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## Needs and Preferences for Receiving Mental Health Information in an African American Focus Group Sample

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### Abstract

The purpose of this study is to better understand the mental health/illness information and service delivery preferences among African American residents of Baltimore. We conducted four focus groups (n=42) among African American adults currently unconnected with the mental health system. Participants expressed fear of stigma and perceptions of racism as major barriers to seeking information and/or services and discussed some normalizing strategies to address these barriers. African Americans harbor cultural and traditional beliefs regarding mental illness which could also act as barriers. Findings have implications for imparting acceptable and culturally-sensitive mental health education and service delivery programs in community settings.

### Keywords

mental health; minority health; help-seeking; stigma; health information; qualitative research

## INTRODUCTION

African Americans face disparities in the recognition and treatment of mental health problems (Borowsky et al., 2000; Diala et al., 2001; Fiscella, Franks, Doescher, & Saver, 2002; Hines-Martin, Malone, Kim, & Brown-Piper, 2003; Miranda & Cooper, 2004), which lead to a host of otherwise avoidable negative outcomes. Despite similarity in the incidence of mental illness across racial and ethnic groups, minorities have a greater burden of unmet mental health needs (U.S. Department of Health and Human Services, 2001), due in varying degrees to patient, provider, and health system barriers (Borowsky et al., 2000; Cooper-

Patrick et al., 1999; Diala et al., 2001; Hines-Martin et al., 2003; Katon, von Korff, Lin, Bush, & Ormel, 1992; U.S. Department of Health and Human Services, 2001).

Stigma, a term that conveys prejudice or negative stereotypes, may play an important role in mental health disparities. African Americans hold more stigmatizing attitudes toward mental illness than do whites (Anglin, Link, & Phelan, 2006; Gary, 2005). African Americans are more likely than whites to perceive the mentally ill as dangerous (Anglin et al., 2006), although they are less likely to endorse blaming and punishing the mentally ill. Even so, seeking treatment for mental health problems may be less culturally acceptable for African Americans who worry about appearing spiritually weak to family members or peers (Cooper-Patrick et al., 1997; Schnittker, Freese, & Powell, 2000) and report a fear of treatment including institutionalization (Sussman, Robins, & Earls, 1987). Fear of stigma may influence patient preferences for how mental health information is received and accessed.

Not much is known about specific mental health information needs of African Americans, nor how, by whom, and in what setting they wish the information conveyed. While studies consistently show that patients and family members of the mentally ill want more information, help communicating with service providers, greater involvement in decisions about their care, and desire good relationships with and better coordination among care providers (Noble & Douglas, 2004), there are very few studies that specifically investigate these needs among African Americans. In addition, there is little understanding about how information needs influence seeking access to mental health services before someone has an actual need to seek help (Alvidrez, 1999). How to provide mental health information in a culturally appropriate manner and address this information needs gap has not been well studied. Moreover, little is known about how African Americans draw on cultural models relating to health and illness to guide decision-making with respect to accessing and utilizing health care services.

One way to address mental health disparities is to develop approaches to care that are responsive to patient values, needs, and preferences. The purpose of this community-based study was to understand, from a group of African American urban residents unconnected with the mental health system, what mental health information needs they perceived, what barriers they faced in accessing information and services, their views of credible information sources, and the ways in which they most wanted to receive the information.

## **METHODS**

### **Study setting and sample**

We conducted the study in urban Baltimore, MD recruiting from and holding the focus groups at three local churches, a community center, and a university site. We used network sampling to invite African American men and women to participate in the focus groups. Eligibility criteria included being between 25–65 years of age, self-identified African American, not receiving treatment for any mental health or substance abuse problems in the 12 months prior to the study, and not being directly involved in the care of a relative or friend with a mental health or substance abuse problem. The Human Research Protections Office of the University of Maryland Baltimore approved all aspects of the research protocol, and participants indicated their consent by participating in the study after reviewing the disclosure form.

### **Focus group procedures**

We conducted five focus groups between March and April 2006, with each group comprised of 8–13 eligible African Americans. Data from the university site were not used in the

analysis due to the failure of our screening process to detect that many of the members were employed in a healthcare setting and thus not eligible for the study.

Led by an African American female moderator who was professionally trained in focus group methods, each group met for approximately two hours. Groups were audio-taped with consent of the participants. The moderator followed an interview guide (available upon request from the corresponding author) that touched on key areas of knowledge of mental illness, attitudes, help-seeking patterns (conventional and alternative) and overall information needs and preferences regarding mental health/illness.

