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"Bad Boys" To Bigger Problems: A Study on Masculinity and Mental Health

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“BAD BOYS” TO BIGGER PROBLEMS:
A STUDY ON MASCULINITY AND MENTAL HEALTH

by

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ABSTRACT

Enacting gendered behaviors and using gendered resources has been a way for boys to "do masculinity." One place where boys do masculinity is the public school system. It plays a large role in facilitating adolescent youths' exposure to peer groups where they learn gendered behaviors. Our culturally imposed social script for hegemonic masculinity emphasizes strength and social dominance which can be seen to influence a variety of psychological areas. This thesis examines the relationship between hegemonic masculine traits and mental health. Mental health and masculinity were operationalized and measured using the 2017 Youth Risk Behavior Survey containing measures of masculinity, mental health, and school connectedness. A univariate analysis was initially performed using the survey frequency procedure. Then a bivariate analysis was performed with the Chi-square test. A weighting factor was applied to adjust for nonresponse and the oversampling of Black and Hispanic students in the sample group. Weighted frequency and percentage were reported. The *p* value at α level 0.05 was considered significant. Finally, a logistical regression analysis was performed to understand whether hegemonic masculinity can predict the odds of reporting poor mental health in the sample controlling for other sociodemographic variables. Findings indicated that masculine ideals exert influence on mental health outcomes and raises concerns for adolescent boys.

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CHAPTER ONE: INTRODUCTION

My first day working in a juvenile detention center was filled with comments from the other workers: “watch out for that one” and “he thinks he runs things here—be careful.” I was among the few female leads meant to assist with, and eventually teach, life skills in an all-teenage boy division. Months later, that same boy my predecessors warned me about had opened up about his experiences at home, his relationship with drugs, his relationship with school, and his deep desire for personal growth. In the course of my time at the detention center, it became evident that these “bad boys” (Ferguson, 2000) are socialized through school connectedness and relationships, which is directly linked to their mental health. It led me to think about how boys are socialized and why adults perceive them as “bad boys” when all they really needed was someone to listen to them.

Masculinity is a set of gendered ways of acting for males that is reinforced, reflected, and enacted every day in social institutions like families, peer groups, and schools. Masculinity has been defined as rigidness and strength (Montes, 2013) in contrast to femininity, which has been defined as nurturing and comparatively soft. Characteristics used to define masculinity follow a trend of power which can be seen through actions like aggression, cultivating strength, or even a sense of rigidness. Boys take chances and risks, boys are more likely to engage in risk-taking behaviors like risky sex practices (Guarini, Marks, Patton, & Garcia-Coll, 2013), drug use, and physical risks related to aggression and fighting (Frøyland & Soest, 2020).

Researchers have identified and defined the concept of hegemonic masculinity as a set of masculine cultural practices that are thought of as the cultural ideal which is used in society to maintain the social power of men. Boys in our society see this masculine ideal and behave in

ways that are characteristic of the types of masculine behaviors considered to be hegemonic. Idealized hegemonic masculinities are the negative aspects of rigidness and restrained emotions. All boys and men engage in masculine behaviors as they construct their gendered identity: commonly, adolescent aggressive behavior occurs in clusters (Lopez & Emmer, 2002), including gang activities such as stealing. Peer relationships play an integral role in adolescent aggressive behavior; it can often lead to a gain in popularity or social status amongst peers, and peer pressure can lead to displays of aggressive behavior out of fear of isolation or loss of social standing (Lopez & Emmer, 2002). The tough boys, the "big men on campus" (or in the juvenile detention center) tend to emulate the cultural ideal of hegemonic masculinity.

Displays of masculinity are often performed through aggression with the point of dominance being power, which has the capability to influence boys' mental health outcomes. As boys mature into adolescents, they face issues related to their identity as young men that can lead to mental health problems later in life. School connectedness is a student's perceptions of their belongingness and support exhibited within their learning environment, which leads to engaging in behaviors that keep up their masculine identities. "Boys for whom there is no hope" (Ferguson, 2000, p. 96) often get caught up in a punishment system that labels these children as "naturally naughty" by attempting to uphold masculine norms: "the... adherence to the masculine norm of emotional control were negatively associated with depressive symptoms while heterosexual presentation and informal support were related to both depressive and anxiety symptoms" (Iwamoto et al., 2012, p. 1). In addition, the number of suspensions and expulsions has increased: "the suspension rate for all students has nearly doubled since the 1970s, and has increased even more for black and Hispanic students" (Justice Policy Institute, 2015). Students' experiences at school, such as their interactions with teachers and classmates or how a student

receives support within their learning environment, have been linked to their behavior and academic performance (Wang et al., 2010).

Goodenow also noted that adolescents' perceptions of their school environment have been constructed and related to "school connectedness," which has been described as "the extent to which students feel personally accepted and respected, included and supported by others in the school social environment" (Goodenow, 1993, p. 80). Students' perspectives on their school environment are influenced by many factors; for example, when schools provide opportunities for students to improve their interpersonal skills, such as conflict resolution, communication, negotiation, sharing, and good manners, and when schools provide outlets to be actively engaged, students' levels of school connectedness increase. Since so much of an adolescent's upbringing is surrounded by school, the education system is the place where boys get to "do masculinity" through latent functions. Children are exposed at a young age to gendered behaviors (i.e., more rough play and physical activity) through different socializing instances, interactions, and experiences. In school, young children begin to form ideas, curate understanding, and challenge interactions. Our understanding of children, as translated by Basterfield, as they grow begins with how they learn in school: "constructions of masculinities and their relationship to violence and risk behaviors are prominent on most schools' agendas around the world" (Basterfield et al., 2014, p. 101). Schools perpetuate hetero-normative practices and stereotypical gender roles (Pascoe, 2007) through toys, sports play, and even curricular materials that elevate gendered roles/behaviors that integrate hegemonic masculine views. As they grow in schools, boys watching these gendered behaviors begin to suppress their emotions and also have a complicated understanding of their own emotions as it relates to their mental health (Depression, 2019).

Using data from the 2017 National Youth Risk Behavior Surveys (YRBS), this study examined hegemonic masculine traits to understand how they are related to mental health and school connectedness. A quantitative approach was taken to identify and analyze these issues using national data collected by the Center for Disease Control and Prevention (CDC) on high schoolers 13 to 17 years of age. This study aimed to discuss the relationship between sex, risk-taking behaviors, and mental health to reveal underlying repressive emotions amongst boys/men that has implications for how we measure, assess, and intervene with regard to mental health in adolescent boys.

CHAPTER TWO: LITERATURE REVIEW

2.1 Gender Roles

Society is filled with a myriad of different expectations and roles. In part, socially, we fulfill set roles; roles are "the process of gendering and its outcome are legitimated by religion, law, science, and the society's entire set of values" (Lorber, 1994, p. 2). Gender roles are roles that both men and women are expected to play into based on their gender. While 'roles' and scripts often guide gendered norms, people do not typically "play" a gender role. Men and women experience these roles differently. Men may sometimes use different language (verbal or non-verbal) to express their distress; this can be seen through avoidance, substance use, violence, etc. A more traditional feminine gender role that would likely be prescribed to women would be their role of being a nurturer. A woman might engage in this behavior as a caretaker to her family instead of or along with traditional employment.

Children begin to comprehend the world in categories within gender at a very early age—which might lead to prejudices. We can see an example of this when we look back at Bem's example in *The Lenses of Gender*, in which kids identify a boy and girl based on their clothes. However, by changing the language children hear and providing positive experiences with diversity, we can prevent the development of essentialist thinking about specific groups. It's important to note that essentialist views on race, sex, nationality, ableism, age, and sexuality are not universal and although the capacity to think in essentialist terms emerges in early childhood development, this does not mean that children inevitably develop essentialist views about social groupings like gender.

