistent with previous work on CBPR and youth participatory action (Hope & Spencer, 2017; Jahangir et al., 2022; C. D. Smith & Hope, 2020), this study suggests that such methods

can be powerful tools for promoting sociopolitical development when paired with opportunities for meaningful engagement and action.

### 2.4.2 Black Adolescents' Coping Strategies and Sociopolitical Development

To manage racism-related stress, Black early adolescents in this study employed coping strategies commonly observed among their peers: avoidance, humor, collective coping, and efforts to defy or fulfill stereotypes. These strategies were shaped by sociopolitical development (SPD) and had mixed implications for mental health.

#### *Avoidance and Humor Reflect Adaptive Stage of SPD*

Youth frequently used humor and avoidance to diffuse tension and strengthen peer bonds in the face of racial stress. These strategies helped mitigate the immediate psychological toll of racism but may also carry long-term costs. Prior research describes this as a form of *culturally compelled coping*, where strategies that offer short-term relief may contribute to worse long-term outcomes (Brownlow, 2023; Brownlow et al., 2024). Within SPD theory, these responses align with the adaptive stage—allowing youth to survive without engaging in critical resistance and attempting to use systems to their benefit (Bentley-Edwards, 2016; Godfrey & Wolf, 2016).

J.L. White's (1984) framework on the psychological strengths of African Americans highlights the use of humor, or "gallows humor," as a culturally embedded form of resilience. Similarly, recent studies show that Black adolescents use humor—both online and in real-life interactions—to lessen the emotional impact of racism (Dance et al., 2024; Tanksley & Hunter, 2024). However, humor can also serve as a barrier to deeper reflection or action. Golden and colleagues (2024) found that adolescents who reported high racism-related stress and used humor often engaged in disengagement and showed only moderate levels of critical action. This profile

aligns with participants who expressed fatigue around discussing race and racism, as captured in themes like *"Does It Have to Be About Race?"* and *"That's So Funny."*

Some young people may view avoiding conversations about racism as an adaptive coping strategy. However, research suggests that steering clear of discussions on race and racism could have more drawbacks than advantages. Golden and colleagues (2024) found that Black youth who use humor and other disengaged coping strategies often exhibit greater awareness of racism. These youth also tend to adopt culturally shaped coping methods, such as avoidance, which may reflect efforts to navigate racial stress (Brownlow, 2023; Brownlow et al., 2024). These findings align with Watts and colleagues' (1999) SPD model, which suggests that the adaptive stage of SPD, in which individuals try to exploit oppressive systems—by using humor or focusing on personal interests instead of discussing oppressive systems—can be more harmful than beneficial.

### *Collective Coping and Cross-Racial Solidarity*

Collective coping emerged as both a protective resource and a site of sociopolitical tension. Participants discussed the importance of unity in the face of racism and expressed interest in cross-racial solidarity. These reflections are consistent with White's (1984) notion of collectivity as a cultural strength, fostering resilience and a sense of shared identity. However, the youth's hopes for cross-racial engagement were not always grounded in a critical understanding of power or oppression.

Research on allyship and coalition-building suggests that uncritical cross-racial contact may inadvertently hinder marginalized groups' ability to fully analyze structural oppression (Craig & Richeson, 2016; Demanarig et al., 2024). In this study, participants' desires for unity were sometimes shaped by adaptive or acritical perspectives, such as focusing more on "Black-

on-Black crime" than police violence. Their frustration with protest as a form of community response—paired with a desire for more “positive” events like college celebrations—illustrates their complex sociopolitical stance. They longed for collective support but felt constrained by how and when that support manifested.

### *Stereotypes, Internalized Racism, and Dialectical Coping*

A third cluster of coping strategies centered on stereotypes. Youth attempted to resist stereotypes through excellence and overachievement—a strategy aligned with findings from Smith and Hope (2020). However, many also leaned into stereotypes, believing it futile to change how adults or authority figures perceived them. Some even saw stereotypes as protective, such as appearing intimidating in groups to prevent being targeted.

This dialectic—both rejecting and reinforcing stereotypes—reflects the tension of adaptive SPD. Youth were navigating multiple realities: recognizing the harms of stereotypes while also internalizing messages from family, peers, and institutions that reinforced those same narratives (T.-K. M. Bailey et al., 2022; Stevenson, 2002; Stevenson et al., 2002). Several participants described being called “bad” by adults or teachers, which may have deepened their negative self-perceptions and limited their sense of agency. Whether they tried to “prove people wrong” or resigned themselves to societal expectations, both responses reflected stalled or adaptive SPD and contributed to negative mental health outcomes.

### *Implications for SPD and Mental Health*

Across all four coping strategies—avoidance, humor, collective responses, and stereotype negotiation—youth navigated complex sociopolitical terrain with limited structural support. Their strategies reflect not only resilience but also constraints. In some cases, they coped in ways that preserved immediate psychological safety but impeded long-term growth, collective action,

or resistance. These patterns deepen our understanding of how Black adolescents' coping mechanisms are shaped by, and in turn shape, their sociopolitical development.

### 2.4.3 Mental Health Consequences of Racism and Sociopolitical Development

Coping with racism while developing the skills to recognize and resist it is a taxing developmental task for Black youth. As their sociopolitical development (SPD) unfolds, they gain greater awareness of racism and adopt coping strategies to navigate it—but these same experiences can significantly affect their mental health.

In this study, youth consistently described stereotypes, discrimination, and microaggressions as emotionally burdensome. The recurring theme of feeling unwanted and invalidated—especially in community and school contexts—emerged as a potential contributor to depressive symptoms. Their emotional responses to racism were nuanced and often linked to how, when, and by whom stereotypes were expressed. This suggests that stereotypes are a salient and complex source of mental distress, particularly when internalized or left unchallenged.

One exchange among participants illustrated the emotional impact of internalized gendered racism. A participant defensively upheld a stereotype about Black girls' sexual promiscuity, reinforcing the Jezebel stereotype—a harmful narrative associated with increased depression, anxiety, hostility, and decreased self-esteem among Black girls and women (D. L. Brown et al., 2013; Jerald et al., 2017). The intensity of this exchange did not reflect violence, but it may indicate how internalized oppression and stereotype endorsement can escalate emotional harm and foreshadow relational strain.

This internalized oppression—shaped by socializing agents such as peers, family, media, and school—further influences Black youths' identity and mental health. Appropriated beliefs about one's own group may undermine self-concept and compound stress from external

discrimination (Nadal et al., 2021). Understanding how youth internalize and resist these messages is critical to disrupting their impact on SPD and well-being.

The youth's discussions of depression often stemmed from experiences of exclusion, rejection, or being misunderstood. These reflections aligned with well-documented patterns of school-based and peer discrimination leading to reduced belonging and increased depressive symptoms (Boyd et al., 2024; Morris et al., 2020; Morris & Seaton, 2025). Youth frequently described withdrawing from school, church, or peer activities following interpersonal conflict, a behavior consistent with depressive symptomatology. Gyan and colleagues (2024) describe this dynamic as "withdrawal syndrome," where racialized students facing chronic microaggressions disengage from social and academic life. This may help explain the participants' sense of being "unwanted" or unseen.

Taken together, the findings underscore that racism-related stressors—particularly those rooted in stereotypes and interpersonal invalidation—can have profound emotional and behavioral consequences for Black adolescents. Their narratives illuminate how racism seeps into daily life, eroding mental health and shaping how they view themselves, others, and their place in the world.

### 2.4.4 Strengths, Limitations, and Future Directions

This project contributes to the field's conceptual understanding of sociopolitical development (SPD) in early adolescence and how it intersects with Black youths' awareness of racism. It also adds nuance to how we think about the mental health consequences of both exposure to and awareness of racism. As noted earlier, Black youth are continuously exposed to racism—regardless of whether they are critically aware of it. To promote their sociopolitical

development during early adolescence, it is important to explore the SPD stages they occupy and how those stages shape their thoughts, feelings, and behaviors related to structural oppression.

While there is no single, static SPD stage that youth remain in, gaining deeper insight into the socializing agents that influence their development—peers, organizations, historical events, parents, and others—helps clarify how SPD unfolds over time. Although the field has increasingly used the SPD process model (Watts & Guessous, 2013), this study suggests that a stages-based lens may also offer important developmental insights. Together, socializing agents and stage models provide a valuable framework for understanding how SPD affects mental health from childhood through emerging adulthood and beyond (Hope et al., 2023).

This study does not attempt to make broad claims about all Black early adolescents. Community-based participatory research is grounded in specific contexts, with findings tied to the problems and solutions within those communities. That said, the patterns observed may still resonate with experiences in other settings. Beyond limits to generalizability, this study's findings are shaped by the nature of secondary analysis. The data reflect youth perspectives from approximately a decade ago. Due to the time gap and changes in the research team, the current analysis could not incorporate member checking or consult the original facilitators to confirm interpretive accuracy. This study would also be further strengthened by the collaboration of researchers to ensure that coding is done in a manner that considers multiple perspectives, allowing for increased inter rater reliability and data saturation (Clarke & Braun, 2014).

Despite these limitations, secondary analysis provides meaningful contributions. It can reduce participant fatigue, especially in communities frequently asked to engage in research, and offer fresh perspectives on existing data (Beck, 2019; Thorne, 1994; Watkins, 2022). In a

research environment often constrained by limited resources and demands for rapid knowledge production, returning to rich, underutilized data sources is both pragmatic and generative.

## 2.5 Conclusion

"Why does racism still live?" That was the question eighth graders asked to make sense of racism's impact on their mental health. In this simple yet powerful question, it's clear they weren't just trying to understand the effects of racism—they were yearning for its end. Until that end comes, activists, scholars, and everyday people will continue to resist racism and protect youth from its harms.

As we wait for a world where imagining life without racism becomes possible, it remains critical to understand how racism affects Black youth, how their sociopolitical development unfolds in response, and how these forces shape their health and well-being. Amplifying youth voices through community-engaged research, preserving data that captures their insights, and using those insights to take action in communities—these are the tools that will help us end racism and imagine worlds free from structural oppression.

## 2.6 Tables and Figures

| | Internalized racism | Microaggressions | Individual racism | Everyday racism (stereotypes) | Cultural racism | Institutional racism | Structural systemic racism |
|---|---|---|---|---|---|---|---|
| Acritical stage | 10 | 0 | 0 | 5 | 3 | 1 | 2 |
| Adaptive stage | 5 | 0 | 3 | 5 | 1 | 2 | 0 |
| Precritical stage | 2 | 1 | 1 | 8 | 5 | 7 | 1 |
| Critical stage | 0 | 0 | 1 | 0 | 1 | 2 | 0 |
| Liberation stage | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

Table 2.1 Table of SPD X levels of racism codes visually depicting commonly co-occurring codes. Darker shades of blue represent more commonly co-occurring codes, with the numerical values listing the number of times codes co-occurred across transcripts.

| | Internalized racism | Microaggressions | Individual racism (racial discrimination) | Everyday racism (stereotypes) | Cultural racism | Institutional racism | Structural systemic racism | Institutional racism |
|---|---|---|---|---|---|---|---|---|
| Mental health consequences | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 |
| Affective-emotional responses | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Confused | 3 | 2 | 0 | 3 | 2 | 1 | 0 | 1 |

| | Internalized racism | Microaggressions | Individual racism (racial discrimination) | Everyday racism (stereotypes) | Cultural racism | Institutional racism | Structural systemic racism | Institutional racism |
|---|---|---|---|---|---|---|---|---|
| Feeling bad | 0 | 1 | 0 | 3 | 0 | 0 | 0 | 0 |
| Angry | 3 | 0 | 5 | 3 | 2 | 1 | 0 | 1 |
| Guilt | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Hopelessness | 0 | 0 | 0 | 2 | 1 | 0 | 0 | 0 |
| Sad | 1 | 1 | 0 | 0 | 1 | 1 | 0 | 1 |
| Scared | 0 | 0 | 0 | 0 | 0 | 2 | 0 | 2 |
| Mental health diagnoses | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 |

Table 2.2 Table of affect/mental health X levels of racism codes visually depicting commonly co-occurring codes. Darker shades of green represent more commonly co-occurring codes, with the numerical values listing the number of times codes co-occurred across transcripts.




Image 2.1 Image of assumed Caucasian man at a Black Lives Matter protest holding up a handmade sign at protests against the killing of an unarmed Black man in Raleigh, NC



Image 2.2 Photograph taken by Brandon of a piano in response to photoprompt 1's research question, "Why does racism still exist?"

**2.7 Appendix:**

# Codebook: Chapter II

| Name | Description |
|---|---|
| Community | Refers to how the youth observe groups of people acting, either in a manner that leads to unity and connection or fragmentation and disconnect. |
| Fragmentation | Refers to anything that is divisive and would impact their community coming together. |
| Racial differences | Refers to times when participants see or experience differences across racial groups, contributing to community fragmentation. |
| Unity in the community | Refers to any action that would lead to individuals connecting or being united as a group of people. |
| Mobilization | Indicates a way that the youth want to gather/organize their community to enact a type of change. |
| Egalitarian Value | We should all be treated equally. |
| generational attitudes | Describes cross-generational differences in the views of the world and the ways each generation operates. |
| Give respect to get respect | Refers to a recurring notion that people should respect each other, and others will respect them. |
| Mental health consequences | Refers to the outcomes commonly associated with Black youths' experiences with racism. |
| Affective-emotional responses | Refers to how the Black youth feel in response to events/experiences occurring in their lives. |
| Confused | Doesn’t inherently mean good or bad, which means that the person is unsure as to why they are having a thought or feeling. Doesn't understand some occurrence or phenomenon. |
| Feeling Bad | Refers to any feelings arising from an event that elicits a negative affective or emotional response. |

| Name | Description |
|---|---|
| Angry | Denotes frustration, annoyance, or other affective/emotional response that is associated with displeasure from a system. |
| Guilt | Feelings that youth have done something wrong or that they feel responsible for. |
| Hopelessness | Referring to when individuals give up, give in, or submit. |
| Sad | Feelings associated with the displeasure of an event that elicit a low mood, or other feelings associated with sadness. |
| Scared | Feelings that are associated with being weary, uneasy, or nervous about an experience or event |
| Feeling good | Refers to any feelings arising from an event that elicits a positive affective or emotional response. |
| Happy | Denotes an event that makes individuals feel pleasure, joy, or other feelings commonly associated with being happy. |
| It's lit | A regularly used colloquialism referring to excitement or something of great enjoyment. |
| Coping strategies | Refers to any skills or tools that individuals use to manage the distress associated with racism or other stressors |
| Avoiding conversations about race | Refers to how youth avoid conversations about race and racism. |
| Confronting racism | Refers to any time individuals stood up to address racism or oppression by speaking out against it. |
| Connecting with others | Refers to individuals building social ties with members of their community or individuals within their photovoice research group. |
| Hope | Refers to being optimistic or feeling a sense of possibility or excitement about a future situation. |
| Isolation and separation | Refers to any time individuals would choose to be by themselves or with their own in-group to protect their mental health. |

| Name | Description |
|---|---|
| Surface-level ennui | Describing the "I don't know" or "I don't care" phenomenon mentioned throughout the text. |
| That is so funny | Using humour to manage feelings of distress, avoiding, making light of, and deflecting. |
| Twice as hard | Refers to the thought that youth have to work twice as hard to ensure that something they want to happen (i.e., defying stereotype, interacting with others). |
| Impacting identity | A threat or support to an individual's sense of self. Commonly associated with their race, gender, age, or another identity marker. |
| Mental health diagnoses | Refers to commonly identified mental health diagnoses discussed in the transcript—depression, anxiety, etc. |
| Socializing agents | Refers to any entity, helpful or unhelpful, that teaches youth about the world, whether directly or indirectly. |
| Helpful-adaptive socializer | socializing agents that have an adaptive or useful socializing strategy that aid the youth in their understanding of the world. |
| Maladaptive-unhelpful socializer | An entity, person, or peer that teaches youth about some aspect of the world that leads to maladaptive outcomes |
| Sociopolitical developmental stages in the awareness of racism | This major code refers to the SPD framework or the process by which youth develop the skills, knowledge, and capacity to understand and resist systems of oppression. May refer to specific behaviours or cognitive and emotional processes. |
| Acritical stage | No awareness of oppression or critical action. |
| Adaptive stage | Asymmetry may be acknowledged, but the system maintaining it cannot be changed. Predatory, antisocial, or accommodation strategies are employed to maintain a positive sense of self and to acquire social and material rewards. |
| Critical stage | When an individual or group develops a sense of agency to challenge the status quo. There is an analysis of oppression, and some critical action taken to address systems of oppression. |

| Name | Description |
|---|---|
| Liberation stage | Regular awareness and criticism of oppression, and regular critical action that works to dismantle systems of oppression |
| Precritical Stage | When the desire to understand oppression supersedes the need to conform to cultural norms. |
| Types of racism | Refers to any named experience of racism that varies across multiple levels depicted in subcodes. |
| Cultural racism | An intergenerational world view characterized by beliefs in the superiority of one group over another that is ingrained in "institutions, ideological beliefs, and everyday actions of people in the culture" (e.g., omission of contributions of people of colour in educational materials, negative stereotypical representation of people of colour in media). |
| Everyday racism (stereotypes) | Day to day interactions that expression or endorsement of false beliefs and negative stereotypes about Black people. |
| Individual racism | Commonly been called racial discrimination or interpersonal racism—refers to beliefs in the superiority of one's race and is characterized by "behavioural enactments" between individuals that maintain a power differential between racial groups. |
| Microaggressions | Behavioural or environmental "indignities" that communicate hostility, derogation, and negativity toward marginalized. |
| Internalized racism | Acceptance of negative messages about one's abilities and intrinsic worth. |
| Structural systemic racism | An organized system in which public policies, institutional practices, cultural representations, and others' norms work together to reinforce and perpetuate racial group inequity. |
| Institutional racism | Laws, customs, and practices that restrict or deny access to the same rights and opportunities promised to all citizens (e.g., segregation, incarceration). |

## Chapter 3 Study II

Black families experience disproportionate stress and strain on their mental health due to persistent inequities across the social determinants of health. These inequities include both barriers to access (e.g., insurance coverage, mental health care) and disproportionate burdens (e.g., heightened exposure to discrimination) that affect family well-being across generations (Murry et al., 2018; Peters & Massey, 1983; Prokosch et al., 2022). Scholars have conceptualized the social determinants of mental health for Black families as racialized experiences, wherein inequities in education, income, housing, and healthcare exact greater harm on racially and ethnically marginalized groups (Iruka et al., 2022; McLoyd, 1998; Murry et al., 2018; Pediatrics & Health, 2010; Trent et al., 2019). These social determinants influence not only the individual mental health of family members, but also the collective mental well-being of Black families as a unit (McNeil Smith & Landor, 2018; Murry et al., 2018). Structural racism—including laws, policies, and institutional practices—drives and sustains these inequities over time (Bailey et al., 2017; Peters & Massey, 1983).

For Black youth and caregivers, such structural inequities are associated with a range of negative outcomes, including worsened mental health (Salami et al., 2022; Yelton et al., 2022), socioeconomic disadvantage (Assari, 2017; Conger et al., 2002), limited access to care (Cook et al., 2017; Hines-Martin et al., 2003; Kawaii-Bogue et al., 2017; Planey et al., 2019), reduced educational opportunities (Flores et al., 2023; Yelton et al., 2022), and unequal housing conditions (Blankenship et al., 2023; Lee et al., 2021). Although these challenges are well

documented, fewer studies examine the mechanisms through which structural oppression shapes these inequities—or how the experiences of structural racism intersect with everyday realities to impact Black families' mental health. These experiences do not occur in isolation. Further research is needed to better understand and conceptualize the racialized determinants of mental health for Black youth, caregivers, and families more broadly.

Importantly, research on the social determinants of mental health must also account for the promotive and protective factors that support well-being within Black families. For instance, Black religious institutions such as churches have long been associated with positive mental health outcomes (Levin et al., 2005; Mattis et al., 2019; McBride, 2013). Likewise, extended family networks and community ties—including support from friends, neighbors, and church members—can have protective or, at times, harmful effects on family mental health (Maríñez-Lora et al., 2021; Park et al., 2019; Shim et al., 2012). Deeper exploration of how community-based supports and religious institutions influence mental health is essential for understanding the full range of social determinants that shape Black families' well-being.

