HHS Public Access

Author manuscript

Ethn Health. Author manuscript; available in PMC 2021 August 01.

Published in final edited form as:

Ethn Health. 2020 August ; 25(6): 777–795. doi:10.1080/13557858.2018.1455811.

‘Sharing things with people that I don’t even know’: Help-seeking for psychological symptoms in injured Black men in Philadelphia

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Abstract

Objectives: Psychological distress is common in survivors of traumatic injury, yet across United States’ trauma systems, it is rare that standard injury care integrates psychological evaluation and professional mental healthcare. The purpose of this study was to explore help-seeking for psychological symptoms in injured Black men living in Philadelphia.

Design: A subset of a cohort of 551 injured Black men admitted to a Trauma Center in Philadelphia participated in qualitative interviews that explored their perceptions of psychological symptoms after injury and the factors that guided their decision to seek professional mental health help. Data from 32 participants were analyzed for narrative and thematic content.

Results: Three overarching themes emerged: (1) facilitators of help-seeking, (2) barriers to help-seeking, and (3) factors underlying the decision not to consider professional help. Five participants felt that their injury-related psychological distress was severe enough to merit professional help despite any perceived barriers. Seventeen participants identified systemic and interpersonal obstacles to professional help that prevented them from seeking this kind of care. These included: financial constraints, limited access to mental healthcare services, and fear of the judgments of mental healthcare professionals. Ten participants would not consider professional help; these men perceived a lack of need and sufficiency in their existing social support networks.

Conclusions: Research is needed to inform or identify interventions that diminish the impact of barriers to care, and identify from whom, where, and how professional mental health help might be more effectively offered to injured Black men in recovery environments like Philadelphia.

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Keywords

Help-seeking; Urban Health; Mental Health; Mental Health Services; Trauma; Injuries; Black Men; Philadelphia

Introduction

Psychological symptoms are common in survivors of traumatic injury. The rate of depression and posttraumatic stress disorder (PTSD) in the injured population is as high as 56% (Zatzick, Russo, and Katon 2003; Zatzick et al. 2004; Vles et al. 2005) and 27% (Holbrook et al. 1998) respectively. Even when an injured person appears to have physically recovered, debilitating psychological symptoms can linger (Richmond, Kauder, and Schwab 1998; Holbrook et al. 1998; Zatzick, Russo, and Katon 2003; D. F. Zatzick et al. 2004). These symptoms present significant challenges to the restoration of social and familial roles, ability to work, and quality of life after injury (Holbrook et al. 1998; Vles et al. 2005; Richmond et al. 2009; Jacoby, Shults, and Richmond 2017)

Screening for psychological symptoms and referral to professional mental healthcare may be key interventions to optimize injury recovery. United States' (US) trauma systems, however, have not been yet been designed for comprehensive integration of psychological evaluation and services (Love and Zatzick 2014). The optimal care of the injured patient as it is currently evaluated across health systems is based on criteria developed by the Committee on Trauma of the American College of Surgeons (Trauma 2014). These criteria focus on injury survival and maximizing physical and functional outcomes in pre-hospital, acute care, and rehabilitation settings (Richmond and Aitken 2011). This focus often leaves injured people responsible for identifying their own psychological symptoms after injury, and to find support and assistance when they perceive that these symptoms are problematic.

Without the burden of recovering from an injury, there are individual and systemic barriers that inhibit help-seeking for psychological distress (the awareness of and disturbance from psychological symptoms). In fact, the majority of people living with psychological symptoms do not seek help from professional mental healthcare providers (Savage et al. 2016). Many interpret their symptoms as unsuited to professional care or favor informal, self-reliant, coping strategies (Savage et al. 2016). The stigma associated with psychological diagnoses can also be a strong disincentive for help-seeking behaviors (Savage et al. 2016; Ward and Besson 2013; Stolzenberg et al. 2017; Kantor, Knefel, and Lueger-Schuster 2017). Other prominent barriers include low mental health literacy, limitations in time and financial resources and fears of re-experiencing traumatic events (Kantor et al. 2017). Though there has been less research attention to the facilitators of help-seeking (Kantor et al. 2017), there is some evidence that health system interventions, like physician referrals, can significantly increase professional mental healthcare utilization after a physical trauma (Wong et al. 2009).