When we perform tasks based on the gender normative role assigned to us, we are said to be *doing* gender. Symbolic interactionism is how we give meaning and value to the social and

physical world (Cohen, 1985). Interactions that are given "meaning" are the foundation of the theory since it focuses on what symbols and interactions emerge between people. Symbolic interactionism is intrinsic to understanding identities; it's why men might engage in symbolic behaviors that are considered inherently masculine like the need to aggressively compete and dominate others. In our understanding of symbolic interactionism, gender roles are socialized and granted meaning in the dynamics of the relationships between people. In an adolescent's upbringing, this theory insinuates that children learn ways of behaving through interaction with parents and in school through teachers and peers, which perpetuates the need to feel connected to their school.

The construction of gender is socially developed through interactions within and outside of institutions like the medical system and schools. Gender is modifiable and ever-changing as our understanding expands on this construct. The meanings behind masculinity and femininity are constantly being modified and are not uniformly defined as they change through cultural, social, and geopolitical areas.

2.2 Masculinities

Masculinity is a set of gendered ways of acting for males that is reinforced, reflected, and enacted every day in social institutions like families, peer groups, and schools. Masculinities are understood as being a "permanent and essentially normative and relational process" (Borde et al., 2020, p. 75). The term "masculinities" will be used in reference to the "prototypical traits and behaviors such as physical and emotional strength, competitiveness, and virility, assertiveness, autonomy, decisiveness, risk-taking, control and invincibility" (Stergiou-Kita et al., 2016, p. 722). It is often seen that traditional "gender ideologies undergird power differentials between men and women by defining masculinity as dominance and aggression, with femininity defined

as submissiveness and nurturance" (Silver et al., 2018, p. 94). Patriarchy is a set of systems that are built on the foundational principle that the "weak" (women) must be dominated by the "strong" (men). A traditional masculine gender role would draw into a patriarchal dynamic; this can be seen by men being the 'head' of their households. Masculinities has become an essential component to heteronormative practices and has been confirmed through gender roles being reinforced through varied acts of socialization.

Hegemony is the dynamic of power that creates and upholds a position of leadership within social life (Messerschmidt, 2018). Hegemonic masculinity—as defined by Connell and Messerschmitt (2005) as the pattern of practice (i.e., things done, not just a set of role expectations) that allows men's dominance over women to continue—is an integral component to this thesis. Hegemonic masculinity has normalized the need for men to hold a dominant position in the gender and social order. Hegemonic masculinity, as a concept, stands in a power hierarchy of other masculinities; this particular version of masculinity gives power and privilege to certain types of men (Connell & Messerschmidt, 2005).

Rosen and Nofziger (2018) argue that "if boys accepted their status as a victim [to bullying], they are admitting their vulnerability and defeat, thereby calling into question their masculinity. In contrast, if boys shrugged off their experiences as just something that 'boys do' in doing gender, the victims were able to save face and once again affirm their masculinity." This study showed that boys who did not "demonstrate masculine traits, either in size, appearance, or sexual behavior, reported these characteristics were relevant to being targeted as victims by their peers" (Rosen & Nofziger, 2018, p. 312). Gender is reinforced through discursive legitimation. Most important to note is that, in *Hegemonic Masculinity*, Messerschmidt clearly points to hegemonic masculinities being relational and existing to a pattern of hegemony, not domination

(2018). Hegemonic masculinities survive and get reinforced through different intersectionalities like race, gender, class, nationality, sexuality, age, etc. Men can display varying forms of hegemonic masculinities that can incorporate different "displays," like androgyny, while still maintaining their ideals and still reinforcing the power dynamics that fall in line with hegemonic masculinity.

When looking at hegemonic masculinity, the problem lies in the expression of insecurity while attempting to fit into a masculine mold, which in turn propagates problematic symptoms that fall in line with hegemonic masculine traits. Men are not born, men are created; there are changes that come with boyhood to manhood. It is absolutely imperative that men begin to examine their own gender programming, especially within the realm of hegemonic masculinity, in order to grow and evolve in deconstructing masculinity (Kimmel & Messner, 2018).

Gender policing is the enforcement of normative gender expressions through behavior and appearance according to the gender assigned at birth. Policing of gender is meant to delegitimize the expressions of those that deviate from gendered normative expressions. Through symbolic interactionism, Policing of Masculinity (POM) amongst adolescents most frequently occurs when someone communicates to a boy that he is *insufficiently* masculine by not partaking in heteronormative masculine characteristics and may involve epithets such as "gay," "fag," or "pussy" (Reigeluth & Addis, 2016). As Kaufman describes it: "There are many things men do to have the type of power we associate with masculinity: We've got to perform and stay in control. We've got to conquer, be on top of things, and call the shots. We've got to tough it out, provide, and achieve, meanwhile, we learn to beat back our feelings, hide our emotions, and suppress our needs" (1994, p. 148).

2.3 Mental Health and Gender

Our society revolves around proclaiming that certain positive qualities are gendered and inherent to men, such as assertiveness, technical insight, fixing broken things, etc. Patriarchy is an understanding and analysis of the organization of male supremacy and the system of power created for men. Patriarchy, as a social construct, has been legitimized throughout the course of history by placing men and women in opposition where men bear the most weight and women are othered as 'less than' or subordinates. Although masculinity is socially constructed, traditional stereotypes of men being socially dominant and normalization of the promotion of violence has increasingly led to the criticism of what can be deemed as traditionally normal masculinity; some criticisms include the "need" for emotional repressions and the need for criticizing their own lives. Societal criticisms of masculinity have created a focus on what is deemed to be a healthy expression of masculinity. Mental health is integral to our comprehension of well-being; being able to do things one has reason to value contributes to their mental health. The ability to do and to be are shaped by social conditions (amongst other factors).

It is increasingly recognized that the emotional repression found in boys as compared to girls has led boys and men to poor mental health outcomes (i.e., depression, substance abuse, etc.). Men are "underrepresented [in studies regarding mental health] because they are less likely to seek care than women" (Courtenay, 2000; Oliver et al., 2005), are less likely to report depressive symptoms when they end up seeking care (Courtenay, 2000), and are less likely to be diagnosed with depression (Swami, 2012) because of their emotional repression. This creates dissonance between boys and girls in their mental health outcomes.

2.3.1 Risk-Taking Behavior

The socialization of boys in patriarchal communities have often prompted the notion of "boys will be boys" with regard to risk-taking behaviors (i.e., aggression, violence, and alcohol consumption). Risk-taking behaviors (aggression, drinking, delinquency, etc.) are masculine behaviors that are negative outcomes. During adolescence, boys and girls experience different capacities in how they develop and internalize their own individual mental health, leading to different outcomes, patterns, relationships amongst maternal and paternal figures in their lives, etc., which can lead to negative mental health outcomes (Ebbert, Infurna, & Luthar, 2019).

The manifestation of mental health problems is shown through the way boys and girls process: boys externalize their behaviors by leaning towards risk-taking or antisocial behaviors while girls tend to internalize through depression and anxiety. As such, boys are also more likely than girls to attribute beliefs surrounding "peers apparent concern about executing an injury-risk activity [having] implications for how successful they themselves would be in so doing. Extending this logic, boys may be more inclined than girls to engage in an injury-risk activity even if they observe a peer get hurt doing the activity" (Morrongiello & Rennie, 1998, p. 40-41). Girls were found to take risks depending on how likely they would get hurt whereas boys would take risks based on how hurt they would get, meaning that they are attracted to a higher propensity for injury. This creates the narrative surrounding risk-taking behaviors as inherently masculine due to being sought after by primarily boys and men. Risk-taking behavior has more drastic negative outcomes for men as they externalize their mental health through these activities, which creates difficulty processing their mental health in positive ways (e.g., self-care).

2.3.2 Self-Esteem and Belonging

The US Centers for Disease Control and Prevention (CDC) define mental health as "emotional well-being, psychological well-being, and social well-being" (Slade, 2010). For the purpose of this research, mental health will specifically be defined as emotional well-being. Emotional well-being includes contentment with life, joy, and a sense of calmness, and it "helps determine how we handle stress, relate to others, and make healthy choices" (Mental Health, 2019). Self-evaluation, as a part of mental health, is crucial to one's well-being. Self-esteem has the power to influence aspirations, goals, and interactions amongst others.

