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Resiliency and Positive Childhood Experiences: Implications for Black Youths' Mental and Behavioral Health and School Engagement

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RESILIENCY AND POSITIVE CHILDHOOD EXPERIENCES: IMPLICATIONS FOR BLACK YOUTHS' MENTAL AND BEHAVIORAL HEALTH, SCHOOL ENGAGEMENT, AND RESILIENCY DEVELOPMENT

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and academic growth. To my beloved grandmother, Jackie Vaughn, you are dearly missed and loved.

Hey, Black Child
Do you know who you are
Who you really are
Do you know you can be
What you want to be
If you try to be
What you can be

Hey, Black child
Do you know where you are going
Where you're really going
Do you know you can learn
What you want to learn
If you try to learn
What you can learn

Hey, Black child
Do you know you are strong
I mean really strong
Do you know you can do
What you want to do
If you try to do
What you can do

Hey, Black child
Be what you can be
Learn what you must learn
Do what you can do
And tomorrow your nation
Will be what you want it to be

Useni Eugene Perkins

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ABSTRACT

Two independent studies were conducted to examine the buffering impact of positive childhood experiences on Black youths' mental and behavioral health and school engagement outcomes. The purpose of Study 1 was to investigate the potential moderating effects of positive childhood experiences on the relationship between adverse childhood experiences and the occurrence of mental or behavioral health conditions (anxiety, depression, ADHD/ADD, and/or a behavioral/conduct problem) and school engagement, using secondary data from the 2020 National Survey of Children's Health, a survey completed by primary caregivers. The study sample included 2,201 Black youth ages 6-17 across the United States. Logistic regression and interactions estimated the association between cumulative ACEs, cumulative and individual PCEs, and study outcome variables separately. There was no significant interaction between cumulative ACEs and cumulative PCEs on the outcome of the MBH Conditions. There was a significant interaction between cumulative ACEs and cumulative PCEs on the outcome of school disengagement. In the expanded logistic regression, lower scores of three PCE items (i.e., constructive social engagement, parent-child connection, and family resilience) were statistically and significantly associated with the outcome of the MBH Conditions. Regarding the school disengagement expanded logistic regression, lower scores on five PCE items (i.e., safe neighborhood, safe school, constructive social engagement, parent-child connection, and family resilience) was associated with an increased likelihood of not being engaged in school. Expanded

logistic regression analyses for both outcomes yielded a significant interaction between cumulative PCEs and living in a safe neighborhood.

The purpose of Study 2 was to supplement the findings of Study 1 by providing a qualitative analysis of Black youth's subjective understanding of the impacts of positive childhood experiences on their mental and behavioral health outcomes and school engagement. The study sample included eight Black young adults ages 18-20 years. Data were collected through a series of audio-recorded semi-structured interviews and then transcribed and analyzed using the Consensual Qualitative Research (CQR) methodology. Four domains and multiple subsequent themes were developed: (1) Positive Childhood Experiences (participation in extracurricular activities, parent and family resiliency and bonding opportunities, community/neighborhood connectedness and engagement, school personnel-student interactions and relationships, and developing and maintaining meaningful friendships); (2) Mental Health Barriers and Remedies (parent-family support, mental health service accessibility and utilization, COVID-19 and subjective wellbeing, and racial/ethnic identity development and belonging); (3) School Engagement Barriers and Protective Factors (school climate and COVID-19 and school engagement); and lastly, (4) Sources of Resiliency (personal growth through independence and self-expression, self-improvement, self-awareness, and self-care, and adversity and consistent problem-solving). Implications for practice and research for both studies' findings are discussed.

CHAPTER ONE

INTRODUCTION

Background

The topic of youth mental health in the United States has gained significant attention at the state and national levels. In July 2022, the Biden-Harris Administration announced two new actions to address the unprecedented youth mental health crisis by way of strengthening school-based mental health services. These new actions included, (1) expanding access to mental health services in schools and (2) encouraging governors to invest more in school-based mental health services. Likewise, at the 2022 American Psychological Association (APA) conference main event, “The Kids are Not Alright,” a panel of clinical and school psychologists discussed a range of factors contributing to the significant decline of mental health and surge in psychological symptoms among youth across racial-ethnic backgrounds pre-and-post the COVID-19 pandemic. Panelists described the role of social media, the increase in suicide behaviors, service-related burdens experienced among mental health professionals, the shortage of school and community-based mental health providers nationwide, systemic racism, trauma, and other factors that are known to have significant and adverse impacts on youths' overall development and mental health. Panelists also discussed evidence-based approaches for addressing youths' mental health and promoting resilience, such as trauma-informed care, culturally informed frameworks, and increased regulation of social media usage. These discussions have highlighted the national emergency related to declines in youth mental health and the critical need for educators, researchers, and caregivers to prioritize these concerns.

Mental health is integral to overall health and well-being; it impacts one's interpersonal relationships and ability to handle stressors, emotions, thoughts, and behaviors (Centers for Disease Control and Prevention, 2022). The World Health Organization (WHO, 2022) refers to mental health as a state of mental well-being that enables people to cope with the stresses of life, realize their abilities, learn well, work well, and contribute to their community. Mental health exists on a complex continuum and is recognized as more than the absence of mental disorders and disabilities (WHO, 2022).

The years of childhood and adolescence are particularly crucial periods for developing healthy social, emotional, and psychological habits that promote better mental health in the long term. Studies show that many mental health concerns begin during childhood and adolescence and have lifelong implications for individuals' current and future well-being (Edmunds & Alcaraz, 2021). An estimated one in seven children and adolescents between the ages of 10-19 years old experience a mental health disorder and symptoms; these include emotional or behavioral disorders, eating disorders, psychosis, risk-taking behaviors, and suicide and self-harm behaviors (WHO, 2021). Mental health disorders in children and adolescents are described as critical changes in how they deal with emotions, learn, and behave; these changes can be distressing and affect their cognitive functioning (CDC, 2023). Mental health disorders can disrupt a child's social or cognitive behaviors. Though it is common for children to experience worries and fears or engage in some disruptive behaviors, if such symptoms and behaviors are persistent, severe, and significantly interfere with their daily activities, they may meet the criteria for a mental health disorder (Okwori, 2022).

A complex interplay of various social, psychological, and biological factors determines an individual's mental health. Research shows multiple social determinants of adolescent mental

health, such as the quality of their home life and living conditions, the quality of their relationships, exposure to violence, lack of access to quality services, and experiences of identity-based stigma, discrimination, and exclusion (WHO, 2021). Along with these interpersonal and community-level factors, research also indicates several school-level determinants of adolescent mental health such as school violence exposure (Walker et al., 2021), sense of school belonging (Pierre et al., 2020), perceptions of school climate (Ancheta et al., 2021; Moore et al., 2018), experiences of peer victimization (Armstrong et al., 2018), access to and utilization of school-based mental health services and supports (Gamble & Lambros, 2014; Kelchner et al., 2019), school policing and discipline practices (Perryman, 2022), and sense of school connectedness (Carney et al., 2017).

Current Mental and Behavioral Health Realities of Black Youth

Over the past several years, there has been a growing interest in the mental health concerns and outcomes of Black and African American youth specifically, as national data on various mental and behavioral health indicators suggest that Black youth are a vulnerable population in the United States (Henderson et al., 2019). National data from the 2021 Mental Health Client-Level Data report by the Substance Abuse and Mental Health Services Administration indicated that among Black youth ages 17 and younger who received mental health support, the most common mental health diagnoses included conduct disorder (26.9%), oppositional defiant disorder (25.9%), and ADHD (23.4%). depressive disorder (13.4%) and anxiety disorder (10.1%) were the least common diagnoses in which Black youth ages 17 and younger received mental health treatment in 2021 (SAMHSA, 2021). These data align with previous research that suggests that Black and African American youth are a particularly disadvantaged group, given that they are often over-diagnosed for certain mental health disorders

(e.g., psychotic, conduct, and disruptive behavioral disorders) while underdiagnosed for others (e.g., autism spectrum disorder [ASD], mood, anxiety, adjustment, and substance abuse disorders; Liang et al., 2016). Further, at the intersections of racial identity, sexual orientation, and gender identity, the mental health challenges experienced and reported among Black youth within the LGBTQ+ community are of even more significant concern. Black youth within the LGBTQ+ community are at an elevated risk for experiencing mental health concerns due to increased exposure to stressors in their environments (Trevor National Survey, 2021). For example, an estimated 65% of Black LGBTQ+ youth experience symptoms of generalized anxiety disorder and major depressive disorder (Trevor National Survey, 2021).

Moreover, given that engagement in suicide ideation and behaviors is a clear sign of a mental health challenge, another critical indicator of the vulnerability of mental health problems among Black youth is the increase in suicide behaviors within this group. Nationally representative school-based Youth Risk Behavior Surveys (YRBS) from 1991-2017 revealed that while rates of suicide ideation and plans are on a downward trend for youth across all other ethnic and racial groups in grades 9-12, Black youth reported increased rates of suicide attempts (Lindsey et al., 2019). This issue has been recognized by members of the Congressional Black Caucus (2019), who regard the increase in suicide amongst Black children and adolescents as a crisis, noting a 73% increase in suicide attempts among Black male and female adolescents over the past 25 years.

The State of Students' School Engagement

While the issue of youth mental health has garnered much attention over the past years, monitoring and promoting students' engagement in schools remains a critical area of focus for educators and caregivers. School engagement refers to the quality of students' subjective

experiences and interactions within their learning environment; these experiences and interactions are examined and understood through students' thoughts, feelings, and behaviors about school and learning. School engagement is commonly recognized as a protective and promotive role for academic achievement (Irvin, 2012).

National data from the YouthTruth (2022) study survey revealed four major findings related to student school engagement: (1) 78% of elementary school students, 59% of middle school students, and 60% of high school students feel engaged in school, (2) 72% of middle school students and 68% of high school students take pride in their work, (3) 54% of middle school students feel that what they are learning in the classroom will help them outside of school, and lastly (4) only 52% of high school students enjoy coming to school. Concerning the last finding, student absenteeism is related to numerous social factors and adversities outside of a student's control such as poverty, community violence exposure, challenging family dynamics, and health problems. Mental health is also a significant predictor of students' ability and willingness to be academically engaged (Nelson et al., 2020).

Risk and Resiliency Factors Associated with Mental Health and School Engagement

For decades, researchers across multiple disciplinary fields (e.g., psychology, social work, education) have extensively explored and examined historical and sociocultural determinants contributing to school engagement and mental health outcomes experienced among youth across all racial and ethnic identities. Much research has highlighted various social determinants of health (SDOH) and risk factors associated with students' outcomes. SDOH are nonmedical factors and conditions that can influence an individual's health outcomes, such as the environments in which individuals live, grow up, work, attend school, etc. (CDC, 2022). SDOH are organized into five domains: economic stability, education access and quality, health care

access and quality, neighborhood and built environment, and social and community context (CDC, 2022).

A well-documented SDOH is adverse childhood experiences (ACEs). ACEs are stressful and traumatic events that occur during childhood (0-17 years) that can increase the risks for significant physical, mental, and behavioral health outcomes later in life (Felitti et al., 1998). ACEs have consistently been associated with poor mental health outcomes (e.g., Bomysoad & Francis, 2020; Hinojosa et al., 2019) and poor academic outcomes (McKelvey et al., 2018) among youth. The literature on the impact of ACEs on minoritized youth outcomes is also well-established. Research shows that children and adolescents of minoritized backgrounds are disproportionately impacted by ACEs (Slopen et al., 2016; Algeria et al., 2015) as they experience higher levels of adversity, poverty, and poor health outcomes compared to their White counterparts (Lui et al., 2018). Black and Hispanic children and children from lower-income family households are exposed to more childhood adversities compared to White children and children from higher-income family households (Slopen et al., 2016). Likewise, Algeria et al. (2015) found family income disadvantages as one of the most common factors that contribute to disparities among children and adolescents from minoritized racial and ethnic backgrounds. It is argued that this disparity is in part due to systemic and historical environmental stressors such as poverty, poorer education and housing quality, and experience and perceptions of racism, discrimination, and oppression (Algeria et al., 2015).

Beyond ACEs, there is a plethora of literature that focuses on risk factors for poor mental health outcomes among Black youth, such as race-related stressors (e.g., systemic racism, discrimination, racial bias, injustice; Goodwin et al., 2021; Pachter et al., 2017), income inequity (i.e., poverty, low socioeconomic status [SES]; Reardon et al., 2013; Wahlback et al., 2017),

living in unsafe communities and neighborhoods (Sargent et al., 2020), and exposure to several types of violent and traumatic events that occur within their communities (Opara et al., 2020). In terms of poor academic outcomes among Black youth, some risk factors include socioeconomic status (SES; Gosa & Alexander, 2007), teacher's low expectations of students (Moore & Lewis, 2012), teacher discrimination (Thomas et al., 2009), and stereotype threat (Woodcock et al., 2012).

While research on ACEs and other risk factors associated with poor academic, mental, and behavioral health outcomes among Black youth has been pivotal in our understanding of these issues, such narratives have inadvertently contributed to deficit-based perspectives of Black youths' experiences and abilities. Within the literature, Black youth are often ascribed terms such as "at-risk" and "urban," which Nicolas et al. (2008) argue "are used as proxies for the youths' personality attributes and themes, such as violence, substance abuse, school underachievement, and family instability" (p. 261). Such deficit-based perspectives negate the existence of protective factors that Black youth pull from to persevere in difficult social conditions and circumstances. Risks are only a fraction of the lived experiences of many Black youth. Thus, "for African American children and adolescents to develop into individuals actively engaged in optimal personal and collective development, they must be placed 'at promise' as opposed to 'at risk' to become contributing members of their families, schools, communities, and the broader society" (APA Task Force on Resilience and Strength in Black Children and Adolescents, 2008, p. 24).

Many Black youth are resilient and hold stories of positive childhood experiences (PCEs) that affected their mental and behavioral health outcomes and school engagement. Resilience refers to the process and outcome of successfully adapting to complex or challenging life

experiences, primarily through mental, emotional, and behavioral flexibility and adjustment to external and internal demands (American Psychological Association, 2022)**.** PCEs are an overarching marker of resiliency. Positive experiences during childhood promote nurturing relationships, safe and equitable environments, constructive social engagement, and emotional competency (Sege & Browne, 2017).

Currently, there is a shortage of research that examines the role of PCEs on Black youths' mental health outcomes and school engagement, demonstrating a significant gap in the literature. Hence, there is a need for a dual-factor perspective to examine and understand Black youths' mental and behavioral health outcomes and school engagement. A dual-factor model of mental health is grounded in the perspective that though mental illness and subjective well-being are separate, an integration of both areas is necessary to create a more comprehensive understanding of mental health (Greenspoon & Saklofske, 2001). In other words, the dual-factor model underlines the importance of recognizing and understanding how risk and resiliency factors change youths' overall development, mental and behavioral health, and educational outcomes.

The Present Study

Black childhood and adolescence are dynamic and encompass a variety of both positive and negative experiences across multiple contexts, including their family and interpersonal relationships and experiences within their school and community. Adverse experiences and risk factors associated with Black youths' health and educational outcomes are well documented in the literature. However, there is a need to expand the literature that also emphasizes resiliency factors, positive experiences, and strengths-based perspectives to understand the mental and behavioral health realities of Black youth and the impacts on their school engagement. The current study's purpose is to address these literature gaps by exploring the extent to which PCEs

buffer the effects of ACEs on Black youths' mental health symptoms and school engagement and contribute to their overall resiliency development. The impact of PCEs on Black youths' mental and behavioral health and school engagement will be examined using quantitative and qualitative methods in two separate studies.

The study aims are as follows: (a) to investigate the relationships between ACE scores and the lifetime occurrence of a mental health condition (anxiety, depression, ADHD, and a behavioral or conduct problem), and ACEs and school disengagement, (b) to examine the buffering impact of PCEs on the relationship between ACEs and mental and behavioral health conditions, and ACEs and school disengagement, and (c) to retrospectively explore Black young adults' understanding of PCEs and how these experiences contributed to their mental and behavioral wellbeing, school engagement, and overall resiliency development. A summary of the study's aims is presented in Table 1.

Study 1: Research Questions and Hypotheses

Using nationally representative data from the 2020 National Survey of Children's Health (NSCH), the purpose of Study 1 is to provide a quantitative examination of the potential moderating impacts of PCEs on the relationship between ACEs, the occurrence of mental health conditions, and school disengagement, among Black youth ages 6-17 years in the United States. This study builds upon existing literature about PCEs and protective factors that have positive effects on Black youths' mental and behavioral health and school engagement. This study also contributes to existing literature on protective factors that may help to reduce the detrimental impacts of adverse experiences among children and adolescents. The findings of this study may provide caregivers, educators, and mental health providers with a more insightful understanding of the potential protective role of various positive experiences that can help to improve Black

youths' mental and behavioral health and educational outcomes. Guided by a social-ecological perspective, Study 1 explores protective factors across multiple contexts (i.e., family, schooling environments, and community/neighborhood influences).

The first research question is, "Is there a relationship between ACE scores and the lifetime occurrence of having one or more mental/ behavioral health (MBH) conditions (i.e., anxiety, depression, ADHD, and/or behavioral/conduct problem) among Black youth ages 6-17 years after controlling for predisposing factors/covariates (age, sex, family income, family structure)?" It is hypothesized that ACEs will be positively correlated with the lifetime occurrence of a mental/ behavioral health condition (anxiety, depression, ADHD, behavioral/conduct problem) among Black youth ages 6-17. The second research question is, "Is there a relationship between ACE scores and school disengagement among Black youth ages 6-17 years (age, sex, family income, family structure)? It is hypothesized that higher ACE scores will result in lower levels of school engagement among Black youth ages 6-17 years. Thus, ACEs will be significantly and negatively related to school engagement levels (i.e., more ACEs will lead to decreased engagement in school). The third research question is, "Do positive childhood experiences (PCEs) (i.e., safe community/ neighborhood, supportive community/ neighborhood, safe school environment, constructive social engagement, parent-child connection, and family resilience) moderate the relationship between ACEs and lifetime occurrence of a mental and behavioral health condition among Black youth, after controlling for predisposing factors/covariates (age, sex, family SES, and family structure)?" It is hypothesized that PCEs will reduce or buffer the impact of ACEs on the lifetime occurrence of a mental or behavioral health condition among Black youth after controlling for predisposing factors/ covariates. That is, it is hypothesized that when PCEs are entered into the model, the strength of

the relationship between ACEs and the lifetime occurrence of a mental/ behavioral health condition will be reduced. Thus, the more PCEs an individual has, the less predictive ACEs will be of the existence of a mental/behavioral health condition. Lastly, the fourth research question is, "Do positive childhood experiences (safe community/ neighborhood, supportive community/ neighborhood, safe school environment, constructive social engagement, parent-child connection, and family resilience) moderate the relationship between ACEs and school disengagement among Black youth after controlling for predisposing factors/ covariates (age, sex, family SES, family structure)?" It is hypothesized that PCEs will reduce or buffer the impact of cumulative ACE scores on school disengagement among Black youth after controlling for predisposing factors/ covariates. That is, it is hypothesized that when PCEs are entered into the model, the strength of the relationship between ACEs and school disengagement will be reduced. Thus, the more PCEs an individual has, the less predictive ACEs will be on school engagement.

Study 2 Research Questions

To the author's knowledge, no studies have qualitatively explored the lived experiences of Black youth regarding PCEs and their perceived impact on Black youths' well-being and school engagement. Thus, in Study 2, qualitative methodologies were employed to explore how Black youth understand PCEs and how they retrospectively perceive the impact of PCEs on their mental and behavioral health, school engagement, and resiliency development. Study 2 builds off Study 1 as it will provide new insights into the concept of PCEs not yet examined in the literature and may guide future methods of measuring and defining PCEs. There are five research questions for Study 2; there are no apriori hypotheses. First, what experiences from childhood do Black young adults perceive to be positive experiences that supported their well-being and resilience? How are these positive childhood experiences described and understood? Second, to

what extent do Black young adults attribute PCEs in their home, school, and community to their mental and behavioral health status? Third, to what extent do Black young adults attribute PCEs in their home, school, and community to their school engagement? Fourth, beyond the contexts of home, school, and community, are there any additional contexts in which positive childhood experiences occurred for Black young adults? And fifth, do Black young adults believe PCEs influenced their ability to build resilience in the face of adversity?

Table 1. Study Aims

Study Aims	**Study I**	**Study 2**
Aim 1: Investigate the relationships between ACEs and the lifetime occurrence of a mental health condition (anxiety, depression, ADD/ADHD, and a behavioral or conduct problem), and ACEs and school disengagement.	RQ1 RQ2	
Aim 2: Examine the buffering impact of PCEs on the relationship between ACEs and mental and behavioral health condition and school disengagement levels	RQ3 RQ4	
Aim 3: Retrospectively explore Black young adults' understanding of positive experiences and how these experiences contributed to their mental and behavioral well-being, school engagement, and overall resiliency development.		RQ1 RQ2 RQ3 RQ4 RQ5

Theoretical Approach and Guiding Frameworks

The current study is grounded in resilience theory (Fergus & Zimmerman, 2005). Resilience theory is a strength-based theory that focuses on positive youth development and the role that promotive factors play in disrupting risk factors that may lead to negative outcomes (Fergus & Zimmerman, 2005; Zimmerman et al., 2013). Resilience theory broadly integrates ideas from many theories, including the ecological theory (Bronfenbrenner,1979), general systems theory (von Bertalanffy,1968), developmental systems theory (Ford & Lerner, 1992), systems thinking in biology (Lickliter, 2013), family systems theory (Goldenberg & Goldenberg,

2013), and developmental psychopathology (Cicchetti, 2013). Thus, decades of research on resilience and factors associated with resilience across settings and age groups have contributed to the conceptual and theoretical frameworks of resilience theory. Resilience theory guides the understanding of why some children and adolescents can thrive and grow up to be healthy and functioning adults despite the adversity experienced and exposure to risks.

Additionally, the guiding framework for this study is the social-ecological model. Both resilience theory and the social-ecological model are heavily grounded in Bronfenbrenner's (1979) ecological theory, which highlights various social mechanisms in which multiple systems (e.g., individual, family, interpersonal relationships, communities and neighborhoods, society, cultures, etc.) interact and impact an individual's overall development (Crandall et al., 2019). In the current study, the social-ecological model was applied to focus primarily on Black youths' mental and behavioral health outcomes and school engagement within their home, school, and community contexts.

Study Contributions to School Psychology

Given that children and adolescents' mental health and well-being and school engagement are interconnected, it is imperative that school psychologists not only have a solid foundational understanding of risk factors but are also able to recognize and implement protective and promotive strategies that promote better mental health and school outcomes for students. School psychologists play a key role as mental health providers, as they are often tasked with providing services to address students' behavioral and mental health needs in schools. School psychologists must understand the specific needs and experiences of Black students in school to better address their mental and behavioral health concerns and help to improve their overall educational experiences and outcomes.

Key Terms and Definitions

Adolescence: the period of human development that starts with puberty (10 to 12 years of age) and ends with physiological and neurobiological maturity, shown in neuroscientific research to extend to at least age 20, with significant brain development in the late adolescent stage of 18 to 20 years (American Psychological Association, 2022).

Adverse Childhood Experiences (ACEs): Stressful and traumatic events that occur during childhood (0-17) that can increase the risks for significant physical, mental, and behavioral health outcomes later in life (Felitti et al., 1998).

Anxiety: an emotion characterized by feelings of tension, worried thoughts, and physical changes; a future-oriented, long-acting response broadly focused on a diffuse threat (American Psychological Association, 2022).

Attention Deficit/ Hyperactivity Disorder (ADHD): an ongoing pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development (National Institute of Mental Health, 2022).

Behavioral/ Conduct Problem: a pattern of disruptive behavior that falls within social norms and does not seriously impair a person's functioning (American Psychological Association, 2022).

Black/ African American: a citizen or resident of the United States whose ancestry, at least in part, can be traced to sub-Saharan Africa (American Psychological Association, 2022).

Depression: a common and serious medical condition that negatively impacts an individual's thoughts, feelings, and behaviors. (American Psychiatry Association, 2020).

Mental Health: a state of mental well-being that enables people to cope with the stresses of life, realize their abilities, learn well, and work well, and contribute to their community (World Health Organization, 2022).

Positive Childhood Experiences (PCEs): experiences during childhood that promote nurturing relationships, safe and equitable environments, constructive social engagement, and emotional competency (Sege and Browne, 2017).

Resilience: the process and outcome of successfully adapting to difficult or challenging life experiences, especially through mental, emotional, and behavioral flexibility and adjustment to external and internal demands (American Psychological Association, 2022).

School Engagement: a protective and promotive role for academic achievement (Irvin, 2012); a multidimensional construct that is conceptualized into three components: cognitive, emotional, and behavioral (Wang et al., 2014).

Social Determinants of Health (SDOH): nonmedical factors and conditions that can influence an individual's health outcomes, such as the environments in which individuals live, grow up, work, attend school, etc. (CDC, 2022).

CHAPTER TWO

LITERATURE REVIEW

In this chapter, the author will provide a deeper analysis of resilience science and its relevance to the current study. This will include a review of the literature on ACEs as it pertains to outcomes studied within Black youth populations and a brief synopsis of the latest research on PCEs. An overview of the social determinants of Black youths' mental and behavioral health and school engagement will also be provided. The social-ecological model guides the organization of this literature review, with research related to risk and resiliency factors impacting Back mental and behavioral health and school engagement presented for the following social contextual influences: (1) family and interpersonal relationships, (2) schooling environments and influences, and (3) community/ neighborhood influences.

Adverse Childhood Experiences

The emergence of resilience research in children is in part due to growing evidence that adverse childhood experiences (ACEs) have detrimental and lasting effects on individuals' health and overall development over the course of their lifespan (Hughes et al., 2017; Masten et al., 2021). Scholars define ACEs as potentially traumatic events that occur during childhood and have lasting negative effects on one's physical and mental health, well-being, and life opportunities; any aspect of a child's environment that undermines their safety, stability, and bonding could be considered an ACE (CDC, 2022). ACEs also interfere with an individual's social-emotional, cognitive, and physiological health (Hampton-Anderson et al., 2021). In the original ACEs study, scholars categorized ACEs into two major categories: (1) abuse and (2)

household dysfunction (Felitti et al., 1998). Subcategories under abuse included: psychological, physical, and sexual abuse. Subcategories under household dysfunction included: substance abuse, mental illness, mother being treated violently, and criminal behavior in the household (Felitti et al., 1998). Since this original study, ACE research has expanded to include an additional major category – neglect – which includes physical and emotional neglect, as well as divorce as a subcategory under household dysfunction (CDC, 2016). It is well established in the literature that ACEs are connected to negative and poor social and health outcomes (Anda et al., 2010; 2006; Mersky et al., 2013). It is also suggested that ACEs are associated with more than 40 distinct types of negative physical, mental, behavioral, and general health outcomes across at least seven different areas: (1) injury, (2) mental health (e.g., depression, anxiety, suicide, etc.), (3) maternal health, (4) infectious diseases, (5) chronic disease, (6) risk behaviors, and (7) opportunity (e.g., education; CDC, 2021).

Regarding the African American population, Hampton-Anderson et al. (2021) posits that "African Americans are at particularly increased vulnerability to ACEs due to a complex interplay of contextual factors that negatively impact physical and mental health over time" (p.315). These contextual factors include various traumatic exposures that change stress-related biological processes such as personal trauma, historic-systemic oppression, and marginalization (e.g., racism, police brutality, etc.), as well as intergenerational traumas (Hampton-Anderson et al., 2021). Such contextual factors can cause individuals to have chronic stress that adversely impacts their health.

Though not explicitly recognized as an ACE, scholars argue that experiences of racial discrimination should be considered an adverse childhood experience (Pachter et al., 2017), as discrimination is consistently associated with profound adverse mental and behavioral health

outcomes (Kirkinis et al., 2018). For several decades, scholars have argued that racism and racial discrimination are significant predictors of health inequities within the United States (Clark et al., 1999; Gee et al., 2012; Paradies et al., 2015; Shavers and Shavers, 2006) and a fundamental cause of adverse health outcomes for racial/ethnic minoritized groups (Williams et al., 2019). Henderson et al. (2019) writes, "drawing attention to deficits in Black youth, their family, and neighborhoods as predictors of poor health outcomes negates the effects of racism" (p. 926). Racial discrimination acts as a pervasive stressor for individuals in social interactions, regardless of intent, and can have harmful impacts across all socioeconomic levels (Braveman & Gottlieb, 2014). Thus, racial identity is an essential factor to consider when examining health disparities, including mental health (Lewis et al., 2018).

Racism, discrimination, biases, microaggressions, and stereotypes not only negatively affect Black people's identity development, but these incidents also have mental health considerations. Scholars have studied the associations between racial identity, experiences with racial stressors, and psychological outcomes for decades and across various age groups, including children (e.g., La Barrie et al., 2022), adolescents (e.g., Ajibewa et al., 2022; Pierre et al., 2020; Sellers et al., 2006), and adults (e.g., Dove-Medows et al., 2020; Greer & Cavalheiri, 2019). Research consistently and continuously shows that race-related stressors experienced amongst Black people across all age groups are serious and have detrimental impacts on their health and well-being. For example, researchers reveal that an estimated 90% of African American youth report experiencing racial discrimination within the past year (Lanier et al., 2017). As aforementioned, Black adolescents have reported experiencing increased instances of individual racism as they entered adolescence (Hughes et al., 2016). As many Black adolescents continue to face stressful experiences related to racism in their everyday lives, these negative

experiences have important implications for Black adolescents' general health and well-being (Hope et al., 2021).

Extensive research has linked experienced and/or perceived experiences of racism, biases, and discrimination to negative mental health outcomes among Black youth. Experiences of racial discrimination are associated with lower levels of psychological functioning (Sellers et al., 2006), such as depressive symptoms (English et al., 2013; Hammond, 2012), anxiety (Zapolski et al., 2019; Gaylord-Harden & Cunningham, 2009), and substance use (Zapolski et al., 2019). Some scholars have also found that racial discrimination impacts other areas of Black adolescents' psychological functioning and well-being, including decreased levels of self-esteem (Green et al., 2006), lower self-concept, and increased feelings of hopelessness (Nyborg & Curry, 2003), and difficulty coping with stress (Stock et al., 2014). Additionally, researchers have found links between perceived racial/ ethnic discrimination and externalizing disorders. For example, results from the Coker et al. (2009) study showed that Black and Hispanic children who experienced racial/ethnic discrimination were also more likely to report symptoms associated with ADHD, ODD (Oppositional Defiant Disorder), and conduct disorder than their White counterparts.

Further, using a national representative sample, Pachter et al. (2018) studied the relationship between discrimination, mental health, and ethnicity among youth who identified as African American or Afro-Caribbean. It was reported that 86% of youth had at least one experience of discrimination. Perceived experiences of racial/ethnic discrimination were significantly associated with higher rates of major depressive disorder (MDD) and anxiety (Pachter et al., 2017). These findings concur with earlier research that suggests that experiences or perceived experiences of racial discrimination are a significant psychological and physical

stressor among children and adolescents of racial and ethnic minoritized backgrounds. Likewise, using data from the National Survey of Children's Health (NSCH) surveys from the years of 2016 through 2019, Bernard et al. (2021) studied the associations between racial discrimination, ACEs, and internalizing concerns among Black children and adolescents ages 0-18 years. Results revealed that racial discrimination was associated with all eight ACEs (i.e., economic hardship, parental divorce, parental death, parental jail, domestic violence, neighborhood violence, mental illness in the household, and substance problems). This association was especially pronounced with witnessing or being a victim of neighborhood violence and living with a person who has a mental illness (Bernard et al., 2021). It was concluded that "youth who experienced racial discrimination were significantly more likely to report all other examined ACEs, multiple ACE exposures, and internalizing diagnoses relative to youth who were not reported to have experienced racial discrimination" (p. 479-480). Thus, anti-Blackness and experiences of racial discrimination are highly correlated with other forms of childhood adversity for Black youth and contribute to increased rates of internalizing symptoms.

Though much of the research on ACEs centers on the experiences of adult populations, within the past decade, there has been an increase in research exploring the connection between ACEs and health outcomes among younger populations. Research shows that children and adolescents of minoritized backgrounds are disproportionately affected by ACEs (Slopen et al., 2015). Black and Hispanic children and children from lower-income family households are exposed to more childhood adversities compared to White children and children from higher-income family households (Slopen et al., 2017). Likewise, Algeria et al. (2015) found family income disadvantages as one of the most common factors that contribute to disparities among children and adolescents from minoritized racial and ethnic backgrounds. It is argued that this

disparity is in part due to systemic and historical environmental stressors such as poverty, poorer education and housing quality, and experience and perceptions of racism, discrimination, and oppression (Algeria et al., 2015). Melton-Fent (2019) explored data from the National Survey of Children's Health of 2016-2017 with a particular focus on the types of ACEs experienced among non-Hispanic Black youth. Parent reports revealed that 62.3% of Black children and adolescents had experienced at least one ACE (Melton-Fent, 2019). Household dysfunction was the most common major category of ACEs found among this sample, with divorce (54.3%), family income (53.9%), and parental incarceration (23.7%) being the most common subcategories of ACEs reported (Melton-Fent, 2019).

Bomysoad and Francis (2020) explored nationally representative data from the 2016-2017 National Survey of Children's Health (NSCH) and found that poor physical and mental health outcomes among children and adolescents under 18 years in the United States are linked to ACEs. Specifically, scholars found that increased levels of ACEs were associated with increased chances of youth having a mental health condition, including depression, anxiety, behavioral/ conduct problems, ADHD, and substance use disorder (SUD; Bomysoad & Francis, 2020). Within these data, Black youth accounted for 6.7% of the sample. Results of this study suggest that Black children and adolescents are at an increased risk of experiencing an adverse childhood event, given that more had reported experiencing at least one ACE compared to no ACE. Specifically, only 8.7% of Black youth within this sample did not have a reported ACE, while 18.4% had one ACE, 25.3% had two ACEs, 18.7% had three ACEs, and 25% had four or more ACEs (Bomysoad & Francis, 2020).

ACEs are increasingly linked to reduced psychological adjustment among children and adolescents, as ACEs have profound effects on youths' psychosocial functioning (Bernard et al,

2021). There is emerging evidence that Black youth are disparately burdened by ACEs and thus are at increased risk for experiencing poor mental and behavioral health outcomes. Bomysoad and Francis (2020) explored data from the National Survey of Children's Health of 2016-2017 and found that poor physical and mental health outcomes among children and adolescents under the age of 18 in the United States are linked to ACEs. Specifically, results from the study revealed that increased levels of ACEs were associated with increased chances of youth having a mental health condition, including depression, anxiety, behavioral/ conduct problems, ADHD, and SUD. Further, these data suggested that Black children and adolescents were at an increased risk of experiencing poor physical and mental health outcomes as they were at an increased risk for experiencing an ACE. Researchers argue that "the disparate rates of ACEs and trauma-related mental health concerns among Black youth may be explained, in part, by the broader typology of ACEs that are more likely to occur among historically marginalized populations" (Bernard et al, 2021, p.474; Cronholm et al., 2015).

