THE UNIVERSITY OF CHICAGO

“WE DON’T COMPLAIN, WE JUST SURVIVE”: BLACK MOTHERS’ EXPERIENCES OF DEPRESSION, RACISM, AND VIOLENCE IN CHICAGO

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Dedication

For my grandmothers Lucille and Mattie, my aunt Marion, my friend Ashley, and my daughter Brooke ~ the true love of my life ~

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"*She's a friend of my mind. She gather me, man. The pieces I am, she gather them and give them right back to me in all the right order. It's good, you know, when you got a woman who is a friend of your mind*."

(Toni Morrison, Beloved)

Abstract

Several socioecological factors have been studied as determinants of mental health disparities among Black Americans. However, while recogzing the unique challenges of mothering within urban neighborhoods characterized by concentrated disadvantage, the relation between the experience of oppression at the intersection of race, class, and gender and mental health among Black mothers has been understudied and undertheorized. Guided by the public health critical race praxis, neighborhood stress process model and weathering hypothesis, this study was designed to address a series of questions regarding depression among Black mothers. Using an explanatory sequential mixed methods research design, this study examined three specific aims; first, the differences in depressive symptoms over time among a sample of Black mothers, and the relation of patterns of depression to biological age, experiences of racial discrimination and community violence exposure, and perceptions of community belonging. Second, analyses were conducted to examine the extent to which perceptions of community belonging buffers the impact of racial discrimination on worsening depressive symptoms. Third, through focus groups and individual interviews, data were gathered to examine how Black mothers make sense of depression, motherhood, racism, community violence, and community belonging in the context of high burden urban communities. Longitudinal quantitative and in-depth qualitative data, collected from two distinct samples of low-income Black adult mothers who resided in Chicago, were analyzed and merged to provide a nuanced and contemporary understanding of how low-income Black mothers' mental health is uniquely impacted and shaped by exposure to neighborhood stressors and contextual risk. The following set of key findings emerged from the study. First, meaningful heterogeneity exist in the experience, expression, and course of depression among low-income Black mothers who live within high-burden neighborhoods. Next,

findings suggest exposure to community violence, fear of violence victimization, experiences of racial discrimination, and structural racism—to varying degrees—negatively affect the mental health of low-income Black mothers. This study provides evidence of the firsthand experiences of low-income Black women mothering in urban neighborhoods characterized by concentrated socioeconomic disadvantage, reveals their perceptions of stressors in the community context, and provides insight into how Black mothers experience and navigate racism, depression, and the strong Black woman stereotype. These findings support the need for transdisciplinary multilevel mental health interventions that consider the historical and present-day sociocultural contexts of low-income Black mothers. This study also has important implications for direct and community level social work practice concerned with dismantling structural racism to achieve mental health equity for racially marginalized communities.

CHAPTER 1 - INTRODUCTION

Black women in the United States occupy a precarious social location, experiencing compounded oppression at the intersection of race, class, and gender. These experiences have been linked to a host of poor health outcomes, including premature aging, among Black women (Belgrave & Abrams, 2016; Geronimus et al., 2010). For example, Black women have disproportionately high rates of hypertension and obesity, putting them at higher risk for stroke and cardiovascular disease when compared with women from other racial or ethnic groups (Chinn et al., 2021). Black women, in comparison to other racial and ethnic groups, are more likely to die from breast and cervical cancer (Belgrave & Abrams, 2016). Black women are 3 to 4 times more likely to die from pregnancy-related causes than their White and Latina counterparts (Chinn et al., 2021). In Chicago, the site of the present study, a recent report found Black women die at almost 6 times the rate of White women from pregnancy-related causes (Chicago Department of Public Health, 2019).

Problem Statement

The problem is while health disparities are found for all Black women, those women living in high burden urban community contexts are at particularly high risk. Further, women who are mothers bear the burden of additional and distinct stressors that may further impact their health and well-being (Jones & Shorter-Gooden, 2003). As O'Reilly (2004) shared:

> As eloquently stated in *Toni Morrison and Motherhood: A Politics of the Heart*,
>
> The struggle for [Black] mothers is not how to balance work and family but rather how to fulfill the important tasks of *motherwork* in the face of racism and poverty . . . Black mothers, despite the power of their maternal standpoint, must mother their children in a

> world hostile to them and often must battle to provide the preservation, nurturance, and cultural bearing necessary for the empowerment of their children. (p. 42)

This study expands previous research on Black women to focus specifically on Black mothers engaged in motherwork in the context of concentrated poverty, pervasive racism, and the impact on Black mothers' mental health.

Black mothers who live in communities characterized by concentrated poverty have described chronic stress associated with limited access to resources, experiences of trauma, and the burden of keeping their children safe (Hicks-Bartlett, 2000; Kotlowitz, 2019). For example, in a study of low-income Black mothers living in high burden neighborhoods in Chicago, mothers described pervasive fear of their children being victims of gun violence, hypervigilance when performing everyday tasks, and anger about the conditions of this "severely challenging, and even deadly context" (Mendenhall et al., 2017, p. 183). Black mothers living in these neighborhoods report serious symptoms of mental health disorders, most notably depression, posttraumatic stress disorder and anxiety (Mendenhall, 2018). Mendenhall (2018) found 56% of a sample of Black mothers living in high burden Chicago neighborhoods reported experiencing symptoms of post-traumatic stress disorder and 48% reported experiencing depressive symptoms. Despite knowing the myriad of challenges faced by Black mothers in the context of racism and poverty, Black mothers' mental health has not been prioritized in research or practice, with little attention to the particular challenges faced by Black mothers. Conducted research tends to cast Black motherhood in a negative light in stark contrast to White dominant ideals and experiences of motherhood. The present study, instead, centered Black mothers and the experience of Black motherhood at the intersection of place, race, gender, and mental health. Depression—a specific mental health outcome—is among the leading causes of disability and

disease worldwide, and among the leading causes of mental health disability among women and racially and ethnically minoritized groups (Safran et al., 2009). To that end, this study examined how experiences of racism at the individual, interpersonal, community, and societal levels; community violence exposure; and perceptions of community belonging relate to differences in trajectories or patterns of depressive symptoms among Black mothers living in high burden urban neighborhoods.

Purpose of Study, Research Aims, Research Questions

The overall purpose of this study was to examine how exposure to community violence and racial discrimination in the context of neighborhoods characterized by socioeconomic disadvantage relate to individual mental health experiences of Black mothers. This study built upon existing research to understand patterns of depressive symptoms among Black mothers living in high burden urban communities and the relationship of those patterns to experiences of racism, community violence exposure, and perceptions of community belonging. Using both longitudinal, quantitative data and qualitative data gathered from two samples of Black mothers who lived in high burden urban neighborhoods in Chicago, this study addressed three specific research aims by examining six research questions:

Research Aim 1

To examine differences in depressive symptoms over time among a sample of Black mothers, and the relation of patterns of depression to biological age, experiences of racial discrimination and community violence exposure, and perceptions of community belonging.

Research Question 1. What differences, if any, are there over time in the trajectories of depressive symptoms among Black mothers who live in high-burden urban community contexts?

Research Question 2. Are older aged Black mothers more likely to experience worsening depressive symptoms over time?

Research Question 3. Do Black mothers with higher levels of exposure to racial discrimination and community violence have a higher likelihood of experiencing worsening depressive symptoms over time?

Research Question 4. Do Black mothers with perceptions of higher levels of community belonging have a lower likelihood of experiencing worsening depressive symptoms over time?

Research Aim 2

To examine the extent to which perceptions of community belonging buffers the impact of racial discrimination on worsening depressive symptoms.

Research Question 5. Are perceptions of higher levels of community belonging protective in the relations between experiences of racial discrimination and worsening depressive symptoms?

Research Aim 3

To examine how Black mothers make sense of depression, motherhood, racism, community violence, and community belonging in the context of high burden urban communities.

Research Question 6. How does the experience of mothering in the context of high-burden urban communities impact the mental health of low-income Black mothers?

Background and Significance

Building on an important body of neighborhood and health research, the present study examined how place, race(-ism), and gender differentially shapes the mental health of low-income Black mothers.

Place, in this study, referred to *high burden urban community* contexts which are those communities with high levels of concentrated economic disadvantage, violent crime, racial residential segregation, and limited access to resources (e.g., grocery stores, health centers, mental health services; Henry et al., 2014). Much of the previous research in this area focused on examining the relation of community context and a host of outcomes including violent crime, delinquency, education, and physical and mental health (Cutrona et al., 2000; Hill & Maimon, 2013; Mair et al., 2008; Tung, 2017). The concentration of poverty and mother-led households are usually key indicators used to measure and characterize neighborhood-level socioeconomic disadvantage (Kim, 2010). Recent research suggests the use of a multigenerational perspective when examining how neighborhood disadvantage and racial inequality is passed down – from parent to child – or reproduced through Black families over time (Sharkey, 2013). However, considerably less attention has been given to how place or the community context shapes the lived experiences and health of Black mothers in the study of urban neighborhoods (Burton & Jarett, 2000).

Dominant sociological theories in neighborhood research typically reference racial inequality as a prelude or a catalyst (Sampson, 2012; Sharkey, 2013) to the creation and endurance of neighborhood inequality. However, empirical studies of "neighborhood effects" are largely ahistorical, lack a racial analysis, and do not explicitly include structural racism in their theoretical frameworks or as an explicit construct related to neighborhood disadvantage (Riley, 2018). Considerable evidence suggests perceptions of racism influence mental health outcomes (Williams & Mohammed, 2009, 2013), though research that links health and place often fails to consider the extent to which residents of high burden communities perceive the conditions of their neighborhood as the result of racism and how, for example, this may impact individual

mental health outcomes. Related, there is a gap in our understanding of how neighborhood perceptions and neighborhood social processes are influenced by dimensions of racism, including internalized racism or racialized fear. To address limitations in the extant neighborhood research, the present study conceptualized neighborhood socioeconomic disadvantage as a distinct form of structural racism and examined Black mothers' experiences and perspectives on racism in the context of living in high burden urban neighborhoods.

Research suggests discrimination associated with race and gender is pervasive, inextricably linked to poverty, and associated with poor mental health outcomes experienced among women (Belle & Doucet, 2003; World Health Organization, 2000). A study on maternal depression found Black mothers, in comparison to White mothers, had lower rates of depression; however, depression among Black mothers was associated with worse physical functioning (Ertel et al., 2011). These mothers were also more likely to experience multiple adversities including poverty, unemployment, or financial difficulties. It is difficult to make sense of the paradox that despite the fact Black mothers disproportionately experience individual and contextual risk for depression (e.g., stress, racial discrimination, poverty, neighborhood disadvantage)—at the intersection of race and gender—Black mothers tend to report experiencing less depression than White mothers.

Some research suggests Black women may experience and express depressive symptoms differently based on cultural schemas and stereotypes such as the *strong Black woman* stereotype in which Black women are expected to display strength, be independent, and assume multiple roles including caretaking in the face of stress and adversity (Beauboeuf-Lafontant, 2009; Walton & Shepard-Payne, 2016). Other scholarship in this area suggests we are limited in our understanding of the experience of depression among Black adults because existing

interdisciplinary health research: (a) relies heavily on the use of quantitative data to examine cross-group (e.g., Black and White) comparisons of health status (Nuru-Jeter et al., 2018); (b) controls for race in statistical models which alone can reproduce harmful and limited conceptualizations of how race affects health (Williams et al., 2003); and (c) lacks conceptual clarity on how race, gender, and poverty impacts health thus ignoring intersectionality (Nuru-Jeter et al., 2018; Walton & Shepard-Payne, 2016). When health research treats race as a biological reality or simply as a confounding variable with no theoretical explanation, findings can be interpreted to mean behavioral outcomes can be explained by biology alone which reifies the false narrative that inherently, in this case, to be a Black mother is bad for one's health (Geronimus, 2000; Katz, 2013; Nuru-Jeter et al., 2018). For Black women, and mothers in particular, science has long been used to contribute to demonizing public narratives and policies (e.g., eugenics, compulsory sterilization, culture of poverty explanations, myth of the Black matriarchy) that render the role of one's social conditions and social location invisible—instead focusing on pathology and individual deficits of Black mothers (Geronimus & Thompson, 2004; Roberts, 1997).

The present study addressed limitations in the existing research in three specific ways: (a) race is conceptualized as a social construct; thus, racialized socioecological factors and lived experiences (e.g., structural racism, racial discrimination) are hypothesized to impact the mental health of Black mothers; (b) differences in depressive symptoms over time are examined among Black women who are mothering in high burden urban community contexts rather than simply in comparison to White women or women from other racial or ethnic groups; and (c) this study used a mixed-methods research design which relies on the integration of both quantitative and qualitative data. Results from this study offer the field a nuanced conceptual model of how place,

race, and gender differentially shape mental health, specifically depression, of low-income Black mothers living in high burden urban community contexts.

Definitions of Key Terms and Concepts

Depression refers to the experience or expression of depressive symptoms including, but not limited to feelings of sadness, worthlessness, guilt, loss of energy, difficulty concentrating, trouble sleeping or sleeping too much (American Psychiatric Association, 2021).

Gender is defined as the "roles and expectations attributed to men and women in a given society, roles which change over time, place, and life stage" (Phillips, 2005, p. 1). This study is particularly concerned with "the composite of both social and biological health effects associated with being either male" or, in the case of this study, female (Phillips, 2005, p.3).

Mental Health refers to one's emotional, psychological, and social wellbeing. Mental health, in this context, does not refer to mental illness or a mental disorder (MentalHealth.gov). For the purposes of this study, mental health is often used to conceptualize one's overall psychological wellbeing or mental health status beyond depressive symptoms.

Place broadly refers to the geographic or location specific context in which one lives. For the purposes of this study, place is conceptualized as high-burden urban neighborhoods or high-burden urban community contexts with high levels of concentrated economic disadvantage, violent crime, racial residential segregation, and limited access to resources (e.g., grocery stores, health centers, mental health services; Henry, 2014). Place, in this study, is used interchangeably with neighborhood and community context.

Racism is defined as "beliefs, attitudes, institutional arrangements, and acts that tend to denigrate individuals or groups because of phenotypic characteristics or ethnic group affiliation" (Clark et al., 1999, p. 805). For the purposes of this study, racism and racial discrimination are

used interchangeably, and race is understood as a social construction denoting racialized groups of people and associated racialized experiences (Ford & Airhihenbuwa, 2010b).

> ***Structural Racism*** is defined, by the Aspen Institute (2014) as:
>
> a system in which public policies, institutional practices, cultural representation, and other norms work in various, often reinforcing ways to perpetuate racial group inequity. It identifies dimensions of our history and culture that have allowed privileges associated with "whiteness" and disadvantages associated with "color" to endure and adapt over time. (Aspen Institute, paragraph 2)

For the purposes of this study, *neighborhood socioeconomic disadvantage* is conceptualized as a distinct form of structural racism (Riley, 2018), and "emphasizes the most influential socioecological levels at which racism may affect racial and ethnic health inequities" (Gee & Ford, 201, p.3).

CHAPTER 2 – THEORETICAL AND CONCEPTUAL FRAMEWORK

This chapter provides an overview of the theoretical and conceptual frameworks that guided the present study. A public health critical race praxis informed the overall research design, methodology, and interpretation of the study results. The study then drew on the neighborhood stress process model, a socioecological perspective on stress and mental health, to explain variation in mental health outcomes (i.e., depression) among low-income Black mothers living in high burden urban community contexts characterized by concentrated socioeconomic disadvantage. The weathering hypothesis, also theoretically grounded in the stress process model, provides a model for understanding mental health inequities among Black women over the life course.

Application of a Public Health Critical Race Praxis

Originating in the academic study of law, critical race theory (CRT) is a transdisciplinary framework, grounded in social justice, that asserts the role of racism and marginalization in the production of knowledge (Delgado & Stefancic, 2001). Scholarship and research to pursue racial equity justice is encouraged. CRT is conceptualized as a practice of interrogating and upending structural and institutional racism through research. Fundamental to CRT is the assertion of race as a social construct rather than a biological reality; therefore, research should be attuned to how racial and ethnic categories and processes of racialization are used to benefit White identified people at the exclusion of Black, Indigenous, and other people of color. CRT also expands our understanding and language of racism beyond individual acts of discrimination to consider the ways in which racism is an ordinary, everyday occurrence inherent and foundational to the systems, institutions, and laws that govern and shape everyday life, individual outcomes, and one's access or lack thereof to power.

A public health critical race praxis (PHCR) integrates CRT into the field of public health and suggests the elimination of racism is key to reducing health disparities and achieving health equity among marginalized people and communities (Ford and Airhihenbuwa, 2010a). Ford and Airhihenbuwa (2010b) frame PHCR as a praxis as it intended to be an iterative methodology and process that moves the very function of public health research beyond documenting health inequities among marginalized communities to developing strategies, informed by research, that work to eliminate inequities. Race consciousness frames the process of PHCR, which in this case means, I as the researcher am attuned to the salience of racialization in both the broader society and in my own life as a racialized person (Ford & Airhihenbuwa, 2010b). In other words, I must start this inquiry with a critical awareness of my own racial socialization process as an African American in the United States. It is important to note race consciousness is key for White identified researchers and people of color as CRT, at its core, challenges scholars to reject colorblindness or race neutrality and instead see race in all aspects of the research process. PHCR outlines four phases of the research process (i.e., contemporary race relations, knowledge production, conceptualization and measurement, action) and 10 applied principles to guide research focused on racial health inequities. These include: (a) race consciousness, (b) primacy of racialization, (c) race as a social construct, (d) ordinariness of racism, (e) structural determinism, (f) social construction of knowledge, (g) critical approaches, (h) intersectionality, (i) disciplinary self-critique, and (j) voice.

This study used the PHCR approach as a guide and framework to understand, through research, the extent to which exposure to community violence and racial discrimination relate to variation in mental health outcomes among Black mothers living in neighborhood contexts characterized by socioeconomic disadvantage. Health inequities among Black mothers are well

established in the literature (Belgrave & Abrams, 2016) and the PHCR principle of primacy of racialization attunes to how racialization processes relate to observed disparities in health outcomes. In this case, primacy of racialization attunes to the ways in which racial stratification and structural racism has influenced the creation of communities characterized by concentrated disadvantage. Unlike much of the previous research that examines racial identity as a biologically determined individual-level risk factor for poor mental health, this study conceptualizes race as a social construct and therefore focuses on Black mothers as a racially marginalized group at increased risk for racism-related exposures that may relate to poor mental health outcomes. Structural determinism considers the enduring role of macro-level policies and institutions in maintaining inequities in health and power over non-dominant group's access to resources over time and across contexts (Ford and Airhihenbuwa, 2010b). The links between, for example, neighborhood socioeconomic disadvantage, low individual socioeconomic status, and poor mental health are not novel; therefore, research from the PHCR perspective examines both the historical and contemporary systemic factors that maintain these relations. Intersectionality refers to the interconnected nature of social classifications (Ford and Airhihenbuwa, 2010a; 2010b); in this case race, gender, social class, and the extent to which Black mothers simultaneously experience sexism or gendered racism in these distinct community contexts. The principle of critical approaches challenges the researcher to dig beneath the surface of social life and consider alternative explanations in contrast to dominant cultural narratives of low-income Black mothers (Ford and Airhihenbuwa, 2010b).

Related to acknowledging my positionality as the researcher, the PHCR principle of voice privileges my analytical perspective—informed by my lived experiences as an "outsider-within" and as a racially marginalized person (i.e., Black or African American; Ford &

Airhihenbuwa, 2010a, 201b). Privileging the voice of marginalized scholars is not done at the exclusion of others nor does it suggest racially marginalized people speak for their race (i.e., tokenism). Instead, this PHCR principle, voice, intends to illuminate—and challenge—the power of the dominant group in shaping discourse around, for example, Black motherhood or expressions of depression symptoms. Further, researchers with outsider-within status may offer novel perspectives on resilience and resistance among marginalized communities. Following the tenants of PHCR, it is hypothesized racism and processes of racialization at multiple socioecological levels are conceptually and empirically linked to mental health outcomes among Black mothers. Specifically, the present study examined how Black mothers' mental health was impacted by racism, structural inequality, and other stressors in the context of urban neighborhoods characterized by socioeconomic disadvantage (Research Aims 1 & 3).

Neighborhood Stress Process Model

The neighborhood stress process model provides a theoretical foundation for examining how the mental health of individuals living in high burden neighborhoods is differentially impacted by exposure to stressors. Based in this theoretical frame, it is hypothesized differences in depressive symptoms over time relate to exposure to racial discrimination and exposure to community violence (Research Aim 1). The neighborhood stress process model is an integration of Pearlin et al.'s (1981) stress process model embedded in a social ecological framework (Bronfrenbrenner, 1979). The integrated model illuminates inequality inherent in the structural context of the neighborhood of the individual stress process.

Pearlin et al.'s (1981) early conceptualization of the stress process model was based in a sociological perspective to explain how an individual's social status is associated with their level of psychological distress. Much of the discourse on stress and health, prior to Pearlin et al., was

largely from a biological or medical model focused on variation in individual physiological responses to acute or chronic exposure to stressors. In a seminal publication, Pearlin (1989) challenged medical sociologists to intentionally shift from an over-emphasis on the individual experiences of "ordinary people" to focus on the structural context of the individual stress process. Around the same time, influential work of urban sociologists emerged which illuminated the role of racial residential segregation and stratification in the creation of inner-city neighborhoods with structural characteristics of socioeconomic disadvantage (Wilson, 1987). To that end, the stress process model offered a way to understand the mechanisms through which the social structuring of our society "manifest in the mental health of its members" (Aneshensel & Mitchell, 2014, p.56). Specifically, the stress process model posits social stratification based on race, ethnicity, gender, and socioeconomic class shapes an individual's exposure to stressors, access to resources to buffer the impact of stressors, and subsequent mental health outcomes.

The stress process model defines a stressor as: "1) the presence of environmental threats, challenges, or demands that tax or exceed the individual's ordinary capacity to adapt, and 2) the absence of the means to attain sought-after ends" (Aneshensel & Mitchell, 2014, p.54). In this framework, the "means" to cope or mitigate the impact of stressors are conceptualized as personal resources which may include social support, self-concept, and self-esteem. In this framework, psychological distress may lead to symptoms of depression, anxiety, or other psychiatric and mental health diagnoses.

According to Aneshensel and Mitchell (2014), previous examinations of the stress process model have revealed several important considerations. Individuals may experience both acute stressors or life events (e.g., death of a loved one, sudden loss of a job) and chronic stressors (e.g., ongoing role strain, economic strain; Aneshensel & Mitchell, 2014). Chronic

stressors can occur at multiple socioecological levels, and specific chronic stressors are not mutually exclusive. The occurrence of one stressor may relate to, or occur because of, the existence of another. Individual mental health outcomes exist on a continuum from psychological distress to psychological disorder, disease, or mental health condition (Aneshensel & Mitchell, 2014).

According to Aneshensel and Mitchell (2014), a social patterning of poor health in urban residential neighborhoods transpired. Scholars were challenged to advance knowledge on the stressors unique to these community contexts. In response, the neighborhood stress process model, as conceptualized by Aneshensel et al. (2015), builds from the stress process model and highlights the structural context of neighborhoods characterized by socioeconomic disadvantage and attempts to explain variation in mental health outcomes among individuals who live in neighborhoods with similar structural characteristics.

On an individual level, the neighborhood stress process model specifies the social location and status of the individual in the larger social hierarchy (Aneshensel et al., 2015). In the case of the present study, the model starts with acknowledging low-income Black mothers, based on their gender, race, and class, may have poor mental health outcomes. Based in this theoretical frame, poor mental health outcomes among low-income Black mothers are associated with greater exposure to stressors. The stress proliferation process is a key pathway in this model suggesting an initial or primary exposure to a stressor may lead to a range of secondary stressors, having a cumulative effect on individual mental health (Aneshensel & Mitchell, 2014; Aneshensel et al., 2015; Harig & Wight, 2015; Pearlin, 1999). In this case, exposure to neighborhood socioeconomic disadvantage may lead to exposure to community violence or experiences of racial discrimination, which together may have a distinct cumulative impact on

depression trajectories among Black mothers. Based in this theoretical frame, it is hypothesized there is quantitative and qualitative variation in how exposure to multiple stressors in the context of neighborhood socioeconomic disadvantage impacts individual mental health over time (Research Aims 1 & 3).

To explain the ecological aspects of the neighborhood stress process model, Anseshensel et al. (2015), draws heavily on the social-ecological model which posits the dynamic processes and interactions between individuals and the multiple systems in which they are nested are mechanisms that influence individual human development (i.e., person-process-context; Bronfenbrenner, 1993). Individuals and their environment, simultaneously, shape one another and interact in complex ways to influence outcomes (Bronfenbrenner, 1979). Furthermore, the individual is situated in a complex, nested hierarchy of systems which include:

- microsystem—most proximal setting in which the individual is directly influenced,
- mesosystem—interaction and relations between microsystems,
- exosystem—external social settings in which individual is indirectly affected,
- macrosystem—most distal setting comprised of cultural milieu, and
- chronosystem—change or continuity across time that influences other systems (Bornstein & Cheah, 2006; Bronfenbrenner, 1993).

The neighborhood stress process model (Aneshensel et al., 2015) attempts to address limitations of the social ecological model, particularly the model's inability to explicitly consider the mechanisms that explain how distal macrosystem factors (i.e., race, gender roles, culture, power, values) relate to the microsystem that directly shapes development for racially minoritized groups. The neighborhood stress process model expands the model to attend to social inequality at the individual and neighborhood level, and how inequality at these levels jointly and differentially impact individual mental health outcomes.

The neighborhood stress process model explicitly considers racial segregation and class stratification at the macrolevel as foundational to the creation and maintenance of neighborhood

inequality and as key drivers of health disparities among residents in these contexts. Anseshensel et al. (2015) hypothesized a process of compound adversity or compound disadvantages (a cross-level interaction) as a key mechanism of neighborhood effects, whereby poor mental health outcomes related to exposures to stressors (i.e., secondary stressors) are "amplified" by neighborhood socioeconomic disadvantage (i.e., primary stressor) and "dampened" by high levels of stress buffering psychosocial resources. From this perspective, variation in mental health outcomes among individuals embedded in neighborhoods characterized by socioeconomic disadvantage is associated with the effectiveness of an individual's psychosocial resources. Examples of psychosocial resources include, but are not limited to, individual socioeconomic status (SES) mastery, and social support (Aneshensel et al., 2015). Previous research on neighborhood effects has often considered perceptions of neighborhood disorder—social signs that trust, cohesion, and informal social control are lacking in neighborhoods—as a key mechanism through which neighborhood socioeconomic disadvantage affects individual health. Alternatively, Anseshensel et al. (2015) conceptualizes perceptions of neighborhood disorder as a secondary stressor in the context of neighborhood socioeconomic disadvantage, with neighborhood disadvantage conceptualized as a primary stressor.

The neighborhood stress process model is relevant to the growing discourse on how place (i.e., community context) influences individual mental health, particularly as the neighborhood stress process model, unlike many of its predecessors, specifies the role of racial segregation and social stratification in mental health inequities. Further, it is vitally important research on health inequities among racialized groups, in this case low-income Black mothers living in neighborhoods characterized by socioeconomic disadvantage, is guided by theories that examine variation in experiences within groups to combat stereotypes suggesting Black mothers

experiencing poverty are a monolithic group. Research based in the neighborhood stress process model has the potential to reveal modifiable mechanisms that may help to explain why some mothers living in the same context experience psychological wellbeing while others experience worsening mental health over time.