The focus group process uses a method that encourages discussion in a non-threatening environment (Krueger, 1994, 1998), with the moderator often using appropriate probes to draw out the breadth of the discussion. The discussion began with questions about what all the participants had in common (all were African American) to highlight that the study sought specifically to hear from African Americans and then launched into a group discussion of what ‘mental health’ meant to them. This was followed by discussion of participants’ views of specific diagnoses and types of professionals and services, and other beliefs, values, and opinions about mental illness and mental health care. Although not all topics were covered in each group due to time constraints, most of the items contained in the interview guide were addressed. The moderator utilized follow-up questions and probes where necessary to pursue a particular discussion thread. The moderator was not trained in mental health and so did not correct misconceptions that were raised by the group members during discussion. Each participant received a \$50 gift card for his/her participation.

### Data analysis

A professional medical transcriber, who was not present at the time of the focus group, transcribed the audio recordings. The project team lead researcher (SM) and a graduate assistant then checked the transcripts for accuracy against the tape. Regarding analysis, the research team first reviewed each group transcript in detail to begin initial coding and analysis of the narratives. Transcripts were reviewed in their entirety so that we could get a sense of the interview flow and format. The research team met bimonthly to map out individual findings and to build and test consensus on the emerging themes. Since it was not possible to know which participant made a particular comment or if successive comments were made by one or several persons in the group, we decided to view all the responses to the questions raised by the moderator as ‘community’ responses rather than making individual attributions. This helped us answer the focal questions about whether the ‘community’ understood concepts of mental health and mental illness and how this understanding affected help seeking. It also helped us discern what the ‘community’ wanted in terms of information about mental health and illness.

Additionally, decisions were made regarding which part of the discussions provided the most density to answer our focal questions about help-seeking. We accomplished this by having teams of two researchers responsible for presenting interview themes from a single group with other team members serving in a questioning role around the presented themes to discern whether they appeared to ‘fit’ with our emerging notions around help-seeking. Team discussions led to an early categorization and indexing of themes in a visual display; this was followed by the task of each team member returning to their assigned group interviews to match individual quotations across the four focus groups with the emerging themes. Due to the small number of focus groups, no qualitative software was used in the analysis.

As the analysis proceeded data were additionally managed and reduced through the use of comparing and contrasting the narratives of the four focus groups and the categories which emerged. The practical model used is one developed by Krueger (Krueger, 1994; Rabiee,

2004). The research team reached consensus on the conceptual framework by reviewing the concordance, elaboration, and intensity of some of the responses to help-seeking while consistently being mindful of the context and make-up of our groups, that is, African Americans in an urban setting who were not directly in contact with the mental health services system.

## RESULTS

### Focus group participants' characteristics

In all, 42 African American men and women participated in the four focus groups. One group comprised only women; whereas there were two men each in two groups and four men in the last group. Table 1 presents socio-demographic characteristics of the participants. The majority of participants were female, single, had either some college level education or had graduated from college, in the workforce, and with private health insurance coverage.

Participants discussed information about mental health/ illnesses and information about accessing mental health *services* as one and the same. This was because, as some participants indicated, they did not see a need for mental health information unless they or a relative/friend were having mental or emotional problems. They did not differentiate between the two regarding information-delivery preferences or other issues. Therefore, discussions about mental health and information about accessing services are addressed together.

### Informational needs regarding mental illness

Despite an overall theme of not feeling a need to know about mental health until there is a perceived need, participants nonetheless readily listed topics of interest when asked what mental health information they would want. The following topics were repeatedly mentioned: how to recognize mental illnesses, how to prevent mental illnesses, how to help someone who is mentally ill or otherwise in emotional distress, how to get a correct diagnosis, what is and is not true about mental illnesses (stereotypes or myths vs. facts), and what is and is not true about mental health professionals and services.

