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Treatment Disparities among African American Men with Depression: Implications for Clinical Practice

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Abstract

A decade has passed since the National Institute of Mental Health initiated its landmark *Real Men Real Depression* public education campaign. Despite increased awareness, depressed African American men continue to underutilize mental health treatment and have the highest all-cause mortality rates of any racial/ethnic group in the United States. We review a complex array of socio-cultural factors, including racism and discrimination, cultural mistrust, misdiagnosis and clinician bias, and informal support networks that contribute to treatment disparities. We identify clinical and community entry points to engage African American men. We provide specific recommendations for frontline mental health workers to increase depression treatment utilization for African American men. Providers who present treatment options within a frame of holistic health promotion may enhance treatment adherence. We encourage the use of multidisciplinary, community-based participatory research approaches to test our hypotheses and engage African American men in clinical research.

Keywords

African Americans; depression; men; health disparities; community-based participatory research

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Major depressive disorder (MDD) is a leading cause of disability worldwide.[1] Depression is associated with high rates of medical and psychiatric comorbidity,[2] poor physical health and functioning,[3] and increased risk of suicide.[4] Lifetime prevalence estimates of MDD range from 14% to 17% in the United States (U.S.).[5,6] African Americans, compared with White Americans, have slightly lower prevalence estimates of lifetime MDD. However, African Americans have depressive episodes that are more disabling, more persistent, and more resistant to treatment relative to their White counterparts.[7]

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There are consistent gender differences in the prevalence and treatment of MDD. Women are twice as likely to be diagnosed with depression compared with men.[5,6] Paradoxically, men in the U.S. are up to four times more likely than women to commit suicide.[8–10] Men, regardless of their race/ethnicity, have lower rates of mental health service utilization for a myriad of stressful life events compared with women.[11,12] Traditional masculinity norms contribute to men's under-utilization of health care services.[13] Men are encouraged to "tough out" illness for as long as possible.[14 [p. 155]] Seeking mental health treatment is perceived by many men to conflict with traditional gender norms.[15]

In light of this gender paradox,[16] the National Institute of Mental Health launched a nationwide public education campaign, *Real Men Real Depression*, in April 2003.[17] This initiative was the first large-scale community mental health campaign in the U.S. that specifically sought to raise awareness about depression among men.[18,19] Despite increased outreach over the last decade, depressed African American men are significantly less likely to seek help compared with depressed White men.[20] Woodward *et al*.[21] recently examined national treatment rates of African American men with a lifetime mood, anxiety, or substance use disorder. Just 14% of men received care from professional mental health services compared with 29% who did not seek any help.[21] The paucity of studies focused on this population is a serious public health concern, as evidenced by the rise in completed suicides among young African American men since the 1980s.[9]

Thus, the purpose of this commentary is twofold: to explore socio-cultural factors that contribute to low treatment rates among depressed African American men and to recommend strategies to engage African American men in outpatient mental health care. We acknowledge that African American men, compared with men from other racial/ethnic groups, are disproportionately exposed to socioeconomic inequalities that contribute to health disparities.[22,23] However, our commentary is focused on selected socio-cultural factors that impact depression help-seeking among African American men, namely: 1) racism and discrimination; 2) mistrust of health care providers; 3) misdiagnosis and clinician bias; 4) and use of informal support networks. Frontline mental health care providers (e.g., primary care physicians, mental health professionals, and faith leaders) are the target audience of our treatment engagement recommendations. It is important to note that mental health research has used the term "Black" to describe individuals from various ethnicities of the African Diaspora (e.g., African American, Haitian, non-Haitian Caribbean, and others). We are focusing our discussion on those men who self-identify as African American.[24]

Racism and Discrimination

Numerous studies have examined the relationship between racism-related life experiences and psychological distress.[25,26] Racism has been hypothesized to affect the mental health of African Americans in several ways. Institutional racial discrimination can limit socioeconomic mobility, leading to poor living conditions that negatively affect mental health. Acceptance of an inferior social position among minority group members could cause impaired psychological functioning.[27]

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Racial discrimination is cited as a depressogenic risk factor among African American men.[28,29] Everyday forms of discrimination, referred to as "micro-aggressions" by Dr. Chester Pierce, may be more stressful than overt acts of racial discrimination because they are repetitive and subtle.[30] Examples of these non-verbal exchanges are being followed because of one's race or being a victim of "Stop and Frisk" policies by police.[31,32] Micro-aggressions are recognized as an integral part of clinical encounters for African Americans.[33–35]