The aim of this analysis was to qualitatively describe how Black men in Philadelphia perceived their experience of psychological symptoms after injury and their need for professional mental healthcare. This study was embedded within a large prospective cohort

study of the psychological effects of traumatic injuries in urban Black men. The specific focus on urban Black men is intended to bring greater attention to a population highly vulnerable to trauma, injury, and challenged recovery experiences; Black men are at heightened risk for life-threatening injuries that result from violence, and suboptimal physical outcomes after injury across US trauma systems (Haider et al. 2008; Arthur et al. 2008; Kalesan et al. 2014). Black men may also have increased susceptibility to psychological symptoms after injury (Rich and Grey 2005) due to disproportionate exposure to social factors associated with depression and posttraumatic stress, including: racial discrimination, unemployment, incarceration and residence in segregated and economically-disadvantaged neighborhoods (Williams and Collins 2001; Pieterse and Carter 2007).

If trauma care systems were designed to better address psychological recovery, mental health services will need to be offered in a way that is accessible and acceptable to all. Mental healthcare utilization after physically and psychologically traumatic events, is significantly lower in individuals who identify as Black, male, and those with lower income and fewer years of education (Ghafoori, Barragan, and Palinkas 2014). Mistrust of providers and perceptions of racial discrimination in healthcare encounters are well-described limitations to help-seeking for mental health issues in Black patients (Nicolaidis et al. 2010; Holden et al. 2012; Williams 2012; Hankerson, Suite, and Bailey 2015). The stigma of help-seeking, the perception that professional mental healthcare is prohibitively expensive, and social norms around masculinity are additional barriers that have been previously described in research focused on Black men (Hudson et al. 2016). Experiencing symptoms after a traumatic event can also change if and how victims seek supportive services. A study of urban crime victims found that acute stress symptoms of avoidance were associated with a lower likelihood of receiving psychotherapy and case management services in the aftermath of assault (Alvidrez et al. 2008). Victims with hyperarousal were more likely to receive case management but not psychotherapy, suggesting that while they perceive a need for assistance, they prefer help meeting concrete needs (Alvidrez et al. 2008). As a second goal of this analysis, we sought to identify the factors that shaped injured Black men's decision to seek professional help and their preferred sources of assistance when experiencing psychological distress.

Methods

Potential participants for this analysis were drawn from a cohort of 551 Black men admitted to a Regional Resource Trauma Center in Philadelphia with a diagnosis of injury and who were consecutively recruited from January, 2013 to May, 2016. To be eligible for inclusion, patients needed to identify as male, Black, reside within the greater Philadelphia metropolitan area, and be hospitalized for an acute traumatic injury. Patients were excluded if they had a pre-existing mental status dysfunction or a central nervous system injury, acute psychotic disorder, or were currently being treated for depression and/or PTSD. Pre-existing mental status dysfunction was defined as any neuropsychiatric issues that would impair functioning, orientation and behavior. All potential participants were screened by a registered nurse to determine if a patient's mental status, level of consciousness or history of mental health diagnoses in their medical chart would render them ineligible to consent to

study participation; drug and alcohol abuse were not considered in exclusion criteria unless they precluded informed consent.

The study protocol was approved by the institutional review board of the University of Pennsylvania. The purpose and procedure of this research were fully explained to eligible patients who met inclusion criteria. After all questions were answered, if an eligible patient agreed to participate, they provided written informed consent. Participants were interviewed in a private setting in the hospital and then at three months after hospital discharge in their homes. Intake interviews included a suite of survey items designed to capture demographic, social, environmental, occupational, life course characteristics, injury descriptors, acute stress responses and peri-traumatic subjective experiences. Intake assessment also included items (yes/no) to capture a history of depression, PTSD and/or general anxiety disorder (GAD), panic disorder, social anxiety and/or obsessive compulsive disorder (OCD) (Centers for Disease Control and Prevention 2011).

The 3-month interview included a structured assessment of depression and PTSD symptom severity. Depression symptom severity was measured using the Quick Inventory for Depressive Symptoms-Short Form (QIDS-SR_{16})(Rush et al. 2003). This inventory has a strong psychometric profile and sensitivity to symptom changes (Rush and Trivedi 2004). Scores range from 0–27 with higher scores indicating more severe symptoms. A cut point of ≥11 was used to identify those who met diagnostic criteria for depression (Lamoureux et al. 2010). PTSD symptom severity was measured using the PTSD Checklist for DSM 5 (PCL-5), a 20 item self-report symptom severity measure with responses elicited in reference to the index injury (Blevins et al. 2015). Scores range from 0 to 80. A cut point of 33 was used to identify those with a provisional diagnosis of PTSD.