As we look at emotional well-being as a reflection of mental health, there's a connection as it relates to self-esteem. Self-esteem refers to an overall examination of one's worth or value (Harter, 2003). Bos et al. (2012) further define that "global self-esteem is distinguished from domain-specific self-esteem, such as scholastic competence, athletic competence, peer likeability, physical appearance and behavioral conduct" (Bos et al., 2012). Self-evaluation in respect to a global understanding of oneself does not occur until adolescence. Toddlers and younger children are not able to make those critical evaluations or verdicts of their respective self-worth in comparison to adolescents (Harter, 1999). Once self-actualization becomes more distinguishable within an adolescent, sectors of their lives become more important: friendships, romantic relationships, and competencies.

Additionally, the concept of 'self' begins to impact one's mental health throughout adolescence when comparing oneself to others, peers, and public figures. It has become commonplace to compare oneself to others in order to uphold a socially acceptable standard. Historically, "fatness in men signaled a lack of self-control or dimness. For elite men, slenderness became bodily proof of rationality and intelligence" (Strings, 2019, p. 41). In

addition to this, Sabrina Strings, in *Fearing the Black Body: The Racial Origins of Fat Phobia*, explores racial stereotypes held throughout history towards the appearance of Black men and women, as well as the changes that take place globally over time in how we view being thin versus large (healthy, durable, and strong or gluttonous, greedy, and unattractive), and the hierarchy of beauty (2019). These mental battles are circumstances that play into one's self-esteem.

As boys mature into adolescents, they face issues related to identity that can be translated negatively throughout their life cycles in relation to their mental health. Self-esteem within adolescent boys, as a part of their upbringing, is frequently overlooked. Self-esteem serves as a "monitor of social belongingness" (Bos et al., 2006). In general, esteem provides us with our value and tells us how socially accepted we are amongst peers and groups (Griffiths et al., 2018). Children very quickly accept the views that others have given them via interactions, including parents and teachers (Griffiths et al., 2018; Bos et al., 2006). Essentially, when parents are more responsive to their children, as opposed to being unresponsive or disapproving, children are more likely to develop a higher level of self-esteem. Men and boys, however, experience some leeway with relation to how "comfortable" they can become around women/girls, in part due to the gendered lens; it's likely due to women/girls inherent femininity, which influences men and boy's level of self-esteem and idea of belongingness in relation to the view of others. Self-esteem in adolescent boys is integral to their mental health as it's tied to their environment; this can link to poor relationships, depression, and anxiety (Hanson & Richards, 2019). However, this does not come without noticing the integral role of intersectionality. Race, educational attainment, and gender all play a role in the integration of the ethnographer's fieldwork. Race, ethnicity, and national origin are significant to ethnography.

2.3.3 Aggression & Drinking

Hill-Collins and Bilge (2016) draw on intersectionality as a point of view to comprehend power relations, experiences that can shape lives, people's upbringings, etc. This intersectional relationship being so interwoven makes intersectionality a complex analysis, which is why it's used in analyzing social spaces. Constructions around hegemonic masculinity emphasize "strength, invulnerability, competitiveness, and control; thus, consuming large amounts of alcohol without apparent consequence is one way that men 'do' gender" (Emslie et al., 2013, p. 34). This is also discussed in Emslie et al.'s (2013) study: "parties were seen as a major contributor to aggression especially when alcohol was present... 'Once they get a bunch of drinks in them, they think they're macho', 'they just want to start fights', and 'it's the alcohol and testosterone.'" Studies have shown a correlation between drinking and increased aggressive tendencies. Research has identified associations between masculine norms and men's self-report of generalized aggressive behavior (Leone & Parrott, 2018).

The case study "The International Arms Trade Treaty" in Cynthia Enloe's *Bananas, Beaches and Bases: Making Feminist Sense of International Politics* (2014) brings understanding to "gender-based violence" as a term and action. The international exports of guns sustain gender-based violence as a pillar of international and national patriarchy. Here the question "where are the men?" is asked in relation to women and the politics involving gun laws: "men living in a dangerous world are commonly imagined to be the natural protectors," as Enloe puts it (2014). This statement is also one that falls in line with politics as we see them today. If we look at the conversations being had around Planned Parenthood in the political sphere, though women in politics can advocate for this organization, men in politics wield the power of signing off on laws that allow for its defunding.

Martin (2001) has found that alcohol consumption has been related to up to two-thirds of crimes committed by juveniles. Similar studies have also shown a correlation between alcohol consumption and aggression (Tinklenberg et al., 1996; Mason et al., 2007), primarily found in men. Though researchers have reported that alcohol consumption has a positive correlation with aggression, they have not yet demonstrated causality. Adolescents consuming alcohol while in school experience a decline in their school connectedness and their mental health. In previous studies, it's been shown that school connectedness in adolescents made them less likely to use substances such as alcohol (Cummins et al., 2019). School connectedness refers to an academic environment in which students believe that adults in the school care about their learning and about them as individuals.

Throughout the discourse and studies surrounding aggression as transpired through drinking, one thing remains clear: violence has not been a new development and seemingly will always be around to further perpetuate the power dynamics between men and women (Farrow, 2019). Society has glorified the patriarchal divisions between men and women; this can be seen through violence and aggression.

Alcohol consumption is a risk factor for aggressive behavior such as physical fighting and verbally aggressive arguments. Alcohol-related aggression has manifold social and neurobiological causes. Social drinking has become a cultural symbol of masculinity amongst peers and through the media: "alcohol consumption may provide another context for men to express socialized masculine beliefs and norms" (Berke et al., 2020, p. 37). Absence of alcohol or not drinking "enough" symbolizes, to some men, weaknesses or femininity (Peralta, 2007). Weakness as an association with femininity opposes the expectations of masculine norms with being strong and tough. Some masculine norms can increase the chance of problematic drinking

or drinking in excess. Masculine norms are strongly associated with drinking to intoxication and alcohol-related problems (Berke et al., 2020).

2.4 Connections to School

An integral role of an adolescent's trajectory in life is their connection to their school. Students who are seen with lower levels of "school connectedness" have been associated with trends of higher likelihood to engage in detrimental behaviors that can impact their health such as substance abuse (Blum, 2005) and to experience lower mental health outcomes. In essence, school connectedness can be conceptualized as a student's perceptions of their safety, belongingness, and support exhibited within their learning environment. Blum (2005) has indicated that positive school connectedness correlates to "positive academic adjustment, self-esteem, and ego resilience" while, in contrast, lower connectedness would indicate disengagement with school. School connectedness is relatively important as adolescents' academic achievement correlates to this concept.

Connectedness to school indicates students' involvement in their school life, belongingness, and proximity to their identity within school. School connectedness has established many forms throughout the academic years and studies have indicated that students begin to experience the largest amounts of distance from their schools during their middle school years (Lam et al., 2012). Additionally, studies have shown that boys are less likely to be connected to their school than girls (Lam et al., 2012). Adolescents place more value in learning when they have a greater sense of connectedness to their school. In a longitudinal sample, for example, Li and Lerner (2011) discovered that students with a higher level of school connectedness also had lower levels of substance use compared to adolescents with moderate to

low levels of school connectedness. This large body of work illustrates the effectiveness of the role of school connectedness on adolescent alcohol consumption.

This study aimed to discuss the relationship between sex, risk-taking behaviors, and mental health as it relates to masculinity. Current literature indicates that there is a long-term influence on men's adult life as it relates to their upbringing and what masculine traits are carried or perpetuated during adolescence and seen throughout adulthood. This is why the research questions asked: Do boys and girls differ in their odds of reporting poor mental health? Do adolescents that engage in risk-taking behaviors (aggression, drinking) have higher odds of having poor mental health outcomes compared to adolescents that do not engage in risk-taking behaviors?