Moreover, some scholars have examined the effects of ACEs on Black youths' internalizing and externalizing behaviors. For instance, Hicks et al. (2021) examined the associations between ACEs, psychological distress, substance use, and delinquency among Black youth ages 11-17 years. Results from this study are consistent with earlier research that shows an association between ACEs and internalizing and externalizing behaviors. Specifically, there was a direct association between ACEs and psychological distress experienced among Black youth. Participants who reported more ACEs also reported higher levels of psychological distress. Further, psychological distress was directly associated with substance use and delinquent behaviors; those who reported higher levels of psychological distress also reported higher rates of substance use, delinquency, and aggressive behaviors. It was concluded that ACEs are related

to internalizing and externalizing behaviors among Black youth. In another study examining the prevalence of ACEs and the associations between ACEs, depression, spirituality, and resilience among African American youth in a southern state, Freeny et al. (2021) found that increased exposure to ACEs correlated with a higher likelihood of experiencing depressive symptoms; participants who reported four or more ACEs were more likely to report depression. In this study, the most common ACEs reported included: (1) the death of a close friend or family member (72%), (2) physical abuse (i.e., being pushed, slapped, grabbed, hit, or having something thrown at them; 56%), (3) witnessing or hearing of violence within their community (48%), and (4) parental divorce (47%).

ACEs have also been shown to have negative impacts on children and adolescents' academic achievement and outcomes. A higher incidence of ACEs is associated with decreased school engagement, grade retention, and school absenteeism (Bethell et al., 2014), increased learning and behavior problems (Burke et al., 2011), and decreased reading abilities (Duplechain et al., 2008). In a more recent study, Hinojosa et al. (2019) examined the impact of ACEs (economic hardship, abuse, neglect, household and family dysfunction, and community violence exposure) on children and adolescents (ages 17 years and younger) grade retention using data from the 2012 NSCH. Results from this study indicated that ACEs are associated with higher rates of grade retention. Youth who have experienced three or more adversities were at a significantly higher risk of grade retention compared to children who had not experienced any ACEs. ACEs even negatively affect the educational outcomes of children during their early education years. Jimenez et al. (2016) studied the impact of ACEs on the educational outcomes of children in kindergarten using secondary analyses of the Fragile Families and Child Wellbeing Study. Results revealed that children who experienced three or more ACEs had below-average

language and literacy skills, math skills, and poorer emergent literacy skills. A higher incidence of ACEs was also associated with behavioral problems such as increased attention problems, aggression, and social problems among kindergarteners. In a study centered on gender differences and the experiences of adolescents in high school, Duke (2020) examined the relationships between ACEs and three educational outcomes (graduation plan, school absences, and low academic achievement) using secondary analyses of the 2016 Minnesota Student Survey. Adverse educational outcomes were significantly associated with exposures to multiple types of ACEs, regardless of gender. However, there were some gender differences in the types of ACEs that negatively impacted specific educational outcomes. For female students, housing instability, food insecurity, and verbal-emotional abuse were strongly associated with no plans to graduate; school absences were strongly associated with housing instability and living with someone with a substance use problem; and lastly, low academic achievement was strongly associated with parental incarceration, housing instability, and living with someone with a substance use problem (Duke, 2020). For male students, no plans to graduate was strongly associated with having experienced sexual abuse by a family or non-family member and food insecurity; school absences were also strongly associated with having experienced sexual abuse by a family or non-family member; and lastly, experiences of any ACE were associated with lower academic achievement (Duke, 2020). To conclude, the incidence of ACEs is strongly associated with numerous indicators of educational success (e.g., school engagement, grade retention, attendance, literary and math skills, graduation plans, and achievement).

An emergence of empirical studies suggests various protective factors that can buffer the negative impact of ACEs on youth outcomes. For example, Lensch et al. (2021) studied the estimated associations between cumulative exposure to adverse childhood experiences (ACEs),

protective factors, and co-occurrence of psychological distress and substance abuse among youth in the juvenile justice system. In this study, protective factors included high internal resilience, family communication, school connectedness, peer role models, and non-parental adult role models. In this study, more than half of the participants reported at least one ACE; the most common ACEs experienced were household substance use (62.9%), parental incarceration (61.5%), neighborhood violence (55%), and verbal abuse (50.3%). More than half of the participants reported at least one protective factor; the most common protective factors reported were high internal resilience (52%) and school connectedness (51%). Further, increases in ACEs were associated with increased co-occurrence of psychological distress and substance abuse. Notably, all five protective factors were associated with decreased odds of co-occurring problems. High internal resilience moderated the relationship between ACEs and co-occurring problems. Additionally, four of the five protective factors (all except having a non-parental adult role model) were shown to result in continued decreases in the odds of co-occurring problems (Lensch et al., 2021). Scholars concluded that high internal resilience, family communication, school connectedness, and peer role models are strong protective factors that influence the co-occurrences of psychological distress and substance abuse among youth in the juvenile justice system. It was suggested that positive youth development programs that foster positive peer and adult relationships and support systems may help to promote resilience and improved well-being among youth exposed to adversities.

In another empirical study, Sparks et al. (2021) examined the moderating role of hope as a protective factor against ACEs, delinquency, and posttraumatic stress symptoms for adolescents in 6th and 9th grade. The concept of hope was measured using the Hopeless Scale for Children. As predicted, a higher incidence of ACEs was significantly associated with increased

engagement in delinquent behaviors and increased rates of posttraumatic stress symptoms. Additionally, ACEs were negatively associated with hope. Conversely, hope was associated with fewer delinquency acts. It was concluded that hope is a protective factor against poor outcomes that may lead to delinquent behaviors.

Robles et al. (2019) examined the association of ACEs and protective familial and community factors on children's school performance and attitudes using cross-sectional data from the 2011-2012 NSCH. This study included seven protective factors: a safe neighborhood, supportive neighbors, four neighborhood amenities, a well-kept neighborhood, no household smoking, five or more family meals per week, and parents who talk to their children. Indicators of school performance and attitudes included grade retention, homework completion, and caring about school. This study revealed that each negative school outcome was associated with higher ACE scores and lower protective factor scores. As ACE scores increased, parents reported higher rates of grade retention and higher percentages of children not completing homework or caring about school. However, when protective factors were added to statistical models, negative school outcomes associated with ACEs were reduced, thus, showing that protective factors may decrease the relationship between ACEs and negative school outcomes. Notably, the protective factor of having parents who talk to their children about things that matter and share ideas was found to be the strongest protective factor against ACEs. Scholars concluded that the mediation of protective factors may help children develop resilience despite exposure to stress and adversity (Robles et al., 2019). Using the same 2011-2012 NSCH survey, Lui et al. (2020) examined the relationship between ACEs and protective factors across school, family, and community contexts among Black, Latinx, and White adolescents ages 12-17. The associations between students' health, resilience, and racial disparities were also examined in this study.

Results suggested that numerous protective factors (good parent-child communication, low parental stress, eating family meals together, mentorship, participation in organized activities, service work, school engagement, school and neighborhood safety, and family-centered care) were associated with overall better health outcomes (Lui et al., 2020). Regarding racial disparities, compared to Black and Latinx youth, White youth were endorsed to have lower incidences of ACEs, greater access to numerous protective factors, and better health outcomes. These findings suggest that racism and discrimination have detrimental impacts on minoritized youths' health outcomes.

Positive Childhood Experiences

Though research acknowledges the lasting effects of adversity in childhood, researchers have also placed great emphasis on promotive and protective factors and positive life experiences that may counteract the negative impacts of ACEs and other risk factors. Early research on resilience focused on positive attributes of the child (e.g., self-efficacy, cognitive skills, etc.), the family (e.g., parenting styles, family cohesion), and other external social supports outside of the family (e.g., teachers, schooling environments, friends; Masten et al., 2021). A growing area of research related to youths' general health and wellbeing outcomes is focused on positive childhood experiences (PCEs).

PCEs are an overarching marker of resilience. The current conceptualization of PCEs stems from the HOPE framework. The HOPE framework is a conventional approach and response to ACEs and how childhood adversity impacts adult health and behaviors later (Sege & Browne, 2017). Sege and Browne argue that ACE studies "have increased our appreciation of the overwhelming importance of childhood experiences on brain growth and lifelong health. ACEs and toxic stress, however, represent only one end of the continuum of childhood experiences that

influence the trajectory of early brain development and subsequent learning, behavior, and health" (p. S80). Thus, the HOPE framework asserts that improving the lives of children, especially those exposed to traumatic and stressful conditions, "requires intentional efforts that reduce adversity and promote positive experiences" (p. S80). This strength-based approach to addressing, examining, and understanding youth development elevates the importance of positive experiences. The notion of HOPE is that PCEs help to create a culture of positive and thriving adults despite having a history of childhood trauma and adversity. The HOPE framework is a pathway to resilience. Additionally, there are three guiding principles for understanding the HOPE Framework. First, a child's health outcomes are influenced by both positive and negative factors across multiple contexts (i.e., individual, interpersonal, community and neighborhood, and society). Thus, the interplay among these factors and contextual influences must be considered and addressed to achieve optimal child health outcomes. Secondly, a child's health is inextricably connected to their parent's health, therefore, positive childhood experiences must promote the health of the child, parent, and the parent-child relationship. It is important to note that "parent" is considered any adult who is responsible for caring for the child. This can include biological and non-biological caregivers, grandparents, and other relatives. Lastly, a child's health encompasses outcomes related to their physical, cognitive, social, and emotional development.

The HOPE framework emphasizes the role of PCEs in youth development across physical, cognitive, social, and emotional domains. PCEs are conceptualized into four building blocks: (1) being in nurturing and supportive relationships, (2) living, developing, playing, and learning in safe, stable, protective, and equitable environments, (3) having opportunities for constructive social engagement and to develop a sense of connectedness (i.e., social and civic

engagement) and (4) learning social and emotional competencies (i.e., emotional growth). Within the first category, nurturing and supportive parent-child relationships include elements such as secure attachments, trusting relationships, and having a physically and mentally healthy parent. Elements of the second category include having a safe and stable home, receiving adequate nutrition and sleep, and access to high quality learning opportunities, medical and dental care. The third category involves experiencing fun and joy, accomplishments, a sense of belonging, and awareness of personal cultural customs and traditions. Lastly, the fourth category emphasizes learning executive functioning skills, positive character traits, self-awareness, and self-regulation (Sege & Browne, 2017).

Due to the nascent nature of PCEs, researchers have measured them in many ways. For example, Slopen et al. (2017) created a PCE index based on the presence or absence of eight components: (1) high parental education, (2) high perceived SES, (3) two-parent family, (4) residential stability, (5) no smokers residing in home, (6) high parental warmth, (7) high emotional support and (8) high instrumental support. In another study, Narayan et al. (2018) developed the 10-point Benevolent Childhood Experiences (BCE) scale to create a more standardized scale measuring PCEs. Items included on the BCE scale centered on experiences related to interpersonal relationships, school, communities/neighborhoods, and self-concepts. Example items on the BCE scale include the following: “Did you have at least one caregiver with whom you felt safe?” “Did you like yourself or feel comfortable with yourself?” “Did you have good neighbors?” and “Did you have at least one teacher who cared about you?” Researchers who have used the BCE scale have found it to be a reliable and valid tool for measuring PCEs, particularly among adult populations (e.g., Oge et al., 2020).

Literature on the impacts of PCEs on mental and behavioral health outcomes among adult and youth populations is limited yet emerging. The earliest studies centering on PCEs of adolescents were conducted by Kosterman et al. (2011), who examined the mediating role of adolescent substance use and PCEs as predictors of positive adult functioning. Positive adult functioning included civic engagement, productivity and responsibility, interpersonal relationships, and physical exercise. PCEs significantly predicted better adult functioning and significantly less substance use. Researchers posit that PCEs continue to have a considerable influence on prosocial and positive functioning into young adulthood.

Moreover, using parent-reported data from the NSCH 2017-2018, Crouch et al. (2022) examined racial and ethnic differences in PCEs among children living in rural areas. The sample included children identified as non-Hispanic White (72.6%), Hispanic (10.1%), and non-Hispanic Black (6%). Like the aforementioned study, the most reported PCEs included mentorship (94.6%) and participation in afterschool activities (74.3%). Family resilience (80.7%) was another commonly reported PCE, as well as living in a safe neighborhood (68.5%). A critical finding from this study, however, is the disparity in frequencies of PCEs reported for youth across racial and ethnic backgrounds. Racial-ethnic minoritized youth in this sample were less likely than White youth to experience these PCEs, suggesting disparities in PCEs across racial and ethnic backgrounds. In another study using NSCH data, Crouch et al. (2021) examined the relationship between PCEs, and challenges related to school success among children and adolescents ages 5-17 years; the final sample included children that were a majority 6-12 years old (58.2%), male (51.2%) and non-Hispanic White (58.2%). In this study, PCEs were conceptualized into seven categories: (1) afterschool activities, (2) volunteering in the community, school, or church, (3) mentor for advice or guidance, (4) sharing ideas with a

caregiver, (5) living in a safe neighborhood, (6) living in supportive neighborhood, and (7) family resilience. Results from this study revealed that the most reported PCEs for children and adolescents were mentorship (89.8%), family resilience (89.8%), and participation in afterschool activities (79.8%). Protective factors for school absenteeism included participation in afterschool activities, family resilience, and living in supportive neighborhoods. Protective factors for grade retention included sharing ideas with caregivers and participation in after-school activities. Thus, findings from this study show that PCEs have a positive impact on children's educational outcomes.

Qu et al. (2022) used cross-sectional survey data to examine how PCEs moderate the impact of ACEs on Chinese adolescents with anxiety and depression. Researchers created a seven-item PCE checklist of items adapted from four subscales of the Child and Youth Resilience Measure-28. The seven items on the PCE checklist included: (1) felt able to talk to their family about feelings; (2) felt their family stood by them during challenging times; (3) enjoyed participating in community traditions; (4) felt a sense of belonging in school; (5) felt supported by friends; (6) had at least two non-parent adults who took a genuine interest in them; and (7) felt safe and protected by an adult in their home. Results showed that PCEs were negatively associated with risks of internalizing symptoms, while ACEs were positively associated with risk for depression and anxiety. Further, all PCEs were protective factors for adolescents with depression and anxiety.

As demonstrated in the previous section, PCEs are operationalized and measured differently. However, the main themes used to indicate PCEs are family/ home dynamics, individual characteristics, community, school, and non-familial support. Table 2 provides a summary of survey items and themes used across multiple studies to measure PCEs. Not only are

there inconsistencies in the way PCEs are understood and measured in the literature, PCEs have also only been measured quantitatively. There is a need for a qualitative analysis of PCEs. Additionally, we know little about how youth understand and conceptualize the role of positive experiences in their childhood on their functioning and well-being. Given that this current study focuses on Black youths' experiences, it is important to understand the impact of PCEs on their mental and behavioral health outcomes and school engagement. It is also important to understand how Black youth think about positive experiences that affect them the most. Black youths' perspectives on PCEs may help to inform researchers' and educators' understanding and measurement of PCEs moving forward. The current study intends to address these gaps within the literature.

Table 2. Items and Theme Indicators of Positive Childhood Experiences

Study	Family/ Home	Individual	Community	School	Non-family Support
Crouch et al. (2022) Crouch et al. (2021)	Share ideas with caregiver Family resilience		Volunteer in community, school, or church Live in safe neighborhood Live in supportive neighborhood	After-school activities	Mentor for advice or guidance
Narayan et al. (2018)	Did you have at least one caregiver with whom you felt safe? Did you have a predictable home routine, like regular meals and a regular bedtime?	Did you have beliefs that gave you comfort? Did you have opportunities to have a good time? Did you like yourself or feel comfortable with yourself?	Did you have good neighbors?	Did you like school? Did you have at least one teacher who cared about you?	Did you have at least one good friend? Was there an adult (not a parent/caregiver or the person from #1) who could provide you with support or advice?
Slopen et al. (2017)	High parental education High perceived SES Two-parent family Residential stability No smokers residing in home High parental warmth High emotional support High instrumental support				
Qu et al., 2022	Felt their family stood by them during challenging times Felt able to talk to their family about feelings Felt safe and protected by an adult in their home.		Enjoyed participating in community traditions	Felt a sense of belonging in school	Felt supported by friends Had at least two non-parent adults who took genuine interest in them

Social Determinants of Black Youth Mental and Behavioral Health:

Social-Ecological Perspective

As previously discussed, ACEs can have a profound impact on a child's overall health, development, and future. However, ACEs are only part of a larger and more complex interplay of social determinants that impacts individuals' health. WHO posits that health and illness conditions follow a social gradient with a particular focus on socioeconomic status; that is, the lower an individual's socioeconomic position is, the worse the health and illness conditions may be. Likewise, other researchers suggest that education, wealth, and income are fundamental drivers of many health outcomes (Braveman and Gottlieb, 2014). SDH can have both positive and negative effects. SDH associated with physical health outcomes are also associated with mental health outcomes and play a critical role in the "development, severity, and chronicity of mental and substance use disorders" (Shim and Compton, 2018, p. 844). Examples of SDH associated with poor mental health include poverty and economic inequities (Manseau, 2014), education inequities and disparities (Dohrmann et al., 2022), housing stability and instability, and food insecurity (Compton, 2014). Further, income inequity has been independently associated with depressive symptoms and prevalence (Messias et al., 2011).

For several decades, researchers have extensively studied the complexities of social determinants that capture the lived experiences and functioning of Black and African American families. Given the unique socio-historical position and experiences of Black people in the United States, much of the research available is situated in a context in which historical stressors and events merge with current stressors and events. In addition to describing and addressing historical and current stressors, researchers have emphasized enduring strength and resilience

among African American populations. Masten (2001) referred to the enduring strength and reliance of African Americans as *ordinary magic*. Ordinary magic is resilience that emerges when individuals can find ways to adapt and respond to adversity faced. Murry et al. (2018) conducted an extensive review of the literature on the social determinants of Black families and stress. From this review, Murry and colleagues developed an integrative model of stress which includes seven interconnected pathways suggested to be associated with stressors and/or strengths among Black families (Figure 1). The following sections of this literature review will explore social determinants that specifically impact the mental and behavioral health for Black youth across multiple contexts including family and interpersonal relationships, community, and the school environment. Many of the factors shown in the integrative model for the study of stress in Black American families align with the influences that will be explored in the later sections.

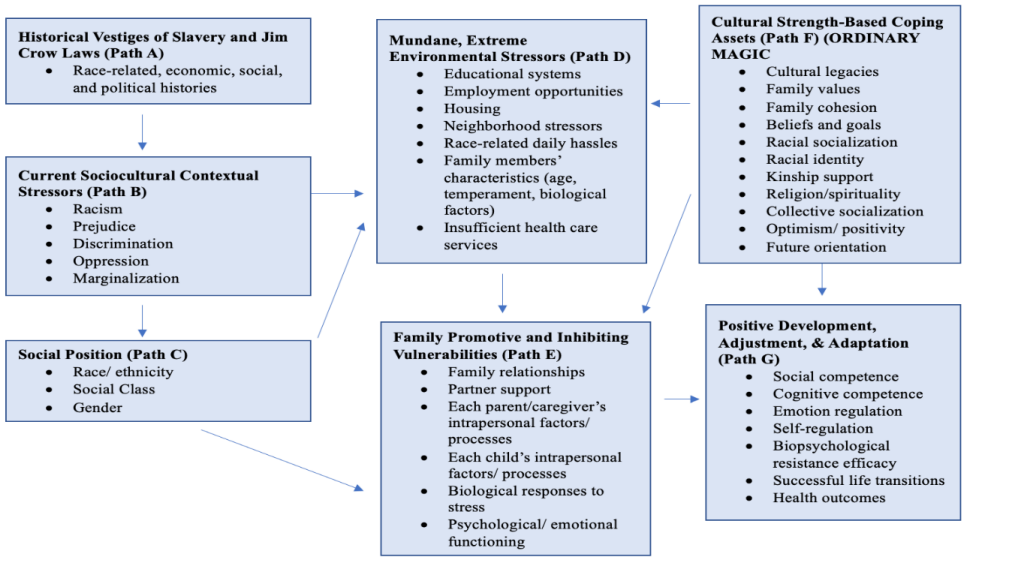

Figure 1. An adaptation of the Integrative Model for the Study of Stress in Black American families (Murry et al., 2018)

Family and Interpersonal Relationships Influence

Familial and parental support has been associated with many positive outcomes for children and adolescents. Having a caring and supportive parent, for instance, is a protective factor against adverse experiences (Barton et al., 2018). In a systemic review of empirical studies that focused on the association between family-level factors and internalizing symptoms (i.e., depression and anxiety) among African American children, Washington et al. (2017) found parenting practices to be the most often examined family-level factor. Positive parenting practices served a protective role in buffering anxiety and depressive symptoms among Black children. Other family-level factors examined in the literature included family conflict and family functioning and environment. Less family conflict was associated with decreased anxiety and depression among Black children. In another study investigating the impact of positive parenting on Black youth psychological outcomes, Lei et al., (2021) examined the effectiveness of a family-based prevention program called Protecting Strong African American Families (ProSAAF). Parent participation in the intervention buffered the impact of racial discrimination on Black youth depressive symptoms. Specifically, increasing positive parenting practices was shown to promote resilience among Black youth and reduce depressive symptoms. The results of these studies contribute to the growing literature that emphasizes the critical role of family-level factors on Black youth mental health outcomes.

Sterrett-Hong et al. (2020) used the compensatory resilience model to examine individual and family-level factors that affect African American adolescents' psychological and social-emotional functioning (i.e., depressive symptoms, hopelessness, and self-esteem). Individual/child-level factors assessed in this study were ethnic identity and religiosity. Family-level factors assessed were maternal warmth/support, monitoring, and psychological control.

This study yielded the following results: positive ethnic identity was associated with higher self-esteem and lower levels of depression and hopelessness; lower levels of maternal psychological control (risk factor) was associated with lower levels of hopelessness and depressive symptoms and higher levels of self-esteem; higher levels of maternal monitoring was associated with lower levels of depression and hopelessness and higher levels of self-esteem. The authors concluded that interventions targeting positive ethnic identity, self-esteem, and maternal psychological control are of particular importance as these factors may be potential protective factors for African American youth.

Studies show that the quality of the parent-child relationship has potentially profound and lasting impacts on youths' health and overall development (Chen et al., 2017). In fact, parent-child conflict is a predictor of internalizing and externalizing behaviors and health problems among adolescents. For example, results from Pinquart's (2017) meta-analysis revealed multiple parental variables are associated with increased externalizing behaviors over time among adolescents, such as harsh control, psychological control, and permissive and neglectful parenting styles. In a study examining the effects of parent-child relationships among Black adolescents and their physical and mental health problems, Shakiba et al. (2022) found that if Black boys with lower levels of cortisol relativity experience high conflictual relationships with their parents, they are more likely to have higher levels of internalizing problems.

Scholars consider racial socialization to be a critical developmental process for Black youth (Neblett et al., 2016), as it has also been found to be a contributing factor to mental and behavioral health outcomes among Black youth (Reynolds & Gonzales-Backen, 2017), including substance use (Neblett et al., 2010) and depressive symptoms (Neblett et al., 2013). Racial socialization refers to "the process through which caregivers convey implicit and explicit

messages about the significance and meaning of race and ethnicity, teach children about what it means to be a member of a racial and/or ethnic minority group, and help youth learn to cope with discrimination" (Neblett et al., 2012, p. 296). Anderson and Stevenson (2019) describe racial socialization as verbal and nonverbal communication about racialized experiences between African American parents and children. Parents and caregivers who anticipate that their child may encounter racial discrimination in the future will try to prepare them to cope and handle such incidents. Butler et al. (2018) position that "positive racial socialization messages may provide adolescents with a mental framework for understanding discrimination experiences and may allow them to cope with negative race-related experiences and develop connected and positive racial identities" (p. 432).

Researchers who study Black girls and women often examine the role that gendered racism, and historical negative stereotypes play in their racial and gender identity development and outcomes across setting. Gendered racism is defined as "simultaneous and compounding forms of oppression women of color experience based on their race and gender" (Jones et al., 2022, p. 39). Research shows that historically negative images such as jezebel (i.e., seductive, manipulative, and hypersexual) and sapphire (i.e., verbally aggressive and argumentative; Collins, 2000) continue to impact Black women and girls' self-perceptions and how others view them. For instance, in a recent study examining adolescent Black girls' ethnic-racial identity development, Mims and Williams (2020) found that socialization, biases, and stereotypes played a critical role in participants' identity development. For example, one of the participants in the study equated having a darker skin complexion to living in lower-income housing (i.e., the projects). Another participant perceived Blackness within two categories: she described the African American peers as "ghetto" and insinuated that her peers with one or both parents from

Africa as better. In another study examining adolescent Black girls' ethnic-racial identity development, Townsend et al. (2010) examined the Black girls' self-esteem and the adverse impacts of racially charged stereotypes and images on their well-being. Results from the studies revealed that participants who endorsed and internalized negative stereotypes showed increased sexual risk. Thus, the internalizing of such negative stereotypes of one's identity can be detrimental to one's well-being. Adultification bias, as defined by researchers at the Georgetown Law Center on Poverty and Inequality, is a term used to reference the perception of Black girls as being less innocent and more adultlike than White girls of the same age (Epstein et al., 2017). According to survey results that compared Black and White girls of the same age, Black girls as young as five years old were perceived as needing less nurturing, support, protection, and comfort. Black girls were also perceived as more independent, knowing more about adult topics, and knowing more about sex (Epstein, et al., 2017).

Further, Brown et al. (2016) posit that gendered racial socialization "serves as a form of dual socialization designed to address the realities of the African American female experience and teach them how to cope with the gendered racism (e.g., racialized sexual stereotyping) they may encounter" (p. 181). Grounded in research documenting the ways in which Black girls experience higher propensities of sexual abuse and assault, criminalization and adultification (Warner, 2017), and racism and racial discrimination (Anderson et al., 2019), Winchester et al. (2022) examined the role of gendered racial socialization on the mental health outcomes of Black girls. Specifically, they examined the moderating role of positive racial messages (i.e., gender racial socialization-pride and empowerment) on the relationship between negative racial messages (i.e., internalized gendered racial oppression) and mental health outcomes (i.e., the prevalence of anxiety, depression, and stress symptoms) of Black girls. Examples of negative

racial messages of Black girls and women include stereotypical beliefs that Black hair is "unattractive," Black women have "bad attitudes," sexual promiscuity, etc. (Winchester et al., 2022). Such messages are steeped in misogynoir and have implications for Black girls' psychological self-concept and overall well-being (Walton and Boone, 2019). Results revealed that greater frequencies of messages of internalized gendered racial oppression, specifically messages about their hair and skin, and the socialization messages from their parents were associated with more depression, anxiety, and stress symptoms. Conversely, a greater frequency of positive gender-racial messages was associated with reduced symptoms of anxiety, depression, and stress. These results support the notion that messages received by Black girls regarding their race and gender impact their mental health.

Lindsey et al. (2017) provides deeper insights into how gender and racial socialization contribute to untreated depression among African American males. The authors discuss the phenomenon of "masking" as a potential reason for misdiagnosing depression among Black males. As supported by literature, males tend to exhibit more externalizing and antisocial behaviors (e.g., aggression, anger) rather than internalizing behaviors. Thus, mental health professionals – including school-based mental health professionals – may misinterpret externalizing behaviors as conduct problems rather than symptoms of depression. Further, Lindsay and colleagues (2017) explained that commonly used messages and notions of masculinity and what it means to be a man may influence how Black boys conceptualize their problems with depression and their willingness to seek treatment. Black boys often receive messages such as "Boys don't cry," "Be tough," and "Man up" from adults and peers starting in early childhood. These messages are often carried into adulthood. Thus, many Black boys are not offered opportunities to explore and discuss behaviors and emotions that are developmentally

and contextually appropriate. Moreover, parent and caregiver beliefs and misunderstandings of mental health as well as school factors such as disparities in discipline policies and low teacher expectations, may contribute to depression symptoms among young Black males (Lindsey et al., 2017).

School Level Influences

School climate is the quality and character of a school; it encompasses students', parents' and educators' perceptions of school norms, values, goals, practices, and structures (National School Climate Center, 2020). Educators use school climate data to examine students' perceptions of their school environment and experience and to determine areas of need in schools. Although mental health is not a distinct dimension of school climate, research on the associations between school climate and students' mental health outcomes is growing. Study findings, however, are mixed. Some studies suggest that a positive school climate supports students' social, emotional, and behavioral well-being (La Salle et al., 2021; Lester and Cross, 2015), whereas other studies suggest that the associations are not causal (Leurent et al., 2021).

Lester and Cross (2015) found that feeling safe at school and connected to school were significant predictors of students' mental and emotional well-being. Likewise, La Salle et al. (2018) studied the perceptions of school climate among students with a diagnosis of emotional and behavioral disorder (EBD) and students without a diagnosed disability. Students with EBD reported significantly lower perceptions of school climate and higher rates of mental health problems and peer victimization compared to their peers without a disability (La Salle et al., 2018). Similarly, Townsend et al. (2017) explored the relationship between school climate and the mental health of students with depression. Results from this study indicated that school climate influences students' help-seeking behaviors in schools in two distinct ways: (1) school

climate influences students' willingness to acknowledge that they are experiencing depression, and (2) school climate influences their decisions to disclose their mental health concerns to others in the school. It was concluded that school climate is a key factor to consider when implementing mental health interventions in schools. Further, Tomek et al. (2018) examined the relationship between school connectedness and suicidality among Black youth living in impoverished neighborhoods. Results revealed that school connectedness served as a strong protective factor. Specifically, school connectedness was shown to reduce the probability of suicide ideations and attempts over time and for Black youth across genders.

Research highlighting the disparities in school climate experiences among Black students suggests that Black students experience their school environments differently from their White peers (Heidelburg et al., 2022). For instance, Lacoe (2015) found that compared to their White and Asian peers, Black students reported lower perceptions of school safety. Black students were also more likely than their White peers to stay home from school due to feeling unsafe at school (Lacoe, 2015). Heidelburg et al. (2022) assert, "For Black students and other marginalized students, the school environment is often physically and emotionally unsafe, and they are targeted by anti-Black policies and practices, ultimately producing inequitable outcomes" (p. 591). These anti-Black policies and practices include unfair school discipline practices. For instance, Black students are more likely to receive office discipline referrals, out-of-school suspensions, and school expulsions than any other racial group (U.S. Department of Education, 2018). Black students are more likely to be disciplined for subjective behavioral violations (e.g., disrespect, defiance) and receive harsher disciplinary consequences than their White peers (Skiba et al., 2016). Such unfair discipline practices contribute to negative school outcomes, such as

higher dropout rates (Balfanz et al., 2014) and lower academic achievement (Anderson et al., 2019).

There are multiple factors to consider when examining Black youths' perceptions of school safety. Hong et al. (2018) examined African American students and their parents' perceptions of school safety from a social-ecological perspective within individual, family, school, and community contexts. Participants in the study were largely recruited from low-income communities. Results revealed the following findings: within individual contexts, African American girls were more likely to report feelings of school safety compared to African American boys; at the family level, parents who had close relationships with their child were likely to report their child's school as safe; at the school level, students' close connections with teachers had a positive effect on students and parents' perceptions of school safety; and lastly, at the community level, students who reported neighborhood satisfaction were more likely to report school safety compared to those who reported less neighborhood satisfaction. Researchers believe these findings may be due to multiple safety precautions used in schools, such as metal detectors and security guards.

Moreover, school resource officers (SROs) play a critical role in students' feelings of school safety (Theriot & Orme, 2016). SROs are increasingly and widely used in schools across the U.S., especially high schools (Wang et al., 2018). However, concerns regarding the criminalization of nonwhite students' misbehaviors in schools have resulted in nationwide debates about the need for SROs (Cowen et al., 2021; National Association of School Psychologists, 2020). Crichlow-Ball et al. (2022) conducted a study examining students' perceptions of SROs and threat reporting and found that more positive perceptions of SROs is associated with increased willingness to report threats of peer violence.

To address these concerns and help improve Black students' sense of school safety, Heidelburg et al. (2022) provide evidence-based and school-based practice recommendations. Included in the recommendations is the implementation of restorative justice practices and conflict resolution interventions (Mayworm et al., 2016; Nese et al., 2021); universal Afrocentric interventions (Aston and Graves, 2016) and mentoring (Wheeler et al., 2010); the incorporation of mindfulness practices (Black and Fernando, 2013), culturally relevant MTSS (Multi-Tiered Systems of Support) practices (Heidelburg et al., 2021), and highlight Black students strengths (Ladson-Billings, 2009) by providing opportunities for them to explore their racial identity (Okeke-Adeyanju et al., 2008).

Experiences of identity-based discrimination and harassment across race, gender, and sexuality are increasingly recognized as a common stressor for Black youth within school settings. Scholars argue that racial discrimination is a persistent and profound stressor that impacts African American youth (English et al., 2014; Pachter et al., 2017; Smith-Bynum et al., 2014). This is partially due to research demonstrating that racial discrimination is associated with lower levels of psychological functioning (Sellers et al., 2006) and increased rates of internalizing symptoms such as depression (English et al., 2016; Hammond, 2012) and anxiety (Gaylord-Harden & Cunningham, 2009; Zapolski et al., 2019). Racial discrimination has also been linked to increased rates of substance use among Black youth (Zapolski et al., 2019). Some scholars have also found that racial discrimination impacts other areas of Black adolescents' psychological functioning and well-being, including decreased levels of self-esteem (Green et al., 2006), lower self-concept, and increased feelings of hopelessness (Nyborg & Curry, 2003). Links between perceived racial/ ethnic discrimination in school and externalizing disorders have also been found. Results from Coker et al. (2009) show that Black and Hispanic children who

reportedly experienced racial/ethnic discrimination were also more likely to report symptoms associated with ADHD, ODD, and conduct disorder than their White counterparts. In another study examining the relationship between school diversity and racial discrimination (Seaton and Douglass, 2014), 97% of the African American adolescents in the sample reported experiencing at least one discriminatory act over the course of a two-week period with an average of 2.5 exposures daily. Participants' perceptions of racial discrimination were linked to increased depressive symptoms. The relationship between school-based racial discrimination exposure and internalizing symptoms was even more profound among participants attending predominately White high schools compared to those who attended predominately Black high schools.