Black families navigate multiple social determinants of mental health—such as experiences with racism in community contexts, disparities in access to healthcare, and inequities in the built environment—all of which are shaped by structural oppression. These determinants do not act independently. Rather, intersecting forces (e.g., racism, classism, sexism) compound across domains (e.g., housing, education, healthcare), creating cumulative disadvantages (Prokosch et al., 2022; S. Williams et al., 2024). These compounding effects are visible in mental health disparities, where structural racism influences multiple determinants that together create unique, overlapping burdens. For example, historic redlining practices have shaped the segregated neighborhoods where many Black families reside, and gentrification now threatens to

displace them further (B. D. Smith et al., 2025). Disinvestment in these neighborhoods, rooted in historical injustice, may also result in reduced access to mental health services (Erikson et al., 2022). The current study uses secondary analysis of a photovoice project to explore how Black maternal caregivers perceive and describe the structural determinants that impact their families' mental health.

### 3.1.1 Theoretical and Conceptual Frameworks

The relationship between social determinants of mental health and Black families' well-being is shaped by intersecting pathways of risk, resilience, and resistance. Foundational frameworks such as the Family Stress Model theorize how structural determinants—like racism, classism, and economic hardship—intensify environmental stressors and disrupt caregiving and child outcomes (McLoyd, 1990, 1998; Peters & Massey, 1983). For example, economic stressors like job loss, especially in already under-resourced families, can heighten caregiver depression and strain parent-child relationships, increasing externalizing behaviors among youth (Conger et al., 2002; Simons et al., 2016). These outcomes are not simply individual but are shaped by structural factors—including racialized patterns of unemployment and poverty—that disproportionately affect Black communities (Hardaway & McLoyd, 2009; McLoyd et al.,1994).

Building on this work, contemporary models offer a more integrative lens. Murry and colleagues' (2018) Integrative Model for the Study of Stress in Black American Families situates current experiences of family stress within historical contexts of racial oppression (e.g., slavery, redlining). Structural racism and related forms of oppression shape Black families' marginalization through laws, policies, and institutional practices (Solar & Irwin, 2010; Yearby, 2020). These structural forces impact everyday social determinants—such as education, healthcare, and housing—which, in turn, shape parenting practices, family dynamics, and mental

health. The model also acknowledges cultural strengths, including religious involvement, kinship support, and collective socialization, as buffers against sociocultural stressors (McNeil Smith & Landor, 2018; Murry et al., 2018).

### 3.1.2 Determinants of Black Maternal Caregivers and Their Families' Mental Health

Black families' mental health is shaped by a sociohistorical context that generates psychosocial stressors and increases vulnerability to psychopathology and other mental health conditions (Campbell & Long, 2014; Neblett, 2019; Prokosch et al., 2022; Yelton et al., 2022). Understanding how Black families interface with the social determinants of health—both directly and indirectly—is essential. Within many Black families, maternal caregivers play a central role. These caregivers—mothers, grandmothers, aunts, and other fictive kin—are often pivotal to family well-being and offer valuable insight into the family's everyday functioning (Brantley, 2023b, 2023a).

#### *3.1.2.1 Racism: The Determinant of the Social Determinants*

To understand the social determinants of mental health for Black families, it is critical to examine the structural forces that create and sustain inequities. Racism—"a system in which individuals or institutions intentionally or unintentionally exercise power against a racial group defined as inferior"—functions as the root determinant shaping all other determinants of health for racially and ethnically marginalized populations (J. M. Jones, 1972; Neblett, 2019). It distributes societal benefits disproportionately to white individuals while placing systemic burdens on Black communities (Z. D. Bailey et al., 2017; Yearby, 2020). These inequities cut across all social determinants Black families navigate—education, health care, housing, and employment—with cumulative consequences for mental health.

#### *3.1.2.2 Healthcare and Black Families' Mental Health across Social and Community Contexts*

Access to healthcare is a critical social determinant of mental health for Black caregivers and their families. Yet, Black individuals often face significant barriers to receiving quality, culturally affirming mental health care compared to their white counterparts (Cook et al., 2017). For example, Black youth and their caregivers are less likely to receive culturally relevant care or be matched with providers who share their racial or cultural background (Carroll et al., 2025; S. C. T. Jones et al., 2020). These disparities are shaped by upstream inequities, such as racial bias in training programs and financial obstacles that limit the presence of Black professionals in the mental health workforce (Bernard et al., 2022).

In addition to underrepresentation, Black communities report a range of barriers to care, including stigma, a lack of culturally affirming providers, and logistical and financial constraints (Busby et al., 2021; Fante-Coleman & Jackson-Best, 2020; Hines-Martin et al., 2003; Planey et al., 2019). These obstacles impede access and have direct consequences for mental health.

Moreover, many Black individuals are at elevated risk for psychological distress while simultaneously encountering limited access to appropriate care (Fante-Coleman & Jackson-Best, 2020; Kawaii-Bogue et al., 2017; Lindsey et al., 2010). Historical and ongoing harms—such as child removal threats from providers (Copeland & Snyder, 2011)—fuel medical mistrust and shape community beliefs (e.g., "Black people don't go to therapy") that may reduce help-seeking (R. E. Taylor & Kuo, 2019). These adaptive coping responses, while protective, can hinder engagement with the healthcare system (Benkert et al., 2019; Jaiswal & Halkitis, 2019).

For Black parents, stigma surrounding mental health often extends to their children's care. Research has linked caregiver self-stigma to decreased likelihood of seeking services for youth (Dempster et al., 2015; Kappi & Martel, 2022; McBride Murry et al., 2011). Cumulatively, stigma, systemic invalidation, and provider harm are associated with increased depressive

(Bodnar-Deren et al., 2017; Rose et al., 2011) and anxiety symptoms (DeFreitas et al., 2018; Grant et al., 2016), underscoring the impact of healthcare access and perception on Black families' mental health.

#### *3.1.2.3 Built Environments and Black Families' Mental Health*

Where Black caregivers and their families are able to live has direct implications for their mental health. Racialized barriers in housing and neighborhood investment reflect structural inequities in the built environment. Systematic reviews show that housing insecurity and perceptions of limited neighborhood access are associated with threats to maternal mental health (Perry et al., 2015; Tsai, 2015). More recent studies using predominantly Black samples have linked housing cost burden (e.g., inability to pay utilities) with elevated anxiety and depressive symptoms among mothers (Marçal, 2024; Marçal et al., 2024). Additionally, mothers living in housing cost-burdened environments were more likely to exhibit psychological and physical aggression, which in turn affected their children. Living in rent-burdened neighborhoods—beyond individual experiences—has also been associated with greater depressive symptoms (McGovern et al., 2023).

Other aspects of the built and social environment, such as green space access, neighborhood demographics, gentrification, and economic disinvestment, also shape mental health. For instance, limited access to green space among pregnant parents was associated with increased risk for depressive disorders, a relationship amplified by residential segregation (Runkle et al., 2022). While residential segregation and other forms of racism have been shown to negatively impact mental health (English et al., 2014; K. White & Lawrence, 2019), some studies highlight protective effects of living in Black-majority neighborhoods (Hurd, Stoddard, et al., 2013; Pasco et al., 2021a). These contrasting findings

may reflect differences between community separation—living in racially homogenous neighborhoods with high social cohesion—and racial residential segregation—the intentional exclusion of racial groups through gentrification and racialized capitalism that economically disenfranchises Black communities (Hurd, Stoddard, et al., 2013; Mumm & Sternberg, 2023; Rucks-Ahidiana, 2021).

Economic disinvestment further mediates the relationship between poverty and mental health. For example, increased poverty was associated with material deprivation and parenting stress, which predicted youth internalizing symptoms (Hollie, 2021). Together, these findings illustrate how neighborhood-level inequities—beyond housing alone—affect parenting, stress, and the well-being of Black families.

### 3.1.3 Protective, Promotive, and Resiliency Factors: Determinants of Black Family Mental Health

Social and community institutions play complex roles in shaping Black families' mental health, serving as protective, promotive, and sometimes harmful influences. Faith-based institutions, in particular, have often provided buffering effects against stressors that negatively affect mental health (Bryant, 2021; Codjoe et al., 2021; Parker et al., 2024; Richardson et al., 2024). Black parents' religious coping strategies have been linked to increased mental health service use for children, with support from church members facilitating youth access to care (Bannon et al., 2008; Breland-Noble et al., 2015; Planey et al., 2019). However, rigid religious values, mental health stigma, and limited literacy among some faith leaders have also been barriers to care (A. M. Breland-Noble et al., 2015; W. P. Cooper & Mitra, 2018; Parker et al., 2023).

Faith communities can both support and hinder mental health service use. For instance, collectivist coping strategies such as reliance on kin or community can mitigate stigma, but they

can also reinforce shame and reduce treatment-seeking (Planey et al., 2019). Despite these tensions, Black families frequently engage in spiritual practices—including prayer, religious coping, and socialization—that foster resilience. One study found religiosity buffered the adverse mental health impacts of poverty and parenting stress among Black mother–child dyads (Hollie, 2021), while another found caregivers often preferred prayer and faith community support over formal services for addressing their children's needs (Lindsey et al., 2013).

Mattis and colleagues, (2019) offer a conceptual framework describing the positive development of Black youth through engagement in religious institutions. This model suggests that faith spaces and communities interact with structural determinants to shape Black families' spiritual and mental health practices. These dynamics highlight the ongoing importance of exploring the role of religion, even as some Black individuals distance themselves from organized religion while maintaining private spiritual practices (Leath et al., 2022). These patterns may be shaped by intergenerational religious socialization, with family members playing distinct roles in transmitting faith-based values and practices (Gutierrez et al., 2014). Future research can help clarify the evolving role of both institutional and individualized religious practices in supporting Black families' mental health.

#### *3.1.3.1 Intergenerational Exchanges and Their Impacts on Black Families' Mental Health*

According to the Integrative Model for the Study of Stress in Black American Families (Murry et al., 2018), caregiver and youth mental health are bidirectionally linked. Structural stressors—such as financial hardship, discrimination, and housing insecurity—can contribute to caregiver strain and mental health difficulties, which in turn affect children's well-being (Holloway & Varner, 2021; Marçal et al., 2024; Rogers et al., 2020; Wagner & Valdez, 2020).

Conversely, children's behavioral or emotional struggles can exacerbate caregiver stress and psychological symptoms.

Despite these stressors, cultural assets and intergenerational support can be protective. Maríñez-Lora et al. (2021) found that social support buffered the effects of health and economic stress on maternal mental health, which in turn shaped caregivers' ability to seek services for their children—underscoring the interdependence of well-being across generations. Similarly, Burton, (1996) documented how older Black women often assume caregiving roles for multiple generations within extended families, providing emotional, instrumental, and logistical support. These findings illustrate how cross-generational support systems help Black families navigate adversity and foster mental health resilience.

### 3.1.4 Gaps in Literature and Study Aims

Although scholarship has extensively documented the racialized determinants of mental health for Black families, far less is known about how these structural forces are experienced and interpreted by Black maternal caregivers themselves. Much of the existing research relies on survey-based or deficit-oriented approaches, with limited attention to the meaning-making processes and everyday realities of Black women who shoulder primary caregiving roles.

In particular, few studies examine how maternal caregivers understand and navigate structural racism as it intersects with healthcare access, housing instability, faith-based support systems, and neighborhood contexts. Even fewer employ participatory qualitative methods that center Black women's voices and lived expertise in exploring these complex dynamics. Without such perspectives, research risks overlooking how caregivers conceptualize and respond to the systemic barriers that shape their family's mental health and well-being.

While existing frameworks offer critical insights into the role of structural racism, most were developed within academic institutions with limited input from Black families themselves. To center Black families' lived experiences—and the strategies they use to resist structural oppression—research must be conducted with, by, and for Black communities (Cross et al., 2022; Letiecq et al., 2022). Community-based participatory research (CBPR) creates space for families to name the problems they face, co-develop solutions, and generate action-oriented knowledge (Israel et al., 1998; Stringer & Aragón, 2020). This study extends existing theories by using CBPR methods to highlight how Black maternal caregivers understand and experience structural determinants of mental health in their families' lives.

This study addresses these gaps through a secondary qualitative analysis of a community-based participatory photovoice project conducted with Black maternal caregivers in a racially segregated southeastern city. Using an ecological and structural racism lens, this analysis explores how caregivers make meaning of racialized determinants and how these forces impact their mental health, family dynamics, and help-seeking strategies.

To guide this analysis, the study is organized around the following research questions:

1. **How do Black maternal caregivers understand and experience the racialized determinants of mental health?**
2. **How do these experiences influence their coping strategies, family functioning, and mental health across generations?**

## 3.2 Method

### *3.2.1 Study Context and Participants*

Participants ($N = 6$) in the original photovoice project were Black mothers and maternal caregivers affiliated with *Strengthening the Black Family*, a community-based organization in

Raleigh, North Carolina, dedicated to promoting health and wellness among Black youth and families. Caregivers identified to participate were at least 18 years old, self-identified as primary caregivers within their households, were African American, and resided in Southeast Raleigh, NC. In consultation with the original data collection team, including the original principal investigators, graduate research assistants, and the lead community partner from Strengthening the Black family, it was confirmed that this represented the full extent of available demographic data.

The project was designed and implemented in partnership with graduate students enrolled in a photovoice course at the University of North Carolina at Chapel Hill, in collaboration with community partners and under the supervision of co-principal investigators Dr. Enrique Neblett and Dr. Alex Lightfoot. Community partners played a key role in recruitment, session facilitation, and interpretation of findings.

The original aim of the project was to explore Black caregivers' lived experiences with racial inequity, stigma, and mental health. Guided by community dialogue, the group co-developed the following research questions:

- How does stigma associated with mental health relate to experiences with racism?
- How does a lack of education or knowledge of mental health affect the Black family?
- How does the Black mama's faith inform and influence her family's mental health?

The present study is a secondary analysis of data from this project, with a focus on how Black maternal caregivers understand and navigate the racialized structural determinants of mental health—and how those forces shape family experiences and outcomes.

### *3.2.2 Photovoice and Community-Based Participatory Research (CBPR) Approach*

Photovoice is a participatory method that combines photography, dialogue, and critical reflection to center community members' lived experiences and insights (Wang & Burris, 1997). Grounded in Paulo Freire's (1970) theory of critical pedagogy and feminist participatory inquiry, photovoice was developed to amplify the voices of those historically marginalized and to promote health equity through community-driven storytelling and action.

In this study, caregivers used photography to document and reflect on structural challenges and sources of support in their lives. Group discussions were guided by the SHOWED method:

- **See** – What do you see?
- **Happening** – What's really happening?
- **Our lives** – How does this relate to our lives or community?
- **Why** – Why does this problem or strength exist?
- **Empowerment** – How does it empower or affect you?
- **Do** – What can we do about it?

This approach was embedded within a broader CBPR framework (Israel et al., 1998, 2012), emphasizing co-learning, mutual respect, and shared decision-making between researchers and community members. Participants were involved in generating the research questions, selecting and discussing photographs, and identifying collective themes for action.

Photovoice has been effectively used with Black adults and caregivers to surface the structural barriers and cultural strengths that shape health and mental health (Kowitt et al., 2015; Ornelas et al., 2009). In this project, the method supported Black maternal caregivers in naming racialized determinants of mental health and envisioning strategies for promoting well-being within their families and communities.

The researcher was not involved in the original data collection. To best engage the community in the secondary analysis of this data, the researcher met with a member of the original data collection team, the principal investigators of the research project, and corresponded with one leader from Strengthening the Black Family. Using Beck's (2019) ethical guidelines for secondary analysis of CBPR data, the researcher took steps to ensure that data were secure, consulted with members of the research team on analysis and accuracy of data, and acknowledged the original data source when reporting on data.

### 3.2.3 Data Collection Procedures

Participants met for five photovoice sessions facilitated by graduate and professional students from the University of North Carolina at Chapel Hill, in collaboration with community partners from Strengthening the Black Family. All sessions were conducted in accordance with CBPR principles and under the supervision of co-principal investigators Dr. Enrique Neblett and Dr. Alex Lightfoot.

The first session included informed consent procedures, group introductions, norm setting, and an overview of the project. Participants also began brainstorming ideas for their first photography assignment. Sessions two through four were each structured around one of three caregiver-generated research questions:

1. How does stigma associated with mental health relate to experiences with racism?
2. How does a lack of education or knowledge about mental health affect the Black family?
3. How does the Black mama's faith inform and influence her family's mental health?

In each session, participants shared photographs taken in response to the guiding prompt and engaged in discussion using the SHOWED method. These conversations were audio-recorded

and transcribed verbatim. Participants also selected a group photo that best represented their shared perspectives for each prompt.

The final session focused on synthesizing insights across the previous discussions and beginning to brainstorm collective actions to address the challenges identified. Products from the data collection process included participant photographs, audio recordings, meeting transcripts, memos, a collaboratively developed codebook, and planning materials such as agendas and flyers.

### 3.2.4 Secondary Data Analysis

Although photovoice is typically used for primary data collection, it also generates rich, contextualized material suitable for secondary analysis (Fleming et al., 2009; Heaton, 2004; Panazzola & Leipert, 2013). This study applied Watkins' (2022) framework for secondary analysis to re-engage the original photovoice dataset with new guiding questions focused on structural racism and Black maternal caregivers' mental health.

The dataset included:

- Participant-generated photographs
- Transcripts from four photovoice sessions
- Memos written by graduate research assistants
- A collaboratively developed codebook
- Recruitment flyers and meeting agendas
- Observational notes from the original research team

The original guiding questions—generated by participants—were:

1. How does stigma associated with mental health relate to experiences with racism?
2. How does a lack of education or knowledge of mental health affect the Black family?

3. How does the Black mama's faith inform and influence her family's mental health?

This secondary analysis revisited those materials to explore two new research questions:

1. What contextual factors shaped by structural racism do Black maternal caregivers identify as determinants of mental health for their families?
2. What outcomes do caregivers associate with these structural determinants?

By analyzing the original data through this new lens, the study expands our understanding of how Black caregivers interpret and respond to structural stressors affecting family well-being.

New research questions and initial codes were developed by the lead author. Through an iterative coding process, the lead author and an undergraduate research assistant developed a codebook that incorporated deductive and inductive codes, with new codes added as continued engagement with the data revealed emerging patterns. Coding proceeded iteratively until no new codes emerged based on mutual consensus. Using Byrne's (2022) approach to reflexive thematic analysis, the coding team continued refining codes and themes until they reached consensus.

### 3.2.5 Analytic Approach and Epistemological Framing

Data were analyzed using critical reflexive thematic analysis, which emphasizes both the identification of patterns and interpretive meaning-making grounded in theoretical frameworks and researcher reflexivity (Braun & Clarke, 2006; Byrne, 2022). This approach allows for theoretical flexibility and supports both inductive and deductive strategies for coding and theme development.

The analytic process included the following steps:

- Familiarization with the data
- Generation of initial codes
- Identification and refinement of cross-cutting themes

- Reflexive discussions among team members
- Development of thematic statements aligned with the study's aims

Deductive codes were derived from key frameworks relevant to the study of Black family mental health and structural racism, including:

- Yelton et al.'s (2022) social determinants of African American mental health review
- Murry et al.'s (2018) model of Black family stress and resilience
- Planey et al.'s (2019) review of barriers and facilitators to mental health service use among Black families

Inductive codes were developed iteratively through team dialogue and close engagement with transcripts and memos. Examples of inductive codes, such as "comparison as security" and "generational attitudes towards mental health," were developed from commonly recurring participant statements and refined through the development of clear definitions. Deductive codes were generated a priori, following initial familiarization with the data to ensure alignment with theoretically driven research questions. Yelton and colleagues' (2022) review of the social determinants of mental health was used to identify key contextual factors (e.g., healthcare access, economic opportunities, and the neighborhood/built environment) that shape maternal caregivers' mental health. In addition, Murry and colleagues' (2018) framework of Black family stress and resilience informed the identification of common coping strategies, mental health outcomes, and broader determinants of mental health within the Black family system.