CHAPTER THREE: METHODOLOGY

3.1 Survey of the Field

The data for this study come from the Centers for Disease Control and Prevention's (CDC) 2017 Youth Risk Behavior Survey (YRBS), which asked about behaviors that contribute to unintentional injuries and violence, sexual behaviors, HIV infection, alcohol and drug use, tobacco use, unhealthy dietary behaviors, and physical activity. The YRBS was created to monitor health behaviors that contribute to the leading causes of death, disability, and social problems among youth and adults in the United States: "these surveys are conducted every two years, usually during the spring semester. The national survey, conducted by the CDC, provides data representative of 9th through 12th grade students in public and private schools in the United States. The state, territorial, tribal government, and local surveys, conducted by the departments of health and education, provide data representative of mostly public high school students in each jurisdiction" (Centers for Disease Control and Prevention [CDC], 2018).

The 2017 YRBS drew from the population of all high school students in the United States in the 2017 academic year. This survey included state, territory, tribal government, and large urban school district participation. However, Minnesota, Oregon, Washington, and Wyoming did not conduct a YRBS in 2017. States that did not participate did not have a large enough population to be generalizable to their total youth population.

The school response rate was 75% (144 of the 192 sampled schools participated). The overall student response rate was 81%. 14,956 of the 18,324 sampled students submitted questionnaires; 14,765 questionnaires were usable after data editing. The survey consisted of 99 questions, including all 89 questions on the standard questionnaire. The questionnaire was used as the starting point for the school district questionnaires. This survey allowed for some

flexibility as states and large urban school districts could add and delete questions from the standard questionnaire. Only four school districts included in the report used the 2017 YRBS standard questionnaire without modifications. Students completed the questionnaire during the course of a class-period directly onto a scannable booklet or answer sheet. It is important to note that there are no skip patterns, missing data in the dataset, in the YRBS questionnaire to help provide consistency with respect to the amount of time the survey takes to complete. After reviewing the data, schools with less than 40 students per grade (9th through 12th grade) were excluded from the data.

3.2 Research Design

This study examined the relationship between sex, risk-taking behaviors, and mental health, testing the relationship between poor mental health and sex (boys' mental health versus girls' mental health). Then, the study tested the same relationship while controlling for risk-taking behaviors. This was a quantitative study using secondary data from the 2017 YRBS to analyze the relationship between the independent and dependent variables. Univariate, bivariate, and multivariate analysis was computed to analyze the statistics. Correlations were calculated in order to assess the association between these variables. The research questions asked, "do adolescents that engage in risk-taking behaviors (aggression, drinking) have higher odds of poor mental health outcomes as compared to adolescents that do not engage in risk-taking behaviors?"

3.3 Hypothesis

It was hypothesized that there are higher rates of poor mental health outcomes for adolescent males in the sampled population because of their repressed emotions and risk-taking behaviors.

3.4 Methods

3.4.1 Dependent Variable

The "considered suicide" variable was used to focus on the beginning stages of suicide and was also coded as did consider suicide (0) and did not consider suicide (1). The "binge drinking" variable was preferred due to the stigmas of aggression and drinking. It was recoded by measuring that they were binge drinking (1) or were not binge drinking (0). Binge drinking, in this study, is considered to be drinking 4 or more drinks; this was the variable Q45.

3.4.2 Masculinity

Hegemonic masculinity, as an independent variable, was operationalized as underage alcohol consumption, drinking and driving, and aggression. Though masculinity cannot be measured directly, this study operationalized hegemonic masculinity via aggressive actions perpetuated, such as aggressive behavior and unhealthy practices related to alcohol consumption. The masculine traits in the codebook were operationalized as (Q40) "During your life, on how many days have you had at least one drink of alcohol?", (Q41) "How old were you when you had your first drink of alcohol other than a few sips?", (Q42) "During the past 30 days, on how many days did you have at least one drink of alcohol?", (Q44) "During the past 30 days, on how many days did you have 4 or more drinks of alcohol in a row (if you are female) or 5 or more drinks of alcohol in a row (if you are male)?", and (Q45) "During the past 30 days, what is the largest number of alcoholic drinks you had in a row?" The "aggression" variable was used to focus on fighting and the use of drugs/alcohol before sex.

3.4.3 Other Independent Variables

The independent variables were considered to be binge drinking and drinking and driving. Other independent variables included sex, race, and ethnicity (Hispanic/Latino status).

Race was coded as letters and given numbers where A became 1=American Indian, B became 2=Asian, C became 3=Black, D became 4=Native Hawaiian/ Other, and E became 6=more than one race. Age was not included as a variable because the study only focused on adolescents ages 13-17. All variables were dummy coded (0 = no, 1 = yes). The dummy coding was used to represent the categorical responses and to facilitate the analysis in the regression models.

3.5 Analytic Strategy

This study aimed to discuss the relationship between sex, risk-taking behaviors, and mental health to reveal underlying repressive emotions amongst boys/men that has implications for how we measure, assess, and intervene with regard to mental health in adolescent boys. Univariate, bivariate, and multivariate analyses were conducted. Several chi-square tests were conducted to compare variables to the prior research that finds higher rates of poor mental health in men and to identify possible relationships between mental health factors and masculinity. Three binary logistic regression models were conducted, which were used to compare binary responses and to predict future outcomes of mental health; this was used to examine different categories of mental health and masculinity. Each model included factors that measure hegemonic masculinity as operationalized as underage alcohol consumption, drinking and driving, and aggression.

CHAPTER FOUR: RESULTS

To investigate mental health and hegemonic masculinity, it was important to examine the variables that make up those topics. Table 1 shows the descriptive statistics of the variables used for the study. Due to missing and/or skipped responses, the sample sizes differ.

Table 1: Descriptive Statistics

Variable	Measure	Portions	N
Mental Health			
Considered Suicide	Yes	17.60%	10,280
	No	82.40%	
Feeling Sad or Hopeless	Yes	31.61%	12,634
	No	68.39%	
Difficulty Concentrating	Yes	32.30%	9,074
	No	67.70%	
Masculinity			
Binge Drinking	Yes	13.31%	8,690
	No	86.69%	
Drinking and Driving	Yes	2.60%	11,925
	No	97.40%	
Aggression: Fighting	Yes	23.75%	10,280
	No	76.25%	
Use of Drugs/Alcohol Before Sex	Yes	6.02%	11,482
	No	93.98%	
Sociodemographics			
Gender	Male	48.07%	12,780
	Female	51.93%	
Race	Non-white	48.30%	12,829
	White	51.70%	
Ethnicity	Hispanic/ Latino	24.51%	12,670
	Not	75.49%	

The variables show that the respondents were generally less likely to report issues related to mental health, with only 17.60% who considered suicide, 31.61% had feelings of being sad or hopeless, and 32.30% had difficulty concentrating. This was also viewed for the masculinity and control variables. Those who engaged in binge drinking equaled 11.93%, 2.60% engaged in drinking and driving, 23.75% participated in fights, and 6.02% used drugs or drank alcohol before sex. The sample consisted of fewer males (48.07%) than females, fewer non-White respondents (48.30%) than White, and fewer Hispanic/Latino individuals than non-Hispanic/Latino (24.51%). The majority of respondents were White (51.70%), followed by Black (20.48%), more than one race (18.33%), Asian (4.73%), American Indian (3.03%), and Native Hawaiian/Other (1.71%).

To view possible relationships between mental health factors and masculinity, several chi-square tests were completed, shown in Table 2.