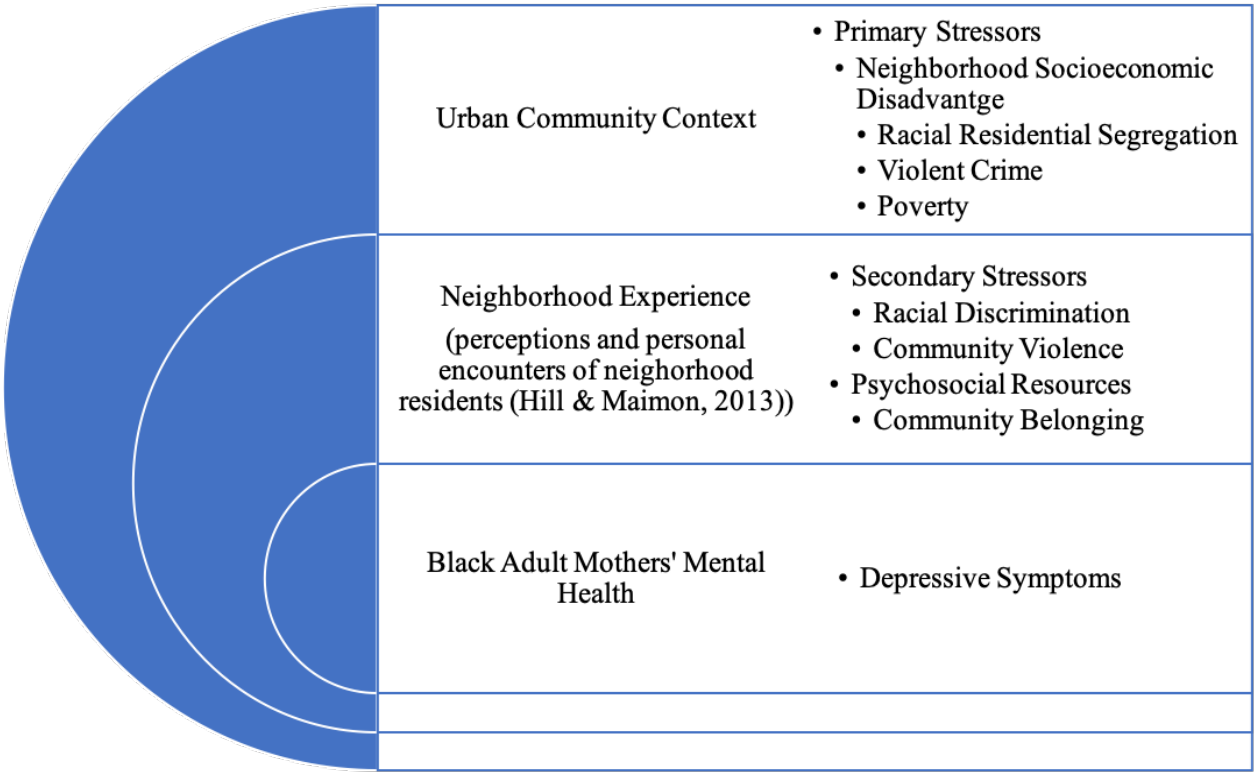
The neighborhood stress process model, however, is limited in its explication of individual psychosocial resources that may buffer the mental health impact of exposure to stressors. Related, this model does not consider how one's psychosocial resources may be shaped by cultural expectations or intersecting identities (e.g., race and gender). To address these limitations, the present study conceptualized perceptions of community belonging as a psychosocial resource that may be stress buffering on effects for depressive symptoms among Black mothers (Research Aim 2). Based in the PHCR perspective, findings from this study illuminated how being racialized as Black or African American and gendered as a woman shapes motherhood identity, expressions of depression, and perspectives on available and effective psychosocial resources (Research Aim 3). An additional limitation of the neighborhood stress process model is omission of the language of racism even in its explicit consideration of structural inequality and racial segregation. Following the PHCR praxis, social policies such as racial residential segregation, should not be examined independently from the historical context of racism; racial oppression, or pervasive racial ideologies have maintained the policy and ultimately shaped individual health outcomes (Massey & Denton, 1993).

As shown in Figure 1, the current study expanded the neighborhood stress process model to explicitly examine the extent to which exposure to racial discrimination— conceptualized as a secondary stressor—relates to variation in depressive symptoms over time (Research Aim 1). The current study also asked "how" exposure to neighborhood socioeconomic disadvantage—

conceptualized as structural racism and a primary stressor—impacts the mental health of Black mothers (Research Aim 3).

Figure 1

Conceptual Model



Weathering Hypothesis

The weathering hypothesis suggests Black women experience early health deterioration and worsening health over time as a consequence of chronic exposure to stressors associated with social, economic, and politically-driven exclusion based on race and gender (Geronimus, 2001). Weathering theorizes Black women—especially those living in communities characterized by socioeconomic disadvantage—engage in high-effort coping strategies (i.e.,

psychosocial resources) to mitigate the effects of structural barriers (i.e., primary stressors) which may in turn lead to biological "wear and tear" and put women at risk for accelerated aging processes.

Geronimus (1996) coined the term weathering following research in which she found Black low-income mothers had greater odds of giving birth to babies with low birth weight as their maternal age increased when compared to White mothers of the same cohort. These findings challenged the public narrative that admonished young women against teenage pregnancy seeing teenage Black and White mothers and babies experienced better health outcomes than Black mothers in their 20s and 30s (Geronimus, 1996). A second study (Geronimus, 2001) found one-third of Black female teens—residing in Chicago neighborhoods characterized by socioeconomic disadvantage—who live to the age of 16 did not survive to the age of 65. Among Black women, in comparison to other racial groups, inequities across several health indicators (e.g., hypertension, smoking, maternal morbidity) are most evident during young to middle adulthood although most of the public health research and interventions target youth (Geronimus et al., 2010). Developmental theories on aging and health are not sufficient to explain the early worsening of health among Black girls and women across socioeconomic class and contexts (Geronimus et al., 2010). In contrast, weathering shifts the focus from individual characteristics and behaviors (e.g., age, low SES, health behaviors) and attempts to explain–in the case of this study-the extent to which mothering, in the context of chronic exposure to racism at multiple socioecological levels, impacts mental health outcomes among Black adult mothers over time (Research Aim 3).

The weathering hypothesis is theoretically grounded in a stress process model, and much of the weathering research to date has focused on understanding physiological responses to stress

that lead to physical health disparities among Black women. This includes disparities in cardiovascular disease, early onset of chronic illness, and pre-term birth weights (Holzman et al., 2009). High allostatic loads have been found and considered biomarkers and measurements that provide evidence of accelerated aging processes (Geronimus, 1996, 2006). Related to mental health, "subjective weathering" has been thought to account for the psychological processes and mechanisms of weathering not being captured through measurements of biomarkers (Foster et al., 2008; Warren-Findlow, 2006). For example, a study of older Black women from Chicago with diagnosed cardiovascular disease revealed women's resilience, will to survive, and cultural expectations to be a strong woman in the face of stressors caused by structural inequality lead to psychological wear and tear associated with depression and anxiety (Warren-Findlow, 2006). Following this theoretical frame, additional research is needed to identify patterns and mechanisms of weathering that may be associated with mental health diagnosis and establish longitudinal relations between physical and mental health symptoms.

Using a PHCR approach, and a race conscious lens, the present study initially drew upon the neighborhood stress process model as the model helps to illuminate the intersection of place, race, and mental health. Specifically, the neighborhood stress process model links individual health and place and theorizes how exposure to stressors and effectiveness of psychosocial resources relate to variation in individual mental health outcomes in the context of what this study conceptualized as a primary stressor and specific form of structural racism: neighborhood socioeconomic disadvantage. Weathering, embedded in the neighborhood stress process model, then offers a conceptual lens through which the lived experiences of Black women are centered, and dominant racial ideologies, structural racism, and race- and gender-based exclusion are specified as antecedents to early health deterioration and worsening health over time. The

integration of these theoretical and conceptual frameworks for the present study reframed the narrative that individual health behaviors or individual SES alone creates mental health inequities among Black mothers. Instead, critical interrogation of mechanisms through which racism is embedded in the very structures of where one lives (i.e., place) and seeps into the everyday lives and minds of Black mothers is needed to improve the health and wellbeing of this marginalized group—who are necessary for the empowerment of Black children and thus survival of the Black community.

CHAPTER 3 – LITERATURE REVIEW

This chapter reviews existing literature on Black women's mental health including: (a) physical health disparities, (b) mental health disparities, (c) depression epidemiology and expressions, and (d) depression among Black mothers. Then this chapter reviews literature on community context and depression including: (a) urban community context, (b) socioeconomic disadvantage, (c) perceptions of community belonging, (d) community violence exposure, and (e) racism.

Black Women's Mental Health

Physical Health Disparities

Disparities in health outcomes, access to health services, and quality of services are pervasive among Black women and persist across individual socioeconomic status, age, and geographic location (Belgrave & Abrams, 2016; Chinn et al., 2021). For example, extensive research suggests Black women, in comparison to other racial and ethnic groups, experience increased morbidity related to diabetes and are more likely to die from breast cancer (Belgrave & Abrams, 2016; Chinn et al., 2021). Black women are 3 to 4 times more likely to die from a pregnancy related cause than White women, and babies born to Black women are twice as likely to have a low-birth weight compared to babies born to White women (Chinn et al., 2021). Data from the U.S. Department of Health and Human Services Healthy People 2010 Report, a federally-funded health initiative to reduce racial health disparities, revealed nationally between 1990 and 2005 disparities between Black and White woman significantly widened for five of 15 health indicators (i.e., heart disease mortality, breast cancer mortality, diabetes mortality, suicide, tuberculosis case rate; Orsi et al., 2010). Also, according to the U.S. Department of Health and Human Services (2010) data specific to Chicago, disparities between Black and White women

widened on 11 of the 15 health indicators, and change was most significant for five of those indicators including all-cause mortality, heart disease mortality, breast cancer mortality, percentage with no prenatal care, and tuberculosis case rate (Orsi et al., 2010). These data are consistent with the weathering hypothesis, suggesting Black women experience early health deterioration in comparison to White women. Evidence for the weathering hypothesis includes, but is not limited to, one study where Black women ages 49–55 years old are biologically older, by 7.5 years, than White women based on biomarkers of aging (i.e., telomere length; Geronimus et al., 2010). The evidence is clear and consistent, Black women tend to experience worse physical health outcomes than women of other racial and ethnic groups. While there has been increasing attention to physical health disparities for Black women, there has been significantly less attention to mental health disparities among Black women.

Mental Health Disparities

Mental health disparities among Black women are best understood in a context that first illuminates the sordid history of the Black community and mental health and psychiatry. The Black community—as compared to other racial and ethnic groups—have long held mistrust for the medical field based on widely documented, pervasive experiences of maltreatment, coercive experimentation (e.g., testing of gynecological instruments on enslaved women without anesthesia, forced sterilization, Tuskegee syphilis study; Washington, 2007) and racial discrimination from healthcare providers (Sacks, 2019). Specific to mental health, enslaved Africans were often diagnosed with drapetomania defined as a "disease of the mind . . . causing the negro to run away from service" (Willoughby, 2018). Additional research (Metzl, 2010) suggests since the 1960s, during the Civil Rights Movement and the rise of the Black Panther Party, Black adults have been misdiagnosed with schizophrenia more often than White adults.

The American Psychiatric Association recently acknowledged its role in enabling racist practices and abuse toward Black, Indigenous, and other people of color in the name of scientific evidence (American Psychiatric Association, 2021). A full review of the literature on the intersection of the historical Black experience in the United States and mental healthcare is outside of the scope of this study. However, the historical context elucidates the complexities inherent in our present-day conceptualization of mental health, disparities in outcomes, and symptom expressions among Black adults.

Research on mental health disparities tends to focus on disparities in mental healthcare as opposed to disparities in prevalence rates of mental health conditions across racial groups (McGuire & Miranda, 2008). Among Black Americans, research on mental health disparities often examines the role of stigma as a barrier to treatment, help-seeking behaviors, and the many social determinants (e.g., poverty, racism) of poor mental health outcomes (Walton & Shepard Payne, 2016). For example, evidence suggests only a third of Black adults in need of mental health care will ever receive treatment (Dalencour et al., 2017. Compared to White adults, older Black adults are more likely to utilize faith-based organizations and religious involvement for mental health support as opposed to traditional care (Chatters et al., 2011). Research suggests positive mental health benefits of religious involvement for Black adults (Nguyen, 2020). Alvidrez et al. (2008) found Black adult mental health consumers (i.e., Black adults currently in treatment) endorsed the perspective that mental illness was incompatible with "Black strength"(26% of the sample); mental health challenges should be addressed among one's family (24%); stigma was a barrier to treatment (65%); and once in treatment, 68% of the sample continued to experience self-stigma and shame.

Unlike physical health disparities, the prevalence rates of most mental health conditions are similar between Black adults and other racial and ethnic groups, and prevalence of major depressive disorder is lower among Black adults (5.4%) when compared with White adults (7.9%; Substance Abuse and Mental Health Services Administration [SAMHSA] 2018). Most research examines depression at a single point in time or lifetime rates of depression. This study took a different approach, examining patterns of depressive symptoms over time among Black mothers. Research on disparities in both physical and mental health outcomes across racial groups is important to inform targeted policy and prevention interventions. However, particularly in the case of mental health, research on disparities in outcomes alone is not sufficient to achieve health equity for racially marginalized groups. Highly stigmatized groups of people (e.g., racial and ethnic minoritized groups, people with severe mental illnesses) are especially vulnerable to mental health stigma which may lead to underreporting on measures of depression as well as barrier to engagement in clinical research from which data on prevalence rates are derived. Research is needed that examines how history and culture shapes individual expressions and experiences of depression to capture the full scope of mental health disparities among racially marginalized groups.

Depression (Epidemiology and Expressions)

The most recent data available from the SAMHSA (2018) National Survey on Drug Use and Health (2018) reported an estimated 17.3 million adults (~ 7.1%) in the United States have had at least one major depressive episode (MDD). Women experience depression at twice the rate of men, and Black adults experienced MDD in the past year at 5.4% (SAMHSA, 2018).

In the largest nationally representative psychiatric epidemiological studies of Black adults to date, researchers found Black adults experienced lower rates of lifetime MDD than White

adults, as measured using the structured clinical interview for DSM-IV, 10.4% and 17.9% respectively (Williams et al., 2007). However, Black adults described their experiences of depression to be more chronic, severe, and disabling than White adults. Chronicity or persistence of MDD was found to be 56% among Black adults compared with 38.6% for White adults. Ninety-four percent of Black adults with 12-month MDD reported their experience of depression as moderate, severe, or very severe as measured by the Quick Inventory of Depressive Symptomatology. Impairment resulting from a diagnosis of major depressive disorder was measured by the respondents' report of their ability to carry out their normal role activities at home, work, relationships, and socially. This seminal study of Black adult mental health also found only 48% of Black adults with severe depression received any form of mental health treatment.

Some research suggests underreporting of depression among Black adults is based on their historical and social experiences in the United States (Carrington, 2006). For example, findings from a 12-month ethnography on perceptions and expressions of depression in a predominately Black urban community with high levels of poverty and crime revealed some Black adults expressed depression in metaphors (e.g., "having a heavy heart," "a heavy cloud"), rather than saying they were depressed. Many did not believe that depression was a "real" sickness, and others viewed depression as a sign of weakness (Alang, 2016). For Black women specifically, cultural psychological schemas and stereotypes such as the strong Black woman led many Black women to deny distress despite exposure to psychosocial stressors, and underreported depressive symptoms (Beauboeuf-Lafontant, 2009; Belgrave & Abrams, 2016; Walton & Shepard-Payne, 2016).

Existing scholarship differs in terminology used to describe the strong Black woman (SBW) (e.g., stereotype, psychological schema, superwoman, sojourner syndrome, sisterella complex), though there is consistency in the central tenets of the SBW: a persona of strength and caregiving (Abrams et al., 2014; Donovan & West, 2015; Evans et al., 2017). Given this study's attunement to racism and focus on mental health, the SBW is conceptualized as a stereotype. Carby (1987) suggested stereotyping is utilized "not to reflect or represent a reality but to function as a disguise, or mystification, of objective social relations." Black feminist scholar Patricia Hill-Collins (2000) adds, "stereotypical images of Black women are designed to make racism, sexism, poverty, and all other forms of social injustice seem natural and further, an inevitable series of events in a Black woman's life" (p.69). Universal stereotypes have harmful psychological consequences. Limited research suggests both positive and negative outcomes associated with acceptance of the SBW stereotype, with research suggesting an association with negative physical and mental health outcomes. At the same time, those outcomes have a positive impact on notions of strength, family preservation, and increased self-reliance (Watson & Hunter, 2015). Jones and Shorter-Gooden (2003) coined the term "sisterella complex" where Black women's lives are focused on work, self-sacrifice, and the needs and desires of others, often leading to functional, though unvoiced, depression. Beauboeuf-Lafontant (2007; 2009) conducted qualitative interviews with a nonclinical convenience sample of Black women and found Black women experiencing depression often "perform" strength, denying feelings of sadness or hopelessness and instead emphasize frustration, physical exhaustion, and anger. Related, expressions of depressive symptoms particular to Black women compared to Black men include increased weight gain, overeating, and insomnia expressed by reports of always being busy and "working" with little need for rest (Walton & Shepard-Payne, 2016). More recently,

among a sample of 95 Black women, majority of whom where college educated, not married, and without children, Watson and Hunter (2015) found endorsement of the strong Black woman race-gender schema was associated with increased depression and anxiety. Woods-Giscombe (2010) conducted focus groups among a sample of Black women, majority mothers, and 75% of whom reported an annual household income below $50,000. Informed by these data, Woods-Giscombe developed the superwoman schema conceptual framework: characterized by Black women's' resistance to vulnerability, dependence on others, suppression of emotions, determination to succeed against all odds, and informed by past experiences of oppression, mistreatment, and socialization from "foremothers." These studies represent different theoretical perspectives and empirical findings on the SBW stereotype to help explain the complex ways Black women may express and experience depressive symptoms and other physical and mental health conditions (e.g., anxiety, hypertension). Taken together, these findings suggest a traditional approach to examine depression among Black women may not capture the complexity of the experience. These studies also suggest a need for an approach to measurement of symptoms and experiences of depression among Black women that considers how depression may change over time based on social or familial roles and cultural expectations.

Depression Among Black Mothers

Women who are mothers, across racial and ethnic groups, are at increased risk for depression. Individual risks for depression among mothers include self-efficacy and self-esteem, experiences of interpersonal violence, and maternal age (Kendall-Tackett, 2009). Social risks for maternal depression include low SES, experience of stressful or negative life events, and minimal access to supports (e.g., father support, maternal parent support; Kendall-Tackett, 2010; Lee et al., 2019). In a cross-sectional analysis of 8,916 adult mothers with a minor child in the

same home across the United States, 10% reported experiencing depression in the previous twelve months (Ertel et al., 2011). In the same study, consistent with previous findings, Black mothers were less likely to be depressed when compared to White mothers. Fifty-four percent of Black mothers who reported experiences of depression in the previous 12 months also reported experiencing multiple and more adversities (i.e., negative life events such as sudden unemployment, separation from or ending the relationship with the partner) and worse physical functioning compared to White mothers who were depressed (Ertel et al., 2011).

Research on depression among mothers is dominated by studies of postpartum depression or links between maternal depression and developmental psychopathology among children. However, evidence suggests mothers are at risk for depression well beyond the postpartum period. For example, Gavin et al. (2011) examined the prevalence of elevated, depressive symptoms among a racially diverse sample of adolescent mothers over the course of 17 years. The investigators followed the same sample from adolescence (mean age range ~14–19 years old) into adulthood (mean age range ~ 29–34 years old) and found depressive symptoms significantly increased over time from 19.8% during the antenatal period to 35.2% during adulthood (Gavin et al., 2011).

Black women who are mothers experience a distinct set of stressors related to their role as parents that may serve to increase risk for depression and depressive symptoms. A study of Black mothers (n = 163) found those with higher sociodemographic risk profiles (i.e., single marital status, low SES, negative perceptions of ability to financially provide for family) had higher levels of depressive symptoms as measured by the Center for Epidemiological Studies Depression (CES-D) over time (i.e., 18 months postpartum; Beeghly et al., 2003). Evidence suggests when compared to White mothers, Black mothers are more likely to live in community

contexts characterized by socioeconomic disadvantage and exposure to high levels of violent crime which means Black mothers are often worried about keeping their children safe. For example, in an ethnographic study of 130 low-income Black mothers living in an urban community, Cricco-Lizza (2008) found many women expressed and displayed anger, anxiety, and sadness as a consequence of their constant battle to survive in the context of racism (e.g., discrimination in employment, healthcare, and retail stores), and poverty. Another study, using in-depth qualitative interviews with a small sample of Black mothers whose child had received at least one school suspension, described stress and trauma associated with the experiences of being a Black mother and navigating school systems in which Black children are disproportionately disciplined, suspended, and ultimately "pushed out" (Powell & Coles, 2021. Black mothers also experience the additional burden and stress related to the unique experience of mothering Black children in the context of pervasive racism (Jones & Shorter-Gooden, 2003; Thornton, 1997). Jones and Shorter-Gooden (2003) conducted a mixed methods study (i.e., survey measures [*n* = 333] and in-depth interviews [*n* = 71]) examining Black women's perceptions and experiences of racism and sexism. Based on data from the mothers in their study Jones and Shorter-Gooden (2003) found Black mothers:

> spend significant energy shifting emotionally and psychologically, constantly anticipating and coping with the assaults that their children encounter. They buffer, filter, deflect, defend, bolster, fortify, and embrace – even as they wrestle with their own sadness, fear and anger about what their children must endure as Black people in this society. (p. 237)

Black mothers, for example, have to teach their children how to "shift" between being children and being "quiet and obedient" to avoid unfair discipline in school settings or survive in the face of a "trigger-happy policeman" (Jones & Shorter-Gooden, 2003, p.238).

Together, these studies suggest low-income Black mothers are at risk for depression well beyond the postpartum period, and additional research is needed to advance our understanding of the contextual and environmental risks for depression among Black mothers beyond individual sociodemographic factors.

Community Context and Depression

Urban Community Contexts

Place, and more specifically spaces of concentrated socioeconomic disadvantage, has been a research interest to scholars for some time. Research spanning public health, sociology, and criminology has long considered the geographic and ecological distribution of individual patterns of behaviors and experiences. For example, Faris and Dunham (1939) observed higher incidences of schizophrenia and psychiatric hospitalizations among adults in the most disorganized areas in Chicago, irrespective of changing populations in these spaces. Similarly, McKay and Shaw (1943) found high rates of juvenile delinquency persisted in Chicago neighborhoods with similar characteristics of disadvantage such as high rates of poverty, crime, and infant mortality (Sampson, 2012). Continuing in the scholarly trajectory of the "Chicago School of Sociology," but with a focus on race, Black Metropolis (Drake & Clayton, 1945) specifically examined the "urban" experience of Black Americans in Chicago after their collective great migration from the U.S. South in pursuit of a promise of a better life. Drake and Clayton (1945) observed Chicago's spatial concentration of disadvantage in which Black Americans lived full nuanced lives to survive particularly burdensome contexts.

Wilson (1987), expanded on the aforementioned work, offering a structural functionalism perspective on inner cities in which he makes several structural arguments that converge issues of race and poverty. First, Wilson (1987) argued the fact of racialized concentration of poverty

among Black people in the United States "inner-cities" due to historical discrimination, industrial, and geographic changes in the economy that dramatically increased joblessness and outmigration of working- and middle-class Black families to "higher-status" racially diverse neighborhoods. Next, Wilson (1987) argued economically poor Black people were socially isolated in the inner-city neighborhoods without employment opportunities or the social and economic resources of the middle-class Black families who left in search of better opportunities. By the 1970's, Black families in the inner cities were beginning to experience the "concentration effects of social isolation" which described the spatial concentration of high levels of poverty, crime, and Black female-headed households (Wilson, 1987). Wilson's seminal analysis of the social transformation of inner-city ghettos and the notion of concentration effects was the impetus for the study of what urban scholars have since termed concentrated disadvantage. Similar to the work of Wilson et al. (1987), Massey and Denton highlighted racial residential segregation (i.e., housing) as a key mechanism through which community contexts may influence disparities in child and family well-being. However, Massey and Denton (1993) are critical of the field using racial residential segregation alone as a measurement of concentrated disadvantage without also naming racial residential segregation results from racial discrimination or racial oppression. The work of Wilson (1987) and Massey and Denton (1993) provides an important historical foundation for current scholarship and research on individual human behavior and development in urban community contexts. The present study was informed by and built upon this scholarship by examining, from a neighborhood or place-based lens, the mental health impact of racism for Black mothers who live in community contexts characterized by concentrated socioeconomic disadvantage.

Socioeconomic Disadvantage

Community contexts characterized by socioeconomic disadvantage, high violent crime rates, and racial residential segregation have consistently been linked to depressive symptomatology among adults, even after controlling for individual sociodemographic factors (Blair et al., 2014; Cutrona et al., 2005; Kim, 2008; Mair et al., 2008; Paczkowski & Galea, 2010; Ross, 2000; Wight et al., 2011). For example, Ross (2000) conducted one of the first studies examining the relationship between neighborhood-level disadvantage (i.e., census tract measurements of poverty, female-headed households' percentages) and individual depression (CES-D) among a large (n = 2,244) probability sample of adult (84% White with a median income of $40,000) residents of several Chicago neighborhoods using data from the 1995 Community, Crime, and Health survey. Ross (2000) found positive and significant relations between individual levels of depressive symptomatology and neighborhood-level disadvantage, and these relations remained significant although effects were reduced by 64% when adjusting for individual-level economic disadvantage.

Another study, using survey data from the national institute of mental health epidemiological catchment area project expanded on this work, examining the relation between neighborhood-level disadvantage and a diagnosis of MDD, rather than depressive symptomatology (Silver et al., 2002). The sample included 11,686 adults representing 261 unique census tracts across five urban cities in the United States, 53% of whom were women, 68% identified as White, 16% as Black, and 13% as Hispanic. Silver et al. (2002) found major depression was more prevalent among women, younger adults, those with lower household incomes, and residents in disadvantaged neighborhoods. They found a 2.2-fold difference in the predicted prevalence rate of major depression in neighborhoods with low levels of disadvantage

compared with highly disadvantaged neighborhoods after controlling for individual socioeconomic factors and demographics.

Research among subgroups including mothers of young children and racial and ethnic groups has revealed inconsistent findings in the relationship between community context and adult mental health. For example, one study examined cross-sectional associations between neighborhood-level poverty and depressive symptoms among a sample of 895 mothers across eight urban and rural U.S. cities (54.7% of whom identified as Black, 11.3% as Hispanic, and 34% as White). Analyses revealed mothers who identified as Black compared to White were more likely to live in "poorer" or more disadvantaged neighborhoods, have less education, receive welfare, and have low household income. Consistent with previous research, Black mothers reported fewer depressive symptoms than White mothers. Further, findings from this study did not reveal a significant link between neighborhood-level income and maternal depression among mothers who lived in low-income community contexts compared to moderate-income community contexts (Klebanov et al., 1994).

In a second study, Cutrona et al. (2005) examined community-level economic disadvantage and depression among a sample consisting of 720 rural and non-inner city dwelling and found Black women had higher levels of disadvantage associated with higher rates of recent onset of major depression after controlling for individual risks (e.g., education, age, marital status, number of children). However, in a prospective analysis of these same data, community-level disadvantage alone, at baseline, did not predict depression at a 2-year follow up; though, an interaction between community disadvantage and recent negative life events was a significant predictor of depression (Cutrona et al., 2005). Findings from Cutrona et al. suggested community contexts may change over the course of time, mental health effects of community disadvantage

alone may diminish over time, or the consistent experience of negative life events in the context of community economic disadvantage drives the development of a MDD.

Taken together, these studies suggest exposure to community contexts characterized by concentrated socioeconomic disadvantage is associated with increased depressive symptoms among adults beyond individual risks. The present study builds on previous research by exploring the long-term mental health impact (i.e., depressive symptoms) of living in disadvantaged community contexts among Black mothers. The present study also advanced knowledge of how exposure to stressors—unique to high burden urban community contexts—may help to explain variation in how community contexts shapes individual mental health.