Cultural Mistrust of Health Care Providers

Medical experimentation on African Americans during slavery laid a foundation of mistrust towards health care providers.[36,37] The infamous U.S. Public Health Service's (USPHS's) *Tuskegee Study of Untreated Syphilis in the Male Negro*[*] represents an egregious incident of inhumane treatment that illustrates how many African American men expect to be treated by health care providers.[38,39] From 1932 through 1972, government scientists conducted a longitudinal study of the effects of syphilis on a group of African American men in rural Alabama. Although penicillin was used to treat syphilis in the 1940s, scientists intentionally withheld this medication to learn the consequences of untreated syphilis among study participants. The legacy of the Tuskegee Syphilis Study has arguably been crystallized in the minds of many African American men as the quintessential motif of how medical communities abuse and neglect African American men.[39]

African American men may harbor distrust specifically towards mental health professionals due to their mode of initial presentation to treatment.[40] African Americans are significantly more likely to utilize psychiatric emergency services compared with white Americans.[2,41] African Americans' greater reliance on psychiatric emergency services may contribute to inconsistent follow-up and high attrition rates from outpatient care.[42] African American men are also more likely to be committed involuntarily for inpatient mental health treatment.[43] Police involvement corresponds to higher rates of involuntary psychiatric hospitalization for men of color.[44] It is within this larger context of cultural mistrust that African American men weigh the decision to enter the mental health care system.

Misdiagnosis and Clinician Bias

Racial and gender differences in depressive symptomatology may contribute to the misdiagnosis of depression among African American men. The core symptoms of MDD are remarkably consistent across cultures, however, African Americans with MDD are more likely to have somatic symptoms (e.g., sleep disturbance or pain) compared to White Americans with MDD.[2,45,46] African Americans' somatization of emotional problems may make it difficult for primary care physicians to detect clinical depression.[47] Researchers have increasingly studied a "male depressive syndrome" to describe how men experience

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[*]This study was conducted in Tuskegee, Alabama from 1932–1972, and therefore is often referred to as the *Tuskegee Syphilis Study*, though it was conducted by the USPHS and not the well-known institution of higher education, Tuskegee University (formerly, the Tuskegee Institute). The USPHS initially recruited approximately 600 impoverished Black sharecroppers from Macon County, Alabama as subjects; nearly two-thirds of these men had contracted syphilis before the study commenced. The men were not informed that they had syphilis, nor were they treated for it, although they were told they were receiving free medical care, as well as free meals and burial insurance.

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and express depression.[48] Depressed men, compared with women, are more likely to exhibit irritability, anger attacks, and abusive behavior. Men may be more likely to engage in externalizing behaviors, such as substance abuse and over-working, as a way to cope with depressive episodes.[16,49] These gender differences in symptom presentation may lead to under-detection and misdiagnosis.

Clinician bias also contributes to the misdiagnosis of depressed African American men.[50] Mental health professionals may harbor negative perceptions of African American men that affect their diagnostic assessment.[51–53] One form of bias is when a clinician underestimates the cognitive capacity of African American men.[52] In such as case, the psychological issues of African American men may seem more simplistic in comparison with their White counterparts.[54] Providers disproportionately diagnose African American men with schizophrenia and other psychotic disorders compared with White men, who are more likely diagnosed with mood disorders.[55] These clinical errors are found even when providers use structured diagnostic interviews.[56,57] Misunderstanding around contextual diagnostic analyses may lead providers to disproportionately misinterpret cultural mistrust as pathological symptoms.[44]

Use of Informal Support Networks

Social support networks have a complex role in help seeking for depressed men: they can either facilitate the use of professional services or be a barrier to seeking specialty care.[58,59] When African American men do seek help for mental health problems, they are more likely to rely exclusively on informal help.[60] Family and social support appear to create a sense of community for health issues among African American men. Studies have found that high levels of intrusive behaviors by family members predicted better mental health outcomes for African Americans compared with Whites.[61] African American men also appear to be more likely to seek help from men with whom they share common characteristics, such as similar age and economic status.[62]

Faith-based organizations are perhaps the most studied sources of informal support among African Americans, who have the highest rates of church attendance of any racial/ethnic group in the U.S.[63,64] The Black Church, classically defined as the set of seven predominantly African American denominations of the Christian faith, is a prominent institution in many communities.[65] Churches provide health education and social support for many community members.[66,67] African American ministers are considered trusted “gatekeepers” for providing pastoral counseling and referring community members to specialty care as needed. Neighbors et al.[58] found that 50% of African Americans utilizing only one source of mental health care sought help from minister providers. Although men generally have lower levels of religious service attendance than women, African American men may feel more comfortable seeking counseling from clergy and other faith-based leaders.[68]

