

“Down in the Sewers”: Perceptions of Depression and Depression Care Among African American Men

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Darrell L. Hudson, PhD, MPH¹, Jake Eaton, MPH¹, Andrae Banks, LCSW¹, Whitney Sewell, MSW¹, and Harold Neighbors, PhD²

Abstract

Depression is one of the most common, costly, and debilitating psychiatric disorders in the United States. One of the most persistent mental health disparities is the underutilization of treatment services among African American men with depression. Little is known about appropriateness or acceptability of depression care among African American men. The purpose of this study was to examine perceptions of depression and determine barriers to depression treatment among African American men. A series of four focus groups were conducted with 26 African American men. The average age of the sample was 41 years and most participants reported that they had completed high school. Nearly half of the participants reported that they are currently unemployed and most had never been married. The most common descriptions of depression in this study were defining depression as feeling down, stressed, and isolated. A small group of participants expressed disbelief of depression. The majority of participants recognized the need to identify depression and were supportive of depression treatment. Nonetheless, most men in this sample had never sought treatment for depression and discussed a number of barriers to depression care including norms of masculinity, mistrust of the health care system, and affordability of treatment. Men also voiced their desire to discuss stress in nonjudgmental support groups. Research findings highlight the need to increase the awareness of symptoms some African American men display and the need to provide appropriate depression treatment options to African American men.

Keywords

depression, health inequality/disparity, health care utilization, qualitative research

Introduction

Depression is one of the most common, costly, and debilitating psychiatric disorders in the United States (Greenberg et al., 2003; Gwynn et al., 2008; Kessler, Chiu, Demler, & Walters, 2005; Üstün, Ayuso-Mateos, Chatterji, Mathers, & Murray, 2004; World Health Organization Mental Health Survey Consortium, 2004). Disability from depression is associated with lower educational attainment, income earned, and increased days off work (Breslau, Lane, Sampson, & Kessler, 2008; Kessler et al., 2010; Kessler, Foster, Saunders, & Stang, 1995; Lorant et al., 2003; Muntaner, Eaton, Miech, & O'Campo, 2004). Depression is also associated with suicide (Brownhill, Wilhelm, Barclay, & Schmied, 2005; Joe, 2006; Oquendo et al., 2001) in addition to a wide range of chronic diseases such as heart disease and diabetes (Carney, Freedland, & Sheps, 2004; Katon et al., 2009; Katon et al., 2010; Mezuk, Eaton, Albrecht, &

Golden, 2008). Factors associated with depression such as unemployment, incarceration, low educational attainment, and low-income disproportionately affect African American men (Harper et al., 2002; Williams, 2003). African American men could be more vulnerable to experience of depression compared to White men (Doherty, Green, Reisinger, & Ensminger, 2008; Estrada-Martínez, Caldwell, Bauermeister, & Zimmerman, 2012; Way, Santos, Niwa, & Kim-Gervey, 2008). While the prevalence of depression among African Americans is lower compared with Whites, researchers have reported

¹Washington University in Saint Louis, St. Louis, MO, USA

²University of Michigan, Ann Arbor, MI, USA

Corresponding Author:

Darrell L. Hudson, Brown School of Social Work, Washington University in Saint Louis, Campus Box 1196, 242 Goldfarb Hall, One Brookings Drive, St. Louis, MO 63130, USA.
Email: dhudson@wustl.edu

that depressive symptoms are more disabling among African Americans compared with Whites (Williams et al., 2007). Yet one of the most persistent mental health disparities is the underutilization of mental health treatment services among African American men (Chandler, 2010; Snowden, 2007; Snowden & Pingitore, 2002). There are links between depression and chronic disease, as well as key social determinants of health such as educational attainment and earning potential (Greenberg et al., 2003; Jackson, Knight, & Rafferty, 2010; Katon et al., 2009; Kessler et al., 1995). It is important to examine perceptions of depression and acceptability of depression care among African American men.