Moreover, teacher bias plays a role in students' psychological outcomes. In another study examining Black girls' experiences with and perceptions of teacher-based discrimination, Butler-Barnes et al. (2022) found that gender and racial discrimination were associated with depressive symptoms and suicide ideation. School policing and unfair discipline practices also play a significant role in Black youths' mental health outcomes (Perryman et al., 2021). In their study, Perryman et al. found that participants who reported experiencing or witnessing school policing (e.g., being stopped by school police or seeing someone else being stopped by police) showed greater odds of experiencing depressive symptoms compared to students who did not report experiencing or witnessing school policing.

Henderson et al. (2019) provides a conceptual framework for race-related trauma in the public education system with causal links between dimensions of racism and physical and psychological behaviors (i.e., internalizing and externalizing) among Black youth. The framework illustrates an interplay between micro-level and macro-level forces of racism. At the macro level, institutional and symbolic representations of racism subjugate racial/ethnic

minoritized groups. Simultaneously, youth internalize and develop cognitive schemas from these institutional and symbolic representations of their racial and ethnic group regardless of the truthfulness of these representations. These macro-level forces influence direct individual interactions at the micro-level in three physically and psychologically harmful/traumatic manners: alienation, violence, and discrimination. An individual's conscious awareness of these traumatic racial experiences prompts the use of internalizing and externalizing behaviors/coping mechanisms for dealing with racial stressors. Alienation is "a physical and psychological disruption to emotional, relational, and physical connectedness" (p. 928). In schools, common forms of alienation include exclusionary discipline practices (i.e., school suspension, expulsion, etc.). Alienation can induce internalizing feelings of hopelessness (Schulz and Rubel, 2011), stress, and psychosomatic symptoms (Natvig et al., 1999). It can also induce externalizing behaviors such as aggression and bullying (Basch et al., 2011; Peguero, 2011). Violence can be perpetuated physically (i.e., bullying, bodily harm, abuse) and psychologically (e.g., name-calling, racial slurs, verbal attacks, threats). Studies show that Black youth are more likely to experience school violence in the form of name-calling and mockery compared to youth from other racial and ethnic groups, which is also associated with internalizing behaviors among Black youth. Experiences of racial discrimination have been linked to poor academic and emotional outcomes such as lower levels of motivation (Chavous et al., 2008), increased rates of problem behaviors (Tobler et al., 2013), substance use (Respress et al., 2013), and depressive symptoms (Cogburn et al., 2011).

Schools are increasingly recognized as accessible settings for supporting students' mental health needs (Kern et. al., 2017) and play a vital role in supporting students' emotional wellness. Hoover and Bostic (2020) assert that "compared with other community mental health settings,

schools can much more easily promote mental health, monitor ongoing progress, and provide interventions for specific issues impeding a child's progress, all while minimizing logistical barriers" (p. 44). As such, the Office of Elementary & Secondary Education through the U.S. Department of Education considers promoting mental health in schools as one of four critical areas for improving and maintaining safe school environments for children and adolescents (OESE, 2020).

However, it is also argued that the mental health needs of students across the United States, especially those in underserved communities (Atkins et al., 2017), and those in urban and racially segregated communities (Anakwenze & Daniyal, 2013), are largely unmet (Atkins et al., 2017). Atkins et al. (2017) argue that students' needs are going unmet because many schools, especially those in high-poverty areas serving students from underserved communities, "have neither the capacity nor the expertise to deliver effective academic programming and mental health services concurrently" (Atkins et al., 2017, p. 126). This argument is consistent with data released by the American Civil Liberties Union documenting nationwide shortages of school-based mental health providers (Whitaker et al., 2019). School mental health providers include school psychologists, school social workers, school nurses, and school counselors. Whitaker et al. (2019) argue that the shortage of school-based mental health providers combined with the persistent presence of law enforcement in schools is harmful to students' mental health as many of their needs go unmet.

Further, Black youths' experiences with and perceptions of school-based mental health services also present challenges to mental health service utilization in schools. For example, in a study centered on African American males' perceptions of SBMH (School Based Mental Health) services (Lindsey, 2010), participants felt as though the "formal mental health service delivery

system does not understand how to best meet their emotional/ psychological needs" (p. 174). Thus, the youth expressed feelings of caution and uncertainty about school mental health providers' ability to provide appropriate and effective care. Furthermore, Lindsey (2010) examined various individual and network factors that influenced participants' engagement and therapeutic alliance. The two primary individual factors that influenced participants' willingness to engage in SBMH services were: (1) the participants' understanding and belief of whether they had a mental health problem and (2) the perceived severity of their mental health problem. Regarding network factors (formal v. informal networks), much attention was given to formal network factors: perceptions of stigma, provider characteristics, and misdiagnosis influenced participants' help-seeking behaviors. Participants noted that general mental health stigma and being perceived as weak if they were to express their emotions resulted in a reluctance to seek support. Participants perceived that they would be stereotyped, and their individual concerns would be turned into generalizations about African American males. Additionally, fear of being misdiagnosed by service providers also contributed to participants' unwillingness to seek support. Lastly, several characteristics of the mental health providers influenced participants' willingness to engage in SBMH services. These characteristics included providers' ability to "keep it real," providers' level of expertise in mental health, providers' style/ approach to engaging with students in treatment, and providers' ability to understand participants' social and environmental contexts. It was concluded that traditional therapeutic approaches may not necessarily be effective in supporting African American males if there is a perceived lack of understanding about the "contextual and cultural realities of African American youth" (p. 175). Accordingly, SBMH providers were encouraged to examine their perceptions of African

American males so that stereotypes and biases do not influence the treatment of African American males.

Research suggests that engagement and participation in school activities and evidence-based interventions are associated with positive mental health and school outcomes. For example, Same et al. (2018) conducted a systemic review of research on evidence-supported school interventions associated with positive and promising educational outcomes among Black youth. Results revealed 22 different interventions found to be promising in increasing Black youths' school outcomes. Such interventions included school level, classroom level, and other interventions. Some examples of school-level interventions included: the Good Behavior Game with enhanced academic curriculum (Bradshaw et al., 2009), the Benjamin E. Mays Institute, which is a mentoring program for Black male students (Gordon et al., 2009), Student Success Skills counseling groups that teach students cognitive, and social and self-management skills (Miranda et al., 2007), and Positive Action program which focuses on social-emotional and character development (Bavarian et al., 2013). Some classroom-level interventions found to be effective included: improving teacher-student relationships (Decker et al., 2007) and setting high expectations for students in math (Woolley et al., 2010). Examples of other interventions found to be effective for Black youth included participation in after-school programs, clubs, sports, and lessons (Nagle, 2013), summer reading programs (Kim, 2006), urban debate leagues (Mezuk, 2009), and self-affirmation interventions that promote Black youth to reflect on personally important values (Hanselman et al., 2014).

Participation in school interventions that foster positive ethnic-racial identity (ERI) is associated with positive psychological adjustment (Carter et al., 2020), increased feelings of school belonging, and increased school engagement (Medina et al., 2020) for Black youth. In a nationally

represented sample of African American and Caribbean boys, Carter et al. (2020) examined the impact that puberty development has on youths' ERI, self-concept, and depressive symptoms. In this study, researchers found that those who had more positive feelings about being Black also showed fewer depressive symptoms and higher self-esteem and self-efficacy (Carter et al., 2020). Likewise, Zapolski et al. (2019) found ERI exploration to have a positive and promotive effect on reducing depressive and anxiety symptoms among African American youth.

In another example, Black girls who participated in the *Sisters of Nia* program demonstrated more positive peer relationships and decreased negative relationships among participants and their peers (Belgrave et al., 2004). The Sisters of Nia intervention significantly increased participants' ethnic-racial identity awareness and decreased their engagement in relational aggression (Belgrave et al., 2004). Similarly, Aston et al. (2017) found this intervention to be effective in reducing externalizing behaviors (i.e., verbal aggression) among the Black girls who participated. It was concluded that the reduction in negative behaviors may be partly due to the increased social support provided to participants and the positive relationships built over time between participants and peers. Researchers also contribute positive outcomes to the positive relationships built between participants and intervention leaders (Aston et al., 2017). Jones et al. (2017) found that the *Sisters of Nia* program also increases school engagement among Black female participants compared to those in the control group.

Community and Neighborhood Influences

Within the African American community, religious practices, beliefs, and values have been reported as strong cultural-historical and protective factors (McBride, 2013). Black Americans are considered the most religious group in the United States (Mohamed et al., 2021). Although much of the empirical studies on Black/ African American families and religion have

centered on the perspectives of adults, similar trends have been found in youth, suggesting that African American youth also place immense importance on religion and religious involvement (Butler-Barnes et al., 2018; Smith et al., 2003).

Empirical studies indicate religious involvement is associated with many benefits, as faith is often used as a coping mechanism. For example, religiosity and maternal parenting style have been shown to be positively correlated with academic achievement, self-regulation, and environmental regulation (Abar et al., 2009). Religiosity has also been shown to have a buffering effect on African American youths' mental and behavioral health, as some reported greater psychological protection against racism and discrimination (Clark et al., 1999) and decreased engagement in health-risk behaviors such as substance use (Nasim et al., 2007). In a more recent study, Cullins et al. (2019) found that spirituality/ religion, community connectedness, and family cohesion were associated with decreased levels of depression among African American and Black Caribbean youth.

Religious practices and beliefs have also been associated with thriving among African American youth. In a study examining strengths and resources present among African American youth ages 11-19 years across five Black Protestant Christian churches, Gooden and McMahon (2016) found that communalism, religious support, and religiosity were all positively and significantly associated with thriving. In this study, indicators of thriving included spark identification and motivation, positive emotions, openness to challenges and discoveries, hopeful purpose, moral and prosocial orientation, and spiritual development. Results suggest that having a sense of communalism and interconnectedness within their community helps African American youth thrive. Also, youth who often engage in religious activities and services are more likely to have access to support from the members and leaders of their church community (Gooden and

McMahon, 2016). Thus, religiosity and connection to church communities is a significant and positive part of many Black youths' development processes as it is associated with thriving.

Black youth are disproportionately exposed to community violence and experience greater victimization (Browning et al., 2017; Lambert et al., 2022; Sheats et al., 2018), with those living in urban areas and neighborhoods concentrated with economic disadvantage being disproportionately exposed to community violence (Whipple et al., 2019). Exposure to unsafe and unsupportive communities and neighborhoods is consistently linked to psychological symptoms among Black adolescents. Community violence is associated with a wide range of negative behavioral, psychological symptoms, and social outcomes; these outcomes may also persist into adulthood (Woods-Jaeger et al., 2020). Exposure to community violence is a well-documented risk factor associated with emotional and behavioral problems among Black youth, including internalizing symptoms, social withdrawal, substance use, and antisocial behaviors (Copeland-Linder et al., 2010). Exposure to community violence has also been linked to suicide ideation and behaviors among Black youth (Lambert et al., 2021). Compared to youth who do not report exposure to community violence, Black adolescents who are exposed to community violence report more problems related to aggression and violent behaviors, depression, and anxiety (Busby et al., 2013). In a study examining the effects of exposure to community violence on Black youths' internalizing symptoms, Gaylord-Harden et al. (2011) found that increases in violence exposure were linked to increases in depressive symptoms among participants. Further, results from this study revealed the disparate prevalence of community violence exposure. Within the study sample, 95% of participants endorsed exposure to more than one violent event. Violence events endorsed included hearing gunshots at school or in the neighborhood (30%), seeing someone carry a weapon (43%), witnessing someone being threatened with a weapon

(65%), being personally physically attacked (78%), being personally threatened with a weapon (88%), witnessing someone get shot or attacked (62%), seeing someone commit a crime (55%), experiencing a home invasion (88%), and having something stolen from them (54%). Further, researchers have also examined the role gender, proximity to violence, and types of violence play in the development of various psychological symptoms among Black youth. In a study with African American middle school students (Sargent et al., 2020), male participants reported greater exposure to violence and victimization across all domains (victimization, family/friend, acquaintance/ stranger, with and without weapons involved). The female participants were more likely to report witnessing sexual violence directed at their friends or family members. Older participants reported greater exposure to violence compared to younger participants.

It is well documented that mental health services are underutilized in the Black community. In a narrative systematic review study examining the barriers and facilitators of mental health service utilization and treatment seeking among Black youth, Planey et al. (2019) highlighted seven predominate barriers: (1) child-related factors, (2) clinician and therapeutic factors, (3) mental health stigma, (4) faith-based factors, (5) treatment affordability, (6) school-based factors, and (7) social networks. Child-related barriers to treatment included perceptions that children do not have serious mental health problems (Abram et al., 2008; Mukolo and Heflinger, 2011; Murry et al., 2011) or that children's mental health problems are simply a "phase" (Murry et al., 2011). Inconsistencies with using mental health treatments (Mukolo and Heflinger, 2011) and cultural tropes of self-reliance, such as beliefs that "black people are resilient and have gone through and over-come numerous hardships and environmental stressors, and that such experiences should toughen their inner strength to handle mental health problems on their own" (Samuel, 2015, p. 37) were also identified as child-level barriers. Regarding

clinicians, mistrust of clinicians (Breland-Noble et al., 2011; Murry et al., 2011), fear of negative consequences of seeking and using mental health services (Kodjo and Auinger, 2004), mental health professionals not responding to Black youths' needs (Graves, 2017), and perceptions of treatment as ineffective (Mukolo and Heflinger, 2011; Samuel, 2015) were identified as barriers. Moreover, mental health stigma and shame are prominent barriers among Black youth. Some Black youth fear being teased or laughed at by their peers (Breland-Noble et al., 2011). Moreover, studies show that reliance on spirituality rather than seeking mental health services (Lindsey et al., 2013) and an emphasis on prayer combined with a lack of psychoeducation about depression and mental illness (Breland-Noble et al., 2015) is a major cultural barrier to accessing treatment. The cost of mental health services, physical accessibility, and access to health literacy are also major barriers to Black youth receiving mental health services. For example, in the Murry et al. (2011) study, 43% of mothers of African American youth expressed worry about mental health services being too expensive.

Bains (2014) conducted a meta-synthesis of six qualitative studies that explored African American adolescents' experiences with mental health conditions, ability to recognize mental health concerns, willingness to accept mental health conditions (e.g., depression), and how these experiences impact their decisions to seek mental health services. Four themes emerged from this meta-synthesis: uncertainty and soul searching, strength in the inner circle, shame and reluctance, and belief in the system. Across multiple studies, participants demonstrated uncertainty and hesitancy in their ability to recognize the role that mental health symptoms played in their behaviors and circumstances (e.g., Lindsey, 2010). In some studies, participants described their reliance on trusting adults within their inner circles (e.g., family members, mothers) and their inner strength when dealing with mental health concerns. Shame,

embarrassment, and hopelessness related to mental health concerns were common contributors to adolescents' refusal to seek mental health services. Participants often expressed worry that they would be perceived negatively by peers for needing mental health support. Lastly, participants across all studies included in the meta-synthesis shared common beliefs about mental healthcare systems. For example, participants expressed distrust and other attitudes toward mental health care professionals (e.g., Lindsey, 2006; Lindsey et al., 2010) and skepticism for treatment effectiveness (e.g., Nabors et al., 1999). Some participants declined to receive mental health services due to stigma and fear of being misdiagnosed (e.g., Lindsey, 2010).

Resiliency

Over several decades, there have been several conceptualizations of resilience. Janas (2002) defined resilience as an individual's ability to bounce back from adversity, frustration, and misfortune. Perry (2002) described resilience as the capacity for an individual to face various stressors without their functioning being significantly disrupted. In her work, Masten (2001) defined resilience as a "class of phenomena characterized by good outcomes despite serious threats to the adaptation of development" (p. 228). Fergus and Zimmerman (2005) referred to resilience as a process in which an individual overcomes the negative effects of exposure to risk (e.g., a traumatic experience) by successfully using coping skills and by avoiding the negative trajectories associated with risks. In essence, resilience is not the nature or intensity of an event, risk, or adversity; rather, resilience is a dynamic process that describes how individuals handle challenging circumstances that have the potential to cause negative outcomes. For the current study, resilience is defined as the process and outcome of successfully adapting to difficult or challenging life experiences, especially through mental, emotional, and behavioral flexibility and adjustment to external and internal demands (American Psychological Association, 2022)

Masten et al. (2021) posit that changes in definitions of resilience are a likely result of the shifts in developmental systems perspectives on resilience in children towards multisystem models of resilience. Hence, contemporary definitions of resilience reflect a dynamic systems perspective that emphasizes the multidirectional interactions between children and their systems (e.g., schools, communities, families). Relational developmental systems perspectives on childhood resilience have been significant in resilience research and hold four core ideas: (1) many interacting systems at multiple levels shape the function and development of living systems, (2) the capacity for adaptation of a system and its development are dynamic and always changing, (3) because of interconnections and interactions inherent to living systems, change can spread across domains and levels of functions, and (4) systems are interdependent (Masten, 2018, p. 15).

Researchers have identified three distinct conceptual models of resilience that directly apply to resilience theory: the compensatory model, the protective factor, and the challenge model (Fergus & Zimmerman, 2005; Zimmerman et al., 2013). In the literature, resilience models are used to test relationships, processes, and associations of various promotive and protective factors that contribute to resilience among individuals. The *compensatory model* of resilience is described as a process in which promotive factors neutralize risk exposures in a counteractive manner. In this model, the promotive factors have either a direct, opposite, or independent effect on an outcome separate from risks. For example, in a study examining ACEs and counter-ACEs (i.e., positive childhood experiences), Crandall et al. (2019) found that both ACEs and counter-ACEs (i.e., PCEs) had a direct impact on adult health and overall well-being, however, the counter-ACEs neutralized the impact of the ACEs on participants' health. In this study, counter ACEs along with age and gender variables were added to the regression models as

control variables; this resulted in an elimination of correlations between ACEs and any health indicators (e.g., smoking, stress, depression.). The *protective factor model* of resilience "refers to processes in which promotive factors moderate the negative effects of risks for predicting negative outcomes" (Zimmerman et al., 2013, p. 215). In this model, resources and assets act as moderators in reducing the impact of risk on outcomes. And lastly, *the challenge model* of resilience "operates as inoculation, with exposure to average levels of risk helping youth overcome subsequent exposure" (Zimmerman et al., 2013, p. 215). Zimmerman et al. (2013) write that, within the challenge model, the risk(s) an individual experiences must be challenging enough to prompt the development and use of coping skills to combat the risk, however, the risk cannot be to a level perceived as too taxing for the individual to use said coping skills. An adaptation of the three conceptual models of resilience is shown in Figure 2.

Hamby et al. (2018) posit that there are three elements of resilience: (1) the occurrence of adversity (i.e., a stressful or traumatic event), (2) evidence of healthy functioning following adversity, and (3) mechanisms, protective factors, and strengths used to recover or avoid distress caused by the adversity experienced. In their study, Hamby et al. (2018) sought to examine how adolescents and adults achieve well-being despite experiencing adverse life events. Researchers also sought to examine the role of poly-strengths – the total number of protective factors an individual possesses – that contributed to them thriving despite adversity (Hamby et al. (2018). Indicators of poly-strengths were measured within the context of subjective well-being, posttraumatic growth, and mental health. Participants in the study reported poly-strengths categorized into three categories: *regulatory strengths, meaning-making strengths, and interpersonal strengths.* Regulatory strengths included: endurance, emotional awareness, emotional regulation, coping, honesty and humility, and anger management. Meaning-making

strengths included purpose, optimism, religious meaning-making, self-orientation, relationship orientation, morals, and family care. Interpersonal strengths included generativity, compassion, social support from family and friends, community support, forgiveness, generous behaviors, generative roles, and maternal and paternal attachment.

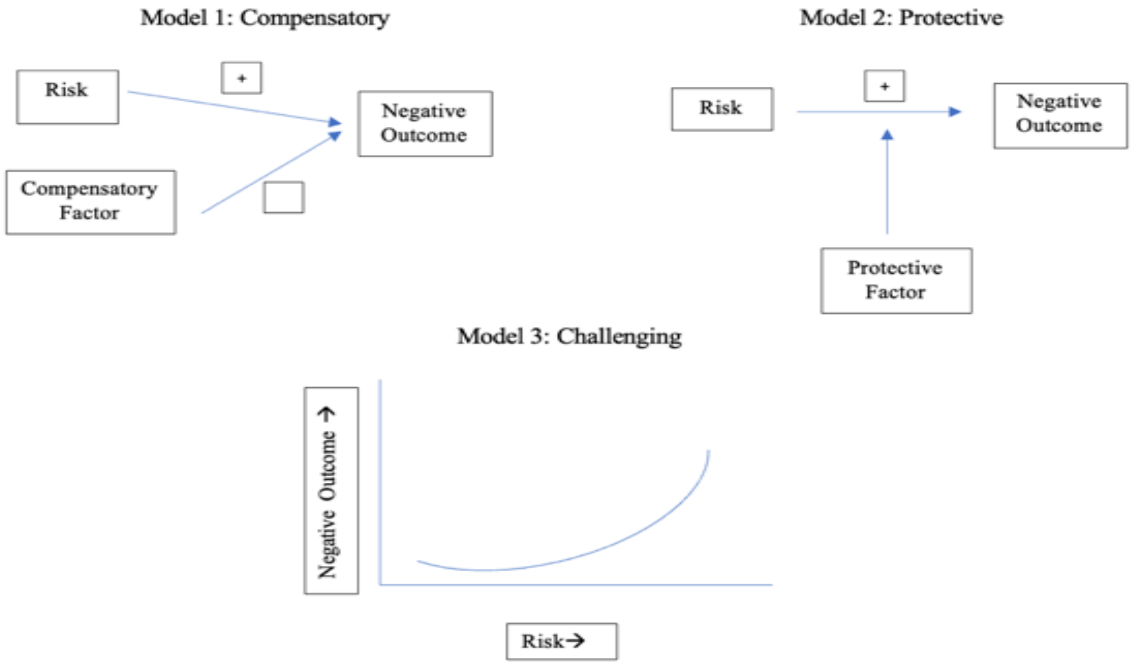

Figure 2. An Adaptation of the Three Conceptual Models of Resilience (Fergus & Zimmerman, 2005)

Black Youth Resiliency

There has been an emergence of resilience research centering on the lives of Black youth over the past several decades (e.g., APA, 2008; Cunningham & Swanson, 2010; Hopps et al., 2022; Winfield, 1991). Within the literature, scholars have consistently acknowledged the critical role that experiences of racism, racial discrimination, and other forms of oppression play in the lives of Black youth living in the United States as it relates to their need for resilience. For instance, Hopps et al. (2022) write, "African Americans in the context of their existence in the United States have survived and overcome oppression in the form of legal institutional slavery

and segregation, and even today continue to rally against the affronts of institutional racism, poor educational opportunities, stressful environments, economic depression, and other engulfing problems" (p. 65). These socio-historical and cultural lenses are necessary to consider when examining a range of factors that contribute to risks experienced among Black youth. However, Anderson (2019) writes, "Promoting resilience without also working to address societal conditions that often make resilience necessary is only a partial response" (p. 386). In this article, Anderson argues for the need for scientists and practitioners to rethink resiliency theory in African American families who face chronic adversity. While resilience is widely recognized as inherently positive, the onus should not be on African American families to continuously adapt to threatening environments and conditions (poverty, institutional racism, etc.); rather, these threatening conditions must improve. Anderson provides practical concepts for social justice allies to consider in their work with African American families. These practical concepts are as follows: motivation (i.e., recognizing their power and privilege and understanding other's oppression); ally to (i.e., being intentional when collaborating with African American families); relationship to the oppressed (i.e., working with and for families through research, advocacy, etc.); focus on the problem (i.e., engaging in practices that promote coping); goals of the work (i.e., using culturally responsive practices that amplify African American families' voices; examining African Americans' processes of resilience); and mistakes (i.e., welcoming critiques, acknowledging mistakes, engaging in dialogue with families, etc.).

Researchers have emphasized the need to acknowledge the strengths exuded by many Black youth despite the risks faced in their daily lives. For example, in their report, "*Resilience in African American Children and Adolescents: A Vision for Optimal Development*," members of this APA Task Force (2008) offered a paradigm shift for understanding strength and resilience

among Black youth. This change in thinking does not ignore socio-historical and cultural contexts; instead, it provides a more strengths-based approach to supporting Black youth. They assert that critical-mindedness, active engagement, flexibility, and communalism are the four main dimensions that promote resilience and optimal functioning among African American youth. Critical mindedness is conceptualized as a tool that helps African American youth understand and critique social conditions and fight against discrimination. Active engagement is "agentic behavior in school, at home, and with peers, such that children and adolescents proactively and positively impact their environment" (p.26). Flexibility involves the adaptation of demands across multiple contexts, including social, physical, emotional, and cognitive situations. Communalism emphasizes the importance of social bonds, connections, and social responsibilities within and across diverse groups. Further, the task force identified five domains that can be protective: identity development (i.e., positive racial identity, racial socialization, etc.), emotional development (e.g., self-regulation, emotional competence), social development (i.e., close and supportive interpersonal relationships), cognitive development (i.e., skills related to intelligence, vocation, academics, and language), and physical health development.

In more recent studies, researchers have examined the role of resilience in the experiences of Black youth across various contexts. For example, Chesmore et al. (2016) studied whether individual and interpersonal level resources for resilience (i.e., adaptive behavioral and cognitive coping skills and social support from caregivers) are associated with African American children's academic performance and behaviors. Results from the study revealed a positive association between social support, behavioral coping skills, and academic performance; students who reported greater support from their caregivers and engagement in behavioral coping skills showed greater academic performance (i.e., higher scores on standardized math and reading

tests). Greater social support and behavioral coping skills were also associated with fewer school misbehaviors.

In another study, DiClemente et al. (2018) studied the moderating effect of family, school, and neighborhood cohesion on the relationship between exposure to violence and internal characteristics of resilience. Participants in this study were 7th and 8th-grade African American youth from lower-income backgrounds. Family cohesion refers to aspects and quality of the parent-child relationship; this includes parenting practices such as parental engagement and supervision. School cohesion, more commonly referred to as school connectedness, is defined as a student's belief about the extent to which adults in the school care about the student and their learning experience. Neighborhood cohesion is "trust and feelings of kinship among community members" (Riina et al., 2013, p. 137). Internal characteristics of resilience were measured using the following variables: sense of belonging (i.e., ethnic identity), mood (i.e., positive affect), and sense of self (i.e., self-esteem). Among 7th grade boys and girls, higher family and neighborhood cohesion predicted higher levels of self-esteem; this finding was especially true for boys. This effect was not significant for school cohesion. Higher levels of exposure to violence contributed to lower levels of self-esteem over time for boys but not for girls. However, among boys who reported higher levels of neighborhood cohesion, their self-esteem was not negatively affected by violence exposure. Researchers suggest that boys who experience violence exposure benefit most from neighborhood cohesion as it has a strong protective effect. Regarding positive affect, family cohesion had the greatest impact; higher levels of positive affect were shown to increase positive affect for boys and girls exposed to higher levels of violence. And lastly, regarding ethnic identity, students with higher levels of school cohesion predicted a stronger sense of ethnic identity, especially for boys. Altogether, it was concluded that family, school, and

neighborhood cohesion moderated the relationship between exposure to violence and internal resources of resilience (i.e., self-esteem, ethnic identity, and positive affect).

Researchers have also examined how Black youth conceptualize resilience within the context of exposure to community violence (Woods-Jaeger et al., 2020). In this qualitative study, African American youth ages 13 to 18 years described three indicators of resilience: (1) the ability to persevere, (2) the ability to self-regulate, and (3) the ability to change or improve yourself to adapt. Perseverance included the ability to overcome adversities and not let challenges "hold you down, put you back" or "break you down" (p. 334). It was also explained as the ability to work through issues, continue being happy, to trust others, and to continue going about your day. Self-regulation in the context of resilience was conceptualized as the ability to control how one responds to situations. And lastly, participants perceived changing/ improving to adapt as the willingness to make themselves better despite the adversity experienced. Some participants described changing their ways and going to therapy as a form of adaptation. Further, some participants described instances of seeking and receiving social support from family members and friends after being exposed to community violence. These supportive interpersonal relationships helped promote resilience among the youth. Self-determination (a cultural value) and communalism also promoted resilience among youth. Participants described self-determination as a strategy for appearing less vulnerable in the context of community violence exposure. And lastly, participants described the impact of mental health stigma at the individual, interpersonal, and community levels. Mental health stigma resulted in participants being reluctant to share emotional experiences with others (e.g., crying), not seeking mental health services, and having mental health concerns minimized or not taken seriously. Researchers concluded that Black youth operationalized resilience as the ability to function well after

exposure to traumatic circumstances and employ various strategies to enhance their resilience. From a social-ecological perspective, results from this study also demonstrate the existence of risks and resilience factors across multiple contexts.

Chapter Summary

In summary, research demonstrates many social determinants of Black youths' mental and behavioral health across multiple social-ecological contexts. In this literature review, interpersonal, school, and community/neighborhood contexts were primarily discussed. Within interpersonal contexts (e.g., parent-child relationships, family dynamics), the research suggests that positive parenting practices and having a caring and supportive parent are protective factors for Black youth, whereas experiencing family conflict may have a more negative impact on Black youths' mental and behavioral health. Additionally, racial and gender socialization not only plays a critical role in Black youths' overall identity development, but it has also been shown to impact their mental health. Negative racial and gender socialization among Black girls (e.g., negative messages on Black girls' hair, skin, and behaviors) and Black boys (e.g., "boys don't cry") are associated with more internalizing symptoms of anxiety and depression and externalizing symptoms and antisocial behaviors.

Further, school-level factors (e.g., school climate and school-based mental health service accessibility) have also been shown to impact Black youths' mental and behavioral health directly or indirectly. Black youth who have more positive perceptions of their school's climate have a greater sense of school connectedness, are more likely to seek support, and thus may demonstrate better mental health outcomes. Conversely, those who have lower perceptions of school climate also tend to experience mental health problems and peer victimization. Experiences of racial discrimination – even within school settings – are also a well-documented

and profound stressor that negatively impacts Black youths' mental health outcomes. Racial discrimination and race-related trauma (e.g., violence, alienation) are associated with increased rates of depression, anxiety, hopelessness, and substance use, and decreased levels of self-esteem among Black youth. Furthermore, participation in evidence-based school interventions and interventions that foster positive ERI development have been shown to improve Black youths' school engagement, academic outcomes, and mental health.

The community and neighborhood in which a child grows up is also a major contributor to their overall development and mental health. This is especially true for Black youth. Religious practices and beliefs are a protective factor among African American youth, as they are associated with academic achievement, thriving, decreases in internalizing and externalizing symptoms, and increases in youths' sense of connectedness to their community. Meanwhile, a lack of mental health service access and utilization and increased exposure to community violence have been shown to have detrimental effects on Black youths' mental health outcomes. Research demonstrates the underutilization of mental health services among Black youth is due to numerous factors, including stigma, treatment affordability, and mistrust of clinicians. Regarding community violence, Black youth – especially those living in neighborhoods concentrated with economic disadvantage – are disproportionately exposed to community violence and have greater victimization. Community violence is strongly associated with internalizing and externalizing symptoms among Black youth.

As previously described in this literature review, ACEs have numerous detrimental impacts on Black youths' mental and behavioral health and school engagement. For Black youth and the Black community in general, experiences of racial discrimination- often rooted in anti-Blackness- is an ACE and is also strongly associated with other ACEs; these negative racial

experiences are linked to chronic stress. As Hampton-Anderson et al. (2021) posits, Black people's increased vulnerability to ACEs are due to a complex interplay of social contextual factors, including historical and systemic oppression, marginalization, and personal and intergenerational trauma. Research on ACEs and the long-term impacts of ACEs has greatly expanded over the past several decades. Research suggests ACEs impact individuals' physical, mental, and behavioral health. Among Black youth, ACEs and racism are strongly linked together and contribute to the presence of internalizing and externalizing symptoms.

In addition to ACEs, research on other social determinants of health outcomes has prompted much awareness of the contextual factors that impact Black youths' mental and behavioral health and school engagement. However, there is growing evidence that many Black youth demonstrate resilience and positive outcomes despite the adversity experienced and/or exposed to in their homes and communities. Researchers who have studied resilience among Black youth within the contexts of interpersonal relationships and community dynamics (e.g., Chesmore et al., 2016, DiClemente et al., 2018, and Woods-Jaeger et al., 2020) have found that many Black youth have internal and interpersonal characteristics of resilience. These characteristics of resilience include cognitive and behavioral coping skills and social support (Chesmore et al., 2016), positive ethnic identity, self-esteem, and positive affect (DiClemente et al., 2018), perseverance, self-regulation, and self-determination (Woods-Jaeger et al., 2020). Additionally, many Black youth experience cohesion across school, family, and neighborhood contexts. These internal and interpersonal characteristics of resilience are positively associated with Black youths' school behaviors and academic performance (Chesmore et al., 2016) and help them navigate exposures to traumatic circumstances (e.g., community violence) that can otherwise result in internalizing and externalizing symptoms.

Studies on Black youth resilience, participation in evidence-based school interventions, and school activities also provide evidence that positive experiences are occurring within Black youths' upbringing and development. Many Black youth have supportive and nurturing relationships with parents, teachers, and other adults, feel a sense of safety and connection in their neighborhood and learning environments, and are provided with opportunities to learn and demonstrate social and emotional competencies (e.g., healthy coping skills). This area of research, however, is limited. Therefore, in this study, the aim is to expand the knowledge and understanding of the types of PCEs experienced among Black youth and the perceived impact of those PCEs on their resilience, mental and behavioral health, and school engagement in the face of adversity. An illustration of the social determinants of Black youths' mental and behavioral health and school engagement from a social-ecological perspective is shown in Figure 3.