Perceptions of Community Belonging

There is evidence to support examining relations between individual perceptions of social factors in one's neighborhood (e.g., social cohesion, community belonging) and adult mental health in socioeconomically disadvantaged community contexts. For example, social cohesion refers to perceptions of social connections, willingness to help, and trust among neighborhood residents (Sampson et al., 1997; Sampson et al., 2002; Henry et al., 2014). The majority of studies have found relationships between individual-level perceptions of greater neighborhood social cohesion and more positive mental health (Mair et al., 2010; McCloskey & Pei, 2019; Mulvaney-Day et al., 2007). One study, using cross-sectional data from the Chicago Community Adult Health study, found associations between higher levels of individual and neighborhood-level perceptions of neighborhood social cohesion (tested separately) and lower individual depressive symptoms among women, not men, of a racially or ethnically diverse sample of adults (Mair et al., 2010).

The present study examined if sense of community belonging may protect Black mothers from the negative mental health impact of stressors (e.g., racial discrimination, community violence exposure) in the context of concentrated socioeconomic disadvantage. *Community belonging* describes an individual's sense of connectedness, loyalty, and similarity to the people in one's neighborhood or community. Perceptions of community belonging is distinct from social cohesion in that belonging refers to how the individual feels in connection to others while cohesion represents how the individual perceives relationships and connections among individuals in a neighborhood. However, community belonging and social cohesion both represent *social connection*: the individual's sense of connection and the connection among the group. Most research has focused on social cohesion with less attention to community belonging. Community belonging has been positively associated with better physical and mental health. One study examined the influence of community belonging and regional contextual factors on individual health-behavior changes on a large sample (n = 119,693) of Canadian adults (Carpiano & Hystad, 2012). Carpiano and Hystad (2012) found a positive dose-response relationship between individual sense of community belonging and health-behavior changes including exercise, weight loss and changed diet, and their study found the influence of community belonging was sensitive to the context (i.e., urban versus rural).

Sense of community belonging is linked to common traditions and customs in the Black community, especially among mothers (Stack, 1997). A significant body of scholarship has pointed to the important role of extended family in supporting Black mothers (Burton & Bengston, 1985; Jones & Shorter-Gooden, 2003; Stacks, 1997). For example, seminal ethnographic work by Stack (1997) described how Black families living within community contexts characterized by concentrated poverty demonstrated resilience through relying on

extended family networks (those who were not blood-relatives) for survival in particularly strategic, functional, and adaptive ways. However, the role of neighborhood or community perceptions (e.g., social cohesion, community belonging) on adult mental health outcomes among racial and ethnic groups, particularly Black mothers, is understudied and undertheorized.

Community Violence Exposure

A significant body of research has focused on the impact of exposure to community violence on the health and well-being of children, youth, and adults living in neighborhoods characterized by high rates of violence (Kim, 2008; McDonald & Richmond, 2008). However, exposure to high violent crime rates (measured at the neighborhood and census tract level) is a distinct exposure or experience that should be independently examined as a determinant of individual mental health outcomes (Compton & Shim, 2015). There is a large body of research (Martinez & Richters, 1993; Mohammed et al., 2015; Schmidt et al., 2018; Zimmerman & Posick, 2016) reporting on the positive associations between exposure to community violence and depressive symptoms among youth and adolescents. However, research unique to adult mental health and exposure to community violence, particularly among Black women and mothers, is limited (Clark et al., 2008). One study examined heterogeneity in the patterns and individual experiences of or exposure to "witnessed community violence" among an exclusive sample (n = 209) of Black mothers between the ages of 21–45 with a young child (2–18 months) living in the Washington D.C. metropolitan area (Ronzio et al., 2011). Findings revealed 68% of mothers reported hearing gunshots, 56% saw an arrest, and 37% saw drug deals. Analyses also found two distinct classes, groups, or patterns of exposure to community violence among this sample (i.e., higher-exposure to community violence, lower-exposure to community violence) in which there was a marginally significant (p = .056) difference in average depressive symptoms

between the two classes and average anxiety symptoms was significantly (p = .034) higher in the high exposure class (Ronzio et al., 2011). Another study found significant cross-sectional associations between community violence exposure and adult mental health (i.e., anxiety and depressive symptoms using the Brief Symptom Inventory) among a sample of adult mothers of which 52% identified as Latina and 44% as White from urban communities in Northeastern United States (Clark et al., 2008). Specifically, Clark et al.'s (2008) data analysis suggests among adult mothers living in urban community contexts, exposure to community violence (compared to no exposure) was associated with increased odds of experience higher levels of anxiety (OR = 2.4) and depressive symptoms (OR = 2.6) beyond individual risk factors (e.g., education, marital status, age) including intimate partner violence victimization. In the extant literature, post-traumatic stress disorder (PTSD) is most often studied as the main mental health outcome to violence exposure (Brown et al., 2005); however, psychological distress, loss and complicated grief, aggression, and parenting challenges have also been noted as adverse consequences and reactions to community violence exposure among Black women (Jenkins, 2002). Together, these studies suggest women in urban communities are exposed to multiple types of community violence and it may negatively impact their mental health, particularly Black and Brown women who are mothers.

Previous research using primarily qualitative methodologies and several journalistic endeavors point to community violence exposure as an omnipresent experience for many Black mothers living in high-burden urban community contexts and suggests a detrimental impact on the mental health and well-being of this vulnerable group (Hicks-Bartlett 2000; Jones & Shorter-Gooden, 2003; Kotlowitz, 2019; Mendenhal, 2017). For example, findings from a study drawing on 9 years of fieldwork examining how Black mothers navigate parenting and working in the

community context of concentrated socioeconomic disadvantage revealed Black mothers often "complain of nerve problems" as they find themselves "between a rock and a hard place" (Hicks-Bartlett, 2000, p. 34) navigating the need to maintain employment while consumed with fear of community violence and hypervigilance around keeping their children safe in communities with inadequate institutional or community supports for parents. Neighborhoods with high levels of crime and violence are also often replete with high levels of police surveillance, which adds to a Black mother's worry about their children being "arrested unfairly, or beaten by the police" (Jones & Shorter-Gooden, 2003, 245).

The present study expanded on previous research by using both quantitative and qualitative methodologies to examine the long-term mental health effects of community violence exposure among a particularly vulnerable group: Black mothers who live in high-burden urban community contexts.

Racism

Racism is defined as "beliefs, attitudes, institutional arrangements, and acts that tend to denigrate individuals or groups because of phenotypic characteristics or ethnic group affiliation" (Clark et al., 1999, p. 805). In addition to personal experiences of racism, this study included attention to the persistent racial inequality embedded in "place" that leads to inequities in employment, education, housing, and health outcomes among Black residents living in high-burdened neighborhoods (Clair & Denis, 2015). Early race scholarship of DuBois, Fanon, Wells, and others theorized on the adverse psychological impact of racism unique to Black Americans who were directly impacted by the institution of chattel slavery in the U.S. contexts. Experiences of racism, particularly perceived racial discrimination, have been empirically and conceptually linked to poor mental health and depression among Black adults in the United States (Williams

& Mohammed, 2009; 2013). Clark et al. (1999) offered a contextual model of the biopsychosocial effects of perceived racism as a stressor among Black Americans that has guided much of the extant research on the mental health impact of racism. Clark et al. suggested acute and chronic exposure to environmental stimuli perceived as racist may cause a particular range of stress-coping responses that ultimately influences mental health outcomes. Generational exposure to structural characteristics of inequality in neighborhoods, housing, education and employment opportunities, and internalized negative stereotypes and beliefs of others are all examples of environmental stimuli Black Americans have perceived as functions of racism (Clark et al., 1999; Nuru-Jeter et al., 2009). In their seminal work, Clark et al. also posited experiences of racism may lead to a range of stress responses (e.g., paranoia, frustration, anger, anxiety, fear, helplessness) that can have detrimental consequences for individual mental health, and Black women experiencing poverty are at an increased risk for exposure to racial discrimination and poor mental health outcomes (Belle & Doucet, 2003).

Empirical evidence has found higher levels of racial discrimination are associated with poorer mental health or higher levels of depression (Kwate & Goodman, 2105; Williams & Mohammed, 2009). For example, Siefert et al. (2007) examined risk and protective factors associated with poverty and race for depressive symptoms among a sample of 863 low-income Black adult mothers with children under 6 years old living across 39 of the poorest neighborhoods in Detroit. Descriptive analysis revealed 34% of mothers indicated clinical levels of depressive symptoms, 19% indicated "probable depression" as measured by the CES-D, and depressed mothers reported higher average scores on the race-related everyday discrimination scale (Siefert et al., 2007). Cross-sectional analysis of these data found experiences of everyday discrimination was a significant risk factor for higher levels of depressive symptoms above and

beyond individual sociodemographic risks, even in the presence of protective factors (i.e., emotional support, tangible support), whereby every one unit increase in reports of discrimination the odds of experiencing probable depression (CES-D score > 23) nearly tripled (*OR* = 2.67, p <. 01) among this sample of African American mothers.

Further, research suggests the daily and continuous nature of racism in the lives of Black women, especially those living in the contexts of concentrated poverty, represents a chronic stress likely more detrimental to one's health and well-being over time (Siefert et al., 2007). For example, Brown et al. (2000), used data from Wave 2 and Wave 3 (i.e., 1987–1988, 1988–1999) of the national survey of Black Americans and conducted cross-sectional and longitudinal analyses to examine experiences of racial discrimination, psychological distress, and a diagnosis of depression among a nationally representative sample of 779 Black American adults. Findings revealed significant cross-sectional associations between experiences of discrimination and higher levels of psychological distress. People who reported experiences of racial discrimination at Wave 2 reported higher levels of psychological distress, not depression, at Wave 3 after controlling for an individual's reports of depression and psychological distress at baseline (Brown et al., 2000).

In another study, Schulz et al. (2006) examined the longitudinal relations between individual reports of everyday discrimination and depressive symptoms among a sample of 343 Black women from a racially segregated area in Detroit. Longitudinal analysis of data collected at two time points over 5 years found increases in experiences of discrimination were positively associated with increased depressive symptoms ($b = .125$; $p < .001$) after controlling for age, income, education, and baseline measures of depression and experiences of everyday. Taken together, these studies suggest experiences of racial discrimination may lead to increased

depressive symptoms and poor mental health over time among Black American adults. Limitations of previous research in this area include an over-reliance on quantitative cross-sectional data, variation in measurements of racial discrimination, and a lack of clarity about the location or site of the racial discrimination (Williams et al., 2003; Williams & Mohammed, 2009). However, the only known meta-analytic review of research on perceived racism and mental health among Black Americans adults to date suggests despite differences in measurement and variation in sample sizes, the relationship between racial discrimination and mental health is "ubiquitous and quite robust" (Pieterse et al., 2012, p. 6). The present study contributed to gaps in the literature by employing a mixed-methods methodology, examining the mental health impact of racial discrimination over time, and investigating how individuals describe experiences of racism in the context of their communities and roles as mothers (Williams & Mohammed, 2009).

Summary of Literature Review

Depression among Black mothers who live in high burden urban community contexts has been understudied and undertheorized in the literature. The neighborhood stress process model helps to explain how individual mental health is shaped by exposure to stressors and access to personal psychosocial resources experienced in one's environment. The weathering hypothesis provides important context for the urgency with which we must address mental health disparities among Black women who are mothers. Existing research and theory help to explain contextual factors that influence individual mental health; however, empirical work in this area often lacks conceptual clarity on how oppression and exclusion based on race, gender, and poverty, differentially shapes individual mental health among marginalized groups. The present study

built upon existing research and aimed to address gaps in the literature related to our understanding of depression among Black mothers in the context of racism and poverty.

CHAPTER 4 – QUANTITATIVE STUDY

Mixed Methods Research Design and Rationale

Mixed methods is an approach to research that integrates both quantitative and qualitative methods and data within one study with the goal of gaining a deeper understanding of the phenomenon of study (Creswell et al., 2003; Creswell & Clark, 2017; Tariq & Woodman, 2013). There are various reasons why researchers choose to conduct mixed method studies including the need for triangulation or to expand on findings from one method. Mixed methods research also has the potential to address limitations and leverage strengths inherent to both quantitative and qualitative approaches. When selecting a specific type of mixed methods research design, researchers should be explicitly guided by their philosophical worldview or paradigmatic approach and orientation to research (Creswell & Clark, 2017; Tariq & Woodman, 2013). Mixed methods researchers should also consider the overall purpose and aims of the study as they make decisions about timing, weighting or prioritizing of methods, and the specific methods used to mix two distinct data sets (Creswell & Clark, 2017; Padgett, 2009).

Based on my positionality, described in in Chapter 5, when I conceived of a dissertation inquiry neither quantitative nor qualitative approaches alone felt sufficient to advance knowledge on the mental health impact of mothering within the context of pervasive racism and concentrated poverty. Guba (1990) suggested researchers should identify their paradigmatic approach as a set of beliefs that guides actions in the research process including one's methodological choices. Quantitative methods are associated with positivism or post-positivism paradigms which values objectivity and assumes that there is one reality that can by observed or known within a specific level of probability using the scientific method (Mertens, 2014). In contrast, qualitative methods are associated with a constructivist or interpretivist paradigm which

assumes that knowledge is socially constructed and there are multiple realities. From the constructivist perspective context matters, including the researcher's values and the interactions between the researcher and the study participants. This dissertation study is designed from a pragmatic paradigmatic approach which is situated in the center of the positivist and constructivist paradigms (Mertens, 2014) and provides a philosophical framework for mixed methods research (Tashakkori and Teddlie, 2003).

The epistemology of pragmatism complements the social justice values essential to social work research and practice (Kaushik & Walsh, 2019). Research within the pragmatic approach assumes that there is a single reality, but that all individuals have their own socially constructed interpretation of that reality. From this perspective, one's knowledge is based on one's experiences and actions, and so lived experiences are valued in a way that has the potential to empower marginalized communities. Pragmatism allows for flexibility in one's epistemological and ontological assumptions depending upon the problem being studied as well as the values and personal politics of the researcher. According to Tashakkori and Teddlie (1998), the pragmatist is free to, "study what interest you and is of value to you, study it in the different ways that you deem appropriate, and utilize the results in ways that can bring about positive consequences within your value system" (p. 30).

Further, a pragmatic approach allows for flexibility in the methodological approach as this framework appreciates the strengths and usefulness of both quantitative and qualitative methods depending upon the research question. According to Merten (2014), pragmatist view mixed methods as a practical solution to tensions created in the research community concerning the use of quantitative or qualitative methods.

Mixed methods research designs, relative to a single method, are critical to novel health and health services research concerned with investigating complex processes related to underlined causes of health disparities (Fetters et al., 2013; Jefferies et al., 2019). Historically, physical health and mental health research has been dominated by the use of quantitative methods. However, qualitative methods alone and mixed methods research (that elicits lived experiences) has become more accepted in health research over the last twenty years (Baum et al., 2006; Tariq & Woodman, 2013). The present study uses an explanatory sequential mixed methods research design. Explanatory sequential mixed methods design occurs in phases that build on each other, specifically quantitative data is first collected and analyzed. These findings then inform the collection and subsequent analysis of qualitative data (Fetters et al., 2013). Using this research design, qualitative data are used to help explain, contextualize and to extend the initial quantitative findings (Creswell et al., 2003; Creswell & Clark, 2017).

In the present study, longitudinal quantitative data, collected between 2000 and 2006, were analyzed, and then findings from those analyses informed the design of an in-depth qualitative study conducted during the Spring of 2021. The quantitative and qualitative data in this study were mixed through a process of connecting analyses from the quantitative data to inform the development of interview guides for the subsequent qualitative study (Creswell & Poth, 2016). The two data sets were also connected through the sampling frame with participants in both the quantitative and qualitative studies having similar individual sociodemographic characteristics (i.e., race, age, household income) and both samples living in in structurally similar neighborhoods in Chicago. Given the gap in time between the quantitative and qualitative study phases (approximately 20 years) and the fact the analytic samples are distinct from one another, the present study also mixed methods through a process of merging results in the

interpretation and discussion phase (Creswell & Poth, 2016). Guided by a pragmatic approach to research and my personal values, I was committed—through the use of qualitative methods—to bringing the voice of Black mothers into this study to tell the story behind the numbers (i.e., quantitative data). The quantitative study was a critical first step to understand relationships between and among variables, and the qualitative data collection and analysis was an opportunity to dig beneath the surface to attain a contemporary in-depth understanding of the constructs analyzed. Therefore, the qualitative methods and findings were weighted more heavily in this dissertation study.

Quantitative Study Design and Dataset

Data from an existing study, Schools and Families Educating (SAFE) Children, a longitudinal randomized controlled trial of a family-focused intervention designed to support educational achievement and decrease risk for aggression and other related behavior problems, were used to address the first set of questions (Tolan et al., 2016). Children and families participating in SAFE Children were drawn from seven elementary schools located in high-burden urban neighborhoods in Chicago, IL. Measured using the 1990 U.S. Census data, these neighborhoods (i.e., census tracts) were characterized by high levels of concentrated economic disadvantage (i.e., percentage below poverty level) and high violent crimes rates. Given the enduring impact of racial residential segregation in the city of Chicago, schools in these neighborhoods served primarily Black and Hispanic or Latino youth.

In the Spring of 1997, parents of all kindergarten students at all seven schools were asked to participate in the study. A total of 507 families (i.e., parents and their first-grade children) were eligible to participate, and 424 families consented to participate in the study. Families were randomly assigned within schools to participate in the intervention (225) or control group (199).

Forty-two percent of the sample identified as Black or African American and 52% as Hispanic or Latino.

Between 1997 and 2008, 11 waves of survey data were collected, approximately every 12 months, from study participants (e.g., primary caregivers, children, and teachers) to measure individual, family, and neighborhood experiences and characteristics. Data were collected from caregivers and children through one-on-one interviews. Primary caregivers were asked about a range of issues including but not limited to demographics and background, pre-natal development, depressive symptoms, substance use, alcohol use, neighborhood stressors, neighborhood characteristics, and service use.

Data Analytic Sample

Given the focus on African American mothers, only data collected from the African American and Black primary caregivers were used for these analyses. Because experiences of racial discrimination was a key variable in this study, analyses were further limited to data collected during Waves 4, 5, 6, 8 and 9 as these were the waves during which caregivers were asked to report on their experiences of racial discrimination. A total of 154 primary caregivers (at baseline) were included in this sample. All participants identified as female. At Wave 4 (2000), this subsample of Black mothers was between the ages of 23 and 48 (M = 34, SD = 6.68), 44.7% of the families reported a total family income between $5,000 and $19,999, and 22% of the mothers reported they were currently married or living with someone as if married. About 25.3% had achieved less than a high school diploma, 30.7% were high school graduates, 36.2% completed some college, and 7.8% were college graduates and beyond. The target child for each of the mothers in the subsample ranged in age from 6 to 8 years old (at baseline), and 55% of the

children identified as female and 45% as male. Table 1 lists the ages of the target child at each wave of data collection.

Table 1

Target Child Age

Wave 4	6-year-old: 14.2%
	7-year-old: 85.1%
	8-year old: .7%
Wave 5	7-year-old: 74.8%
	8-year old: 25.2%
Wave 6	8-year old: 2.8%
	9-year-old: 88.8%
	10-year-old: 8.4%
Wave 8	9-year-old: 18.9%
	10-year-old: 80.4%
	11-year-old:.7%
Wave 9	10-year-old: 14.7%
	11-year-old: 82.9%
	12-year-old: 2.3%

Measures

Community Violence Exposure

Exposure to violence was assessed using an 11-item subscale from the *Chicago Youth Development Stress and Coping Manual* (see Appendix A; Tolan & Gorman-Smith, 1999). Participants were asked if they experienced or been exposed to 11 different types of violence "ever," "in the last year," and the number of exposure events in the last year. Participants were asked if they experienced or been exposed to any of the following: "property wrecked," "anyone in family ever got arrested or went to court or jail," "anyone in family ever robbed/attacked," "know anyone outside family who was robbed/attacked," "seen someone beaten," "seen

someone shot or killed," "been victim of violent crime," "witnessed violent crime," "victim of non-violent crime," "family member killed by a drunk driver," or "forced for a sexual contact." To assess community violence exposure "ever" or "in the last ever," participants' responses were dichotomous (e.g., yes or no). If participants responded "yes" to experiencing or being exposed to any of the 11 items in the last year, they were then asked the frequency of the events in the last year. The sum of participants' exposures to community violence, measured at baseline (i.e., Wave 4), were used for these analyses.

Depressive Symptoms

Symptoms of depression were assessed using the Beck Depression Inventory—II (see Appendix B; Beck et al., 1996), a 21-item scale that requires participants to report on the presence and severity of depressive symptoms in the last week. This scale was designed to align with the diagnostic criteria for depression in the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)*. Participants were asked if, for example, they felt sad, guilty, discouraged, or experienced a loss of appetite or interest in the last week. For each item, responses range from 0 = *I do not feel sad* to 3 = *I am so sad and unhappy that I can't stand it*. A raw cut-off score of 14 or higher, out of a maximum of 63, indicated minimal clinical levels of depression. This assessment has been widely used and has good psychometric properties. Cronbach's Alpha for this sample was .833.

Experiences of Racism

Experiences of racial discrimination were assessed using a 7-item subscale from the Chicago Youth Development Stress and Coping Manual (see Appendix C; Tolan et al., 2016). Participants were asked if they had experienced 7 different types of racial discrimination "ever," "in the last year," and the number of racial discrimination events in the last year. Participants

were asked if they had ever been "unfairly accused because of race," "put down because of customs of race," "excluded from group for culture or race," "criticized for hanging with other ethnic groups," "heard people say jokes or bad words for your race," "been called a racial name," or "seen someone racially discriminated." Participants were asked to report whether they had ever experienced each event, and if so, if they had experienced the event in the last year. If participants responded "yes" to experiencing any of the seven items in the last year, they were then asked the frequency of the events and to report how they felt after the experience. In the present study, the sum of participants' experiences of racial discrimination in the last year was used at each wave. Cronbach's Alpha for this sample was .638.

Individual Perceptions of Community Belonging

Individual perceptions of neighborhood social organization and social processes were assessed using the 45-item Chicago Youth Development Neighborhood Measure (Tolan et al., 2016). The community belonging 9-item subscale was used for these analyses (see Appendix D). The measure uses a Likert scale with responses ranging from *strongly agree* to *strongly disagree*. Participants were asked, for example, if they "feel like I belong to the neighborhood," "I feel loyal to people in my neighborhood," "I think of myself similar to the people of this neighborhood," and "I am attracted to living in this neighborhood."

Control Variables

Age

Data on participants' biological age and age at the time of the birth of the target child was gathered from the background questionnaire. This measure was tested as both a continuous variable and a categorical variable (age groups).

Education

Data on participants' highest level of education were gathered from the background questionnaire. This measure was recoded and analyzed as a dichotomous measure (i.e., high school or less, more than high school). All statistical models adjusted for education level.

Income

Data on participants' total household income was gathered from the background questionnaire. This measure was analyzed as a categorical variable. All statistical models adjusted for income level.

Intervention

All statistical models controlled for intervention status, with 0 representing the control group and 1 the intervention group.

Analytic Strategy

Descriptive Analyses

SPSS Statistics software was used for preparation and management of all data, creation of subsets of data to only include cases of African American or Black primary female caregivers, merging of all cases and study variables at each wave of data, and descriptive statistics of all study variables. Means, standard deviations or frequencies, and normality of all study variables were analyzed, and correlations among all variables were examined using SPSS. Mplus was used to run descriptive analyses again to ensure data were successfully transported from SPSS to Mplus, and all further analyses were conducted using Mplus.

Statistical Analyses

Using Mplus, general growth mixture modeling (GMM) was used to identify heterogeneity in participants' individual depressive symptoms over the course of 5 years or participants' growth or developmental trajectories. GMM is a "constrained exploratory technique

. . . that seeks out the story the data are trying to tell" (Ram & Grimm, 2009, p.11). GMM is used to analyze longitudinal data and examines the patterns of individual responses, similarities, and differences between unobserved subgroups of individuals (Jung & Wickrama, 2008; Ram & Grimm, 2009). According to Muthén and Muthén (2000) growth mixture modeling builds and extends latent class growth analysis by examining a single outcome variable (i.e., depressive symptoms) at multiple time points to identify unobserved latent classes that represent different mean growth curves (i.e., intercept and slope) for the outcome variable and individual variation around each mean growth curve (i.e., class). Mplus was also used to examine the independent influence of several covariates of interests on the identified growth trajectories.

Preliminary analyses were conducted to identify a baseline single-group representation of change (i.e., baseline growth model) for these data. Linear growth and quadratic models were fit to these data. By fitting a univariate or single class growth model to these data, it was determined a linear growth model (i.e., significant estimated means and variance of the intercept and slope) was the best fit. Next, using latent class growth analysis (LCGA), with no within-class variance, a series of models (i.e., two classes, three classes, four classes) were fit and compared in an exploratory fashion (Jung & Wickrama, 2008) to determine if the model improved with an increase of classes. Using a number of fit statistics as described below, the model seemed to improve with more classes, so further analyses of data were conducted using the proposed GMM which allowed for between-class variability, similar to LCGA, and within-class variability in the growth curves (i.e., trajectories) captured by adding random effects to the model.

Research Aim 1

Patterns of Depressive Symptoms

Using GMM, I expected to identify at least three distinct patterns or trajectories (i.e., three unobserved latent classes) of depressive symptoms that differed with respect to mean growth curves among this sample of Black mothers. GMM was conducted and two-class, three-class, four-class, and five-class models were fit and compared to determine the final number of classes. Parameter estimates, probability of most likely class membership, and statistical tests were used to select the best model and determine the ideal number of classes. First, each model was specified and estimated using maximum likelihood. Mplus uses full information maximum likelihood (i.e., missing at random assumptions) to account for missing data (Muthén & Muthén , 2000). Additional statistical tests for model comparison included: the Akaike's Information Criterion (AIC), Bayesian Information Criterion (BIC), sample size adjusted Bayesian Information Criterion (ssBIC), and entropy values. Smaller values of the AIC, BIC, and ssBIC suggests a better fitting model, and entropy values closest to one suggests optimal class separation (McLachlan & Peel, 2000). The Lo-Mendell-Rubin likelihood ratio test and the bootstrapped likelihood ratio test were conducted to determine if one additional class would improve each specific model.

Predictors of Patterns of Depressive Symptoms

Using GMM, I expected to find Black mothers with older biological age, higher levels of exposure to racial discrimination, and higher levels of exposure to community violence would have a higher likelihood of membership in a latent class or subgroup characterized by worsening depressive symptoms over the course of 5 years. I also expected to find Black mothers with perceptions of higher levels of community belonging and community support would have a lower likelihood of membership in a latent class or subgroup characterized by worsening depressive symptoms over the course of 5 years. After GMM was conducted and the optimal

number of classes were identified, analyses were conducted using Vermunt's (2010) 3-step approach implemented via the R3STEP function in Mplus to determine whether biological age, exposure to racial discrimination, exposure to community violence, perceptions of community belonging, and perceptions of community support—all measured at baseline (i.e., Wave 4)—was predictive of latent class membership. Vermunt's 3 step approach attempts to correct statistical error in prediction of class membership by using a case's (i.e., individual) assigned class as a nominal latent class indicator for a multinomial logistic regression (Vermunt, 2010).

Research Aim 2

Using GMM and moderation analysis, I expected to find perceptions of community belonging would be protective in the relations between experiences of racial discrimination and worsening depressive symptoms over time. In other words, as perceptions of community belonging go up, does the association between racial discrimination and depression get weaker. To examine the protective or buffering effects of perceptions of community belonging, GMM was conducted to identify the optimal number of classes using a number of fit statistics (e.g., AIC, BIC, ssBIC, entropy). Moderation analysis was then conducted by creating interaction terms between key variables (i.e., community belonging x racial discrimination). Again, Vermunt's (2010) 3-step approach was implemented via the R3STEP function in Mplus to determine whether an interaction between perceptions of community belonging and racial discrimination measured at baseline was predictive of latent class membership (Vermunt, 2010).