### Preferences for how mental health information is conveyed

[First response]...If I didn't know about [mental illness] and I wanted to learn about it, I want to be in a place that was very comfortable. [Second response]... [invited] to some place by someone I trusted...I would say my church and...I know the people that are involved. [Third response]... Health fairs...with plenty of information and no questions asked...I should not have to answer questions about why...but someone should be on hand if maybe I have questions. (Group 4). If ... right then I needed to deal with what was happening before me, I could pick up the phone and call and ask questions and get information. (Group 3)

**1. Health information and/or services are better received if conveyed in a reassuring manner**—Participants gave many examples and preferences about *how* mental health information should be conveyed to African American communities in particular, and to the public in general. The most prominent overarching theme was that information be delivered in ways that feel *non-threatening* and *reassuring*.

I was at a health fair and they were doing screening for vision, high blood pressure, and they were also doing depression screening. I was like, I'm going on the other side of the room as far away from that little booth as I can because that's where the crazy people are going to be. But I'm thinking, if groups like this [focus groups] get

together and make people feel comfortable like we're not crazy, we just need somebody to talk to, to see if you're about at the edge or you can be helped...[then] some people would have went to that booth. (Group 1)

Participants specified five ways that this reassurance can take place (see Table 2 for exemplary quotations on aspects of reassurance). First, if information is available in ways that allow the person in need to remain *anonymous*, participants said it would be reassuring because there would be no chance of the person being stigmatized by their need for the information. Second, similar reassurance is possible if the person in need trusts that their identity and need for or receipt of the information (or services) will remain entirely *confidential*. Third, participants said that having mental health assistance available through people or settings that they are *familiar* with is the most likely way for the process to feel trustworthy and reassuring. Numerous participants suggested mental health information be offered through their neighborhood churches, local leaders, or other institutions within “our” community, by which they meant both geographic neighborhoods and (non-geographically bound) African American communities.

Fourth, participants noted that while familiarity and confidentiality or anonymity help, reassurance is also a matter of encountering *supportive* people providing the information—people who are pleasant and not judgmental, impatient, or punitive about one’s need for mental health information or services. Some felt that African Americans in particular are afraid of being coerced into treatment or institutionalized if deemed mentally ill and so are especially sensitive to the demeanor of service/information providers; others did not connect this fear to race. Fifth, a number of participants summed up the above by equating *multifaceted trust* with reassurance. They said that they would be most comfortable if they trust a person or source to give good quality information, treat them with respect, keep their confidences, and provide a comfortable setting.

## **2. Health information and/or services are better received if conveyed by a credible source**

—Related to reassurance but more content-driven, participants also said that to be well received mental health information and recommendations for services must come from *credible* sources. The participants enumerated several possible sources of credibility, and suggested that they are cumulative (see Table 3 for exemplary quotations on credibility of information source).

Being known as an *expert*, such as a medical doctor or research scientist was mentioned as a source of credibility, but a vocal minority of participants expressed considerable skepticism about doctor’s motives (“*pill pushing*”, “*just in it for money*”) and others felt that primary care doctors cannot be credible sources about mental health because they receive insufficient training in that area. Numerous participants also mentioned *celebrity* (being a well-known and respected public figure) as a source of credibility. Also, a source of information was more credible if the source “*looks like me*” meaning is African American because being of the same race gives a sense of trustworthiness. A few participants also expressed the opinion that the same effect held for gender – that same-gender sources might be seen as more credible.

Participants further felt that someone who is *known* to them – familiar and positively regarded such as a family doctor – is more credible. Similarly, some said that any source affiliated with their church would likely be credible because of its association with a familiar and trusted body. However, one participant noted that not everyone feels supported by their church or is even affiliated with a church, or is even Christian. Finally, some participants said that they would find people who “*have been there*” to be credible. That is, they want to receive information about mental illnesses and services from people who had been mentally

ill and experienced treatment, because they know what its like. However, at the same time, many participants expressed considerable fear of people with mental illnesses.

### **3. Health information and/or services are better received if they are accessible**

—Participants indicated that avenues for receiving information and mental health assistance or services must be *accessible*. Their comments included two types of accessibility. Some discussions focused on material or economic accessibility, such as the fear of not being able to afford care, not having transportation, not having health insurance that covered mental health services. Even more emphatic were participants about accessibility related to perceived power differences between themselves and mental health professionals. That is, some said that to be accessible information and services need to “*not talk over my head*” with medical jargon, and to avoid seeming coercive or threatening.