Table 2: Chi-Square of Mental Health and Masculinity

	Did Not / Did Binge	**Did Not / Did Drink+Drive**	**Did Not / Did Fight**	**No / Yes Sub**	**Female/ Male**	**White / Non-White**	**Not Hisp/Lat / Hisp/Lat**
Did not consider suicide	84.91% / 71.64%	82.90% / 68.67%	85.10% / 75.5%	83.18% / 69.49%	77.17% / 88.28%	81.96% / 82.87%	82.20% / 83.23%
Considered suicide	15.09% / 28.36%	17.10% / 31.33%	14.90% / 24.90%	16.81% / 30.51%	22.83% / 11.72%	18.04% / 17.13%	17.80% / 16.77%
Chi2	124.64**	41.10**	119.66**	83.13**	269.06**	1.82	1.71
n =	8,586	11,780	10,180	11,361	12,616	12,659	12,512
Did not feel sad or hopeless	71.81% / 53.31%	68.99% / 52.36%	71.31% / 59.17%	68.82% / 53.36%	58.87% / 78.86%	68.97% / 67.76%	69.31% / 65.48%
Did feel sad or hopeless	28.19% / 46.69%	31.01% / 47.64%	28.69% / 40.83%	31.18% / 46.64%	41.13% / 21.14%	31.03% / 32.24%	30.69% / 34.52%
Chi2	160.05**	37.02**	125.95**	70.48**	582.15**	2.12	15.68**
n =	8,593	11,758	10,187	11,349	12,594	12,634	12,496
Did not have difficulty concentrating	70.11% / 58.72%	68.09% / 60.19%	70.54% / 58.86%	68.32% / 55.12%	61.12% / 74.97%	68.64% / 66.61%	68.34% / 65.72%
Had difficulty concentrating	29.89% / 41.28%	31.91% / 39.81%	29.46% / 41.14%	31.68% / 44.88%	38.88% / 25.03%	31.36% / 33.39%	31.66% / 34.28%

	Did Not / Did Binge	**Did Not / Did Drink+Drive**	**Did Not / Did Fight**	**No / Yes Sub**	**Female/ Male**	**White / Non-White**	**Not Hisp/Lat / Hisp/Lat**
Chi2	54.55**	5.89*	1023**	37.96**	198.41**	4.25*	5.46*
n =	7,701		8,696	8,466	9,054	9,074	8,993

Note: Sub=substance (alcohol/drug) use before sex. @ *$p < .05$, **$p<.01$

The first tests ran for chi-square and looked at masculinity factors related to an individual who considered suicide. A chi-square test was the most appropriate test because it measures how well the observed distribution of data fits with the independent variables. All variables except a person's race and ethnicity were significant in a person's consideration. Those factors that did have a relationship were binge drinking, drinking and driving, aggression, being male, and the consumption of alcohol or drugs before sex. Those who participated in binge drinking were more likely (28.36%) to consider suicide than those who did not (15.09%). We can see that those who engaged in drunk driving had a higher than average rate of considering suicide at 31.33% compared to those who did not drink and drive (17.10%). Respondents that engaged in fights (24.90%) compared to those who did not (14.90%), and respondents that used drugs or alcohol before sex (30.51%) compared to those who did not (16.81%) were both more likely to consider suicide. Respondents who were male, as a whole, (male at 11.72% compared to female at 22.83%) were less likely to consider suicide.

The second set of chi-square results examined masculinity factors and their association to feeling sad and/or hopeless. Every variable in the model was significant, except for race, in possibly influencing a person's feelings of sadness or hopelessness. Binge drinking (46.69% compared to those who did not at 28.19%), drinking and driving (47.64% compared to those who did not at 31.01%), fighting (40.83% compared to those who did not at 28.69%), using drugs or alcohol before sex (46.64% compared to those who did not at 31.18%), and being Hispanic/Latino (34.52% compared to non-Hispanic/Latino participants at 30.69%) were less likely of feeling sad or hopeless than those of the opposite spectrum. Males (21.14% compared to females at 41.13%) were less likely of feeling sad and/or hopeless.

The third set of chi-square tests viewed masculinity factors and difficulty concentrating. All variables in model 3 were significant. Those who participated in binge drinking were more likely (41.28%) to have difficulty concentrating than those who did not (29.89%). Respondents who engaged in drunk driving had a higher-than-average rate of considering suicide at 39.81% compared to those who did not drink and drive at 31.91%. Those who engaged in fights (41.14% compared to those who did not at 29.46%), used drugs or alcohol before sex (44.88% compared to those who did not at 31.68%), were non-White (33.39% compared to White at 31.36%), and were Hispanic/Latino (34.28% compared to non-Hispanic/Latino participants at 31.66%) all had a higher-than-average rate of difficulty concentrating. Male respondents (25.03% compared to female at 38.88%) were less likely to have difficulty concentrating.

Three models, all of which were binary logistic regressions, were conducted to examine different categories of mental health and masculinity (see Table 3). Model 1 looked at those who considered suicide, model 2 explored those who had feelings of sadness or hopelessness, and model 3 examined respondents who had difficulty concentrating. Each model included factors that measure hegemonic masculinity.

Table 3: Logistic Regression of Mental Health and Masculinity

Dependent Variable	**Independent Variable**	**Odds Ratio**	**SE**	**CI**
Model 1: Considered Suicide				
	Binge Drinking	1.49**	.14	1.25/1.78
LR Chi2: 367.25	Drinking and Driving	1.34	.24	.93/1.92
p-value: .000	Aggression: Fighting	2.13**	.16	1.84/2.46
R-square: .054	Use of Drugs/Alcohol Before Sex	1.62**	.21	1.27/2.08
n: 7,395	Male	.41**	.03	.36/.47

Dependent Variable	Independent Variable	Odds Ratio	SE	CI
	Non-White	.85*	.06	.74/.97
	Hispanic/Latino	.89	.07	.77/1.03
Model 2: Feeling Sad or Hopeless				
	Binge Drinking	1.57**	.13	1.34/1.84
LR Chi2: 589.57	Drinking and Driving	1.37	.23	.98/1.91
p-value: .000	Aggression: Fighting	2.04**	.13	1.79/2.31
R-square: .064	Use of Drugs/Alcohol Before Sex	1.39**	.16	1.11/1.75
n: 7,394	Male	.35**	.02	.31/.39
	Non-White	.99	.05	.89/1.11
	Hispanic/Latino	1.15*	.07	1.02/1.30
Model 3: Difficulty Concentrating				
	Binge Drinking	1.22*	.10	1.03/1.44
LR Chi2: 319.56	Drinking and Driving	1.07	.19	.76/1.51
p-value: .000	Aggression: Fighting	1.97**	.13	1.74/2.25
R-square: .038	Use of Drugs/Alcohol Before Sex	1.48**	.18	1.17/1.87
n: 6,763	Male	.47**	.03	.42/.53
	Non-White	1.03	.06	.93/1.15
	Hispanic/Latino	1.12	.07	.99/1.27

Note: SE = standard error. CI = Confidence Interval @ *$p < .05$, **$p<.01$.

Further examination of each independent variable was conducted using predicted probabilities (see Table 4). Predicted probabilities indicate that when all other variables are held at their mean level, there is a percent of adolescents that considered suicide, felt sad and/or hopeless, or had difficulty concentrating given different levels of the independent variables within each model.

Table 4: Predicted Probabilities

Dependent Variable	Independent Variable	Predicted Probability
Model 1: Considered Suicide	Binge Drinking	
	Yes	21.95%
	No	16.11%
n: 7,395		
	Drinking and Driving	-----
	Yes	
	No	
	Aggression: Fighting	
	Yes	26.09%
	No	14.61%
	Use of Drugs/Alcohol Before Sex	
	Yes	23.92%
	No	16.55%
	Male	10.98%
	Female	22.64%
	Non-White	15.80%
	White	18.02%
	Hispanic/ Latino	-----
	Not Hispanic/ Latino	
Model 2: Feeling Sad or Hopeless	Binge Drinking	
	Yes	39.18%
	No	29.77%
n: 7,394		
	Drinking and Driving	-----
	Yes	
	No	
	Aggression: Fighting	
	Yes	42.93%
	No	27.95%
	Use of Drugs/Alcohol Before Sex	
	Yes	37.51%
	No	30.69%
	Male	20.05%

Dependent Variable	Independent Variable	Predicted Probability
	Female	41.09%
	Non-White	-----
	White	
	Hispanic/ Latino	33.20%
	Not Hispanic/ Latino	30.34%
Model 3: Difficulty Concentrating	Binge Drinking	
	Yes	34.90%
	No	30.72%
n: 6,763		
	Drinking and Driving	-----
	Yes	
	No	
	Aggression: Fighting	
	Yes	43.05%
	No	28.16%
	Use of Drugs/Alcohol Before Sex	
	Yes	39.27%
	No	30.83%
	Male	23.32%
	Female	38.62%
	Non-White	-----
	White	
	Hispanic/ Latino	-----
	Not Hispanic/ Latino	

Model 1 contributed to an understanding of mental health related to consideration of suicide. This was determined using the likelihood ratio chi-square statistic of 367.25 and a *p* value of .000. Although the model is considered weak (R-square = .054), there were several significant relationships with the independent variables. Binge drinking, fighting, the use of alcohol or drugs before sex, being male, and race were related to the odds of considering suicide.