Sentiment coding was used to identify whether participants described specific determinants as barriers or facilitators, following the framework outlined in Planey and colleagues' (2019) review of mental health service use among Black families. To ensure cultural responsiveness, the team coded not only for risk and adversity but also for context-specific facilitators. For instance,

when a participant described anxiety as protective for her children, it was coded as a **facilitator** to reflect the participant's own framing. Interpretive codes captured recurring values and collective themes, such as the **importance of representation**, and were grounded in participants' words and perspectives (Saldaña, 2013). These codes emerged through repeated transcript review and discussion between the lead investigator and research assistant, who jointly refined and expanded codes as new insights surfaced. A complete list of codes and operationalized definitions is provided in the Appendix.

Current secondary analysis was conducted using NVivo 12 (Welsh, 2002). Cluster analysis and matrix coding queries supported the development of thematic maps, from which the research team identified overarching themes that addressed the secondary research questions. The study was grounded in a critical constructivist epistemology (Phillips, 2023), which posits that knowledge is socially constructed through interaction, historical context, and critical interpretation. This framing aligns with the participatory and emancipatory goals of photovoice, positioning Black maternal caregivers as co-constructors of knowledge and experts on their lived experiences.

Following code consolidation, **NVivo's cluster analysis** tool was used to identify conceptually related code groupings. From these, the team developed thematic statements that summarized core insights from the data. Final themes were shaped through reflexive dialogue and returned to the data for validation.

This thematic meaning-making process reflects Braun and Clarke's (2019) emphasis on flexibility, reflexivity, and theory-informed interpretation in qualitative analysis. It also honors the participatory and political roots of photovoice by centering the lived expertise and sociocultural contexts of Black maternal caregivers.

## 3.3 Results

Themes were organized into two domains: **Social Determinants** and **Consequences of Social Determinants**. The focus across themes was to identify the structural forces that protect, harm, or otherwise shape Black families' mental health.

The **Social Determinants** domain includes themes that name specific institutions and structures that Black maternal caregivers and their communities regularly contend with, as reflected in the photovoice discussions. This domain includes three themes:

1. *Healthcare Ain't Fair*
2. *How the [My] Community Is Valued*
3. *Pulpit Permission*

The **Consequences of Social Determinants** domain captures the experiences and processes that Black maternal caregivers, their families, and their communities navigate in response to these structural forces. It includes three themes:

1. *Anxiously Guarding*
2. *I Tried to Pray It Away*
3. *Working Together for Good*

### *3.3.1* Domain 1: Social Determinants

Themes in the social determinants group address the first research question, which sought to understand the broader social and structural determinants that Black maternal caregivers identify. Each theme has a conceptual definition created based on literature and informed by the author's critical constructivist epistemological frame. Conceptual themes were generated based on the author's positionality and relationship to the methodology, constructs, themes, and ideas that emerged from the data. The themes speak to Black maternal care givers experiences with

institutions, naming the inequities they experience as well as the way they shape institutions for their communities' benefit.

***Theme 1: Healthcare Ain't Fair: Community Stigma, Historical Racial Trauma, and Provider Access Keeping the Black Family from Mental Wellness.***

Health care emerged as the most salient social determinant discussed by Black maternal caregivers. Participants emphasized how limited access to trustworthy providers, community stigma, and collective experiences of racial trauma all shape their families' ability to receive mental health care. They reflected on both structural barriers—such as rurality, lack of Black providers, and the high cost of medical education—and cultural-historical barriers like stigma and medical mistrust rooted in systemic racism.

Caregivers described living in rural areas with few accessible providers, especially psychiatrists or culturally competent professionals. Alicia reflected on how this lack of care contributes to missed or delayed diagnoses:

> "I live in a small town with two doctors, one an OBGYN, the other a general MD. When he tells me my little boy is okay, then I'm okay with that. I'll just take the doctor's note up to the school, and that's the end of that."

This quote illustrates how structural barriers in the built environment constrain access to accurate diagnoses and intersect with educational systems. Without specialty providers nearby, families may accept reassurances that overlook critical issues—leading to untreated conditions like ADHD and downstream consequences such as school struggles or substance use. Several participants noted that families with more resources or proximity to urban centers might have access to better care, underscoring inequities within and across Black communities.

Beyond access, caregivers also named the **absence of Black providers** in their communities as a source of disconnection and mistrust. Alicia imagined a different future:

> "We need professionals in our community so our people can have access to you and your knowledge... I want to go to southeast Raleigh where they used to be."

This longing for community-based care reflects both historical memory and a vision of mental health systems rooted in cultural trust and local investment. The group linked these gaps to broader forces—such as the cost of medical education—that prevent Black professionals from returning to serve in their communities.

Caregivers also emphasized **internalized stigma and cultural mistrust** that keep Black families from seeking help. Tosha shared:

> "There's still some anxiousness from mothers. Who wants their child labeled?... We don't want our kids to get labeled—rightly or wrongly—because it's not so easy to come from under that label."

Others connected this stigma to historical racial trauma. Mesha reflected:

> "We can't forget our history in this country… we don't want to be yet another study like the Tuskegee syphilis study."

These insights reflect how structural racism operates not just through systems of access, but also through cultural memory and fear, shaping perceptions of care and comfort with seeking support. Medical mistrust and labeling anxiety function as **cultural mechanisms** that restrict help-seeking even when services exist.

Together, these narratives illustrate how **caregivers' experiences with health care are shaped by interlocking social determinants**, including geographic isolation, systemic

underinvestment, and cultural harm. These structural and cultural forces both constrain access and erode trust, impeding the mental wellness of Black families.

### *Theme 2: "You Know How That Community Is Valued": Housing Insecurity, Neighborhood Disinvestment, and the Mental Health of Black Families*

Black maternal caregivers described how neighborhood conditions and access to safe, stable housing are central to the mental health of their families and communities. They emphasized that **housing insecurity**, **community disinvestment**, and **gentrification** are not just material issues but reflect how society values—or devalues—Black lives.

Caregivers spoke about the impact of **homelessness and housing precarity**, not only for those directly affected but for the broader community. Mesha shared the story of a veteran family who avoided their newly secured apartment and continued sleeping outdoors:

"Even though they had housing—an apartment—for the first couple of months… they would leave and sleep outside. That was mental health. Some people would say that was a choice… but it was their mental health. They didn't understand; they thought when they were going to sleep—the walls were closing in on them."

This reflection shows how trauma and mental illness can make traditional forms of housing feel unsafe or unmanageable. In other cases, caregivers described being **desensitized** to growing levels of visible homelessness and untreated mental illness in their neighborhoods, signaling how widespread housing instability affects community morale.

Beyond homelessness, participants viewed **neighborhood upkeep** as a reflection of both individual and community mental health. They described how deteriorating housing, vacant lots, and lack of investment signal societal neglect and deepen feelings of stigma. Alicia explained:

"It's stigmatizing to my home… if I haven't kept it up, [people think] 'oh no wonder.' From the standpoint of mental health, some of us may have a perception… that something is seriously wrong—you're dead, you're dying, something is seriously wrong."

The **physical condition of homes and neighborhoods** was interpreted not only as an outcome of disinvestment but also as a cue for mental health struggles that may be hidden or ignored.

The women also described **gentrification** and unequal economic investment as visible markers of structural racism. In some cases, caregivers noted the contrast between new developments and long-standing neglect:

"You have gentrification, so you can have a $300k home beside a home where people have no income… They tore down the old house… or they're outpricing people from their homes… you know how that community is valued."

They pointed to symbolic indicators of how value is assigned: where fast food chains or liquor stores are placed, which businesses are welcomed, and whose parks and streets are maintained. These conditions impacted their own well-being and reflected a broader **devaluation of Black spaces** and lives.

This theme illustrates how caregivers connect **housing conditions and neighborhood investment to community mental health**, recognizing these environmental and economic factors as social determinants rooted in structural racism. Whether through exposure to homelessness, deterioration of property, or exclusion from urban renewal, Black families experience these forces as psychological burdens—manifesting in anxiety, stigma, and chronic stress.

### *Theme 3: "Pulpit Permission": A Church-Based Intervention to Address the Mental Health Literacy Needs of Black Communities*

Black maternal caregivers described the Black church as a trusted but underutilized institution in promoting mental health within their communities. While acknowledging its imperfections, participants emphasized the church's enduring influence and proposed a model of "pulpit permission" as a culturally grounded intervention. Through this model, pastors would use the pulpit—either during sermons or by inviting guest experts—to address mental health topics, increase mental health literacy, and combat stigma. Mesha explained:

> "I would say 'pulpit permission.' And pulpit references. It gives people permission from the pulpit… to talk about these issues. The reason we do so many things with health is because our pastor gave pulpit permission and pulpit time to focus on a relevant component for us in the Black community, to talk about mental health… I think you would begin to see momentum."

Caregivers emphasized that the church's endorsement could open the door to practical education around mental health diagnoses, services, and strategies for seeking care. Alicia shared:

> "If we have pulpit permission and professionals can come in and tell us what we're looking for… like routine—how do they manage routine? Are you constantly going in there to say, 'didn't I tell you to sit down?' Everyone is saying to check for ADHD, but what am I checking for?"

This lack of clarity around diagnoses was part of a broader gap in mental health knowledge. Caregivers noted that many people in their communities do not understand the distinctions between psychologists, psychiatrists, counselors, and social workers. Some were unaware that primary care physicians could play a role in mental health care. This limited literacy, they

argued, could be addressed through **faith-based education efforts** embedded within trusted religious spaces.

Caregivers also envisioned the church as a vehicle for **connecting families with mental health resources** and providing sermons on broader structural determinants—like homelessness or food insecurity—that shape mental well-being. In several cases, participants referenced partnerships between churches and grassroots mental health organizations working to bring services and education into the sanctuary.

At the same time, caregivers were candid about the **stigma perpetuated within church communities**. They described how religious messages sometimes discouraged professional help-seeking:

> "I think of a friend who has, like, 'I'm not gonna send my kids to a therapist; what am I gonna do that for? I'm going to just pray.'… But that affects your children's mental health. Are they going to suppress stuff or learn how to talk about things?"

Rather than rejecting religious coping, caregivers called for **integration**—a theology that affirms both spiritual and clinical support. One woman reframed this belief using scripture:

> "When I read the Bible, I hear that he gave us pastors, preachers, and teachers… I'm going to add mental health people. I'm not going to pray my car is better; I'm going to take it to a mechanic. I'm not going to pray my kids better; I'm going to take them to a therapist."

Through pulpit permission, caregivers positioned the church as a **potentially protective social determinant of mental health**—one that could reshape community norms, challenge stigma, and empower families with knowledge and tools for healing. By shifting both **narratives and**

**resources**, churches can become active agents in transforming Black communities' social and mental health landscapes.

### 3.3.2 Domain 2: Consequences of Inequities Across Social Determinants

As Black maternal caregivers reflected on structural and social determinants of mental health, they also described the emotional and behavioral consequences of navigating these contexts. The themes in this domain were developed through a critical-constructivist lens and informed by the author's positionality as a Black scholar with both lived and scholarly understanding of structural racism and Black family life. Interpretive choices were guided by a commitment to honoring participant voice, spiritual framing, and collective resilience.

This domain includes three emergent themes that reflect outcomes and coping strategies:

1. *Anxiously Guarding*
2. *I Tried to Pray it Away*
3. *Working Together for Good*

These themes illustrate how caregivers experience and respond to mental health challenges shaped by inequity, often balancing distress with resilience and protective strategies.

***Theme 4: Anxiously Guarding: Black Maternal Caregivers Experiencing Anxious and Depressed Affect Because They Always Have to Protect the Black Family.***

"Anxiously guarding" captures how Black maternal caregivers experience emotional strain—particularly anxiety and depressive symptoms—as they constantly protect their children, homes, and communities from structural threats. This protective posture was described as both necessary and exhausting.

For example, Tosha expressed worry about the risk of her child receiving a stigmatizing diagnosis, particularly in education and healthcare settings. She viewed such labels as difficult to

escape and damaging to children's mental health. Similarly, Mesha spoke of her concern not only for her own child, but for all Black children, highlighting a collective maternal vigilance rooted in lived experience.

A vivid visual metaphor emerged in a photovoice discussion of an image showing a shopping cart (Image 3.1) chained to a pole. Caregivers interpreted the cart as a stand-in for their homes and families—valuable but vulnerable, exposed yet constrained. Mesha shared:

"It has all these holes in it so you can see everything... As much as we may be saying that there's some value in what's in the cart, think of how exposed the person may feel... I've got the cart, and I'm trying to prevent people from taking what's in it." Lynn added:

> "That gut feeling of exposure—you have no control. There's no covering... That chain, I just feel that absence of freedom. It takes me to a place I don't like to go [mentally] but I visit a lot."

Together, these reflections illustrate a *hypervigilant mental state*, in which caregivers feel both metaphorically "chained" by external systems and emotionally taxed by their responsibility to shield their families from harm. This emotional burden was not limited to anxiety. Caregivers described depressive symptoms—sadness, desensitization, and overwhelm—rooted in their ongoing efforts to protect their children from hardship. One maternal caregiver reflected:

> "I don't want nobody's children bound or chained—I don't want them living a life on guard... It just makes me sad."

She described the painful responsibility of raising children to be cautious and prepared for adversity, knowing this may perpetuate the very anxiety and guardedness she hoped to protect them from.

Overall, “Anxiously Guarding” reflects how structural stressors such as inadequate healthcare, housing insecurity, and institutional bias shape not only external actions but internal experiences. Black maternal caregivers report emotional exhaustion, vigilance, and sadness as they strive to shield their families—often at great personal cost.

***Theme 5: “I tried to pray it away”: Religious socialization to protect the Black family from the harms of structural determinants of health***

One of the most salient and recurring insights across caregiver narratives was the central role of faith and religious coping in responding to structural adversity. Black maternal caregivers described prayer, scripture, and spiritual teachings not only as sources of personal resilience but also as tools for teaching and evangelizing mental wellness within their families and communities.

> “Yeah, so as a mother, you’re teaching your kids beliefs, and that gives them education and knowledge, for them to be able to navigate through mental health.”

Faith practices were often positioned as primary, and sometimes sole, methods for coping with racialized stressors such as discrimination, resource scarcity, and systemic exclusion. Participants described how spiritual guidance—from God, pastors, or scripture—provided emotional grounding even when no other tangible resources were available. As one caregiver put it, faith was not optional—it was *essential* for survival. In a participant-generated photoprompt, one caregiver shared:

> “It is important that the Black mama inform her family about the need for God according to the scripture… to maintain health, mental, physical, social, academic, relational, etc.”

This quote underscores the idea that religious coping is not just individual but deeply communal and intergenerational, serving as a spiritual infrastructure that supports all domains of family life.

Several caregivers reflected on how this religious socialization has changed across generations. Alicia described the expectations and limitations placed on Black women of her generation, who often faced systemic inequities with little access to mental health services:

> "You were expected not to be treated fairly... so even if we did have, 'I'm feeling blue,' you just wrapped it up and kept going. If you went too deep, you went to your pastor. They would pray with you, give you some scripture. Your grandmother would tell you to pray… now we know it's out there, this generation understands there is someone out there who can help you."

This reflection captures both the constraints of earlier generations and a shifting openness to professional mental health care. While older generations primarily relied on prayer, participants emphasized that younger caregivers are beginning to embrace a *both/and* approach—honoring faith while seeking therapeutic support. One caregiver succinctly captured this evolution:

> "When you ask me, 'Girl, how your kids end up like that?' I'm going to answer you—we went to church on Sunday and therapy on Thursday."

Across stories, caregivers conveyed that while prayer and religious teachings remain foundational, they increasingly see them as complementary to—rather than exclusive of—professional care. In doing so, they are socializing the next generation to approach mental health with more tools, less stigma, and deeper integration of spiritual and clinical strategies.

***Theme 6: "Working together for good": Black families and communities' collective approach to improve their material conditions***

Across caregiver narratives, a strong ethic of interdependence emerged—rooted in faith, family, and community—as a vital strategy for navigating structural adversity and supporting mental health. Black maternal caregivers described how pooling resources, sharing life lessons,

and leaning on one another are not just practical survival strategies, but also deeply spiritual and culturally grounded ways of life.

> "For this mom, her belief is that like the family is strongest when everybody is working together… She believes that the family sticks together. You know, we support each other. Their mental health and their ability to go out and function in the world is propelled by that belief that, you know, we're this unit that works together."

This caregiver reflected on a woman who welcomed her adult children to live at home, allowing them to share material resources (e.g., cars, housing) while maintaining a sense of cohesion and mental wellness. Across multiple accounts, caregivers emphasized that this ethos of "sticking together" was driven by faith, generational values, and a deep sense of responsibility to one another.

A recurring image was what caregivers called the "go tell it on the mountain" phenomenon—a practice of testimony and communal storytelling, where women shared their own hardships and lessons with others as a form of social support. This form of knowledge-sharing, primarily exchanged among mothers, was described as a critical mechanism for navigating structural barriers and improving collective well-being.

> "One thing that I've seen that works well in terms of the Black family's mental health is relationships with your neighbors… Getting help by asking 'What do you think?' about something as big as mental health or as basic as a job."

In this context, mental health promotion extended beyond individual solutions. It included everyday acts of collective meaning-making—swapping stories, offering advice, and affirming others' struggles. These interactions were grounded in communal care and often framed by

scripture. Many caregivers cited **Romans 8:28**—"all things work together for good"—as a spiritual anchor and interpretive lens.

Caregivers drew on this scripture to explain how even their most painful experiences had purpose and could be used to help others. For example, one woman described how her struggles became life lessons that she passed on to younger mothers. Another recounted the story of a mother who, despite lacking formal education, understood its importance and instilled that value in her children—resulting in their eventual academic and professional success.

These testimonies illustrated a powerful process of collective resilience: caregivers shared their wisdom not only within their families but also with broader community networks. They worked together—across generations and institutions—to support youth and promote thriving, even in the face of racialized structural barriers.

### 3.4 Discussion

This study offers an in-depth examination of how Black maternal caregivers conceptualize, navigate, and cope with racialized structural determinants of mental health (SDOMH) that impact their families and communities. The findings from this photovoice project enrich the current literature on the Black family as both a site of resilience and a context for mental health risk and protection (Bannon et al., 2008; McLoyd et al., 2000). Through a critical-constructivist lens, the study emphasizes maternal caregiver insight as a rich source of meaning-making, demonstrating how their perspectives reflect broader sociopolitical realities while also shaping adaptive strategies for family well-being (Brantley, 2023a; Murry et al., 2018). This discussion situates the study findings within five interrelated areas of literature: (1) racialized experiences of structural determinants across domains like healthcare and housing; (2) the emotional and psychological consequences of structural vulnerability; (3) religious and spiritual

socialization as coping; (4) collectivist family and community responses; and (5) the role of trusted institutions, such as the Black church, as mechanisms for intervention and change. Together, these threads reveal how Black families, and particularly Black maternal caregivers, experience and respond to entrenched systems of inequality while sustaining hope, community, and care.

#### *3.4.1.1 Racialized Healthcare Contexts*

One of the most prominent findings from this study concerns the persistent inequities Black families experience in healthcare settings. Black maternal caregivers in this project described navigating a healthcare system they perceived as structurally biased, dehumanizing, and often harmful to their children's well-being. This theme echoes long-standing literature documenting racial disparities in healthcare access, quality, and outcomes for Black families (Z. D. Bailey et al., 2017; Gee & Ford, 2011; D. R. Williams & Mohammed, 2009).

Participants expressed concerns about being pathologized or misdiagnosed, especially in relation to their children's mental health and behavior. These fears were often rooted in past experiences of discrimination or institutional neglect and were compounded by a lack of culturally responsive care. Such concerns align with existing research highlighting how provider bias, stereotyping, and structural barriers shape Black families' mistrust of health systems (Metzl & Roberts, 2014).

Importantly, the caregivers' narratives reveal not only individual instances of mistreatment but also a broader critique of how systems are designed to surveil and discipline Black families, rather than support them. These insights support a structural racism framework that sees poor health outcomes not as accidental, but as the predictable result of historically rooted inequities in medical institutions and policy (Bailey et al., 2021). In response to these

challenges, many caregivers described heightened vigilance—careful monitoring of interactions with providers, questioning of diagnoses, and seeking out of alternative or supplemental care—as both a protective strategy and a psychological burden (B. D. Smith et al., 2025) This aligns with research on that maternal overprotection—commonly seen as a form of anxiety (L. B. Jones et al., 2021). The most recent review of maternal overprotection and anxiety by L. B. Jones and Colleagues (2021) included thirteen articles, all of which had either no reported race or samples with less than 5% of the sample being African American. One empirical study to date has examined the relationship between maternal overprotection and anxiety of Black young adults, finding no significant relationship between the two. However, the study only examined a small sample of African Americans (n=55), using only bivariate correlations with the child's anxiety levels, and retrospective reports of maternal caregivers' overprotection (Carter et al., 2001).