There are significant mental health service utilization differences between African Americans and Whites; African Americans are half as likely to use services for any mental health problem compared with Whites (Substance Abuse and Mental Health Services Administration [SAMHSA], 2015). The diagnosis of mental health problems in general is an especially challenging task for clinicians and results from multiple studies note difficulties in diagnosis of depression, irrespective of race/ethnicity (Hudson et al., 2013; Kales et al., 2005; U.S. Department of Health and Human Services, 2001). There are concerns about whether depression is underreported and/or underdiagnosed in African American men compared with White men (Metzl, 2009; Snowden, 2003, 2007; Whaley, 1997). Some researchers have argued that African American men are overdiagnosed with schizophrenia relative to mood disorders compared with White men (Metzl, 2009; Whaley, 1997). It is possible that African American men who suffer from depression are missed when they seek medical treatment in primary care settings and since this is where most Americans are diagnosed with depression, they may never be seen by mental health specialty providers (Gonzalez et al., 2010; Miranda & Cooper, 2004; Nutting et al., 2008). There is the likely underutilization of mental health treatment services due to lower overall access to health care among African Americans compared with Whites (U.S. Department of Health and Human Services, 2001).

Data on depression among African American men are limited. The SAMHSA's 2014 report, *Racial/Ethnic Differences in Mental Health Service Use among Adult*, notes that national estimates of mental health service use among racial/ethnic groups are based on data that are close to or more than a decade old (SAMHSA, 2015). For instance, prevalence estimates from the latest national psychiatric epidemiologic studies indicate lower levels of depression among African Americans (Williams et al., 2007) but these data were collected over 12 to 13 years ago. As the 2001 Mental Health Supplement highlights, prevalence rates are imperfect measures of need (U.S. Department of Health and Human Services, 2001). For

instance, most extant studies do not include institutionalized individuals, such as those in psychiatric hospital or prisons. It is also more difficult to recruit African Americans who reside in inner cities or in poor rural areas, as they are not readily accessible to researchers who conduct household surveys (Metzl, 2013; U.S. Department of Health and Human Services, 2001). Thus, there could be significant, unmet mental health needs among African American men that researchers and practitioners are missing.

Understanding differences in the experience of mental disorders across race/ethnicity and gender is part of a national effort to aid in the development of more effective, high-quality treatments for mental disorders (SAMHSA, 2015; U.S. Department of Health and Human Services, 2001). One of SAMHSA's current goals is to increase the availability of services for mental illness, particularly among communities of color that reside in areas that are underserved, in addition to increasing public awareness and understanding of mental and substance use disorders. As noted in SAMHSA's 2014 report, *Racial/Ethnic Differences in Mental Health Service Use among Adults*, aspects of mental health care access, especially affordability of mental health care, have been identified as a critical factor to consider (SAMHSA, 2015). Little is known about appropriateness or acceptability of depression care among African American men. Uncovering factors that improve the service delivery of depression treatment of African American men may help provide a pathway to increase the number of African American men who seek depression treatment and improve the quality of treatment for African American men who do seek services.

Few studies have used qualitative methods to examine barriers that African American men perceive in seeking depression care and there is a dearth of research examining the treatment seeking experience of African American men or their feelings about appropriateness, acceptability, or effectiveness of depression care (Nutting et al., 2008; Ward & Besson, 2013; Williams, Neighbors, & Jackson, 2008). The results from extant studies, however, indicate that African American men have experienced depression and would consider treatment, but there are significant barriers to treatment such as perceived differences in the expression of depressive symptoms (Bryant-Bedell & Waite, 2010; Hudson, Lewis, Eaton, Grant, & Gilbert, 2016; Watkins & Neighbors, 2007). Although stigma is considered a common barrier to depression treatment, Ward and Besson (2012) noted that most of the 17 African American men in their interview study did not perceive stigma against mental health problems or consider it as a barrier to treatment seeking. In another interview study with 10 African American men who self-reported that they had experienced depression, Bryant-Bedell and Waite (2010) uncovered that participants had experienced

depression in the past but did not realize that they were depressed. Participants in their study described feelings of depression, including irritability, isolation, and depressed mood; however, they did not seek treatment (Bryant-Bedell & Waite, 2010). Rather, men in this study reported that they only sought treatment after a “breakdown.” These breakdowns ranged from the simple realization that they were not feeling like themselves to encouragement to seek help from members of their social support networks to suicide ideation and “hitting rock bottom.” Bryant-Bedell and Waite (2010) concluded that better mental health screening efforts are needed and that providers must account for gender and cultural differences to better recognize depression in African American men.

In their 2007 focus group study with 46 young (18-26 years of age) African American men, Watkins and Neighbors' (2007) participants expressed the belief that African American men experience, define, and describe depression differently than White men. They observed that participants described depression using alternative expressions and colloquialisms that mental health providers would not understand.