Quantitative Study Findings

Findings from the quantitative phase of this study are organized by specific research aims. Research Aim 1 describes longitudinal differences in patterns of depressive symptoms among Black mothers in this sample who all reside in neighborhoods characterized by

concentrated socioeconomic disadvantage. Research Aim 1 also examines potential predictors of differences in patterns of depressive symptoms including biological age, experiences of racial discrimination, community violence exposure, perceptions of community belonging, and perceptions of community support. Research Aim 2 examines perceptions of community belonging as a buffer for the harmful effects of racial discrimination on depression.

Research Aim 1

Patterns of Depressive Symptoms

Using GMM, I expected to identify at least three distinct patterns or trajectories (i.e., three unobserved latent classes) of depressive symptoms that differed with respect to mean growth curves among this sample of Black mothers. Black mothers' reports of depressive symptoms was measured using the BDI-II at five time points between 2000 and 2006. The mean depressive scores among the sample at each time point are presented in Table 2. Overall, levels of depressive symptomatology are low among this sample, with most reporting symptoms in the minimal range (0–13) which are below the clinical cut-off for the BDI-II.

Table 2

Mean Depressive Scores at Each Wave of Data

BDI total score	Year 1	Year 2	Year 3	Year 4	Year 5
n =	154	158	142	139	130
Mean	2.48	2.50	4.73	4.69	5.51
Median	.0	.0	3	3	4
Standard Deviation	3.89	4.73	5.46	5.22	6.26

Using GMM and adjusting for individual levels of education, household income, and intervention status, analyses were conducted to identify subgroups or patterns of depression

trajectories over time. The class enumeration process in which parameter estimates and statistical test and fit indices including the AIC, BIC, ssBIC, and entropy were used to compare models is presented in Table 3. Moving from a two- to three-class model the AIC, BIC, and ssBIC decreased. Moving from a three-class (BIC = 3788.94) to four-class (BIC = 3792.20) model, the BIC increased, and previous research suggested BIC with smaller values is the best indicator of fit (Nylund et al., 2007). An entropy closest to one indicates optimal separation between classes, and although the entropy increased when moving from a three- to four-class model, the addition of a fourth class only represented 3% of the sample (n = 6) and participants in this group still had similar trajectories as the other groups. The Lo-Mendell-Rubin likelihood ratio test also supports a three-class model versus a two-class model (p = .01). Initially, the three-class model had convergence issues which were corrected by fixing the negative variance (e.g., for the slope in latent class 1) to = 0. Ultimately, statistical test and fit indices used to compare models suggested three latent classes (i.e., distinct subgroups) best represents these data.

Table 3

Growth Mixture Modeling Class Enumeration

Model descript-tion	Log likelihood	No. of para-meters	AIC	BIC	ssBIC	Entropy	*n* of smallest class (%)	Class sizes
1 class model	-2146.136	4	4300.27	4312.91	4300.24	N/A	N/A	N/A
2 class model	-1919.858	8	3869.72	3917.10	3869.60	.89	73(41)	1–73 2–101
3 class model	-1860.94	13	3747.88	3788.94	3747.78	.82	37(21)	1–76 2–61 3–37

Table 3 Continued

Model descript -tion	Log likelihood	No. of para- meters	AIC	BIC	ssBIC	Entropy	*n* of smallest class (%)	Class sizes
4 class model	-1852.246	17	3738.493	3792.20	3738.36	.84	6(3)	1–76 2–61 3–31 4–6

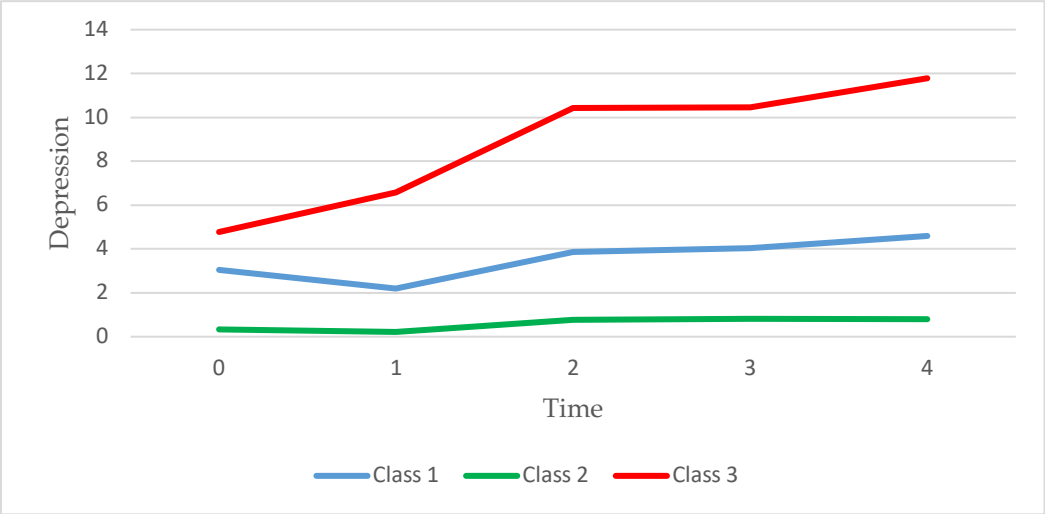
Note. (*n* = 174)

Figure 1 provides a visual representation of the three-class model that best represented these data using GMM. Three distinct subgroups (i.e., latent classes) represent unique trajectories of depressive symptoms among this sample of Black mothers: (a) stable and low levels of depression (*n* = 76, 44% of sample), (b) minimal-to-none (*n* = 61, 35% of sample), and (c) moderate and increasing levels of depression (*n* = 37, 21% of sample). The stable and low levels class (Class 1) described a pattern of depressive symptoms, among 44% of the sample, estimated to begin at 3.04, slightly decreasing to 2.19 at Year 2 and then slightly increasing through Year 5 to 4.59. On average, the individuals in the low-risk class had a .911 probability of being assigned to this class. The minimal-to-none class (Class 2) described a subgroup (35% of the sample) of individuals that reported minimal-to-no depressive symptoms at each time point. On average, the individuals in the minimal-to-none class had a .922 probability of being assigned to this class. The moderate and increasing class (Class 3) described a pattern of depressive symptoms, among 21% of the sample, estimated to begin at 4.77 with a steep increase in symptoms through Year 3 to 10.42 and a final level of 11.78. The individuals assigned to Class 3 on average had a .954 probability of being assigned to this class. Figure 2 is a visual representation of the mean depressive symptoms for each class at each time point which illustrates the growth for each class

across the 5 years of data. Table 4 shows the data gathered for the Growth Mixture Modeling Results figure. Table 5 displays the intercepts and slopes for each latent class in the optimal three-class model which can be understood as the baseline depressive symptoms and the rate of change across the 5 years of data for each subgroup of Black mothers in this sample. Table 5 also shows the slopes and intercepts for each subgroup (i.e., latent class) are statistically significant and meaningfully different from zero.

Figure 2

Growth Mixture Modeling Results



Note. Ages of the target child at each time point are listed in Table 1.

Table 4

Data for Growth Mixture Modeling Results

Year	Class 1	Class 2	Class 3
n =	76	61	37
0	3.04	0.34	4.77
1	2.19	0.22	6.56
2	3.86	0.77	10.42
3	4.02	0.81	10.46
4	4.59	0.79	11.78

Table 5

Growth Mixture Modeling Results

Class	Intercept (S.E.)	Slope (S.E.)	*p*-value for I	*p*-value for S	Class size
Class 1	2.56 (.40)	.49 (.16)	.00	.00	76
Class 2	.27 (.10)	.15 (.07)	.01	.03	61
Class 3	5.25 (.95)	1.78 (.41)	.00	.00	37

These findings supported my hypothesis in that at least three distinct patterns or trajectories (i.e., three unobserved latent classes or subgroups) of depressive symptoms that differed with respect to average growth curves were found among this sample of Black mothers. Using GMM, three subgroups of depression trajectories can be characterized: (a) stable-to-low depression, (b) minimal-to-no depression, and (3) moderate-to-increasing depression. It is important to note that GMM is a post-hoc exploratory statistical technique used to identify unobserved groups and patterns of change in a population using longitudinal data. Taken together, these findings suggest that, controlling for individual levels of education, income, and

intervention status, there is meaningful heterogeneity in patterns of depressive symptoms over time among a sample of Black mothers in high-burden urban community contexts. Just over a third of the sample reported minimal-to-no depressive symptoms, 44% of the sample persistently reported low levels of depressive symptoms suggesting low risk for experiencing clinical levels of depression, and 21% of the sample reported moderate and increasing levels of depressive symptoms or worsening depression over the course of 5 years. These analyses alone do not provide insight into individual experiences that may predict membership into one of the three subgroups.

Predictors of Patterns of Depressive Symptoms

After a three-class model was selected to best represent patterns of change in depressive symptoms among this sample of Black mothers, the GMM was expanded to examine the independent influence of several covariates of interests on the identified growth trajectories. I expected to find Black mothers with older biological age, higher levels of exposure to racial discrimination, and higher levels of exposure to community violence would have a higher likelihood of membership in a latent class or subgroup characterized by worsening depressive symptoms over the course of 5 years.

Biological age, experiences of racial discrimination, and community violence exposure—all measured at baseline—were independently analyzed as covariates to predict membership in one of the three subgroups or latent classes of depression trajectories (i.e., minimal-to-no, stable-to-low, moderate-to-increasing) among the Black mothers in this sample. Covariate, odds ratios for test of categorical latent variable multinomial logistic regressions, 95% confidence intervals, and significance levels (*p* value) are presented in Table 6. Analyses found biological age and community violence exposure were not related to membership in any of the groups.

As hypothesized, analyses found participants with higher levels of exposure to racial discrimination had a lower likelihood of being in the minimal-to-no depression (*OR* = .53; *p* = .001) and stable-to-low depression (*OR* = .66; *p* = .056) groups relative to the moderate-to-increasing depression (i.e., Class 3) group. Since individual experiences of racial discrimination were found to be predictive of membership in a latent class characterized by worsening depression over time, analyses of parallel process growth curve models were conducted to examine the relationship between the rates of change of individual depressive symptoms and individual experiences of racial discrimination over five time points. These analyses were different than the primary analytical approach of this study (i.e., GMM) based on previous research and hypothesis that changes in depressive symptoms (i.e., growth) are associated with changes in experiences of racial discrimination. However, a parallel process growth model would not converge because there was minimal variation in individual experiences of racial discrimination year to year among this sample. Taken together, these findings suggest among Black mothers who live in high-burden urban community contexts, adjusting for individual levels of education, income, and intervention status, and individual experiences of racial discrimination, increases the likelihood of membership in a subgroup characterized by moderate and increasing levels of depressive symptoms or worsening depression over time measured at baseline.

Using an expanded GMM, I expected to find Black mothers with perceptions of higher levels of community belonging and community support would have a lower likelihood of membership in a latent class or subgroup characterized by worsening depressive symptoms over the course of 5 years. Individual perceptions of community belonging and community support, measured at baseline, were analyzed independently and in the same model as covariates to

predict membership in one of the three subgroups or latent classes of depression trajectories (i.e., minimal-to-no, stable-to-low, moderate-to-increasing) among Black mothers in this sample. First, the effects of these covariates were tested in the same model given my conceptual understanding of perceptions of community belonging and community support as it relates to the construct of neighborhood social cohesion. In the same model, statistically significant effects of community belonging and community support were revealed but in opposite and unexpected directions. As expected, perceptions of higher levels of community belonging were associated with greater likelihood of membership in the minimal-to-no class, but perceptions of higher levels of community support were associated with greater likelihood of membership in the class characterized by worsening (i.e. moderate-to-increasing) depression over time.

Using SPSS, I conducted exploratory factor analysis to confirm my conceptual understanding of these constructs as it relates to these data, to determine if community belonging and community support should be tested independently. Exploratory factor analysis revealed the ratio of eigenvalues of the first two factor loadings (4.27/1.62) was less than three, and thus the two constructs—community belonging and community support—represent two distinct constructs or components. All the communalities indicate 58% or more of the variance in each variable is explained by the two constructs combined. Using principal component analysis as the extraction method and Varimax with Kaiser Normalization as the rotation method, the two constructs are correlated which may explain the unexpected findings when tested together in the same model.

Individual perceptions of community belonging and community support were then analyzed independently as covariates to predict membership in one of the three subgroups or latent classes of depression trajectories. Covariates, odds ratios for test of the categorical latent variable

multinomial logistic regressions, 95% confidence intervals and significance levels (*p* value) are presented in Table 6 These findings revealed perceptions of higher levels of community belonging is consistently associated with membership in the stable-to-low and minimal-to-no depression subgroups (*OR* = 1.46; *OR* = 1.47) respectively though these effects were not statistically significant. Test of perceptions of community support did not yield significant predictive effects on membership in the minimal-to-no or stable-to-low subgroups, respectively, of depression trajectories.

Table 6

Multinomial Logistic Regressions of Predictors of Class Membership

	Class 1 (Stable-to-low)			Class 2 (Minimal-to-no)		
Covariate	Odds Ratio	*p* value	95% *CI*	Odds Ratio	*p* value	95% *CI*
Age	1.05	.26	.96–1.15	1.06	.18	.97–1.16
Racial discrimination	.66	.056	.39–1.11	.54	.002	.31–.92
Violence Exposure	1.01	.91	.87–1.17	.86	.13	.71–1.06
Community belonging	1.46	.23	.88–2.43	1.47	.13	.97–2.22
Community support	1.10	.72	.66–1.85	.69	.07	.43–1.12

Note. Class 3 (Moderate-to-increasing) is the Reference Class. (*n* = 154)

Research Aim 2

I hypothesized perceptions of community belonging would be protective in the relations between experiences of racial discrimination and worsening depressive symptoms over time. An interaction term was created with perceptions of community belonging and experiences of racism as a covariate to predict class membership (i.e., depression trajectories) and thus moderation effects using categorical latent variable multinomial logistic regressions were examined. In other words, I tested if an interaction between perceptions of community belonging and experiences of

racism would change the relationship between racial discrimination and depression. Significant effects were not found.

Summary of Quantitative Study Findings

Among this sample of Black mothers living in community contexts characterized by concentrated socioeconomic disadvantage and high violent crime rates, quantitative data analyses suggest there is heterogeneity in the course of depression over 5 years. Specifically, I found evidence of three subgroups of depression trajectories that can be characterized as: (a) stable-to-low depression (b) minimal-to-no depression, and (c) moderate-to-increasing levels of depression. Further, above and beyond individual levels of education, income, and participation in a family-based intervention, individual experiences of racial discrimination were found to increase the likelihood of membership in a subgroup characterized by worsening depression over time. Community violence exposure, biological age, and perceptions of community belonging were not found to be associated with individual depression despite what I expected based on theory and previous research.

While dated, these findings provide insight into the long-term harmful impact of racial discrimination on the mental health of low-income Black mothers. However, these data are limited in their ability to help explain how racism impacts the individual mental health of Black mothers in 2021. Twenty years ago, depression, community violence, and even racial discrimination were known to relate, however research and practice often addressed these social issues in silos. Over time and across health-related disciplines it has become widely accepted that issues of mental health, community contexts, violence, and racism are nuanced, complex, intersecting, and tightly wound together like a Gordian knot. In 2021, substantially more research is concerned with the health effects of racism more broadly including structural and systemic

racism. The Centers for Disease Control and Prevention (CDC) recently asserted that racism is a "serious threat to the public's health" and a fundamental cause of disparities among Black, Brown, Indigenous and other people of color (CDC, 2021). In 2021, in contrast to 2000 when quantitative study data was collected, a scholar would be seen as negligent to theorize or offer an explanation on the persistence of mental health disparities in marginalized communities of color without explicitly discussing community contexts and the intersection of race, class and gender-based oppression.

Given the complexity and enduring nature of the problem of racial mental health disparities among Black mothers, creative and novel approaches (e.g., mixed methods research) to research and practice are needed. The subsequent qualitative phase of this dissertation study was intended to interrogate, extend, and yield a deeper explanation of quantitative findings by offering a contemporary nuanced understanding of the mental health impact of mothering within the context of high-burden urban neighborhoods characterized by socioecomic disadvantage.

CHAPTER 5 – QUALITATIVE STUDY

Study Design and Sampling

This qualitative study was designed to interrogate and provide contemporary insights and perspectives on findings from the initial quantitative component of this dissertation study. Qualitative methods were used to provide depth and nuance to my understanding of how racism impacts the mental health of Black mothers and generate new ideas about the mental health impact of mothering in the context of neighborhoods characterized by socioeconomic disadvantage. Based on findings from the quantitative study, I developed interview guides and conducted three focus groups and 16 semi-structured interviews with Black mothers[1]. The sampling frame, also based on the quantitative study, included low-income Black adult mothers with at least one elementary aged child who lived in high-burden neighborhoods in Chicago for at least one year. While the neighborhoods sampled are not the same in both study phases, the neighborhoods are structurally similar based on demographic characteristics and levels of crime.

Recruitment

Recruitment for the qualitative component of this study occurred in the context of the COVID-19 global pandemic. The COVID-19 global pandemic disproportionately impacted Black and Brown communities and exacerbated already existing physical and mental health disparities and socioeconomic challenges. Further, potential participants (i.e., low-income mothers of young children) were uniquely challenged with supporting their children engaged in virtual learning as Chicago Public Schools were not holding in-person classes due to

[1] Between the focus groups and individual interviews 17 different mothers participated in the qualitative study. A total of 8 mothers participated in 3 different focus groups, and a total of 16 mothers participated in individual interviews.

recommendations from federal (i.e., CDC) and local mandates and guidelines. Despite existing professional relationships and networks in the communities from which I planned to recruit based on my 15-year social work practitioner career in Chicago, the pandemic made recruitment much more challenging than expected. In the United States, most consumer-based industries (e.g., education, mental health services) moved to conducting business online or virtually. In March 2020, the University of Chicago temporarily halted the majority of research activities to slow the spread of COVID-19 and protect members of the community. In mid-June 2020, the University began the gradual, phased resumption of on-campus lab-based and non-lab-based research. In-person field research involving human subjects remained restricted. Because I was not able to recruit or interview participants in-person, my dissertation commmitte chair and I made a decision to conduct recruitment through virtual platforms.

I attended virtual community meetings in which school administrators and educators, youth-serving organizations, local church members, and parents were present. In these spaces, I shared electronic recruitment fliers and information about the study. When organizational representatives or individuals expressed interest in the study or willingness to share information with their constituents, I followed up via email to share the recruitment information and a link to a Google-Docs form for interested participants to sign-up to learn more about the study. Convenience sampling (Etikan et al., 2016) was used to recruit participants who met the following inclusion criteria:

- over the age of 23
- identify as Black or African American (U.S. born)
- primary caregiver (“mother”) of at least one elementary aged child
- total household income less than $40,000

- resident of a high-burden neighborhood in inner-city Chicago for at least 1year (i.e., those communities with high levels of concentrated economic disadvantage, violent crime, racial residential segregation, and limited access to resources (e.g., grocery stores, health centers, mental health services; Gorman-Smith, 2014)

Based on my recruitment efforts, potential participants contacted me via email or phone at which time I reviewed eligibility criteria. If eligible, I provided information regarding the length of the interview (60–120 minutes) and let them know that the interview would be conducted on a day and time most convenient to them. If participants expressed interest in the study, they were emailed an informed consent, and following IRB approved protocol, I obtained verbal consent for participation in the study at the beginning of the interview. Participants were compensated, via email, with a $50 electronic gift card for their time.

A total of 25 Black adult mothers expressed interest in the study. Three mothers who expressed interest were ineligible for the study: one mother had only lived in Chicago for a month; one mother reported a household income of more than $40,000; and another mother lived in the suburbs of Chicago. Five mothers expressed interest and were eligible, but they never completed the study. One of those mothers consented to the study and attempted to join two different focus groups via Zoom, but she consistently had technical challenges and eventually became unresponsive to my follow-up calls. The remaining four mothers who were eligible for the study were seemingly unable to find time to participate or became nonresponsive to recruitment efforts A final sample of 17 Black mothers met the eligibility criteria, consented to[2] participate in the study, and completed data collection. All recruitment, consenting, and data

[2] Between the focus groups and individual interviews 17 different mothers participated in the qualitative study. A total of 8 mothers participated in 3 different focus groups, and a total of 16 mothers participated in individual interviews.

collection procedures were approved by the University of Chicago Crown Family School Institutional Review Board.

Phenomenological Approach

Phenomenonology is the study of "being" (Larkin & Thompson, 2012) and phenomenological research is concerned with describing how participants, in this case low-income Black mothers, perceive and make sense of their everyday lived experiences (Creswell & Poth, 2016; Giorgi, 2009). Phenomenology is grounded in a philosophical assumption suggesting that all individuals are intentionally conscious of a specific object or reality but individuals' experience of the object is subjective. For example, an individual may be conscious or aware that he or she is experiencing a loss or grief (a common experience for most), but the experience of grief is subjective and unique to the individual (Creswell & Poth, 2016). Because phenomenology is focused on describing the "common meaning for several individuals of their lived experience of a concept or phenomenon" sample sizes are usually small (e.g., between 3 and 15) and homogenous (Creswell & Poth, 2016, p.74). In-depth interviews are typically used to collect data in phenomenological research, and the interviews are intended to elicit information on "the essence of a lived phenomenon" (Smith & Osborn, 2007, p.58). Therefore, using a phenomenological approach (Colaizzi, 1978; Kvale & Brinkmann, 2009), focus groups and semi-structured interviews (Russell Bernard, 1994; Spradley, 1979) were used as qualitative methodologies to elicit in-depth descriptions of the lived experiences of study participants.

Phenomenological research can have both descriptive and interpretative goals from which examples of everyday life can be obtained, through interviewing, and used as a source of qualitative evidence (Larkin & Thompson, 2012; Mayoh & Onwuegbuzie, 2013). Kvale and Brinkmann (2009) suggested researchers assume a stance of "deliberate naivete" in the interview

process which gives primacy to the informant's description and experience of the phenomenon. Descriptive goals of phenomenological research are met through a method called *contextualizing* in which questions are asked that enable the interviewee to describe their experience of a particular phenomenon (e.g., loss, violence, racial discrimination) in the form of a narrative which describes complex contextual elements ultimately revealing meaning of the experience for the interviewee (Bevan 2014).

During the interviewing process, researchers should acknowledge and then bracket off or suspend their own assumptions (Creswell & Poth, 2016; Moustaka, 1994) "to develop a greater understanding [and interpretation] of individuals' experiences through the consciousness of the experiencer" (Mayoh & Onwuegbuzie, 2013, p.92). Bracketing occurs when the researcher acknowledges their personal experiences with the phenomenon of study and then sets it aside to focus on the research process (Creswell & Poth, 2016). Based on phenomenological theory, Seidman (2006) stated, "the interviewer should recognize it is not his or her ego that is important but to stay focused on the person being interviewed" (p. 32). In other words, in the phenomenological interview, "the participants are trying to make sense of their world; the researcher is trying to make sense of the participants trying to make sense of their world" (Smith & Osborn, 2007, p. 53). According to Creswell and Poth (2016), researchers have effectively captured the essence of a particular lived experience or phenomenon when they are able to describe "what" a participant experienced and "how" they experienced it.

A phenomenological research approach is appropriate for the present study for several reasons. Phenomenological research is a complementary approach to mixed method studies, especially explanatory mixed methods design that uses qualitative methods to interpret and contextualize quantitative data (Creswell & Poth, 2016; Mayoh & Onwuegbuzie, 2013). Next,

Larkin and Thompson (2012) emphasized the importance of interpretative goals of phenomenological research for the study of mental health as it illuminates what, for example, the experience of depression is like for a particular group of people in a particular context. Mental health research has historically been dominated by the use of quantitative methodologies though they are limited in their ability to provide insight into the nuanced experiences and contexts in which individual mental health challenges occur. Interpretative phenomenological research has the potential to help mental health researchers "situate and understand people in their socio-cultural contexts, and to interpret the associative findings from conventional quantitative research" (Larkin & Thompson, 2012, p.114).

Data Collection Procedures

Interview guides were the main data collection tool used to conduct focus groups (see Appendix E) and semi-structured interviews (see Appendix F) for this study. Interview guides were developed using a series of open-ended questions to give primacy to Black mothers' experiences (Bevan, 2014) of mothering or motherwork in the context of concentrated poverty and pervasive racism. The focus groups and semi-structured interviews were conversational, relaxed, and probes were used to gain clarity and understanding of what was being shared.

I conducted three focus groups with a total of eight Black adult mothers. The focus groups were intended to address the 20-year gap in time between the quantitative and current qualitative phase of this study. I designed the focus group interview guide to assist me in reflecting on how the themes and constructs analyzed in the quantitative study have changed over time. The quantitative study found Black mothers experiences of racial discrimination are associated with worsening depression over time; however, those analyses were unable to provide insight into "how" Black mothers' mental health is impacted by racism in the current sociocultural context.

For example, in 2008, Barack Obama became the first Black president of the United States leading many (including some Black people) to think the United States had become a post-racial society (Taylor, 2017). Then, during the summer of 2020, there were global protests and uprisings demanding Black Lives Matter after the world watched a White Minneapolis police officer murder George Floyd—an unarmed Black man—in broad daylight (Hill et al., 2021). In 2021, race is in the air we breathe in a distinctly different way than it was 2000, and the focus groups helped me begin to understand how a small sample of Black mothers in Chicago were talking about and making sense of racism and mental health during these unprecedented times (e.g., COVID-19, Black Lives Matter).

A research assistant was present during the focus groups for technical support with Zoom and to observe and take notes to include in data analysis. Of note, the research assistant did not identify as Black or White, and given the potentially sensitive nature of the subject matter explored in my study (i.e., mental health, racism, trauma, stigma), my research assistant kept her camera off on Zoom. As such, I was able to create a relaxed, virtual space of all Black mothers, including myself, to help with flow and ease of the focus group interview. The following are sample questions from the focus groups:

1. When you hear the word "mental health" what comes to mind; what about "depression"?
2. What do you think may be happening in the lives of moms who, over 5 years, reported they were depressed and the depression kept getting worse over time?
3. Has anyone experienced racism in this neighborhood? If yes, please share some examples.
4. You all are Black mothers, what does that mean to each of you?
5. When you hear racial discrimination, what comes to mind; what about racism?

After the focus groups, I conducted semi-structured in-depth interviews with a total of 16 Black adult mothers. Findings from the focus groups and the quantitative components of this dissertation were used to inform the development of an interview guide. All focus group participants were invited to participate in an individual interview (i.e., convenience sampling). As such, Black mothers who had participated in the focus groups (n = 6) were already primed for the individual interviews. I designed the interview guide to further explore and expand upon themes and constructs analyzed in the quantitative phase of this study and themes that emerged from the focus groups. In contrast to the focus groups, the semi-structured individual interviews could facilitate an in-depth understanding of the motherwork experiences of 16 Black mothers currently living in high-burden neighborhoods in Chicago. Given the potentially sensitive nature of the subject matter explored in my study (i.e., mental health, racism, trauma, stigma), I took time to establish rapport with the study participants. At the end of each interview, except for five, I administered the Beck Depression Inventory (BDI-II) to assess current depressive symptomatology as an additional point of data. Four study participants did not have time to complete the BDI-II, and it did not seem clinically appropriate to administer the BDI-II to one participant. Participants were asked to provide a pseudonym to ensure anonymity and confidentiality. The interviews ranged from 59–111 minutes in length after participants verbally consented. The following are sample questions from the semi-structured individual interview protocol:

1. How do you see yourself as a mom?
2. What do you find challenging about motherhood?
3. Tell me about the first time you experienced racism as a mother?
4. How do you feel emotionally when you experience racism?

5. How would motherhood or parenting change for you if you lived in a community where you felt safer?

All focus groups and interviews were conducted on the secured UChicago Zoom platform due to the COVID-19 global pandemic and public health guidelines. Interviews were video recorded and stored to the secured UChicago Cloud to assure confidentiality, data safety, and accuracy of later transcription of data. Although the Zoom format automatically transcribes recorded content, a research assistant and I conducted additional verbatim transcription and formatting of text for data analysis.