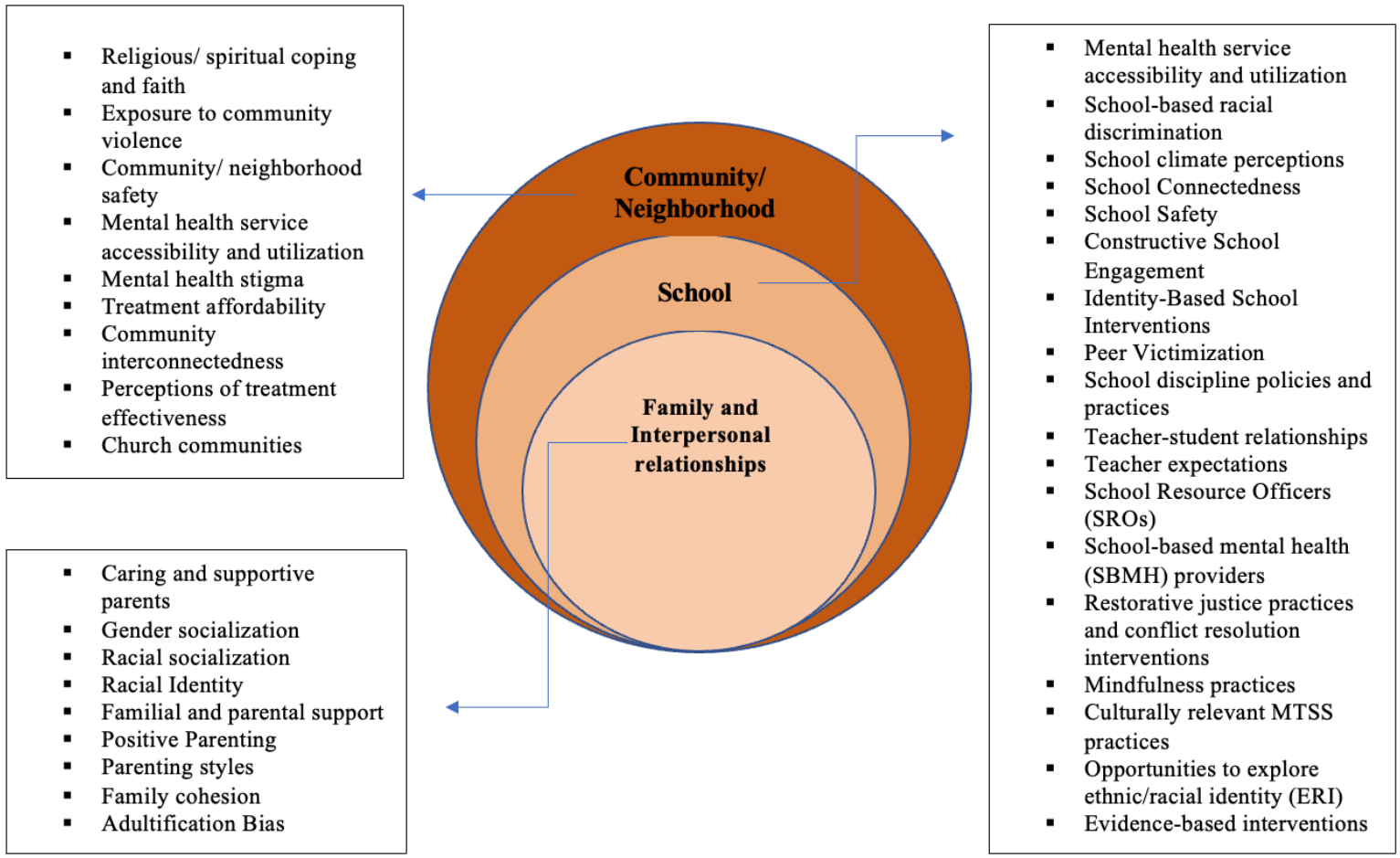

Figure 3. Social Determinants of Black Youths' Mental and Behavioral Health and School Engagement from a Social-Ecological Perspective

CHAPTER THREE:
THE MODERATING IMPACT OF POSITIVE CHILDHOOD EXPERIENCES (PCES) ON BLACK YOUTHS' MENTAL AND BEHAVIORAL HEALTH AND SCHOOL ENGAGEMENT OUTCOMES

Method

Study Design and Data Collection

Secondary data from the 2020 National Survey of Children's Health (NSCH) dataset (United States Census Bureau, U.S. Department of Commerce, 2021) was selected for this study because it is weighted to be nationally representative of non-institutionalized children and adolescents ages 0-17 years old in the United States, thus allowing for greater generalizability of results. The NSCH provides data on multiple intersecting aspects of youths' lives, including their family demographics (e.g., family income, family structure, parental education achievement), interactions with primary caregivers, physical and mental health, school experiences, neighborhood characteristics, and access to quality physical and mental health services and supports. Given that the social-ecological model guides the current study, the NSCH provides rich information on youths' social contexts, including the individual child, familial influences, school characteristics, and community/neighborhood characteristics. Further, the NSCH includes variables that adequately measure constructs of interest in the current study, including ACEs, PCEs, youth mental and behavioral health, and academic engagement.

The 2020 NSCH was developed and carried out by the U.S. Census Bureau for the Health Resources and Services Administration, Maternal and Child Health Bureau (HRSA MCHB; U.S.

Department of Commerce, 2023). Data collection occurred between July 2020 and January 2021 (U.S. Department of Commerce, 2023). Approximately 240,000 households were randomly sampled to complete the survey via web/online (90.4%); the remainder were completed via mail/paper instrument (9.6%; United States Census Bureau, U.S. Department of Commerce, 2021). Survey respondents (i.e., primary caregivers or relatives) were asked to complete a screener questionnaire identifying all children residing in the household between 0-17 years old. Participation in the survey was voluntary, and all personal information was kept private and confidential. For households with more than one child, the NSCH randomly selected one child from each household to be the questionnaire subject. Of the national sample of 240,000 addresses used, 93,500 screeners were completed, and of those, 51,107 surveys completed were eligible for topical questionnaire follow-ups. Overall, 42,777 households completed topical interviews for the 2020 NSCH survey (United States Census Bureau, U.S. Department of Commerce, 2023).

Participants

Of the 42,777 completed interviews in the 2020 NSCH survey, the sample for the current study was delimited to caregivers with children and adolescents who identify as Black/African American, non-Hispanic, and between the ages of 6-17 years. Thus, survey participants eligible for the current study included 2,201 Black/ African American children and adolescents (M_{age}=12 years, 52.3% male, 47.7% female). Regarding family income (M_{income}=2.34, SD= 1.109), 30.8% (*n*=679) reported at the 0-99% federal poverty level (FPL) status, 23.4% (*n*=516) reported at the 100-199% FPL status, 26.3% (*n*=579) reported at the 26.3% FPL status, and 19.4% (*n*=427) reported at the 400% FPL status. Regarding family structure, 39.6% (*n*=874) of youth lived in a two-parent household, nearly half (46.3%, *n*=959) lived in a single-parent (mother or father)

household, 8.6% (*n*=178) lived with grandparents, and 3% (*n*=62) lived with other familial relatives. There were 128 (5.8%) missing responses to the household question. Full demographic information for the study participants is presented in Table 3.

A post hoc statistical power analysis for multiple regression was conducted to determine the estimated minimum sample size required to test the current study hypotheses. Results indicated the sample size of *N*=2,201 would achieve a 100% power for detecting a medium effect at a significance criterion of α = .05, an observed R^2 (multiple correlation coefficient) at 0.25, and two predictors (i.e., ACEs, PCEs,). Given a standard of 80% recommended for adequate power, the current sample size of 2,201 is more than adequate to test the study hypotheses.

Measures

Covariates

Sociodemographic Information. This study used the following sociodemographic information as covariates/ control variables: age, sex, family income, and family structure. These sociodemographic characteristics are all essential to control for in the current moderation models because prior research suggests that age (Alegria et al., 2015), sex/gender (e.g., Gajos et al., 2022; Jones et al., 2022), family income (Anderson et al., 2022) and family structure (Kim et al., 2021) are associated with the relationship between ACEs and prevalence of mental health condition among youth populations. Respondents reported their child's age (range from 0-17 years) and sex (1 "male", 2 "female). In this study, age is treated as a continuous variable. Sex was dichotomously dummy-coded (i.e., 0=male, 1=female). Respondents also reported the household family structure using the following response options: 1= "Two parents, currently married", 2= "Two parents, not currently married, 3= "Single parent, (mother or father)", 4= "Grandparent household", and 5= "Other family type". In this study, the family structure variable

is dummy coded into four categories: 1=Two parents (married or not married), 2= Single parent (mother or father), 3= Grandparent household, and 4= Other family type. Lastly, respondents reported the income level of their household. Based on the income reported, the NSCH administrators organized the income status based on the federal poverty level (FPL) into four categories: 1= "0-99% FPL", 2="100-199% FPL", 3= "200-399% FPL", and 4= "400% FPL or greater". In this study, the family income variable is dummy-coded into the same four categories (i.e., 0=0-99% FPL, 1=100-199% FPL, 2=200-399% FPL, and 3=400% FPL or greater).

Independent Variable (X): *Adverse Childhood Experiences*

ACE Score. The NSCH included 10 questions that measured the construct of ACEs. Respondents were asked, "To the best of your knowledge, has this child EVER experienced any of the following?": hard to cover the basics, like food or housing, on family's income (ACE1 and ACE2); parent or guardian divorced or separated (ACE3); parent or guardian died (ACE4); parent or guardian served time in jail (ACE5); saw or heard parents or adults slap, hit, kick, punch one another in the home (ACE6); was a victim of violence or witnessed violence in their neighborhood (ACE7); lived with anyone who was mentally ill, suicidal, or severely depressed (ACE8); lived with anyone who had a problem with alcohol or drugs (ACE9); treated or judged unfairly due to race/ethnicity (ACE10); and treated or judged unfairly due to sexual orientation or gender identity (ACE12). There was no ACE11 item.

Regarding income, the ACE1 item asked respondents to indicate if it is hard to cover the basics such as food and housing on the family's income. Response options are as follows: 1= "Never hard to get by on family income", 2= "Rarely hard to get by on family income", 3= Somewhat hard to get by on family income", and 4= Very often hard to get by on family income". For ACE2, options 3 and 4 were combined to create category 1= "very often or

somewhat often" and options 1 and 2 were combined to create category 2= "Never or rarely". In this study, the ACE2 item was dichotomously dummy coded as "0" = No (No income hardship) or "1" = Yes (Income hardship). For ACE items 3-10 and 12, respondents were asked to indicate "Yes" or "No" to each item. In this study, ACE items 3-10 and 12 were dichotomously dummy coded as "0" = No, "1" = Yes.

In prior studies, researchers have analyzed the dosage-response effect of ACEs by creating cumulative ACE scores, which is the sum of the number of ACEs a person reports (Bethell et al., 2017). Cumulative ACE scores can be analyzed using subcategory scales (e.g., 1 ACE, 2 ACEs, 3 or more ACEs) and continuous scales (e.g., 0-10 ACES; Lui et al., 2022). In the current study, cumulative ACEs are analyzed as continuous.

Moderating (M) Variable: Positive Childhood Experiences

PCEs are the moderator variable in the current study. Informed by prior research (Crouch et al., 2021; Crouch et al., 2022), PCEs in the proposed study are operationalized and grouped into six categories: *(1) safe schooling environment, (2) safe community/ neighborhood, (3) supportive community/ neighborhood, (4) constructive social engagement, (5) parent-child connection, and (6) family resilience.* Specific items within each variable category were selected because they align with the HOPE framework for developing healthy children: (1) being in nurturing and supportive relationships, (2) living, developing, playing, and learning in safe, stable, protective, and equitable environments, (3) having opportunities for constructive social engagement and to develop a sense of connectedness (i.e., social, and civic engagement) and (4) learning social and emotional competencies (i.e., emotional growth). The HOPE framework also emphasizes the importance of developing and maintaining positive parent-child connections. Further, multiple studies have used the HOPE framework to examine the relationship between

various indicators of PCEs and child outcomes (Crouch et al., 2021; Crouch et al., 2022; Qu et al., 2022; Wang et al., 2021).

Safe School. One item related to school safety was included in the 2020 NSCH. The NSCH asked the caregiver the following question, "To what extent do you agree with these statements about your neighborhood or community?" (1) this child is safe at school (K10Q41_R). Potential responses were on a Likert scale and included "definitely agree" (1), "somewhat agree" (2), "somewhat disagree" (3), and "definitely disagree" (4). A dichotomous variable was created by organizing responses into two categories: 1= the child attends a safe school (if parents selected "definitely agree" or "somewhat agree" to this item), and 0= the child's school is unsafe (if parents chose "somewhat disagree" and "definitely disagree" on this item).

Safe Neighborhood. One item related to neighborhood safety was included in the NSCH. The NSCH asked the caregiver, "To what extent do you agree with these statements about your neighborhood or community?" This child is safe in our neighborhood (K10Q40_R). Potential responses were on a Likert scale and included "definitely agree" (1), "somewhat agree" (2), "somewhat disagree" (3), and "definitely disagree" (4). A dichotomous variable was created by organizing responses into two categories: 1= the child's neighborhood is safe (if parents selected "definitely agree" or "somewhat agree" to this item), and 0= the child's neighborhood is unsafe (if parents chose "somewhat disagree" and "definitely disagree" on this item).

Supportive Neighborhood. Three items related to the respondents' perception of the support provided within the community or neighborhood were used to measure neighborhood supportiveness. The NSCH asked the caregiver, "To what extent do you agree with these statements about your neighborhood or community?": (1) People in this neighborhood help each

other out (K10Q30), (2) We watch out for each other's children in this neighborhood (K10Q31), and (3) When we encounter difficulties, we know where to go for help in our community (GOFORHELP). Potential responses were on a Likert scale and included "definitely agree" (1), "somewhat agree" (2), "somewhat disagree" (3), and "definitely disagree" (4). A dichotomous variable was created by organizing responses into two categories: 1= the child's community is supportive (if parents selected "definitely agree" or "somewhat agree" to this item), and 0= the child's community is unsupportive (if parents chose "somewhat disagree" and "definitely disagree" on this item).

Constructive Social Engagement. Three items were used to measure a child's engagement and participation in clubs or other organized activities. To measure the child's participation in activities across various settings, the NSCH asked the caregiver the following questions, "During the past 12 months, did this child participate in" (1) a sports team or did they take sports lessons after school or on weekends (K7Q30), (2) any other organized activities or lessons such as music, dance, language, or other arts (K7Q32), and (3) any clubs of organizations after school or on weekends (K7Q31). Answers were scored dichotomously (yes=1, no=0) for each item. The NSCH created a dichotomous composite score for these items under the category of "participation in organized activities" (AftSchAct_20), if respondents answered "yes" to at least one of these items they received a score of 1, if no items were scored yes, they received a score of 0. These are the dichotomous dummy codes used in this study (0= no participation in organized activities, 1= participation in organized activities).

Parent-child Connection. The parent-child connection PCE was measured with one item asking, "How well do you and this child share ideas or talk about things that really matter?" (K8Q21). Response options were a Likert scale and were as follows: 1= "Very well", 2=

"Somewhat well", 3=" Not very well", and 4= "Not well at all". In an earlier study using the NCSH data, this item has been categorized as "sharing ideas" (Crouch et al., 2022). However, in the current study, this item is conceptualized as parent-child connection because it serves as a proxy for a positive, open, and trusting interaction between a caregiver and a child. A dichotomous variable was created by organizing responses into two categories: 1= parent-child connection (if parents selected 1= "Very well" or 2= "Somewhat well" (2) to this item), and 0= no parent-child connection (if parents selected 3= "Not very well" or 4= "Not well at all" on this item).

Family Resilience. Family resilience was measured using the following four items: "When your family faces problems, how often are you likely to do each of the following?" (1) talk together about what to do (TALKABOUT), (2) work together to solve our problems (WKTOSOLVE), (3) know we have strengths to draw on (STRENGTHS), and (4) stay hopeful even in difficult times (HOPEFUL). Potential answers included 1= "All the time", 2= "Most of the time", 3= "Some of the time", and 4= "None of the time". The NSCH then created three categories for organizing responses to the four items: 1= "All or most of the time to 0-1 items", 2= "All or most of the time to 2-3 items", and 3= "All or most of the time to all 4 items". For this study, a dichotomous score for family resilience was created. Responses that fell in category 1 (All or most of the time to 0-1 items) were dummy coded as "0=No", indicating not living in a resilient family. Responses that fell in categories 2 and 3 were combined and dummy coded as "1=Yes", indicating living in a resilient family.

After dummy coding all six PCE items, a cumulative PCE score was created, which ranged from 0-6, similar to the cumulative ACE approach. For example, those who indicated *yes* to three of the six items had an overall PCE score of 3.

Outcome Variables

Mental/Behavioral Health (MBH) Condition (Y1). The outcome of mental/behavioral health (MBH) condition was measured by survey items related to mental, emotional, developmental, or behavioral (MEDB) problems for children ages 3-17 years. The NSCH included 10 MEDB conditions (i.e., Tourette Syndrome, anxiety problems, depression, behavioral or conduct problems, developmental delay, intellectual disability, speech or other language disorder, learning disability, Autism or autism spectrum disorder, and attention deficit disorder or Attention-Deficit/ Hyperactivity Disorder [ADD/ADHD]). In the current study, four of the ten conditions were used to measure the outcome of a child having a mental/behavioral health condition: anxiety problems, depression, behavioral or conduct problems, and ADD/ADHD. These four were selected because they are the most diagnosed mental, emotional, and behavioral disorders among children (CDC, 2023) and capture both internalizing and externalizing problems.

Respondents were asked the following questions, “Has a doctor or other health provider EVER told you that this child has anxiety problems?” (K2Q33A), “Has a doctor or other health provider EVER told you that this child has depression?” (K2Q32A), “Has a doctor, other health care provider, or educator EVER told you that this child has… (*Examples of educators are teachers and school nurses*) behavioral or conduct problems?” (K2Q34A), and “Has a doctor or other health care provider EVER told you that this child has attention deficit disorder or Attention Deficit/Hyperactivity Disorder, that is, ADD or ADHD?” (K2Q31A). Respondents answered “yes” (1) or “no” (2) to these questions. A dichotomous variable was created by organizing children into two categories: 0= no MBH conditions and 1= one or more MBH conditions.

School Disengagement (Y2). Two items were used to measure the construct of school disengagement (SchlEngage_20). The 2020 NSCH asked parents and caregivers the following questions, "How often does this child engage in school…" "cares about doing well in school?" (K7Q82_R), and "Does all required homework?" (K7Q83_R). Respondents rated each child as "always" (1), "usually" (2), "sometimes" (3), and "never" (4; CAHMI, 2023). Comparable items measuring the construct of school engagement are included in various self-report measures. For example, the Student School Engagement Measure (SEEM) includes items such as "When I have an assignment due, I keep working until it is finished" (Hazel et al., 2013). The Student Engagement Scale (SES) uses items such as "I check my schoolwork for mistakes" and "I like being at school" (Fredricks et al., 2004). Additionally, the two items used in this study align with the Student Engagement Model, which emphasizes four types of student engagement: academic (e.g., homework completion), behavioral (e.g., classroom participation), cognitive (e.g., value of learning), and affective (sense of belonging at school; Christenson et al., 2008). Following the organization of the MBH condition variable, a dichotomous variable was created by organizing the sample into two categories: 0= School Engagement and 1= School Disengagement.

The current study aims to determine whether PCEs buffer the impact of ACEs on the study outcomes separately. It is important to note that both outcome variables are organized in such a way that the analyses will predict the probability of a youth falling into the undesirable category. This conceptual approach aligns with the Protective Factor resiliency model by Fergus and Zimmerman (2005) in which PCEs act as the protective factor in the relationship between a risk factor (ACEs) and a negative outcome (i.e., having one or more MBH conditions, and school disengagement). An illustration of this study's conceptual model is shown in Figure 4. A summary of the study variables is presented in Table 4.

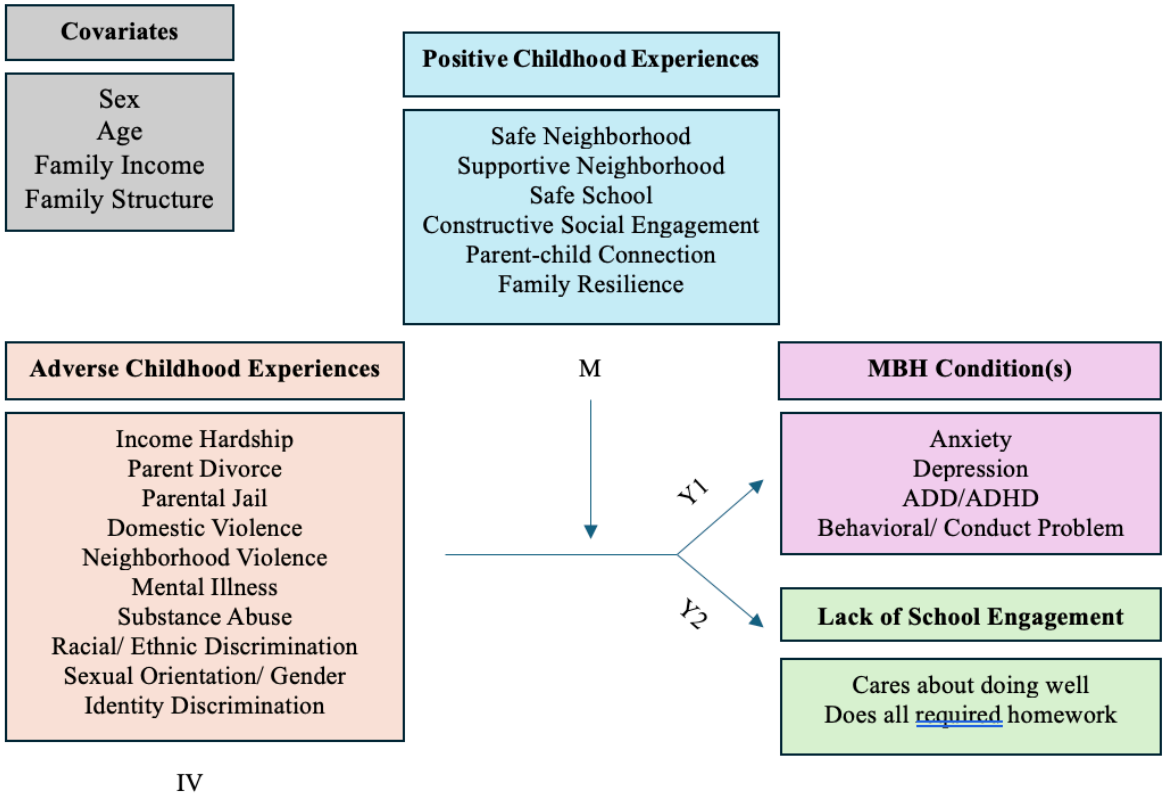

Figure 4. Study 1 Conceptual Model of Moderation Analysis

Table 3. Study 1 Sample Socio-Demographic Information

Demographic Categories (N=2201)	Mean (SD)	Frequency	Valid Percentage
Race			
Black/ African American		2201	100%
Sex	1.48 (.5)		
Male		1151	52.3%
Female		1050	47.7%
Age (years)			
6		158	7.2%
7		148	6.7%
8		151	6.9%
9		150	6.8%
10		170	7.7%
11		179	8.1%
12		162	7.4%
13		207	9.4%
14		224	10.2%
15		205	9.3%
16		235	10.7%
17		212	9.6%
Household Income Level	2.34 (1.11)		
0-99% FPL		679	30.8%
100-199% FPL		516	23.4%
200-399% FPL		579	26.3%
400% FPL or greater		427	19.4%
Family Structure (of child's household)	2.36 (1.14)		
Two-parents		874	42.2%
Single parent (mother or father)		959	46.3%
Grandparent household		178	8.6%
Other family type		62	3.0%
Missing		*128*	*5.8%*

Table 4. Summary of Study Variables and NSCH Items

Category	Variable	NCSH Question(s)	Recoded Items	New Variable Items
Socio-demographic Characteristics (CV)	Age	How old is this child?	Continuous scale	
	Sex	What is the child's sex?	Male= 0 Female= 1	
	Family Income	What is the income level of the household that this child lives in?	1= 0-99% FPL 2= 100%-199% FPL 3= 200-399% FPL 4= 400% FPL or greater	
	Family Structure	What is the family structure that this child lives in?	1=Two parents-current married 2= Two-parents-currently not married 3= Single parent 4= Grandparent household 5= and other family type	
Adverse Childhood Experiences (ACEs) (PV)	Income Hardship	How often has it been very hard to cover the basics, like food or housing, on your family's income?	Yes= 1 (*Somewhat Often* or *Very Often)* No= 0 (*Never* or *Rarely*)	New Variable: Cumulative ACE score (range 0-10)
	Divorce	Parent or guardian divorced or separated		
	Parental Death	Parent or guardian died		
	Jail	Parent or guardian served time in jail	Yes= 1 No= 0	
	Domestic Violence	Saw or heard parents or adults slap, hit, kick, punch one another in the home		
	Neighborhood Violence	Was a victim of violence or witnessed violence in their neighborhood		

	Mental Illness	Lived with anyone who was mentally ill, suicidal, or severely depressed		
	Substance Abuse	Lived with anyone who had a problem with alcohol or drugs		
	Racial/Ethnic Discrimination	Treated or judged unfairly because of their race or ethnic group		
	Gender/Sexuality Discrimination	Treated or judged unfairly because of their sexual orientation or gender		
Positive Childhood Experiences (PCEs) (MV)	Safe Neighborhood	This child is safe in our neighborhood.	Yes= 1 (*definitely agree* or *somewhat agree*) No= 0 *(Somewhat disagree* or *definitely disagree*)	New Variable: Cumulative PCE score (range 0-6)
	Supportive Neighborhood	People in this neighborhood help each other out We watch out for each other's children in this neighborhood When we encounter difficulties, we know where to go for help in our community		
	Safe School	This child is safe at school		
	Constructive Social Engagement	During the past 12 months, did this child participate in… A sports team or did they take sports lessons after school or on weekends Any other organized activities or lessons such as music, dance, language, or other arts Any clubs of organizations after school or on weekends	Yes= 1 No=0	
	Parent-child Connection	How well do you and this child share ideas or talk about things that really matter?"	Yes= 1 (*Very Well and Somewhat* Well)	

	Family Resilience	When your family faces problems, how often are you likely to do each of the following?" Talk together about what to do Work together to solve our problems Know we have strengths to draw on Stay hopeful even in difficult times	No=0 (*not very well* or *not well at all*) Yes= 1 (*all of the time, most of the time)* *No=0 (some of the time, and none of the time)*	
Mental and Behavioral Health (MBH) Condition (OV)	Internalizing symptoms Externalizing symptoms	Does this child currently have… Anxiety problems? Depression? Does this child currently have…Behavioral or Conduct Problems? Does this child currently have… ADD or ADHD?	Yes=1 (*always* or *usually)* No=0 (*sometimes* or *never*)	Dichotomous Variable: 0= No MBH Conditions 1= 1 or more MBH condition
School Engagement (OV)	Care Homework	How often does this child engage in school… Care about doing well in school? Do all required homework?		Dichotomous Variable: 0= school engagement; 1= school disengagement

Analytic Plan 2

Statistical analyses were performed using the IBM SPSS Statistics version 28.0.1.1(14) (IBM SPSS, 2022) to conduct descriptive and logistic regression analyses, and the correlation matrix. The analytic approach proceeded in five steps. First, the dataset was cleaned to only include all key study variables. Categorical variables were dummy-coded, outcome variables were dichotomously dummy-coded, and/or continuous variables were mean centered. Second, missing values within all key variables were identified. As explained in the NSCH Methodology Report (2020), missing values were coded to identify missing data. Missing data occurred for four reasons: (a) Logical/ Legitimate skip- the item was not applicable to the respondent, as determined by a previous answer to a root question; (b) No valid Response/ Missing in Error- the value is missing due to the respondent or system errors, or the respondent did not provide a valid answer; (c) Not in Universe- the item was not included on the respondent's age-appropriate version of the topical questionnaire; and (d) Suppressed for Confidentiality- the value is suppressed to protect respondent confidentiality (U.S. Department of Commerce, 2023). All missing and invalid responses were replaced with multiply imputed values by the survey administrators (U.S. Department of Commerce, 2023). The values are as follows: logical skip=95, missing in error=99, not in the universe=90, and suppressed for confidentiality =98. For missing data analyses, a missing value analysis for all study variables was conducted using SPSS. Missing values were excluded in final analyses using pairwise deletion.

Second, inferential statistics and assumptions testing of logistic regression were examined. Assumptions testing for logistic regression were guided by Laerd Statistics (n.d.) and Stoltzfus (2011) and included: (1) dependent variables are measured on a dichotomous scale and independent variables can be continuous (interval or ratio) or categorical (ordinal or nominal),

(2) there is independence of observations (3) absence of multicollinearity, and (4) linearity in the logit for continuous variables. The first two assumptions were met during the cleaning and recoding of all study variables. Specifically, both study outcomes in this study are dichotomously coded: Y1 (0= N MBH Condition(s), 1= 1 or more MBH Conditions), and Y2 (0= Engaged in School, 1= Lack of School Engagement). Age, the independent, and predictor variables are continuous. Bivariate regression correlation analyses were conducted to determine whether there is independence of observations and determine the significance of associations between covariates (age, sex, family income, family structure), the independent variable (cumulative ACEs), the predictor/ moderating variables (individual PCEs), and both outcome variables separately. Scatterplots were conducted to assess linearity of logits and probabilities of each continuous variable. Positive linearity was detected for age, income, and cumulative ACEs and negative linearity was detected for cumulative PCEs. Variance inflation factor (VIF) and tolerance scores were conducted to detect and rule out multicollinearity (Schreiber & Jackson, 2017) between covariates, independent variables, and predictor variables. Tolerance values that fall below 0.1 and VIF values that are above 10 indicate multicollinearity (Schreiber & Jackson, 2017). Tolerance values for all variables were between .85-.99 and all VIF values were between 1.00-1.08, indicating a lack of multicollinearity. Thus, the assumption of multicollinearity is met. Overall, assumptions of binary outcomes, independence of observations, absence of multicollinearity, and linearity of logit for continuous variables were met.

Third, a descriptive analysis was calculated to obtain the measures of variability in the dataset. Percentages and frequency distributions were examined for all covariates (i.e., age, sex, family income, family structure), independent (i.e., individual ACEs), predictor variables (i.e.,

individual PCEs), and each outcome variables (i.e., each MBH condition and comorbidity of conditions, school engagement).

Fourth, logistic regression was used to test all four research questions and hypotheses. Logistic regression provided estimates of odds ratios and 95% confidence for each model. All continuous variables (i.e., age, cumulative ACEs, and cumulative PCEs) were mean centered before computing moderation terms to improve the interpretation of intercept values (Goldstein, 2015; Newsom, 2024). Sex, family income, and family structure remained categorical variables in the analyses, and the effects of cumulative ACEs (model 1) and cumulative PCEs (model 2) were examined for each outcome variable. To test for moderation, the interaction term between cumulative ACEs and cumulative PCEs was entered into model 3 (See Table 6). Fifth, to follow up on any significant terms involving PCEs, expanded logistic regression analyses were conducted using individual PCE items for each outcome variable separately. Model 1 included only statistically significant covariates (from previous logistic regression) and cumulative ACE scores were entered. However, model 2 included individual PCE items rather than cumulative PCE scores. In model 3, interaction terms were entered between cumulative ACEs and each PCE (Table 7). All inferential analyses used a $<.05$ alpha to test statistical significance. See Table 5 for a summary of the sequential analysis steps.

Table 5. Sequential Analysis Steps

	Analysis	Objective
1	Dataset Cleaning	- Reduce dataset to analytic sample - Recode all key study items into categorical and/or continuous variables - Conduct missing values analysis
2	Preliminary Inferential Statistics and Assumptions Testing	- Bivariate regression analyses conducted to determine the significance of associations between independent variables (i.e., age, sex, income, family structure, aces, and individual PCEs) and both outcome variables (i.e., MBH conditions and school engagement) - Variance inflation factor (VIF) scores to detect and rule out multicollinearity between independent variables
3	Descriptive Statistics	- Frequencies and percentages for categorical variables - Means and standard deviations for continuous variables
4	Logistic Regression and Moderation Terms	- Estimate odds ratios (*OR*) and 95% confidence intervals for each model - Detect any moderating effects of the independent variables (i.e., continuous ACEs) and predictor variables (continuous PCEs) on both outcome variables separately
5	Expanded Logistic Regression and Moderation Terms	- Detect main effects of individual PCEs and to detect any moderating effects of the independent (i.e., continuous ACEs) and predictor (i.e., individual PCEs) variables on both outcome variables separately

Table 6. Summary of Primary Analytic Approach: Hierarchical Logistic Regression

Stage	Model
Step 1 Main Effects	Age Sex Family Income Family Structure Cumulative ACEs
Step 2 Main Effects	Cumulative PCEs
Step 3 Interaction Terms	Interaction cumulative ACEs*cumulative PCEs

Table 7. Summary of Expanded Analytic Approach: Hierarchical Logistic Regression

Stage	Model
Step 1 Main Effects	Sex Cumulative ACEs
Step 2 Main Effects	Safe Neighborhood (SN) Supportive Neighborhood (SuN) Safe School Const. Social Engagement (CSE) Parent-child Connection (PCC) Family Resilience (FR)
Step 3 Interaction Terms	Cumulative ACEs * Safe Neighborhood (SN) Cumulative ACEs * Supportive Neighborhood (SuN) Cumulative ACEs * Safe School Cumulative ACEs * Const. Social Engagement (CSE) Cumulative ACEs * Parent-child Connection (PCC) Cumulative ACEs * Family Resilience (FR)

Results

Descriptive Results

Descriptive analyses were conducted to estimate the frequencies and percentages of individual ACEs, PCEs, and outcome study variables (Table 8). The most common reported childhood adversities, or ACEs, experienced amongst the sample were parental divorce (34.7%), racial discrimination (21%), and income hardship (17.4%). More than a third of the sample reported no ACEs (37%), and nearly one-third had experienced one adversity (32.7%), 21.3% had an ACE score of 2 or 3, and 9% had an ACE score of 4 or higher. Regarding PCEs, 94.8% of the sample are connected to their parent. Ninety-five percent (95.4%) attend a safe school, and 73.5% participate in one or more constructive social activities (i.e., after-school activities). Approximately 91.7 % of the sample reside in a safe neighborhood; however, only 47% reportedly reside in a supportive neighborhood. Lastly, 94.3% reportedly live in a resilient family. Only 1.2% of the sample did not have any PCEs. In total, the majority (86.9%) of children and adolescents in the sample have experienced four or more PCEs. Thus, PCEs are more commonly experienced than ACEs in the sample.

Children and adolescents in the sample were more likely to have a lifetime occurrence of ADD/ADHD (13.8%) and/or a behavior/conduct problem (12.2%) compared to anxiety (9.9%) and depression (5.9%). However, the majority of the sample did not endorse having a mental/behavioral health condition (76.6%). Amongst children and adolescents with a mental/behavioral health condition, 11% had only one of the four conditions. Comorbidity was also examined in the data. Nearly eight percent (7.9%) reported having two conditions, 3.1% reported having three conditions, and 1.4% reported having all four conditions. Lastly, regarding school engagement, most of the children and adolescents in the sample demonstrate school

engagement (80.9%) whereas 19.1% do not demonstrate school engagement. The prevalence of ACEs and PCEs by sociodemographic characteristics are shown in Table 9.