Implications for Clinical Practice

There are several entry points through which to engage African American men in depression care. A model that integrates community engagement with improved clinical care was

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recently cited as a promising way to reduce disparities.[69] In line with this care model, we encourage the dissemination of mental health outreach and psycho-education in trusted community settings frequented by men of color, such as barbershops, churches, and fraternities. Engaging African American men in these community settings has improved health outcomes for hypertension and cancer,[70,71] but their use in depression is limited.[66] We also support the dissemination of depression screenings through the internet. This online platform can anonymously screen a large number of individuals,[72] and the confidentiality may be appealing for African American men.

To improve clinical care, we have specific recommendations for frontline mental health workers, e.g., mental health professionals, primary care physicians, and faith leaders who are likely to encounter depressed African American men. We shall subsequently refer to these frontline mental health workers as "providers."

1. Build trust through a collaborative clinical partnership

Providers must build a therapeutic alliance that preserves African American men's masculinity and cultural identity, allays cultural distrust associated with the health care system, and acknowledges psychosocial stressors unique to African American men.[40] This is no easy task. Providers can ask African American men about previous clinical encounters with the health care system. Providers should allow patients to describe any negative encounters and micro-aggressions they may have had with health care professionals. Providers who use this line of inquiry acknowledge that this kind of disrespect may be subtle and difficult to describe.[73,74] This line of inquiry may come as a surprise to most African American men, because it is not something typically addressed by mental health workers. However, it acknowledges the historically negative treatment of African American men in everyday situations.[54,75]

We encourage providers to explicitly tell African American male patients that they want to earn their trust. Inviting African American men to be active participants in their treatment decision-making process is one way to build trust.[76] Though it may be more time consuming in the short-term, encouraging African American men to clearly articulate any reservations about treatment can be extremely empowering and may result in greater compliance in the long-term.

2. Mobilize kinship and social networks, with a specific inquiry about religious involvement

Inquiring about social support networks is a critical aspect of treating depressed African American men,[77] who may present to their initial clinical encounter with family members or other key people in their lives. Providers must recognize that these collateral parties can be either strategic allies or barriers to mental health intervention.[11] We recommend that providers conduct a systematic inventory of the key people (i.e., romantic partners, parents, siblings, and friends) in the lives of African America men.[78] Providers should ask African American men how others in their social circle perceive depression. Equipped with this knowledge about who may facilitate or impede treatment, providers can suggest specific people from whom the patient can seek support. Providers can also provide information

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about family psycho-educational programs, which have been used to increase depression literacy, improve problem-solving and communication skills, and enhance social networks in times of crisis.[79]

Providers must inquire about the role of religiosity and spirituality in the lives of African American men. Providers should ask about past and current church involvement, importance of religious practices, frequency of service attendance, and feasibility of engaging people from faith-based support networks.[80] Many African American faith-based organizations provide community members with short-term financial and housing assistance, which can address environmental stressors.[65] Providers should also inquire about the patient's contact with faith leaders, such as clergy or Imams, who may be providing counseling and other health advice.[81] Collaborative outreach between African American faith leaders and mental health providers has been used to increase depression awareness and reduce stigma in communities of color.[82]

Some African American men are not affiliated with a formal religious network, but may want to incorporate spirituality into their treatment. We offer a systematic approach by which providers can inquire about spirituality. First, providers can ask to what degree and by what means, if any, men would like spirituality incorporated into their treatment. Second, providers can administer a validated instrument, such as the HOPE questions,[83] to assess spirituality. Third, providers can consult with a spiritual advisor to receive education about the male patient's spiritual perspective.[84]

3. Discuss treatment options for depression within a holistic framework of health promotion

Providers may be well suited to frame the mental health care of African American men holistically.[85] Patients are more likely to engage in depression treatment when clinicians describe both the psychological and physical symptoms of depression.[86] Providers can highlight how depression makes it more difficult for men to carry out their various social roles.[87] By framing depression holistically, providers can more easily incorporate health promoting strategies that may reduce stigma associated with depression mono-therapy. For example, providers can relay that exercise reduces depressive symptoms and improves cardiovascular health.[88]

When considering treatment, African Americans in primary care samples express a preference for psychotherapy over medications.[89] It is important for providers to discuss multiple treatment options and acknowledge that finding an effective treatment can take time.[86] We encourage the use of evidence-based psychotherapies, such as Interpersonal Psychotherapy (IPT) and Cognitive Behavioral Therapy (CBT), which have demonstrated efficacy among African Americans.[90] It is important to consider how evidence-based psychotherapies may need to be culturally adapted to make them relevant for African American men.[91] Narrative therapy, which encourages patients to construct a preferred reality, may also be appealing for African American men.[92] Within the framework of a culturally sensitive, therapeutic approach, depressed African American men can leverage aspects of their life experiences to pursue a fulfilled and meaningful life.