These results from previous qualitative studies indicate that African American men do experience depression but even when they do seek treatment, there are significant delays and treatment may only result from “hitting rock bottom.” These findings also indicate that African American men have concerns about the likelihood that mental health providers would be able to relate to them or understand their experience of depression. For instance, Breland-Noble, Bell, and Burriss (2011) conducted a focus group study designed to examine adult perceptions of adolescent depression and depression treatment with 24 African Americans. Although the majority were African American women (21 of 24 participants) the authors reported that culture-bound beliefs about depression as well as beliefs about cultural insensitivity from mental health providers were significant barriers to depression treatment (Breland-Noble et al., 2011).

There is still a great need to understand African American men's views on depression and depression treatment (Mitchell, Watkins, Shires, Chapman, & Burnett, 2015; Ward & Mengesha, 2013). For one, there is a paucity of previous studies and existing data that examine depression, including prevalence estimates and barriers to treatment, among African Americans. For instance, Ward and Mengesha (2013) reported that over a 25-year span, there were only 19 studies that examined depression among African American men. Of those, there is little information about perceptions of depression or depression treatment among African American men. They also reported that prevalence rates of depression range between 5% and 10% in extant studies. However,

depression may be underestimated in African American men due to gender differences in symptom endorsement, lack of access to mental health services, lower participation of African American men in survey research studies, and an overrepresentation of African American men in institutional settings (Martin, Neighbors, & Griffith, 2013; Williams, 1995). It is possible that some African American men are suffering from depression but do not recognize that they are depressed or are unwilling or unable to seek treatment. The goal of this focus group study was to determine perceptions of depression and views of depression treatment, including financial, attitudinal, and educational barriers that could prevent African American men from seeking depression treatment.

The research team was conducting this focus group study at a community center located in North St. Louis City in the days preceding and immediately following the tragic shooting death of Michael Brown in nearby Ferguson. There are deeply entrenched, historic racial tensions in the St. Louis region that have fueled racial disparities in education quality, socioeconomic status, and health. The frustration over constant racial profiling, dubious court systems, as well as high levels of poverty and inequality have resulted in a tinderbox, fully ignited by the outrage over death of Michael Brown as well as the decision not to charge Officer Darren Wilson for this shooting.

Method

Focus groups were chosen as the data collection method for this study because this design is useful for contrasting views of subgroups as well as establishing which views are common across groups (Morgan, 1996; Morgan & Krueger, 1998). The goal of this study was to gather perspectives on depression and depression treatment from a sample of African American men in St. Louis, regardless of mental health history or previous experience seeking mental health services. There were no efforts to segment based on mental health status, previous mental health service utilization, or sociodemographic factors such as age or socioeconomic status.

Twenty-six African American men from the St. Louis area participated in four focus groups. Each group comprised six to seven participants. Study eligibility criteria were that participants were African American men, aged 18 years or older. Participants were not screened for depression or other mental health conditions prior to participation in the study. Participants were recruited through paper flyers that were placed at community agencies, such as fatherhood support centers, in addition to direct referrals from contacts at these community agencies. Recruitment materials stated that the principal investigator was looking to recruit African American men, 18 years and older, for

Table 1. Sociodemographic Characteristics of the Sample.

Variable	N (%)
Total	26
Age	
M (SD)	40.6 (1.64)
Marital status	
Married	2 (8)
Living with a partner	2 (8)
Separated	2 (8)
Divorced	4 (17)
Widowed	1 (4)
Never been married	13 (54)
Education	
8th Grade or less	1 (4)
9th, 10th, or 11th Grade	8 (31)
12th Grade	9 (35)
Some college (no degree)	8 (31)
Current work status	
Full-time	7 (27)
Part-time	4 (15)
Unemployed	10 (39)

participation in a focus group on stress, sessions would last approximately 90 minutes, and participants would be given \$75 for their completion of the study. This study was approved by the institutional review board at Washington University in St. Louis.

The average age of the sample was 41 years ($SD = 1.64$). Most men had completed high school (35%; 9 of 26) or some college (31%; 8 of 26). There was an even split in employment status as half the men in the sample were currently employed full-time (27%; 7 of 26) or part-time (15%; 4 of 26) and the other half were unemployed (39%; 10 of 26). The majority of participants indicated that they had never been married (54%; 17 of 26). Table 1 displays the full sociodemographic characteristics of the study sample. Four focus groups were scheduled with the plan to conduct more groups if necessary. At the end of four groups, the research team sent the audio recordings out for transcription and on receipt of the transcripts, began the coding process. At the end of this process, described in detail below, the research team concluded that more focus groups would not likely reveal new information (Morgan, 1997). Given the racial and socioeconomic homogeneity of this group, it is not likely that conducting more focus groups would provide additional information (Rice & Ezzy, 1999).