Main Effects and Moderation of MBH Conditions Outcome

Main effects of covariates (i.e., age, sex, family income, and family structure) and cumulative ACEs for the occurrence of one or more MBH conditions are shown in Table 10, MBH Model 1. Model 1 explained 8.4% (Cox & Snell R square) and 12.6% (Nagelkerke R square) of variance and correctly classified 78% of cases. Compared to males, being female was associated with statistically lower odds of having one or more MBH conditions (*OR*=.56, 95% C.I. [.45, .71], *p*= <.001). Compared to those in the sample with zero ACEs, cumulative ACE scores were associated with statistically higher odds of having one or more MBH conditions (*OR*=1.47, 95% C.I. [.1.37, 1.58], *p*= <.001). In MBH Model 2, cumulative PCEs were added to examine potential main effects on the MBH condition outcome. Higher cumulative PCEs scores were associated with statistically lower odds of having one or more MBH conditions (*OR*=.63, 95% C.I. [.57, 1.72], *p*= <.001). The interaction term for cumulative ACEs and cumulative PCEs was not statistically significant on the MBH condition outcome (*OR*=1.03, 95% C.I. [.97, 1.11], *p*= .29). MBH Model 1 explained 8.4% (Cox & Snell R square) and 12.6% (Nagelkerke R square) of variance and correctly classified 78% of cases. MBH Models 2 and 3 explained 11% (Cox & Snell R square) and 16% (Nagelkerke R square) of variance and correctly classified 78% of cases.

Main Effects and Moderation of School Disengagement (SE) Outcome

SE Model 1 (Table 11) explained 8.3% (Cox & Snell R square) and 13.2% (Nagelkerke R square) of variance and correctly classified 81% of cases. As shown in Table 11, compared to males, being female was associated with statistically lower odds of falling in the “school

disengagement" group (*OR*=.40, 95% C.I. [.31, .53]), *p* =<.001). Compared to those in the sample with zero ACEs, higher cumulative ACE scores were associated with statistically higher odds of falling in the "school disengagement" group (*OR*=1.40, 95% C.I. [1.30, 1.50], *p*= <.001). No statistically significant main effects were found for age, family income, and family structure for either outcome variable. Higher cumulative PCEs scores were associated with statistically lower odds of falling in the "school disengagement" group (*OR*=.53, 95% C.I. [.46, .61]), *p* =<.001) (Table 8). The interaction term for cumulative ACEs and cumulative PCEs was statistically significant at p<.05 (*OR*=1.07, 95% C.I. [1.00, 1.14], *p*=.04). The significant interaction indicates a buffering effect of cumulative PCEs on the association between cumulative ACEs and school disengagement (Table 8). SE Models 2 and 3 explained 12% (Cox & Snell R square) and 20% (Nagelkerke R square) of variance and corrected classified 81-82% of cases.

Expanded Logistic Regression of Individual PCE Main Effects and Moderation

Within the expanded logistic regression models in Tables 12 and 13, sex was the only covariate included in the analyses due to previous statistical significance shown in Tables 10 and 11. Age, family income, and family structure were not included as covariates. Regarding the MBH Conditions outcome (Table 9, MBH Model 1), being female (*OR*= -.578, 95% C.I. [.44, .70]), *p* =<.001) was associated with statistically lower odds of having one or more MBH conditions. Cumulative ACE scores (*OR*=1.48, 95% C.I. [1.38, 1.59]), *p* =<.001) were associated with statistically higher odds of having one or more MBH conditions. When individual PCE items were entered into Model 2, only three of the six were statistically significant. Higher scores of constructive social activities (*OR*=.62, 95% C.I. [.48, 80]), *p* =<.001), parent-child connection (*OR*=.20, 95% C.I. [.13, .33]), *p* =<.001), and family resilience (*OR*=.56, 95% C.I. [.35, 88]), *p*

=<.01) were associated with statistically decreased odds of having one or more MBH conditions. Living in a safe neighborhood (*OR*=.89, 95% C.I. [.60, 1.53]), *p* =.62), supportive neighborhood (*OR*=.93, 95% C.I. [.73, 1.17], p=.54), and attending a safe school (*OR*=.68, 95% C.I. [.40, 1.16, p=.16]) were not statistically significant. The interaction term of cumulative ACEs and safe neighborhood was statistically significant (*OR*= 1.29, 95% C.I. [1.04, 1.62]), *p* =<.02), indicating a moderating effect of living in a safe neighborhood on the relationship between ACEs and having one or more MBH Conditions. None of the other interaction terms in Table 12 were significant, suggesting that overall, the association between cumulative ACEs and having one or more MBH Conditions is not moderated by living in a supportive neighborhood, attending a safe school, participating in constructive social activities, having a positive parent-child connection, and living in a family that is resilient.

As shown in Table 13 (SE Model 1), being female (*OR*= .40, 95% C.I. [.31, .52]), *p* =<.001) was associated with statistically lower odds of falling in the "school disengagement" group. Cumulative ACE scores (*OR*=1.38, 95% C.I. [1.31, 1.52]), *p* =<.001) were associated with statistically higher odds of falling in the "school disengagement" group. Statistically significant main effects were found for five of the six PCEs. Specifically, living in a safe neighborhood (*OR*=.56, 95% C.I. [.35, .87]), *p* =<.05), attending a safe school (*OR*=.46, 95% C.I. [.27, .80]), *p* =<.05), participating in constructive social activities (*OR*=.52, 95% C.I. [.39, .68]), *p* =<.001), having a parent-child connection (*OR*=.12, 95% C.I. [.07, .20]), *p* =<.001), and living in a family that is resilient (*OR*=.39, 95% C.I. [.24, .62]), *p* =<.001), were associated with statistically lower odds of being disengaged in school. Living in a supportive neighborhood (*OR*=.24, 95% C.I. [.95, 1.61]), *p* =.10), was not statistically significant, indicating that this PCE does not have a main effect on the relationship between cumulative ACEs and the probability of

being disengaged in school. The interaction term of cumulative ACEs and safe neighborhood was statistically significant (*OR*=1.30, 95% C.I. [1.04, 1.63]), *p* =.02) indicating a moderating effect of living in a safe neighborhood on the relationship between cumulative ACEs and school disengagement. None of the other interaction terms were significant.

Table 8. Descriptive Statistical Analyses of Individual Predictor, Moderators, and Outcome Variables

Study Variable	Frequency	Percentages
Individual ACEs (Yes)		
ACE 1- Income	366	17.4%
ACE 2- Divorce	703	34.7%
ACE 3- Parental Death	146	7.2%
ACE 4- Parental Jail	254	12.6%
ACE 5- Witness Domestic Violence	147	7.3%
ACE 6- Victim of Violence	168	8.3%
ACE 7- Mental Illness	164	8.1%
ACE 8- Substance Problem	170	8.4%
ACE 9- Racial Discrimination	425	21%
ACE 10- Sexual Ori. Gender Discrimination	38	1.9%
Individual PCEs (Yes)		
Safe Neighborhood	1899	91.7%
Supportive Neighborhood	969	47%
Safe School	1952	95.4%
Constructive Social Engagement	1574	73.5%
Parent-child Connection	1988	94.8%
Family Resilience	1924	94.3%
Mental and Behavioral Health Conditions (Yes)		
Anxiety	216	9.9%
Depression	129	5.9%
ADHD/ ADD	303	13.8%
Behavioral/ Conduct Problem	269	12.2%
MBH Conditions		
No MBH Conditions	1669	76.6%
1 or more MBH Conditions	515	23.4 %
1 MBH condition	243	11%
2 MBH Conditions	173	7.9%
3 MBH Conditions	68	3.1%
4 MBH Conditions	31	1.4%
School Engagement		
Not Engaged in School	405	19.1%
Engaged in School	1712	80.9%

Table 9. Prevalence of ACEs, PCEs, and Covariates (Demographics)

	Zero ACEs	1 ACE	2-3 ACEs	4+ ACEs	Zero PCEs	1 PCE	2-3 PCEs	4+ PCEs
Sex								
Male (*n*=1151)	399 (53.6%)	336 (51.1%)	226 (52.7%)	94 (51.9%)	15 (55.6%)	27 (51.9%)	113 (53.8%)	993 (52.0%)
Female (*n*=1050)	346 (46.4)	321 (48.9%)	203 (47.3%)	87 (48.1%)	12 (44.4%)	25 (48.1%)	97 (46.2%)	916 (48.0%)
Age (years)								
6-11 years (*n*=956)	358 (48.1%)	278 (42.4)	163 (37.9%)	65 (40%)	13 (45.4%)	21 (40.4%)	94 (44.7%)	955 (43.4%)
12-17 (n=1245)	387 (51.9%)	379 (57.8%)	266 (62.1%)	116 (64%)	14 (54.6%)	31 (59.6%)	116 (55.3%)	1082 (56.6%)
Household Income Level								
0-99% FPL (n=679)	216 (29.0%)	182 (27.7%)	142 (33.1%)	79 (43.6%)	8 (29.6%)	20 (38.5%)	87 (41.4%)	562 (29.4%)
100-199% FPL (n=516)	159 (21.3%)	153 (23.3%)	106 (24.7%)	48 (26.5%)	6 (22.2%)	13 (25.0%)	47 (22.4%)	449 (23.5%)
200-399% FPL (n=579)	208 (27.9%)	178 (27.1%)	115 (26.8%)	35 (19.3%)	7 (25.9%)	10 (19.2%)	48 (22.9%)	514 (26.9%)
400% FPL or greater (n=427)	162 (21.7%)	144 (21.9%)	66 (15.4%)	19 (10.5%)	6 (22.2%)	9 (17.3%)	28 (13.3%)	384 (20.1%)
Family Structure								
Two-parents (n=874)	286 (40.9%)	256 (41.2%)	188 (46.1%)	64 (39.3%)	8 (30.8%)	25 (49.0%)	81 (42.0%)	760 (42.2%)
Single parent (n=959)	329 (47.0%)	289 (46.5%)	173 (42.4%)	82 (50.3%)	16 (61.5%)	21 (41.2%)	89 (46.1%)	832 (46.2%)
Grandparent (n=178)	61 (8.7%)	58 (9.3%)	36 (8.8%)	12 (7.4%)	2 (7.7%)	2 (3.9%)	17 (8.8%)	157 (8.7%)
Other family type (n=62)	24 (3.4%)	18 (2.9%)	11 (2.7%)	5 (3.1%)	0 (0.0%)	3 (5.9%)	6 (3.1%)	53 (2.9%)
Missing (n=128)								

Table 10. MBH Condition Statistical Estimates of Continuous Variables Main Effects and Moderating Effects (N=1783)

Effect	Model 1				Model 2				Model 3			
	B	OR	95% CI OR		B	OR	95% CI OR		B	OR	95% CI OR	
			LL	*UL*			LL	*UL*			LL	UL
Constant	-.98	.73**			-1.10	.33**			-1.07	.33**		
Age	.03	1.03	.99	1.06	.03	1.03	.99	1.07	.03	.1.03	.99	1.07
Sex	-.57	.56**	.45	.71	-.56	.56**	.45	.72	-.56	.57**	.45	.72
Family Income												
Single Parent	.14	1.15	.90	1.48	.14	1.15	.89	1.47	.14	1.15	.89	1.47
Grandparent	.14	1.16	.76	1.76	.15	1.16	.76	1.79	.15	1.16	.76	1.79
Other Family Type	.20	1.22	.61	2.43	.20	1.21	.61	2.43	.19	1.21	.61	2.41
Family Structure												
100-199% FPL	-.25	.77	.56	1.06	-.19	.82	.60	1.14	.-.18	.83	.60	1.14
200-399% FPL	-.02	.97	.72	1.32	.10	.1.11	.81	1.51	.11	.1.12	.82	1.52
400%+ FPL	-.23	.88	.88	1.23	.06	1.06	.75	1.50	.07	1.07	.76	1.51
Cumulative ACEs	.39	1.47**	1.37	1.58	.36	1.43**	1.34	1.54	.36	1.44**	1.34	1.56
Cumulative PCEs					-.45	.63**	.57	.72	-.47	.62**	.52	.71
Interaction ACEs X PCEs									.03	1.03	.97	1.11

Note. CI= Confidence Interval; LL= Lower Limit; UL= Upper Limit. ***p<.001, **p<.01, *p>.05
Model 1: adjusted for age, sex, family income, family structure, and cumulative ACEs
Model 2: adjusted for age, sex, family income, family structure, and cumulative ACEs, and cumulative PCEs
Model 3: adjusted for age, sex, family income, family structure, and cumulative ACEs, cumulative PCEs, and interaction effects of ACEs and PCEs

Table 11. School Disengagement Statistical Estimates of Continuous Variables Main Effects and Moderating Effects (N=1710)

Effect	Model 1				Model 2				Model 3			
	B	OR	95% CI OR		B	OR	95% CI OR		B	OR	95% CI OR	
			LL	*UL*			LL	*UL*			LL	UL
Constant	-.93	.39**			-1.09	.33**			-1.12	.32**		
Age	.03	1.03	.99	1.07	.03	1.03	.99	1.07	.04	1.03	.99	1.08
Sex	-.90	.40**	.31	.53	-.92	. 40**	.30	.52	-.91	. 40**	.31	.52
Family Income												
Single Parent	.07	1.07	.82	1.39	.06	1.06	.81	1.39	.06	1.07	.81	1.40
Grandparent	.10	1.10	.70	1.73	.10	1.10	.69	1.76	.11	1.11	.70	1.78
Other Family Type	-.57	.56	.23	1.36	-.58	.55	.23	1.40	-.60	.55	.22	1.33
Family Structure												
100-199% FPL	-.33	.72	.52	1.00	-.30	.77	.54	1.11	-.24	.78	.55	1.11
200-399% FPL	-.20	.82	.59	1.12	-.03	.96	.69	1.35	-.02	.98	.70	1.37
400%+ FPL	-.60	.55	.37	.80	-.35	.70	.47	1.04	-.34	.71	.48	1.06
Cumulative ACEs	.33	1.40**	1.30	1.50	.29	1.33**	1.24	1.44	.32	1.37**	1.26	1.48
Cumulative PCEs					-.62	.53**	.46	.62	-.67	.51**	.44	.59
Interaction ACEs X PCEs									.06	1.07*	1.00	1.14

Note. CI= Confidence Interval; LL= Lower Limit; UL= Upper Limit. ***p<.001, **p<.01, *p>.05
Model 1: adjusted for age, sex, family income, family structure, and cumulative ACEs
Model 2: adjusted for age, sex, family income, family structure, and cumulative ACEs, and cumulative PCEs
Model 3: adjusted for age, sex, family income, family structure, and cumulative ACEs, cumulative PCEs, and interaction effects of ACEs and PCEs

Table 12. Expanded MBH Condition Statistical Estimates of Continuous Variables Main Effects and Moderating Effects (N=1816)

Effect	Model 1				Model 2				Model 3			
	B	OR	95% CI OR		B	OR	95% CI OR		B	OR	95% CI OR	
			LL	*UL*			LL	*UL*			LL	UL
Constant	-.97	.38**			1.86	6.44**			1.96	7.14**		
Sex	-.57	.56**	.44	.70	-.57	.56**	.44	.71	-.57	.56**	.44	.71
Cumulative ACEs	.39	1.48**	1.38	1.59	.35	1.42**	1.32	1.53	.28	1.32	.86	2.01
PCEs												
Safe Neighborhood					-.12	.62	.58	1.37	-.32	.73	.46	1.14
Supportive Neighborhood					-.07	.93	.73	1.17	-.08	.92	.72	1.17
Safe School					-.38	.68	.40	1.16	-.27	.76	.41	1.40
Const. Social Engagement					-.47	.62**	.48	.80	-.47	.62**	.47	.80
Parent-Child Connection					-1.58	.20**	.13	.33	-1.54	.21**	.13	.35
Family Resilience					-.57	.56*	.35	.88	-.61	.54*	.33	.87
Interaction Terms												
ACEs X Safe Neighborhood									.27	1.30*	1.04	1.62
ACEs X Supportive Neighborhood									.05	1.05	.90	1.22
ACEs X Safe School									-.10	.90	.66	1.21
ACEs X Const. Social Engagement									.06	1.06	.90	1.24
ACEs X Parent-Child Connection									-.71	.84	.63	1.15
ACEs X Family Resilience									.04	1.04	.81	1.34

Note. CI= Confidence Interval; LL= Lower Limit; UL= Upper Limit. ***p<.001, **p<.01, *p>.05
Model 1: adjusted for sex and cumulative ACEs
Model 2: adjusted for sex, cumulative ACEs, and individual PCEs
Model 3: adjusted for sex, cumulative ACEs, individual PCEs, and interaction terms.

Table 13. Expanded School Disengagement Statistical Estimates of Continuous Variables Main Effects and Moderating Effects (N=1813)

Effect	Model 1				Model 2				Model 3			
	B	OR	95% CI OR		B	OR	95% CI OR		B	OR	95% CI OR	
			LL	UL			LL	UL			LL	UL
Constant	-1.13	.32**			3.30	27.05**			3.67	39.34**		
Sex	-.91	.40**	.31	.52	-.97	.37**	.31	.52	-.96	.38**	.30	.50
Cumulative ACEs	.34	1.38**	1.31	1.52	.27	1.31**	1.31	1.52	-.15	.785	.60	1.20
PCEs												
Safe Neighborhood					-.57	.56*	.37	.87	-.81	.44**	.28	.70
Supportive Neighborhood					.22	1.24	.95	1.61	.20	1.23	.93	1.61
Safe School					-.76	.46*	.27	.80	-.69	.50*	.27	.92
Const. Social Engagement					-.66	.52**	.39	.68	-.64	.53**	.39	.70
Parent-Child Connection					-2.10	.12**	.19	.20	-2.21	.11**	.06	.18
Family Resilience					-.94	.39**	.62	.62	-1.07	.34**	.21	.56
Interaction Terms												
ACEs X Safe Neighborhood									.27	1.30*	1.04	1.63
ACEs X Supportive Neighborhood									.05	1.05	.90	1.23
ACEs X Safe School									-.06	.94	.72	1.23
ACEs X Const. Social Engagement									.00	1.00	.85	1.18
ACEs X Parent-Child Connection									.13	1.14	.88	1.47
ACEs X Family Resilience									.13	1.14	.90	1.50

Note. CI= Confidence Interval; LL= Lower Limit; UL= Upper Limit. ***p<.001, **p<.01, *p>.05
Model 1: adjusted for sex and cumulative ACEs
Model 2: adjusted for sex, cumulative ACEs, and individual PCEs
Model 3: adjusted for sex, cumulative ACEs, individual PCEs, and interaction terms.

CHAPTER FOUR:

A QUALITATIVE ANALYSIS OF THE IMPACT OF POSITIVE CHILDHOOD EXPERIENCES ON BLACK YOUTHS' MENTAL AND BEHAVIORAL HEALTH, SCHOOL ENGAGEMENT, AND RESILIENCY DEVELOPMENT

Method

The phenomenon of "positive childhood experiences" (PCEs) has primarily been studied and measured using quantitative inquiry. As previously described in the literature, PCEs are generally measured and categorized within the contexts of family relationships and home environments, individual, school settings, community, and non-familial support. Given these contextual categories, PCEs were measured in Study 1 using items reflecting the variables of attending a safe school, living in a safe and supportive neighborhood, constructive social engagement (i.e., participation in extracurricular activities in school or the community), having a positive parent-child connection (i.e., sharing ideas and talking about things that matter), and living in a resilient family (i.e., a family that talks and works together to solve problems, have strengths to draw on and remain hopeful in difficult times). While the quantitative analyses of this phenomenon have provided an objective and numerical interpretation of the correlational relationships between several types of PCEs and outcomes related to PCEs, quantitative inquiry can be lacking in explaining the 'why' behind a phenomenon.

There is a need for qualitative approaches to understanding PCEs as a phenomenon, as qualitative analyses may provide additional perspectives that are either missed or overlooked using quantitative methods alone. Thus, in the current study, a qualitative approach was used to

further understand the complexities of PCEs as a phenomenon. Therefore, the purpose of Study 2 is to supplement the findings from Study 1, by elucidating how Black young adults conceptualize and make sense of PCEs and the impact such experiences had on their mental and behavioral well-being, school outcomes, and resiliency development during their upbringings.

Research Design

Merriam and Tisdell (2016) suggest that "qualitative researchers are interested in understanding how people interpret their experiences, how they construct their worlds, and what meaning they attribute to their experiences" (p. 6). Therefore, this research study aimed to uncover and interpret the meaning of participants' childhood experiences that were affirming, helpful, and positive. As participants shared their experiences, the researcher learned how and why specific experiences were positively impactful to their overall well-being, school success, and resiliency development. As opposed to utilizing a quantitative survey and limiting the participants' responses, the researcher conducted semi-structured interviews which allowed for the emergence and inclusion of important themes to be uncovered that had not been previously measured in the literature.

Consensual Qualitative Research (CQR)

In this study, data was analyzed using the Consensual Qualitative Research (CQR) approach (Hill, 2005). The philosophical underpinning of the CQR approach is that it is "predominantly constructivist, with some post-positivist elements" (Hill et al., 2005, p. 197), in that "CQR relies on naturalistic, interactive, qualitative methods" (Stahl et al., 2012). The meaning of PCEs as a phenomenon is derived from words, the context of participants' words, and the interactions between the researcher and participants as the researcher used probes and clarification to understand participants' experiences. CQR incorporates elements from multiple

qualitative research approaches including phenomenology, grounded theory, comprehensive process analysis (Hill et al., 2005) and exploratory and discovery-oriented methods. Further, there are five essential components to CQR: (1) an in-depth examination of individuals' experiences through open-ended questions (typically through interviews or questionnaires), (2) the construction of a primary research team that includes several researchers as "judges"; judges provide multiple perspectives throughout the data analysis process, (3) a consensus between judges on the meaning of data collected, (4) the incorporation of at least one auditor to check the judges work and minimize possible group-think effects, and (5) the development of domain, core ideas and cross analyses in the data analysis process (Hill et al., 2005). Another aspect of CQR is the number of cases used in the study. It is recommended that the sample size is small, between 8 to 15 participants, so that each case is studied intensively (Hill et al., 2005).

Given that this is a dissertation study, modifications were made to the CQR approach. The primary researcher conducted and transcribed all interviews. To protect participants' identities, all interviews were conducted, audio recorded, and transcribed by the primary researcher. All interview transcripts were deidentified and labeled with a four-digit code before dissemination amongst the research team. The research team was formed to assist with data analyses only.

Procedures

Guided by the recommendations and steps for conducting CQR, the researcher thoroughly reviewed the literature on the topic and identified the purpose and aim of the study. This study aims to retrospectively explore Black young adults' understanding of PCEs and how these experiences contributed to their mental and behavioral well-being, school engagement, and overall resiliency development. After determining the study's purpose and aim, the researcher

developed research questions for the study. Next, the target sample and criteria for selecting participants were established. The goal was to recruit a maximum of 10 participants for the study. Inclusionary criteria for participation in the study were as follows: participants must (1) identify as Black or African American, (2) be 18-20 years of age, (3) have experienced an adversity during childhood (0-17 years), and (4) have experienced symptoms of anxiety, depression, ADHD, or a behavioral concern during their childhood (0-17 years; a medical diagnosis or educational classification is not required for participation). Diversity in terms of gender identity was also considered for recruitment. The researcher aimed to include an equal number of participants who identified as male, female, transgender, and non-binary in the final sample.

Instrumentation

An initial interview protocol was developed and piloted with one person who met the inclusionary criteria for the study. The pilot protocol included more general questions related to childhood upbringing (e.g., What is your earliest childhood memory?) and experiences in school settings (e.g., What aspects of school made you feel connected or disconnected from school?) and within neighborhoods/ communities (e.g., What community-based organizations or activities did you participate in?). The initial pilot interview took two hours to complete. Although much information was gathered from the interview, it wasn't easy to distinguish which experiences the interviewee perceived as positive and impactful to their mental and behavioral health and educational outcomes. This was an indication that the initial protocol needed to be more narrowly focused on positive childhood experiences, mental health, school engagement, and resiliency. Data collected through the pilot interview are not included in the final sample.

The researcher then created a new interview protocol including eight direct and open-ended scripted questions intended to stimulate participants' thinking and elicit rich responses. Unscripted probe questions (from the initial protocol) were also included in the protocol if participants needed help with elaborating on details. The new interview protocol was comprised of three main sections: (1) opening, (2) main section, and (3) closure (Hill, 2012). Each participant completed two separate interviews. Hill (2012) suggests that "multiple interviews… may forge a stronger relationship between the researcher and participants, enabling the latter to feel greater comfort in describing emotionally evocative experiences because he or she had prior contact with the researcher (i.e., the first interview) and has established at least a basic level of trust" (p. 90). The first interview included the opening and main section questions of the protocol. The second interview included the third/closure section of the protocol. The opening section allows the researcher to build rapport with the participants and inquire about less emotional topics (Hill, 2012). In the protocol, the opening section of the protocol asks participants to describe themselves in terms of their most salient identities, beliefs, and values. The researcher also responded to this question, which helped to build rapport and identify commonalities and differences in identities, beliefs, and values. The second/main section of the interview protocol included scripted and open-ended questions used to explore topics germane to the study. In the protocol, participants were asked to reflect on their childhood and describe the positive and challenging experiences that came to mind. Participants were also asked to describe how their childhood experiences impacted their mental and behavioral health, school engagement, and resiliency development. In the second/ follow-up interview, the participants were provided a summary of the content discussed in the first interview. Participants were provided the opportunity to make additions and corrections to topics discussed in the first

interview. Finally, the participants were asked the closure question of the interview protocol. The closure section allowed participants to reflect on broader issues related to the topic, specifically, advice and suggestions for educators, school-based mental health providers, and parents/caregivers on ways to better support Black youths' mental and behavioral health and school engagement. As an additional measure of determining whether the protocol would elicit the information sought, the researcher consulted with other researchers who were more knowledgeable about the topic and qualitative research methodologies and asked them to review and provide feedback on the protocol. The researcher used the feedback given and adjusted some of the research questions so that the topics flowed more seamlessly from one topic to the next. The final version of the interview protocol is included in Appendix C.

Recruitment

The researcher obtained approval by the Loyola University Chicago Institutional Review Board (#8863) before all recruitment efforts were implemented and interviews were conducted. A recruitment flyer (Appendix B), created by the researcher, was posted on various social media platforms (i.e., Facebook, Twitter, Instagram, and LinkedIn). Thus, a snowball recruitment method was utilized; individuals who accessed the flyer via social media were encouraged to share the post with friends, family, acquaintances, and followers on their accounts to increase the visibility of the flyer to potential individuals who meet inclusionary criteria for the study. The research also emailed some college student organizations (e.g., Black Student Unions, Cultural Centers) to recruit eligible participants. Recruitment began in September 2023 and was completed at the end of March 2024. As an incentive for participating, each participant received a $35 Amazon e-gift card for the completion of the initial interview, and an additional $15 Amazon e-gift card for the completion of the second interview.

Individuals interested in participating in the study were provided a link to a Qualtrics survey that served as a brief intake screener (included on the flyer). The brief screener asked to complete demographic information (i.e., age, race, gender identity). Participants were asked close-ended questions centered on their experiences with symptoms of anxiety, depression, ADHD, and/ or behavioral problems. Participants were also asked to indicate the severity of the internalizing and externalizing symptoms experienced (mild, moderate, or severe). Lastly, participants were asked to identify any adversities (i.e., ACEs) experienced during their childhood. At the end of the survey, participants who wished to be interviewed for the study provided an email address so the researcher could contact them directly to establish a time and date for the first virtual interview using an online scheduling platform called Calendly.

Study Sample. The initial goal was to recruit a maximum of 10 participants for the study, however, only eight participants were recruited in total. All participants met the inclusionary criteria for the study, completed the brief intake screener, and completed the initial interview. Only six of the eight participants completed the follow-up interview, despite many attempts to schedule it. A summary of the participants' sociodemographic information and data from the intake screener is shown in Table 14.

Table 14. Sample Demographics

Participant #	Age	Gender	Mental Health Challenges (Severity Level)	ACE Score
Participant 1	19	Female	Depression (Severe) Anxiety (Moderate) Behavior/ Conduct Problem (Mild)	1
Participant 2	20	Female	Depression (Moderate) Anxiety (Mild)	1
Participant 3	18	Female	Depression (Mild) Anxiety (Moderate)	3
Participant 4	18	Female	Depression (Severe) Anxiety (Severe) ADD/ADHD (Severe)	3
Participant 5	18	Male	Anxiety (Moderate) Behavioral/ Conduct problem (Mild)	4
Participant 6	19	Male	Depression (Mild) Anxiety (Mild) Behavioral/ Conduct problem (Mild)	1
Participant 7	20	Female	Depression (Moderate) Anxiety (Mild)	2
Participant 8	20	Male	Anxiety (Mild)	1

Positionality Statement

Positionality comprises the practice of a researcher delineating their culturally ascribed intersectional identities, personal life experiences, and contextual factors that shape their identity and role in research (Bukamal, 2022). Reflexivity “is the act of examining one's assumption, belief, and judgment systems, and thinking carefully and critically about how this influences the research process” (Jamieson et al., 2022, p. X). It is the process in which a researcher engages in critical and continuous self-reflection of how personal biases and assumptions may guide and inform research processes and general worldviews (Jamieson et al., 2022). Though qualitative

researchers are more readily encouraged to engage in these practices, positionality, and reflexivity are also necessary for quantitative research (Jamieson et al., 2022). Thus, the primary researcher engaged in these practices during both studies of this dissertation using reflexivity journaling prompts to guide processing throughout each research stage.

The primary researcher approaches this work from her position as a 28-year-old Black/ African American, heterosexual, and cisgender woman born and raised in a lower-socioeconomic status family on the west side of Chicago, IL. The neighborhood and the Chicago Public Schools the researcher attended had predominately Black populations. Some of the researcher's fondest memories of childhood and adolescence were being aware of how various forms of oppression (e.g., neighborhood violence, domestic violence, identity-based discrimination, poverty/ income inequities, educational inequities, lack of access to mental health care) created adversities for and shaped the lives of members of her family, community, and school. Because these challenges were the norm for the researcher's upbringing and for many people she knew, there was a lack of acknowledgment and understanding of how living and experiencing such chronic stressors impacted children's and adolescents' mental and behavioral health and their ability to thrive academically. These direct and vicarious exposures to adversities during this period of the researcher's life not only shaped her worldview and identity development but also influenced her interests in mental and behavioral health and education equity for marginalized youth, especially Black youth.

These challenges and adversities were moments of pure joy, comfort, support, love, and success. The researcher graduated as valedictorian of her high school class and earned two prestigious scholarships- The Gates Millennium Scholarship and the Posse Scholarship- to the University of Wisconsin, Madison and became a first-generation college graduate. Beyond the

internal characteristics of resilience (e.g., being future and goal-oriented, strong-willed, confident), other contextual factors and influences within her home, school, and community greatly contributed to her resilience and success. The researcher had many close and supportive interpersonal relationships with family members, friends, educators, school staff, and members of her neighborhood church. She also participated in extracurricular activities within my school and community (e.g., After School Matters programs, CPS (Chicago Public Schools) Groundbreakers, choir). These positive experiences helped to build confidence, maintain engagement in school, and contributed to the researcher's overall mental and behavioral well-being.

The complexities of the primary researcher's childhood and adolescent experiences guided her research as she approached this work with the understanding that childhood adversities do not tell the full story of an individual's life. Many Black youth hold stories centered on positivity, resilience, and joy; these stories deserve to be shared and heard. The primary researcher recognized that although she may share similar identities (e.g., race) and experiences with participants, which would make her an "insider" of this research (Bukamal, 2022), Black youth are not a monolith group. Each participant possesses unique life stories that helped to shape their worldview, well-being, and educational outcomes. Acknowledging her positionality encouraged her to continuously engage in reflexivity, separate her lived experience from the participants, and check any biases and/or assumptions that may arise throughout any part of the research processes of both studies.

The Research Team

The primary researcher established a research team to analyze the data using CQR techniques. Vivino et al. (2012) suggest that the "richness and validity of the data obtained the

consensual qualitative research (CQR) is in large part dependent on the functioning of the team, given that the team works together to transform the data into concepts that can be compared across cases" (p. 47). The research team included the primary researcher, two graduate students who acted as "judges" and supported the development of the domains and core ideas, and an associate professor who acted as the "auditor" and monitored and provided consistent feedback throughout the analysis process. Both judges are doctoral-level students in the same study program as the primary researcher. One of the graduate students identifies as a Black, Washington, DC native. She is the daughter of an educator and a chef and has an older sister. Her experiences progressing through DC Public Schools and later HBCUs in addition to the experiences shared with her by her loved ones provide her with a perspective of the world similar to that of many of the participants of the study. The other graduate student is a Nigerian American immigrant who grew up in Minneapolis, Minnesota. She is the eldest daughter of four. Her undergraduate education and research experiences have fostered an interest in adverse childhood experiences (ACES), racial, ethnic, and cultural identity formation. She hopes to continue doing meaningful research like this on Black children and adolescents to better understand their resiliency in and outside of the school system. An associate professor on the dissertation committee served as the auditor and monitored the data analysis process. She identifies as a white, cisgender, woman, as well as a mother of two young children. She acknowledges the unearned privileges she has experienced due to her race and socio-economic status. Thus, she recognizes that she does not share similar lived experiences to the Black youth participants in this study. Her work and training are grounded in commitment to social justice and anti-racism, which informs her approach to the work and commitment to engaging in ongoing reflection about her biases and positionality. All research team members had previous

research experiences and exposure to graduate-level coursework in qualitative methodologies. Additionally, all members of the research team had a shared interest in the topic and were familiar with the CQR approach.

Hierarchical and power differences were also considered in the process, as these differences naturally emerge in teams (Vivino et al., 2012). To address this issue, the primary researcher's role in the consensual team was the same as all the other members. To establish trust (Hill, 2012), all members were expected to contribute equally to all discussions, support each other, and be sensitive to nonverbal communication during discussions. However, the primary researcher undertook most of the tasks of the study included conducting and transcribing interviews, assigning an equal number of cases between the primary researcher and the judges, establishing the initial domains list, and sharing feedback from the auditor with the judges during discussions. Lastly, the biases and expectations of all members were reflected on and discussed throughout the data analysis process (Sim et al., 2012). Further descriptions of the CQR analysis techniques are included below.

Analytic Approach

The primary researcher developed an initial domain list based on the review of the literature and the interview protocol questions (Thompson, Vivino, & Hill, 2012). Domains are broad topics used to organize participants' data. There are two general approaches to creating a domain list. The first approach is to review the literature and/or the research questions to develop a list of potential domains. A second approach is to allow the domains to emerge directly from the transcripts rather than relying on their preconceived ideas (Hill et al., 2005). Given that the interview protocol was structured in a way that focuses on four areas (i.e., PCEs, mental health, school engagement, and resiliency), the initial domain list was developed prior to data collection.