A random sample of approximately 20% of cohort participants, representative of the larger cohort, was invited to participate in additional in-depth qualitative interviews. A trained interviewer conducted all interviews using a semi-structured guide to prompt participants' description of their experiences after injury, and the strategies and challenges that they felt enhanced or worsened their recovery. The interviewer elicited perceptions of help-seeking using the question: 'Has there ever been a time when you've considered talking to a professional about these experiences?' Each participant could interpret who and what training or background comprised a 'professional.' If they had considered talking to a professional, participants were asked to identify from whom and where they had (or would) seek this kind of healthcare and their appraisal of its effectiveness. If they hadn't or wouldn't consider talking to a professional, participants were asked what prevented help-seeking. They were then asked the characteristics of care providers, healthcare settings, and financial and/or logistical access that would make help-seeking more likely.

Each audio-recorded interview was transcribed verbatim using standardized transcription instructions, after which each transcript was checked for accuracy against original audio recordings. Names and other identifiers were removed to protect participants' anonymity. Data were then managed for analysis using NVivo version 10. Descriptive statistical analyses were conducted using SPSS v. 24.

Analysis

We analyzed interview data using both thematic and structural narrative analysis. To facilitate the structural narrative analysis, the interview text was parsed into stanzas, where each stanza is a group of lines about one important character, topic or perspective. In this approach stanzas come together to tell the entire story (or narrative) (Riessman 2008). Each stanza provides a source of understanding (as opposed to the single line) through which to capture the richness of participants' perspectives on their psychological distress and help-seeking.

Four members of the research team created a codebook through a series of iterative readings of interview data, meetings to discuss initial nodes, clarification of nodes and sub-nodes, and consensus on any points of disagreement. Using the codebook, all of the interviews that had been completed through August 2016 (n=75) were coded for content related to participants' experiences after injury. Content on help-seeking was identified in 38 interviews.

Three team members independently reviewed all 38 interview transcripts and used narrative analysis approach to identify attitudes towards help-seeking. Interviews were first categorized by the way in which their narrative indicated help-seeking intent (would or have considered talking to a professional after injury/would not consider talking to a professional after injury). Categorization was consistent between team members in the majority of cases, and all differences were discussed and collaboratively categorized by consensus. At this point 6 interviews were removed due to lack of substantive content specific to help-seeking. In the remaining 32 interviews, data were re-reviewed and analyzed to identify and describe the underlying facilitators and barriers to help-seeking intent. We then constructed a thematic schema which captured the ways in which participants described their perspectives on help-seeking for psychological distress.

Sample

Select characteristics of study participants are described in Table 1. Twenty-one participants (approximately 65%) were injured through interpersonal violence and 11 (approximately 35%) were injured unintentionally (e.g., motor vehicle crash, fall). This sample is generally representative of the larger study cohort; men in this qualitative analysis ranged in age from 18–67 years of age and had a relatively high rate of poverty which may challenge access to elective health services.

Participants were asked if they had ever been diagnosed with depression, PTSD, or an anxiety disorder prior to their injury (Table 2). Anxiety disorder was the most frequent diagnosis (25%) and PTSD the least (6.3%). Post-injury psychological symptoms, assessed at 3 months after hospital discharge, indicates that nearly 70% of participants met screening criteria for depression and more than half met criteria for PTSD (Table 2).

Results

Three key themes emerged from the analysis of participant interviews. These themes, listed below, are exemplified by participants' verbatim quotes: (1) Facilitators of help-seeking: 'I do need help'; (2) Barriers to seeking professional help: 'I don't want to end up in a strait

jacket'; and (3) Factors in the decision not to consider professional help: 'I don't want to talk to nobody about it' In our analysis, participants in the study fell into one of these three groups as shown in Figure 1.

Facilitators of seeking professional help: 'I do need help'

Five participants, all injured through interpersonal violence, acknowledged that they would seek or had sought professional help for psychological symptoms related to their injury at the 3-month follow-up. At the time of follow-up, two participants were actively engaged in treatment (1 in individual therapy through victims' assistance, 1 in substance abuse treatment program and individual counseling). Another participant had consulted with a mental health professional while in the hospital but was no longer in treatment. Two remaining participants acknowledged that they needed help and that their existing supports and coping strategies were insufficient.