Potential participants called the study coordinator, an African American woman, who determined eligibility and scheduled participants for a focus group via telephone. During the focus group sessions, research assistants welcomed participants, led them through the informed consent process, and served as note takers

during the focus group sessions. Participants provided verbal and written consent for participation prior to the start of the focus groups. Participants completed a short (20-item) questionnaire, while they waited for the focus group to start. The questionnaire captured demographic data such as age, educational attainment, and marital status. This questionnaire was self-administered and provided useful demographic data for the sample that could not be captured during the focus group sessions.

The research team was led by a trained and experienced African American, male focus group facilitator. Two trained graduate students, one African American male and one African American female, served as research assistants for the study. The focus group guide included the following questions:

- Everyone has stress. What things stress you the most?
- What does the word “depression” mean to you?
- How would you feel if one of your friends told you that he was depressed?
- How do you deal with stress or negative feelings?
- Would you be open to talking to a professional, such as a counselor, to help you deal with stress?
- Would you be open to talking to clergy, like a pastor or priest, to help you deal with stress?
- What do you think prevents men, particularly Black men, from seeking depression treatment?
- What resources would be helpful to you if you were feeling stressed or depressed?

As a way of introduction, the facilitator welcomed participants, introduced the research team, thanked participants for their time and participation, and had a brief ice-breaking activity to help build rapport among the group. Sessions lasted an average of 90 minutes. Each session was audio recorded and digital recordings were sent to a professional transcription company for verbatim transcription. The focus group facilitator and graduate student note takers reviewed transcripts carefully to ensure the transcripts captured nuances and colloquialisms. Transcripts were later uploaded into the qualitative data analysis software package NVivo 10 (QSR International, 2012).

The coding process was carried out by four independent analysts. Each analyst listened to the audio recorded focus groups and read the notes taken from each focus group. Analysts made marginal notes to underscore potential themes and highlighted specific text segments as an initial step in reviewing the transcripts and creating codes. The research team developed a list of codes, and a subsequent codebook, from review of the focus group transcripts and notes. In order to create codes, analysts identified text segments, coded those segments, and

sorted them to identify higher order themes (Morgan & Krueger, 1998).

Using electronic file sharing and a series of in-person meetings, analysts created a codebook that represented unique, independent text segments that captured the full breath of what participants said. The results of the coding efforts were reviewed, comparing code lists and eliminating duplication. In cases of disagreements, analysts discussed reasons for their coding of different text segments in different ways. In some cases, new codes were suggested and in others, the team agreed that some text segments would be more accurately represented by another code. Through this process, coders were also able to identify problems in the codebook from the initial coding and make appropriate changes to the codebook where necessary. Once a final list of codes was developed, coders independently coded the transcripts according to the final codebook and met once again to reach agreement on the codes that were applied.

The data were analyzed for key themes from the open coding process described above. The research team used thematic analysis to identify themes in the focus group data (Braun & Clarke, 2006). An inductive approach to identifying themes, based on what participants said rather than using a list of a priori codes or adhering to preexisting theoretical framework, was used in analysis (Braun & Clarke, 2006). The goal of this study was to characterize participants' perceptions of depression and depression treatment. The research team identified themes related to perceptions of depression and feelings about depression treatment that the focus group participants discussed in response to the research questions described above. A latent approach was used in characterizing themes. That is, the coding team looked for overarching themes out of the focus group discussions. Using the codebook, the analysts held a series of meetings to discuss the phenomena, meaning, and characteristics within the data (Dill et al., 2016).

Results

Prior to the discussion about depression, the moderator first posed the following question, "Everyone has stress. What things stress you the most?" This led to spirited discussions about the different stressors that participants experienced. Common responses included financial distress, parenting or child custody issues, and racial discrimination. Participants described a great deal of stress derived from financial instability, often due to unemployment or underemployment. Once participants engaged in the conversation and shared experiences of stress, specific questions about depression were asked.