The initial domain list was applied to all interview transcripts by the coding team. Following the first run-through of the data reviewing and domain application, the team met to modify and refine the domain list. The refined domains list captured the participants' responses more accurately. This process was repeated until the domain list stabilized and accurately "fit" the data (Thompson et al., 2012). The research team reread interview transcripts and assigned "blocks" or "chunks" of the raw interview data into appropriate domains (Thompson et al., 2012). Double coding also occurred during this process, which refers to putting the same blocks into two different domains when the block seemed to fit more than one domain. The primary researcher then compiled an extensive dataset of all the blocks of data (along with agreed-upon domains) into one document, referred to as the team's consensus version (Thompson et al., 2012). Data not related to the transfer process was assigned to a domain called "Other" (Thompson et al., 2012). Noncoded data was clearly defined and agreed upon by the team and eventually eliminated from the final consensus version of each interview transcript.

The next step of the analysis process involved constructing core ideas or summaries (two to three sentences) of the raw data that "captured the essence" of participants' experiences (Thompson et al., 2012). The goal of this process was to yield a concise and clear wording of the raw data. The primary researcher independently read each block and developed a core idea that reflected the participants' true sentiments. These core ideas were shared, discussed, and modified with the research team until a consensus was reached for all the interview transcripts. The final version of all core ideas was added to the consensus version and shared with the auditor to review and provide feedback. The feedback from the auditor was shared and discussed with the research team until a final consensus was reached.

The last step of the data analysis process was cross-analysis. The cross-analysis was conducted one domain at a time. Each team member reviewed all the core ideas from the domains and identified common elements across the cases. The team then met to discuss the common elements derived from the core ideas, developed categories, and placed each core idea into one or more categories. Frequency labels (general, typical, variant, rare) were also assigned to each category based on the number of cases included in them. Once consensus was reached on the domains and categories, the primary researcher added these data to the consensus version and submitted it to the auditor for review. The auditor reviewed the cross-analysis for adequacy and provided feedback to the research team. The auditor and research team corresponded numerous times until a consensus was reached.

Saturation

Qualitative researchers define saturation as "the point at which little or no relevant new codes and/or categories were found in data, when issues begin to be repeated with no further understanding or contribution to the study phenomenon, its dimensions, nuances, or variability" (Hennink & Kaiser, 2022). Saturation is a guiding principle used in qualitative research to ensure qualitative rigor (Morse, 2015) and assess the "adequacy of purposeful sampling" (Hennink & Kaiser, 2022, p.1), thus, indicating that it is possible to reach saturation with small sample sizes. Research suggests that saturation can be achieved with a narrow range of interviews, with the lowest sample size being 5 interviews (Constantinous et al., 2017), and the highest being 20-40 interviews (Hagaman and Wuitch, 2017). Although all participants shared unique experiences, saturation was reached, particularly in the domain of PCEs, which was the primary focus on the interview and overall study. Table 2 shows all the themes within the PCE domain were shared across all eight participants (as indicated by the general frequency). Thus, the data collected

across all participants' interviews contributed to an expanded understanding of the study's phenomenon of PCEs.

Validity, Trustworthiness, and Member Checking

In qualitative research, validity is an essential process by which researchers provide evidence that their findings are an accurate reflection of subjects' situations and experiences (Guion et al., 2011; McKim, 2023). Descriptive (i.e., key characteristics such as people, places, times), theoretical (i.e., how, and why phenomenon operate), and interpretative (ensuring that participants' experiences, intentions, and feelings are captured accurately) are common types of validity (McKim, 2023). Member-checking, the process of presenting transcribed data to some or all participants for feedback (Varpio et al., 2017), is a common technique for establishing validity in qualitative research (McKim, 2023). Thus, to ensure trustworthiness of data analyses and interpretations of findings, the primary researcher engaged in member checking processing.

As briefly mentioned in the Instrumentation section of this chapter, during the second interview (in which only six of the eight participants completed), the researcher provided each participant with a summary of their first interview and were asked if their experiences had been accurately captured and if anything was missing. Participants were able to use their time to share additional information about experiences discussed in the initial interview as well as if they would like anything to be removed from their transcripts. The questions asked in the follow-up interview also align with McKim's (2023) new member-checking approach interview questions. The primary researcher's intent was to ensure the trustworthiness of my interpretations and analyses of their lived experiences. All participants who completed the follow-up interview verbally stated their agreement with the summary and themes that emerged from their interviews. None of the participants requested to have parts of their interview removed or changed. Overall,

the follow-up interview was helpful for member checking and ensuring the validity of the transcripts and themes. Additionally, verbatim quotations from participants interviewed were used in the CQR data analysis process and final write up of findings. Using direct quotation is a common technique used to establish interpretative validity (McKim, 2023).

Results

The results of this study reflect the domains and themes derived from the interview data that emerged from the CQR analysis procedures described previously. Five domains emerged from this study: (1) *Positive Childhood Experiences*, (2) *Mental Health Barriers and Remedies*, (3) *School Engagement Barriers and Protective Factors*, and (4) S*ources of Resiliency*. Several themes emerged within each domain. Within the Positive Childhood Experiences domain, six themes emerged: (a) participation in extracurricular activities in school (i.e., sports, clubs, volunteering), (b) parent and family resiliency and bonding opportunities (c) community/neighborhood connectedness and engagement, (d) school personnel-student interactions and relationships, and (e) developing and maintaining meaningful friendships. The *Mental Health Barriers and Remedies* domain included four themes: (a) parent and family support, (b) mental health service accessibility and utilization, (c) COVID-19 and subjective mental health, and (d) racial and ethnic identity and belonging. The *School Engagement Barriers and Protective Factors* domain included two themes: (a) School climate and (b) COVID-19 pandemic and school engagement. Lastly, the S*ources of Resiliency* included three domains: (a) personal growth through independence and self-expression, (b) self-improvement, self-awareness, and self-care, and (c) improved problem-solving skills. A summary of the study domains and theme frequency data is presented in Table 15. An illustration of the domains is shown in Figure 5.

Table 15. Study Domains and Themes Frequency Data

Domain/ Theme	Frequency
Domain 1: Positive Childhood Experiences	
Participation in Extracurricular activities in School	General
Parent and Family Resiliency and Bonding Opportunities	General
Community/ Neighborhood Connectedness and Engagement	General
School Personnel- Student Interactions and Relationships	General
Developing and Maintaining Meaningful Friendships	General
Domain 2: Mental Health Barriers and Remedies	
Parent and Family Support	Typical
Mental Health Service Accessibility and Utilization	Typical
COVID-19 and Subjective Mental Wellbeing	Variant
Racial and Ethnic Identity Development and Belonging	Variant
Domain 3: School Engagement Barriers and Protective Factors	
School Climate	General
Positive Teacher-Student Relationships	General
School Safety	Variant
Negative Teacher-Student Relationships	Variant
COVID-19 and School Engagement	Variant
Domain 4: Sources of Resiliency	
Personal Growth through Independence and Self-Expression	Variant
Self-Improvement, Self-Awareness, and Self-Care	Variant
Problem-Solving Skills	Variant

Note. Cross-analysis frequency descriptions: General= 7+, Typical= 4-6 cases, Variant= 2-3

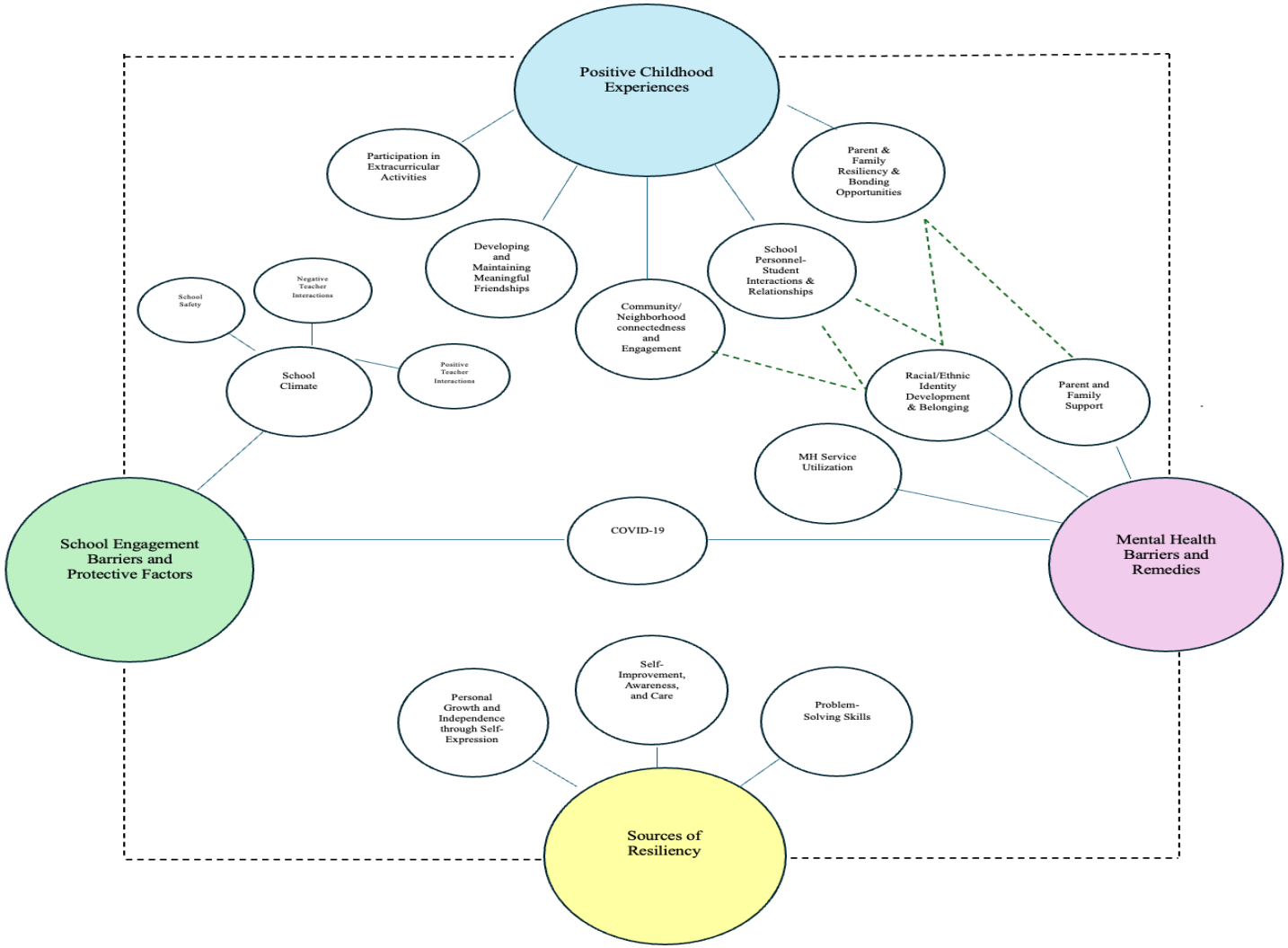

Figure 5. An Illustration of the Study Domains and Themes

Research Question 1

The first research question posed for this study was, *"What experiences from childhood do Black young adults perceive to be positive experiences that supported their well-being and resilience? How are these positive childhood experiences described and understood?"* Participants were asked to reflect on their upbringing and describe life experiences that occurred before the age of 18, that they perceived as positive. This research question was the basis of the first domain, Positive Childhood Experiences. Within this domain, five themes were identified across participants' responses including (a) participation in extracurricular activities in school (i.e., sports, clubs, volunteering), (b) parent and family resiliency and bonding opportunities, (c) community/neighborhood connectedness and engagement, (d) school personnel-student interactions and relationships, and (e) developing and maintaining meaningful friendships. Participants not only identified several enriching experiences, but they also described why specific positive experiences contributed to their resiliency development.

Domain 1: Positive Childhood Experiences

Participation in Extracurricular Activities in School. The most widely cited shared PCE was the participation in extracurricular activities in school. All eight participants described their participation in several sports (e.g., basketball, softball), student-led organizations, and clubs and the impacts these activities had on their character development and their ability to make new connections in school. For example, Participant 3 described how joining the basketball and softball sports teams at her school helped her adjust to high school and make new friends:

> When I first came to high school, I was very shy. I didn't really talk to anyone. I had my two friends [from middle school] and went about my day. But joining basketball my sophomore year, I made new friends and engaged more because I was kind of forced to on the team… I was forced to get to know new people, which I'm very grateful for. And

> then one of my other best friends convinced me to do softball… I've never played softball before… It was something new. At first, I didn't want to. I was kind of scared. But doing it made me gain a passion for the sport… and that sport allowed me to make new connections with people and friendships. I'm glad I did those sports. I thank myself for trying to meet new people.

Similarly, Participant 6 shared a love for basketball and described it as the primary motivation for his overall engagement in high school. When reflecting on this experience, he stated, "I used to love basketball, like, I love basketball. Like, that was something I loved and like enjoyed doing. I feel like that is the only reason I was really into the school stuff." Having the opportunity to play basketball was particularly important given the fact that the high school he attended in his first year was not his choice. He explained that his mother decided to place him in a privately funded high school with the hopes that he would have a rigorous educational experience. Initially, Participant 6 was against this decision because he did not know anyone else who would be attending the school. Thus, being on the basketball team not only provided Participant 6 the opportunity to participate in a sport he loved, but it also helped him adjust to his new school environment and make positive connections with his peers and coaches.

Participant 7 described her experience being in the theater club at her high school through her drama class. She enjoyed watching musicals, reading, and practicing different plays, and learning about theater. Being part of the theater club taught Participant 7 how to express her emotions in several ways. She also described her love of dance and how eager she was to join her high school's cheerleader/pompom team in her first and senior years. In fact, she was made captain of the pompom team her senior year. Participant 7 enjoyed choreographing and performing at various school and sports events including pep rallies and football and basketball games. Being captain was both challenging and rewarding,

> It was challenging because as the leader of the team, I had to make sure I did everything right. There was no time for mess-ups. I had to make sure I kept the team in order. I was

> also responsible for everything, like being at every practice, and making sure everyone had their uniforms. But it was fun. I enjoyed putting on a good show!

In high school, Participant 2 found a love for sports, particularly basketball and track. When asked to reflect on why her participation on sports teams was positive and important, she explained,

> The reason why being on the basketball and track team was important to me is because it distracted me from my actual feelings. Also, [I thought to myself] since I was talented, why not put my talents into a sport that can mold me? Basketball and track taught me how to be strong and how to be confident as well. I got the opportunity to make lifelong friendships in those two sports…They both also taught me how to be a leader as well.

While Participant 2's decision to participate on sports teams was initially an effort to distract her form internal difficulties, being an athlete increased her confidence, improved her leadership abilities, and helped her to foster positive and long-term friendships with her peers. Being an athlete also increased her desire to be a positive role model to younger athletes:

> In high school, sports were very fun to be a part of, especially my freshman year. I had a lot of role models that were on the basketball team and on the track team. As my high school career went on with both sports, it made me think to myself that I want to continue after high school. I knew I wasn't going to be the best school for both sports but all I knew was I wanted to do sports in college. After seeing all my role models leave [high school], I knew I had to step in to be a role model to the next class because doing sports can be very hard on your body and on your mental health. I wanted to be that person that everybody could go to when they were going through it or felt unsure about the sport. I continue to play sports in college because I just didn't want to stop doing something that I have been doing half of my life. Once I'm completely done playing, I want to be a coach. I just don't see myself leaving the sports industry. Even though I have my ups and downs with sports, I keep pushing.

Although participant 2 does not regard herself as a star athlete, her athleticism and accomplishments have not gone unnoticed, as evidenced by her ongoing athletic career as a current college student. What began as a distraction from internal challenges has led to a college athletic career and potentially a future career as a sports coach.

Participant 4 played various sports, including soccer, softball, and volleyball. She started off playing sports in the younger leagues in her neighborhood and eventually joined sports teams in schools. She shared that, "being a part of sports, I learned to never give up when times are hard." As expressed by other participants, being an athlete was a challenging but worthwhile experience as it improved Participant 4's ability to move past and overcome perceived difficulties.

Participant 8 participated in his high school's wrestling and football teams and highlighted the positive impacts of these teams on his life. As an athlete, he learned a valuable lesson on the importance of self-discipline and sportsmanship. Wrestling was a significant and positive experience because he grew up watching WWE and was inspired by famous wrestlers:

> When I got to high school… at first, I wasn't gonna do it [wrestling]. But I was like, 'you know what, I want to try it' because I wanted to be a wrestler. Wrestling gave me a lot of discipline. It's more like a military type of training. Wrestling is a very good sport that teaches you a lot of stuff. I think a lot of people should do wrestling because it teaches you self-discipline… When I joined the football team… football taught me to encourage my teammates to do better.

Participant 8 found wrestling to be the most challenging sport he ever participated in because it required intense discipline and physical endurance to handle heavyweight competition. However, over time, he learned how to push himself past his physical and mental limits in practice. As a football player, he improved his leadership skills as he encouraged his teammates to do better.

Beyond sports, participants described the positive impacts of being members of student-led organizations and clubs at school. For example, Participant 1 described her participation on a spoken word team where they could compete with other school poetry teams. Her experience on the poetry team made her "fall in love with writing." Participant 1 also described why her involvement in a school-based paid summer internship was positive and helpful to her readjustment to school and being around people again after restrictions from the COVID-19

pandemic began to lift in society. These adjustments also positively impacted her mental health as she experienced a positive shift in her energy and mindset, after experiencing severe depression during the isolation periods of COVID-19. Participant 1 shared,

> There was a period in between COVID and going back to school that they [school personnel] allowed us to do this internship over the summer. We had to wear masks and stuff… I finally got to get out of the house... and get paid… I think that helped with the transition back into school. The internship was a program that had different things like accounting, human resources, and stuff like that. I completed the program and then I ended up doing an internship at a facility service company… I was in the Inclusion and Diversity Department. I was in charge of creating a calendar of all the holidays, making sure that everybody felt included, starting team leadership meetings, and making the space more comfortable…It was fun.

Participant 2 also shared the positive impacts of being a part of a school-based mentoring program intended to reduce and prevent incidences of bullying in school. Her participation in this program provided opportunities to build resiliency from past bullying experiences, build positive connections with peers, and support other students who experienced identity-based bullying victimization in school. She shared,

> In middle school, I was a part of Best Buddies. That's when you like, go out and like, you know, be friends with the like, special needs kids. I also did peer tutoring. So, like, I got to help them with homework and make them feel like they're somebody... Every year we had this assembly… to prevent bullying…All the people that got bullied all came together and connected and became really good friends and then like. We kind of came up with ways to prevent people from getting bullied....

Through Participant 2's participation in the Best Buddies program, she stated that she learned a valuable lesson about getting to know people for themselves rather than simply believing what others say about people. Guided by an old idiom, "never judge a book by its cover," she stated that she learned to "to never judge someone by their cover;" "It's better to get to know them for yourself instead of believing what other people may say."

Throughout Participant 5's childhood, he described his involvement in various activities in elementary school, including an after-school program called Space, where he played sports, received tutoring support with his homework, and learned to play an instrument:

> I remember being outside playing soccer. And then we'd switch to the other sports, and they look up and I'd be gone because I was getting help with my math homework... I was also into music. I learned to play the xylophone. I also learned to play the drums... I also remember just reading... I just remember picking up all these things.

Participants 4 and 3 described how their participation in their school's Black Student Union was a positive experience that helped them connect with peers and their culture. Participant 3 stated, "In BSU, I felt closer to my culture, black culture, and black community..." For Participant 4, being a part of BSU made her feel less lonely.

Parent and Family Resiliency and Bonding Opportunities. Each participant described childhood experiences shared with siblings, close relatives, and family members, indicating that the time spent with family members was significant in their upbringing. For example, Participant 6 described the close bonds he shared with his cousins and how his cousins made him feel safe and protected. His older cousins were not only protectors, but also playmates, and created a sense of safety and camaraderie in his neighborhood:

> My cousins are like my friends. We are all around the same age. ... Like as far as going outside, hanging out, playing the game, or just being around each other and protecting each other…. Let's say for instance, like, if we are outside and like, like somebody that was a little older than me, was kind of messing with me.... [names redacted] were older than me. So, it always felt good having them around because they didn't really let nobody mess with me.

The first PCE Participant 3 shared was how bonding opportunities with family members contributed to feelings of belonging in her family. "One of my childhood experiences was like hanging out with my sister and my cousin, which brought me closer to him...And it like, gave me a belonging in the family." Participant 1 and 8 shared how family traditions such as gathering

during holidays and family reunions were important. For example, Participant 8 shared that spending holidays such as Memorial Day and the Fourth of July with family popping fireworks were positive experiences from his childhood. Participant 1 stated that such family gatherings made her feel like herself and were a reminder that she had support in her family:

> My family has big gatherings... They only happen a couple times a year where people come from out of town and stuff… I grew up sheltered. So, when I finally got to do stuff with my family, I was just like, "wow, this is fun. This is who I am." I was able to be myself instead of just like, you know, being trapped in a room all day or something like that... I think it just reminds me that I do have support if I need it...

Participants also recalled doing fun activities with family members. For example, one of Participant 4's fondest childhood memories was the time she spent traveling with family.

> I went to Florida. It was the happiest time of my life. I could not stop smiling. I went to Cape Carol, Florida... It was a family trip. So, I went to Florida to go see my baby sister... We just spent time; I think we spent maybe a week... five days. We went boating, we were on canoes. We went to a little plaza [shopping]. And this milkshake place. It had a bunch of crazy milkshakes with candy on top. That trip was fun!

Participant 4 briefly described other family trips including a trip to California. She enjoyed these opportunities to travel and spend time with family because during these time periods in her life, the closest family member she had was her mother

Similarly, Participant 7 discussed going to various places with her mother and siblings and engaging in creative play using materials available to them:

> My mom used to take us to like the Shedd Aquarium, the zoo, …we used to go to like indoor amusement parks, Safari Land, Enchanted Castle. Easter was like one of the big holidays with our parents… Well, my mom used to take us out. You know, just to go outside and be happy. Easter was fun, she used to dress us up nicely. Like my sisters and I always dressed alike and my brother just color-coordinated with us... It was fun, you know, especially having two older sisters and a brother… I'm the youngest… I always looked up to my siblings, especially my sisters. Like, when we didn't have a barbie house, we used to build a Barbie house with some [VCR] tapes. And you know, we had to make some shake.

Participant 2 stated, “Spending time with my cousins was also a positive experience I had. Every time we get together, we always have a good time. We’d play the game... go outside and play with the kids outside.” Participant 5 reminisced on the fun times he shared with family members during the summer breaks:

> My family... we spent time at a lot of pools and beaches, mostly pools. We are also very competitive, which means there were a lot of fights in that pool. And losers had to eat something not good while the winners just sat there, and gloated. I usually never lost which means I was always the one that made the nasty stuff... It was always like something I genuinely looked forward to… A lot of it… It was just like being able to being a kid.

Sentiments of family resiliency were shared experiences between Participant 7 and 8. For Participant 7, family resilience was described in terms of her family’s willingness and ability to show love and respect to each other and be there for each other regardless of challenges and conflict:

> When I think about family, I think about the love we all have for one another. The respect we all have for one another. That, you know, I got your back, and you got my back, at the end of the day.

Participant 8 described the positive and close connection he had with his parents and how the lessons they taught him contributed to his resiliency. Specifically, he shared how his parents’ work ethic inspired him to work hard to achieve his goals and taught him the importance of determination. His father also taught him lessons on being independent:

> My pops always told me to never depend on somebody, always depend on myself. He always told me to never depend on somebody for money. Go work for it... don’t rush and never break the bank. Don’t try to impress somebody... He always told me to make my own decisions... always try to think ahead... think about the future.

Participant 8 also made statements that aligned with the idea of family resiliency:

> We would all talk about anything and just be sitting there listening to each other. And we can always figure out a solution if anybody has a problem or has anything they want us to say or get off the chest. So pretty much nobody really had a problem. We were always talking to each other. So, it wasn’t hidden motives or anything.

Community/ Neighborhood Connectedness and Engagement. Many positive experiences shared amongst the participants occurred within their neighborhoods and communities. A common subtheme expressed amongst some participants regarded knowing everyone in neighborhoods. “Everybody knew everybody” was a sentiment shared between Participant 1,5, 6, and 8. However, unique aspects of their neighborhood were also shared. For example, knowing everyone in the neighborhood was also accompanied by a sense of community safety for Participant 1:

> I grew up on the Southside [city in the Midwest] … My block specifically, was probably like the safest block in the neighborhood… even though the neighborhood itself was really bad…We had a lot of support on our block. So, like, everybody knew everybody… there’s really no issue in terms of like safety or feeling like unsafe or whatever….

For Participant 5, neighborhood familiarity was also accompanied by a sense of trust, community, and belonging among people of diverse races and backgrounds. The parents in his community were friends with each other. Parents' connections with each other helped the children in the neighborhood form close bonds with each other and create an overall tight-knit community. He stated,

> Everyone knew each other…. I really liked how the parents were comfortable enough to let their kids go out, hang out with other kids. The community really trusted each other... So, the community I grew up in was predominantly Black, but there was a sprinkle of [Hispanic/Latinx] people. I guess we kind of bonded by realizing that we were kind of in the minority. But we really didn’t care about that. What I remember specifically is that all the parents knew each other because they worked together, or their jobs were similar. We [kids] became friends because of our parents. We had playdates... and we ended up forming our own relationships... The community wasn’t a really big community... but it was healthy. It was very energetic.

When reflecting on his upbringing and neighborhood, Participant 6 shared that a positive experience was the connections between people in his neighborhood. These connections were evident in parents looking out for others’ children in the neighborhood:

> It was like everybody used to know each other. Like, like people used to know each other's mamas. Or their parents used to know your parents. It was like everything was connected. Like if you did something… like let's say if I did something and they [neighbor] knew my mom, they would call my mom and be like, "[redacted] did this, you want me to do something to him?" Like, you know what I'm saying?

Participant 8 shared that people in his neighborhood also looked out for each other by sharing resources when needed. Sharing resources and looking out for each other contributed to Participant 8's sense of connectedness, safety, and support within his neighborhood. Overall, the neighborhood in which he grew up fostered numerous positive childhood memories and experiences. "Everybody was nice to each other. We helped each other out... giving items to each other… I will say that the neighborhood was giving." Further, Participant 8 described times when people in the neighborhood gathered during holidays such as the Fourth of July and celebrated by popping fireworks and sharing barbecue food.

Participants also described many ways in which they were engaged within their neighborhoods and communities. For example, Participant 7 described joining her community's dance team as a positive childhood experience because it was an opportunity to do an activity she loved, be surrounded by other girls in her neighborhood, build a positive connection with the dance director, and learn how to be a team member:

> This was positive for me because, you know, I've always liked to dance. And I didn't see many dance teams in the area where we grew up. And so like, I and two of my classmates … we danced at the [redacted community center] I learned that we had to be a team. There were days when, you know, we were like "I'm not gonna talk to you" and all that stuff, because everybody was from different areas. But we had to be a team. Our coach was one of those types of coaches that was like," it's one band, one sound." So, when one person messed up, the whole team got in trouble. I learned about myself.

Participant 2 described her participation in summer camp programs through her local YMCA throughout her childhood:

> Summer camp was held at like the YMCA and like, basically, every day Monday through Friday, you're with a group of people that's your age and get to like, I guess bond and

> like, build friendships and play. Do fun stuff. Go on field trips, go swimming on Fridays, and, I don't know, just be a kid. I feel like yeah, just being a kid. But then once I got older, I kind of grew out of that because it's like, okay, 'why am I here? I could be at home. I can sleep right now.' But like, I guess when I was younger at summer camp, it was so much fun because like, I had people that I could play with. In summer camp, anybody can join. So, it was kind of cool to meet people from different states or different cities.

Some of Participant 5's fondest childhood memories were also filled with times in which he attended community-based events such as the Back Lot Bash carnivals in the summertime and Horror Fest in the fall. His memories centered around neighborhood games and community connections. Another fond and positive childhood memory Participant 4 shared was attending Bahamian Independence Day activities with her family, as it made her feel closer to her Bahamian culture.

Further, three participants also shared stories of volunteering opportunities within their neighborhood. For example, Participant 8 volunteered at local museums and learned about bones, fossils, and dinosaurs. These volunteering experiences piqued his interest in paleontology. Participant 2 described volunteering at a local church's soup kitchen. This experience not only taught her the importance of giving back to those less fortunate than herself, but to also be grateful for the material items and resources available to her. This experience also exposed her to the unfortunate realities of food insecurity and homelessness in her community. Participant 7 described providing mentorship to kindergarten students at an elementary school in her neighborhood. As a mentor, she talked to the students about the importance of school. Mentoring younger children was a positive experience for her because it taught her valuable lessons on how to communicate ideas to younger children.

> I played a big role in their lives. It was special. I learned a lot from that day. I learned how to communicate with kids. They were attached to me. It was something I was looking forward to doing because I always wanted to play a big role in kids' lives. I want to be a role model...

School-Personnel- Student Interactions and Relationships. Seven of the eight participants described the impacts of having a positive and supportive relationship with at least one trusted adult in their school, including teachers, administrators, and coaches. For instance, Participant 7 explained that her favorite eighth-grade teacher was motivational, supportive, and made sure that she was on track to graduate. Participant 8 shared that he had positive relationships with his teachers throughout middle and high school. Both Participant 2 and 6 described the positive impact their coaches had on their educational and athletic performance. Participant 2 expressed gratitude to her coaches for helping her become a better person and encouraging her potential, despite facing challenges as an athlete. Participant 6 regarded his basketball coaches as the only school personnel who provided support and encouragement throughout his academic and athletic journey at school:

> The coaches, they really loved me. They're the reason why I even got into that school... Even to this day, I can still call them. It's been two years since I been out of school. They still reach out to me to ask me how I'm doing, making sure that I'm good.

Participant 3 described the positive impact that her sophomore math teacher had on her desire to do well in school, "He made me actually want to try in school and want to go to class. Because there's someone that I did not want to disappoint, other than myself. Someone else was motivating me." Similarly, Participant 1 described the positive influence a high school teacher had on her writing skills, interest in poetry, and development of coping skills related to anxiety. The teacher's encouragement helped her to overcome anxiety related to public speaking fears and find a passion for writing:

> My freshman year, when I was in poetry class, my teacher said that my writing was great. Although I didn't think so. And she allowed me to be on the poetry team called [redacted] and go to different competitions… That just really made me fall in love with writing and stuff…

Further, she explained strategies this teacher took to help reduce her anxiety related to public speaking:

> I had severe anxiety. So, like we had to present in front of the class. And she would make me like pick a number…like we will have numbers and it was strictly just for me. Like, she would list the numbers of how many people were in the class that day. And she's like, "You must pick which number you will go. And no matter what, no matter what day no matter what time you must go with that number" and I was like, okay… I always used to take maybe #10 because it was in the middle. But then I started to pick #5, #3 because nobody else wanted to, you know… and then I really started to see the progress [in my anxiety]. I was like, "okay; I can really start speaking." And then I wanted to become an ambassador. So, I had to get out of that shyness and anxiety.

The many positive interactions with this teacher reassured Participant 1 that the teacher was trustworthy, as she stated, "I can trust this teacher, she believes in me."

Participant 2 told a story about how her school principal intervened in a bullying situation on her behalf:

> I just got sick and tired of people just making fun of me because I had a disability. So, I decided to speak up instead of just taking the bully's criticism…. That day when I got to my breaking point, I decided to tell the person to stop bullying me. 'it's not fair that you bully me because I have this learning disability'…. Then I went ahead and told the teacher, "This person has been bullying me going for so long, and I don't know what to do, but like, something needs to happen" … I went to the assistant principal… and I basically told her what was going on and she was like, "Oh my God, why didn't you say anything?" And I was like, "I was just scared because like, you know, I didn't think anybody was gonna believe that I was getting bullied" and she was like, "okay, let's fill out these reports." Because like... I guess, that technically counted as an incident report. So, we had to fill out the incident report. And then me and the girl had to do a mediation..."

She described the mediation implemented by the principal. The principal's intervention was not only helpful but empowering because she stood up to the person who was bullying her. Following this mediation, the bullying behaviors ceased. She expressed her gratitude for the principal stepping in and resolving this issue.

Participant 4 stated that she would always remember the care her 3rd-grade teacher showed her on picture day, highlighting the impact of small acts of kindness and inclusivity in school.

> One positive experience that really jumps out at me was picture day. I always had my hair straighten. And… just that day it was not working out for me. I don't know if it was like the weather that sweated out my hair. But my teacher in the third grade took the time to put my hair in a nice little bun. Like the ballerina bun. It just meant a lot because I was sitting in class stressing about my hair. And I wanted my hair to be nice. So, she just stepped up and it meant a lot.

Participant 4 further explained that although her teacher was of a different racial identity (i.e., White), the teacher's husband and children were Black, thus emphasizing the importance of cultural representation and understanding of Black hair. The teacher's act of kindness did not stop here, however. The teacher continued to demonstrate care and support to Participant 4 by reporting good deeds to her mom:

> She would always like be in touch with my mom in a good way, because they were close… And it always felt like she had my back in and out of school, especially when it came to like academics and stuff. She would always make sure I had the things I needed.

Developing and Maintaining Meaningful Friendships. Another theme that emerged amongst seven participants was the development and maintenance of meaningful friendships. Many friendships formed through shared activities and experiences such as participation in school sports and programs, and familiarity within their communities. Friendships were a significant theme throughout Participant 3's interview, as many of her experiences involved making new friends and having shared interests with friends in school through her involvement in school activities. In fact, she credited her friend group for changing her into a better person, citing her friends' maturity and respect for their mothers as positive experiences.

> ...I feel like they changed who I am... At first, in [midwest city], me and my sister were bad. Like, we didn't ask to go out. Even when she [mother] said no, we still went out. And that's one of the reasons we moved here [suburb in the Midwest]. With these friends, ... they're more mature, even at such a young age. They respected their mothers. They asked for permission... and took no as no. I feel like I followed that and started trying to be more trustworthy to my mom and get her trust back because I lost that. So, I feel like they made me a better person.
>
> Participants also described the various activities they enjoyed doing with their friends.

For instance, in elementary school, Participant 4 and her friends enjoyed creating creative presentations together, hanging out at the park, and making music together. Participant 7 and her friends enjoyed listening to music (e.g., Destiny's Child, Mindless Behavior), making up dances together, and hanging outside at the local park. Further, Participant 1's participation in her school-based summer internship provided the opportunities to create new friendships. She described the connections with friends as feeling that they were all on the "same wavelength," as they shared the same mindset and perspectives during the internship. As a child, Participant 8 enjoyed riding bikes and stopping at snow cone shops with friends in his neighborhood. Participant 5 also recalled having different friend groups with shared interests and how often he and his friends won school awards (i.e., charms) during his participation across several clubs. For instance, he and his sports friends won charms for their participation in the soccer, football, and track teams. He and his "geeky" friends won charms for their participation in reading, science, and math clubs. "I remember constantly going back and forth [between groups] ... I remember feeling so accomplished... like, this is amazing."