#### *3.4.1.2 Racialized Neighborhoods as Determinants of Mental Health*

The mental health of Black families is shaped not only by the direct experience of interpersonal discrimination but also by the environmental and spatial contexts in which they live. In this study, Black maternal caregivers highlighted housing instability, neighborhood disinvestment, and gentrification as central to how they and their communities experience mental well-being. These neighborhood-level conditions reflect structural racism—materializing in unequal access to safe, stable housing and signaling how society devalues Black lives and spaces (Bailey et al., 2017; Williams et al., 2019).

Consistent with broader literature on neighborhood effects, caregivers drew attention to both the physical and symbolic consequences of disinvestment. Poor housing conditions, dilapidated buildings, and a lack of public infrastructure contribute to chronic stress and shape perceptions of personal and communal worth (Fullilove, 2016; Marçal, 2024). As one

participant noted, stigma was embedded in how others viewed the upkeep of homes, revealing how neighborhood aesthetics are read as proxies for mental health status. This aligns with research showing that perceptions of neighborhood disorder are associated with psychological distress, especially among residents of racially marginalized communities (Haney, 2007; Hill et al., 2005; South et al., 2015).

In addition, participants' reflections on gentrification illustrated how market-driven redevelopment can function as a form of structural exclusion. As caregivers described, the emergence of high-value housing alongside deeply disinvested properties revealed the "valuation" of some communities over others. This mirrors research showing how gentrification can contribute to displacement, community fragmentation, and loss of cultural belonging—all of which are associated with adverse mental health outcomes (Smith et al., 2025).

Caregivers also pointed to the emotional toll of visible homelessness and untreated mental illness in their communities. This resonates with prior findings that community-level stressors—such as witnessing others' suffering—can result in vicarious trauma and collective distress (Gee & Ford, 2011). At the same time, their insights reflected a nuanced understanding: housing insecurity was not simply framed as a material problem but also as a psychological one, with trauma often rendering traditional housing unlivable or unsafe. This perspective aligns with trauma-informed research that situates housing as both a social determinant and a site of healing or harm (Hopper, 2010).

Taken together, these narratives underscore that housing and neighborhood conditions are not neutral backdrops but active sites of racialized structural violence. Black maternal caregivers in this study illuminated how such environments—often ignored in clinical mental health discourse—are core to understanding and addressing Black family well-being.

### 3.4.2 Coping with Structural Determinants: Vigilance, Faith, and Collective Strength

Black maternal caregivers described a range of coping strategies to manage the psychological toll of navigating structurally rooted stressors, including anxiety, social stigma, and constrained access to care. These strategies were shaped by personal histories, faith traditions, and cultural values centered on collective resilience. Caregivers often expressed vigilance as a form of protective coping. This vigilance manifested as constant awareness of their children's environment, hyper-responsibility for their mental and emotional well-being, and sustained attention to external threats such as misdiagnosis or racial profiling in school and medical settings. Prior research has documented this anticipatory vigilance as a key component of racialized stress responses in Black families (Anderson & Stevenson, 2019; Brantley, 2023b) .

Religious faith emerged as one of the most consistent coping mechanisms discussed by participants. Across multiple generations, caregivers reported relying on prayer, scripture, and church involvement to make sense of hardship and to sustain themselves and their families through moments of emotional and material scarcity. This aligns with existing scholarship on religious socialization and the central role of faith-based coping in Black communities (Gutierrez et al., 2014; Leath et al., 2022; R. J. Taylor et al., 2014). Importantly, caregivers in this study did not always frame faith as an alternative to mental health care; rather, some described a model in which "church on Sunday and therapy on Thursday" could co-exist—a perspective that reflects growing openness in Black communities to integrate professional care and spiritual healing (Hankerson & Weissman, 2012; Richardson et al., 2024)

The "working together for good" theme also revealed interdependence and collective reliance (i.e., sharing experiences, lessons learned) to be successful. In the Black family system, interdependence has been associated with protective mental health factors (i.e., socioemotional development, supportive networks), particularly for the socioeconomically disadvantaged

(Billingsley et al., 2022; Rivens et al., 2022). However, findings on social support effectiveness within families are mixed, showing both protective and risk factors for family closeness and mental health impacts (C. J. Cross et al., 2018; Levine et al., 2015; R. J. Taylor et al., 2013; Williams-Butler et al., 2023). Research suggests that Black families endorse interdependence regardless of socioeconomic status (P. A. Gibson, 2005; Kane, 2000; Marks et al., 2008), both theoretically and qualitatively (Denby, 2018; Kane, 2000; Littlejohn-Blake & Darling, 1993; Schiele, 2013). A component of that interdependence, knowledge sharing, is frequently reflected in the literature as a common practice in Black communities, (C. Smith et al., 2023; Waites, 2009), particularly between maternal caregivers and their peers as they socialize their children (Devido et al., 2020; L. M. Jones et al., 2018). The participants described intergenerational wisdom-sharing, resource pooling, and neighborhood relationships as vital for navigating the stress of structural oppression. This collectivist approach—offering emotional, logistical, and spiritual support to one another—is deeply embedded in African American cultural traditions and has been linked to more adaptive mental health outcomes (Denby, 2018) Several participants invoked Romans 8:28 ("all things work together for good") as a guiding belief that hardships, when shared and spiritually interpreted, could serve a higher communal purpose.

Together, these findings highlight how Black maternal caregivers simultaneously engage in individual, spiritual, and collective coping strategies to protect their families. While these practices offer strength and meaning, they also speak to the need for more systemic change so that Black families are not left to cope in isolation with challenges that are structurally produced.

These findings also reveal important directions for both research and clinical practice. In particular, future studies should explore how chronic vigilance—manifested through guarding children, managing household safety, and sustaining self-protection—may contribute to anxiety

and depressive symptoms among Black maternal caregivers (Anderson & Stevenson, 2019; Jones et al., 2021). For clinicians, recognizing these culturally grounded expressions of distress can support more responsive and equitable mental health care for Black families.

### 3.4.3 Mechanisms and Contexts for Change: Pulpit Permission and the Black Church

A central thread across participants' narratives was the influential role of the Black church in shaping responses to mental health challenges and social adversity. Maternal caregivers described the church not only as a source of coping and support but also as a potential **mechanism for structural change**—what one participant referred to as pulpit permission. This phrase encapsulates the idea that when church leaders speak openly and affirmatively about mental health, they grant moral and spiritual license for others in the congregation to do the same. This mechanism—anchored in both faith and authority—reduces stigma, encourages help-seeking, and reinforces a collective ethic of care.

The idea of pulpit permission builds on prior research demonstrating how trusted faith leaders can shift cultural norms around mental health within Black communities (Avent Harris et al., 2022; Hankerson & Weissman, 2012; Richardson et al., 2024). Pastors who frame therapy, medication, or emotional vulnerability as spiritually acceptable help dismantle the notion that mental health struggles reflect a lack of faith. In this study, caregivers expressed that when faith leaders normalized these conversations, it created ripples through the congregation—encouraging others to seek support without shame. As one participant noted, "when the pastor says it, it's like God gave us permission."

This mechanism reflects what researchers have termed "religious coping leadership," wherein pastors and other faith leaders serve as informal gatekeepers to care, either facilitating or impeding access depending on their stance. In this context, the church operates as a cultural

broker and a community intervention site. It provides continuity, ritual, and a moral framework for resilience that blends spiritual practice with public health goals (Mattis & Jagers, 2001). As caregivers in this study affirmed, pastors who explicitly engage mental health topics—and who encourage faith and therapy—can transform the church into a healing-centered institution.

Moreover, the potential of pulpit permission as a mechanism for change is amplified when paired with communal storytelling. Caregivers described testifying to others—especially other mothers—about their experiences with depression, anxiety, or institutional harm. These stories functioned not only as emotional catharsis but also as informal psychoeducation. As such, they offer insight into how lay leadership and lived experience can work in tandem with faith leadership to promote well-being (Lincoln & Mamiya, 1990; Mattis & Jagers, 2001).

Taken together, these narratives suggest that the Black church—and the pulpit in particular—can function as a culturally responsive mechanism for both individual and systemic transformation. Through spiritual authority, shared testimony, and communal care, the church has the potential to interrupt stigma, facilitate access to resources, and model what healing can look like when grounded in culturally affirming practices.

### 3.4.4 Study Strengths, Limitations, and Future Directions

This study contributes a rich, contextualized understanding of how Black maternal caregivers perceive and experience SDOMH in their families and communities. Using **photovoice** as a participatory method enabled participants to articulate the lived nuances of these experiences through both narrative and visual forms. As with all photovoice projects, the goal was not generalizability but rather **depth and specificity**, with findings grounded in the unique sociocultural and structural realities of the partner community communities (Wallerstein et al., 2019). Even so, the emergent themes build on broader literature addressing: the impact of

SDOMH on Black families (Bailey et al., 2017); the sociocultural dimensions of Black family mental health (Avent Harris et al., 2022; Richardson et al., 2024); cross-generational socialization (Waites, 2009); and collective coping strategies rooted in faith, storytelling, and mutual support (Denby, 2018).

A central strength of this study is its emphasis on the **Black family as a unit of analysis**, particularly through the perspectives of Black maternal caregivers. Their insights enrich existing research by illuminating not only individual stress responses but also shared cultural values, intergenerational responsibilities, and collective efforts to manage adversity. Additionally, the interpretive orientation—grounded in critical constructivism and informed by the researcher's positionality as a Black scholar—centered community voice and honored the epistemological authority of Black women's lived experiences (Collins, 2000).

Despite these strengths, several limitations must be noted. First, this was a **secondary analysis** of data collected from a community-based participatory research (CBPR) project. The original investigators were not involved in this phase of interpretation, and the research questions guiding this analysis were formulated after the initial data collection. A more collaborative member checking approach would yield greater potential accuracy of interpretive results and conclusions drawn from this research study. While this opens the door to **novel insights** from existing data, it also introduces the possibility of interpretive distance from the original context. Still, secondary qualitative analysis is increasingly recognized as a valuable strategy, particularly when re-analysis avoids re-burdening participants and draws on rich, underutilized data sets (Beck, 2019; Mannheimer, 2024; Thorne, 1994).

Second, the dataset was affected by **missing information**, including participant demographics (e.g., age, number of children, socioeconomic status) and portions of the transcript

lost due to technological errors or incomplete documentation. These omissions limited the ability to explore patterns across different subgroups and may have obscured potentially important contextual details (E. Smith, 2008; Watkins, 2022). Finally, while the findings provide insight into coping and consequences, the analysis was limited to what participants shared during a single photovoice project—additional forms of engagement, such as follow-up interviews or journaling, might have expanded interpretive depth.

## 3.5 Conclusion

Future research should continue to engage **community-driven and participatory methods** to investigate SDOMH across the Black family system, particularly across genders, generations, and geographic regions. Additionally, the strategic and ethical use of **secondary qualitative data** can yield important contributions when handled with transparency and contextual sensitivity. Such work can expand understanding of how structural forces and local coping mechanisms shape family mental health, while advancing calls for **equity- and justice-centered intervention models** (Berge et al., 2009; Ford & Airhihenbuwa, 2010).

### 3.6 Figures and Tables



Image 3.1 An image taken by a Black maternal caregiver where they describe this need to protect/guard resources and their children as a source of anxious distress but also recognizing they cannot keep the cart or its contents safe.

### 3.7 Appendix:

# Codebook: Chapter III

| Name | Description |
|---|---|
| Comparison as Security | The act of feeling or the state of being comfortable, stable, safe in one's environment or physical and mental state BECAUSE an individual feels that their emotional physical, or environmental state is better or worse than someone else' |
| Downstream consequences (topical) | Refers to the outcomes of the social determinants of mental health. |
| Anxiety | Refers to the diagnoses of anxiety, feelings of restlessness, scared, jitteriness, feeling nervous anxious or on edge, safety checking, |

| Name | Description |
|---|---|
| Caregiving | Refers to the changes in the way that individual's parent, rear, or engage with the youth that they are caring for |
| Comparison as security | The act of feeling or the state of being comfortable, stable, safe in one's environment or physical and mental state BECAUSE an individual feels that their emotional physical, or environmental state is better or worse than someone else's. |
| Coping | Refers to the methods by which individuals deal with stress, struggling with lack of resources, challenges, or any other event that occurs in their lives or the lives of individuals within their community |
| Active coping | Refers to individual engaging in some activity to address the issue/challenge/stressor that they or a member of their community face |
| Passive coping | Refers to activities or things done by a caregiver or a member of their community to mitigate stress, challenges, and mental health conditions Does not work to address problem directly. |
| Religious coping | Refers to individuals seeking out God, practicing faith, prayer or some other ritual that is helping them to deal with what they or their community face |
| Depression | Refers to the diagnosis of depression and or feeling down, sad, hopeless, numb, disengaged, desensitized, lack of appetite, loss of interest in pleasurable activities. |
| Frustration with institutions | Describes feelings of anger, hopelessness, fear, because of difficulty navigating institutions. |

| Name | Description |
|---|---|
| Lack of resources | Describes inadequate access to resources necessary for daily functioning. |
| Mental health | More broadly relates to a mental health topic that is not stress, anxiety, depression, or other mental health challenges in other sections. |
| Perseverance | The act of continuing on despite obstacles that a person or someone in their family or community may face |
| Stigma (topical) | Refers to an internal or external thought that a person or group of people are less than for some reason. |
| Stress | Refers to challenges/difficulties/ that the caregivers, their families, or their communities face |
| Family and community dynamics (interpretive) | Discusses how interpersonal interactions between family shapes the mental health of caregivers and their communities |
| Generational attitudes of mental health (interpretive) | Refers to differing or similar attitudes towards mental health for caregivers, those they caregiver for, and their communities. |
| Importance of representation (interpretation) | Describes how having a person with similar identities in a position of power (from an institution like a doctor, lawyer, judge, politician, teacher) can be helpful |
| Structural Determinants of Mental Health (topical) | Refers to the "“the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks" |

| Name | Description |
|---|---|
| Built Environment | Refers to any aspect of neighbourhoods, environment, or other components of an area where a person lives, works, plays, can refer to blight, playgrounds, sidewalks, etc. |
| Housing (topical) | Refers to factors that impede, aid, and or impact a person, their family, or members of their community from accessing safe and secure housing. |
| Economic Opportunity | Refers to the ability for individuals to make money, build wealth, access funds, or other factors related to financial wellbeing |
| Employment | Refers to opportunities for personal economic development or lack thereof within their community via work or career options |
| Education | Refers to access to knowledge, schooling, trades, or other skills that impact the participants and or their communities |
| Health Care (topical) | Refers to challenges accessing treatment, prevention, diagnosis, and management of diseases and disorders. |
| Housing (topical) | Refers to factors that impede, aid, and or impact a person, their family, or members of their community from accessing safe and secure housing. |
| Racism | Refers to the unequal treatment of racially marginalized individuals on the basis of power and privilege in society. |
| Religion | Refers to church, faith institutions, and other religiously affiliated factors that impact the way that caregivers engage with their health. |

| Name | Description |
| --- | --- |
| Social Services | Refers to the receipt or benefit of social services provided by the government like access to food, housing, (TANF, Food STAMPS, etc.) |

## Chapter 4 Study III

Structural racism is a persistent and pervasive force that undermines the health and well-being of Black youth and their (Bailey et al., 2017; Bonilla-Silva, 1997; Gee & Ford, 2011; R. Williams & Williams-Morris, 2000). It refers to the accumulation of discriminatory practices and inequities across institutional, cultural, and interpersonal levels (Bailey et al., 2017). Scholars have theorized the mechanisms through which structural racism affects racially marginalized individuals, but quantitative efforts to directly measure these impacts—particularly on Black youth—remain limited (Adkins-Jackson et al., 2022; T. Brown & Homan, 2024; Neblett & Neal, 2022).

Most existing studies focus on individuals' perceptions of racism across multiple levels (Bernard et al., 2022; Gibson et al., 2022; Hope et al., 2021), with less attention to how the institutions themselves act as structural determinants of mental health (Neblett, 2019). As psychology continues to grapple with structural causes of mental health disparities, improving how we conceptualize and measure structural racism is essential families (Groos et al., 2018; Neblett & Neal, 2022; Needham et al., 2022).

Racialized institutions such as the criminal legal system, education, and neighborhoods are among the most common social determinants of health for Black youth (Berry et al., 2021; Iruka et al., 2022; Trent et al., 2019; Yelton et al., 2022). Yet these institutions are often studied in isolation. Black youth do not experience racism within a single domain—they navigate overlapping systems that shape their lives in compounding ways.

This study uses secondary data from the Fragile Families and Child Wellbeing Study to construct a multidimensional model of structural racism. The model includes indicators from three key institutions: education, criminal justice, and neighborhood. This composite will be used to examine associations with Black youths' depressive symptoms, along with mediating factors such as parenting, neighborhood collective efficacy, and parental depression.

### 4.1.1 Theoretical Models

Conceptual models of structural racism emphasize that minoritized youth experience racism across multiple socioecological levels, which constrains their access to social and physical capital and impacts mental health and well-being (Iruka et al., 2022; Trent et al., 2019). These frameworks highlight racialized institutions—such as education, neighborhoods, and the criminal legal system—as key mechanisms that generate inequities with direct and indirect effects on youth and families.

While such models address broad impacts on mental and physical health, few explicitly consider how structural racism contributes to depression in Black youth. Hammack's (2003) model fills this gap, positing that historical discrimination, white supremacy, and racialized policy environments increase depression among Black adolescents. The model also highlights how structural racism drives socioeconomic disadvantage and family stress, leading to compromised parenting and elevated risk for depressive symptoms.

Several scholars have proposed statistical approaches to operationalize structural racism, offering varied perspectives on how to measure the construct (Adkins-Jackson et al., 2022; Brown & Homan, 2024; Needham et al., 2023). In line with Bonilla-Silva's (1997) framework, these approaches argue that measurement should reflect systemic forces—such as laws and policies—rather than individual perceptions. Public health definitions similarly underscore the

cumulative impact of racism across domains like housing, education, employment, and criminal justice (Reskin, 2012; Krieger, 2014). Although these interdisciplinary efforts have advanced the field, psychology is still developing robust tools to quantify how structural racism manifests and affects individual mental health.

### 4.1.2 Racialized Institutions and Mental Health

While structural racism affects Black youth across multiple domains, most studies examine each racialized institution—such as neighborhoods, schools, and the criminal legal system—in isolation. This section focuses on how these individual institutions influence mental health, particularly depressive symptoms.

#### *4.1.2.1 Racialized Neighborhoods*

Neighborhoods serve as critical developmental contexts shaped by historical segregation, disinvestment, and systemic racism (Leventhal & Dupéré, 2019; R. M. B. White et al., 2021). Scholars have linked neighborhood disadvantage—measured by indicators such as racial composition and poverty concentration—to elevated depressive symptoms in Black youth (Thomas Tobin et al., 2023; Wight et al., 2005). One study found that chronic poverty predicted greater maternal depression, which in turn was associated with more depressive symptoms in their children (Pachter et al., 2006). Other studies show that racial composition influences perceptions of racism and social cohesion: greater minority concentration may signal heightened awareness of racism (Benner & Graham, 2013), whereas neighborhood cohesion and support may buffer against depressive and anxious symptoms (Hurd et al., 2013). Residential segregation, often operationalized through neighborhood racial makeup, has been identified as a structural racism marker that influences poverty exposure, maternal mental health, and ultimately youth outcomes (Pasco et al., 2021).

#### *4.1.2.2 Racialized School Contexts*

School environments are also racialized and play a key role in shaping youth well-being (Eccles & Roeser, 2011; Iruka et al., 2022). Structural inequities such as school-wide suspension rates and teacher turnover create contexts that differentially affect Black students' mental health (Polos et al., 2022). While structural racism alone was not always associated with depressive symptoms, its interaction with contextual disadvantage produced significant effects. Racial diversity within schools has shown mixed effects—while having more same-race peers tends to support well-being (DuPont-Reyes & Villatoro, 2019), increased diversity sometimes correlates with heightened perceptions of institutional discrimination and worse outcomes (Seaton & Douglass, 2014; Seaton & Yip, 2009). Other work has found that school-wide discrimination and discipline disparities correlate with greater depressive symptoms and lower school persistence (Cooper et al., 2022).