## **Barriers to receiving mental health information or services**

Although asking about barriers is in some ways simply the converse of asking about preferences, the focus group discussions about barriers added important insights into the underpinnings of the preferences summarized above. Accessibility issues were often the first ones elaborated when participants were asked explicitly about barriers—lack of money, insurance, unfamiliar impersonal settings, unpleasantly official or authoritarian seeming personnel or processes were mentioned most prominently. However, as the discussions unfolded, participants spent much more time and were even more emphatic talking about stigma and African American collective experiences as impeding their access to information and services. Therefore, the subsequent section focuses on these two topics.

### **1. Stigma**

[Confidentiality is] huge because of the stigma. I had to think about that. It goes back to the stigma and if we could answer questions in the general practitioner’s office according to a number versus your name, I’ll bet that would be a flood of questions pertaining to mental illness. (Group 4)

Stigma emerged as a central organizing concern, undergirding many preferences and barriers. It was sometimes difficult to discern which aspects of stigma participants believed personally versus those they perceived to be influential in the community but personally eschewed. However, the discussions made clear that either was enough to create barriers and the intense needs for anonymity, confidentiality, and reassurance discussed in sections above.

First, participants’ discussed the following stereotypes or myths as components of stigma that create fear of rejection, disrepute, and discrimination:

- The assumption or image that mental illness is contagious
- The assumption that people with mental illnesses are all dangerous and unpredictable
- The assumption that people with mental illness never recover, are hopeless
- Generalized fear of mental illnesses as unknown, unpredictable
- Shame and dishonor associated with mental illness because it is perceived to represent a personal weakness, a curse or stain, or sin
- The assumption that if one goes to a professional for mental health assistance one is likely to be labeled, pigeon-holed, and forced into treatment regardless of one’s wishes.

As a result, they described, people who believe the above assumptions or know that others around them do are profoundly afraid of being “found out,” because they fear the loss of “normal” status, the association with these assumptions, and the loss of relationships and opportunities that can follow. Participants then described this fear of stigma as leading people to hide their distress, symptoms, and need for help, to deny to one’s self or within a family or community that someone has a mental illness, to avoid professional mental health treatment because accessing it would “admit” that one has a mental illness, and to live in fear of being labeled or revealed.

For instance, one participant mentioned, *there’s no way back from mental illness. If I tell someone that I have a mental illness that’s it, I’m finished. There’s no way back. I can’t function anymore. They don’t trust themselves around me, they confront me. So I’m not going to tell them. They’ll write me off. (Group 5)*. Another participant indicated that, ... *Socially, if a person in your family had a mental disorder it was looked upon as something went awry or for the love of superstition or revenge kind of thing. They looked upon it like it was a curse from above or somebody in their family sinned and lost his honor. So people shunned people. Not just the individual but people related to them. (Group 3)*

An interesting caveat on the above is that participants drew a distinction between a person having “emotional problems” which are seen as less serious and less stigmatizing, and a person having a “mental illness,” with schizophrenia or psychosis as the worst and most dreaded. For example, one participant said, *mental illness is more terminal and I think emotional [problem] you can kind of recover from an emotional battle. (Group 3)* and another participant mentioned that, *emotional people can deal with better than mental because with the mental you think something is going to happen...like you might attack them or something like that. Whereas if it’s more emotional, I’ll just say get over it. (Group 3)*

**2. Historical and current racism as an aspect of stigma and as an additional barrier**—Historical and current racism came up in two main ways related to barriers. First, participants cited the effects of well-known historical incidents of profound racism (i.e., Tuskegee), of knowledge of racism in society generally, and of more localized experiences of disrespectful treatment in healthcare settings (of a friend, family, neighbor, one’s self) as barriers to African American’s seeking mental health care.

One participant said, *“I go back to trust again because the Tuskegee experiment was suppose to make these brothers feel real good...you see what happened to them. I’m like I don’t know you, I don’t trust you, don’t try to help me with nothing, I mean that’s a barrier. (Group 1)*

The exchange below illustrates one way participants experience this mistrust and racism:

[First response] I tend to think some of the [non-African American] psychiatrist have preconceived ideas. The minute you enter they look at you and they’ve already put you in a category. [Second response] Yes. [Third response] And they’ll ask you questions that are leading to come to that conclusion that you are this. Oh come in...I’ll say this one must be homeless, drug abuse, alcoholic, [Fourth response] Or in jail. [Fifth response] And they’ll put you in that box and the treatment with it regardless of what you’re suffering from; they’ve already made up their mind. [Sixth response] I went to someone and they just couldn’t believe that I hadn’t been to jail. They think all black people have been to jail. You don’t have a “background”? No I don’t! [Seventh response] I’ll take it even to another level. For a black person to go seek professional help the professional needs to know that you’re taking a stretch. (Group 1)

Second, participants articulated several aspects of the overall mental health stigma dynamic that they tie to African American experiences of racism and its effects: a self-protective need to hide one's (individual, family or community) vulnerabilities, to be self-sufficient and solve things "in house" rather than exposing one's self to risks from unknown outsiders, and the need to present a proud and unblemished public face.