Each focus group was lively and men appeared to participate freely and expressed that they enjoyed the

experience at the end of the groups. Some men remarked that they would like to participate in more focus groups. While there were many shared opinions about depression and mental health services, there were some disparate views expressed. For instance, in discussion of perceptions of depression in one of the groups, three men expressed the viewpoint that depression is not "real" or is simply a matter of perspective or attitude. These contrasts are discussed in further detail below. Perspectives about religion and spirituality were a common point of contention across the groups. The majority of participants expressed that spirituality and religious practices such as church attendance were important sources of support and shared that they would turn to clergy or fellow church members to help cope with stress and depression. However, a minority of men throughout the different groups expressed that they did not find religious practices to be helpful to them or shared that they had different religious beliefs than those that were shared by other participants. One of the focus groups was conducted just 3 days following the tragic shooting death of Michael Brown in nearby Ferguson. African American men in this group expressed a great deal of frustration and there were explosive conversations about perceptions of racial discrimination and discussion of instances of racial profiling by the police.

Perceptions of Depression

The facilitator asked participants the following, "What does the word 'depression' mean to you?" The most frequently occurring responses to this question were descriptions of depression as being down, feeling hopeless, and being stressed. The majority of responses related to perceptions of depression mapped onto common depressive symptoms such as anhedonia, depressed mood, appetite changes, sleep disturbances, and feelings of sadness (American Psychiatric Association, 2013).

A small number of participants across the four focus groups suspected that they had suffered from depression in the past or had experienced depression over their entire lives. In general, these men pointed to critical, traumatic events early in life, such as the untimely death of immediate family members, as key factors that lead to a battle with depression over the life course. One participant in his early 30s shared, "I've been depressed all my life. Just down, down, down . . . I'm in the sewers. I'm a ninja turtle." This participant further described depression as intense sadness and hopelessness. This comment referred to the cartoon and motion picture, *Teenage Mutant Ninja Turtles*, which chronicled the adventures of four mutant turtles who resided in the sewers. This participant used this analogy to indicate that he had been feeling so down and depressed for so long, he might be considered a ninja turtle.

Another theme related to perceptions of depression was the feeling of isolation. Participants described the process of separating themselves from family and friends. One participant in his early 30s described depression as the bottling up of emotions “you don’t open up about it, you just keep it [depression] to yourself, it just starts to, it can wear on your health, you mental state.” Another African American man in his mid-30s remarked about depression, “I go in a room turn all the lights out. I go in a room lay down on the bed, won’t get up.”

The description of depression as stress was a theme from this study as participants described depression and stress almost interchangeably. For instance, an African American man in his mid-30s described depression as follows:

Depression is the same as stress. Depression is the result of stress. Depression is when I’m stressed then I can’t get it out . . . I lose my appetite.

I think stress, worrying, being down about a situation and just struggling and keeping it bottled up in yourself and letting it just, you don’t open up about it, you just keep it to yourself, it just starts to, it can wear on your health, your mental state . . .

Another common description of depression expressed throughout the groups was depression being akin to death. Death was discussed in the context of suicide and suicide ideation; participants in one group noted a number of notable celebrity suicides that had recently occurred. An African American man in his mid-30s described depression as follows:

When I think of depression, I think of death. When you say the word depression . . . end result . . . taking your life. Too depressed . . . they don’t want to go on. Don’t want to live. I don’t look at death as being in the ground. I look at death as giving up on your life. Giving up period!

Participants also described death as giving up or “just existing.” One participant described depression as death with the following statement, “I think of depression is when you feel hopeless, when you have no hope, no faith, you feel powerless, and you are not living. You just exist. You are nothing.” These descriptions indicate that African American men in this sample grasped the severity and disabling nature of depression.

The research team used focus groups as the data collection method for this study to compare and contrast different viewpoints. In this case, contrary to the perspectives of depression discussed above, there were a small number of participants that remarked that depression does not exist. Rather, a few participants in one group described depression as a feeling that is volitional and indicated that

one could choose whether to succumb to feelings of depression. The participants who expressed this view of depression used words like weakness, pity, and pointless. For instance, a participant in his mid-30s stated: “Me personally, I don’t believe in depression. I don’t. I don’t believe it. I consider it a pity party. It’s excuses. I don’t believe in excuses.” Other participants who did not think that depression was real described that depression was a choice and that people should not be depressed. For instance, an African American man in his mid-30s expressed the following, “In my opinion, it [depression] really is a state of mind. I don’t want to say it’s weakness but that’s kind of how I feel. I feel its weakness taking over.” He continued with the following statement:

I think we put our own self in a state of depression. I had to learn it the hard way. Depression is basically built on you. So you actually throw your own self under the bus when it comes to depression. It’s a mind thing. I think depression is like pointless now, since I understand and got over. I feel like it’s pointless. People shouldn’t be depressed.