The severity and persistence of psychological and emotional symptoms were a primary motivation for help-seeking. A 48-year old man who had been stabbed described the burden of his symptoms:

> I don't know how to put it in words.
>
> But, I'm just lost in a lot of areas because of this.
>
> But, it's really a lot of pressure on me right now.
>
> I do need, I do need help.

Participants' symptoms included difficulty sleeping, depressed mood, anxious thoughts, disturbing memories and mood swings. An 18-year old man who had been shot spoke about his anxiety and disturbed sleep.

> Then, if I do go to sleep I wake right back up.
>
> I have to take some medicine or something.
>
> I just be thinking about it.
>
> My mind is going to a thousand and one places.

A 27-year old man who had also been shot talked about his struggle to maintain focus and concentration.

> My mind cuts off and like automatically switches over.
>
> Just into laymen's terms. 'On its own.'
>
> Or sometimes when I'm walking,
>
> I'll go blank.

Distressing flashbacks came in the form of disturbing thoughts and sensations that were triggered by memories, conversations, or physical pain. After returning home from the hospital, the aforementioned 27-year old man described the pervasiveness of his flashback triggers.

[My flashbacks come from] certain commercials.

Or if me and my wife are talking about something.

Bringing up my kids or,

If I try to bend over and it hurts or something.

It's pretty much anything that'll trigger it.

Flashbacks were also triggered by violent events experienced by others in participants' social network. For the 18-year old man who was having difficulty sleeping, flashbacks were prompted during regular social interactions in his neighborhood.

I hear somebody talk about how they got shot.

Any little thing that I hear, it just sets me off.

For a 50-year old man who fell and was assaulted while drunk, his assault prompted flashbacks of being slashed with a box-cutter at 15 years of age.

It stirred it up.

I guess the assault triggered it.

I guess the assault triggered the thoughts.

This participant had history of alcohol and drug abuse and coped with the psychological symptoms he was experiencing by drinking. This made other aspects of his recovery more difficult. For him and others, overwhelming psychological distress was compounded by social, familial and economic stressors. He describes:

Couldn't get a job because of my alcoholism.

If I couldn't get a job there is no way possible I could get a place to stay

an apartment or a room.

So, I was just done.

That was like the breaking point.

Two participants reported thoughts of death or suicide after their injury. Neither had any previous comparable experiences but both perceived that feelings of helplessness, pain, and functional limitations, contributed to suicidal ideation. The 18-year old gunshot injured man described:

I can't do nothing. I feel like I'm helpless.

I feel like, damn, then I had thoughts.

I wasn't thinking about suicide.

I was thinking about 'yeah I want to live' and sometimes I was like 'nah.'

It's just crazy. Like sometimes I don't.

For these participants, their injury-related psychological distress affected their basic functioning enough that they felt open to seeking professional help despite any perceived barriers.

Barriers to seeking professional help: ‘I don’t want to end up in a strait jacket’

Seventeen participants had considered or would consider seeking help for their psychological distress after injury, but had not done so at the 3-month follow-up. Although these participants differ in the ways that they were injured (7 from intentional injuries and 10 from unintentional injuries) their symptoms were similarly frequent and persistent.

Participants identified a range of barriers that prevented outreach to a mental health professional. Four kinds of barriers were described: fear of judgment, the perception that mental health services were ineffective, lack of access to care, and inhibitive perceptions of social norms. All participants who considered seeking help described more than one kind of barrier. This suggests that the factors that discourage or prevent help-seeking may be multifaceted and mutually reinforcing.

Fear of judgment—Several participants believed that seeking care would subject them to negative judgments. They also expressed concerns about their privacy and reluctance for ‘sharing things’ with strangers. A 46-year old man who had been stabbed multiple times and then beaten by a stranger explained:

> I don’t want to end up in a strait jacket.
>
> Or someone telling me I’m crazy,
>
> That I’m a harm to myself or others,
>
> Because I’m not.

Other participants were similarly dissuaded from seeking help because they thought that they would be labelled as ‘crazy’ and/or that mental healthcare providers would not understand their lives. A 52-year old man who had been stabbed by an intoxicated acquaintance described his fear of being judged by a mental health professional:

> They would look at me and say I’m crazy or stupid,
>
> or just like I don’t matter.