Analytic Strategy

Research Aim 3

Drawing on a phenomenological approach to qualitative research, I used a hybrid coding process for deductive and inductive thematic analysis to interpret raw data and text on the lived experiences of Black mothers engaged in motherwork in the context of concentrated poverty and pervasive racism (Saldana, 2013).

As a part of my analytic strategy throughout data collection, I wrote theoretical, analytical, and process memos to document and reflect on the interviewing process and what I was actually hearing and thereby interpreting (Saldana, 2016). Memoing is a strategy commonly used in qualitative research that assists interviewers in closely engaging with the data, and it is a mechanism used to ensure accurate documentation and recall of research activities including decision making that ultimately guides the study (Birks et al., 2008; Glaser, 1978; Glaser & Strauss, 2017). I used these memos and discussions with qualitative experts on my dissertation committee to revise questions and probes for subsequent interviews. All my interview data were uploaded to MAXQDA, a computer–assisted qualitative data analysis software, to facilitate coding and data analysis.

In the first stage of analysis, I read through two of the 16 interview transcripts twice and highlighted relevant text and themes related to the phenomenon of study (i.e., motherwork in the context of concentrated poverty and pervasive racism) and the constructs analyzed in the quantitative phase of the study (e.g., depression, racial discrimination, violence exposure). Initial coding at this stage included a line-by-line analysis of the transcripts. During this stage of analysis, I relied heavily on in-vivo coding which emphasizes the actual spoken words or voice of the interviewee to begin to understand the story being told (Maning, 2017; Saldana, 2013). Then, I developed a codebook integrating both data-driven and theory-driven codes using quotes from the text to illustrate each initial code.

To reduce researcher bias and establish reliability of codes, a research assistant was actively engaged in the data analysis process (Sandelowski, 1993). Using the codebook, she and I read and coded the same two of the remaining 14 interviews to assess inter-rater agreement. We compared coding, discussed discrepancies and disagreements, reached consensus, and made edits to the codebook. We then divided and individually coded the remaining 12 interview transcripts. We met several more times to review and compare coding and made additional edits to the codebook. This initial phase of analysis used a more deductive approach with the intention of using data to expand upon specific findings from the quantitative phase of this dissertation study.

In the second stage of analysis, I utilized a more inductive approach to theming the data. My research assistant and I divided and read through all the transcripts for a second time to code for common themes that emerged across interviews. We closely examined interview transcripts for patterns, relationships, and meaningful variation in experiences among participants, for example, mother's age or gender of children. Memos were particularly helpful throughout this phase of the analytic process as it helped me track and organize my thoughts, hunches, and

emerging hypotheses about relationships between concepts and themes in the data (Saldana, 2016). She and I again reviewed each other's coding and discussed discrepancies, especially coding of the two specific interviews we both coded in the first stage of analysis to evaluate inter-rater agreement.

Reflexivity

My positionality as a Black woman, mother, native Chicagoan, and clinical social worker with 15 years of direct mental health experience undoubtedly framed my interview process as well as my analysis and interpretation of these data. Although my positionality (described below) may be viewed as a challenge or limitation of this study, scholars (Becker, 1967; Moustakas, 1994) contend that a researcher could never perfectly suspend their own assumptions and experiences during data analysis. However, as Van Manen (1990) stated "phenomenology projects and their methods often have transformative effects on the researcher himself or herself. Indeed, phenomenological research is often itself a form of deep learning, leading to a transformation of consciousness, heightened perceptiveness, increased thoughtfulness" (p. 163). Larkin and Thompson (2012) suggested instead of trying to seal off our preconceived notions about a phenomenon in a vacuum, we should reveal, process, and challenge our biases to reduce their impact on the research process and thus establish or improve credibility. My engagement of a research assistant in the data analysis process was a strategy I used to challenge my biases. I also engaged in critical reflexive processes through discussions with my research assistant and qualitative experts on my dissertation committee, and through reflexive journaling (Larkin & Thompson, 2012) often and throughout data collection and data analyses.

Positionality

During the winter and spring months of 2021 there was a drastic increase in carjackings throughout the city of Chicago, though it was concentrated in and near my neighborhood of North Kenwood-Bronzeville on the south side of the city. One bitterly cold morning I was sitting in my car in front of my home. I had planned to get coffee, but first I allowed my car to warm up given the frigid temperatures. A police car approached me and a Black woman officer motioned for me to roll down my window and proceeded to tell me that it was not safe for me to sit in my car given the rise in violent carjackings and that I should quickly move along to my destination. During several of my interviews with Black mothers who also lived on the south side, mothers described fear, distress and anxiety related to the sudden increase in carjackings and random violence in our neighborhoods. This is one of many moments I had—before, during and after conducting this study—where I was reminded that despite my level of education, household income, and current status as a student at the University of Chicago . . . I am these mothers and these mothers are me, and we share the experience of mothering in our city.

I am a Black woman, born and raised on the south side of Chicago, and currently mothering a 1-year-old daughter in the same community contexts as many of the mothers who are the focus of my research. I was raised in a fairly large family. My mom had 3 siblings and my Dad had 9 siblings. My parents grew up in the storied Chicago housing projects, Ida B. Wells and the Robert Taylor Homes respectively, and so my extended family included many fictive kin who to this day engender a deep sense of belonging. I also feel a sense of belonging to my community, which for me encompasses the south side of the city and the Black families or *my people* that live within these spaces. Long before I had the language of structural racism or social determinants of health, I believed that my people - those who experienced homelessness,

struggled with addiction or were caught in the revolving doors of prison—were struggling within social conditions that they, as Audre Lorde states, were never meant to survive. And so, when I was able to bear witness to the mothers, grandmothers and aunts in my family surviving I was humbled, moved and inspired to help.

I came to the study of mental health and social work after being rejected from law school but still yearning for a career that would allow me to use what my family called my "motor mouth" to help others. Later, throughout my career, I would consistently hear (even from several of the mothers in my study) that I was naturally skilled at bearing witness to and holding space for people in pain and so a career in mental health was perfect for me. Prior to starting doctoral studies, I provided mental health treatment to adults in Chicago, many of whom were from my community. I worked in a range of mental health settings including my own private practice, community mental health centers and inpatient psychiatric units. I worked on primarily White interdisciplinary teams, with colleagues with limited understanding of the lived experiences and cultural realities of Black Chicagoans. Consequently, psychiatric diagnosis and treatment decisions for Black patients were highly subjective and, from my perspective, biased in favor of White values and norms. These mental health treatment settings were heavily guided by the biomedical model of disease. However, the biomedical model of disease alone is insufficient as it is preoccupied with investigating problems and deficits within the individual rather than understanding the historical, environmental, and social factors that shapes individual mental health. Metzl (2010) poignantly describes what I witnessed as a social work practitioner in *The Protest Psychosis: How Schizophrenia Became a Black Disease* (2010) in which he makes the argument:

> Racialized assumptions and biases are historically embedded into the very DNA of healthcare delivery systems, and shape interactions and outcomes long before the participants appear on the scene (p. 202)

Unbeknownst to many of my White colleagues (and even some of my middle-class colleagues of color), most of my Black clients had a sophisticated race and class-based analysis of their own mental health challenges which they often associated with the experience of "being poor and Black" in America. My clients often felt that they could relate to me as a Black woman, and so, in stolen moments, away from the rest of the treatment team, my people would share their stories and theorize on how and why they struggled with their mental health. A large part of my social work practice was about bringing my client's voices, stories and lived experiences into the often cold brightly lit rooms where I had a seat at the table of medical professional (i.e., psychiatrist, psychologist, nurses) who had the power to determine if a client should be admitted to or discharged from a locked psychiatric unit. In these rooms, at these tables, we had the power to give:

> psychiatric diagnoses [which] can also define, circumscribe, and contain abject populations in ways that harm people in these populations under the guise of helping them (Metzl, 2010, p. 203)

When trying to help my clients understand the experience of depression, I would tell them that it was like wearing a dirty pair of glasses through which everything looked bleak and hopeless. I would go on to tell them that if they engaged in therapy slowly but surely the glasses would become clearer, and they would begin to feel better. Part of the reason I left direct practice was because I came to realize that this metaphor did not hold true for everyone. There was no magical amount of counseling or dose of psychotropic medication that could erase or clear away pervasive experiences of racism, community disinvestment, heightened police surveillance, and community violence exposure. I also learned that for Black and Brown people there is no amount

of individual "progress" (e.g., education, income, health behaviors) that can clean a pair of glasses smeared with contextual risk and muddied with social conditions not meant to survive. One may ask how do I know this.

In the fall of 2018, soon after learning that I had passed my doctoral qualifying exams, I learned that my cousin's 25-year-old son had been shot to death in the Grand Boulevard neighborhood of the city approximately 10 minutes (driving) away from campus. This particular cousin was a part of my fictive kin (Stack, 1997) formed during our parents' childhood together in the Robert Taylor Homes housing project. While I can't say that I was particularly close with the young man who was murdered, I was and continue to be very close with his father – my cousin. So, despite fears of retaliatory shootings and violence that could take place in the wake of his death, I was committed to paying my respects and supporting my cousin as he laid his son to rest. At this funeral in the Burnside community—my community—my parents (both in their 60s) and I found ourselves running and hiding under church pews as six people were shot as the funeral service ended. I was traumatized and in the Twilight Zone as I made my way past shooting victims and police to retreat to my childhood home (adjacent to Burnside) with my parents, and then (still committed to work) I remembered to call my one Black colleague (a fellow south sider) at the University's Chicago Center for Youth Violence Prevention to tell him why I could not attend our scheduled meeting that afternoon.

These are the types of experiences that constructed the lens through which I conceptualized my research study which aims to deepen our understanding of how mothering within community contexts characterized by concentrated poverty, pervasive racism and high levels of violence impacts the mental health of Black mothers. The stories that I shared are about my community and my people and are the reasons why, when I interviewed mothers in my study,

I was consistently reminded of our similarities instead of our differences. When interviewing and analyzing these data I was keenly aware and at times uncomfortable with my outsider-within status. For example, I worried about coming across to my informants as "too familiar" or unaware of the power differential that exist in the researcher and participant relationship. As a pragmatist using a mixed methods research design, I was concerned about giving equal weight to both methods in the analytical stage. Further, as a trained clinician conducting a study about depression, I was attuned to the interviewees affect, range of emotions and overall mental status. While my clinical background is a strength I bring to mental health research, I have to be vigilant about pathologizing the mothers' experiences and strategies they used to cope and survive. Finally, I am new Black mother at a time in our country where Black children and Black bodies are being assaulted and killed in schools and on the streets, and Black mothers are dying at three times the rate of White mothers due to pregnancy. Thus, I felt personally and politically committed to hearing the often-silenced voices and documenting the underreported stories of Black mothers.

Qualitative Study Findings

Every day, across eight neighborhoods on the South Side of Chicago, Black women are engaged in motherwork in the context of concentrated poverty, violent crime, and pervasive racism. Amid the COVID-19 global pandemic and during the last month of the Derek Chauvin trial, I engaged a total of 17 [3] of these mothers in virtual focus groups and one-on-one interviews to help explain findings from the quantitative phase of this study and deepen understanding of the mental health impact of mothering in in these community contexts. This sample of Black

[3] Between the focus groups and individual interviews 17 different mothers participated in the qualitative study. A total of 8 mothers participated in 3 different focus groups, and a total of 16 mothers participated in individual interviews.

women were between the ages of 23 and 50 ($M = 35$), 53% completed some college or beyond, and they all reported a total family income of $40K. All the mothers had at least one elementary aged child (or younger), though collectively their children ranged in age between six months and 25 years old. All the mothers in this sample were born and raised in Chicago and currently lived in their neighborhood for at least one year.

Depression Among Black Mothers

In talking with Black mothers about depression, two perspectives illuminated two ends of a spectrum on which the Black mothers I interviewed made sense of depression. One mother, Keisha, shared:

> As black women, there's no such thing as 'you are not depressed.

Another mother, Renae shared:

> When you look at me and because, I'm black and I'm a mother and don't make it seem like it, but I could still be happy and I could still be okay. So everybody's not going through something at all times of life, every day, all day.

Many of the mothers I interviewed tended to believe depression is an unfortunate, yet inevitable experience associated with living in the Black community. MannMocha, a 43-year-old mother of two boys stated, "at some point or another, you will experience some form of depression, in some state or another." Another mother shared, "[I] don't actually believe that there is no such thing as a woman, a Black woman with children [who] is not depressed." On the other hand, Keisha, a 49-year-old mother offered her perspective on depression among Black mothers stating, "[some Black mothers] allow depression to take over them, instead of controlling it [some people may be] born with [depression] and some may grow into [depression]."

While the mothers in this sample shared differing perspectives on the extent to which Black mothers experience depression, they had similar ideas about external circumstances that

may be associated with depression. When asked what comes to mind when you hear the word "depression," mothers in this focus group sample quickly reached consensus on the idea poverty, unemployment, housing, and lack of resources may cause low-income Black mothers to experience depression.

As a mental health clinician, I am familiar with the standard measures of depression (e.g., Beck Depression Inventory) used in many clinical and research settings, so I was intrigued—though not surprised—by the distinctive ways these Black mothers talked about depression. The Black mothers I interviewed often used the words depression, mental health, and, at times, anxiety and trauma interchangeably to mean the same thing. Black mothers talked about depression as: "overwhelming;" "exhausting;" "a rock in my chest . . . it's not even a knot it's a rock;" "I'm anxious all the time;" "a funny feeling in my body;" "upset;" or "my spirit was just leaving my body. I wasn't really living I was just existing." Similar to previous research, these findings suggest these Black women have unique cultural expressions of depression distinct from Black men that tend to be focused on somatic symptoms or changes in physical functioning (Walton & Shepard Payne, 2016).

All mothers interviewed were asked to describe, in-depth, a time in the last 5 years (2016–2021) when they felt particularly depressed or struggled emotionally. Mothers shared harrowing stories of homelessness, domestic violence, complicated pregnancy and childbirths, loss, and trauma. Barbara, a mother of four, shared she felt depressed while experiencing homelessness, and despite describing a strong familial support system, she gave birth to her youngest child while living at a shelter on the southside. MannMocha described a recent experience of homelessness as "traumatic and painful." Allison, a 33-year-old mother of an 8-

year-old daughter with autism and an 11-year-old son whom she described as a "politically correct kid" who loves the latest Malcolm X documentary shared:

> Actually, [in] 2016, I was at my lowest of my low points. I was [in] an abusive relationship with their father. We were having problems with finding places to stay, and it was really, really hard. Because—who could I turn to? I mean, I really couldn't tell all my friends or family members that my kids' father was putting his hands on me. And I still loved him. Because, you know how that goes, and it's just, like, I was in a dark place. I mean, I got evicted from my apartment not because I wasn't paying bills, [but] because it was moldy. And my doctor sent a note saying that I needed to be moved to a new unit, but Parkway said that it was me and I wasn't paying rent. And they evicted me. And then, like, I had to figure out what I had to do, where to go with me and my kids. It was like, my kids' father, even though we're in an abusive relationship, he that's who watch the kids so I could work.

Allison described this experience of depression as a "downward spiral" and "just hard" while also mentioning she "had to keep a smile on [her] face" for the sake of her children.

Niecy, another young mother, with an 8-year-old daughter, shared:

> I was in an abusive relationship. And I had just got out in 2016, and that was very . . . you know. I knew that I should have got help, like talk to a therapist or something like that. But I just didn't. I just held everything in and every day I just, you know, took it a day at a time. And I was just able to keep a smile on my face. Some people didn't even know what I was going through because the way I have presented myself . . . I had gained relationship with some of them people [at the new job], so it was just like they didn't know until they started seeing bruises, you know. Bruises on my face and little things like that. But even when I [had] bruises on my face and I tried covering up, and things like that. They were just amazed—and they [were] just like, "You're going through all this and, how you able to maintain? How are you able to go to school? How you able to work? How you able to be a mother?" They'd just be like, "wow." And it affected me a lot because it was just, they didn't know that I was really hurt. I was damaged. I was really bad [in] 2016 when I left that situation. It was just—it got worse, and a lot of people didn't even know. And they didn't even notice. Some people didn't even notice. But it was really bad. It was just, I wasn't suicidal. But it was thoughts, you know, that came to my mind. Because the only reason why I wasn't suicidal [was] just because my daughter. I know I had to live for her. So, it was really bad, and I just had to take it a day at a time, and I had to just heal. I just had to heal myself. Well, I prayed. Like, I just prayed. You know, I was, I was grateful. I was thankful that I was out this situation, but it still damaged me because I was in it for so long.

Niecy's story described how she experienced and expressed depression during domestic violence, starting a new job, and mothering a young child.

Two mothers told stories of depression in the last 5 years related to maternal health challenges. For example, Keisha a mother of four girls shared:

> The last five years, I was struggling so emotionally because, like I said, I was going through so much around that time frame because, like I said, I had a set of twins, and they were premature. 2 pounds 12 ounces. And I was going through a lot with doctors' appointments. And one of the twins actually was the biggest, the biggest eye-opener, the biggest—I don't even know how to say it, but she had a feeding tube. So, we was in and out the hospital, nurses coming to the house. I was just so overwhelmed, overwhelmed.

Poor physical health outcomes emerged as a common experience among this sample of mothers; however, mothers did not talk about physical health challenges in relation to depression. Rather, to describe experiences of racial discrimination in healthcare settings or in relation to stress associated with living in constant fear of violence.

These stories of depression describe different expressions, experiences, and circumstances associated with depression among this sample of Black mothers. They also illuminated the persistent struggle for many low-income Black mothers to access basic needs and resources (e.g., housing, employment, childcare, healthcare safety) in these eight southside neighborhoods. For example, Niecy was in desperate need of a safe housing option when trying to leave an abusive relationship with her daughter's father, but she was unable to find resources in her predominately Black neighborhood. She shared:

> Yeah it wasn't in the community. I had to travel really far. I had to travel really far. It was up north. I had to travel. I was going back, and I was still in school, and I was working, and I had to drop my daughter off to daycare as well. So, it was rough. It was really rough.

At the time of the interview she stated, "I'm still trying to get therapy with my doctor. I'm trying to schedule an appointment and ask her if she could like sign me up or something. I was gonna call her up for me and my daughter actually."

The mothers I interviewed openly shared distinct experiences and expressions of depression, but they also discussed the fact that many Black mothers, including themselves, typically do not express depression at all. Mothers discussed the role of stigma and the fear of being labeled or judged as a reason why many Black mothers may "just hold everything in" and thus deny being depressed. Mothers also discussed the idea many Black mothers feel the need to present as a "strong Black woman" and wear a "mask" to hide feelings of depression. At the end of each interview, with the exception of five, mothers were screened for depressive symptoms using the BDI-II. Specific scores are reported in Appendix G.

The Strong Black Woman Stereotype

All interviewed mothers, across ages, expressed intimate familiarity with the strong Black woman stereotype (SBW)—a race and gender based psychological schema—which, among other things, suggest Black women should be independent and self-sufficient, care for others, and exhibit strength in the face of unrelenting adversity. Similar to previous research on Black women's mental health and depression, many of the mothers I interviewed seemed to internalize the SBW stereotype as central to their motherhood identity (Hills-Collins, 2000). When asked "what does it mean to be a Black mother," mothers responded with "powerful," "determined," "resilient," "strong-willed," and most common "strong." Keisha stated:

> I say powerful because no matter what we go through, we make our toughest times look easy. We're going to get through it all. We may scream. We may get tired, want to give up. But giving up is never an option because we got to show our kids a better way. So, I say I say powerful, determination, you know.

Nicole a 42-year-old mother added:

> I definitely would say the same thing. I will say that we are very strong individuals. Very determined. Always knowing how to overcome the struggle. I believe Black women have learned to play many roles [chuckle] and learn how to make a way out of nowhere. You know, we are the ultimate sacrifice, especially when it comes to kids. I know me myself, no matter what I go through, my kids will never go [through the] struggle that I'm going

> through, you know. Because I'm gonna do my darndest to, you know, for them not to have to go through none of my pain, my struggles. Because they're kids.

One aspect of the SBW stereotype, based on previous research, is the idea Black women minimize their feelings and emotional struggles by "wearing a mask" (Beauboeuf-Lafontant, 2009). Ram, a 39-year-old mother, likened the SBW mask to putting on a smile and said, "like putting on a show, or a wig. . . . You put it on when you leave the house, you come back home and take it off. I'm putting it on [a wig] every day."

Niecy described motherhood as:

> It's just so much that we have to have on our shoulders. Black moms, we put everything on our shoulders. We hold everything together. We have to, you know, no matter what we go through, no matter what we face personally, no matter what obstacles we go through in life, we have to still put a smile on our face. We still have to go around people, go around, be around our children and be happy, even if we're not happy. We just put on that, you know. We just sometimes have to be someone else to just get through days.

Allison added:

> When we want to cry, we got to put on that mask. Even when you're in your lowest of low. Because no matter what, the baby's looking up at you like, "Mama, are we doing that?" You know, "What's the next move?" We have to be the other person.

While many mothers internalized and seemed to be motivated by the SBW stereotype, some of the mothers were more cognizant of the "myth" and the challenges associated with wearing a mask, including worsening depression and a lack of engagement with or trust in potential sources of support. When asked how she navigates the SBW stereotype, MannMocha irately stated:

> That's a myth. That's a fucking myth! There's no—it's not real. There's no such thing as a strong, independent Black woman. You should not be being all of that. You should not have to be all of that. That's not real. And I hate that that's the dumbest shit. I hate it . . . Because we don't want to admit when we wrong. We don't want to admit when we fail. We don't want to admit when we need help. We don't want to admit that we're low.

She elaborated:

> You feel like you're the only one going through the shit, you know what I'm saying. And then you can't be weak going through the shit. You can't be vulnerable. You can't be feminine. You can't be a woman.

MannMocha's sentiments about the SBW stereotype highlights the centrality of stereotype to one's gender identity. Further, MannMocha's emotions and affect during this part of our conversation illustrated the stark contrast between those Black mothers in this sample who have internalized or accepted the SBW stereotype as a means for survival and those who have been dehumanized by it. Preliminary analysis of data, aside from the aims of the present study, suggests Black mothers' perception and internalization of the SBW schema may meaningfully change over time or with age.

One mother's story describes a range of experiences and processes through which Black mothers may come to internalize the SBW stereotype and its potential harmful effects. Skylar is a 24-year-old mother, engaged to be married to the father of their 3-year-old daughter and a 1-year-old son. She spoke at length about what she described as a "terrible" first pregnancy while living in Pontiac Illinois, a small town west of Chicago. She lived in Pontiac with her fiancé who continues to be her biggest source of support. She described her pregnancy:

> I couldn't eat. Everything, liquids as well. I couldn't even have ice chips. It was that bad with me. I was puking up ice chips like, of course, it turned to water, but I just have a cup of ice chips, and taking down the whole cup, I'd throw it up. I couldn't have like. It was like. The only way I could keep something in, it was through fluid, going through tubes in my arm. Cuz anything else, it was coming back up regardless. Everything. Anything. It was nothing I could eat with her. Nothing. I couldn't really eat until I (unintelligible) almost seven months with her. So, almost the whole pregnancy, I couldn't really eat. And they like, okay you gotta eat because then you automatically not gonna make it. You got to eat. You gotta drink, need fluids. I was dehydrated for the whole seven months. I was going to the hospital on a regular. It got so bad, I was going to hospital, I had to go no desk, none of that. They saw me, they just opened the door. And send me to my room. I had a room. I went to the same room in the hospital almost like, no exaggeration, I was going to hospital like every three days just for fluid.

Skylar shared that she had not been able to gain clarity on the exact cause of her inability to keep food down and chronic nausea. Meanwhile, she continued to work as a cashier at Walmart, but as her pregnancy progressed, it became harder for her to work because she was physically "weak." She shared:

> never got no medical leaves, never. They just strictly like, Okay, the job still needs to be done. You can't keep coming to work. They told me like, you can't keep coming to work. You sick and you're not really on the register.

One day at work Skylar went to the bathroom. Water was dripping from the sink and she slipped, fell, hit her head and went unconscious. In the process of falling, she urinated on herself, which is common among pregnant women, and as a result of the fall she had a seizure. Her employer knew that Skylar had been previously diagnosed with Epilepsy and so to avoid any liability for the fall, management reported to the ambulance that "an employee had a seizure and she's in the bathroom on the floor." Angrily she stated:

> They didn't tell them what I told them, which was, when they asked me what happened, I said, look at the floor. Look at my pants. I was soaking wet. I slipped and fell and went unconscious. And then had a seizure after the fact. Because I just hit my head. So yeah, I did have a seizure, but originally that's not what happened. I remember falling because I tried to grab the sink, and that was wet. So nothing could have broke my (unintelligible). That lady, I kid you -- that lady -- she was Caucasian. She told the ambulance that I had a seizure. She never mentioned nothing about that I told her I slipped and fell.

Skylar spoke with an attorney, to no avail, in attempt to pursue justice for her experience at Walmart. When probed further on how racism played a part in this experience she stated:

> It was another girl that worked there, and I don't know her race, but she was not Black. And they never had a problem with her, where she was calling off, when she was going to have her bathroom breaks, and even sitting down. But with me, the same situation, they was making it seem like I couldn't do that. She got leave for her pregnancy and everything. When she got ready to have a baby, she got the leave and everything . . . I didn't get nothing. I had to resign.

At her wits end, she took a two-hour train ride to the southside of Chicago in hopes of receiving better healthcare at a hospital outside of small-town Pontiac. Here, she sat in a

southside Chicago waiting room for hours in pain "crying [and] steady puking." By time she got to the back for actual medical care (where she eventually learned that she had an untreated pancreatic infection) she shared:

> So after waiting still in a room while they ran tests. . . .They come in there and they say, I don't remember, of course. Because that was a little bit ago, exactly what was said. But, in other words, they said, you could have died on the train on the way here. They said it's no way possible. They don't even understand how I even made it from Pontiac to here on a train.

She went on to say:

> I felt so bad even thinking. I asked them [healthcare providers at Mercy] to terminate my pregnancy. I really did. I asked Mercy [Hospital] that, and it was like, "It's too late. You're soon to be due." And I was just like, "I cannot do this no more." Like I've been going through this for seven months. I am in so much pain. I'm like, if this is what it is like, I have to go through, I'm just ready to give up.

When I asked Skylar about how she as a Black woman and mother emotionally navigated these kinds of experiences she shared:

> With a lot of stuff, we are seen as, "oh you're overreacting," "you're doing too much," or "you know it wasn't that serious."

Skylar's place of employment, two different healthcare settings, and her failed attempt to pursue justice (or at least be heard in the court of law) became environmental pathways through which she, over time, received messages that her voice and lived experiences "aint matter no way." Further, she adds:

> And how I been raised and different stuff I've seen—it seems like we just always supposed to bounce back. We supposed to hold it together and deal with it. Like, you just have to deal with it. It just is what it is. . . . I feel how I feel, but I can't do nothing about it, so, hey, just suck it up.

Here, Skylar, says that she was "raised" and socialized to minimize and ultimately ignore her feelings and righteous pain. Through tears, as she looked embarrassed, she stated, "Look I'm always crying." She went on to describe confusion, tension and anguish she currently feels

whenever she cries in front of her daughter because, as she explains, she never saw her own mother cry until she herself was an adult and she wants to raise her daughter differently stating:

> It's just really hard, though, it really is. I'm still trying to figure out like okay, I need to find a balance, I need to figure out what. how to go about it

For Skylar and many of the mothers I interviewed the SBW stereotype shapes the extent to which one identifies, experiences and expresses depressive symptoms. For example, Skylar shared:

> I can admit [I have], a lot of stuff that go on, I live [and], I completely shut down. I don't want to talk. I don't want to do none of that. I just want to be left alone. I literally just literally—I know when I say literally, "leave me alone," I mean leave me alone. . . . I'm just so used to keeping stuff to myself, like it has to be hidden. . . . I don't like it, but it's just one of those learn[ed]—it's a it's a habit. It's something I learned, and it stuck with me.