[First response] I think as a group we don't like to wash our linens in public. I think it's not only with this but it's with a lot of [painful] things that need airing but it's just not talked about. Many things... crime. [Second response]... we don't want anybody to know what our business is. (Group 4)

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We were taught that because of so much that we have been through in our lives we just learn to roll with the punches...that we just feel as though we can overcome whatever. You have to be crazy [to need professional help], you don't go get no help, there is nothing wrong with you, you're not crazy. (Group 1)

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I think it's also the upbringing with what happens in the house stays in the house, we can work it out here. (Group 2)

### Cultural and traditional belief systems

Participants also described some African American families and communities as understanding "mental illness" through the ontological and causal lens of religion, curse, sin, and spirituality, rather than health. Although participants sometimes mentioned changes over the generations, most felt that the spiritual framework is still powerful in shaping African American communities' understanding of mental illness and emotional distress.

As such, letting it be known that you or a family member has a mental illness can be tantamount to revealing the family is spiritually dirtied.

Because...it [going to a mental health professional] would admit that you had a person in your family with something wrong... Socially, if a person in your family had a mental disorder it was looked upon as something went awry or for the love of superstition or revenge kind of thing. They looked upon it like it was a curse from above or somebody in their family sinned and lost his honor. So people shunned people, not just the individual but people related to them. (Group 3)

Another Group 3 participant stated the same theme in more contemporary terms:

You walk in a room and they say that's Ms. X, her son was admitted to [psychiatric facility], and they'd all look at her like she was crazy.

Such frameworks have powerful strengths, but can also form barriers to people accepting mental health information and services. This is because ontological frameworks that define one's problem as spiritual will therefore value remedies within that paradigm, sometimes entirely rejecting other frameworks (such as "mental health") and their suggested treatments. One participant in Group 4 illustrated this with a childhood story:

I remember saying to my grandmother, who is now 94, this had to be 60 years ago, I mentioned the word stress. She turned around and looked at me, and when she finished I felt so worthless. I mean she just said that in her day that nobody talked about stress, maybe I needed to pray more and ask God to order my steps, and this whole stress thing I don't need to buy into it.

A participant in Group 3 stated the same thing more globally and in the present:



We demonize everything...spiritualize everything to an extreme of one way or the other. So when we deal with mental illness we try to relate it to the demonic, everything is demonic, it's a spiritual thing. So then we rely on superstitions. We got the old folk old remedies that prevent you from going [for help]. That's been the problem and that has been the problem in the Black community.

## DISCUSSION

This research was motivated by the need to understand how information needs influence the processes of seeking mental health services among African American adults so far unconnected to the mental health system. The findings from this study suggest that fear of stigma and racism are major barriers faced by African Americans seeking mental health/illness information and/or services. Moreover, they may lead some African Americans to deny mental illness to oneself and/or others and to avoid actively seeking help. In addition, some African Americans espouse culturally- and traditionally-based belief systems regarding mental health/illness. Strategies and concrete steps recommended by the participants towards the design and implementation of educational interventions to address the salient barriers of stigma and racism included the need for the information and/or service to be accessible and be delivered by credible sources within a non-threatening and reassuring context.

Our results corroborated findings by others (Anglin et al., 2006; Corrigan, 2007; Gary, 2005; Hines-Martin et al., 2003; Link & Phelan, 2006) that people's fear of stigma regarding mental illnesses leads them to sometimes hide or deny their distress, frame it (and other's distress) in alternative ways, and/or avoid help modalities that might imply mental illness (Alvidrez, 1999; Hines-Martin et al., 2003). This study extends such knowledge by adding participants' articulation of secondary needs that stigma creates, which then shape preferences for how to receive mental health information and/or access services. These preferences thereby become the beginning of strategies that may help close the gap between mental health needs and information and services received among African American individuals and families.