Compared to those who did not binge drink, the odds of considering suicide were higher for those who participated in binge drinking by a factor of 1.49, controlling for all other factors in the model. The odds of considering suicide was higher for those who participated in fights, compared to those who did not, by a factor of 2.13. The odds of considering suicide for respondents who used alcohol or drugs before sex was 1.62 times higher than those who didn't, while controlling for all other factors in the model. Interestingly, compared to females, the odds of considering suicide were lower for males by a factor of .41, controlling for all other variables. The odds of considering suicide were also .85 times lower for those who identified as non-White compared those who were White, controlling for other variables in the model. Further exploration was necessary using predicted probabilities.

The predicted probability of considering suicide for those who participated in binge drinking was 21.94%, compared to those who did not at 16.11%, when all other variables were held constant. The predicted probability of considering suicide for respondents who got in fights was 26.09%, compared to those who did not fight, with a predicted probability of 14.61%. Individuals who used alcohol or drugs before sex had a predicted probability of considering suicide at 23.92%. In contrast, the predicted probability of those who did not use substances before sex was 16.55%. The predicted probability of considering suicide for males was 10.98%, compared to females at 22.64%. In addition, the findings in terms of racial demographics were interesting. Respondents who were not White had a predicted probability of considering suicide at 15.80%, compared to White respondents at 18.02%, when all other variables were held constant.

Model 2 also contributed to an understanding of mental health but focused on those who have feelings of sadness or hopelessness. This was determined using the likelihood ratio chi-

square statistic of 589.57 and a *p* value of .000. The model is considered weak (R-square = .064), but there were significant relationships between those who participated in binge drinking, were involved in fights, used alcohol or drugs before sex, and were male and Hispanic or Latino. Compared to those who did not binge drink, the odds of feeling sad or hopeless were higher for those who binge drink by a factor of 1.57, controlling for all other factors in the model. The odds of feeling sad or hopeless were higher for those who participated in fights, compared to those who did not, by a factor of 2.04. The odds of feeling sad or hopeless for respondents who used alcohol or drugs before sex were 1.39 times higher than those who didn't, while controlling for all other factors in the model. Compared to females, the odds of feeling sad or hopeless were lower for males by a factor of .35, controlling for other variables. The odds of these feelings were 1.15 times higher for those who identified as Hispanic or Latino, compared to those who did not.

Stata, the statistical software used in this study, provided the predicted probability of feeling sad or hopeless for those who participated in binge drinking as 39.18%, compared to those who did not at 29.77%, when all other variables were held constant. The predicted probability of feeling sad or hopeless for respondents who got in fights was 42.93%, compared to those who did not get in fights, with a predicted probability of 27.95%. Individuals who used alcohol or drugs before sex had a predicted probability of feeling sad or hopeless at 37.51%. In contrast, the predicted probability of those who did not use substances before sex was 30.69%. The predicted probability of feeling sad or hopeless for males was 20.05%, compared to females at 41.09%. The predicted probability of feeling sad or hopeless for individuals who identified as Hispanic or Latino was 33.20%, compared to those who did not identify as such at 30.34%.

Additionally, model 3 contributed to an understanding of mental health in relation to having difficulty concentrating. This was determined using the likelihood ratio chi-square statistic of 319.56 and a *p* value of .000. The model is considered weak (R-square = .038) and had significant relationships with those involved in binge drinking, fights, use of alcohol or drugs before sex, and male sex. Compared to the individuals who did not binge drink, the odds of having difficulty concentrating were higher for individuals who participated in binge drinking by a factor of 1.22, controlling for all other variables in the model. Compared to respondents who did not get into fights, the odds of having difficulty concentrating were higher for individuals who were in fights by a factor of 1.97, controlling for all other factors in the model. The odds of having difficulty concentrating were higher for those who used alcohol or drugs before sex, compared to those who didn't, by a factor of 1.48, controlling for all other factors. The odds of having difficulty concentrating for males was .47 times lower than females, while controlling for all other factors in the model.

Individuals who participated in binge drinking had a predicted probability of having difficulty concentrating at 34.90%. In contrast, the predicted probability of those who did not use substances before sex was 30.72%. Having difficulty concentrating for individuals who got into fights was 43.05%, compared to people who did not at 28.16%, when all other variables were held constant. The predicted probability of having difficulty concentrating for respondents who used alcohol or drugs before sex was 39.27%, when all other variables were held constant. Respondents who did not use substances before sex equaled 30.83%. Individuals who were male had a predicted probability of having difficulty concentrating at 23.32%, compared to females at 38.62%, when all other variables were held constant.

CHAPTER FIVE: CONCLUSION

During my time at the juvenile detention center, I worked with many kids that had a burning desire to become better – in a new sense of the word. I realized very quickly that the boys and men in this program were frequently suffering from more than just their confinement. The stigma of vulnerability in men throughout their upbringing has frequently been swept under the rug. The relic of previous generations' lack of acknowledgement of mental health has become increasingly outdated as we learn more and recognize the importance of mental health. Results of this study suggest that there's a significant relationship between masculinity factors and their association to feeling sadness and/or hopelessness. Using the 2017 Youth Risk Behavior Survey (YRBS), this study has identified a consistent trend for modern adolescent boys moving into adulthood who exhibit the same continual habits of negative masculine norms, such as restricted behaviors (e.g., crying) and proceeding with negative behaviors like binge drinking, drinking and driving, and aggression.

Masculinity has a close connection to the ways in which men are brought up. Social stereotypes of having to be strong and quiet about personal sentiments have created a social genre that's encouraged poor mental health outcomes amongst men. Men being more likely to underreport symptoms of things like depression, suicidal thoughts, etc., can lead to substance misuse (Call et al., 2018). This paper's analysis stands to emphasize and acknowledge the ways in which boys and men repress their emotions creating underreporting of poor mental health outcomes. The research did appear to fall in line with my hypothesis and with previous literature: men suffer from poor mental health outcomes and that can be seen in the ways they under report and in the direct connection to suicide rates. A "gender gap" exists in the general population,

with women receiving diagnoses of depression at approximately twice the rate of men (Englar-Carlson, 2006). As it stands, the data outlines that females have higher odds of considering suicide in comparison to males (controlling for other variables). This does not stand to negate that men also are likely to consider suicide and to face poor mental health outcomes. It's also been suggested that men with poor mental health outcomes devolve to an internal conflict because their experience of gender role conflict is predictive of an increase in depressive symptoms while simultaneously decreasing the likelihood of seeking out treatment (Good & Wood, 1995). This internalized conflict can lead to reifying gender roles.

This study's findings are consistent with literature on mental health in relation to men. For example, the literature has outlined that men and boys are less likely to report depressive symptoms when they end up seeking care (Courtenay, 2000), which has been confirmed by the research. Moreover, the literature discussed significant associations between masculine factors and men's aggressive behavior (Leone & Parrott, 2018), which is apparent in this study's findings. This study has identified significant relationships with those who binge drink, are involved in fights, use alcohol or drugs before sex, and are male; thus, the study confirms that boys may be more inclined than girls to engage in an injury-risk activity, just as Morrongiello and Rennie (1998) found in their research. Additionally, it's important to recognize the varying ways that may have, in part, impacted the results to create underreporting. In identifying underreporting in relation to risk-taking behaviors, adolescents that have already given in to excessive risk-taking behaviors, the nation's population of youth tested in the survey is also impacted by adolescents that are already incarcerated in detention centers. In the same vain, adolescents that have also made the choice to commit suicide, in partial recognition of mental health outcomes, are also not included in the sample analyzed for the results.