#### *4.1.2.3 Racialized Criminal Legal Systems*

Criminal legal systems—including policing, incarceration, and judicial practices—function as racialized institutions that disproportionately harm Black youth (DeVylder et al., 2020; E. Harrell & Davis, 2020). Black adolescents report more negative police interactions and lower perceptions of procedural justice, both of which are tied to worsened mental health (Jackson et al., 2021). Beyond direct contact, vicarious exposure to police violence—either through witnessing or hearing about incidents—has been linked to increased depressive symptoms, emotional distress, and PTSD (Bor et al., 2018; Turney, 2020). Perceived procedural injustice exacerbates these effects (McFarland et al., 2019). Exposure to community violence, another manifestation of structural racism, is also consistently associated with poor mental health (Assari & Caldwell, 2017; Fowler et al., 2009; Perry et al., 2015).

#### *4.1.2.4 Compounded Effects Across Institutions*

While each institution affects Black youth individually, emerging research underscores their combined effects. For example, Lozada et al. (2022) found that youth living in predominantly Black neighborhoods but attending predominantly non-Black schools reported worse socioemotional outcomes. Studies have also documented how school-based police contact increases mental health risk, particularly when paired with racialized discipline practices (Perryman et al., 2022). These interactions reflect broader systemic issues like the school-to-prison pipeline (Prins et al., 2023). Indirect effects through family systems further compound risk: parental incarceration and chronic poverty are associated with increased parental depression and disrupted parenting, both of which predict depressive symptoms in youth (Assari, 2024; Holmes et al., 2020; McLoyd, 1998). Prior research also indicates that parental mental health may serve as a pathway through which structural racism impacts youth outcomes, as racial stressors can strain caregiver well-being and family functioning (Assari, 2024; Caughy et al., 2004; Hollie, 2021; Marçal, 2024).

#### *4.1.2.5 Structural Racism and Depressive Symptoms*

Structural racism acts as a determinant for mental health; however, this study focuses on depressive symptomology in Black youth. Studies have connected structural racism to increased depressive symptoms in Black populations (Adkins-Jackson et al., 2025; T. Brown & Homan, 2024; English et al., 2022b; Polos et al., 2022). These studies examined how structural racism in specific institutions, like education, affects depressive symptoms in Black youth and adults. However, this studies' conceptualization of structural racism encompasses all ways racism manifests in racially marginalized individuals' lives, suggesting we consider both individual perceptions and institutional racism across racialized contexts (Z. D. Bailey et al., 2017).

Depressive symptoms are a key mental health outcome due to structural racism's impact on Black youth's cognitive and emotional well-being. Helplessness mediates the relationship between racial discrimination and depressive symptoms (Madubata et al., 2018). Black youth experiencing greater cultural racism and lower cognitive awareness of racism showed worse depressive symptoms (S. M. Gibson et al., 2022). Research found that Black youths' cognitive development and perceptions of institutional racism were associated with worse self-esteem (Seaton, 2010). These findings indicate that Black youth's perceptions of racism across multiple levels impact their depressive symptoms, and institutional racism in racialized spaces (schools, neighborhoods) is simultaneously shaping their depressive symptoms (Seaton & Yip, 2009). Some emerging literature has begun to examine structural racism and its association with depressive symptoms, though the measurement approaches used (e.g., geometric mean, single indicators for a latent variable; state level indices) may not be accounting for all the many pathways by which structural racism is impacting depressive symptoms (Adkins-Jackson et al., 2025; T. Brown & Homan, 2024; Polos et al., 2022) Limited research has examined how multiple forms of institutional racism across racialized contexts (disproportionate criminal legal contact, inequitable neighborhoods, and schools) are uniquely connected to depressive symptoms.

### 4.1.3 Measurement: A Key Gap in the Structural Racism Literature

Despite growing interest in the role of structural racism in shaping mental health outcomes, there is a lack of consensus in the field regarding how best to measure this construct, particularly in relation to Black youth depression. Efforts to measure structural racism as a determinant of mental health have used individual-level perceptions, indices, and latent models (Adkins-Jackson et al., 2025; T. Brown & Homan, 2024; Homan & Brown, 2022; Neblett &

Neal, 2022; Polos et al., 2022). Each approach offers partial insight but faces limitations around construct validity, theoretical alignment, and capturing the cumulative burden of racism. Ongoing methodological innovation is needed to more precisely operationalize this complex construct.

Individual perceptions remain central, despite critiques. Adkins-Jackson et al. (2022) caution against relying solely on perceptive measures, given that racism operates independently of individual awareness. Still, perceptions are important given that structural racism shapes lived experiences across multiple contexts (Hope et al., 2021; Rucker & Richeson, 2021b, 2021a; Seider et al., 2022).

State-level structural racism indices—such as those reflecting disparities in imprisonment or maternal mortality—provide a broader systems-level view (Adkins-Jackson et al., 2025; Siegel et al., 2023b, 2023a). These indices have been linked to mental health outcomes among Black populations (Adkins-Jackson et al., 2025; English et al., 2021, 2022a; Mesic et al., 2018). However, their utility may be limited for understanding Black youth, whose mental health is more directly shaped by local contexts like counties, cities, or neighborhoods (Alvarez et al., 2022; Wright et al., 2025). Even within the same geographic area, exposure to structural racism varies by institutional touchpoints—school, healthcare, community organizations—underscoring the need for more proximal, context-sensitive approaches.

To address these challenges, latent modeling has gained traction. These models incorporate multiple indicators to approximate structural racism more robustly than composite means, which do not allow for unequal weighting across indicators (Gerstein et al., 2021). Latent variable approaches have shown associations between structural racism and physical health (e.g., obesity, gun violence), (Dougherty et al., 2020; Siegel et al., 2023a, 2023b) and are

increasingly used in mental health research (T. Brown & Homan, 2024). Brown and Homan (2024) used confirmatory factor analysis to model structural racism across domains (education, economics, segregation, criminal-legal), with indicators loading onto a single latent factor. However, their model—like Siegel et al. (2023a)—did not examine how specific institutions uniquely or synergistically contribute to outcomes. A second-order CFA may better reflect the theory, modeling how institutional inequities jointly define structural racism (Rindskopf & Rose, 1988).

Building on this, latent profile and class analyses (LPA/LCA) have emerged as tools to capture typologies of structural racism exposure (Adkins-Jackson et al., 2022; Chantarat et al., 2021; Martz et al., 2024; Riley et al., 2024). These methods group individuals based on shared neighborhood or school characteristics, offering insight into how within-group variation in exposure relates to health. For example, Chantarat et al. (2021) identified distinct classes of structural racism exposure predicting vaccine uptake, while Martz et al. (2024) used LCA with FFCWS data to examine early-life exposure to school and neighborhood inequities and later biological stress markers. These models account for the ways Black youth may experience structurally racist environments differently—even within similar geographies—and offer promising tools for identifying differential risk based on context-specific profiles.

### 4.1.4 Current Study

This study aims to examine how multiple forms of institutional racism—across education, neighborhoods, and the criminal legal system—interact to create a multidimensional construct of structural racism that, in turn, influences depressive symptoms among Black youth. Specifically, the study investigates how racial inequities across these institutional contexts coalesce and how distinct patterns of exposure relate to youth mental health. It also explores the

mediating roles of neighborhood collective efficacy, parental mental health, and parental discipline in this relationship.

To address these aims, the study proceeds in several steps. First, a composite model of structural racism is developed using second-order structural equation modeling (SEM). Racial inequities in education, neighborhood context, and the criminal legal system are represented by multiple indicators, which load onto three first-order latent variables. These first-order factors then load onto a second-order latent construct representing structural racism. We anticipate good model fit and strong factor loadings ($\geq 0.60$) for both first- and second-order constructs, consistent with established psychometric guidelines (Furr, 2021; Tucker & Lewis, 1973).

Next, the structural racism construct is used to examine its relationship to depressive symptoms in Black adolescents, along with theory-driven mediators. Based on existing literature, we hypothesize that higher structural racism will be associated with greater depressive symptoms, and that this relationship will be mediated by increased parental depressive symptoms and harsher parental discipline. Conversely, we expect that neighborhood collective efficacy will serve as a protective factor, buffering the impact of structural racism on youth mental health. These mediators are included based on their theoretical role in linking institutional conditions to youth outcomes and prior evidence in family stress literature.

Finally, the study employs Latent Profile Analysis (LPA) to identify meaningful subgroups based on differential exposure to structural racism. This exploratory aim seeks to uncover distinct profiles of contextual racial inequities and their associations with adolescent and young adult depressive symptoms. We expect to identify well-fitting profiles that provide insight into how different combinations of institutional inequities shape mental health outcomes.

## 4.2 Method

### 4.2.1 Data and Study Population

Data for this study comes from the Future of Families and Child Wellbeing Study (FFCWS), a nationally representative birth cohort that has followed 4,898 primarily urban children and their families from birth through early adulthood. Data were collected across seven waves (1998–2024), corresponding to child ages 0,1, 3, 5, 9, 15, and 22. The data collected were over-sampled for low-income, racially minoritized, and unmarried parents, many of whom self-identified as African American (Reichman et al., 2001).

The current analyses use data from waves 5, 6, and 7 (ages 9, 15, and 22). The analytic sample includes 616 Black adolescents. FFCWS data were merged with external sources— the U.S. Census (*2023*), the United States Department of Education Civil Rights Data Collection (*Civil Rights Data (CRDC) | U.S. Department of Education*, 2025) National Center for Education Statistics ((*National Center for Education Statistics (NCES) | IES*, 2024), and the US County Uniform Crime Report *(United States Department of Justice. Federal Bureau of Investigation, 2017)* —to assess racial inequities across criminal legal, neighborhood, and school contexts.

#### *4.2.1.1 Racialized Context Variables*

***Neighborhood Racial Inequities.*** Indicators of neighborhood inequality were selected based on theory, prior literature, and data availability. Ten tract-level variables from the U.S. Census were used: (1) median home value, (2) percent of vacant housing, (3) percent Black residents, (4) percent on public assistance, (5) percent of families below the poverty line, (6) percent college educated, (7) percent unemployed, (8) percent with professional/managerial employment, (9) percent of female-headed households, and (10) unemployment rate. Higher values on advantage-related indicators were reverse-coded for interpretability and consistency. **Table 4.1** provides descriptive statistics.

***School Racial Inequities.*** School-level inequities were captured via NCES data linked to FFCWS Wave 6 (2013–2017). Three indicators were used: (1) percent of students receiving free or reduced-price lunch, (2) percent Black student enrollment, and (3) Title I eligibility. Free lunch and racial composition were averaged across four academic years. Title I eligibility was operationalized as a count variable, with higher scores reflecting more years of eligibility.

***Criminal Legal Inequities.*** Criminal legal system level inequities were captured using four indicators. First, direct police contact was measured by the self-reported number of times participants had been stopped by police. Second, vicarious police contact was measured by the number of times participants observed someone in their school or neighborhood context being stopped by police. Third, the number of students referred to law enforcement in each participant's school context was obtained from the CRDC. Finally, county-level crime rates were calculated using the Uniform Crime Report.

#### *4.2.1.2 Mediators*

***Parental Depression.*** Parental mental health was measured using the Composite International Diagnostic Interview–Short Form (CIDI-SF) at Wave 6. Parents reported on symptoms of depression (e.g., fatigue, anhedonia, feelings of worthlessness) over the past year. A clinical cutoff score of ≥3 indicated probable depression ((Kessler et al., 1998); N = 608).

***Neighborhood Collective Efficacy.*** This construct was measured using parent responses to items assessing social cohesion and informal social control (e.g., "This is a close-knit neighborhood," "Neighbors would intervene if a child skipped school"). Items were rated from 1 (strongly disagree) to 4 (strongly agree), with some items reverse-coded. The scale demonstrated acceptable reliability ($\alpha = .77$, N = 553).

#### *4.2.1.3 Depressive Symptom Outcomes*

***Self-Report CES-D.*** Youth self-reported depressive symptoms at ages 15 and 22 using the Center for Epidemiologic Studies Depression Scale (CES-D). At age 15, a 5-item CES-D was administered; at age 22, a longer version was used. Items assessed affective and somatic symptoms (e.g., sadness, anhedonia). Reliability was acceptable at Wave 6 (α = .73, N = 606) and strong at Wave 7 (α = .94, N = 236 The CES-D has demonstrated adequate reliability for Black youth in the FFCWS (α = .73 at age 15; α = .94 at age 22) (Choi et al., 2023; Perryman et al., 2022).

***Parent-Reported Internalizing Symptoms.*** Parents reported on youth internalizing symptoms at Waves 5 and 6 using the Child Behavior Checklist (Achenbach, 1999). Subscales for withdrawn behavior, anxiety, and depression were used. Items were rated on a 3-point scale from 0 (not true) to 2 (very true). Internal consistency was strong (α = .87 at Wave 5; α = .74 at Wave 6).

### 4.2.2 Analysis

Analyses followed a three-step process. First, data were cleaned, and descriptive statistics were conducted in SPSS (George & Mallery, 2024). Next, a latent structural racism model was estimated using Mplus Version 8 (Muthén & Muthén, 2017) Structural equation modeling (SEM) tested the mediating roles of parental depression, neighborhood collective efficacy, and parenting discipline in both cross-sectional (Wave 6) and longitudinal (Wave 6 to Wave 7) associations between structural racism and depressive symptoms. Finally, Latent Profile Analysis (LPA) was used to detect distinct typologies of exposure to racialized structural contexts, which were then tested for associations with depressive symptoms via odds ratios.

#### *4.2.2.1 Covariates*

Models included socioeconomic status, gender (as a proxy for sex assigned at birth), and prior depressive symptoms as covariates. Socioeconomic status was measured using a five-

category constructed poverty variable based on U.S. Census thresholds, with categories increasing in 20% increments above the federal poverty line. Gender was determined based on maternal report of the child's sex at enrollment. Prior depressive symptoms were assessed using parent-reported CBCL internalizing symptoms at Wave 5 (for Wave 6 models) and youth self-reported CES-D scores at Wave 6 (for Wave 7 models).

#### *4.2.2.2 Structural Equation Modeling: Latent Structural Racism*

Structural racism was modeled as a second-order latent factor (Siegel et al., 2024) composed of three domains: educational, neighborhood, and criminal-legal racial inequities. Due to low variance and poor correlation, the criminal-legal domain was excluded from final analyses. The remaining 12 indicators were assessed for multicollinearity and theoretical fit, resulting in a second-order CFA structure with strong model fit (see **Table 4.3** and **Figure 4.1**). This latent construct was used to predict depressive symptoms directly and indirectly via mediators.

Indicators of structural racial inequity were chosen based on prior theory and work examining structural racism as a latent construct (Pasco et al., 2021b; Seon, 2021; Witherspoon et al., 2022; Yen & Syme, 1999).

A list of 21 variables (see **Table 4.10**) was identified as possible variables of interest from available context data. A preliminary correlation matrix was run to identify problematic variables (i.e., those with high multicollinearity, inconsistent or weak correlations, or significant negative correlations). Variables that showed potential conceptual or statistical overlap were either reverse-coded or removed. For example, the variable "percent white" was removed because it was highly negatively correlated ($r > -.90$) with "percent Black," suggesting they

captured similar constructs. Other overlapping variables included, “college educated” and “percentage high school graduates,” as well as “median home value” and “rent burdened.”

Criminal legal context variables were removed from the model due to inconsistencies in measurement (i.e., self-report vs. observed contextual data). Count variables in this domain also exhibited low variance. For example, the number of Black students referred to law enforcement ($N$=545, $M$=0.52, $SD$ = 2.99) ranged from 0 to 33, with 82% of the sample reporting zero referrals. Additional issues arose with the use of self-reported measures of direct and vicarious police contact, which were the only self-report items included among otherwise observational exposure variables – a practice cautioned against in the measurement of structural racism (Adkins-Jackson et al., 2022). The remaining criminal legal variable – total county crime – was excluded due to concerns about the limitations of single indicators representing a latent construct (Kline, 2023). As a result, the variable list was reduced to 12 contextual indicators.

Following previous protocols, authors attempted a unifactorial structural equation model, loading all 12 indicators onto one latent construct, structural racism (T. Brown & Homan, 2024; Dougherty et al., 2020; Siegel et al., 2024). This approach aligns with theoretical models of structural racism that conceptualize it as a second-order factor comprising multiple institutional domains. Upon the completion of the model with good fit indices, the authors then tested it for associations with cross-sectional depressive symptoms (year 15 structural racism exposure with year 15 depressive symptoms) as well as longitudinal depressive symptoms (year 15 structural racism exposure with year 22 depressive symptoms).

To identify distinct typologies of structural racism exposure, Latent Profile Analysis (LPA) was conducted using the 12 continuous indicators included in the structural racism measurement model. LPA is a probabilistic clustering technique that classifies individuals into

latent profiles based on similarities across observed indicators (Vermunt, 2010). This approach is consistent with structural racism measurement recommendations that emphasize heterogeneity in lived exposure (Chantarat et al., 2021).

Models ranging from two to six classes were estimated. Model selection was guided by multiple criteria:

- ***Statistical Fit***: Akaike Information Criterion (AIC), Bayesian Information Criterion (BIC), and sample-size adjusted BIC (SABIC)
- ***Classification Accuracy***: Entropy values
- ***Model Comparison***: Lo–Mendell–Rubin Likelihood Ratio Test (LMR-LRT) and Bootstrap Likelihood Ratio Test (BLRT)
- ***Substantive Considerations***: Conceptual coherence of profiles and minimum class size of at least 10% of the sample (Chantarat et al., 2021; Pastor et al., 2007; Riley et al., 2024)
- Model fit indices and classification diagnostics were reviewed to determine the optimal number of profiles. Once identified, latent profiles were used to examine associations with depressive symptoms at ages 15 and 22 using odds ratios.

## 4.3 Results

### 4.3.1 Descriptive Statistics

Participants included in the sample self-identified as Black or African American at Wave 6 (age 15). Gender was not directly available, but maternal report of sex at enrollment indicated an even split (51.1% girls; coded as 2). The average age at Wave 6 was 15.4 years. Based on the constructed poverty category variable, the sample fell on average between the second and third poverty levels, indicating that 69.9% of participants lived at or below the federal poverty line for

their census tract. Educationally, most primary caregivers had completed some college but had not graduated ($M$ = 2.68, $SD$ = 0.90), with 84.1% completing at least some college.

Across structural indicators, descriptive statistics revealed generally low mean values and narrow variability. For instance, the mean percentage of the census tract workforce in professional or managerial positions was extremely low ($M$ = .002, $SD$ = .0001). Full descriptive statistics and sample characteristics are presented in **Table 4.1**

*Sociodemographic characteristics of participants*. Correlations between key study variables are presented in **Table 4.2**

### 4.3.2 Composite Model of Structural Racism

Confirmatory Factor Analysis (CFA) was used to examine whether 12 indicators of neighborhood and school inequality loaded onto a single latent construct representing structural racism. A one-factor model (see **Figure 4.1**

*12 indicators of structural inequity at year 15 loaded onto one construct, structural racism.*) demonstrated poor fit across indices, $\chi^2$ (55) = 1270.39, $p < .001$; CFI = .679; TLI = .615; RMSEA = .190, 90% CI [.181, .199].

Next, a second-order model was estimated with three first-order factors—school inequities, neighborhood disadvantage, and neighborhood advantage—each loading onto a second-order latent variable representing structural racism (see **Figure 4.2**). Model fit improved considerably: $\chi^2$ (51) = 581.92, $p < .001$; CFI = .890; TLI = .860; RMSEA = .130, 90% CI [.121, .140]. Although RMSEA remained above conventional thresholds, this model was retained due to improved overall fit and theoretical coherence.

Three indicators—median home value, percentage college educated, and percentage employed in professional/managerial roles—were initially negatively loaded and subsequently reverse-coded for model consistency. Model fit statistics are provided in **Table Table 4.3**. Factor loadings for the second-order model are shown in **Table 4.4**.