These data also suggest that the stereotype is passed down intergenerationally and reinforced by insidious forms of cultural racism (e.g., media images, stereotypes, tropes, etc.), and through experiences of racial discrimination. For example, when asking Skylar how the idea of being strong relates to Black women she shared:

> no matter what a woman has gone through, experienced or whatever, I think we just still supposed to be, it's just [an] image. That we are just supposed to be.

Normalization of the SBW stereotype also seemed to be a barrier to many of the mothers in this sample engaging with other mothers and potential sources of support. For many of the women, the drive to be strong and just "suck it up" precluded seeking support and trusting others to be available and able to help. All the mothers interviewed were asked to share advice with younger mothers in their communities about "how to get through." Across nearly all interviews, mothers encouraged younger mothers to "talk to someone," " ask for help," "put your own mental health first," "stick together and be there for one another," and know that they are "not alone." Again, the tension for these mothers lies in their recognition that social connection and,

at times professional support (e.g., therapy, counseling), is critical to achieve wellness and well-being. At the same time, they themselves struggle to be vulnerable, trust others with "their business," or initiate connection with others. This phenomenon is particularly challenging for Black mothers in this sample because their financial status often caused them to move a lot which made it difficult to feel a sense of belonging in one's neighborhood. All of these women live in high-burden neighborhoods where most public community mental health centers were closed in 2012. At the point when these or other low-income Black mothers are willing to be vulnerable and seek mental health treatment there may be few options in the community.

Community Contexts

Although many of the previous stories of depression may be viewed as representing individual-level risk for depression (e.g., income, education, domestic violence), these Black mothers had a keen awareness of how their intersecting social identities—race, gender, and class—intertwined with contextual risks either directly influenced their experience of depression or shaped their access to needed supports to achieve some level of reprieve.

Race(-ism)

Experiences of racial discrimination was measured, analyzed, and emerged as a statistically significant neighborhood stressor associated with worsening depression among the sample of Black mothers in the quantitative phase of this study. As such, I asked Black mothers to describe their experiences of racism in the context of their neighborhood and its impact on their mental health. Of note, I conducted these interviews in April and May of 2021 during the trial of Derek Chauvin, a White police officer who murdered George Floyd in broad daylight on May 25, 2020, in Minneapolis, Minnesota (Hill et al., 2021). The murder of George Floyd was the catalyst for global uprisings and protest that continue to this day demanding the United States

acknowledge, in policy and practice, Black lives matter and end state–sanctioned violence toward Black people and Black communities. While racism continues to be a pervasive experience and reality for Black Americans, 2020 thrust conversations on race into the national spotlight unlike anything witnessed since the 1960s Civil Rights Movement, so my conversations about racism and mothering Black children on the southside of Chicago were timely, insightful, and at times as one mom described "therapeutic."

Black mothers across these eight high-burden neighborhoods in Chicago experienced and talked about racism in some similar and differing ways. Some Black mothers initially denied ever experiencing racism and the story of Sasha, a recently divorced mother of 5 and 6-year-old daughters helped to explain this phenomenon. Sasha described herself as "the person that doesn't want to say everything is racism" and instead prefers to think the collective Black community can "decide to do better." When probed further, Sasha described a tension between acknowledging the ubiquitous nature of racism in her lived experience as a Black mom in Chicago and outright denial of racism as a means to protect her mental health. She stated:

> If I was in an ideal world, if I had power to do something, like to affect a city, then that's what my heart's desire would be. For us just not use that as a scapegoat any more. But in my reality, what I feel like, a lot of it does have to do with racism. I think I'm still conflicted because a lot of me is "what's your reality?" versus "what you want it to be?" Right? And, sometimes, I feel like, "Well, if I disregard what I want it to be, it'll be dreary, right? And it's like, "Oh my gosh, this is it." So, it's like the hopelessness. And I don't want that, but I also don't want to live in a fairy tale land to where I don't see what's going on in front of me. So, again, it's like, what's that balance? And, sometimes, what I'll do is, instead of facing what the reality of it is, it's just like, "Well, let me just take mine up and let's move somewhere else. Like I'll just avoid it all together."

Other mothers I interviewed initially denied experiencing racism as they assumed I was directly asking if they had experienced a child or family member being killed by the police. Melissa, a 49-year-old mother of three explicitly talked about the George Floyd murder in her reflection on racism:

> You know, I tell you I watched that trial. And it was a lot of things I did not see. And it just hurts me because I have a 21-year-old son. And people say I shelter him. I don't shelter him. I don't know what I would do if somebody killed my son. I wouldn't be no good. I wouldn't be no good. I wouldn't stop until—every little bit of me is—justice has been served.

Renae, a 43-year-old mother of two sons, stated:

> I haven't personally experience[d] them doing anything to me. But if they did something to you, then they did something to me. Like I haven't experienced … the police doing anything to the kids, but I have boys. So if something happens to your son, I have to [feel it] because that could have been me

Mothers shared stories of inter-group racial discrimination, ranging from White people "clutching their purse" when they got on the elevator in the workplace to teaching their children how to "conduct themselves" and explaining (i.e., racial socialization practices) to their Black sons why they were referred to as "niggers" and "gangbangers" by White boys during a school trip to the zoo (i.e., racial socialization). Some mothers also shared experiences of intra-group discrimination such as being told their children "act White" or that they are "bourgeois because [their] kids have stability."

Black mothers in this sample were asked to reflect on the realities of racism for Black mothers and children. In response MannMocha stated:

> I'm 46 and its driving me up a wall I like I'm telling you, I have not felt. You know, you know the phrase felt some type of way, I have not felt some type of way like this, like this is, in my heart, like, I feel some type of way about this, some type of way about us still being murdered, I feel some type of way that [the] police are being brutal and aggressive with children and arresting kids and macing kids and putting kids in handcuffs and shit now you know.

MannMocha also described her process of racial socialization practices with her children sharing:

> The moment, that could be the life changing, life threatening, or lifesaving moment and it's serious like that now, you know [what] I'm saying. And I hate that because I feel so much angst, anxiety, and anxiousness all the time, [and] I don't want to put that on them

> but it's real you know. I don't ever want to put them in a position where they're like blinded

Shay, a 28-year-old mother of a 10-year-old daughter shared that thinking about racism makes her

feel scared. I probed "scared of what?" and she responded:

> Really that my daughter will have to deal with it. Like I can't protect her from everything because I know [I ain't always going to] be there. She got to deal with it. I dealt with it, but I am not ready for her to deal with [it].

Renae talked about a recent television show she watched highlighting racism in healthcare, and

the show has caused her to feel "scared" and mistrusting of healthcare stating:

> That's all you hear like every day that's what they talking about now so it's like it gives you something else to think about that I didn't have to worry about 10 years ago that I have to worry about today. It's just it's just different stuff that you have to, simple stuff you have to worry [about] that you have to think about. . . . I don't want to be the person that complain about it I want to help figure it out.

Sasha, the same mother who explained how she typically denies the realities of racism to protect

her mental health shared a memory of being called a racial slur by a White man when she was

pregnant and driving outside of her neighborhood. She shared:

> I was in a car driving, I just wanted a salad for me and my unborn child. And I don't know if I was driving too slow, but I remember him zooming past in a truck, and at first he like stared at me. It was a very like, "What?" And then I remember he met me at a light, and he…rolled down his window. Ok this is weird, and then, when I kept going, like we were both driving, he rolled down his window and he yelled it [nigger]. I was like, what did I do? Like I was so lost . . . like I remember having to pull over. I was like, "Come on, it's not that serious," but it did something [pointed with her hand to her heart]. Because in my head, at that time, I thought . . . you're not just talking to me, but then [you called] my kid that. Like that's how I started feeling. It [was] beyond just me, in that moment, so . . . I felt like [they're going to] find me hanging from a tree, like that's my mind went that far.

Place

Many of the mothers I interviewed experience and make sense of place—the

neighborhoods and communities in which they live—through a racial lens. In other words, these

mothers understand the structural characteristics of their neighborhoods and their everyday experiences in them as inextricably linked to their racial identity as Black mothers. For example, Nicole, a mom of four girls, reflected on feeling depressed after having to leave a job because she could not arrange consistent childcare for her daughters after school. When I asked if she felt racism played a part in that experience, she stated:

> If you look at a lot of the schools and the Bronzeville, Oakland, Kenwood community, Washington Park. Our kids don't have access to what the kids have available in Lakeview, Lake Park, Lincoln Park. And, downtown . . . you know, the better schools, the magnet schools, the Disney schools. The access is totally different. Their parents, they can drop their kids off. Because, guess what? The majority of them are White. White, they can drop their kids off at a morning program, and schools have everything they need for their parents to bribe and be successful. They have afterschool programs. We over here are fighting for books. You know, we over here are fighting for our kids to just be in a clean school even. And those parents, they have it all.

Tabatha, a 38-year-old mother of two, talked about a period of time when she was caring for her niece and nephew (i.e., other mothering) who had been living in a suburb of Chicago as a moment when it became clear to her the ways in which racism permeated her everyday life as a mother. Tabatha shared when she was supporting her niece and nephew with school work, she realized how much "better prepared" they were academically for high school than her daughter who was older in age and unfortunately "struggling" in Chicago Public Schools. She went on to discuss the differences in schools and access to resources between predominately White and predominately Black neighborhoods describing the inequity as "flat out not right." Tabatha's reflection is especially significant as it illustrates how class intersects with race and simultaneously shapes the everyday experiences of Black mothers, as she explains:

> The messed up part done this, if I want some good produce, I have to go to a store that's catered toward middle class Blacks or White people to get the best. To get the best, I got and I actually cook a lot. And I have to go to a middle class black store or a Whole Foods or something like that in the White neighborhood to get, you know I'm saying, that stuff that's good.

In addition to inequities in access and resources, community violence emerged as a dominant experience in the everyday lives of these Black mothers and a significant factor through which we may deepen our understanding of the mental health impact of mothering in the context of a neighborhood characterized by concentrated poverty and pervasive racism.

Violence Exposure

Exposure to community violence was measured and analyzed as a neighborhood stressor associated with worsening depression among the sample of Black mothers in the quantitative phase of this study. Surprisingly, exposure to community violence did not emerge as a statistically significant predictor of depression. However, every Black mother interviewed in the qualitative phase of this study described varying degrees of stress, sadness, worry, and fear associated with keeping their children safe from violence. The story of Tammy exemplifies how many low-income Black mothers' mental health may be impacted by their lived experiences mothering in Chicago neighborhoods characterized by socioeconomic disadvantages and high violent crime rates.

Tammy is a 37-year-old mother of a 10-year-old son whom she describes as "juicy" and beams when talking about how much she loves to squeeze and kiss on him. Tammy has lupus which created a struggle for her to conceive and so her son "is a gift" to her. In my conversation with her, even through Zoom, it was evident she loved being a mother and watching him grow. When I asked her how she sees herself as a mother she replied "I see myself trying to fight my way out the jungle, so my son can be safe and I'm being stopped because there's no help." She said she feels "a little weak" that she cannot afford to move to a safe neighborhood or pay for him to engage in some extracurricular activities that may help to keep him safe. She shared with me she has not had a good night of sleep or felt safe in her home since a bullet went through her

son's window in the middle of the day just a few months ago. At the time of the interview, the bullet hole and semi-shattered glass remained in her son's bedroom window as a daily reminder she is not safe. She also described hearing "15 shots" outside in the back of her apartment building where many children in the neighborhood play. Tammy said her son feels safer at his grandmothers' house though it is located in a similarly structured neighborhood, also on the southside of Chicago, and he recently told her about a shooting he heard while at his grandmother's house. From Tammy's perspective, the violence that occurs in her neighborhood is "unacceptable" and its persistence has everything to do with the fact the neighborhood is predominately Black. She shared, "I just feel that you can't do what they do here in Beverly. You can't do what they do here in Orland . . . It's just you don't hear that happening over there in no White people areas."

She added:

> That's not fair. Everybody wants to live decent. We want to live in a decent area. We want to have nice blocks. Want to have nice parks. And we want a lot of community centers where kids can go somewhere and do something with their selves. It's like none of that.

Tammy, like other mothers I interviewed, shared physical and mental health consequences of mothering under the aforementioned conditions. Tammy shared she has felt depressed for years and her body has prematurely gone into menopause as a result of the stress associated with her experience of motherhood stating:

> You know my lupus has been calm, but when you got stress going on and in this build up and you constantly worrying, and you trying to make ways you keep going back and forth to the building management, they ain't hearing you. It's hard to sleep. I'm not getting proper sleep.

Several mothers I interviewed talked about the constant fear of violence specific to Chicago and often think about leaving the city to keep their kids safe. For example, Sasha, a teacher and mother of two young girls shared:

> I'm scared. I always say that I know I'm not gonna live in Chicago all my life, and I really feel like the South is where I want to be. Like, I always say that. And people are like, "No, you're not. You're not going nowhere." But I really, really am. I'm just scared. Like I remember instances, being in high school and [being] a young Black girl walking to a bus stop. I just don't want that for them. And I don't know if it's because I'm in it, we all feel that way, right? Like I don't know if that's the world everywhere. Like, maybe it's not just Chicago, and you know how Chicago is portrayed on the news. Like, maybe that's it. You go to Chicago. And so I'm here, and then I'm hearing that on TV, and so it's—I just want to see what else is there. Can I provide better? Is there better for them as young Black girls?

Melissa also talked about leaving Chicago because she does not like "living in fear." She referenced the recent increases in car jackings in Chicago and police violence as two types of violence she fears and causes her anxiety. She elaborated, "I have anxiety when I'm out driving, especially with my kids and stuff and I don't like to feel like that." I asked how long she felt that she was living in fear and she shared:

> When all that carjacking and stuff started, it was like this. And then it was just like, with my son being 21 years old, I'm like, oh my God. I couldn't imagine stuff that happened to George Floyd and Daunte Wright and all these other people. You know, this mistaken identity, and you know that I just couldn't live with stuff like that.

Black mothers in this sample tended to describe depression as a weight, and in contrast, when I asked them to imagine mothering in a safer community, most of the mothers open mouth exhaled at the thought of them and their children being safe. Lisa, a 37-year-old mother of four children smiled and said:

> That would be a relief! That would be. I could get stuff done in the house. I could be laughing little bit. Sit down and watch movie a while or TV and no noise but kids arguing with each other.

Another mother shared:

> I [would] feel a lot better if I was in a better and safer community. I mean, you still, even in a safe community, you still have to, you know, that's normal. But it won't be—it won't be so overwhelming. For, you know, trying to figure out, once your child leaves or walks out the door, if they are going to come back, or you know, it's just a lot now.

Other mothers described sentiments of "relief," "ease," "calm," and "happy" at the thought and vision of safety. As one mother stated, "I need to be able to breathe. I need for them to be able to breathe."

Community Belonging

Community belonging was analyzed in the quantitative phase of this dissertation study, and conceptualized as feeling a sense of belonging, loyalty, and similarity to one's neighbors and a feeling a desire to living in one's neighborhood. Community belonging was not found to relate to depression, however qualitative interviews with this sample shed some light into how Black mothers make sense of community belonging and social connections within high burden neighborhoods on the southside of Chicago.

Some of the mothers I interviewed had only lived in their neighborhoods for a little more than 2 years - due to experiences of homelessness or financial instability—and so the current pandemic and stay-at-home orders precluded them from connecting with others in their residential neighborhood. When asked about perceptions of community belonging, one mother, Allison, talked about feeling a sense of belonging in the neighborhood because it's a "Black community" stating:

> I say, in a sense I belong, cuz I mean, this is the black community. I don't have a problem with it. But as far as my morals, my goals, and how I am, I say no. Because some say it's crazy the fact that my kids go to museums versus chucky cheese. Or we'll read a book. We watch documentaries. "Oh that's boring stuff. Your kids actually like that?" Yeah.

Tammy, who had lived in her neighborhood for more than 15 years, talked about the violence she has experienced (burglarized home and car) as a barrier to her feeling a sense of community belonging. She shared:

> No, I don't I still like when I first moved down there my car have got broken in maybe three times um and you would think like the neighborhood know you because you know I've been East all my life, since high school. I went to South shore high school, so you think like even if everybody watching you, and if you live in a community for like. 20 some 20 some years you feel like you should be a little safe I'm not gonna say like life just peaches and cream, but you feel like you have some kind of respect in your neighborhood I don't I don't feel that. Not, when my car keep getting broken into you know. You know my apartment got broken into you know somebody broke into my home so it's a lot of bad stuff has been happening since I've been over here.

Barbara has lived in the same community on and off since childhood, and generations of her family (including most of her children) attended the same neighborhood school. Barbara, shared the she feels a sense of belonging stating:

> Everybody know that's my daddy. I walk these streets, everybody know whose daughter I am. They know who my grandmama is. They know who I am. They know me. All that gangbanging and stuff I ain't got nothing to do with that, baby. "Y'all got the wrong one. Y'all know who my people is." My people got it going on.

She seemed to take pride in the sense of belonging and safety she feels in the neighborhood as evidenced by her allowing her 5- and 12-year-old daughters to walk to the local gas station stating "all of them know my kids, the security guard, the cashier and the manager know my kids so it don't be no problems." These two stories suggest that community belonging is related to feelings of safety in the community.

Another mother, Melea, understood community belonging to mean connections or familiarity with others in the neighborhood and she worked at a neighborhood school so she "knows everybody." She also understood belonging as one's right to live in the neighborhood stating:

> I feel like I belong here. I feel like anyone, like you or you or you. Anybody should be able to come here and feel belong. Like, you can't tell people where they need to live. . . . As long as they come here, pay their bills, and their rent, and don't cause any harm, and . . . be a bad citizen. You know, everybody should be able to welcome, if you're black, white, Asian,—as long as you come and you being a decent neighbor, you should be able to belong here.

Interestingly, four of the mothers (including Melea) who described feelings of belonging or seemed more connected to their neighborhood all lived in the same neighborhood—Bronzeville. These four mothers did not speak of specific neighborhood characteristics that may cultivate a sense of belonging for Black mothers. However, my personal knowledge of the neighborhood suggests that in spite of the widespread violence it is a neighborhood in which there is financial investment and opportunities for community and civic engagement (disproportionate to the other neighborhoods in this sample), active local school councils and rich cultural traditions. Of the eight neighborhoods sampled in this study, anyone familiar with the southside of Chicago could have predicted that Black mothers would feel a sense of belonging or connection to Bronzeville.

Overall, most of the mothers I interviewed did not talk about or describe a sense of community belonging as it was conceptualized in the quantitative phase of this dissertation study, but a theme did emerge across interviews that seems related to the construct of community belonging and may have implications for mental health. First, many of the mothers seemed to experience a sense of loss or sadness related to their experiences of what many Chicago neighborhoods or communities "used to be." Many mothers used the language of "back in the day" to reference times where community members provided tangible support to each other, everyone knew each other, and most importantly women and children were safe in the community. For example, Niecy shared:

> A lot has changed. Like when I was a child, I was able to go outside, and I was able to do a lot. Like you know, the neighborhood, everybody looked out for one another, you know…When I was raised , [and I] lived in the projects, and when living in the projects my mom, she can just she can go to the store, and her friend be right there outside watching us. Like everybody watched out for, look[ed] out for each other. Everybody, you know, made sure everybody was good, but it's just like now, it's just different. You got to make sure the neighborhood don't have nobody in the basement or something like that. Like it's scary out here. You have to really get to know people now. Instead of just like, it's just people not, people not as friendly.

MannMocha added:

> We always had family, we always stood up for each other, we always came together in times of need, and we always work together for a common goal with each other. Whether it's in the community, whether it was in a business venture. Whatever the case may be, like I said, all the misters on the block knew all the children on the block. I remember, being a latchkey kid but I was never alone.

Also related the safety of children Tammy shared:

> It's a park right behind, back [of] my house that we built up in the back end. Because of new people in the neighborhood, you have to go back there literally [to] watch your kids. And it shouldn't be like that. Because you know old school, you go out there and play. I [could] go out there, if I [heard] a kid crying, [and say] "what's going on?", "what's wrong?", "you did what?" Now, we can't do that no more.

Findings suggest that these mothers have experienced a loss of community which may be more related to the universal sentiment of nostalgia or longing for the past than a feeling that should be pathologized. As communities and society at large continue to modernize and depend on connection through social media for example many, regardless of race or gender, feel a sense of loss. Feelings of loss of community and connection are further complicated in the context of a global pandemic. Further analysis of this phenomenon among this sample of Black mothers is outside of the scope and aims of this dissertation study.

COVID-19

The COVID 19 pandemic has been described as "the great equalizer" because regardless of income, fame, or age everyone was vulnerable to contracting the virus and everyone's lives

were impacted by the shelter-in-place orders. However, women who are mothers were particularly burdened with the responsibility of care work for children as schools across the country closed and parents had to juggle working from home with supporting children's educational needs (Green & O'Reily, 2021). Further, low-income Black mothers bore an additional cost and burden associated with the COVID 19 pandemic given already existing inequities in health, wages/wealth, and access to needed supports including adequate childcare (Mein, 2020). All the mothers interviewed were asked about changes in their everyday lives since the start of the pandemic. Sasha shared:

> Just small tasks that were already hard as it is, became like 4 times harder. And then in December, my father passed, which is the primary resource for our home at that time. So a lot of changes . . . and then, as a mom, right? You're expected to keep the train moving. So just trying to make sure my own personal mental health and emotional health was intact, as well as for my children, right? Checking in on them with all the variants happening in their life. Yeah that's what the pandemic has been for me. . . .I'm a structured person, so when you throw things in like this, it really does throw me off. So making sure that I was able to keep everything flowing, right? With a smile on your face, of course, so that [the children are] not too [impacted].

Another mother lamented over the arduous nature of everyday life in a pandemic adding:

> A lot more task [are a lot] more tedious because you have to do all this preparation and then sanitizing gel and mask and covered up to [go] here and make sure you stand six feet apart and we don't have our own personal transportation so public transportation and you know all of that so yeah I think that part was the most drastic change for us.

Mothers in this sample described changes in several areas of their lives that impacted their mental health including employment, housing, and child wellbeing. Related to employment and housing Niecy stated:

> I was homeless for about 6 months . . . it was a real struggle for me and my daughter . . . [I] was in a real rough place at the time. It was real rough for us, you know. It was just too overwhelming because I was just so stressed. I just, I just broke down, I was going I was really going through a breakthrough. So COVID really, it affected me a lot, because I thought that, you know, I had a plan. Once I finished school, I was already working at a law firm, but once I finished school, I was going to go straight into being a para-legal. And you know I had everything planned out, and then COVID hit, and I was just like

> man, you know, I was just, I was questioning myself and everything. I was just like, you know, is it meant for me to be a paralegal? Like is it, is that's not what I should be? Or you know, it was just, it was just a lot, you know. It was just, it was real stressful and overwhelming. And it was really it was really, it's really tough.

When asked about how their lives have been impacted by the COVID-19 pandemic most mothers thought first about how their children were faring during the pandemic. For example, Allison shared:

> It's actually quite harder, because my daughter is autistic and so she needs routine. And so it's just like before, like okay, yes she had issues, but now is just like… and like trying to explain to kids there's a pandemic, because they just think they are going to wake up one day and it's over. We're going back to our regular lives. We're going back to school. And so it can be overwhelming, frustrating, and it could it make you feel a bit separated at times too . . . Like with the pandemic it's going to push her back because even though she's eight, she still acts like a 5 or 6 year old.

Lisa shared:

> It's hard. It's difficult like, I had a, my twins, both of them, have a problem. One is deaf, one has a speech problem. So, it's very hard. It's difficult for them to even to sit there and learn. Like my son, like he's deaf, and he's failing [school].

Also related to supporting children academically, Tabatha expressed worry about her son stating:

> It's really bothering me, and I'm sorry if I get emotional about it, but both of my children, they usually do all right in school. You know, and they're not you know, like the smartest, but they're capable of learning, and they're capable of being responsible . . .He was more into work and school work before the pandemic than now. You know it's like he's telling me stories that he's doing his work, and I'm checking it, and he has so many unfinished assignments. It's not even funny. And it's in reading, and I just had to ask him, like what like really what is going on? Like why is this happening, you know I'm trying, you know.

Tabatha works at a neighborhood school so when talking about how she has been impacted by the pandemic she also talked about some of the challenges she has witnessed with other Black families:

> They have a way worse situation than I do. I have seen when the pandemic happen, I've seen parents that say, I can't do online learning because this is messing with me mentally. I can't function. I'm going to have a breakdown. I've literally seen this from moms. I've heard people say, it's messing with their PTSD. Like, I cannot help my child online

> because it's affecting my PTSD. And sometimes we're looking at these parents, and saying well how we know that, but this new generation of parents, I'm sorry to say, don't have some of the upbringing that we older young adults had.

Two mothers talked specifically about their children's mental health and psychological wellbeing. Keisha shared:

> They getting overwhelmed too. Like even my little one, you know, with the daycare and kids and this and this, with the COVID. She cries, and she's only three years old. She cries to go back to school, and they're ready to go back to school. Like they are ready to go back to school, and with so much going on right now it's like hard for them to go back to school.

Melea added:

> Um, my daughter, I feel she has been depressed because even though she don't talk, she don't talk already. So, now that COVID happened, she don't talk more. And then through couple of girlfriends who she had, she don't even have those, the girlfriends no more. So, I just think kids need to be around with other kids, even though they have, like, phones and game, like different things that they could do. Still they need, I guess, people. So, when all this COVID stuff was happening, I ain't gonna say I'm over it. But a lot of kids going to probably need some kind of counseling or just [something] do to get them back into the right state of mind.

Some mothers reflected on both positive and negative changes in their neighborhoods and communities since the pandemic. For example, Barbara, who of note currently lives in her childhood neighborhood and feels a strong sense of community belonging, described a decrease in violence in her community sharing:

> A lot of the little gang banging and shooting kind of slowed down because whoever was around is not around anymore. People have a routine over here. Like the senior citizens. They get up every day. They go play their lottery. Some of them go to liquor store at a certain time because the liquor store opens up. A lot of them get to the bus stop at a certain time. It's like a routine. Like, nothing over here has changed.

On the other hand, Tammy who had recently been directly exposed to violence and who adamantly denied feeling a sense of belonging in her community shared:

> It seem like since the pandemic crimes got worse to me. It gave people more time to just do stupid stuff. Like right now I've been stressed out and crying almost every day because it was a shooting in front of my building and it went through my window. . . . It's

> has changed drastically like it was bad over [here], but it got a lot worse than what it was. A lot of people been out of their jobs and everything, so it's been a lot of um, as you heard, a lot of car jackings over here, and then a lot of people breaking in the houses over here. So it's like, you know you got your bad areas.

For Sasha, the pandemic seemed to increase her sense of community belonging as she shared:

> What I've noticed in my community is, for some reason, when things get hard and only when things get hard do African American somehow come together, right? And help each other out. I don't want to say that, but that's what's been my experience. So even in the middle of COVID, like people were so nice in the store. Like so nice! Like "hey, what do you need? Hey I got this paper towels. I'll reach [them] for you." I have numerous people just helping, so that's what I've seen in the community, even um with the snow in the winter. Like things that had never happened before, to be honest. Like, I got stuck in the snow. There were people coming out of their homes, to help us shovel which never happened before. Just things like that, and seeing the community really trying to work together during this. Even had people knocking on the doors, because my mother is older. "Hey do you have everything you need?" And they found out my dad passed. Some of the older gentlemen would come visit and shovel our snow and do all of those things. We had people go run to the store to get us salt. Just a lot of community and teamwork, right? is what I witnessed.

A complete analysis of how the COVID-19 pandemic impacted the mental health of low-income Black mothers is outside of the scope of this dissertation study. However, these findings suggest the COVID-19 pandemic has impacted the mental health of Black mothers and their children living in the context of concentrated socioeconomic disadvantage, and as one mother shared families will likely feel the impact of the pandemic for years to come. At the time these interviews were conducted the COVID-19 pandemic persisted, and so I would be remiss not to acknowledge this universal contextual risk for depression and other mental health challenges.