While the concept of stigma is far from novel in this arena, focus group participants' discussions included their articulating ways that mental health information/service delivery might circumvent the barrier of stigma by being delivered in ways that are non-threatening and credible, and which acknowledge the resonance of collective personal, racial, and community histories. Participants described stigma (and fear of the loss of status that stigma can cause) as creating in them strong preferences for services and information offered in ways and by people and settings that are familiar, reassuring, confidential or anonymous, and trustworthy.

Several specific areas of future intervention (and additional research) are suggested by the participants' data. First, anonymous information and mental health screening could allow individuals to access information they otherwise would not. Second, research and interventions regarding confidentiality assurances and the *perceptions* of trustworthiness and confidentiality could facilitate more effective service and information delivery. Third, information and service delivery agencies and personnel may want to examine and improve their interpersonal style and patient care practices so that they are perceived/received as highly non-threatening, non-authoritarian, and respectful. Fourth, there are several different ways that an information source may be perceived as "credible". These sources could be more thoroughly adopted by mental health agencies and providers. Fifth, a commonly accepted idea but underutilized is the extent to which *familiar* people and institutions convey reassurance and credibility, especially to communities such as African Americans which are

often discriminated against. According to the participants familiar may mean “looks like me” or personally known to me, or well-regarded in the community, or widely known / famous. All could be beneficial strategies for delivering accurate mental health information and services.

On the basis of this one limited study we cannot be sure that stigma plays the central role across various African American communities (nor even other sectors of Baltimore) that we perceived it to do among our participants. At the same time, it fits with and elaborates on current knowledge and there is little reason to assume it does not. Therefore, the themes generated here need to be further explored and developed into a working model of the interface between community needs, community explanation of need and actual services offered. An exploration of heterogeneity of opinions among the various African American communities based on attributes such as gender, age, and education is necessary as is the need to identify and put in context individual responses of participants. Further, as the moderator was not trained in mental health and followed a scripted approach to the questioning, she may not have pursued some lines of discussion in greater depth. Knowledge about mental health issues may have led to different and more in-depth lines of inquiry. The findings from this study are neither representative nor generalizable to any other population of urban African Americans who might answer questions about their knowledge of mental health diagnoses and services. Focus groups serve us best in piloting some strategies to gain targeted information about the main research questions. However, there was convergence on the main themes reported from these four groups which is suggestive of ways to structure services and information so that it reaches the intended group.

In conclusion, although stigma and racism are major barriers faced by African Americans seeking mental health/ illness information and/or services, there are appropriate normalizing strategies which could be incorporated towards the development and implementation of acceptable and culturally-sensitive mental health education and service delivery programs in community setting.

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**Table 1**

Socio-Demographic characteristics of the focus group participants (N=42)

Characteristics	All (N=42)	
	n	%
Age		
22–65 years	41	100
Gender		
Female	34	81
Male	8	19
Education level		
Some high school or less	2	5
High school graduate	8	19
Some college	15	36
College graduate	17	41
Marital status		
Married	8	21
Single	31	79
Employment status		
Not in the workforce	7	17
In the workforce	34	83
Health insurance status		
Only private insurance	26	67
Only government insurance	3	8
Uninsured	10	26

**Table 2**

**Quotations Illustrating Five Facets of Reassurance Regarding How Mental Health Information and/or Services Should be Conveyed**