### *4.3.3 Latent profile analysis*

LPA was conducted to examine heterogeneity in youth exposure to structural racism. Models with two through six classes were tested. Fit indices, including AIC, BIC, entropy, the Lo–Mendell–Rubin Likelihood Ratio Test (LMR-LRT), and the Bootstrap Likelihood Ratio Test (BLRT), informed model selection (see **Table 4.5**). The four-profile solution was selected based on its favorable fit (e.g., lower AIC/BIC, entropy = .90) and conceptual interpretability. Importantly, the LMR-LRT and BLRT p-values were significant for the four-class solution, indicating a statistically significant improvement in model fit compared to the three-class solution. Five- and six-class solutions did not yield significant improvements ($p > .05$), despite slightly lower AIC/BIC values. All four profiles also met the minimum 10% sample size threshold (see **Figure 4.4**). Therefore, the four-class solution was chosen for further analysis. Once the structural racism latent variable was established, it was used to predict depressive symptoms in cross-sectional and longitudinal SEM models.

#### *4.3.3.1 Wave 6 (Age 15)*

Controlling for gender, primary caregiver poverty status, and youth depressive symptoms at age 9, greater structural racism exposure at age 15 was significantly associated with more depressive symptoms at age 15 ($\beta = .136$, $p = .007$). Mediation analysis revealed a significant indirect effect through maternal depression: structural racism predicted more maternal depressive symptoms ($\beta = .125$, $p = .010$), which in turn predicted more youth depressive symptoms ($\beta =$

.45, $p < .001$). The indirect effect was significant (β = .113, $p = .025$). Neighborhood collective efficacy, although associated with structural racism, did not mediate the relationship. See **Table 4.6** and **Figure 4.3** for results.

#### *4.3.3.2 Wave 7 (Age 22)*

A similar model predicting depressive symptoms at age 22 yielded no significant direct effect of age 15 structural racism (β = .002, $p = .497$). Although structural racism was associated with maternal depression at age 15 (β = .224, $p = .011$), no other indirect or direct paths were significant. Full model results are shown in **Table 4.7**.

### 4.3.4 Depressive Symptoms by Latent Profile Membership

Youth depressive symptoms were regressed onto structural racism profile membership derived from the four-class LPA solution.

At age 15, youth in the "Low Structural Inequity Exposure" group reported significantly fewer depressive symptoms than those in the "High Exposure" group (β = 0.87, SE = 0.38, $z = 2.29$, $p = .022$). Youth in the "High-Moderate Exposure" profile showed a trend towards significance (β = 0.49, SE = 0.25, $z = 1.92$, $p = .055$) compared to the high-exposure group. No other profile comparisons were statistically significant (**Table 4.8**).

In longitudinal analyses, year 15 profile membership did not significantly predict depressive symptoms at age 22, suggesting limited long-term predictive utility of adolescent structural exposure classes (**Table 4.9**).

## 4.4 Discussion

This study examined how structural racism, conceptualized as inequities across racialized contexts, shapes depressive symptoms among Black youth. Across three aims, we evaluated a second-order composite model of structural racism, tested associations with youth mental health

outcomes both cross-sectionally and longitudinally. And then explored heterogeneity in exposure using latent profile analysis (LPA).

### 4.4.1 Composite Model of Structural Racism

Findings from the first aim supported a multidimensional approach to modeling structural racism. A second-order factor model demonstrated improved fit over a single-factor model, offering a more theoretically coherent representation of how inequities in school and neighborhood contexts intersect to form a broader structural force. While RMSEA remained above conventional thresholds, this may reflect model complexity and the challenges of adequately capturing a phenomenon as intricate and context specific as structural racism. As Kenny et al., (2015) note, RMSEA should not be interpreted in isolation, especially in complex models with many parameters and modest sample sizes. Structural racism, by its very nature, involves numerous interlocking systems and exposures that resist easy reduction.

The reversal of factor loadings for indicators such as median home value, percent college-educated residents, and professional employment levels highlighted an important theoretical nuance. These indicators—typically considered markers of advantage—were negatively associated with the structural racism factor and thus were reverse-coded for consistency. This aligns with Bailey et al.'s (2017) emphasis on both the burdens and absence of benefits as key dimensions of structural racism. Yet, modeling these advantages alongside burdens complicates interpretation, particularly in racially segregated spaces shaped by policies like redlining and exclusionary zoning (Couture & Handbury, 2023; Rucks-Ahidiana, 2021).

More broadly, this model contributes to ongoing efforts to quantify how racialized spaces—like disinvested neighborhoods and under-resourced schools—operate as institutional channels of racism. As others have argued (Joo & Kim, 2023), studying multiple racialized

contexts in tandem rather than isolation better reflects the lived experience of Black youth, for whom exposure to disadvantage is cumulative and intersectional.

### 4.4.2 Ethical Considerations in Measurement

As the field advances methods to quantify structural racism, ethical considerations remain critical. Several indicators in this study—such as the percentage of single-parent households or public assistance rates—are frequently used as proxies for structural disadvantage. However, these indicators may inadvertently reinforce harmful stereotypes, particularly about Black families. For example, interpreting single motherhood as a sign of neighborhood disorganization ignores the cultural diversity of family structures and risks perpetuating heteropatriarchal and racist narratives (C. J. Cross et al., 2022). Cammett (2014) and others have shown how these narratives shape public policy, contributing to stigmatizing and resource-restricting practices. Scholars like Brown & colleagues (2023), have also warned against using racial inequities as decontextualized proxies for racism without addressing their etiology.

In this study, indicators like these loaded strongly onto the latent construct of structural racism, suggesting that the social conditions they represent are indeed patterned by racism. Yet their inclusion underscores the importance of framing and interpretation: structural racism research must interrogate the meanings embedded in its measures, not just their statistical validity. For studies like this one, which use structural equation modeling to construct latent variables, these ethical dimensions should inform indicator selection, model interpretation, and reporting practices.

### 4.4.3 Latent Profile Analysis and Heterogeneity of Exposure

The LPA revealed four distinct profiles of structural racism exposure—ranging from low to high—that varied in both composition and association with depressive symptoms. This

approach aligns with emerging research using latent class and profile models to capture typologies of structural racism across communities (Brown & Homan, 2024; Chantarat et al., 2021). Notably, profiles meeting the 10% sample size threshold were identified across a national, multi-site sample, suggesting that even within a broad dataset like FFCWS, meaningful distinctions in structural exposure can be empirically derived. A four-profile model was selected to reflect variation in social environments shaped by race, with a greater number of profiles capturing more distinct experiences with structural racism exposure (Celious & Oyserman, 2001).

An intriguing finding emerged: youth in the "low exposure" profile reported significantly more depressive symptoms than some peers in higher-exposure profiles. While initially counterintuitive, this may reflect a desensitization process among youth in chronically disadvantaged environments, consistent with prior work on the stress-inoculation hypothesis and emotion suppression in high-risk settings (Chen et al., 2020; Gaylord-Harden et al., 2011, 2016). Alternatively, youth in lower-exposure environments may experience more interpersonal discrimination, racial isolation, or invalidation, which could contribute to internalizing symptoms (Heard-Garris, Boyd, et al., 2021; Seaton & Douglass, 2014; Thomas Tobin et al., 2023; D. T. Williams, 2023). Given the absence of racial composition data, these interpretations remain speculative but underscore the need for intersectional, multilevel frameworks in future studies.

### 4.4.4 Impacts on Black Families and Cross-Generational Effects

This study also found evidence of a mediating pathway through maternal depression, further supporting theoretical frameworks that link structural racism to family-level psychological distress. These results align with the integrative model (Coll et al., 1996) and family systems perspectives that position parental mental health as a critical mechanism linking

structural conditions to youth outcomes. They also echo findings from Murry et al. (2018) and Adkins-Jackson et al. (2025) on the intergenerational transmission of stress in racially marginalized families. Structural racism impacts not only the individual child, but also the adults around them, amplifying risk across generations.

### 4.4.5 Limitations and Future Directions

Despite its strengths, this study is not without limitations. First, all analyses relied on secondary data, which constrained the ability to include certain theoretically relevant indicators, such as local policy measures or exposure to institutional actors (e.g., police, school discipline). Second, the use of cross-sectional mediation limits causal inference; while theory and model fit support the indirect pathway, longitudinal designs are needed to test temporal precedence. Third, although the latent structural racism model improved fit over simpler models, its RMSEA fell outside conventional cutoffs—raising questions about indicator selection, construct validity, and sample power.

Originally proposed analyses aimed to examine the role of ethnic identity (as a proxy for racial identity), microaggressions (a proxy for racial discrimination), and parental discipline in the relationship between structural racism exposure and adolescent depressive symptoms. However, the available sample sizes for ethnic identity ($N$=166) and microaggressions ($N$=181) were insufficient to detect statistically meaningful effects. Future studies should continue to examine how perceived racism contributes to the relationship between structural racism and adolescent depressive symptoms to better operationalize structural racism as the totality of ways that racism manifests across systems and contexts (Z. D. Bailey et al., 2017).

Measures of parental discipline and ethnic identity presented notable concerns related to inter-rater reliability and construct validity, respectively. Parental discipline was assessed using a

shortened version of the Conflict Tactics Scale (Straus, 1987), which had poor reliability ($N$=614, $\alpha$ = .33). This low reliability was likely due to the reduced four-item scale, which included items of varying severity—two reflecting harsh discipline (e.g., being yelled at or hit), and two reflecting milder approaches (e.g., being grounded or receiving an explanation). The Multigroup Ethnic Identity Measure was excluded due to concerns about its limited conceptual scope; the measure focused only on ethnic identity exploration and commitment (K. Cokley, 2007), which inadequately capture the multidimensionality of racial and ethnic identity (W. E. Cross Jr., 1995; Sellers et al., 1998). Future research should examine how parental discipline and racial identity are shaped by structural racism and, in turn, impact Black adolescents' mental health.

## 4.5 Conclusion

Taken together, findings from this study contribute to the growing literature on structural racism as a determinant of Black youth mental health. By modeling structural racism as a multidimensional, latent construct and examining its associations with depressive symptoms, this research provides a theoretically grounded, empirically supported approach to understanding the mental health toll of racialized environments. It also highlights the importance of examining both burdens and benefits, cross-generational transmission of risk, and within-group heterogeneity in exposure and response. As the field continues to refine its tools for measuring structural racism, attention to context, ethics, and lived experience will remain paramount. These findings affirm what many scholars and communities already know: structural racism not only shapes the opportunities available to Black youth—it shapes how they feel, cope, and thrive.

## 4.6 Tables and Figures

**Table 4.1**

*Sociodemographic characteristics of participants*

| | N | M | SD | Min | Max |
|---|---|---|---|---|---|
| Sex (female = 2) | 616 | 1.51 | .5 | 1 | 2 |
| Age (wave 6) | 495 | 15.5 | 0.53 | 14.69 | 17.65 |
| Socioeconomic Status (PCG) Poverty Category | | | | | |
| Year 15 Poverty Category | 615 | 2.9 | 1.32 | 1 | 5 |
| Year 22 Poverty Category | 423 | 3.18 | 1.56 | 1 | 5 |
| Year 15 PCG Education | 611 | 2.68 | 0.9 | 1 | 4 |
| Year 22 PCG Education | 448 | 2.5 | 0.94 | 1 | 4 |
| *Key Study Variables* | | | | | |
| Dependent Variables | | | | | |
| Year 15 Self-Report Dep Symp | 615 | 2.95 | 0.47 | 1.4 | 4 |
| Year 15 Parent Report Dep Symp | 607 | 1.77 | 2.20 | 0 | 15 |
| Year 22 Self Report Dep Symp | 253 | 12.42 | 12.27 | 0 | 60 |
| Mediators (Year 15) | | | | | |
| Neighborhood Collective Efficacy | 609 | 2.81 | 0.65 | 1 | 4 |
| Maternal Depression | 562 | 0.17 | 0.38 | 0 | 1 |
| Parent Discipline | 616 | 2.01 | 0.35 | 1 | 3 |
| Independents (Indicators Year 15) | | | | | |
| School Inequities | | | | | |
| Title 1 | 549 | 4.26 | 1.41 | 1 | 8 |
| % Free Lunch | 550 | 0.63 | 0.24 | 0 | 1 |
| % Black in School | 587 | 0.60 | 0.33 | 0 | 1 |
| Neighborhood Disadvantage | | | | | |
| % Vacant Housing | 608 | 0.17 | 0.11 | 0 | 0.68 |

| | N | M | SD | Min | Max |
|---|---|---|---|---|---|
| % Families Below Poverty Line | 608 | 0.30 | 0.16 | 0 | 0.82 |
| % Female Head of Household | 608 | 0.25 | 0.12 | 0 | 0.69 |
| % Black in census tract | 608 | 0.60 | 0.32 | 0 | 0.99 |
| % Unemployed | 608 | 0.17 | 0.09 | 0.06 | 0.55 |
| % Receiving Public Assistance | 608 | 0.30 | 0.04 | 0 | 0.22 |
| Neighborhood Advantage<br>% College Educated | 608 | 0.19 | 0.13 | .001 | 0.81 |
| % Professional Work Force | 608 | .002 | .0001 | 0 | 0.01 |
| Median Home Value/10000 | 608 | 9.71 | 5.84 | 1.53 | 40.19 |

*Note.* M = mean; SD = standard deviation. Dep Symp = Depressive symptoms. PCG = Primary Caregiver, Min = Minimum, Max = Maximum .

**Table 4.2**

*Descriptive statistics and correlations for study variables*

| Variables | n | M | SD | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 Gender | 616 | 1.511 | 0.500 | 1.000 | | | | | | | | | | | | | | | | | | | | | | |
| 2 Year 9 Depression | 504 | 0.524 | 2.324 | 0.036 | 1.000 | | | | | | | | | | | | | | | | | | | | | |
| 3 Year 22 PCG SES | 423 | 3.180 | 1.563 | -0.090 | 0.006 | 1.000 | | | | | | | | | | | | | | | | | | | | |
| 4 Year 15 PCG SES | 615 | 2.901 | 1.321 | -0.042 | 0.020 | .549** | 1.000 | | | | | | | | | | | | | | | | | | | |
| 5 Maternal Depression | 615 | 0.180 | 0.386 | -0.044 | 0.014 | -0.094 | -.204** | 1.000 | | | | | | | | | | | | | | | | | | |
| 6 Neighborhood Collective Efficacy | 609 | 2.814 | 0.655 | 0.036 | -0.006 | -0.064 | 0.007 | 0.015 | 1.000 | | | | | | | | | | | | | | | | | |
| 7 Year 15 Parent Discipline | 616 | 2.008 | 0.351 | 0.035 | -0.007 | 0.012 | -0.048 | 0.065 | -0.009 | 1.000 | | | | | | | | | | | | | | | | |
| 8 Year 15 Youth Self-Report Depression | 615 | 3.393 | 0.589 | -.086* | -0.019 | .101* | .171** | -.123** | 0.017 | -0.064 | 1.000 | | | | | | | | | | | | | | | |
| 9 Year 15 Parent report Depression | 607 | 1.771 | 2.208 | 0.053 | .098* | -.117* | -.138** | .181** | 0.036 | 0.066 | -.200** | 1.000 | | | | | | | | | | | | | | |
| 10 Year 22 Self Report Depression | 253 | 12.423 | 12.280 | .175** | -0.011 | -0.074 | -0.025 | 0.066 | 0.084 | -0.109 | -.194** | 0.034 | 1.000 | | | | | | | | | | | | | |
| 11 Year 15 County Crime | 610 | 4.254 | 1.356 | -0.052 | 0.045 | -.113* | -.113** | -0.063 | 0.049 | 0.029 | -0.005 | .086* | -0.024 | 1.000 | | | | | | | | | | | | |
| 12 Year 15 College Educated | 608 | 0.190 | 0.135 | 0.014 | 0.011 | -.276** | -.329** | 0.067 | 0.071 | -0.018 | -.145** | 0.070 | -0.002 | -0.096 | 1.000 | | | | | | | | | | | |
| 13 Year 15 Work Force | 608 | 0.002 | 0.001 | -0.006 | 0.011 | -.244** | -.277** | 0.012 | 0.070 | 0.032 | -.127** | 0.048 | -0.055 | -0.119 | .866** | 1.000 | | | | | | | | | | |
| 14 Year 15 Median Home Value | 601 | 9.713 | 5.837 | -0.041 | -0.004 | -.214** | -.301** | 0.054 | 0.001 | 0.067 | -0.027 | 0.041 | 0.033 | -0.020 | .730** | .656** | 1.000 | | | | | | | | | |
| 15 Year 15 School Percentage Black | 587 | 0.603 | 0.329 | 0.039 | -0.036 | -.262** | -.260** | .091* | 0.005 | 0.073 | -0.019 | -0.019 | -0.003 | -0.011 | .300** | .257** | .380** | 1.000 | | | | | | | | |
| 16 Year 15 Title 1 Eligibility | 549 | 4.262 | 1.414 | 0.056 | 0.045 | -.192** | -.255** | 0.043 | .086* | 0.065 | -0.070 | 0.016 | 0.033 | -0.029 | .302** | .264** | .227** | .490** | 1.000 | | | | | | | |
| 17 Year 15 Free Lunch | 550 | 0.628 | 0.238 | 0.015 | 0.073 | -.356** | -.373** | 0.072 | 0.008 | 0.043 | -.090* | 0.056 | -0.062 | -0.033 | .374** | .335** | .343** | .650** | .598** | 1.000 | | | | | | |
| 18 Year 15 Below Poverty Line | 608 | 0.298 | 0.157 | -0.019 | 0.073 | -.297** | -.349** | .114** | 0.035 | 0.041 | -.151** | .117** | 0.013 | -0.014 | .670** | .591** | .587** | .349** | .356** | .424** | 1.000 | | | | | |
| 19 Year 15 Public Assistance | 608 | 0.055 | 0.043 | 0.006 | 0.061 | -.184** | -.162** | 0.037 | -0.022 | 0.019 | -0.039 | 0.010 | 0.027 | -0.110 | .490** | .441** | .347** | .244** | .211** | .312** | .578** | 1.000 | | | | |
| 20 Year 15 Neighborhood Percent Black | 608 | 0.595 | 0.320 | 0.032 | 0.058 | -.216** | -.239** | 0.060 | -0.005 | 0.037 | -0.031 | 0.069 | -0.067 | 0.016 | .459** | .373** | .430** | .634** | .419** | .469** | .536** | .384** | 1.000 | | | |
| 21 Year 15 Single Mother | 608 | 0.253 | 0.123 | 0.066 | 0.066 | -.251** | -.304** | .089* | 0.064 | 0.017 | -.096* | .108** | 0.015 | 0.029 | .593** | .527** | .443** | .335** | .303** | .363** | .728** | .539** | .559** | 1.000 | | |
| 22 Year 15 Vacant Homes | 608 | 0.170 | 0.114 | -0.027 | 0.017 | -.241** | -.284** | .103* | 0.005 | -0.007 | -0.075 | 0.032 | -0.076 | -0.063 | .477** | .403** | .530** | .383** | .287** | .309** | .626** | .337** | .511** | .348** | 1.000 | |
| 23 Year 15 Unemployment | 608 | 0.172 | 0.094 | 0.019 | 0.053 | -.261** | -.293** | 0.033 | 0.040 | -0.005 | -0.063 | 0.057 | -0.057 | 0.009 | .596** | .510** | .530** | .457** | .350** | .422** | .725** | .503** | .660** | .530** | .639** | 1.000 |

*Note. PCG SES = Primary Caregiver Socioeconomic status*

**Table 4.3**

*Model fit statistics for one factor vs. 2nd order factor model*

| Model | $\chi^2$ | df | p-value | CFI | TLI | RMSEA | 90% CI RMSEA |
|---|---|---|---|---|---|---|---|
| 1 Factor Model | 1270.39 | 55 | 0 | 0.679 | 0.615 | 0.19 | [0.181, 0.199] |
| 2nd Order factor | 581.922 | 51 | 0 | 0.89 | 0.86 | 0.13 | [0.121, 0.140] |

*Note.* $\chi^2$ = Chi Square, df = Degrees of Freedom CFI = C, TLI = Tucker Lewis Index, RMSEA = Root Mean Square error of approximation, CI = Confidence Interval

**Table 4.4**

*Factor loadings for 2nd Order SEM*

| Latent Factor | Indicator | Estimate | S.E. | Est./S.E. | p-value |
|---|---|---|---|---|---|
| **School Inequity** | Free Lunch | .856 | .021 | — | < .001 |
| | School Racial Composition Percent Black | 0.885 | 0.052 | 17.105 | < .001 |
| | Title 1 Eligibility | 0.797 | 0.05 | 15.956 | < .001 |
| **Neighborhood Disadvantage** | Percent Below Poverty Line | 1.000 (fixed) | — | — | < .001 |
| | Percent Single Parent | 0.842 | 0.037 | 22.998 | < .001 |
| | Percent Black in Census Tract | 0.778 | 0.041 | 19.1 | < .001 |
| | Percent on Public Assistance | 0.704 | 0.04 | 17.437 | < .001 |
| | Percent Unemployed | 0.925 | 0.052 | 25.822 | < .001 |
| | Percent Vacant houses | 0.756 | 0.040 | 19.094 | < .001 |
| **Neighborhood Advantage** | Percent with a College Degree | 1.000 (fixed) | — | — | — |
| | Percent Professional Work Force | 0.902 | 0.024 | 37.44 | < .001 |
| | Median Home Value | 0.763 | 0.031 | 24.917 | < .001 |

*Note.* SE = Standard Error, Est SE = Estimated Standard Error

**Table 4.5**

*LPA model fit statistics*

| Classes | AIC | BIC | SABIC | Entropy | LMR-LRT p | BLRT p |
|---|---|---|---|---|---|---|
| 2 | 16397.862 | 16548.197 | 16440.25 | 0.92 | P <.001 | P <.001 |
| 3 | 16471.64 | 16692.81 | 16534.07 | 0.89 | P < .05 | P <.05 |
| 4 | 15182.65 | 15439.10 | 15254.96 | 0.90 | P <.05 | P <.05 |
| 5 | 14985.714 | 15295.23 | 15072.99 | 0.88 | P=.20 | P=.20 |
| 6 | 14770.19 | 15132.76 | 14872.43 | 0.89 | P = .40 | P=.40 |

*Note.* AIC = Akaike Information Criterion, BIC = Bayesian Information Criterion, SABIC = sample-size adjusted Bayesian Information Criterion. LMR-LR = Lo-Mendell-Rubin adjusted likelihood ratio test, BLRT = Bootstrapped Likelihood Ratio Test.