Although these perceptions of depression were in the minority, they emphasize those participants’ desire to control depressive feelings and minimize their effect on their lives. For instance, one participant shared,

I internalize things, some people say that is not good, I internalize it and make everything that happens in my life my fault. I make it my fault because then that way it will help me find a solution and make me better myself.

These perspectives, while counter to the feelings of depression as sadness or feeling down, could indicate that some African American men would prefer to consider depression as a problem that can be fixed.

Perceptions of Depression Treatment

Following the discussion of stress and perceptions of depression, the focus group facilitator transitioned to discussion of depression treatment. The facilitator asked a series of questions to understand how participant coped with feelings of stress as well as their perceptions of using mental health services to help with depression. The facilitator opened this discussion posing a general question, “How do you deal with stress or negative feelings?” and then probed for specific opinions on mental health service use. In response to the question “What do you think prevents men, particularly Black men, from seeking depression treatment?” participants mentioned several significant barriers, including affordability, stigma, mistrust, and masculinity related social norms. Nonetheless, the majority of participants shared that they believed that it was important to seek help for depression when necessary. While most

men did not want to take medications or expressed access related barriers to seeking mental health services, they did provide specific examples of the forms of help they would find acceptable.

A significant barrier to mental health treatment for majority of men in this study was that participants did not want to seek regular medical treatment. The affordability of treatment was a concern for mental health problems along with health care in general. Men expressed that they did not want to have another stressor to worry about and felt they would be better off not knowing about a particular disease or health condition, especially if they did not have health insurance or adequate financial resources to do anything about it. One participant noted that while he was initially excited to learn about the Affordable Care Act, he perceived that he would only be eligible for coverage if he had a job. Another African American man in his early 50s stated, "The only time I go to the doctor is if I am on my deathbed or something. When it comes to health, you just stress period." He continued by saying the following:

The only thing that can probably put me in bad health is going broke around this time. Going broke, I know I will be in bad health. I know that will put me in bad health going broke around here. My money is tight enough around here. It is stressful.

These perspectives indicate that costs associated with health care in general are a major barrier to seeking formal mental health services, such as a counselor or psychiatrist, among African American men in this study. Furthermore, participants noted that they were not quite sure how to seek mental health services but knew it was expensive. Overall, men in this study perceived that interacting with the health care system was a stressor in itself and considered health care, including mental health services, as an additional expense that they did not have the financial resources to cover.

Another theme related to depression treatment was concern over use of antidepressant medication. Participants largely indicated that they did not find medication an acceptable form of treatment. These views were informed by a general mistrust of the medical system along with fears over antidepressant usage. A participant in his mid-30s stated, "When you medicate yourself, you are killing everything that you have . . . now you are living for the medication to medicate yourself. Everything isn't medical but it is spiritual." Another participant in his late 40s stated, ". . . you remember One Flew Over the Cuckoo's Nest, you remember they had what you call back in the day . . . they would give them a lobotomy."

When asked if there were any additional comments at the conclusion of one group, a participant in his mid-30s

simply leaned into the voice recorder and stated plainly, "No Pills!" The African American men in this study overwhelmingly did not want to take medications as a form of treatment for depression. Fears about medication, especially the concern that their personality could be altered, appeared to be the primary reason men did not agree with medications as an acceptable treatment modality.

Concerns about privacy, particularly discomfort with the idea of being judged by a professional that they did not identify with culturally or socioeconomically. For instance, an African American man in his early 50s remarked, "Being judged, that's what prevents it [seeking treatment], people don't like, and we're very secretive, we [Black men] don't like people to know our business." Another participant in his early 30s stated as follows:

. . . as far as the psychiatrist, certain people feel like that's being judged . . . they [psychiatrists] don't say nothing, they just sit and write, sit and write, people feel like they're being judged, so a lot of people are not going to speak.

These excerpts indicate that African American men in this study did not feel comfortable seeking mental health services from formal service providers such as psychiatrists due to concerns about privacy and being judged. These perspectives may also indicate that participants did not trust providers.