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Regarding pharmacotherapy, African Americans may be reluctant to take psychiatric medications due to specific beliefs about their side effects and effectiveness.[93] We recommend that providers thoroughly investigate African American men's attitudes about taking anti-depressant medication. Providers should offer sufficient education about side effects, anticipated treatment duration, expected treatment response, and addictive potential when considering pharmacological treatment with depressed African American men. Thoroughly exploring African American men's perceptions about taking medications may increase compliance and solidify the therapeutic relationship.

4. Providers should explore their own racial biases

Many providers hold unconscious stereotypes about African American men that can negatively affect assessment and treatment.[33] To address these internalized racial biases, it is important to conduct trainings for providers at multiple time periods across their career. Betancourt *et al*.[94] have implemented a curriculum to increase awareness, impart knowledge, and teach cross-cultural skills to medical students over the four years of their graduate education. Longitudinal courses taught in small groups create safe environments for students to more openly discuss racism and their own internalized biases. We encourage providers to pursue "cultural humility," which involves a lifelong commitment to self-evaluation and self-critique regarding the position of power that clinicians hold over all patients.[95] Providers can attend on-going educational forums to explore their own racial identities and unconscious perceptions about other racial groups. Educational trainings in health care settings have been effective at reducing health care professionals' fears, biases, and resistance to working with culturally diverse patients.[96]

Mental health professionals will have greater opportunity to explore racial biases with efforts to increase numbers of African Americans' entering the mental health care field. African Americans constitute only 2% of psychiatrists, 2% of psychologists, and 4% of social workers in the U.S.[97] Mentoring programs for African American high school and college students have demonstrated efficacy at increasing their matriculation in medical schools.[98] Graduate mental health educational programs are enriched by having a greater percentage of students of color, who can encourage their classmates to examine unconscious cultural insensitivities.[40] Health care organizations should increase the representation of African Americans in top-level institutional discussions around training, research, policy, and education. This degree of organizational sensitivity will likely require interdepartmental collaborations. It also demands a courageous commitment to address the effects of institutional racism and White privilege.[40]

Future Directions

Studying depression in African Americans is hampered by their under-representation in clinical research. A multi-level research agenda is needed to address the social determinants that contribute to health disparities.[23] Research is needed to investigate how to optimally engage men at multiple entry points for mental health care, including primary care, community settings, and the criminal justice system. Future studies should investigate the efficacy of culturally tailoring empirically supported treatments for African American men.[99] Systematic strategies to reduce stigma should also be explored.[100] Mixed-methods

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studies, which employ qualitative and quantitative methods, are ideal for investigating complex behaviors and identifying issues for treatment.[101]

Community-based participatory research (CBPR) is a promising approach by which to pursue this research agenda.[102] Community-based participatory research is a collaborative process between academic researchers and community members that is designed to improve community health and reduce health disparities.[103] Community-based participatory research focuses on fostering trust, building capacity, and fostering action for social change. Participatory research approaches have been effective in engaging African American communities in depression research,[104] but studies focused on men are lacking. Multidisciplinary research teams that include health care professionals, educators, policy makers, and community members are well suited to use participatory approaches

Conclusion

Major depression is a "silent killer" of African American men, similar in that respect to hypertension. Increasing depression care for African American men is a complex problem for which there is no single solution. A singular focus on widespread educational campaigns, though important, does not account for social determinants that contribute to health disparities. We have outlined how specific social factors disproportionately affect African American men and deter them from seeking depression treatment. We have also highlighted community and clinical entry points to engage African American men. Interventions for depressed African American men that do not account for racism, cultural mistrust, misdiagnosis, and informal support networks will likely have limited impact. Frontline mental health workers must build trust, mobilize social networks, explore how to incorporate spirituality, and examine their own racial biases. Multidisciplinary research partnerships hold promise for addressing racial disparities in depression care. Future research is needed to investigate how to optimally identify, engage, and retain depressed African American men in treatment.

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