CHAPTER 6 - DISCUSSION

The overall goal of this dissertation study was to advance understanding of the individual mental health experiences of low-income Black women engaged in mothering or mother work in the context of urban neighborhoods characterized by socioeconomic disadvantage. This study, informed by the neighborhood stress process model and weathering theory, centered the lived experiences of Black mothers—a group who experiences disproportionate physical health and mental health disparities—to illuminate how community contexts differentially impacts individual depressive symptoms.

Applying an explanatory sequential mixed methods research design, longitudinal quantitative data and in-depth qualitative data, gathered from two distinct samples of Black mothers who resided in high-burden neighborhoods in Chicago, were used to examine six specific research questions:

- What differences, if any, are there over time in the trajectories of depressive symptoms among Black mothers who live in high-burden urban community contexts?
- Are older aged Black mothers more likely to experience worsening depressive symptoms over time?
- Do Black mothers with higher levels of exposure to racial discrimination and community violence have a higher likelihood of experiencing worsening depressive symptoms over time?
- Do Black mothers with perceptions of higher levels of community belonging have a lower likelihood of experiencing worsening depressive symptoms over time?

- Are perceptions of higher levels of community belonging protective in the relations between experiences of racial discrimination and worsening depressive symptoms?
- How does the experience of mothering within the context of high-burden urban communities impact the mental health of low-income Black mothers?

In this chapter, I merge the quantitative and qualitative datasets of this dissertation study through an interpretive discussion of the relevance of my findings (Creswell et al., 2003). Based on the aims and design of my research study, the discussion focuses on the constructs and themes analyzed in the initial quantitative study (i.e., depression, community violence, racism, community belonging) and other relevant themes that emerged from the qualitative study. This chapter concludes with implications for theory, future research, and social work practice.

Summary of Key Findings

Summary of key findings and insights gained from both the quantitative and qualitative analyses that comprised this dissertation study are as follows. Among low-income Black mothers who lived in the urban neighborhoods characterized by socioeconomic disadvantage:

- Meaningful heterogeneity exists in patterns of depressive symptoms or trajectories of depressive symptoms over the course of 5 years. Specifically, three latent classes or subgroups were identified and characterized as: (1) Stable-to-Low Depression (n = 76, 44% of sample); (2) Minimal-to-No Depression (n = 61, 35% of sample); and (3) Moderate-to-Increasing Depression (n = 37, 21% of sample)
- Heterogeneity in patterns of depressive symptoms is related to experiences of racial discrimination. Specifically, Black mothers with higher levels of exposure

to racial discrimination had a lower likelihood of being in the minimal-to-no depression (*OR* = .53; *p* = .001) and stable-to-low depression (*OR* = .66; *p* = .056) groups relative to the moderate and increasing group.

- The strong Black woman (SBW) stereotype shapes how Black mothers experience and express depression and relates to underreporting of depressive symptoms.
- Acceptance and internalization of the SBW stereotype shapes motherhood identity.
- Motherhood and the task of mothering in these community contexts is dominated by the fear of keeping children safe from violence which leads to experiences of depression and anxiety.
- Black mothers perceive and experience racism as embedded in place (i.e., community contexts) and through their experience of community violence exposure.
- Black mothers perceive and experience racism through their perception of inequities between predominately Black and predominately White neighborhoods.

Depression Among Black Mothers

This study was informed by the neighborhood stress process model, which links individual health and place and theorizes how exposure to stressors and effectiveness of psychosocial resources relate to variation in individual mental health outcomes in the context of neighborhood socioeconomic disadvantage. Much of the previous research linking community context and individual mental health tends to compare individual mental health outcomes between residents living in different types of neighborhoods, often differentiated by

neighborhood-levels of socioeconomic disadvantage (Hill & Maimon, 2013). Further, much of the previous scholarship on mental health disparities has used cross-sectional quantitative data examining differences in mental health outcomes between racial and ethnic groups. This study extended previous research in two specific and important ways. I examined heterogeneity of depression in two samples of Black mothers living in high burden neighborhoods. Second, data from the quantitative phase of my study were used to examine variation in patterns of depressive symptoms over time.

Among the sample of Black mothers in the quantitative study, three distinct subgroups of depression trajectories were identified and were characterized as: (a) women with stable-to-low levels of depression over time, (b) women with minimal-or-no depressive symptoms over time, and (c) women experiencing moderate-to-increasing levels of depression over time. A little over a third of the sample experienced minimal-to-no depressive symptoms, 44% of the sample experienced stable-to-low levels of depressive symptoms, and 21% of the sample were found to experience worsening depressive symptoms over time. These subgroups emerged while controlling for individual level risks for depression including income and education, though it is important to note there are other individual risk factors for depression (e.g., age, experiences of interpersonal violence, family history, chronic medical conditions) not controlled for in this study. These findings are consistent with the neighborhood stress process model (Aneshensel et al., 2015) and suggest there may be important neighborhood or environmental stressors beyond individual level risk (i.e., income and education) that may impact or lead to meaningful variation and heterogeneity in mental health outcomes (i.e., depressive symptoms) among Black mothers who live in the context of neighborhood socioeconomic disadvantage.

These findings confirm the hypothesis that there is variation in patterns of depression in a sample of Black mothers living in high burden neighborhoods. However, overall levels of depressive symptoms were relatively low across all groups. Even the group with moderate and increasing symptoms did not reach clinical level of depression. These findings are consistent with previous research in which Black adults, in comparison to other racial and ethnic groups, tend to report lower rates or prevalence of depression (Williams et al., 2007). Findings from my qualitative study suggest some Black women do report experiencing clinical levels of depression. At the end of each interview, I screened mothers (n = 11) for current depression using the BDI-II. Some mothers reported minimal-to-no depressive symptoms, and three mothers reported symptoms in the borderline clinical-to-moderate depression range (M = 8.90, SD = 10.01). Depression scores for each mother who completed the screening can be seen in Appendix G. Participants linked their depressive symptoms to stress associated with the inability to access material resources (e.g., safe housing, employment). These findings are consistent with a neighborhood stress process model that highlights the importance of considering how exposure to stressors relate to variation in individual mental health outcomes changes over time.

Most of the mothers in my qualitative study believed the experience of depression was an inevitable consequence of Black motherhood in these contexts. All the mothers in this sample described experiencing periods of depression during the last five years and they related these experiences to a range of individual and environmental risks including maternal health challenges, domestic violence, homelessness, employment instability, poverty, racial discrimination, and community violence exposure. The women described their depression in ways that may not be well captured using traditional measures of depressive symptoms (e.g., BDI-II, Center for Epidemiological Studies Depression (CESD). Consistent with previous

research, this sample of Black mothers tended to describe or express depressive symptoms as feelings of anger, feeling overwhelmed, heavy, weighted down, or other somatically focused language (Walton & Shepard-Payne, 2016).

The SBW stereotype emerged as a major theme that adds nuance and extends the quantitative findings by illustrating the ways in which many Black mothers may minimize and thus underreport depressive symptoms to appear "strong" in the face of adversity imposed on the Black women through racist social welfare policies and insidious forms of cultural racism (e.g., media images, stereotypes). The SBW stereotype has, to varying degrees, dehumanized Black women, and prevented them from being able to identify and express the full spectrum of human emotions and feelings. Stewart (2017) suggested internalization of the SBW stereotype leaves the Black woman "emotionally zombified and disabled . . . She is supposed to be perpetually on guard emotionally and invulnerable to those around her" (p. 33). Acceptance and normalization of the SBW stereotype may, unconsciously, be a way Black mothers have learned to cope with the harsh realities of their precarious social location (Woods-Giscombe, 2010). However, the SBW stereotype, when internalized, has the potential to cause psychological distress leading to depression and other mental health challenges (Beauboeuf-Lafontant 2009; Warren-Findlow, 2006; Watson & Hunter, 2015). According to the weathering hypothesis, internalization of the SBW stereotype among Black women has been conceptualized as a high effort coping strategy leading to worsening physical health over time (Geronimus, 2001).

It is also plausible that Black mothers, who historically have been over-policed and under-protected, may underreport depression or other mental health challenges, especially in the context of a research study, for fear of initiating involvement of child welfare or justice systems that have disproportionately removed Black and Brown children from their families of origin

(Crenshaw et al., 2015). Across race, low-income mothers have been found to distrust institutions and systems that, in theory, are designed to support economically disadvantaged families (Levine, 2013). Taken together, these findings point to the importance of considering historical contexts when developing measurements of depression attuned to contemporary cultural expressions of depression among low-income Black mothers who live in the context of high-burden urban communities.

Racism and Depression

Experiences of racial discrimination was conceptualized as a neighborhood stressor that relates to variation in patterns of depressive symptoms. Findings from the quantitative study suggest individual experiences of racial discrimination increased the likelihood of membership in the subgroup of Black mothers characterized by worsening depressive symptoms over time. These findings align with previous research that has found positive associations between racial discrimination and depressive symptoms among Black Americans (Brown et al., 2000; Clark et al., 1999; Williams & Mohammed, 2009; Williams & Williams, 2000). This study's finding is a contribution to the literature as it is uses longitudinal quantitative data, and this study is focused exclusively on a sample of low-income Black mothers who reside in community contexts characterized by concentrated neighborhood socioeconomic disadvantage. Much of the previous research examining racial discrimination and depression used cross-sectional quantitative data, and of the few studies using longitudinal quantitative data (Brody et al., 2006; Greene et al., 2006), most have been conducted with adolescent or teen samples (Williams & Mohammed, 2009).

Overall, the mothers in the quantitative sample did not report as many instances of racial discrimination as expected and there was little change in the number of occurrences across the

five waves or years of data. Williams and Mohammod (2009), leaders in the study of racial discrimination and health, pointed to several limitations with survey measurements of discrimination and imply underreporting may occur due to the sensitive nature of the topic of race, social desirability, mode of administration of the survey, and the race of the researcher or interviewer. Findings from the qualitative study provide a nuanced contemporary understanding of how Black mothers make sense of racism and provides insight into how racism may relate to depression.

Low reporting of racial discrimination in the quantitative study could be explained by incongruency between the specific questions asked on the quantitative survey measure and the way Black mothers describe or experience racial discrimination in the context of high-burden urban neighborhoods. For example, there were some mothers in the study who initially denied ever experiencing racism. It seemed this was the case because their reference point for racism had shifted. The interviews were conducted during the unprecedented rise in media coverage of police killings of unarmed Black men and women, so some Black mothers only initially thought of racism in terms of losing a child to police violence even though they went on to describe experiences of structural racism or racial discrimination. Additionally, Black mothers may have been more aware or attended to a wider variety of racism-related experiences considering increased public awareness of anti-Blackness and violence against Black bodies. As such, quantitative measurements of racial discrimination should always consider timing and sociocultural contexts (e.g., race relations) in which data is collected and analyzed.

Underreporting in experiences of racism may also be explained by what one mother described as intentional avoidance to prevent feelings of hopelessness and protect her mental health. It is possible the process of avoiding or denying the realities of racism may be a way of

coping with related stress (Williams & Mohammed, 2009). Denial of racism as a coping strategy or means of survival may also relate to acceptance of the SBW stereotype among Black mothers. Research on the SBW stereotype suggests the "mask" of the SBW is often adorned in anticipation of racial discrimination and so one could imagine Black mothers denying racism-related stress in an effort to cope by appearing happy, well, and strong as the "mask" would suggest (Beauboeuf-Lafontant, 2009). Avoiding or perhaps refusing to talk about racism, and instead centering joy and resilience, may also be viewed as a form of resistance to what Morrison (1975) described as the "distraction" of racism. Additional research is needed to operationalize the construct of the SBW stereotype and examine the extent to which internalization of the stereotype and denial of racism are adaptive coping strategies or leads to improved mental health outcomes among Black women (Speight, 2007).

All but one of the questions on the racism survey asked about direct experiences of racial discrimination. However, research suggests Black Americans may vicariously experience the damaging mental health effects of racism, even though they may not have personal encounters of discrimination. One study, for example, examined the mental health effects of being exposed via radio, tv, social media, or word of mouth to police killings of unarmed Black Americans in their state of residence. Black American adults were found to experience poorer mental health 1–2 months after exposure (Bor et al., 2018). A second study found, among a sample of Black women, vicarious racism-related stress was associated with greater disease activity (i.e., systemic lupus erythematosus [SLW]) above and beyond personal experiences of racial discrimination (Martz et al., 2019). Some mothers in this study described feelings of angst and anxiety when talking with their children about racism. Vicarious experiences of racism are especially common among Black mothers as they often bear the burden of preparing their children to respond to

racism they may encounter (i.e., racial socialization practices) and experience undo fear and stress associated with the hypervigilance needed to raise and protect Black children from racism (Jones & Shorter-Gooden, 2003).

While findings from the quantitative study suggest racial discrimination relates to worsening depression, they were limited in their ability to identify where or in what contexts the discrimination occurred or was experienced. For example, did Black mothers experience racial discrimination at work, in their child's school, or among non-Black people in the neighborhood? Experiences of interpersonal racial discrimination alone does not capture one's full experience of racism as racism permeates social systems and structures shaping the everyday lives and experiences of people of color (Ford & Airhihenbuwa, 2010a). Qualitative findings from this study provide insight into the settings and contexts in which Black mothers—in 2021—experienced racial discrimination which has important implications for social work practice.

Like previous research, Black mothers in this study described experiences of racism and discrimination during their own childhood, and in healthcare and employment settings outside of their residential neighborhoods (Nuru-jeter et al., 2009). Additionally, many of the mothers I interviewed experienced and perceived racism as embedded in place or in the very structures of their everyday life experiences in community contexts characterized by socioeconomic disadvantage. Previous research suggested Black Americans with low-socioeconomic status tend to experience less exposure to racial discrimination than those Black Americans with higher socioeconomic status (SES) because Black Americans with high-SES are thought to have more interactions with non-Black people in racially integrated neighborhoods or work settings (Hudson et al., 2013.

This is distinct from the structural racism experienced by the women in this study. Bailey et al. (2021) argued structural racism affects population and individual health among Black adults through three interrelated domains: redlining and racial residential segregation, mass incarceration and police violence, and unequal medical care. Chicago's history of redlining and racial residential segregation is particularly relevant to the life experiences of the low-income Black mothers in this study. Evidence links racial residential segregation to a range of adverse health outcomes including adverse birth outcomes, exposure to air pollutants, increased risk of chronic disease, and increased rates of homicide (Bailey et al., 2017; Williams & Collins, 2001). Many of the mothers I interviewed, who were all born and raised in Chicago, described the unambiguous contrast between predominately Black and predominately White neighborhoods in Chicago as an example or context of racism. For the low-income Black mothers in this study, the structural characteristics of their neighborhoods (e.g., unsafe housing, lack of green spaces, closed or poorly functioning schools, community violence, etc.) in comparison to predominately White neighborhoods represents inequity and is inextricably linked to race, class, gender, or their social location as low-income Black women who are mothers. While these mothers may not use the language of structural racism, they are aware that their lived experiences in these neighborhoods reflect racism, and this realization has negative consequences for their mental health. For example, one mother stated that she felt "hurt" that she wasn't able to access needed resources in her community. Another mother became emotional during the interview when talking about her son's academic challenges and the inequities between schools in predominately Black and predominately White neighborhoods in Chicago. Other mothers described a range of feelings in response to their everyday lived experiences of racism in the context of their

neighborhoods including, sadness, disappointment, frustration, injustice, powerlessness, anger, disgust, and anxiety.

Taken together, these findings suggest low-income Black mothers are directly or indirectly experiencing racism at multiple socioecological levels (e.g., interpersonal racial discrimination, structural racism, racial residential segregation) and these experiences relate to depression and overall psychological wellbeing. Despite what we know about the ways structural racism shapes population health outcomes, empirical research in this area is limited, especially research on the development and evaluation of interventions to dismantle structural racism (Bailey et al., 2017, 2021). Additional research is needed to accurately measure structural racism and its impact on individual mental health among Black mothers who live in high-burdened urban neighborhoods and communities.

Community Context and Depression

Violence Exposure

In the quantitative analyses, community violence exposure did not emerge as a significant predictor of patterns of depression. This was surprising given previous research showing the relation between violence exposure and depression (Hill & Maimon, 2013; Mendenhall, 2017). One explanation may be among Black mothers who live in these community contexts, exposure to community violence permeates their everyday lives to the point that recent exposure to a violent event, as it was measured on the quantitative survey, may not directly relate to acute psychological distress (i.e., stress response) or depressive symptoms. Instead, future research using quantitative measurement may examine fear of crime victimization as a possible mechanism through which chronic exposure to community violence may relate to individual depressive symptoms. Findings from the qualitative study provides insight into how Black mothers, in 2021, experience and are impacted by community violence.

The mothers in both study samples resided in neighborhoods and communities on the south side of Chicago often sensationalized in the media as violent war zones (e.g., Chiraq). Over time, predominately Black and Brown communities in Chicago have gained a reputation for being among the most violent in the United States, and grieving, inconsolable Black mothers pleading for peace and an end to violence are regularly the focus of media coverage. However, research on the mental health experiences of Black mothers chronically exposed to community violence is limited. Like the health effects of indirect or vicarious racism exposure, previous research has posited one need not personally experience violence to feel the effects (Fleckman et al., 2016; Schmidt et al., 2018; Voisin, 2019; Zimmerman & Posick, 2016). My findings highlight the ubiquitous nature of community violence in these neighborhoods and the lives of the women engaged in motherwork in these contexts. Although increased news coverage of violence may desensitize or normalize one to community violence (Neria & Sullivan, 2011), findings from this study suggest Black mothers experience harmful mental health consequences related to violence exposure.

Findings from the qualitative component of this study are consistent with other research that suggests community violence is a particularly stressful and prominent aspect of the life experiences of low-income Black mothers who live in high-burden urban neighborhoods in Chicago (Mendenhall, 2017). Several study participants described their primary focus as mothers is keeping their children safe from violence. This focus induces varying levels of fear, anxiety, sadness, physical tension, and other symptoms of depression. Further, mothers were explicit in their belief that living in a safer community would immediately provide relief from this constant fear and worry. Mothers described the ability to feel “calm” and have “the chance to breathe” when asked to imagine mothering in different (i.e., safer) community contexts.

Findings from my study also suggest an increase in violence since the COVID-19 global pandemic based on several mothers' description of increased fear related to crime and violent carjackings in Chicago which more than doubled throughout 2020 (Margos, 2021). A recent cross-sectional analysis of gun violence during the COVID-19 global pandemic found a 23% increase in shooting incidents compared to 2019, and a 6% increase compared to 2018 in Chicago (Sutherland et al., 2021). What may matter most to the mothers in my study is the perception violence in Chicago has become more random and unpredictable over time. A recent study based in Chicago examined communication between Black fathers and sons about gun violence (Johnson, 2020). Fathers in that study described their perception that the nature of violence has changed over time. In their view, increased access to guns has allowed gun violence to replace the physical fights once used to resolve disputes. Johnson et al. (2020) study also found when gang members in Chicago attempt retaliation against rivals they may engage in what is known as a "slide'—understood to mean shoot anyone they see—which has increased random violence whereby innocent people and residents of the most disadvantaged neighborhoods may become victims of gun violence (Johnson et al., 2020). One mother in my qualitative study described a mental and behavioral process—akin to stop, drop, and roll—that she engages in attempt to prevent random violence victimization when leaving out of her apartment, "you gotta stop, look, hear first, then you go to your car."

Findings from my qualitative study suggest among low-income Black mothers who reside within high-burden neighborhoods the lived experience of violence intersects with the experience of racism such that quantitative measurement alone may have been insufficient to examine the true mental health impact of exposure to community violence. For instance, several Black mothers in my study described fear of their children being killed by the police for simply

being Black. Previous research suggests many Black mothers, irrespective of class, experience fear of their children being murdered by police (Jones & Shorter-Gooden, 2003), but this study suggests that fear of violence may be exacerbated for low-income Black mothers who live in high-burden neighborhoods. Violence associated with policing results in the death of hundreds of Black people each year, and the threat of violence induced by constant police surveillance has indirect effects on the mental health of residents of high-burdened urban neighborhoods (Bailey et al., 2021; Hannig, 2019). In this case, violence exposure and fear of violence victimization intersects with structural racism and combines as a distinct stressor that extends to people and systems that exists outside of the neighborhood to have a unique mental health impact on Black mothers.

Black mothers' perceptions of neighborhood inequity are another example of the intersecting nature of the lived experience of violence and racism. Many of the mothers described community violence as an example of neighborhood inequity based on their racial identity and racism. Black mothers in this sample were adamant that the violence and fear they have become accustomed to persists because they live in predominately low-income Black neighborhoods in Chicago—one of the most racially segregated cities in the U.S. (Sandavol, 2011). As described in the previous section, racial residential segregation exemplifies a consequence of structural racism, and it leads to increased exposure to high rates of homicide and other crimes (Bailey et al., 2017). Again, these mothers may not use the language of structural racism to describe their experiences of violence exposure. However, their lived experiences in these neighborhoods—including chronic exposure to violence—are shaped by racist policies (e.g., redlining, discrimination in mortgage acquisition and rates, home valuation)

which have led to disinvestment, concentrated poverty, and unprecedented closing of public schools and community mental health centers (Bailey et al., 2017; Desmond, 2012).

Taken together, these findings suggest that low-income Black mothers perceive or make sense of racism through their experiences and exposures to community violence, and thus their experience of racism is embedded in their experience of place. These findings also demonstrate the intersecting nature of neighborhood stressors and contextual risks that shapes individual mental health which undergirds the need for multilevel mental health interventions.

Community Belonging

Perceptions of community belonging were not found to be associated with variation in depressive symptoms in the quantitative analyses. However, findings from the qualitative study provide some insight into how Black mothers make sense of this construct. In the quantitative study, community belonging was conceptualized as feeling a sense of belonging, likeness, and loyalty to one's residential neighborhood. However, findings from my qualitative study suggest there are important variations in how Black mothers interpret or make sense of the idea of "community" in Chicago in 2021. For example, when asked about community belonging, some mothers talked about belonging within the larger community of Black people in the United States beyond their residential neighborhoods. Another mother understood community belonging to mean a sense of belonging within the broader south "eastside" (i.e., East of the Dan Ryan Expressway) of Chicago as opposed to her specific neighborhood as defined by a census tract or zip code. In a critical review of the existing literature on neighborhood disadvantage, structural racism, and health, Riley (2018) suggested future neighborhood research should consider identifying a unit of analysis beyond neighborhoods (i.e., census tracts) that are informed by specific research questions, theoretically meaningful, and more easily connected to policy (e.g.,

school districts, cities, states). This study's findings suggest a discrepancy in how the construct of community belonging, as measured in the quantitative study, was conceptualized in comparison to how study participants (i.e., Black mothers) interpret, understand, or experience community belonging in 2021. To date, research on the construct of community belonging related to belonging in one's residential neighborhood is limited within the United States. Future research using qualitative methods may help to inform the development of a culturally and contextually relevant quantitative survey measure to examine the association between community belonging and depression.

Overall, findings from both the quantitative and qualitative studies did not reveal a clear relationship between perceptions of community belonging and depression. This may be explained by the fact that both samples were comprised of mothers with low socioeconomic status who may at some point experienced housing instability precluding longevity in one's residential neighborhood or community that would engender a sense of belonging. For example, several mothers interviewed described experiences of homelessness within the last 5 years, and even though they had lived in their neighborhood for at least one year, they did not yet feel a sense of belonging. My research also suggests chronic exposure to community violence or fear of violence victimization may prevent mothers from feeling a sense of community belonging in their residential neighborhood. Even though the qualitative component of this study had the potential to deepen and expand our understanding of community belonging among Black mothers, the COVID-19 global pandemic prevented social gatherings and connections between people for more than a year. Further, amid the COVID-19 global pandemic, many adults, not just Black mothers, engaged with alternative outlets to connect with people outside of their residential neighborhoods (e.g., Instagram Live, FaceTime).

In the quantitative study, I expected to find perceptions of community belonging would be a stress buffering or protective mechanism in the relations between racial discrimination and depression, though these relations did not emerge in analyses. Findings from the qualitative study suggest in the face of exposure to pervasive racism at multiple socioecological levels and the simultaneous experience of class and gender-based oppression, community belonging may not be effective or sufficient to protect against interpersonal racial discrimination. One unexpected finding related to the notion of community and mental health was some Black mothers' descriptions of loss of community. Some of the mothers in the qualitative sample, particularly those who were older in age or had lived in southside neighborhoods all their lives described feelings of loss, grief, and sadness related to a particular sense of community belonging that engendered a sense of safety from violence "back in the day." Overall, findings suggest social connections in a residential neighborhood may still matter for the psychological well-being of low-income Black mothers, but further research and analysis is needed to understand the mental health benefit of place-based social connections (Sharkey & Faber, 2014).

Summary of Findings: "We Don't Complain. We Just Survive"

The words of one mother summarizes the central findings of this dissertation, "We don't complain. We just survive." Black mothers' mental health has been understudied and undertheorized, and low-income Black mothers who live in urban community contexts characterized by concentrated poverty have especially been overlooked across health-related disciplines. Mothering is a universally stressful, demanding, and physically taxing responsibility, especially in the context of a persisting global pandemic. However, low-income Black mothers bear an additional cost and burden associated with mothering in these particularly disadvantaged community contexts. Using intersectionality (Crenshaw, 1994) as an analytical framework,

violence exposure—in the context of high burden urban neighborhoods—emerged as a theme from these data that illustrates how low-income Black mothers' mental health is uniquely shaped by the intersection of race, class, and gender-based oppression.

The Black mothers in this study are exposed to structural racism everyday through the experience of living in neighborhoods and community contexts characterized by concentrated socioeconomic disadvantage and racial residential segregation. These mothers are acutely aware structural conditions of their neighborhoods (e.g., unsafe housing, lack of green spaces, closed or poorly functioning schools, community violence) endure because they live in predominately Black neighborhoods; thus, their racial identity as Black makes them prone to mothering in community contexts created and maintained by racist policies.

Related to race and gender, the SBW stereotype emerged as a theme that helps to explain why these Black mothers "don't complain and just survive." Among all the mothers in this study, the SBW stereotype—a culturally specific expectation Black women should perform strength, independence, and unwavering care for others—is normalized, accepted, and to varying degrees, internalized. The SBW stereotype is an example of a "racist cultural trope" that, when internalized, may help to reproduce the cycle of racial oppression as it may "prevent one from seeing the destructive social context and accept the dominant group's exploitation as simply "the way things are" (Friere, 1999 as cited in Speight, 2007 p. 131). The Black mothers in this study are exposed to a myriad of stressors about which they could and should complain, and chief among them is exposure to violence. All the mothers in this study described direct and indirect exposure to violence that extends beyond their residential neighborhoods. Black mothers in the study experience pervasive fear of violence victimization, and for them, motherhood and mothering are defined by the need to keep their children safe from gun violence. Protecting one's

child is a universal aspect of motherhood and mothering. However, for these low-income Black mothers, the burden is compounded with experiences of racism at multiple socioecological levels, personal experiences of poverty (i.e., class) preventing mothers' from leaving these particularly burdensome neighborhoods, and race and gender-based expectations to be strong and just survive.

In the face of adversity, constrained choices, and a lack of resources, acceptance of the SBW stereotype may be a helpful coping mechanism or means for survival, but over time, internalization of the stereotype may come at a cost to the psychological well-being of Black mothers. The Black mothers in this study struggled to describe their emotions and feelings about their everyday lived experiences at the intersection of race, class, and gender-based oppression. In parallel, social work, public health, and other health-related fields have grappled with how to improve physical health and mental health outcomes among Black mothers. Based on findings from this study, I would argue the SBW stereotype is an insidious mechanism of cultural racism that, to varying degrees, dehumanizes low-income Black mothers, shapes their experiences and expressions of depression, and ultimately contributes to persistent mental health disparities.