Masculinity, specifically concerns about being labeled as weak or crazy, was another barrier to seeking mental health services that was identified in the focus group data. A participant in his early 30s stated, "Man don't want to see them cry, breakdown." Another man in his mid-30s stated the following regarding depression and seeking help for depression:

The fact of being a man, you know, I don't feel like, but it's just like if we show a sign of weakness . . . so you got to be strong and hard forever, you can't cry not one time, you can't say nothing weak, it's just like alright, I'm going to just be this tough forever. You even bring your children up like that now. You tell your child, kill all that crying, he comes whining to you, calm all that down, even with the girls too, even with the girls, I don't want to see no tears.

These data indicate that African American men in these focus groups did not want to seek depression care due to concerns about being perceived as weak. Norms of masculinity was a factor that lead participants in this study to conceal their emotions and not share feelings of depression or seek treatment.

Discussion

The goal of this focus group study was to examine perceptions of depression and views on depression treatment

among African American men in St. Louis. Participants described depression as sadness, depressed mood, and changes in appetite as well as being down and feeling hurt or pain and in addition to feelings of weakness. These descriptions are consistent with *Diagnostic and Statistical Manual of Mental Disorders—Fifth edition* symptoms as well as results in the extant literature (American Psychiatric Association, 2013; Bryant-Bedell & Waite, 2010; Watkins & Neighbors, 2007). Similar to results from previous studies, the terms depression and stress were used interchangeably and participants often identified stress as the primary cause of depression among this sample of African American men (Kendrick, Anderson, & Moore, 2007). Men also discussed the experience of becoming isolated and disengaging from social support networks. These findings indicate that in the face of stress, some African American men found it necessary to withdraw from their networks, which, in turn, could increase risk of depression or worsen depressive symptoms.

Most men in this sample had never sought treatment for depression and participants discussed a number of barriers to seeking depression treatment, including norms of masculinity, mistrust of the medical system, and affordability of care. When asked about acceptability of depression treatment, participants expressed that they did not want to be treated with antidepressant medications. Participants' objections to medication use were primarily due to concerns over potential side effects and mistrust. These findings are consistent with results from previous studies, as researchers have observed that African Americans were less likely than Whites to perceive antidepressants as acceptable (Cooper et al., 2003). Among the small minority of men who reported that they had sought mental health services in the past, participants shared that they felt negatively judged by providers or felt that providers could not relate to the stressors in their daily lives. Mistrust may prevent men who need help from seeking it and may have likely limited what they shared with providers, which could negatively affect the quality of treatment they receive. Results from this study and others indicate that African American men realize that they may have been depressed in the past but did not seek treatment. The need to increase the number of African American men in depression care and to improve the treatment quality of African American men who seek mental health services, including improving relationships with mental health providers, is clear.

Several interesting findings emerged from this study. First, most participants in this study did not indicate that they were unwilling to seek out professional assistance in dealing with depression. The majority of African American men in this focus group study considered depression a debilitating problem and were supportive of depression treatment. Engagement with the health care system was

perceived as an additional stressor and unless there was a health concern that was absolutely emergent, such as being shot or stabbed, men in this sample reported that they were unlikely to seek medical treatment for any condition, including depression. Although there are increasing efforts to integrate behavioral health care into primary care settings, many African American men do not regularly engage with the medical system (Chandler, 2010; Snowden, Catalano, & Shumway, 2009; Van Houlven et al., 2005). In the 2015 SAMHSA Racial/Ethnic Differences in Mental Health Service Use among Adults report, cost of treatment and lack of insurance coverage were the most frequently cited reasons for not utilizing mental health services across all racial/ethnic groups. Considering that cost is a major barrier to depression treatment, more efforts are needed to alert African American men of their coverage and to find ways to provide affordable treatment to those who need services most.

Relatedly, a second unique finding from this study was that men in this study voiced their desire to discuss stress in nonjudgmental support groups. Some men shared their experiences in other types of support groups, such as alcoholics anonymous and narcotics anonymous, and expressed their belief that support groups could be helpful in finding support and solutions to the problems they faced. Participants reported that just talking about their stressors in a comfortable, nonjudgmental group setting, such as participation in this focus group study, was helpful and they would welcome more opportunities to do so. These findings lend support to recommendations to involve the kin networks of African American men who may suffer from depression (Hankerson, Suite, & Bailey, 2015; Watkins & Neighbors, 2007).