The study emphasizes the important of mental health amongst all adolescents, especially as we gauge more current research and the rise in poor mental health outcomes (Hertz & Barrios, 2020). Schools can develop referral programs that provide equal access to services and supports. Additionally, unconscious bias training can also heavily impact the way teachers and staff interact with students and to assist with identifying students that are likely to need intervention with students. Early intervention services for students to deal with anxiety, anger, and sadness can lead to improved mental health outcomes as well.

Though this study provides information regarding mental health in adolescent youth, there are certain limitations that are important to note. Since this data was collected as secondary data, we did not have the capability to control for the questions found in the study, the formatting of the collection of data, or methodology behind the data acquisition. Some participants skipped certain questions, which accounted for some variance in *N*. Schools could also opt out of assigning this survey, which also accounted for a gap in understanding national data. Reporting procedures varied from state to state with respect to parental consent and permissions.

Additionally, this data was self-reported by students, which means there is no way to account for under- or over-reporting. Self-reported answers may be exaggerated, and respondents may be too embarrassed to reveal private details or could be self-conscious of details. Various biases may have affected the results, such as not considering racial, cultural, and familial factors. Moreover, due to the nature of the data having been collected in 2017, there are now more updated survey results that would closely interpret more recent data. The 2021 Youth Risk Behavior Survey will include new mental health and household financial instability questions, and questions that examine the impact of the COVID-19 pandemic. The 2019 Youth Risk Behavior Survey data has outlined a significant “increase in adolescent related suicide-related

behaviors and feelings of sadness or hopelessness" (Hertz & Barrios, 2020). In noting that many respondents were less likely to report issues related to mental health, it's imperative to identify the factors that played a significant relationship in the survey data: drinking, drinking and driving, aggression, being male, and the consumption of alcohol or drugs before sex.

Future research should examine the significance of other more expressive levels of suicide; girls often suffer from more internalized mental health concerns like depression while "boys' mental health outcomes are more often external – involving antisocial behavior and substance abuse disorders" (Brännlund & Edlund, 2017, p. 333). In regard to the theory on symbolic interactionism, recognition of the need for more open and positive relationships with the people around boys in their academic institutions may lead to better mental health outcomes. Langeland et al.'s (2019) study examined differences in health-related qualities of life between boys and girls in their secondary school experiences (3 years) and outlined the significant decrease in health-related quality of life over a 3-year period in both boys and girls. This study supports previous literature on masculinity; the results outline a correlation between poor mental health outcomes in relation to adolescent masculinity (Langeland et al., 2019). In our understanding of symbolic interactionism, gender roles are socialized and granted meaning in the dynamics of the relationships between people. It may be beneficial to look directly at adolescents that have a history of poor mental health or adolescents that are directly experiencing depression. Future research should also focus on more than just one year of data to reference generational differences/distinctions.

In consideration for future research, in thinking about underreporting for adolescent boys, there's also room to recognize the significance of how race and ethnicity came to not show a significant place in the study's outcomes. Race and ethnicity variables parallel the

underreporting of boy's mental health outcomes; Connell (2005) discusses "marginalized masculinities" as they relate to hegemonic masculinity. Future research should identify age/race/ethnicity of students to see if the approach in questioning different communities will attribute to differing responses/results.

Additionally, future research should also consider mentioning the additional risk factors that can potentially exist due to the effects of isolation due to the COVID-19 pandemic in which boys and men may also exhibit additional mental health stress. This specific period of isolation can create a significant barrier to accessing mental health resources amongst those who are less likely to seek professional assistance. The amount of telehealth resources that have become accessible during the pandemic has increased significantly and while there is "robust evidence to support the efficacy of telemental health as an effective means of delivering treatment for mental health conditions, including depression, substance use disorder, and suicidal ideation, it may not be universally desirable and effective, and there are barriers to access (e.g., Internet subscriptions) in under-resourced communities" (Czeisler et al., 2021, p. 305), which poses a significant risk to adolescents and young adults.

Socialization to gender norms plays a significant impact in shaping adolescent's views about mental health and help-seeking. As we move towards a more technologically accessible community of adolescents surpassing "generation Z," integrating positive social media interventions based on social learning theory should be designed and implemented to evaluate the impact on adolescent's comprehension of mental health and their views on help-seeking as it becomes more widely accepted and encouraged. Schools are very instrumental for harvesting positive emotional connections and positive attitudes can help promote positive mental health outcomes.

APPENDIX A
CODEBOOK QUESTIONS AND PRELIMINARY NUMBERS

Questions for Updated Codebook	**Preliminary Numbers**
Q2: What is your sex?	sex Freq. Percent Cum. Male 7,526 51.41 51.41 Female 7,112 48.59 100.00 Total 14,638 100.00
Q4: Are you Hispanic or Latino?	HispanicLatino Freq. Percent Cum. Yes 3,653 25.18 25.18 No 10,857 74.82 100.00 Total 14,510 100.00
Q5: What is your race? A. American Indian or Alaska Native B. Asian C. Black or African American D. Native Hawaiian or Other Pacific Islander E. White	Race Freq. Percent Cum. H 6 0.05 0.05 F 3 0.02 0.07 E 7,519 57.63 57.70 E G 1 0.01 57.71 EF 1 0.01 57.72 D 252 1.93 59.65 DE 47 0.36 60.01 C 3,053 23.40 83.41 C E 283 2.17 85.58 CD 40 0.31 85.89 CDE 11 0.08 85.97 B 725 5.56 91.53 B H 1 0.01 91.54 B E 120 0.92 92.46 B D 31 0.24 92.70 B DE 20 0.15 92.85 BC 50 0.38 93.23 BC E 13 0.10 93.33 BCD 6 0.05 93.38 BCDE 1 0.01 93.38 A 458 3.51 96.90 A F 1 0.01 96.90 A E 185 1.42 98.32 A D 10 0.08 98.40 A DE 6 0.05 98.44 A C 89 0.68 99.13 A C E 57 0.44 99.56

	A CD 4 0.03 99.59 A CDE 6 0.05 99.64 AB 5 0.04 99.68 AB E 10 0.08 99.75 AB D 1 0.01 99.76 AB DE 1 0.01 99.77 ABC 3 0.02 99.79 ABC E 8 0.06 99.85 ABCD 2 0.02 99.87 ABCDE 17 0.13 100.00 Total 13,046 100.00
Q17: During the past 12 months, how many times were you in a physical fight? A/1. 0 times B/2. 1 time C/3. 2 or 3 times D/4. 4 or 5 times E/5. 6 or 7 times F/6. 8 or 9 times G/7. 10 or 11 times H/8. 12 or more times	PhysFighting Freq. Percent Cum. 1 9,239 76.63 76.63 2 1,241 10.29 86.92 3 947 7.85 94.77 4 247 2.05 96.82 5 113 0.94 97.76 6 64 0.53 98.29 7 34 0.28 98.57 8 172 1.43 100.00 Total 12,057 100.00
Q18: During the past 12 months, how many times were you in a physical fight on school property? A/1. 0 times B/2. 1 time C/3. 2 or 3 times D/4. 4 or 5 times E/5. 6 or 7 times F/6. 8 or 9 times G/7. 10 or 11 times H/8. 12 or more times	PhysFightingAtSchool Freq. Percent Cum. 1 13,177 91.01 91.01 2 810 5.59 96.61 3 304 2.10 98.71 4 66 0.46 99.16 5 27 0.19 99.35 6 8 0.06 99.41 7 7 0.05 99.45 8 79 0.55 100.00 Total 14,478 100.00
Q23: During the past 12 months, have you ever been bullied on school property?	BulliedAtSchool Freq. Percent Cum. Yes 2,665 18.25 18.25 No 11,941 81.75 100.00