Research Question Two

The second research question of this study was, "*To what extent do Black young adults attribute PCEs in their home, school, and community to their mental and behavioral health status?"* To answer this question, one-fourth of the interview protocol focused on the topic of mental and behavioral health and well-being. Participants were asked to reflect on the

experiences that impacted their mental and behavioral health. Participants varied in the mental health symptoms experienced and the severity of such symptoms. Domain 2: Mental Health Barriers and Remedies, helps to answer this research question. Within this domain, four themes emerged: (a) parent and familial support, (b) mental health service accessibility and utilization, (c) COVID-19 and mental wellbeing, and (d) racial/ethnic identity development and belonging. It is important to note that most of the participants did not receive formal mental health treatment. Rather, all participants shared unique experiences related to learning about mental health, recognizing symptoms, and their process for developing coping skills or seeking support through close relatives or mental health providers in their community or school environment.

Domain 2: Mental Health Barriers and Remedies

Parent and Family Support. Familial and parental support, or the lack thereof, was a common theme that emerged in participants' interviews. Many participants expressed feelings of isolation and loneliness due to not receiving mental health support. For example, Participant 1 described multiple childhood events that negatively impacted her mental health and wellbeing. Negative experiences included experiencing parental division in the home, a lack of family support and open communication, growing up in a religious and strict household, and COVID-19.

The combination of negative experiences listed above resulted in Participant 1 feeling isolated and unsupported in her mental health journey. In her early adolescent years, she received formal mental health treatment through therapy services which ultimately led to her receiving diagnoses for anxiety and depressive disorders. These diagnoses also led to her learning about her family's history of depression. This newfound information complicated her understanding of her struggles. Receiving the diagnoses and learning of her family's history of depression was

helpful because it increased her understanding of what she was going through. Yet, it also made her feel less empowered as she often questioned why she needed to exert additional efforts just to do things that "normal" people can do without support.

> I didn't feel like I had no support. I think also because I was raised very strict, and like sheltered. I just felt like I could only depend on myself. So, like that just made me not want to ask anybody for anything…

While much of Participant 1's journey with depression and anxiety was accompanied by feeling unsupported, she recalled a time in which her mother tried various strategies to increase her self-advocacy skills and reduce her anxiety related to social interactions.

> One thing that I can remember in my younger years was my mom would try to get me to speak up for myself. I would never order my own food, never make any of my own appointments, never do anything on my own. So, she would write down my order, give me the phone, and make me read off the paper... I'll say that part was positive. She was trying to get me out of...being scared to talk to people."

Other participants also shared similar feelings of being unsupported in their mental health journeys. For example, Participant 3 spoke about feeling invalidated and ignored by her family when she tried to express her concerns.

> There were times when like, I felt like I couldn't go to my parents or anything… I feel like in my household I grew up with family and a mother that thought like, "you're a kid, you don't have stress; what can you be stressed about?" ... So mental health was never really talked about. When I did like bring it up... at times when I was really struggling and went to people that I thought I could go to... it's like they brushed me off.

As a result, Participant 3's untreated mental health concerns grew worse overtime. Unable to find someone that she could trust and confide in regarding the decline in her mental health, she silently suffered through her feelings.

> I was very sad. I was very sad almost every day. Like at times I had suicidal thoughts. At times I had anxiety attacks, like at school. And I wouldn't like to talk to people. I distanced myself from like a lot of my friends because of the thoughts in my head like "these people don't want to be around me" and "these people don't like me."

Participant 2 experienced mental health challenges throughout her childhood and adolescent years. There was a lack of discussion in her home and school regarding mental health. Thus, she rarely had opportunities to express her feelings and receive support. Participant 2 described her upbringing and how her family often swept personal issues "under the rug" rather than openly discussing them with each other.

Participant 7 described experiencing anxiety and depression symptoms throughout her childhood, however, she did not understand, nor did she have the language to express her internal struggles. Thus, she did not disclose her issues with family members or school-based providers. Rather, she attempted to cope with her emotions alone. "I suffered with anxiety and depression… and it felt strange. But I didn't do much and I kept quiet about it. I tried to figure it out on my own what was going on…." However, after learning about mental health during a school-wide health event in high school, she decided to confide in and receive support from a family member about her mental health struggles,

> When you're in middle school, you don't know what you're going through. You don't get the answers. But, in high school, I talked to my sister about it. She always had an answer for everything. We had a good conversation about it.

Mental Health Service Accessibility and Utilization. Access and the decision to utilize support from school-based or community-based mental health providers was another theme that emerged in the data. Some participants actively sought out support from school counselors and school social workers while others declined seeking the support available to them. Participant 1 was the only participant that received formal mental health support through outpatient therapy services. Participant 7 described having access to mental health support in school, however, she declined seeking services due to believing that she could handle her issues on her own. Participant 4 shared experiences related to mental health in school, particularly the importance of

having spaces for marginalized groups to be connected and supported so that they are not alone. Participant 4 recalled feeling frustrated due to the lack of general conversations on mental health. She mentioned that mental health was only discussed on a one-on-one basis, such as with a school counselor or social worker, rather than schoolwide. Thus, while mental health support was accessible to and utilized by herself and other students in school, she wished that schoolwide conversations on mental health occurred in school settings.

Participant 3 expressed how grateful she was that a school provider noticed her struggles and offered her opportunities to talk about her difficulties. The school social worker became the first trusted adult in the school. Participant 3 believed she could confide in without judgement. She explained that Ms. R [social worker] not only educated her on the symptoms she was experiencing, but Ms. R also educated Participant 3's mom, in an effort to increase support at home.

> I started meeting with Ms. R. And since that day... I'm so thankful that they saw that I actually needed someone to talk to...So, that was a big change in my mental health... As a kid in high school, you should not have to go through that alone. You should always have someone in your corner. And I feel like Ms. R was that person that was in my corner... Someone saw me for the first time, and I'm grateful for that...

Meeting with Ms. R and establishing a trusting relationship was the positive experience that Participant 3 attributes to significantly improving her mental and behavioral health and well-being. She appreciated Ms. R for educating her on mental health signs and symptoms, helping her to recognize her own cognitive distortions, and helping her to learn how to set healthy boundaries in relationships.

In addition to receiving support from a school-based mental health provider, Participant 3 recalled her participation in a school counseling group as an additional experience that positively impacted her mental health and well-being. The counseling group was led by two Black school counselors at her school. The group provided young Black high school girls with a safe space to

explore their racial and ethnic identities and discuss various related topics including culture, mental health, self-care, friendships, ways to healthily resolve interpersonal conflict, and more. Participant 3 explained that this group supported her mental health because it taught her how to speak up for herself and practice various healthy coping skills.

> In the girls' group and Softball, I got closer to Ms. B [school counselor]. The group allowed me to be able to speak out...and talk about the feelings I felt, and journal... I wrote a lot on my feelings... that's all I really had to express myself. So, in the girls' group, I would really express myself which made a positive change in my mental health.

In Participant 2's interview, she spoke about her identity as a person in the LGBTQ+ community and why experiences related to being misunderstood and unsupported contributed to her mental health concerns. She expressed how she wished teachers and other school personnel were more aware of and supportive of LGBTQ+ students in school. As a high school student, Participant 2 sought out support from her school counselor. However, the interaction was unhelpful and resulted in a general lack of trust in the SBMH provider's ability to help her with her mental health challenges. The SBMH provider she talked to seemed disingenuous and unable to relate to her issues. This exacerbated Participant 2's feelings of being alone and unsupported. These feelings were even more pronounced after experiencing trauma due to the loss of two close friends by suicide.

> I just wish that at high school, we had more awareness of mental health. They were so quick to say, "Well If you feel this way, go talk to this person. But then that, after a time, doesn't really work. I used to see a therapist. And I felt like she wasn't really like doing her job… Because I feel like she was just sitting there and like, saying stuff that I wanted to hear... and I just felt like that drove me away. Because it'd be times when I did need to talk to someone, but it's like, what's the point in talking to somebody if you know they can't relate or they can't help you in a way? And I just wished I wish that we have more awareness of mental health cause like a couple of friends that committed suicide because of their mental health, and they didn't get the help that they needed it, or the school wasn't being supportive at all. Two of my friends passed away because they were getting bullied because of their sexuality. And then the other one passed away because their mental health was just getting the best of them and they felt like well, maybe if I, you know, wasn't here, life would be better.

Participant 6 described how the changes in his neighborhood impacted his mental health, personality, and views of community safety and security.

> At first, like when I was little, I was nice and kind...didn't use to get into trouble... I just stayed in my own lane. Like, but as I got older again, me being that environment like... it forced me to change like... it forced me to change how I was because like, I feel like if I was the same person I was when I was, I'd probably be dead. it puts me in real deep thoughts … I was just thinking of a lot of stuff, wishing a lot of stuff was different. I wish I was able to like, go out, have fun, or go to certain places. But I have to look over my shoulder and stuff.

Participant 6 discussed learning about mental health through his participation in a community-based program focused on gun violence prevention. In this program, he built positive connections with the male mentors because "they all came from the same type of background, so it was easier to connect with them." Prior to this program, Participant 6 stated that he'd never had a conversation about mental health, neither with family members nor within his school settings. Participant 6 spoke highly of the program and the mentors, regarding the program as an overall positive experience that has encouraged and empowered him to make better decisions that "elevate" his life.

COVID-19 and Subjective Mental Wellbeing. The topic of COVID-19 emerged in interviews with Participants 1 and 5 when discussing their journeys with navigating mental health. Participant 1 experienced more negative effects of COVID-19 on their mental wellbeing, whereas Participant 5 experienced more positive experiences related to COVID-19. Participant 1 explained that while depression and anxiety symptoms were prevalent throughout her entire upbringing, her symptoms were exacerbated by the school closure mandates during the onset of the COVID-19 pandemic. She described experiencing many days of "extremely low lows" and then days of "extremely high highs" with regard to her mood. During these episodes, she stated

that she spent most of her time alone in her bedroom on the internet. This isolation resulted in strong feelings of loneliness due to not having anyone to confide in.

> I spent a lot of time on my thoughts and everything... For most of the years, I was angry on top of sadness. just pondering on sadness and anger at the same time; it was just an endless cycle...in my room is just like anger sadness, anger, sadness, happiness, anger, sadness, anger, sadness, anger, sadness. Happiness. That was like my worst years like, very depressed, no sunlight, no eating. Very bad hygiene…I felt like I was bedbound for like a very long time. And so, when I got one of those little highs I was like, "okay, I could do everything." And then I crashed right away, went back to the room, and repeated the same cycle over again for two years.

Conversely, Participant 5 experienced improved mental wellbeing during the school closure mandates of COVID-19. During these extended periods of isolation during the pandemic, Participant 5 discovered his true self in his solitude. He used this period as an opportunity to explore his musical and entertainment interests. He learned that he loves the murder mystery genre of books and movies, and the rap and R&B music genres. These discoveries were not only fun to explore, but he also found them to be helpful coping mechanisms.

> I feel like where I am now, with all the things I want to do and all the things that I've done up until now, is because of quarantine. I didn't find myself changing the way that I dressed to fit in a certain group. Now, I like and I know my sense of style. And I know myself better than... So, if someone doesn't like something about me, I'm not going to change. I learned that by being by myself... I discovered I like being alone sometimes, it's great because...You can't find your true self if you're constantly changing that person... So, the fact that I was like forced to just be myself for a while and got comfortable with myself, it became a lot easier to be myself and became a lot harder to keep changing myself.

Participant 5 stated that quarantine made him a "stronger person;" he is now more confident and surer of himself. "I feel like I got so many like positive stuff from quarantine. And I feel like that shaped me to like going on today." Upon reentry to school, he gained new friendships and connections by remaining true to his newfound identity and love for himself.

Racial/ Ethnic Identity Development and Belonging. Participants 4 and 5 shared unique experiences related to the ways in which their racial and ethnic identity, specifically how

others perceived and treated them, impacted their mental health. Participant 4 described when she experienced low self-esteem due to how others perceived and treated her. She recalled experiences growing up in a predominately White neighborhood as one of the only Black children. As the only Black girl from a middle-to-lower income family in her environment, she found "fitting in" with her White peers to be difficult. She felt that because of her intersecting identities, she could not reach the standards of her White peers; nor were certain opportunities and connections afforded to her. These experiences impacted her self-esteem and mental health because she began to feel "overlooked" and "unimportant" to others.

> I was, of course the only Black girl on the [sports] team. And it would just feel like I didn't reach their standards because I was not White... and I am not rich... And with the [Midwest suburb] standards came the connections and opportunities that were not available to me.

Feelings of being overlooked or unimportant due to her racial identity remained present for Participant 4 throughout her high school years. However, she attributed joining her schools' Black Student Union and affinity counseling group as positive experiences that made a significant difference in her mental health, as well as her sense of connectedness to other students who shared the same racial and ethnic identity. She expressed, "...there are spaces for me...So being at school and having spaces like that helped me not feel so lonely."

As a young, dark-skinned Black boy growing up in the suburbs in the Midwest, Participant 5 described how experiences with colorism negatively impacted his mental health and self-esteem. During this time in his life, he also experienced insecurities and a lack of support and understanding from family members.

> I became very insecure about my skin tone. Because I remember during elementary school, there was like a battle between like light skinned and dark skinned…. But you know light skins are so like romanticized, that everybody wanted to be light skinned. And all of that praise gave light skinned people a mentality that they're better than dark skinned people…. I remember I would cry to my mom and say, "I don't want to be Black." And it was also hard because at that time, I didn't really have my dad. And my mom was light skinned and my older brother was light skinned. And my younger brother, he was young, but he was also very light at that time… So, like being the only dark skinned and then them not fully understanding how I felt just made things worse… I was very insecure. I tried a lot to get rid of my Black-scent and be as proper as possible so that hopefully people would look past my skin color, but it never really worked. No matter how many times I tried to change.

For years, Participant 5 tried changing parts of his identity and self-expression to fit in with others and improve his self-esteem. He described the school closure mandates during the COVID-19 pandemic as a saving grace in his mental health and identity development.

> … I ended up like, getting in tune with myself. I never used to really listen to music like that. But there will always be music playing because my parents always played music, or I always had a sound in the background... I've gotten to rap and R&B. I found my genres of music. It was like my de-stressor… I also picked up reading. And then I realized that I'm like a murder-mystery type of person. And then that ended up leading me to like, watching more TVshows.

Research Question Three

The third research question of this study was, **"**To what extent do Black young adults attribute PCEs in their home, school, and community to their school engagement?

To answer this research question, participants were asked to reflect on the schooling experiences and describe the experiences which they believe contributed to their ability to be engaged in school and which experiences made it difficult to be engaged in school.

Domain 3: School Engagement

School Climate. When discussing their experiences in school settings, participants discussed unique experiences that positively and negatively impacted their school engagement. Thus, school climate perceptions were a common theme that emerged across interviews. Factors

that contributed to some participants' positive school climate perceptions included having positive teacher-student relationships, feelings of school connectedness, and feeling a sense of safety.

Positive Teacher-Student Relationships. Most of the participants described how having positive relationships with teachers was a significant factor in their school engagement and success. These stories are also shared in a previous section of this chapter. For example, Participant 2 stated that the teachers at her high school made the school environment feel like "family" as they were supportive and caring to students personal and academic success. Others shared how their teachers were encouraging and supportive.

School Safety. Regarding school safety, Participant 7 perceived safety through the presence of school security guards and the use of metal detectors, which all students were required to go through to ensure that weapons were not present in the school building. Similarly, school safety for Participant 8 was indicated through metal detectors and the absence of life-threatening violence in the school. More specifically, he perceived his school to be safe because the school had never experienced an active school shooting. And although physical fights between students were typical, there were not any incidents in which a student was seriously injured.

Negative Teacher-Student Relationships. While many participants shared stories of positive interactions with teachers and other school personnel (i.e., administrators, coaches), some participants also shared stories of negative teacher/staff interactions and situations that adversely impacted their school engagement and school climate perceptions. For instance, as previously explained, Participant 6 expressed that the only positive experience that came from attending the private school during his first year was the promise made by the school's basketball

coach that he would be able to play basketball. Unbeknownst to him, a prerequisite for playing basketball at his high school was cutting off his hair which was styled in a blonde mohawk. He strongly disagreed with this school rule and tried to push back on the policy by expressing his belief that the policy was unfair and discriminatory. Unwilling to cut his hair, school leaders made the decision not to allow him to be on the school's basketball team. This decision was detrimental to Participant 6's school engagement and resulted in an overall negative school climate perception. Participant 6 became less academically engaged in school and experienced an increase in behavioral problems. He often engaged in disruptive classroom behaviors. which prompted numerous home calls and in-school suspension.

Participants 1 and 7 shared how negative encounters with teachers adversely impacted their school engagement and sense of connection to the school, thus, resulting in a more negative school climate perception. Participant 7 shared that she had numerous negative encounters with a particular teacher who often perceived her as having a "smart mouth" during situations in which she attempted to speak up for herself in class. Similarly, for Participant 1, she was perceived by teachers as defiant in situations in which she "talked back" to teachers. These "talking back" behaviors were often reported to her mother and/or resulted in disciplinary actions including getting sent home from school or being sent to the Dean's office. Unbeknownst to her teachers, Participant 1's school behaviors reflected her internal and unaddressed mental health concerns. Like Participant 7, Participant 1 stated that her behaviors in school were an attempt to stand up for herself. However, her teachers did not respond in a helpful or supportive manner. Rather,

> Some of the teachers would say rude things to me. Like one of my teachers said [in front of the entire class] something about how my mouth is just so big and I just wouldn't be quiet. He paused the whole class and said that... I was just so embarrassed. And then a week later he wrote on my disciplinary card like something like, "I hope when you die, they leave your mouth open because you just don't stop talking."

These negative encounters, combined with past bullying experiences and unaddressed mental health concerns resulted in Participant 1 holding an overall negative perception of her elementary school's climate. Upon graduating from 8th grade, she recalled telling her younger brother, who would be attending the school the following school year, "I'm done with this school. This school is so traumatic bro."

Participant 1 experienced a positive shift in her school engagement and behaviors in high school when her mother was in a leadership position at her school. She regarded her mother's position as the school administrator as a significant motivating factor in her desire to do well academically and behaviorally.

> …The switch in my behaviors came with my mom being my principal my freshman year. She said, "You are a reflection of me. You can't act a fool. You must follow the rules... although you are my daughter, we have to separate that life when we come to school." And I respected that... and I didn't want other people to think that my mother did not know how to parent or that she was a bad parent. So... I went to high school with a completely different mindset.

Participant 1's decision and efforts to make better behavioral decisions was an indication that she respected and valued her mother's position as a school leader and wanted to make her proud. Thus, attending a school in which her mother was present had a positive impact on Participant 1's transition and adjustment to high school.

COVID-19 and School Engagement. The COVID-19 pandemic, and the impact of school closure mandates and virtual learning emerged across two interviews, however, the experiences shared were vastly different. For Participant 1, transitioning to a virtual learning setting at the start of the pandemic negatively impacted her school engagement, specifically in terms of her attendance and ability to focus. Participant 1 shared that although she desired to attend classes regularly and participate, the feeling of being "stuck" at home attending classes was extremely overwhelming and made it difficult for her to pay attention. Although she still

managed to complete assignments, her grades were still negatively impacted by her lack of attendance. She expressed feeling as if her mind was "clouded," which made it difficult to remain focused in class.

> I had no getaway. I couldn't go to school. I didn't like going outside because I wasn't raised to go outside or anything. And if I did, I was by myself...I didn't have anybody to talk to. My friends started getting a little distance but rightfully, so. Everybody was going through the same thing... I just felt like mine [life] was harder.

School closure mandates had the complete opposite impact on Participant 5. Participant 5 found enjoyment in COVID-19 quarantine as it allowed him to be more confident in his answers and to ask questions without having to verbally speak in class. While attending school virtually, Participant 5 participated in class primarily through the Google chat feature. He expressed that using Google chat to ask questions during tests helped him boost his grades because teachers provided direct responses to his questions rather than avoiding or "beating around the bush," as these were common experiences for him prior to attending school virtually.

> I know quarantine and COVID-19 2020 was bad for a lot of people...but for me personally, I completely enjoyed every minute of it... I didn't really like raising my hand and making myself known in class. So [during virtually schooling], I was able to ask questions in the chat [Google chat] ... That impacted me positively because I became more confident in my answers... It also boosted my grade. During tests [prior to quarantine], sometimes I would raise my hand and ask a question and the teachers wouldn't really answer the questions. But over G-chat, they got straight to the point.

Research Question Four

The fourth research question of this study was, *Beyond the contexts of home, school, and community, are there any additional contexts in which positive childhood experiences occurred for Black young adults?"* All positive experiences described throughout participants' interviews occurred within the context of their homes, school settings, and neighborhood. Therefore, no additional contexts were significant in participants' stories shared during this study's interview process.

Research Question Five

The final research question of this study was, "*Do Black young adults believe PCEs influenced their ability to build resilience in the face of adversity?"* To answer this research question, participants were asked to reflect on the childhood experiences shared throughout their interviews and describe the experiences which they believe contributed to their resiliency development. All participants stated that accumulating positive and negative childhood experiences contributed to their resiliency.

Domain 4: Internal Sources of Resiliency

Personal Growth through Independence and Self-Expression. Participants 1, 2, 3, and 7 highlighted how their childhood experiences fostered a greater sense of independence and self-expression. Participant 1 stated that her overall experiences made her more independent, expressive, and courageous. Her experiences also helped her realize that she has supportive people in her life,

> I would say independence allowed me to grow into someone I know I want to be. I have a standard for what I like and the people I like around me. It helped me become more open with how I'm feeling and to know that not everybody in the world is against me. I have support if I absolutely need it. I'm able to express myself with certain people… I'm glad that I'm able to work on articulating myself further and just get my point across.

Participant 2 stated that the positive experiences and challenges of her childhood made her more confident, outgoing, and a leader. "Going through what I went through, kind of like, made me into this person that I am today… I'm very confident, outgoing. I will say I'm a leader." Participant 7 stated, "My experiences made me strong, independent, and creative." Participant 3 stated that allowing herself to be open to receiving support resulted in her feeling more independent and resilient,

> And I'm happy that I allowed myself to like, be open with them, and feel like I become more independent and resilient. I feel like I'm more mature and open-minded. I don't settle. I don't allow myself to settle for less. I feel my happiness level is high now.

Self-Improvement, Self-Awareness, and Self-Care. Participants 4 and 8 emphasized the importance of recognizing and prioritizing their value through different forms of self-care. Participant 8 shared that his experiences helped him to learn to prioritize self-awareness and self-care amidst challenges. For Participant 4, positive and negative experiences in childhood influenced her desire to push herself harder into the person she wants to be in the areas of organization, education, and fitness. Building internal validation through self-awareness of her own abilities contributed to her ability to overcome self-doubt and become resilient,

> I want to be able to push myself. So, because I was always overlooked, and no one really needed to, like, had the desire to push me. I want to be that person for myself. Right now, that's what I'm working on to become resilient within my life and just have a better life for myself. Yeah. Through like organization, education, fitness.

Improved Problem-Solving Skills. Participants 5 and 6 shared a common theme of maintaining a positive mindset in the face of adversity. Their approach to maintaining a positive mindset is through employing problem-solving strategies. Participant 5 stated that his childhood experiences helped him to remain true to his core value of seeing the positives in any situation, even challenging and negative situations.

> I think from my childhood, my goals have always changed. But I feel that how I approach the problem has always been the same. I always grew up in a community where, like, everyone knew each other, and everyone was nice to each other. Like there was no bullying and there's like no, no toughness in the group. There's nothing like that. So, anytime I saw a problem, I always tried do my best to stay positive in that even though like sometimes it might break me down and I might go into like a negative bubble for a while but eventually I will break out of it. The negatives might be overbearing compared to the positives but I'm still able to see the positive. I push myself to look at the positive aspects of negative things. And I feel like that's always been the same with me.

Thus, Participant 6 reflected on how their approach to problem-solving has remained consistent despite the adversity and changes experienced. Participant 6 attributed his experiences to the

development of his internal motivation, which pushed him to succeed in school and graduate: “I wanted to graduate even despite everything that was going on.”

CHAPTER FIVE:

DISCUSSION

Summary of Study 1 Quantitative Findings

Using a nationally representative same of Black youth ages 6-17 years, Study 1 is an examination of the extent to which parent/guardian reported childhood adversities was associated with the odds of having one or more mental or behavioral health conditions (i.e., anxiety, depression, ADD/ADHD/ and/or a behavioral/conduct problem) and the odds being disengaged in school, as well as whether or not positive childhood experiences can buffer (or reduce) the hypothesized association between ACEs and undesirable outcomes. The first aim of the present research was to determine the relationship between cumulative ACEs and both outcome variables separately, when controlling for sociodemographic characteristics (i.e., age, sex, family income, and family structure). It was hypothesized that higher ACE scores would be positively associated with an increased likelihood of having one or more MBH conditions. These hypotheses were supported, as the results revealed that higher ACE scores were associated with statistically significant increased odds of being in the "one or more MBH Conditions" group. This finding supports previous studies suggesting a positive association between multiple ACE exposure and poorer mental health outcomes (e.g., Bernard et al, 2021; Hicks et al., 2021) and statistically significant increased odds of having anxiety, depression, ADHD, and/or a behavioral/conduct problem (Bomysoad & Francis, 2020). In the current study, parental divorce (34.7%), racial discrimination (21%), income hardship (17.4%), and parental incarceration (12%) were the most common ACEs reported by survey respondents. This finding is consistent

with previous research (e.g., Melton-Fent, 2019) indicating that divorce, family income, and parental incarceration are the most common subcategories of ACEs reported. These findings also support other empirical studies that have examined the detrimental impacts of divorce (Clark, 2013), family income hardship (Kim et al., 2022), racial discrimination (Pachter et al., 2017), and parental incarceration (Davis & Shlafer, 2017) have on children's and adolescents' mental health.

In terms of racial discrimination, the percentage of children reported to have experienced this in the current study is lower than rates reported in a previous study (i.e., Lanier et al., 2017) in which 90% of black youth reported experiencing racial discrimination within the past year. A possible explanation to this discrepancy is that in the current study, parents/ guardians reported based on their knowledge of whether their child has experienced racial discrimination, whereas in studies in which these rates are higher, the reports are from Black youth themselves. The NSCH does not include the youth's self-reported experiences of adversities, therefore, the accuracy of particular adversities may be unclear. This may also be the case for ACE items related to experiences of sexual orientation and gender identity discrimination. In this study, parents/guardians reported that 1.3% of youth experienced sexual orientation and gender identity discrimination. Research also indicates that Black youth are reportedly experiencing increased rates of racial discrimination over the past several years. Elenwo et al. (2022) examined the rates of racial discrimination among children across various racial and ethnic backgrounds in the U.S. based on reports from the 2016 to 2020 NSCH. Results from that study indicated that racial discrimination among Black children increased from 9.69% in 2016 to 15.04% in 2020. The results of the current study and Elenwo et al. (2022) suggest that racial discrimination is a serious stressor that may have detrimental impacts on a child's wellbeing.

Regarding the school engagement outcome variable, it was hypothesized that higher ACE scores would be positively associated with a greater likelihood of being disengaged in school. These hypotheses were also supported. The results revealed that higher ACE scores were associated with statistically significant increased odds of being in the "school disengagement" group. This finding is similar to other studies that indicate the influence of external factors on a child's ability to be engaged in school. For example, Webb et al. (2022) found that family income hardship and parental incarceration were the most important predictors of school engagement for youth across diverse racial and ethnic backgrounds. However, Webb et al. (2022) included different variables related to school engagement such as grade repetition, absenteeism, in-school and out-of-school suspensions, and educational aspirations. To the primary researcher's knowledge, this is the first study that exclusively examined the relationship between cumulative ACEs and school disengagement among Black youth only. Thus, the result of this study highlights a new and important finding regarding the impact of varied levels of ACEs on a child's ability to be engaged in school.

A significant association was found with only one covariate variable (i.e., sex) for both outcome variables. Results for sex across all statistical models indicated that being female was associated with a lower log odd of being disengaged in school and having one or more MBH conditions compared to being male. Simply put, higher ACEs was associated with an increased likelihood of males being in the "one or more MBH condition" group and the "school disengagement" group than females. This finding is consistent with previous studies that have reported gender differences in terms of prevalence and presentation of mental health conditions and school engagement. For example, some researchers have found that girls are more vulnerable to mental health problems than boys (Antia et al., 2023; Campbell et al., 2021; Yoon

et al., 2022). Researchers have also found that internalizing problems (e.g., anxiety) are more common is girls (Van Droogenbroeck et al., 2018) and externalizing problems (e.g., conduct problems) are more prevalent in boys (Verhulst et al., 2003; Slobodin & Davidovich, 2019). In terms of school engagement, research results are mixed such that some have indicated higher school engagement levels in girls compared to boys (e.g., Bang et al., 2020; Van Houtte, 2023). However, in studies that specifically examined school engagement among Black youth, researchers have found that school engagement is influenced by external factors such as perceptions of racial fairness and discipline practices (Griffin et al., 2020), police interactions (Del Toro & Wang, 2023), violence exposure (Voisin et al., 2011). Three covariates (i.e., age, family income, and family structure) did not yield statistically significant results for both outcome variables. Although these sociodemographic characteristics are important to consider when, it may be the case that cumulative ACEs have more of an impact on the outcome variables for youth regardless of their age, family structure, and family income.

Main Effects and Moderating Role of Cumulative PCEs

The study's second aim was to test whether PCEs buffer, or moderate, the impact of cumulative ACEs on the outcome variables. That is, if ACEs do predict the undesirable outcome variables, can PCEs help to lessen that impact or serve as a protective factor? Before examining the potential moderating effect, first a main effect between cumulative PCEs and the outcome variables needed to be established. Cumulative PCEs significantly contributed to the MBH Conditions model and School Disengagement model. However, the interaction between cumulative ACEs and cumulative PCEs was not statistically significant for the MBH condition. This indicates that the effect of cumulative PCEs does not moderate the impact of cumulative ACEs on a child's mental wellbeing. Conversely, the interaction between cumulative ACEs and

cumulative PCEs was statistically significant for the school engagement outcome, indicating that multiple PCEs may moderate the adverse impact of cumulative ACEs on a child's ability to care about doing well in school and complete homework.

Main Effects and Moderating Role of Individual PCEs

In the expanded logistic regression, individual PCE items were added to each outcome model. For the MBH condition outcome, main effects were only found for three of the six PCEs (i.e., constructive social engagement, parent-child connection, and family resilience). Higher scores on constructive social engagement, parent-child connection, and family resilience items are associated with lower odds of being in the "one or more MBH Conditions group." These findings support previous research studies that have demonstrated positive impacts of social connection and participation in social activities such as sports (Fossati et al., 2021), afterschool programs (Frazier et al., 2022), identity-based school programs (Carter et al., 2020; Gordon et al., 2009; Jones et al., 2017), the importance of having a positive connection with a parent or guardian (Chen et al., 2017), and the role of family resilience on youths' mental health (Zhuo et al., 2022) and on youths' mental wellbeing. Living in a safe neighborhood, supportive neighborhood, and attending a safe school did not have statistically significant effect on the MBH condition outcome. Although the role of ACEs and neighborhood factors are understudied (Karatekin et al., 2022), previous research has linked neighborhood safety concerns and a lack of cohesiveness (i.e., neighbors who cannot trust or rely on each other) to poorer health outcomes among adults (Robinette et al., 2018) and adolescents (Assari et al., 2015). Conversely, research has also linked perceived neighborhood safety to less psychological distress (Both et al., 2012). Regardless, the literature consistently shows that multiple neighborhood characteristics, beyond safety and support, are meaningful and impact the relationship between ACEs and mental health

outcomes such as poverty (Graif et al., 2017), racial segregation, and food accessibility (Bower et al., 2014). Similarly, multiple school characteristics, beyond safety, impact a child's mental health outcomes including positive school climate (Ancheta et al., 2021; Moore et al., 2018), access to school-based mental health services and supports (Gamble & Lambros, 2014; Kelchner et al., 2019), and discipline practices (Perryman, 2022). However, studies show that school characteristics only account for a small variation (3% to 4.5%) in children's mental health outcomes (Patalay et al., 2020). Therefore, attending a safe school alone may not be enough of a protective factor to counteract the impact of ACEs on a child's mental health.

For the school disengagement outcome, main effects were found for five of the six PCEs: safe neighborhood, safe school, constructive social engagement, parent-child connection, and family resilience. Similarly to the MBH conditions, higher scores on these PCEs were associated with statistically decreased likelihood of being in the "school disengagement" group. These findings are consistent with previous research demonstrating the impact of perceived neighborhood safety (Milam et al., 2010; Opara et al., 2020; Sargent et al., 2020), attending a safe school, and participating in social activities (Medina et al., 2020) on a child's ability to be engaged in school. These findings also support research suggesting that having a strong parent-child connection (Robles et al., 2020) and family resilience (Bethell et al., 2014) are protective factors in the association between ACEs and school performance.

Given that living in a supportive neighborhood did not significantly contribute to either outcome variable, it is possible that additional factors related to neighborhood support would help to better capture the impact of this PCE. For example, Nguyen et al. (2023) measured the impact of multiple neighborhood factors on the relationship between parental incarceration (ACE item) and school engagement. However, in this study, Nguyen et al. (2023) included seven

additional social and neighborhood infrastructure amenities into their models to examine the relationship between study variables. These factors included the presence (of lack thereof) of libraries, recreational centers, sidewalks, vandalism, poor housing, and littering. The results of this study revealed that higher counts of neighborhood amenities and sidewalks were positively associated with caring about doing well in school. Further, social support and social infrastructure was associated with completing homework (Nguyen et al., 2023). Thus, the supportive neighborhood variable in this study, measured using one item, may not fully capture the key elements of this construct.

Interaction Terms

For both the MBH conditions outcome and the school disengagement outcome, a significant interaction term was only found between cumulative ACEs and living in a safe neighborhood. This finding suggests that cumulative ACEs have a more pronounced and negative effect on the likelihood of having one or more mental health conditions for youth that live in a safe neighborhood. The influence of cumulative ACEs on school disengagement is also statistically stronger and has a more pronounced negative effect for youth in safe neighborhoods.