<p>Anonymous</p>	<p><i>I think there would have to be plenty of information with no questions asked. ... Meaning that I should not have to answer any questions about why I'm picking it up. (Group 4)</i></p>
<p>Confidential</p>	<p>Moderator: Is there any advantage in depression to using the counselor?  <i>[First response] Probably it has more experience of dealing with depression and it might be a benefit that that person doesn't know you. That's makes me think confidential.</i>  <i>[Second response] Right. (Group 1)</i>                  Moderator: Help me understand non-threatening.  <i>[First response] Confidential</i>  <i>[Second response] Yes, confidential. (Group 2)</i>  <i>[First response] Confidentiality is huge, especially in the neighborhood or in the community I should say.</i>  <i>[Second response] Figure out what makes it so huge... people just don't trust and you have to figure out what would help people trust. (Group 4)</i></p>
<p>Familiar Sources or Settings</p>	<p><i>... a lot of people don't like to go outside of their community for that type of service. You know, seen by a professional or doctor if you could bring it to the community, a nursing staff or a household or a school system, or within a facility such as this [church]. (Group 2)</i>  <i>So like say if I was in school or something was going on at my school, or at my church, or a community center, or some place that I would go into and from someone who I trusted said "Come to this", that sort of thing and then I'll say, "Maybe I'll give it a try." (Group 4)</i>  <i>I'd say it would be more trust in my minister than in a counselor, someone that you don't know. (Group 1)</i></p>
<p>Supportive</p>	<p><i>You notice that sometimes that helps when people talk and it kind of opens up the door for the next step but you have to let people know that you care. You have to care about people for that to happen. (Group 2)</i>  <i>[First response] You feel crazier sitting there talking to I mean a psychiatrist and he's sitting there going mm-mmm, and you're sitting there going "Oh God what's going to come out of this?" So you felt like it was a waste of time. I mean I had a bad experience. This man made me feel crazier.</i>  <i>[Second response] All they do is shake their head and write. (Group 1)</i>  <i>[First response] Yeah you got to watch out, especially now a days. All the shrinks is labeling...everybody is bipolar...everybody...</i>  <i>[Second response] They go to a therapist now and everybody is bipolar now.</i>  <i>[Third response] Everybody yeah.</i>  <i>[Fourth response] I think it's because they get more money now with treating people that's bipolar. (Group 1)</i></p>
<p>Multifaceted Trust (cumulative)</p>	<p><i>... you don't want to go into an environment where they are not willing to assist you or give you information. It's going to be more welcome or some place that welcomes you with open arms, so a warn environment is important.</i></p>

Table 3

Quotations Illustrating Sources of Credibility Regarding How Mental Health Information and/or Services Should be Conveyed

Expert	<p><i>I think that if they have a regular primary care doctor and they have a relationship with their doctor and the doctor see something in them you know that would encourage them that they may need to go because of the trust that they have with their doctor, then he can encourage them to go seek further help. (Group 1)</i></p> <p>Moderator: how would that information need to come to you in order for it to be useful to you?</p> <p><i>[First response] Workshops</i></p> <p><i>[Second response] Yeah seminars and workshops</i></p> <p><i>[Third response] And if they had a hot line where you could call and ask questions. (Group 3)</i></p> <p><i>Medical doctors at schools, I like to talk to people who have experience at the school either themselves or the people they're around. (Group 2)</i></p>
Celebrity	<p><i>[First response] Perhaps people that are public figures that we know come out and let people know like, I'm not saying I trust Mike Wallace but I didn't know that he was depressed. ... But "60 Minutes" had been on forever and I'm like Mike Wallace was depressed, what! And now he's out there talking about it.</i></p> <p><i>[Second response] I think a lot of the rappers can help a lot of teenagers too. Yeah because a lot of teenagers are committing suicide too</i></p> <p><i>[Third response] Because that's the same with Magic Johnson when he became public about HIV, you know he helped a lot of people by doing that.</i></p> <p><i>[Fourth response] A lot of athletes are speaking out on all of their situations which is good. (Group 1)</i></p>
Looks like me	<p><i>I think it would be more acceptable to me if it was somebody who looks like me, that's of my ethnic background because in my mind there are differences in mental illnesses, the way one group of people go through it and the way of another. (Group 3)</i></p> <p><i>That's probably why African-Americans probably were over looked because we went to these Caucasian shrinks and we just was hiding it, whereas we'd probably be more receptive to an African-American psychiatrist. (Group 1)</i></p> <p><i>But if a man looked like you and carried himself like you and you saw that he accessed help would you be more than likely to follow his example. (Group 1)</i></p>
Known to them	<p><i>I trust my family so I'm thinking if my family discussed it I'd trust it better than talking to somebody else. (Group 1)</i></p> <p><i>I'll go and seek help there. I'll go to my minister or whoever is here [because I trust them. If they had the resources or they talked about mental illness in the church people would feel freer to go over there and get help. (Group 1)</i></p>
Have been there	<p><i>[First response] Somebody who has gone through it</i></p> <p><i>[Second response] Somebody going through it (Group 4)</i></p> <p><i>Get some people who are on medication and going through it to talk about it to share the experience.</i></p> <p><i>(Others: Yeah / Let them talk about it)</i></p> <p><i>That's just as good as having a doctor or a professional tell us but what about the people who are going through it themselves. (Group 3)</i></p>