	Total 14,606 100.00
Q24: During the past 12 months, have you ever been electronically bullied? (Count being bullied through texting, Instagram, Facebook, or other social media.)	EBullying Freq. Percent Cum. Yes 2,113 14.48 14.48 No 12,482 85.52 100.00 Total 14,595 100.00
Q10: During the past 30 days, how many times did you drive a car or other vehicle when you had been drinking alcohol? A/1. Did not drive B/2. 0 times C/3. 1 time D/4. 2 or 3 times E/5. 4 or 5 times F/6. 6 or more times	DrinkDrive Freq. Percent Cum. 1 5,627 41.09 41.09 2 7,606 55.54 96.63 3 226 1.65 98.28 4 125 0.91 99.19 5 26 0.19 99.38 6 85 0.62 100.00 Total 13,695 100.00
Q40: During your life, on how many days have you had at least one drink of alcohol? A/1. 0 days B/2. 1 or 2 days C/3. 3 to 9 days D/4. 10 to 19 days E/5. 20 to 39 days F/6. 40 to 99 days G/7. 100 or more days	OneDrink Freq. Percent Cum. 1 5,528 40.12 40.12 2 2,384 17.30 57.42 3 2,276 16.52 73.94 4 1,292 9.38 83.32 5 951 6.90 90.22 6 656 4.76 94.98 7 692 5.02 100.00 Total 13,779 100.00
Q41: How old were you when you had your first drink of alcohol other than a few sips? A/1. I have never had a drink of alcohol other than a few sips B/2. 8 years old or younger C/3. 9 or 10 years old D/4. 11 or 12 years old E/5. 13 or 14 years old F/6. 15 or 16 years old G/7. 17 years old or older	FirstDrink Freq. Percent Cum. 1 5,995 44.06 44.06 2 674 4.95 49.02 3 545 4.01 53.02 4 951 6.99 60.01 5 2,352 17.29 77.30 6 2,607 19.16 96.46 7 482 3.54 100.00 Total 13,606 100.00

Q42: During the past 30 days, on how many days did you have at least one drink of alcohol? A/1. 0 days B/2. 1 or 2 days C/3. 3 to 5 days D/4. 6 to 9 days E/5. 10 to 19 days F/6. 20 to 29 days G/7. All 30 days	MinOneDrink	Freq.	Percent	Cum.
	1	9,224	71.04	71.04
	2	2,103	16.20	87.24
	3	808	6.22	93.46
	4	451	3.47	96.93
	5	260	2.00	98.94
	6	59	0.45	99.39
	7	79	0.61	100.00
	Total	12,984	100.00	
Q43: During the past 30 days, how did you usually get the alcohol you drank? A/1. Did not drink in past 30 days B/2. Bought in store C/3. Bought in restaurant D/4. Bought at public event E/5. I gave someone money to buy F/6. Someone gave it to me G/7. Took from a store/family H/8. Some other way	PurchaseDrink		Freq.	Percent Cum.
	1	7,317	70.42	70.42
	2	143	1.38	71.80
	3	41	0.39	72.19
	4	24	0.23	72.43
	5	582	5.60	78.03
	6	1,324	12.74	90.77
	7	388	3.73	94.50
	8	571	5.50	100.00
	Total	10,390	100.00	
Q44: During the past 30 days, on how many days did you have 4 or more drinks of alcohol in a row (if you are female) or 5 or more drinks of alcohol in a row (if you are male)?	4PlusDrink	Freq.	Percent	Cum.
	0da	11,903	87.04	87.04
	1da	581	4.25	91.29
	2da	452	3.31	94.60
	3-5da	407	2.98	97.57
	6-9da	174	1.27	98.84
	10-19	80	0.59	99.43
	20+da	78	0.57	100.00
	Total	13,675	100.00	
Q45: During the past 30 days, what is the largest number of alcoholic drinks you had in a row?	DrinksInRow	Freq.	Percent	Cum.
	None	7,428	73.35	73.35
	1-2 dr	1,033	10.20	83.55
	3 dr	173	1.71	85.26
	4 dr	199	1.97	87.22
	5 dr	347	3.43	90.65
	6-7 dr	378	3.73	94.38

	8-9 dr 175 1.73 96.11 10+ dr 394 3.89 100.00 Total 10,127 100.00
Q63: Did you drink alcohol or use drugs before you had sexual intercourse the last time?	DrinkSex Freq. Percent Cum. Never 8,017 60.78 60.78 Yes 911 6.91 67.68 No 4,263 32.32 100.00 Total 13,191 100.00
Q25: During the past 12 months, did you ever feel so sad or hopeless almost every day for two weeks or more in a row that you stopped doing some usual activities?	MentalHealth2 Freq. Percent Cum. Yes 4,631 31.88 31.88 No 9,896 68.12 100.00 Total 14,527 100.00
Q26: During the past 12 months, did you ever seriously consider attempting suicide?	SuicideConsider Freq. Percent Cum. Yes 2,571 17.67 17.67 No 11,982 82.33 100.00 Total 14,553 100.00
Q27: During the past 12 months, did you make a plan about how you would attempt suicide?	SuicidePlan Freq. Percent Cum. Yes 2,030 13.96 13.96 No 12,511 86.04 100.00 Total 14,541 100.00
Q28: During the past 12 months, how many times did you actually attempt suicide? A/1. 0 times B/2. 1 time C/3. 2 or 3 times D/4. 4 or 5 times E/5. 6 or more times	SuicideAttempt Freq. Percent Cum. 1 9,849 92.17 92.17 2 411 3.85 96.01 3 278 2.60 98.62 4 63 0.59 99.20 5 85 0.80 100.00 Total 10,686 100.00
Q29: If you attempted suicide during the past 12 months, did any attempt result in an injury,	SuicideInjury Freq. Percent Cum.

poisoning, or overdose that had to be treated by a doctor or nurse? A/1. I did not attempt suicide during the past 12 months B/2. Yes C/3. No	1 9,779 92.08 92.08 2 286 2.69 94.77 3 555 5.23 100.00 Total 10,620 100.00
Q98: Because of a physical, mental, or emotional problem, do you have serious difficulty concentrating, remembering, or making decisions?	MentalHealthCon Freq. PercentCum. Yes 3,445 32.29 32.29 No 7,223 67.71 100.00 Total 10,668 100.00

APPENDIX B
IRB NOT HUMAN RESEARCH

UNIVERSITY OF CENTRAL FLORIDA

Institutional Review Board
FWA00000351
IRB00001138, IRB00012110
Office of Research
12201 Research Parkway
Orlando, FL 32826-3246

NOT HUMAN RESEARCH DETERMINATION

July 17, 2020

Dear Yesenia Conde:

On 7/17/2020, the IRB reviewed the following protocol:

Type of Review:	Initial Study
Title of Study:	"BAD BOYS" TO BIGGER PROBLEMS
Investigator:	Yesenia Conde
IRB ID:	STUDY00001903
Funding:	None
Grant ID:	None
Documents Reviewed:	• HRP-251- FORM - Faculty Advisor Scientific-Scholarly Review fillable form (1).pdf, Category: Faculty Research Approval; • Data Collection Form.docx, Category: Other; • HRP 250 Form, Category: IRB Protocol;

The IRB determined that the proposed activity is not research involving human subjects as defined by DHHS and FDA regulations.

IRB review and approval by this organization is not required. This determination applies only to the activities described in the IRB submission and does not apply should any changes be made. If changes are made and there are questions about whether these activities are research involving human in which the organization is engaged, please submit a new request to the IRB for a determination. You can create a modification by clicking **Create Modification / CR** within the study.

If you have any questions, please contact the UCF IRB at 407-823-2901 or irb@ucf.edu. Please include your project title and IRB number in all correspondence with this office.

Due to current COVID-19 restrictions, in-person research is not permitted to begin until you receive further correspondence from the Office of Research stating that the restrictions have been lifted.

Sincerely,

Kanilla C. Berkbeck

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