Summary of Study 2 Qualitative Findings

In study 2, the primary researcher aimed to qualitatively explore Black young adults' understanding of PCEs and how particular experiences contributed to their mental and behavioral health, school engagement, and overall resiliency development. Overall, the results indicated consistency among participants' responses within the domain of PCEs, and great variability in experiences related to mental wellbeing, school engagement, and resiliency. The ideas that emerged in the PCE domain attained *general* levels of consensus in this study (Ladanay et al., 2012)– a frequency category indicating that almost all participants endorsed the same ideas

despite the broad research question regarding asked in the individual interviews. However, much variance was examined in participants' lived experiences related to mental health, school engagement, and resiliency. The great extent of variance also demonstrates the importance of using qualitative methods to explore the concept of PCEs, especially within the context of the impacts of PCEs on mental and behavioral wellbeing, school engagement, and mental health, as they are a varied and complex construct.

Within the context of PCEs, five general core ideas and themes emerged from the interviews: (1) participation in extracurricular activities in school (i.e., sports, clubs, volunteering), (2) parent and family resiliency and bonding opportunities, (3) community/neighborhood connectedness and engagement, (4) school personnel-student interactions and relationships, and (5) developing and maintaining meaningful friendships.

All participants regarded their participation in extracurricular activities including school sports (e.g., basketball, softball, wrestling), student organizations (e.g., Black Student Unions, Best Buddies, internships), and volunteering opportunities as positive experiences. Participating in school-based sports and clubs helped participants to enhance character traits such leadership and confidence and helped to foster a sense of connectedness to their peers and school setting. This theme directly aligns with the fourth PCE item in Study 1 – constructive social engagement – as participants highlighted the importance of being involved in structured and constructive social activities. School-based extracurricular activities provide enriching experiences that promote positive outcomes for children and adolescents such as opportunities to build skills and competencies in specialized areas (Mahoney et al., 2005) and expand their social networks through forming new friendships with same-aged peers (Schaefer et al., 2011). Studies also demonstrate that participation in extracurricular activities (i.e., school sports, student

organizations) is associated with academic achievement (Eccles et al., 2003; Fredricks & Eccles, 2008), including increased likelihood of enrolling in college (Eccles & Barber, 1999). Regarding mental health, research also indicates that participation in extracurricular activities is associated with better mental health and well-being (Berle et al, 2020) and predicts better coping efficacy to external stressors in an adaptative and healthy manner (Heaslip et al., 2021). Most of the aforementioned studies examined the impact of constructive social engagement among non-Black youth. This study's focus on Black youth supports and expands the research on this topic as this finding is similar to this study's sample. This study's findings also align with prior research demonstrating the positive effects of being involved in student clubs such as increased confidence, persistence, responsibility, and other leadership skills (Smith et al., 2015).

The second theme – family resiliency and bonding opportunities – emphasized the importance of feeling connected and supported by close family members and having opportunities to bond with family members. Participants regarded spending quality time with family members during holidays and other family events as positive and fond memories of their past. This theme aligns with the fifth and sixth PCE items in Study 1, parent-child connection, and family resilience. Participants shared positive stories related to their connections with their parents and their sense of support present within their family. However, many of the participants' stories extend beyond the parent-child connection to relationships with siblings, extended family, and other individuals. Participants' understanding of family resilience also extended beyond being able to talk about and overcome challenges; it included a general sense of social support and connectedness. Nonparental figures within youth's social networks, such as kin, fictive kin, and natural mentors, are influential in Black youth's development because they provide multiple sources of security and social support (Stern et al., 2024). Fictive kin are defined as "the

extensions of kinship obligations and relationships to individual's specifically not otherwise included in the kinship universe" (Spruill et al., 2014, p. 4) and can include teachers, coaches, community members, and other individuals who serve as part of extended social networks (Stern et al., 2024). Natural mentors are nonparental adults who provide support and guidance (Stern et al., 2024). As explained by Stewart (2007),

> African Americans continue to exist within the context of extended family structure rather than as discrete units despite the influence of the larger society. The members are interdependent and may share the responsibilities of childrearing and household funding across or among nuclear family units. What appears to be a "single parent family," from a Western European perspective, may in actuality be part of a larger extended family system. (p. 165)

Stern et al. (2024) regards extended social networks as a family resilience factor as it is associated with positive childhood outcomes. Thus, future measures of PCEs should include social networks beyond parental figures. Further, many participants shared positive experiences related to close relationships with siblings. Research suggests that siblings can serve as sources of support (Conger et al., 2020) and play a key role in youths' wellbeing (Kramer et al., 2019). Studies demonstrate that siblings can serve as role models (Whiteman et al., 2014) and confidants (Killoren et al., 2019) for each other as well as teach social skills (Manceillas, 2011). Therefore, future measures of PCEs should also include items related to the quality of sibling relationships and bonding opportunities.

The third theme – community/neighborhood connectedness and engagement – speaks to the importance of living in an environment where various families share resources, promote connectedness through events and organizations, and look out for each other. "Everybody knew everybody" was a sentiment shared amongst many interview participants. This familiarity appeared to be a critical factor in participants' sense of connectedness to their neighborhoods. Even in neighborhoods that may lack a true sense of safety, knowing who is in your

neighborhood plays a role in perceptions of community connectedness. This theme is related to the first and second PCE items in Study 1 – neighborhood safety and support. A strong connection to one's community members and neighborhood is associated with coping resources (Kliewer et al., 2004) and can serve as a protective factor against mental and behavioral problems (Aneshensel & Sucoff, 1996). For African Americans, peer support and community connectedness are also associated with decreased suicidality and depressive symptoms (Matlin et al., 2011).

Themes four (school personnel-student interactions and relationships) and five (developing and maintaining meaningful friendships) are unique contributions to the conceptualization of PCE, as these themes were not captured in the measure of PCEs in Study 1 or prior empirical studies on the topic. In the interviews, participants emphasized the importance of having a positive connection with staff members in school settings. Many of the participants shared childhood experiences related to the support and encouragement provided by teachers, coaches, and administrators. These data provide further support for the unique contributions of having a positive connection to an adult in the school setting as it is connected to improved academic achievement (Cadima et al., 2010; Zhu et al., 2018) and increased sense of school belonging (Uslu & Gizir, 2017; Virat et al., 2022). Further, most of the participants shared stories related to the role of friendships and peer-to-peer connectedness. The formation and maintenance of positive friendships and peer relationships are essential to children's and adolescents' development (Fernandes et al., 2020) and are associated with positive outcomes such as improved academic achievement (King & Ganotice Jr, 2013; Zhang et al., 2024), subjective wellbeing (Haanpää et al., 2019), lower levels of loneliness (Kingery et al., 2011), and increased

feelings of belonging (Lee & Owens, 2021). These findings indicate that peer relationships (i.e., friendships) play a critical role in youth's development and socialization.

Within the context of childhood experiences that positively and negatively impacted participants' mental health, four themes emerged:(a) parent and familial support, mental health service accessibility and utilization, (c) COVID-19 and mental wellbeing, and (d) racial/ethnic identity development and belonging. Social support from parents/caregivers and extended family members, or the lack therefore, was influential in participants' ability to overcome mental health challenges. These data align with previous studies documenting the role of positive and supportive parent-child relationships (Rasalingam et al., 2017; Ravens-Sieberer et al., 2007), and parental involvement (Wang et al., 2022) on the reduction of mental health problems studies and improved/ positive mental health (Hu & Cai, 2023). Research also suggests that the level of family support youth receive influences youth's utilization of mental health services (LeCloux et al., 2016). The accessibility and utilization of mental health services also played a role in participants' mental health journeys. While some had negative encounters with mental health providers or declined seeking services available, most who had access utilized the services. Further, the impacts of COVID-19 were a unique theme shared by only two participants in the study, indicating that people experienced the school closure mandates of the pandemic differently. One participant struggled with the isolation that naturally occurred during the pandemic, resulting in poor mental health outcomes. Whereas the other participant had more positive experiences from COVID-19, which they attributed to improving their mental health. While adolescent mental health concerns were of great concern before the Covid-19 pandemic, prevalence rates of anxiety were higher in 2020 than 2019, particularly for youth with less positive future orientations, low family engagement, and a lack of supportive nonparental adult

relationships in school (Rogers et al., 2019). Thus, family support and engagement, supportive nonparental adult relationships, and positive future orientations were regarded as protective and resiliency factors on adolescents' mental health during the pandemic.

Regarding the childhood experiences that positively and negatively impacted participants' school engagement, two themes emerged in this domain: (a) school climate and (b) COVID-19. School climate encompassed three subthemes: positive school climate, negative school climate, and school safety. Participants shared stories related to having positive teacher-student relationships, feelings of school connectedness, and feeling a sense of safety. These data provide further support for the importance of establishing and maintaining positive teacher-student relationships (Bear, 2020), feelings of school belonging (Vang & Nishina, 2021), and school safety (Zacharia & Yaacov, 2022) to promote students' engagement in school. Conversely, more negative school climate perceptions, such as poor teacher-student relationships (Kang et al., 2023), experiencing bullying victimization (Yang et al., 2018), and discrimination (Bottiani et al., 2020) are associated with lower levels of school engagement and greater disconnection from school. Thus, school climate is a critical factor to consider for improving students' engagement in school.

Lastly, participants were prompted to reflect on the combination of positive and negative childhood experiences and the ways in which these experiences contributed to their resiliency development. In the domain of sources of resiliency, three themes emerged: (1) personal growth through Independence, (2) Self-Improvement, Self-Awareness, and Self-Care, and (3) Adversity and Problem-Solving. These themes collectively reflect the diverse experiences of each participant in the study. Participants' understandings and definitions of resiliency also supports the four dimensions of resiliency development described in the APA Task Force (2008) report,

"*Resilience in African American Children and Adolescents: A Vision for Optimal Development*" in Chapter 2 of this dissertation: (1) critical mindedness, (2) active engagement, (3) flexibility, and (4) communalism. As participants transitioned from childhood to adolescence and encountered challenges, they developed an understanding and critique of certain social conditions and learned how to stand up against perceived discrimination. For example, some participants described standing up for themselves against bullies, teachers who mistreated them, and unfair school policies. All participants were active in their school settings (e.g., sports, clubs) and their proactive engagement had a positive impact on their environments. Regarding flexibility, many of the participants noticed an increase in their emotional, cognitive, and social skills (i.e., self-awareness, self-improvement) across multiple settings (e.g., home, school, neighborhood) which contributed to their abilities to adapt to the demands and challenges on their environments. An example of this is shown in participant's ability to quickly adapt to the social isolation that naturally occurred during the onset of the COVID-19 pandemic. During such a challenging time, students learned to adapt to virtual school demands and learned to find healthy coping skills. Lastly, all participants' stories emphasized the importance of community and creating social bonds with loved ones, friends, and neighbors. Overall, the combination of unique and shared positive and challenging childhood experiences and opportunities shaped participants' resiliency development in the form of developed critical consciousness, constructive social engagement, cognitive and emotional flexibility, and community connectedness.

Integration of Studies 1 and 2

The PCEs themes that emerged in Study 2 directly support all the PCE items examined in Study 1. The participation in extracurricular activities in school theme is directly related to PCE4

(constructive social engagement) as both highlights the importance of sports, clubs, and student organizations. The family resilience and bonding opportunity's theme is related to PCE5 (parent-child connection) and PCE6 (family resilience). Many of the stories shared in Study 2 reflected the importance of having strong connections with close parents and family members. Participants' ideas of family resilience also aligned with Study 1 PCE6 items. However, Study 2 expanded PCE5 because participants described the role that siblings, cousins and extended family members also played in their lives, as opposed to just having a strong connection with a parent. Theme three- community/neighborhood connectedness and engagement- aligns with Study 1 PCE items 1 (safe neighborhood) and 2 (supportive neighborhood). Participants in Study 2 described various elements of the communities they grew up in and the aspects that fostered a sense of connected, support, and safety. These aspects included knowing everyone in their neighborhood, providing and sharing food with each other, kids playing together, and parents ensuring the safety of other parents' children. Theme four- school-personal-student interactions and relationships- is related to Study 1 PCE3 (safe neighborhood). Some participants in Study 2 described their school as safe in terms of security presence and a lack of extreme violence and others described the role of teachers and school personnel as factors that contributed to their sense of safety in school. Thus, Study 2 provides a fuller understanding of factors that make a school feel safe for Black youth. Theme five- developing and maintaining meaningful friendships- is a complete divergence from Study 1 as Study 1 did not include any items related to peer relationships and friendships. Overall, the six PCE items in Study 1 provided a foundational perspective of possible factors that may be perceived as positive and impactful for a child's development. However, the PCE themes in Study 2 painted a more colorful picture and perspective for *why* certain experiences are positive, impactful, and meaningful. The findings of

both studies complement each other and contribute to an expanded conceptualization of PCEs in the context of mental health, school engagement, and resiliency.

Study Strengths and Limitations

Study 1: Quantitative Analysis

A strength of Study 1 is the use of a nationally representative survey which includes numerous items related to the intersecting aspects of children's and caregivers' physical and emotional health, sociodemographic information, and neighborhood characteristics. The large study sample (N=2201) used in this study supports generalization of the findings. The sample size was also large enough to focus just on Black youth. Additionally, very few studies using the NSCH have focused primarily on Black youth. The primary variables of interest in Study 1 were ACEs, PCEs, the prevalence of mental and behavioral health conditions (anxiety, depression, ADHD/ADD, and a behavioral/conduct problem), and school engagement. Regarding ACEs, the NSCH includes measures of X ACEs, all of which are aligned with the major ACEs measured in prior research. In addition, the prevalence of racial discrimination and sexual orientation discrimination as ACE items. This presents another strength, as many prior measures of ACEs have not considered these forms of identity-based discrimination as adverse experiences (e.g., Felitti et al., 1998; Ramiro et al., 2010). However, this survey excluded ACE items related to abuse (e.g., physical, and sexual abuse), which are adversities consistently linked to poor health outcomes (e.g., Bochicchio et al., 2024). The exclusion of these ACE items is a limitation as it may undermine the impact of these adversities on the outcome variables.

While Study 1 utilizes a nationally representative survey to assess the role of PCEs on the relationships between ACEs and the two outcome variables separately, the dataset in Study 1 is cross-sectional in nature, which means that participants were selected based on inclusion and

exclusion criteria set for the study. It is used to assess the prevalence and outcomes of physical and emotional health-related disorders of children and adolescents ages 17 years and younger at a single point in time. Because the data provides a 1-time measure analysis of exposures and outcomes, it can be challenging to derive a sufficient understanding of the casual relationships between study variables (Setia, 2016); ideally, a longitudinal study would have allowed for measurement of ACEs, PCEs, and the outcome variables at different time points to better understand for impact over time. To mitigate this limitation, logistic regression analyses were completed. Rather than examining causal relationships and risks between study variables, logistic regression analysis produces odd ratios to predict the probability of outcome variables occurring. Logistic regression analyses are frequently used when measuring cross-sectional studies with binary outcomes (Barros & Hirakata, 2003). Another consideration of using cross-sectional data is the issue of nonresponse bias analysis. To address this issue, a nonresponse bias analysis was conducted, in accordance with the Office of Management and Budget standards (U.S. Census Bureau, 2021). The results of this analysis revealed there was "no strong or consistent evidence of nonresponse bias in the 2020 NSCH" (U.S. Census Bureau, 2021, p. 18). All analyses were conducted survey sampling weights, thus, accounting for nonresponse bias.

Another limitation of Study 1 is the self-reporting of children's experiences by caregivers. Caregivers may have overstated PCEs because PCEs are socially desirable events. Thus, it is not possible to identify and examine biases reported by respondents. Further, using the NSCH, not all possible PCEs are necessarily included (i.e., such as the PCEs described in Study 2), which limited the researcher's ability to decide which variables are best for the study. Instead, the researcher used variables available in the dataset. Therefore, having a large dataset is a trade off with limited variable options that may more accurately reflect what researchers are intending

to study. However, the primary researcher attempted to address these limitations in Study 2. Study 2 allowed participants to explore and describe their own perspectives of PCEs and how the PCE impacted their subjective mental well-being, school engagement, and resiliency development. Results of Study 2 not only revealed PCEs not included in the NSCH data of Study 1, but they also provided an explanation of why and how particular experiences resulted in poor or improved mental health and school engagement.

Study 2: Qualitative Analysis

Study 2 is one of the first studies that qualitatively explores the concept of PCEs as related to mental health, school engagement, and resiliency in Black youth specifically. Data gathered from in-depth one-on-one interviews provided an enriching insight into the lived experiences of eight young Black adults who have learned how to navigate adversities throughout their childhood and adolescent years. The interviewees' lived experiences demonstrated the nuances of how an individual's perceptions of and ability to process through adversities impacts their mental wellbeing, school success, and resiliency development. Conducting two-series interviews enhanced the credibility of the data as it allowed the primary researcher to check for the validity of the experiences shared and themes derived from each interview. Participants were given the opportunity to clarify, expand on, and retract any aspect of their primary interview.

Further, the CQR method allowed for a more transparent, rigorous, and comprehensive examination and exploration of the interview data from multiple perspectives. The primary researcher, two coders, and auditors independently analyzed the data and came together to share and compare interpretations of the data. This process enhanced the credibility of and confidence in the findings. The primary researcher used best practices of CRQ, which included establishing

clear research questions prior to conducting interviews, selecting a diverse research team with members who are familiar with qualitative research methods and can offer unique perspectives, establishing consensus on domains and themes throughout the analysis process, openly and regularly practicing reflexivity with team members, and implementing member checking during follow-up interviews with participants to ensure accuracy and validity of themes related to their experiences. The unique perspectives presented by the multiple coders and an auditor enhanced the interpretability of the findings.

There were also several limitations of Study 2 that are important to acknowledge. A limitation of Study 2 is that it is not a direct reflection of the responses provided in Study 1, meaning that the experiences of the children represented in Study 1 are not the participants used in Study 2. If possible, future studies on PCE should take a mixed methods approach to assessing the quantitative and qualitative data. Further, although qualitative saturation was reached in Study 2 regarding PCEs, which speaks to the reliability and validity of the study methods and results, it is still possible that not all PCEs experienced by participants were addressed in the interviews. Even though generalizability is not a typical expectation for qualitative studies (Leung, 2015), future qualitative studies may consider using a larger sample size which may produce additional perspectives related to PCE not addressed in Study 1 and 2. Further, the researcher aimed to recruit at least 10 participants for this study. This number was not met, as only eight participants completed the initial interview. Having a smaller sample size was a limitation because it did not allow for greater diversity of participants in terms of gender identity, sexual orientation, religious beliefs and practices, ability, culture, racial and ethnic identity, and more, which was a goal set by the primary research before and during recruitment. Also, the primary researcher could not implement member checking with the two participants who did not

complete a follow-up interview. This attrition limitation is important to consider as it impacted the completeness and representation of the two participants' experiences shared in their initial interviews.

Implications for Practice

Based on the results of these studies, there several implications for school psychology practitioners who are working to promote positive childhood experiences in schools and communities that foster healthy development and well-being among Black children and adolescents. In this study, results revealed that cumulative PCEs did not have a statistically significant moderating impact on the association between cumulative ACEs and the likelihood of having one or more MBH conditions. This finding indicates that a child who has experienced multiple adversities may still be vulnerable to significant mental health concerns, despite also having multiple PCEs. Simply put, while PCEs are important and should continue to be encouraged, PCEs may not be enough of a buffer for reducing mental health concerns among children who have experienced or are experiencing ongoing stressors. Therefore, additional mental health supports, such as individual or group therapy, may be necessary for treating significant mental health concerns experienced by Black youth. School psychologists and other school-based mental health providers are encouraged to provide comprehensive school-based counseling services for students. Individual and/or group therapy may be beneficial for students who are experiencing bullying, ongoing personal stressors in their home and community, interpersonal conflict, and more. If a youth's mental health needs cannot be fully addressed in a school setting, it is recommended that school psychologists connect Black youth and their families to community-based organizations that offer resources and mental health services.

Referrals to outpatient mental health services and support may also help to reduce the misdiagnoses of disorders among Black youth (Liang et al., 2016).

School psychologists are also encouraged to assist with conducting universal mental health screenings in schools to identify students who are experiencing and/or displaying characteristics associated with internalizing or externalizing symptoms (Wood & Ellis, 2022). Universal screening is a great approach for identifying students whose symptoms may otherwise go unnoticed or misunderstood. Universal screening tools should include items that not only measures mental health and behavioral health concerns, but also protective factors such as PCEs. The combination of risk and protective factors identified in universal screenings may provide a better understanding of students needs and strengths. Including PCEs and protective factor items in universal screening tools may also contribute to a more strength-based perspective of students. Tools that only measure risk factors may contribute to a more deficit-based model of conceptualizing a student in need of mental health support. Further, school psychologists should continue to advocate for trauma-informed perspectives and care in schools to help create a safe and supportive learning environment for students. This is especially essential when working with students of minoritized backgrounds and those who have experienced trauma and adversity. Although it is not a widespread practice for school personnel to screen for trauma (e.g., ACEs), having a trauma-informed perspective may help school psychologist better recognize signs and symptoms of trauma and psychological distress among children, adolescents, and families. It may also help school psychologists recognize if school policies and/or unaddressed interpersonal conflicts are inadvertently causing stress and barriers for students and families.

Participants in Study 2 described many experiences that contributed to their sense of school connectedness such as participating in sports, clubs, organizations, and identity-based

groups. Participation in various social activities helped students build connections and friendships with others and enhanced their social-emotion skills. Therefore, school psychologists should advocate for the integration of social-emotional learning policies, programs, and evidence-based interventions in schools to help foster the development of students' self-regulations and management skills, empathy capacity, socialization, and ability to make good choices. Examples of social-emotional programs are: (a) include identity-based (e.g., race/ethnicity, gender, sexual orientation) intervention groups that help students explore and develop positive salient identities; and (b) skill-based groups that target the development of specific skills (e.g., perspective-taking, conflict resolution, healthy coping). Groups should be based on the needs of students identified as needing more support.

Given that racial discrimination was one of the most common adversities identified in Study 1, and opportunities for positive racial identity development in school was identified as a PCE in Study 2, educators and school psychologist are encouraged to consider adopting a culturally responsive MTSS framework for supporting Black children and adolescents. Malone and Turner (2021) provides several recommendations and guidance for ways to implement culturally responsive interventions across all three tiers that promotes positive racial school climate and positive racial identity development for minoritized students.

Multiple opportunities exist in schools to foster PCEs among Black children and adolescents in schools. These include participating extracurricular activities, receiving mental health services and support, gaining social-emotional learning opportunities, building positive peer relationships, building positive teacher-student connections, etc. The accumulation of such positive experiences overtime may help improve students' abilities to handle life stressors, promote positive mental health, increase school engagement, and nurture students' resiliency

development. School psychologists are uniquely qualified to provide direct and consultative services that support students' educational endeavors and social-emotional and psychological wellbeing. School-based PCEs are integral to Black youths' overall development, and school psychologists can advocate for and facilitate experiences that create a greater sense of safety and connection to school among Black youth.

Future Directions for Research

These studies provided valuable insights into the phenomenon of PCEs and the potential impacts PCEs have on Black youth's mental wellbeing and school experiences. Yet, there are several avenues of future research that warrant further exploration and understanding of this topic. Future research should explore the development and assessment of a more comprehensive PCE survey that includes items related to the PCEs examined in studies 1 and 2, and additional items related to PCEs found in the literature. It is also recommended that survey items include themes related to resiliency development to help establish a quantifiable relationship between PCEs and resiliency. With established confidence in a broader PCE survey, future researchers are encouraged to employ mixed-methods studies that integrates data from the PCE survey with qualitative approaches (e.g., interviews), using a large sample size to enhance the generalizability of the findings. The combination of quantitative and qualitative data could offer a more comprehensive understanding of the role and impact of PCEs. Intersectional and cross-cultural comparisons could incorporate mixed methods designs to further investigate PCEs across different racial and ethnic groups and other salient identities. Pursuing these next steps may result in advancing knowledge of PCEs and informing practice to school psychology and other disciplines with children, adolescents, and young adults.

Future research should also explore the relationship between school engagement and MBH conditions (e.g., Klassen & Stewart, 2022). An examination of this relationship across critical developmental transitions (e.g., middle school to high school) may prompt the implementation of interventions that supports and improves students' wellbeing and educational performance. Future research may also want to examine individual ACEs and PCEs on school engagement and mental health outcomes through a latent profile analysis LPA. An LPA statistical approach may provide a better understanding the varying groups of people who have an increased vulnerability to school disengagement and significant mental health concerns. This may also support the promotion of interventions that targets students with increased vulnerabilities.

Conclusion

The findings from Study 1 and Study 2 illuminates the complex interplay of interpersonal and environmental factors across multiple settings (i.e., school, home, neighborhood/ community) that directly or indirectly influences Black youth's mental and subjective wellbeing and ability to be engaged in school. The quality of their interpersonal relationships with extended and close family members, friends, peers, teachers, other school personnel, and mental health providers in the school and community may significantly impacts Black youths' ability to navigate their immediate surroundings and adequately tackle the challenges they encounter in their daily lives. The same is true for the quality of the characteristics of Black youths' home, school, and neighborhood. Enriched environments that are psychologically and physically safe and provide numerous opportunities for constructive socialization may positively impact their ability to handle stressors, employ healthy coping strategies in times of trouble, improve their decision-making skills, and increase their levels of self-awareness, self-regulation, and self-love.

Although varied levels of childhood adversity and mental health concerns are part of some Black children's and adolescents' life stories, these studies are a testament that quality relationships, caring environments, and enrichment social opportunities are protection factors. As the alarms continues to ring regarding the decline in youth mental health and the struggles of school engagement, stakeholders are encouraged to prioritize building healthy and positive connections with young people, promote their engagement in extracurricular activities, and create safe spaces for young people to talk through the challenges they are facing. These positive encounters and experiences may be catalysts of hope and resiliency in a child's story. The findings presented in this work is foundational for guiding practice implications and future research studies and informing targeted interventions that supports Black youths' specific needs across multiple contexts.

APPENDIX A

IRB APPROVAL LETTERS

OFFICE OF
RESEARCH SERVICES

Printed on: Wednesday, January 3, 2024

Dear Sharnequa Hunter,

On Sunday, July 16, 2023 the Loyola University Chicago Institutional Review Board (IRB) reviewed your application for confirmation of exemption titled "**Resiliency and Positive Childhood Experiences: Implications for Black Youth's Mental and Behavioral Health and School Engagement - Study 1 Using Secondary Data** ". Based on the information you provided, the IRB determined that this human subject research project is exempt from the IRB oversight requirements according to 45 CFR 46.101.

If you make changes to the research procedures that could affect the exempt status of this project, your proposal should be reevaluated by the IRB to confirm it is still exempt from the IRB oversight requirements. To modify this proposal, please submit an Amendment/Project Update Application using the online CAP program. Complete details about the application process and your responsibilities can be found on the Office for Research Services web site.

Please notify the IRB of completion of this research and/or departure from the Loyola University Chicago by submitting a Project Closure Application. In all correspondence with the IRB regarding this project, please refer to IRB project number #3744 or IRB application number #8938.

Best wishes for your research,

Loretta Stalans

Loretta Stalans, Ph.D.
Chairperson, Institutional Review Board
lstalan@luc.edu

LOYOLA UNIVERSITY CHICAGO

OFFICE OF RESEARCH SERVICES

Printed on: Wednesday, January 3, 2024

Dear Sharnequa Hunter,

On Sunday, October 29, 2023 the Loyola University Chicago Institutional Review Board (IRB) reviewed and approved your Amendment application for the project titled "**Resiliency and Positive Childhood Experiences: Implications for Black Youth's Mental and Behavioral Health and School Engagement**". Based on the information you provided, the IRB determined that:

- the risks to subjects are minimized through (i) the utilization of procedures consistent with sound research design and do not unnecessarily expose participants to risk, and (ii) whenever appropriate, the research utilizes procedures already being performed on the subjects for diagnostic or treatment purposes
- the risks to participants are reasonable in relation to anticipated benefits, if any, to participants, and the importance of the knowledge that may reasonably be expected to result
- the selection of subjects is equitable
- informed consent be sought from each prospective subject or the subject's legally authorized representative, in accordance with, and to the extent required by §46.116
- informed consent be appropriately documented, in accordance with, and to the extent required by §46.117
- when appropriate, the research plan makes adequate provisions for monitoring the data collected to ensure the safety of subjects
- when appropriate, there are adequate provisions to protect the privacy of subjects and to maintain the confidentiality of data
- when some or all of the subjects are likely to be vulnerable to coercion or undue influence, such as children, prisoners, pregnant women, mentally disabled persons, or economically or educationally disadvantaged persons, additional safeguards have been included in the study to protect the rights and welfare of these subjects

In addition, the IRB determined that documented consent is not required for all participants.
The IRB approved a waiver of documentation of informed consent.

This review procedure, administered by the IRB, in no way absolves you, the researcher, from the obligation to adhere to all Federal, State, and local laws and the Loyola University Chicago policies. Immediately inform the IRB if you would like to change aspects of your approved project (please consult our website for specific instructions). You, the researcher, are respectfully reminded that the University's ability to support its researchers in litigation is dependent upon conformity with continuing approval for their work.

Please notify the IRB of completion of this research and/or departure from the Loyola University Chicago by submitting a Project Closure Report using the CAP system. In all correspondence with the IRB regarding this project, please refer to IRB project number #3729 or IRB application number #9147.
The IRB approval granted for this project expires on **7/31/2024 12:00:00 AM**

If you have any questions about this IRB approval, please feel free to contact the IRB chairperson, Loretta Stalans, at lstalan@luc.edu or the co-vice chair who signed this letter. For any other questions about the Loyola University Human Protections Program or CAP, please contact the Associate Director of Research, Andrew Ellis at (773) 508-2629 or email the irb@luc.edu.

Best wishes for your research,

Loretta Stalans, Ph.D.
Chairperson, Institutional Review Board
lstalan@luc.edu

APPENDIX B

RECRUITMENT FLYER

RESILIENCY AND POSITIVE CHILDHOOD EXPERIENCES

CALL FOR RESEARCH PARTICIPANTS

STUDY PURPOSE

The purpose of this study is to explore Black young adults' understanding of positive childhood experiences, how these experiences impacted their school engagement and mental and behavioral health, and how these experiences contributed to their resiliency development.

ELIGIBILITY CRITERIA

- Self-identity as Black/ African American
- Ages 18-20 years
- Experienced symptoms of anxiety, depression, ADHD, and/or a behavioral problem at any time during your childhood (0-17 years)
- Have experienced adversity during your childhood (0-17 years)

PARTICIPATION AND COMPENSATION

1. Online Demographic Screener (2 minutes to complete)
2. Two individual semi-structured interviews via Zoom:
    a. Initial Interview: 60-75 mins ($35 Amazon Gift-card)
    b. Follow-up Interview- 15-20 mins ($15 Amazon Gift-card)

All interviews will be audio-recorded and transcribed by the primary investigator

INTERESTED?

If you would like to participate in the study, please complete the online demographic screener using the link below:
https://qfreeaccountssjc1.az1.qualtrics.com/jfe/form/SV_7QJDaeaXEjkKtoi

Upon completion of the brief screener, the researcher will contact you via email to schedule your initial interview

SHARNEQUA N. HUNTER, M.ED
DOCTORAL CANDIDATE
LOYOLA UNIVERSITY CHICAGO
Primary Investigator
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This study has been approved by the Loyola University Chicago IRB #3729

APPENDIX C

SEMI-STRUCTURED INTERVIEW PROTOCOL

SEMI-STRUCTURED INTERVIEW PROTOCOL

Introduction

"I am studying Black youths' understanding of positive childhood experiences and how these experiences impacted their mental and behavioral health and academic engagement during their high school years. It is my hope that understanding these experiences will inform caregivers, educators, and school-based mental health providers of ways to better support Black youth in school settings, in their home, and within their communities. As a component of this study, I am gathering information from Black and African American youth between the ages of 18-20 years. I am conducting individual interviews so that I can better understand the unique and positive experiences of Black youth."

"Participants will be asked to participate in two interviews. The first interview should take approximately 60-75 minutes in duration. The second interview will be a follow-up interview and should take approximately 15-20 minutes to complete. To maintain the accuracy of your reporting, all interviews will be audio recorded to allow for transcription. Due to the length of the interview, audio recording is an important aspect of gathering the most accurate representation of your experience. During the interview, I will ask questions about your personal childhood experience(s) in your home, school, and community. I will also ask questions regarding how you conceptualize positive experiences with resilience."

"To make the interview more accessible to participants, the interviews will take place remotely using a secure platform called Zoom. Participants will choose the environment in which they feel the comfortable and their privacy is maintained (e.g., home). If you are still willing to participate, I would like to go over the Informed Consent Form with you."

Consent Process

[Present and review informed consent, limits of confidentiality, and authorization for release of confidential health information if participant is willing to complete case study interviews.]

[If yes, proceed. If no, confirm that the individual is not interested in participating and end by thanking them for their time and consideration]

Proceed with Interview

"First, do you have any questions about the interview or the study?" (Answer any questions the participant may have regarding the interview or research.) "I am now going to begin recording the interview. At any point during the interview if you need a break, are feeling uncomfortable or would like a specific question to not be recorded, I will turn the recorder off."

Interview Questions

First Interview

Main interview Question

1. Describe yourself in terms of your most salient identities, values, and beliefs.
2. When reflecting on your childhood and upbringing, what positive experiences come to mind?
3. When reflecting on your childhood and upbringing, what challenges or difficulties come to mind?
4. Have your childhood experiences positively impacted your mental and behavioral health? How so?
5. Have your childhood experiences negatively impacted your mental and behavioral health? How so?
6. Have your childhood experiences positively impacted your educational outcomes and engagement in school? How so?
7. Have your childhood experiences negatively impacted your educational outcomes and engagement in school? How so?
8. In what ways have your childhood experiences helped you to build resiliency?

Probe Questions:

Family/ Home

Given your most salient identities…

- What messages did you receive about mental and behavioral health in your home?
- What messages did you receive about education and school expectations in your home?

School

Given your most salient identities…

- What about your school setting made you feel connected to the school? What made you feel disconnected from school?
- Who were the people in your school who cared about you and/or helped you when you're having a hard time?
- What extra-curricular activities did you participate in?
- What messages did you receive about mental and behavioral health in high school?
- What messages did you receive about education and school expectations in your school?

Community/ Neighborhood

Given your most salient identities…

- Describe the demographic characteristics of your neighborhood
- What made you feel connected and disconnected from your community?
- Did living in this neighborhood have any impact on your mental and behavioral health? Why or why not?
- Did living in this neighborhood have any impact on school engagement? Why or why not?

Second Interview

1. Since our first interview, have any other past experiences and stories come to mind that you would like to share?
2. Would you like to expand on anything you said in the first interview?
3. It seems to me that the following themes (list examples of themes) are in your responses. Do you agree or disagree? How might you change or add to these themes?
4. How can educators, other school personnel, and school-based mental health providers better support Black children and adolescents' mental health?
5. School-based mental health providers are school psychologists, counselors, social workers, and school nurses.
6. Is there anything else you feel is important to share?

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VITA

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