**Table 4.6**

*Indirect effect and model fit for year 15 structural racism predicting Black youth depressive symptoms at year 15 with indirect effect paths.*

| Path | Unstd. (*β*) | SE | *p* | Std. (*β*) | SE | *p* | Sig. |
|---|---|---|---|---|---|---|---|
| SR → DEP15 | 0.107 | 0.053 | .045 | 0.132 | 0.047 | .01 | * |
| SR → MATDEP | 0.250 | 0.099 | .012 | 0.124 | 0.048 | .01 | ** |
| SR → NCE15 | 0.107 | 0.053 | .045 | 0.098 | 0.048 | .04 | * |
| MATDEP → DEP15 | 0.457 | 0.095 | .001 | 0.210 | 0.04 | .00 | *** |
| NCE15 → DEP15 | 0.262 | 0.177 | .138 | 0.065 | 1.48 | .14 | — |
| GENDER → SR | 0.003 | 0.045 | .942 | 0.003 | 0.04 | .94 | — |
| PovCat15 → SR | -0.151 | 0.023 | .001 | -0.393 | 0.04 | .00 | *** |
| DEP9 → SR | 0.017 | 0.010 | .073 | 0.081 | 0.04 | .07 | — |
| SR → MATDEP → DEP15 | 0.114 | 0.055 | .035 | 0.026 | 0.01 | .02 | * |
| SR → NCE → DEP15 | 0.028 | 0.019 | .138 | 0.006 | 0.01 | .13 | — |
| SR → DEP15 (Indirect) | 0.142 | 0.058 | .014 | 0.032 | 0.01 | .01 | ** |
| Total Effects | 0.719 | 0.218 | 0.00 | 0.164 | 0.047 | 000 | *** |

| Fit Index | Value | Degrees of Freedom | 90% CI | p-value |
|---|---|---|---|---|
| Chi-Square ($\chi^2$) | 394.99 | 96 | | < .001 |
| RMSEA (Root Mean Square Error of Approx.) | 0.079 | | 0.071 – 0.087 | < .001 |
| CFI (Comparative Fit Index) | 0.904 | | | |
| TLI (Tucker-Lewis Index) | 0.883 | | | |
| SRMR (Standardized Root Mean Square Residual) | 0.053 | | | |
| AIC (Akaike Information Criterion) | 15311.74 | | | |
| BIC (Bayesian Information Criterion) | 15510.11 | | | |

Significance Key:

*** p < .001. ** p < .01. * p < .05. < .10. — not significant

*Note*. SR= Structural Racism; DEP15 = depressive symptoms at year 15; DEP9 = Depressive symptoms at year 9; MATDEP = Maternal Depression; NCE15 = Neighborhood collective efficacy at year 15; PovCat15 = Poverty Category at year 15.

**Table 4.7**

*Mediation and model fit for year 15 structural racism predicting Black young adults' depressive symptoms at year 22 with mediation paths.*

| Path | Unstd. ($\beta$) | SE | *p* | Std. ($\beta$) | SE | *p* | Sig. |
|---|---|---|---|---|---|---|---|
| SR → DEP22 | 0.039 | 1.417 | .978 | 0.002 | 0.073 | .978 | — |
| SR → NCE15 | 0.067 | 0.047 | .154 | 0.074 | 0.052 | .150 | — |
| SR → MATDEP | 0.201 | 0.088 | .022 | 0.120 | 0.052 | .020 | * |
| NCEY15 → DEP22 | 3.079 | 1.486 | .038 | 0.142 | 0.068 | .036 | * |
| MATDEP → DEP22 | 0.058 | 0.881 | .947 | 0.005 | 0.075 | .947 | — |
| GENDER → SR | 0.019 | 0.059 | .329 | 0.032 | 0.098 | .742 | — |
| PCGPOVCAT22 → SR | -0.137 | 0.022 | .000 | -0.227 | 0.030 | .000 | *** |
| DEP15 → SR | -0.185 | 0.066 | .005 | -0.306 | 0.106 | .004 | ** |

| Path | Unstd. (*β*) | SE | *p* | Std. (*β*) | SE | *p* | Sig. |
|---|---|---|---|---|---|---|---|
| SR → DEP22 (Total indirect effect) | 0.218 | 0.244 | .372 | 0.131 | 0.147 | .372 | — |
| SR → MATDEP → DEP22 | 0.012 | 0.177 | .947 | 0.007 | 0.107 | .947 | — |
| SR→NCEY15→ DEP22 | 0.206 | 0.176 | .241 | 0.124 | 0.106 | .239 | — |
| SR → DEP22 (Indirect) | 0.039 | 1.417 | .978 | 0.024 | 0.855 | .978 | — |
| SR → DEP22 (Total effect) | 0.257 | 1.412 | .855 | 0.155 | 0.852 | .855 | — |

| Fit Index | Value | Degrees of Freedom | 90% CI | p-value |
|---|---|---|---|---|
| Chi-Square ($\chi^2$) | 519.20 | 127 | | < .001 |
| RMSEA (Root Mean Square Error of Approx.) | 0.09 | | 0.078 – 0.093 | < .001 |
| CFI (Comparative Fit Index) | 0.89 | | | |
| TLI (Tucker-Lewis Index) | 0.87 | | | |
| SRMR (Standardized Root Mean Square Residual) | 0.052 | | | |
| AIC (Akaike Information Criterion) | 14437.35 | | | |
| BIC (Bayesian Information Criterion) | 14651.74 | | | |

Significance Key:

*** p < .001. ** p < .01. * p < .05. < .10. — not significant

*Note*. SR= Structural Racism; DEP15 = depressive symptoms at year 15; DEP22 = Depressive symptoms at year 22; MATDEP = Maternal Depression; NCEY15 = Neighborhood collective efficacy at year 15; PCGPovCat22 = Primary Caregiver Poverty Category at year 22, SR = Structural Racism.

**Table 4.8**

*Cross sectional analysis of structural inequities and adolescent depressive symptoms.*

| Fit Index | Value |
|---|---|
| Number of Parameters | 58 |
| Loglikelihood (H0) | -7533.32 |
| Akaike Information Criterion (AIC) | 15182.65 |
| Bayesian Information Criterion (BIC) | 15439.10 |
| Adjusted BIC | 15254.96 |

| Fit Index | Value |
|---|---|
| Entropy | 0.895 |
| Number of Classes | 4 |
| Class Proportions | 9.9%, 41.2%, 25.6%, 23.4% |

| Intercept | Outcome Class | Estimate (*β*) | SE | z | *p* |
|---|---|---|---|---|---|
| Intercept | Class 2 | -0.029 | 0.702 | -0.04 | .967 |
| Intercept | Class 3 | -1.346 | 0.760 | -1.77 | .077 † |
| Intercept | Class 4 | -3.479 | 1.170 | -2.97 | .003 ** |

Significance Key:

*** p < .001. ** p < .01. * p < .05. < .10. — not significant

*Note*. SE = Standard Error

**Table 4.9**

*Cross sectional analysis of structural inequities and adolescent depressive symptoms.*

| Predictor | Outcome Class | Estimate (*β*) | SE | z | *p* |
|---|---|---|---|---|---|
| YSRD15 | Class 2 | 0.202 | 0.238 | 0.85 | 0.394 |
| YSRD15 | Class 3 | 0.487 | 0.254 | 1.92 | .055 † |
| YSRD15 | Class 4 | 0.873 | 0.381 | 2.29 | .022 * |
| | | | | | |
| CESD22 | Class 2 | –0.009 | 0.016 | –0.53 | 0.595 |
| CESD22 | Class 3 | –0.015 | 0.018 | –0.81 | 0.421 |
| CESD22 | Class 4 | –0.015 | 0.018 | –0.86 | 0.392 |

**Model Fit and Classification Quality**

| | |
|---|---|
| Number of Parameters | 58 |
| Loglikelihood (H0) | –7533.324 |
| Akaike Information Criterion (AIC) | 15182.65 |
| Bayesian Information Criterion (BIC) | 15439.10 |
| Adjusted BIC | 15254.96 |

**Model Fit and Classification Quality**

| | |
|---|---|
| Entropy | 0.895 |
| Number of Classes | 4 |
| Class proportions | 9.8%, 41.2%, 25.6%, 23.4% |

Significance Key:

*** p < .001. ** p < .01. * p < .05. < .10. — not significant

*Note*. SE = Standard Error, YSRD15 = Youth Self Report Depressive symptoms at Year 15, CES-D = Center for Epidemiological Studies Depression at year 22.

**Table 4.10**

*Supplemental variables list*

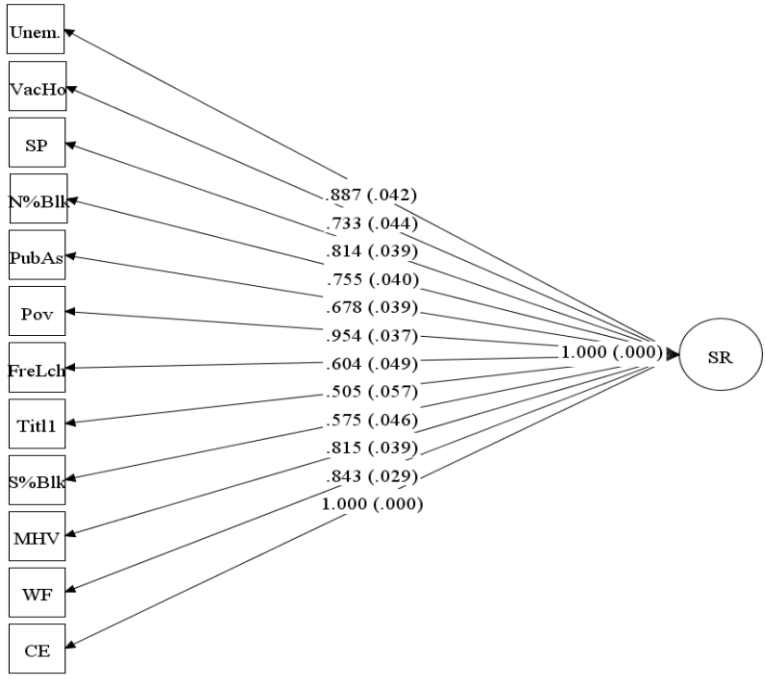
**Criminal Legal**
Vicarious Police Exposure
Direct police Exposure
Number of Students Referred to Law Enforcement
Total Crime Reported in the County.

**School Inequality**
Teacher-Student Ratio
Percentage of Students Receiving Free Lunch
Percentage of Black Students
Percentage of white students
School Racial Composition
Number of Students Bullied on the Basis of Race

**Neighborhood Inequality**
Percentage of Individuals Unemployed
Percentage of People Employed in the Professional Workforce
Median Home Value
Percentage Vacant Housing
Percentage on Public Assistance
Percentage Below Poverty
Percentage of Single Parents (Female Head of Household)
Percentage Black in Neighborhood
Percentage of College Educated
Percentage Graduated with a High School Diploma
Percentage of Rent-Burdened Residents

**Figure 4.1**

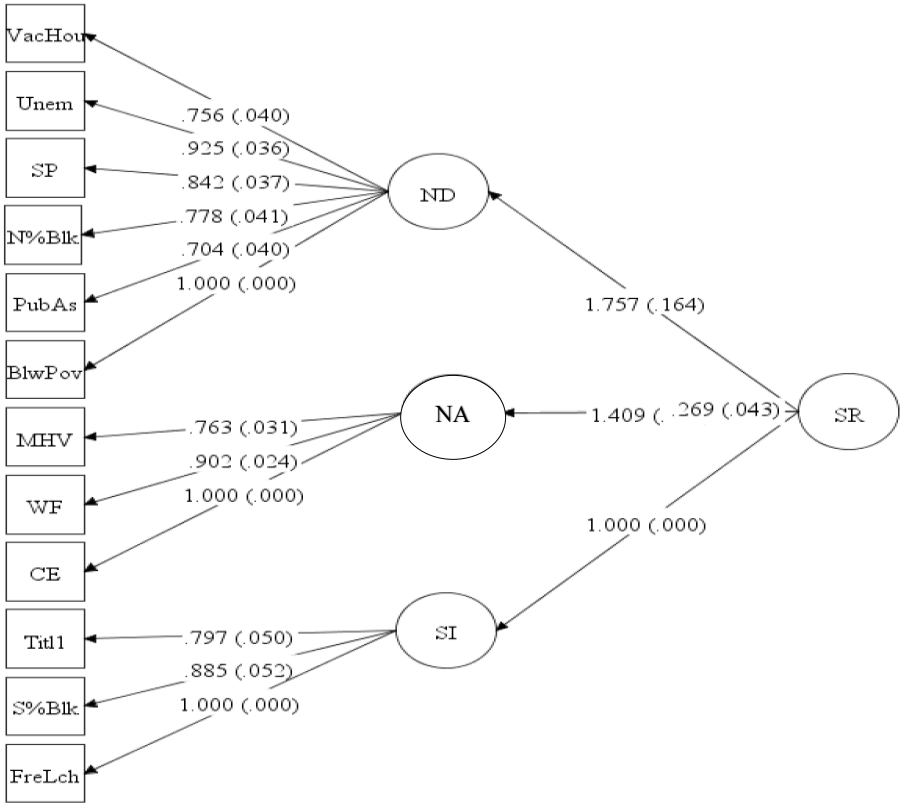
*12 indicators of structural inequity at year 15 loaded onto one construct, structural racism.*




12 Indicators of structural inequity at year 15 loaded onto single latent variable structural racism. CE=College educated, WF = Work force, MHV= Median home value, S% BLK = school percent Black, FreLch = Percentage of students eligible for free or reduced lunch, N%Black = Percentage of neighborhood that is Black, PubAs = Percentage of neighborhood on public assistance, Pov= Percentage of families whose household income falls below the poverty line, SP = Percentage of single parent (female head of household), VacHou= Percentage vacant housing in neighborhood, Unem = Percentage Titl1 = School eligibility for title 1 funding.

**Figure 4.2**

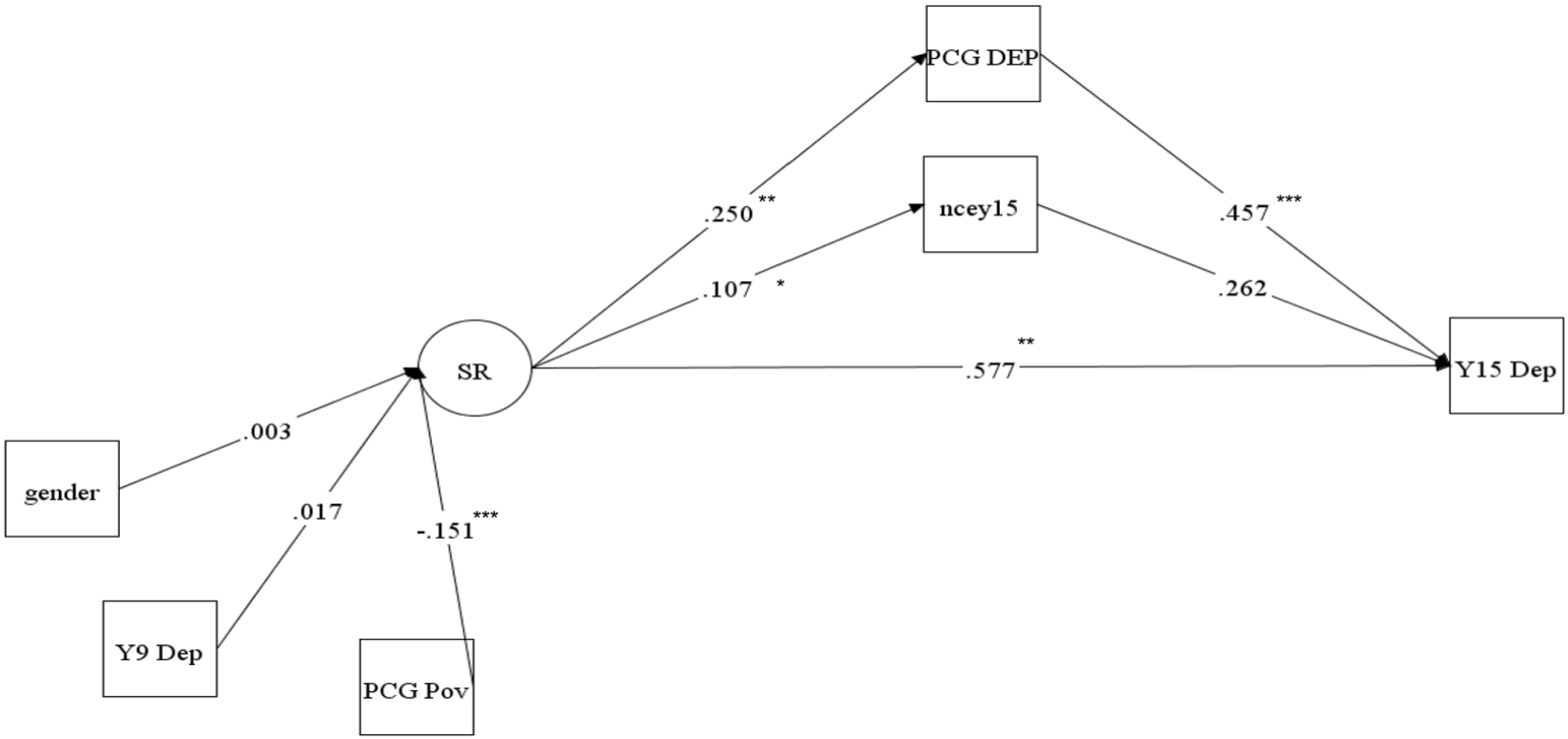
*2nd order confirmatory factor analysis of 12 indicators loaded onto institutional inequity latent constructs, loaded onto latent construct, structural racism.*