Although there are few studies that have examined the effectiveness of group support models that have been tailored to address mental health needs among African American men, there is evidence that support groups may be an effective strategy in treating depression in this population. For instance, Elligan and Utsey (1999) evaluated the efficacy of support groups among African American men and identified that support groups can be used to help African American men cultivate coping strategies to address stress, particularly race-related stress. Utsey, Howard, and Williams (2003) also developed an effective group based support program for African American male adolescents and their program was successful in reducing maladaptive behaviors.

Third, a small group of participants expressed disbelief of the idea of depression. Conversely, these participants explained their desire work through stress and depression rather than being weak or "throwing a pity party" (Ofonedu, Percy, Harris-Britt, & Belcher, 2012). These perspectives underscore results from previous studies that indicate men attempt to overcome feelings of

depression with work or stoicism (Ofonedu et al., 2012; Teti et al., 2012). Findings from previous research indicate that African American men attempt to work hard to overcome stress and feelings of depression (Hudson et al., 2016; Hudson, Neighbors, Geronimus, & Jackson, 2016; Ofonedu et al., 2012). This finding indicates that it may be difficult to identify some African American men who could be suffering from depression but choose not to discuss their feelings, especially with mental health providers. Furthermore, about half of the sample reported that they were currently unemployed and most participants described a great deal of stress due to unemployment or underemployment. So men in this sample may have been at increased risk of depression due to lack of viable employment opportunities, especially since unemployment is so strongly associated with depression (Hudson, Neighbors, Geronimus, & Jackson, 2012). Unemployment, especially over a long period of time, is associated with feelings of shame, embarrassment, and isolation. These factors are associated with depression and could further undermine efforts to remain stoic and cope with negative mood through hard work (Van Horn & Zukin, 2011).

Strengths and Limitations

The focus group structure helped the participants feel comfortable sharing their thoughts and nearly all participants mentioned that they would have like to participate in another group because they found the experience helpful and reduced the stress they felt. There are a number of limitations that should be considered when interpreting these findings. The inclusion criteria for this study was broad and there the composition of the groups were not conditioned on mental health status, previous mental health service utilization, or sociodemographic factors such as age or socioeconomic status. The focus group facilitator was an African American man, so it is possible that bias was introduced into the study. For instance, there could have been assumptions made by the facilitator rather than probing deeper and uncovering more information. Similarly, one of the questions in the focus group guide, "What do you think prevents men, particularly Black men, from seeking depression treatment?" could have introduced bias into the study since respondents were restricted to think about prevention of depression care. Another limitation is potential history bias. These focus groups were conducted in North St. Louis City in the days preceding and immediately following the tragic shooting death of Michael Brown in nearby Ferguson, Missouri and the subsequent protests and uprisings throughout the community could have influenced the findings garnered from this study. For instance, participants in the group that was conducted just 3 days following the shooting focused much more on perceptions of racism

and expressed more frustration than the previous groups. It is possible that the tone of this group could have affected men's perspectives on stress as well as feelings of mistrust.

Future Research

While the findings from this study are important, many of the men in this sample were uninsured. There have been national policy changes related to mental health coverage. The Patient Protection and Affordable Care Act of 2010 has expanded health care coverage to over 16 million previously uninsured Americans and sought to improve quality of care (Blumenthal & Collins, 2014), and the Mental Health Parity and Addiction Equity Act (Centers for Medicare & Medicaid Services, n.d.) requires health plans and health insurance companies to provide coverage that is no more restrictive in care for mental health or substance use disorders, such as co-pays, deductibles, and number of visits, than is it is for medical or surgical procedures. One future line of inquiry is the examination of perceptions of mental health service use among African American men who have health insurance. Another future direction could be the examination of mental health treatment experiences among African American men who have recently pursued depression treatment after gaining health care access through the Affordable Care Act. Additionally, future research should examine includes factors on the provider side of the equation that could explain differential diagnosis of depression in African American men. For instance, some researchers have argued that African American men are more likely to be diagnosed with serious mental illness, such as schizophrenia, rather than depression (Metzl, 2009; Snowden, 2003; Whaley, 1997, 2001).

Considering that African American men likely underutilize mental health services, the results from this study indicate that some African American men could be suffering from depression. These men may not recognize that they are depressed due to differences in the conceptualization of depression. Additionally, there are also formidable barriers to depression treatment such as affordability, acceptability of treatment, mistrust of providers, and norms of masculinity. The results garnered from this study are informative for practice, policy, and future research this study highlight the need to increase the awareness of symptoms some African American men display and the need to provide culturally appropriate depression treatment options to African American men.

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