Implications for Theory

The present study was informed by the neighborhood stress process model (Aneshensel et al., 2015) and findings have important implications for further theory development. The neighborhood stress process model links individual mental health and place and examines how exposure to stressors and effectiveness of psychosocial resources relate to variation in individual mental health outcomes in the context of neighborhood socioeconomic disadvantage. Findings from this study underscore the importance of understanding how community contexts differentially shape individual mental health. This study revealed differences in patterns of

depressive symptoms over time and important qualitative differences in the experience and expression of depression were found among low-income Black mothers who live in the same community contexts.

This study also offers evidence the neighborhood stress process model should operationalize the construct of neighborhood socioeconomic disadvantage as a specific form of structural racism as low-income Black mothers in this sample experience and perceive racism as embedded within place. To adequately document the health impact of racism, empirical scholarship and theoretical frameworks must be explicit about the role of structural racism. For many of the Black mothers in this sample, place, race, and class intersect or overlap with experiences of oppression which underscore the need for a shift from traditional neighborhood research which is ahistorical and lacks a racial analysis (Riley, 2018). Further, theories linking place and individual mental health should consider variation in how structural racism functions to impact mental health in specific times and specific context (e.g., urban neighborhoods in the Midwest, urban neighborhoods in the South). Findings also indicate individual experiences of racial discrimination are associated with variation in patterns of depressive symptoms which further supports extension of theory to include exposure to racism as specific stressors in the neighborhood stress process model.

Aligned with weathering theory, findings from this study indicate low-income Black mothers experience racism at multiple socioecological levels, and experiences of racism negatively impacts their mental health and psychological well-being. Findings from this study also offers evidence to a key assertion of weathering theory, suggesting Black women engage in high-effort coping mechanisms, like acceptance and internalization of the SBW stereotype, to mitigate the impact of stress associated with racism (Geronimus et al., 2010; Warren-Findlow,

2006). The pervasiveness of racism in the everyday lives of Black mothers who live in neighborhoods characterized by socioeconomic disadvantage and high violent crime rates supports the need for social work research to embrace critical theoretical orientations, frameworks, and praxis (e.g., weathering theory, public health critical race praxis) that are explicitly race conscious and acknowledge the role of dominant racial ideologies in all aspects of the research process (i.e., data collection, analysis, publication).

Implications for Future Research

The present study underscores the need for advances in social work research to better understand and reduce mental health disparities among low-income Black mothers. There is a large body of research documenting health disparities between racial and ethnic groups or between residents of neighborhoods with low and high socioeconomic status (Nuru-Jeter et al, 2018; Mair et al., 2008). However, this research is limited in the ability to inform practice relevant and attuned to the diverse needs in the population. Social work research must resist the tendency to compare groups of people and contexts to document one group's deviation from the "norm," especially in the case of research focused on Black, Indigenous, and other people or communities of color. This study approached the problem of health disparities among Black women by examining variations in mental health outcomes and experiences within a specific subgroup of Black women within a specific social context. Understanding variation in populations is critically important to providing needed services.

Based on findings from this dissertation, mixed methods research may be a useful method for future social work research focused on examining heterogeneity in the mental health experiences of Black women. The quantitative and qualitative components of this dissertation study could exist independent of each other, however there is much to learn from exploration of

the convergence and the divergence of findings from both. For example, there are clear cultural and contextual nuances to the experiences and expressions of depression that emerged in in the qualitative study phase that would have been missed on a standard quantitative survey measure alone. The quantitative component of this study helped to establish differences in the course of depression among low-income Black mothers, and the qualitative findings deepened our understanding of how the experience differs among this sample. Additionally, community violence exposure was not found to be related to depression in the quantitative study phase, but qualitative exploration of Black mothers' experiences of community violence revealed persistent fear of violence victimization and worry about keeping their children safe from violence was associated with depressive symptoms among Black mothers. The divergence of these findings support the need for inclusion of participants' voice (via qualitative methodologies) in research to increase validity and confidence in widely-used scales use to measure experiences of racism, community violence and depression among Black women. Using multiple methods, future research could include using qualitative findings to develop and validate a quantitative measurement of, for example, internalization of the SBW stereotype or experiences of structural racism.

Based on findings from this dissertation, there are several substatntive areas that warrant further research. First, future research on racial discrimination and mental health should consider how interpersonal racial discrimination combines with or relates to other forms of racism (e.g., structural racism, institutional racism; Williams & Mohammod, 2009) to uniquely impact mental health. In the study of depression among Black mothers, research is needed that examines the role of the SBW stereotype, specifically how internalization of the SBW stereotype relates to changes in depressive symptoms over time. Although the SBW stereotype is normalized among

most Black women (Abrams, et al., 2014) it would be interesting to explore differences in the phenomenology of the SBW stereotype between Black women who are mothers and those who are not, and between low-income and middle-class Black mothers. Related to the study of high burden urban neighborhoods, findings from this dissertation suggest a need for research using quantitative and qualitative methods to examine direct and indirect fear of crime victimization among Black mothers and how fear of crime relates to individual and population level mental health outcomes over time. Finally, given what we learned about the cultural and contextual nuances in expressions of depression, more research is needed to understand how low-income Black mothers express other mental health diagnosis beyond depression including anxiety, post-traumatic stress disorder (PTSD), and the spectrum of psychotic disorders.

Implications for Social Work Practice

Clinical Social Work

Findings from this dissertation study have important implications for clinical social work practice. Based on the findings of meaningful quantitative and qualitative variation in the experience, expression, and course of depression among low-income Black mothers who live in high-burden urban community contexts a one-size fits all approach to counseling, group therapy, case management, or other practice modalities will be ineffective. Instead, social workers in direct practice should adopt a stance of cultural humility (Fisher-Borne et al., 2015; Gottlieb, 2020), or in some cases, multiracial cultural attunement (Jackson & Samuels, 2019) to support the unique and varied experiences of mothers who identify as Black or African American. Practitioners should also engage in critical reflexivity and clinical supervision or consultation to acknowledge how their positionality shapes their clinical assessments and ongoing engagement with low-income Black mothers.

Findings from this study suggest low-income Black mothers experience racism at multiple socioecological levels and it may lead to worsening mental health over time. Accordingly, social work practitioners should reframe assessment processes for Black mothers to explicitly consider how structural inequalities, race, gender-based oppression, and the SBW stereotype relates to symptoms of depression or other mental health challenges (Finn, 2016). For example, during a biopsychosocial assessment in the context of individual therapy, a practitioner might ask a Black mother how she navigates the SBW stereotype or what she been taught about the SBW stereotype from her family of origin. Social work practitioners should also consider trauma-informed approaches, and adapt postmodern or radical theoretical orientations (e.g., queer theory, womanist theory) developed by and for marginalized communities. For example, *In My Grandmother's Hands*, Menakem (2017), a Black clinical social worker explores intergenerational transmission of racialized trauma and suggests use of body-centered communal healing practices rooted in African American ancestry.

Mezzo- and Macro-Level Social Work

This study offers insight into the contexts and experiences through which Black mothers perceive racism (e.g., fear of crime and violence victimization, perceptions of neighborhood inequity) as racism was found to relate to worsening depression over time. As such, there are several opportunities to reduce mental health disparities and promote mental health and psychological well-being among low-income Black mothers who live in high-burden urban community contexts. For example, community-wide violence prevention programming (e.g., Communities That Care model; Chicago Center for Youth Violence Prevention) attuned to the enduring impact of racial oppression on marginalized communities could increase feelings of safety and ultimately reduce depression and anxiety among Black mothers (Haggerty & Shapiro,

2013). Novel evidence-based interventions like the "friendship benches" could be implemented in high-burden neighborhoods to address mental health needs of Black mothers. Originating in Zimbabwe in 2006, the friendship benches trains grandmothers from residential communities to provide free brief cognitive behavioral therapy to other community members dealing with depression and anxiety (Chibanda et al., 2011). Community-based programs that include community members as healthcare providers, particularly those of the same race and gender, could reduce experiences of racial discrimination, engender a sense of safety and belonging, and ultimately improve mental health outcomes for low-income Black mothers.

Lastly, policy-level interventions aimed at dismantling structural racism and achieving racial equity can support the mental health and well-being of low-income Black mothers. For example, between 1991and 2012, the city of Chicago closed 13 of the 19 public community mental health centers (CMHC), and Illinois' mental health funding was cut by $113.7 million (Cusac, 2015; Foiles, 2018). Like the historic Chicago public school closing of 2013, most closed community mental health centers were on the South and West sides of the city which are predominately Black and Brown communities. The CMHC closings occurred amid rising rates of violence and homicide in the city, and based on findings from this study, violence exposure, fear of crime victimization, and racism are interconnected and associated with depressive symptoms among low-income Black mothers. As stated in a Belt Magazine article "living amidst such terror [i.e., gun violence] leaves deep psychological scars, and Chicago's mental health system has not been adequate to task" (Foiles, 2018). Fiscal investment in public mental health centers in predominately Black and Brown communities would at the very least increase access to mental health treatment, and at best, improve mental health outcomes among these marginalized communities.

Limitations

This dissertation study has many strengths though there are some limitations that should be noted. First, the quantitative data was collected in 2000 with a sample distinct from the qualitative study conducted in 2021. The qualitative study aided in deepening our understanding of the constructs analyzed in the quantitative study, though it could never truly explain the quantitative findings. The qualitative study allowed for interrogation of the quantitative findings and offered meaningful, contemporary insights on the constructs being studied. Even though the quantitative study findings were dated (i.e., 2000–2006), very few studies have examined individual experiences of racial discrimination and depressive symptoms using longitudinal data. Further, analyses of the quantitative data established foundational relationships between variables (e.g., depressive symptoms, racial discrimination) from which I was able to design interview guides as a data collection tool for the in-depth, qualitative study. In both studies, the sample sizes were small and exclusive to low-income Black mothers in Chicago. Therefore, findings may not be generalizable to all low-income Black mothers who live in socioeconomically disadvantaged neighborhoods. Additionally, findings may not be generalizable to Black mothers who live in disadvantaged neighborhoods in rural areas or to middle-class Black mothers.

The COVID-19 global pandemic presented challenges related to recruitment, data collection, and data analysis. All participants were recruited through convenience sampling. This sampling strategy may be viewed as a limitation though it was a pragmatic choice to conduct research during a global pandemic. Approximately half of the mothers who participated in the semi-structured, individual interviews had also participated in one of the three focus groups, so they may have been primed to think about communities, racism, and depression in the

interviews. Further, these findings, particularly mothers' descriptions of depression and racism, should be understood in the context of the COVID-19 global pandemic and the largest global movement for Black lives and civil rights in modern-day history.

Interviews were conducted on Zoom due to social distancing requirements, so there were times when internet connectivity issues interrupted flow of the interview or caused participants to turn off their cameras to participate. However, interviewing over Zoom may have had some advantages. For instance, one participant engaged in a focus group while driving and running errands with her daughter in the back seat with a face covering on most of the time. This mother insisted she wanted to participate, despite my urging that we could find another time, and surprisingly she was very engaged and provided in-depth responses to my questions. This participant's ability to join the focus group from the car gave me additional insight into her everyday life as a mother in a way that may not have come through if the interview were at a coffee shop or an office space.

Conclusion

This dissertation examined how exposure to community violence and racial discrimination in the context of neighborhoods characterized by socioeconomic disadvantage relate to individual mental health experiences of low-income Black mothers. This study merged quantitative and qualitative data collected from two distinct samples of Black mothers to provide empirical evidence of heterogeneity in the experience, expression, and course of depression among low-income Black mothers who live in high burden neighborhoods in Chicago. These findings may not generalize to low-income Black mothers in nonurban settings.

This study centered the experiences of low-income Black mothers across fields of study (i.e., urban neighborhoods, mental health, public health, social work) where they are often

overlooked to advance knowledge on contextual risks for depression which has important implications for mental health interventions and direct social work practice. Evidence that exposure to community violence, fear of violence victimization, and experiences of racial discrimination negatively affects the mental health of low-income Black mothers support the need for interventions that consider the historical and present-day sociocultural contexts of Black mothers. This study provides evidence of the firsthand experiences of low-income Black women mothering in urban neighborhoods characterized by concentrated socioeconomic disadvantage, reveals their perceptions of stressors in the community context, and provides insight into how Black mothers experience and navigate racism, depression, and the strong Black womna stereotype.

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Appendix A. Community Violence Exposure

Chicago Youth Development Study Stress and Coping Manual

Since the last time we talked….

1. Has your property been wrecked
0 = No
1 = Yes

2. Anyone in family been arrested or went to court or jail
0 = No
1 = Yes

3. Anyone in family been robbed
0 = No
1 = Yes

4. Anyone outside of family been robbed
0 = No
1 = Yes

5. Seen someone beaten up
0 = No
1 = Yes

6. Seen someone shot or killed
0 = No
1 = Yes

7. Have you been victim of a violent crime
0 = No
1 = Yes

8. Witnessed a violent crime
0 = No
1 = Yes

9. Have you been victim of a non-violent crime
0 = No
1 = Yes

10. Family member killed by drunk driver
0 = No

1 = Yes

11. Had forced sexual contact
0 = No
1 = Yes

Appendix B. Beck Depression Inventory

This depression inventory can be self-scored. The scoring scale is at the end of the questionnaire.

1.
- 0 I do not feel sad.
- 1 I feel sad
- 2 I am sad all the time and I can't snap out of it.
- 3 I am so sad and unhappy that I can't stand it.

2.
- 0 I am not particularly discouraged about the future.
- 1 I feel discouraged about the future.
- 2 I feel I have nothing to look forward to.
- 3 I feel the future is hopeless and that things cannot improve.

3.
- 0 I do not feel like a failure.
- 1 I feel I have failed more than the average person.
- 2 As I look back on my life, all I can see is a lot of failures.
- 3 I feel I am a complete failure as a person.

4.
- 0 I get as much satisfaction out of things as I used to.
- 1 I don't enjoy things the way I used to.
- 2 I don't get real satisfaction out of anything anymore.
- 3 I am dissatisfied or bored with everything.

5.
- 0 I don't feel particularly guilty
- 1 I feel guilty a good part of the time.
- 2 I feel quite guilty most of the time.
- 3 I feel guilty all of the time.

6.
- 0 I don't feel I am being punished.
- 1 I feel I may be punished.
- 2 I expect to be punished.
- 3 I feel I am being punished.

7.
- 0 I don't feel disappointed in myself.
- 1 I am disappointed in myself.
- 2 I am disgusted with myself.
- 3 I hate myself.

8.
- 0 I don't feel I am any worse than anybody else.
- 1 I am critical of myself for my weaknesses or mistakes.
- 2 I blame myself all the time for my faults.
- 3 I blame myself for everything bad that happens.

9.
- 0 I don't have any thoughts of killing myself.

1 I have thoughts of killing myself, but I would not carry them out.
2 I would like to kill myself.
3 I would kill myself if I had the chance.

10.
0 I don't cry any more than usual.
1 I cry more now than I used to.
2 I cry all the time now.
3 I used to be able to cry, but now I can't cry even though I want to.

11.
0 I am no more irritated by things than I ever was.
1 I am slightly more irritated now than usual.
2 I am quite annoyed or irritated a good deal of the time.
3 I feel irritated all the time.

12.
0 I have not lost interest in other people.
1 I am less interested in other people than I used to be.
2 I have lost most of my interest in other people.
3 I have lost all of my interest in other people.

13.
0 I make decisions about as well as I ever could.
1 I put off making decisions more than I used to.
2 I have greater difficulty in making decisions more than I used to.
3 I can't make decisions at all anymore.

14.
0 I don't feel that I look any worse than I used to.
1 I am worried that I am looking old or unattractive.
2 I feel there are permanent changes in my appearance that make me look unattractive
3 I believe that I look ugly.

15.
0 I can work about as well as before.
1 It takes an extra effort to get started at doing something.
2 I have to push myself very hard to do anything.
3 I can't do any work at all.

16.
0 I can sleep as well as usual.
1 I don't sleep as well as I used to.
2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
3 I wake up several hours earlier than I used to and cannot get back to sleep.

17.
0 I don't get more tired than usual.
1 I get tired more easily than I used to.
2 I get tired from doing almost anything.
3 I am too tired to do anything.

18.
0 My appetite is no worse than usual.

1 My appetite is not as good as it used to be.
2 My appetite is much worse now.
3 I have no appetite at all anymore.

19.

0 I haven't lost much weight, if any, lately.
1 I have lost more than five pounds.
2 I have lost more than ten pounds.
3 I have lost more than fifteen pounds.

20.

0 I am no more worried about my health than usual.
1 I am worried about physical problems like aches, pains, upset stomach, or constipation.
2 I am very worried about physical problems and it's hard to think of much else.
3 I am so worried about my physical problems that I cannot think of anything else.

21.

0 I have not noticed any recent change in my interest in sex.
1 I am less interested in sex than I used to be.
2 I have almost no interest in sex.
3 I have lost interest in sex completely.

INTERPRETING THE BECK DEPRESSION INVENTORY

Now that you have completed the questionnaire, add up the score for each of the twenty-one questions by counting the number to the right of each question you marked. The highest possible total for the whole test would be sixty-three. This would mean you circled number three on all twenty-one questions. Since the lowest possible score for each question is zero, the lowest possible score for the test would be zero. This would mean you circles zero on each question. You can evaluate your depression according to the Table below.

Total Score	Levels of Depression
1-10	These ups and downs are considered normal
11-16	Mild mood disturbance
17-20	Borderline clinical depression
21-30	Moderate depression
31-40	Severe depression
over 40	Extreme depression

Appendix C. Experiences of Racial Discrimination

Chicago Youth Development Study Stress and Coping Manual

Since the last time we talked…..

1. Have you been unfairly accused because of race or ethnicity
   0 = No
   1 = Yes

2. Have you been put down because of customs of your race
   0 = No
   1 = Yes

3. Have you been excluded from a group for culture or race
   0 = No
   1 = Yes

4. Have your friends criticized you for hanging with other ethnic groups
   0 = No
   1 = Yes

5. Have you heard people say jokes or bad words about your race
   0 = No
   1 = Yes

6. Have you been called a racial name
   0 = No
   1 = Yes

7. Have you seen someone racially discriminated
   0 = No
   1 = Yes

Appendix D. Community Belonging and Community Support

Chicago Youth Development Study Neighborhood Measure

1. I feel like I belong to the neighborhood
   1 = Strongly agree
   2 = Agree
   3 = Neither agree or disagree
   4 = Disagree
   5 = Strongly disagree

2. I feel loyal to the people in my neighborhood
   1 = Strongly agree
   2 = Agree
   3 = Neither agree or disagree
   4 = Disagree
   5 = Strongly disagree

3. I think myself similar to the people of this neighborhood
   1 = Strongly agree
   2 = Agree
   3 = Neither agree or disagree
   4 = Disagree
   5 = Strongly disagree

4. Overall I am attracted to living in this neighborhood
   1 = Strongly agree
   2 = Agree
   3 = Neither agree or disagree
   4 = Disagree
   5 = Strongly disagree

5. I visit with my neighbors in their homes – reversed
   5 = Strongly agree
   4 = Agree
   3 = Neither agree nor disagree
   2 = Disagree
   1 = Strongly disagree

6. I could go for advice to someone in my neighborhood – reversed
   5 = Strongly agree
   4 = Agree
   3 = Neither agree nor disagree
   2 = Disagree
   1 = Strongly disagree

7. I regularly stop to talk with people in my neighborhood – reversed
   5 = Strongly agree
   4 = Agree
   3 = Neither agree nor disagree
   2 = Disagree
   1 = Strongly disagree

8. I know most of the name of people on my block – reversed
   5 = Strongly agree
   4 = Agree
   3 = Neither agree nor disagree
   2 = Disagree
   1 = Strongly disagree

9. I am comfortable in borrowing food or tool from people on my block - reversed
   5 = Strongly agree
   4 = Agree
   3 = Neither agree nor disagree
   2 = Disagree
   1 = Strongly disagree

Appendix E. Focus Group Interview Guide

INTRODUCTION: Thank you for being part of our study! As you know, today's conversation is part of a study about Black mothers experiences of racism and mental health in the context of high burden urban neighborhoods here in Chicago.

Before we begin, I just want to remind you that your participation is completely voluntary – you may decline to answer any questions that make you uncomfortable and can end your participation at any time.

My Research Assistant Grace is here today to help me with logistics and technical challenges that may arise during the group.

We plan to talk for between 60-90 minutes, but I hope to keep the time as short as possible.

We are recording the conversation for completeness and accuracy. When the tapes are transcribed, we will remove any mention of names and we will delete the recording. We keep your information private and do not connect your name with what you say during the interview. We ask that you have the same courtesy for each other. If you talk about what anyone in the group today says, please never mention anyone's name or identity. During the group we are using first names, initials or nick names that you provided for this purpose when we scheduled the discussion.

A few ground rules for our discussion:

- We are interested in hearing from everyone – please do speak up, because we want to hear from you.
- Please do go ahead and talk with each other, it's a conversation between all of us, not just with me.
- Everyone has different opinions and experiences – we are not trying to change any one's mind or come to an agreement. Everyone should feel free to express their own ideas. If you have ideas or experiences different from others who have talked, please do speak up and add your voice because we are interested in all points of view – not just one.
- We have a certain number of questions to cover in the time we have. I may have to interrupt sometimes to move us along – if I do, please bear with me and don't take it personal.

Does anyone have any questions before we start?------- I am starting the recording now

1. I want to start by going around and asking each of you the first two words that come to mind when you think about where you live.
    - Now that we have heard from everyone, is there anything else that is important for me to know when describing your communities?
    - Physical structure/ aesthetic
    - People/families

- Likes/dislikes
- Violence
- Loss

TRANSITION: I'd like to switch gears and discuss your communities in relation to mental health

2. When you hear the word "mental health" what comes to mind; what about "depression"?

1) Mind/Psychology
2) Medicine
3) Stress
4) Crazy people/Inpatient
5) Sadness
6) Anxiety

TRANSITION: I want you all to help me understand depression among Black mothers in particular. Remember I am not looking for one right answer. I want to hear your different opinions about depression among moms.

Here is a graph I created from a small group of Black moms who told us about their experiences with depression several years ago. These were moms who lived in communities/neighborhoods very similar (i.e., high levels of violence, concentrated poverty, lack of resources) to yours. *Show graph of the different depression trajectories from (Quantitative Study) as a visual to ask:

3. What do you think may be happening in the lives of the moms who, over five years, reported that they were depressed and the depression kept getting worse over time;?
    - Unemployment
    - Children struggling developmentally or in school
    - Grief/loss
    - Exposure to or fear of violence
    - Racism
    - How do moms "act/behave" when they are depressed or struggling emotionally ?

4. What do you think may be happening in the lives of the moms who, over five years, reported that they never experienced depression?
    - Stable employment
    - Children doing well in school
    - Therapy
    - Family support
    - Partnership
    - How do moms "act/behave" when they are happy or doing well?

TRANSITION: The last thing I want you all to help me think about is racism.

5. You all are Black mothers, what does that mean to each of you?
6. When you hear racial discrimination what comes to mind; what about racism?
    - Harassment/Violence
    - White people
    - Disinvestment/lack of care about Black people
    - Internalized racism
    - Historic examples

7. Has anyone experienced racism within this neighborhood? If yes, please share some examples.
    - Stigmatization Harassment/Violence
    - Neighbors
    - Lack of access
    - Schools
    - Healthcare
    - Employment
    - Retail/Grocery
    - State/City Agencies
    - Media/Social Media
8. Has anyone experienced racism outside of this neighborhood? If yes, please share some examples.
    - Stigmatization Harassment/Violence
    - Neighbors
    - Lack of access
    - Schools
    - Healthcare
    - Employment
    - Retail/Grocery
    - State/City Agencies
    - Media/Social Media
9. What, if anything, do you think your communities need to support Black mothers who are struggling with depression; experiencing racism

    - Parks/green spaces
    - Less violence
    - Support groups
    - Healthy food options
    - Community mental health centers
    - Churches
    - Financial investment
    - Housing

10. Is there anything else you all think I should know about mental health and racism among Black mothers in this community?

Thank you all very much for your time, and for sharing your thoughts and experiences. As a reminder, I will be emailing you a gift card w/in 48-72 hours for your time. Also, I will be reaching out to you again to see if you would like to volunteer to participate in the next part of my project where I would like to talk to Black mothers one on one about some of these same topics we discussed today.

Appendix F. Semi-structured Interview Guide

INTRODUCTION: Thank you for being part of this study! As you know, today's conversation is part of a study about Black mothers experiences of racism and mental health in the context of high burden urban neighborhoods here in Chicago.

Before we begin, I just want to remind you that your participation is completely voluntary – you may decline to answer any questions that make you uncomfortable and can end your participation at any time.

This interview will likely take between 60-90 minutes.

I am recording the conversation for completeness and accuracy. When the tapes are transcribed, I will remove any mention of names and I will delete the recording. I will keep your information private and will not connect your name with what you say during the interview.

A few ground rules for our discussion:

- We have a certain number of questions to cover in the time we have. I may have to interrupt sometimes to move us along – if I do, please bear with me and don't take it personal.
- You are the expert here and I want to learn about your experiences

Do you have any questions before we start?

1. How has everyday life as a mom in this community changed since the COVID-19 pandemic?
    - At home schooling/Virtual Learning
    - How do engage with people/places outside of your home
    - Describe a typical day

2. How did you come to live in this community?
    - Has your family lived here for a while
    - What side of city did you grow up
    - Displacement from previous job/housing

3. How do you see yourself as a mom?
    - How do you show love
    - How do you show concern
    - How do you see yourself in comparison to your mom, or other moms in your circle

4. How do you think your kids see you?
    - What kinds of things do you do with your child
    - What do you and your child talk about
    - How do you handle disagreements/conflict

5. What do you find challenging about motherhood?
    - What makes motherhood/parenting hard
    - What is stressful about parenting
    - What do you think about/worry about as a mom?
    - How do you keep your kids safe
    - What are your fears as a parent
    - What is rewarding about motherhood
    - What do you like/love about being a mother

6. I want you to think about the last 5 years…since 2016….describe a time when you have struggled emotionally
    - A time when you felt down, sad, anxious
    - Tell me about a time, over the last 5 years, when you felt well or good emotionally
    - A time when you were really happy, hopeful, optimistic

7. Thinking about the time you just described (struggling emotionally) how did racism play a part in that experience
    - Moms describe racism as multidimensional/multi-level – inequities in the schools, neighborhoods, access to resources for children

8. Tell me about the first time you experienced racism as a mother
    - You are raising young Black boys/girls in this community – how does that make you feel emotionally

9. How do you feel emotionally when you experience racism
    - How do you feel when you think about the racism that exist in our communities
    - Does racism make you feel sad, hopeless, depressed, anxious, fearful

10. Other moms that I've met with talked a lot about having to present as strong black woman or the idea of always wearing a mask to appear strong; - how do you navigate this in your own life ?
    - How does it make you feel emotionally to wear a mask

11. Tell me about supportive relationships and supportive aspects of your community
    - Are there other mothers in your neighborhood that you have connected with
    - Do you feel a sense of belonging in this neighborhood?; what does that feel like; how does that make you feel emotionally
    - What are places in the neighborhood where you get support with parenting

12. How would motherhood/parenting change for you if you lived in a community where you felt safer
    - What kinds of things would you be able to do outside
    - How would you feel day to day
    - Would it impact your level of stress

13. Thinking about the last year we have had with COVID-19, Black Lives Matters movements last summer, and the consistent rise in community violence - What advice would you give to young Black moms in your community about how to get through
    - What are your practices to get through each day
    - Exercise, meditation, prayer, social media
    - Motivated by kids

Thank you so much for your time, and for sharing your thoughts and experiences. As a reminder, I will be emailing you a gift card w/in 48-72 hours for your time.

Appendix G. Qualitative Study Sample Beck Depression Inventory Scores

Participant Pseudonym	Beck Depression Inventory (BDI-II) Score
Barbara	7
Skylar	7
Tammy	0
Sanequa	0
Allison	20
Renae	4
Nicole	19
Melea	0
Shay	30
Keisha	1
Niecy	10
MannMocha	Did not complete
Tabatha	Did not complete
Sasha	Did not complete
Lisa	Did not complete
Melissa	Did not complete