12 Indicators of structural Inequity at year 15 loaded onto 3 domains of institutional equity all loaded onto structural racism. CE=College educated, WF = Work force, MHV= Median home value, S% BLK = school percent Black, FreLch = Percentage of students eligible for free or reduced lunch, N%Black = Percentage of neighborhood that is Black, PubAs = Percentage of neighborhood on public assistance, Pov= Percentage of families whose household income falls below the poverty line, SP = Percentage of single parent (female head of household), VacHou= Percentage vacant housing in neighborhood, Unem = Percentage Titl1 = School eligibility for title 1 funding. , Latent variables ( ND = Neighborhood Disadvantage, NA = Neighborhood Advantage, SI = School Inequality SR = Structural Racism)

**Figure 4.3**

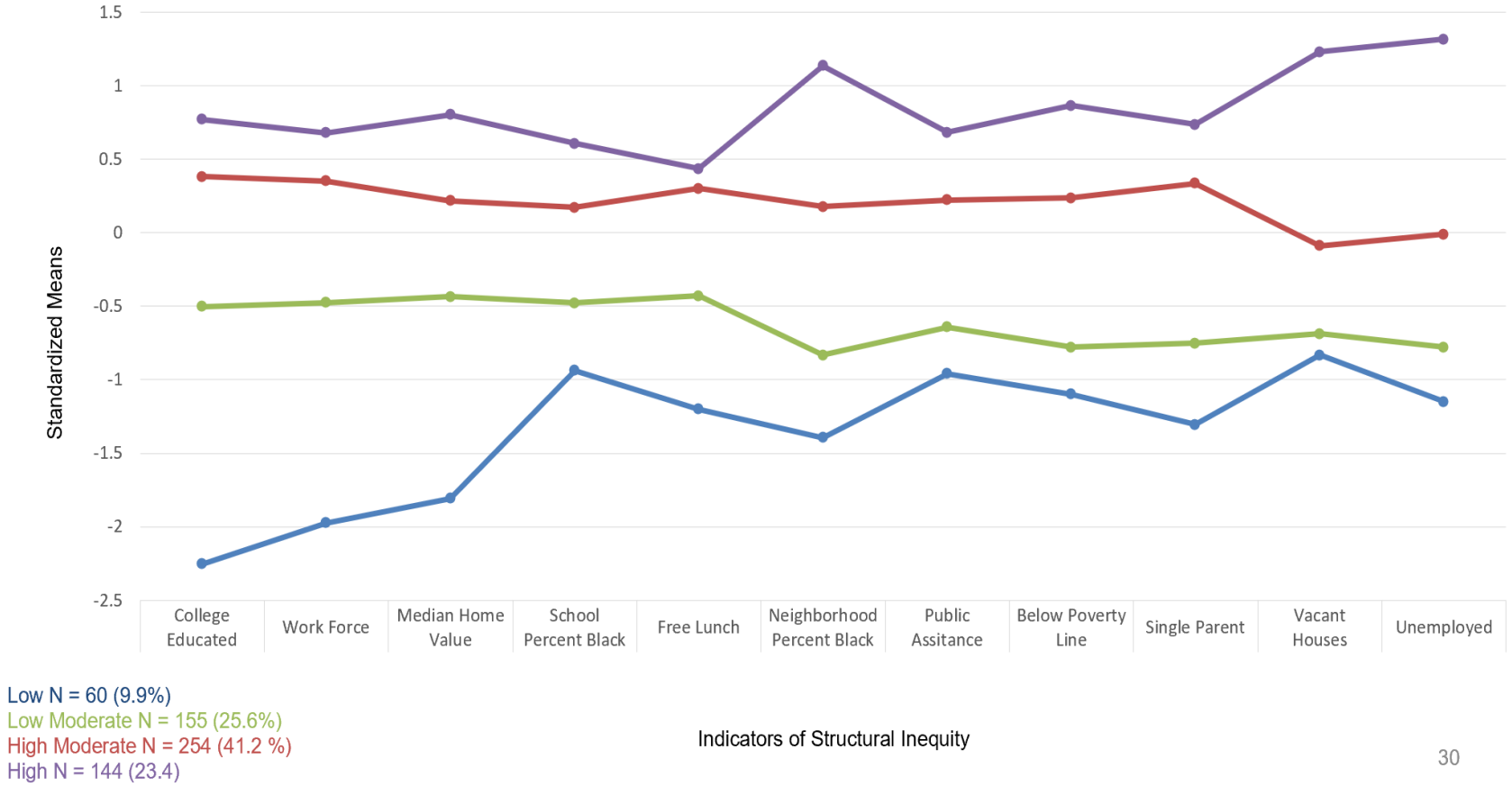
*Cross sectional indirect effect model year 15*




*Note.* Figure three is a cross-sectional indirect effect model with covariates (gender, year 9 depressive symptoms, primary caregiver poverty category at year 15). Mediators are neighborhood collective Efficacy at Year 15 = NCEY15 and primary caregiver depression diagnosis at Year 15. Outcome is year 15 depressive symptoms. SR= structural racism. $p$ <.05 = * $p$<.01 =** $p$<.001=***

**Figure 4.4**

*Latent profile analysis of standardized means across four profiles of structural racism exposure.*




*Note.* Figure 4 is a line graph representing the latent profiles showing the standardized means of structural inequity indicators for each profile at each node.

# Chapter 5 Conclusion

Black youth and their families display inordinate levels of resilience every day, as they experience the impact of structural racism on their mental health. Racism is often misconstrued as interpersonal encounters between racially marginalized and white people. However, that is just a symptom of the larger structure built upon a culture and history of racialization, racial hierarchies, and subjugation of Black people (Heard-Garris, Ekwueme, et al., 2021; D. T. Williams, 2023). Racialized structures creating structural racism have had lasting impacts on the mental health of Black children and their families. Because of its pervasiveness and impact at the individual level, the focus, particularly in psychology, has often been on approaches to problematize, pathologize, or change the individuals rather than the structures that allow those individual actors to perpetuate and experience racism (Neblett Jr, 2019; Rucker & Richeson, 2021a; Trawalter et al., 2020). To eradicate racism and support Black youth as they heal from its effects on their mental health, there needs to be an intentional practice of: (1) identifying the root causes of racism, (2) identifying the types of harm inflicted by racism, and (3) identifying the key ingredients necessary to heal from the damage done. This dissertation aimed to accomplish all three objectives. This final chapter ties together findings, discussing innovations in the measurement of racism, identifying how it impacts Black youth and their families, and addressing what the necessary components are to heal from racism's harmful effects.

This project sought to: (1) Elucidate youths' perceptions and experiences of racism across multiple ecological levels and their relation to their mental health and Sociopolitical

Development (SPD); (2) Examine contextual factors, shaped by structural racism, that Black youth and their caregivers name as determinants of mental health; and (3) Investigate how racism across multiple levels—specifically institutions—coalesces to create a unique overarching stressor for Black youth (i.e., structural racism) that leads to depressive symptoms. Findings from all three chapters further the field's understanding of how structural racism shapes the social determinants of health and, consequently, the mental health of Black youth and their families.

### 5.1 Key Findings Across Studies

Study 1 provided a rich, youth-centered analysis of how Black early adolescents perceive, cope with, and internalize racism across multiple ecological levels. Eight emergent themes captured three major dimensions: the developmental trajectory of sociopolitical awareness; the coping strategies youth employ—including collective support, humor, avoidance, and counter-narratives; and the emotional consequences of racial stress, including sadness, anger, numbness, and symptoms resembling depression. Importantly, the study situated early adolescence as a formative period for sociopolitical development, with youth voices offering insight into how they begin to make sense of systemic oppression. Their narratives revealed the tensions between protection and resistance, as coping mechanisms often reflected both strategic adaptation and internalized misinformation. This study advanced understanding of how Black youth navigate racism in their everyday lives and how those experiences influence mental health and developmental growth.

Study 2 centered the voices of Black maternal caregivers to explore how racialized structural determinants of mental health shape family and community well-being. Drawing from a critical-constructivist framework, six themes highlighted the everyday realities of structural

inequality—including disinvestment in healthcare and housing—and the spiritual, psychological, and communal strategies caregivers use to respond. Participants named trusted institutions, particularly the Black church, as key sources of resilience and intervention. The study also illuminated the ways maternal caregivers transform lived experience into meaning-making, drawing on faith, intergenerational wisdom, and critical awareness to protect their families. Their narratives not only exposed systemic harms but also offered powerful counterpoints to deficit-based portrayals of Black families. These findings underscore the centrality of Black women's insight and labor in navigating structural barriers and cultivating mental health resources within the family and broader community.

Study 3 introduced a multidimensional approach to operationalizing structural racism by modeling racial inequities across school and neighborhood contexts using a large, nationally representative dataset. A second-order confirmatory factor analysis identified three latent domains—neighborhood advantages, neighborhood disadvantages, and school inequities—that collectively formed a higher-order structural racism factor. This latent variable was significantly associated with depressive symptoms in Black adolescents. Additional analyses used latent profile analysis to examine how varying configurations of exposure to neighborhood cohesion, parenting factors, and structural racism related to youth mental health. This study provided a methodological innovation for measuring structural racism beyond self-report and interpersonal discrimination, translating macro-level inequities into testable models with direct implications for Black youth's psychological well-being.

Taken together, the three studies offer a multidimensional exploration of how structural racism shapes the mental health of Black youth and families, centering their lived experiences and perspectives across both qualitative and quantitative methodologies. Study 1 amplified youth

voices, illuminating their emerging sociopolitical development and the coping strategies they employ to manage racial stress during early adolescence. Study 2 deepened this lens by elevating the perspectives of Black maternal caregivers, revealing how faith, vigilance, and collective action shape family responses to racialized structural determinants. Study 3 extended these insights through an innovative, empirically tested measure of structural racism across neighborhood and school contexts—linking macro-level inequities to depressive symptoms in Black youth. Across all three studies, the findings underscore the psychological toll of racism, the protective role of community and spirituality, and the urgent need to address structural racism as a central determinant of Black youth mental health. Together, the dissertation not only affirms the value of community perspectives in understanding social determinants of mental health, but also advances the field's tools for capturing how structural forces shape emotional well-being and developmental trajectories.

### 5.2 Integrative Insights Across Studies

This dissertation provides a multifaceted understanding of how structural racism functions as both a lived reality and a measurable determinant of mental health in the lives of Black youth and their families. The qualitative findings from Studies 1 and 2 reveal how Black early adolescents and maternal caregivers perceive and interpret structural racism in schools, neighborhoods, and healthcare institutions—offering rich narrative evidence of how these systems constrain psychological safety and shape sociopolitical awareness. Study 3 builds on these lived accounts by constructing and validating a multidimensional latent model of structural racism using national data, linking geographic inequities in school and neighborhood contexts to youth depressive symptoms. Taken together, the three studies bridge subjective narratives and quantitative modeling, illustrating how structural racism is both experienced and embedded—

reinforcing the need for research that integrates community voice with multilevel empirical indicators.

Mental health emerged as a central thread across all three studies. Youth in Study 1 described internalizing symptoms such as sadness, anger, and emotional numbness in response to persistent racial stressors. Their narratives reflected the psychological toll of occupying racialized spaces like predominantly white gifted classrooms—where many described feeling "unwanted" or "invalid." These qualitative reflections were echoed in Study 3, where youth in schools with a low percentage of Black students were significantly more likely to report depressive symptoms. Latent class analysis facilitated the connection to the qualitative findings in Study 1, revealing how isolation in white-dominated settings may exacerbate risk. Study 2 complements this picture by illuminating how Black maternal caregivers witness and respond to these mental health risks—both their own and their children's—through vigilance, spiritual coping, and collective care. These intergenerational perspectives foreground the importance of cultural socialization and community resilience in mitigating the harms of racialized stress.

Finally, the dissertation exemplifies theoretical and methodological innovation. Across the three studies, the integration of reflexive thematic analysis, photovoice participatory methods, and structural equation modeling offers a rare multimethod approach to understanding structural racism. This work advances sociopolitical development theory by anchoring it in youth and caregiver voice and contributes a validated multidomain measure of structural racism rooted in real-world inequities. Continued attention to Black youths' awareness of structural racism is as essential as the quantitative modeling of its effects. This integrated approach underscores the need to move beyond individual-level interventions, instead of addressing the layered systems that shape youth well-being. By foregrounding both narrative and statistical truths, this

dissertation advances a powerful model for developmental science and public mental health research alike.

### 5.3 Key Contributions to the Literature

This dissertation makes several key contributions to the literature on structural racism, mental health, and Black youth development. Theoretically, it expands sociopolitical development (SPD) frameworks by demonstrating how structural racism is not merely a backdrop for youth development but an active, ecological force that shapes awareness, coping, and wellbeing. By centering the voices of youth and caregivers, the studies offer empirical evidence that sociopolitical consciousness is deeply intertwined with institutional realities and daily experiences of marginalization. Recognition and resistance—core components of SPD—are shown to emerge not only through individual insight but also in response to structural and cultural constraints, including school tracking, neighborhood disinvestment, and health care bias.

Theoretical contributions further the fields need to ensure that measurement should rely on policy- and law-focused research, rather than observations of racial disparities across institutions. While proxy measures are an initial step, policies and laws should serve as predictors of racial inequality for construct validity (Adkins-Jackson et al., 2022; Brown & Homan, 2024; Neblett & Neal, 2022). Community-engaged research will be necessary to identify community-level changes from policy shifts. Communities experience structural racism's effects directly, similar to how academics feel the impacts of federal funding changes under the current presidential administration (Late Career Health Scientist Group, 2025). As researchers can speak to policy ramifications, marginalized communities can articulate the costs of changing laws and policies in their communities. Community engagement is crucial given rapid policy changes (i.e., cuts to DEI programming, Medicaid rollback, criminalization of homelessness, immigration,

Title 1 funding reduction etc.). Several of those shifts are reflected in the models used in study three (e.g., Title I funding, homelessness). Communities have experienced increased psychological distress from policies rooted in racism, classism, and xenophobia, and other forms of oppression (Offidani-Bertrand, 2023) Engaging communities about policy awareness and its effects is essential for research reflecting vulnerable communities' issues (Akintobi et al., 2020; Corrigan et al., 2015; Miranda et al., 2020; Wright et al., 2025).

Conceptually, the dissertation offers a multidimensional model of structural racism that spans youth-serving institutions, including schools, neighborhoods, and the criminal legal system. This broadens the field's reliance on single-domain indicators and invites researchers to attend to how structural forces accumulate and interact. Across all three studies, new insights emerge regarding how racism is linked to internalizing symptoms, not only through exposure to structural stressors but also through the narratives that youth and caregivers construct to make meaning of their experiences. These narratives highlight forms of resilience that are often overlooked. For example, the use of humor as a coping strategy among youth; the concept of "pulpit permission," in which Black churches create spaces for mental health dialogue; and the framing of Black mothers as vigilant protectors within structurally vulnerable environments—each of these themes offers fresh insight into how Black families resist, adapt, and attempt to heal from racial harm.

Methodologically, the dissertation exemplifies a multimethod approach that integrates participatory qualitative methods (e.g., photovoice and reflexive thematic analysis) with advanced quantitative techniques such as second-order confirmatory factor analysis and latent profile analysis. The development of a multidomain, second-order latent factor model of structural racism represents a significant innovation in how the construct is operationalized using

existing administrative and geospatial data. By pairing this model with the rich narrative data collected in Studies 1 and 2, the project illustrates the value of integrating macro-level measurement with micro-level meaning-making. This synthesis not only enhances our understanding of racism as a multilevel construct but also models an approach for conducting antiracist research that is empirically rigorous and grounded in community perspectives.

Taken together, these contributions move the field toward a more holistic, justice-oriented understanding of Black youth mental health. They demonstrate that healing from racism requires both recognition of structural harms and amplification of culturally rooted strategies for resilience. The findings offer not just critique but also vision—inviting scholars, practitioners, and communities to imagine new ways of supporting Black families as they navigate and challenge structural inequity.

### 5.4 Future Directions

Findings from this dissertation suggest several important directions for future research. First, there is a clear need for *longitudinal and place-based investigations* of structural racism. The cross-sectional design in Study 3 limited causal inference, and future studies could benefit from exploring how structural inequities—particularly across schools and neighborhoods—evolve over time and shape mental health trajectories. Latent class or profile approaches, when paired with longitudinal data, offer a promising methodological pathway for uncovering risk and resilience patterns across development. Future studies should also consider how *geographic variation, local policy environments, and interactions with institutional actors* (e.g., police, educators, healthcare providers) deepen our understanding of structural determinants of health.

Second, research should continue to explore the *relationship of contextual disadvantages to minoritized youth's mental health*, especially given findings that suggest isolation in

predominantly white spaces may contribute to depressive symptoms among Black youth. As the Study 3 latent profile analysis revealed, the relationship between structural disadvantage and mental health may not be linear—highlighting the need for intersectional frameworks that account for both protective and compounding risks. Future work might examine whether cultural socialization or collective coping strategies buffer these risks, especially in contexts where racial isolation intensifies emotional vulnerability.

Third, continued engagement with *community-led and participatory approaches* is essential. Studies 1 and 2 illustrate the value of elevating youth and caregiver voices in shaping how we understand structural racism, coping, and resilience. These approaches not only deepen conceptual insight but also align with calls for justice-centered models of inquiry. Future research should consider extending this participatory lens across family systems, genders, and generations—and across diverse Black communities.

Fourth, several findings point to novel *clinical and intervention targets*. For example, Black maternal caregivers' chronic vigilance and emotional guarding—while adaptive—may contribute to distress over time, suggesting a need for culturally responsive mental health supports. Similarly, the insight and agency expressed by caregivers and youth alike underscore the potential of *community-based institutions*, such as Black churches and neighborhood organizations, as sites of prevention, healing, and change.

Lastly, it is essential to continue critically examining *theoretical models that may reinforce racism*. The racialization of contexts (space) explains why inequities are sequestered to arbitrary census tracts counties or schools. Redlining and modern-day segregation hinder social and economic mobility, gentrification sequesters resources and displaces marginalized families, and school dis/disinvestment links to housing values—all by design through policies that

disproportionately impact Black people. When studying racial inequities, the field must avoid reinforcing them as root causes. Analyzing inequities without examining their driving forces can lead to blaming communities rather than the laws and policies creating those inequities. Social disorganization theory has driven neighborhood research through deficit framing, without explaining why social disorganization occurs. Werth (2024) critiques this theory by comparing it with Du Bois' work on racial disharmony, noting that Shaw & McKay's (1942) theory overlooks structural causes like economic deprivation, segregation, and racial injustice. As shown in Chapter IV, inequities like Black population percentages in schools and census tracts can suggest that Black presence causes community issues. However, when considering racialized contexts, focusing on social disorganization in Black communities should be about racist policies that confined Black people to certain areas, and deprived them of resources—shifting focus from labeling communities "socially disorganized" to identifying root causes of disorganization.

Taken together, these directions point toward a research agenda that is ecologically grounded, methodologically pluralistic, and explicitly oriented toward equity and liberation.

### 5.5 Conclusion

This dissertation has illuminated the ways structural racism shapes the mental health of Black youth and families—across systems, generations, and developmental stages. Through a combination of qualitative and quantitative methods, the findings underscore both the urgency of the problem and the resilience of the communities most affected. Structural racism, whether named or unnamed, acknowledged or ignored, exerts a profound influence on emotional well-being. The studies demonstrate how this influence unfolds—in school hallways, neighborhood streets, and caregiving relationships—and how Black youth and families resist, survive, and reimagine life within these constraints.

Regardless of whether Black people are aware of racism, it permeates the very air that we breathe. Salter and colleagues (2018) describe racism as being akin to polluted water. Some may be aware of and recognize that there are better ways for us all to have clean water—for racism to make everyone less sick—while others may continue to reap the personal benefits of polluting water. As we gather knowledge on racism's costs and mechanisms through community-engaged research, reflecting concerns that inhabitants have about the water, and develop responsibility to ensure pollution stops by more accurately measuring pollutants (structural racism), we can work collaboratively to clean the water and rid society of pollutants like structural racism. This is not an individual project. As is the Black tradition, we must rely on one another as we resist the racialized oppressive forces that detrimentally shape almost every aspect of the Black American experience.

In conclusion, I leave readers with a quote from one of the young people who participated in this project—one that echoes the traditions of many ancestors who have come before him and inspires my commitment to community resistance against structural racism:

**"Black people should stick together, if you actually want to get free."**

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