Fear of judgment was also a deterrent to mental healthcare in group settings. A 24-year old man who had been stabbed, interpreted professional help to be group therapy and stated:

> I don’t think I want to be in a room with a full group
>
> and just talking about my issues.

Perceived ineffectiveness of professional help—Some participants had previous experiences with healthcare providers that made them skeptical of professional mental healthcare. A 46-year old man who had been stabbed spoke to a therapist immediately after his injury, but did not continue, because he did not believe it had any potential to help him.

> I really don’t think [there’s] much

they could [have said] or [done]

to make me feel much better.

A 63-year old man who had fallen, relied on public health clinics for his healthcare and did not feel he had been treated well in the past. This made him reluctant to seek help for the psychological symptoms he was experiencing after his injury.

they don't have compassion for people

…it's just poor service.

Perceived limitations in access to local mental health services—The most commonly described barrier to help-seeking was difficulty accessing services. This barrier was associated with poverty, lack of health insurance and limited knowledge of how to get professional assistance. For a number of participants, the cost of mental health services was perceived as prohibitive, particularly when they lacked health insurance. A 59-year old man who was struck by a car as a pedestrian, explained:

I get very, very depressed.

And I be wishing that I could talk to somebody.

But, I don't have insurance to do that.

Lack of information or direct referral to mental health services also prevented participants from seeking care. A 25-year old man who had been injured after falling from a window, stated:

I don't know who to talk to.

Tell me which way to go.

How to get counseling.

Another participant, a 42-year old man who had been intentionally hit by a vehicle, felt that he was refused healthcare services in the past because he had not completed prescribed intensive outpatient programs (IOP) for substance abuse. He believed that he would be denied help for his current symptoms and consequently he did not attempt to seek care.

They wouldn't treat me. Cause 'he's been there too many times,'

Not only that 'he has no insurance.'

Third, 'he never completes his IOP.'

Perceived social norms—Several participants talked about how their identity as men and being Black affected their willingness to seek help. These perceptions were described in concert with perceived financial barriers. A 32-year old man who was stabbed in a robbery explained he believed mental health services were for people who had 'a lot of money.' If these kinds of services were free of cost, then he'd consider seeking care, but would also have to contend with his perception (which he attributed to his father) that this kind of help-seeking was not masculine.

And you know, like, you don’t go talk to people,

About your problems.

For a female, yes.

But, it’s not manly for a man to do it.

It’s not seen as a manly thing to do.

In this generation.

How he raised me.

It’s like a sign of weakness,

To go sit there on a couch,

You know, and express your feelings.

‘Society’ was the main deterrent for a 49-year old man who was injured in a motor vehicle crash. He explained that:

Because those resources are [not] normally available to us.

when I say ‘us’ I mean Black people.

It’s not part of our culture.

It’s not part of our upbringing.

He further explained that he did not regard stigma, per se, as the primary barrier to seeking professional mental healthcare but rather:

That is more so lack of resources,

and lack of examples of people who have done the same thing.

Factors in the decision not to consider professional help: ‘I don’t want to talk to nobody about it’

Ten participants said that they would not seek or accept professional help in the aftermath of their injuries. Of these, eight had sustained intentional injuries and two sustained unintentional injuries. Reasons for declining professional help fell into two categories: those who acknowledged a potential need for guidance and support but did not want professional help and those denied needing any help.

Alternative strategies to cope with symptoms—Participants who did indicate a need for support described different ways they met their needs. These participants identified people in their family or community who could provide support. For these men, declining professional help was consistent with their strategies for coping. Some received counseling and advice from their support system, including spouses, close friends, family and church members/leaders. Several leaned on their faith in God for support while several others used alcohol or marijuana to deal with their symptoms.

A 47-year man who was hit by a car talked about help from his ex-wife and the use of prayer as his strategies for dealing with the anger he was experiencing after his injury.

She is the person that I look to when I'm angry or mad at the situation.

She kind of know how to kind get in my head to calm me down.

Also, I pray. And ask God to take the anger away from me.

'Cause for my whole life I've been angry.

I've been pretty much an angry person.

Another participant, a 67-year old man who had fallen at home, said that his faith in God and counsel from a church deacon met his need.

My deacon in church,

he comes the second Sunday of every month to give me communion.

And I can call him at any time for a prayer.

He's a man of God.

He knows power of prayer.

Several participants who did not want professional care but who acknowledged that they were experiencing distress favored self-reliance for coping. A 50-year old man who was stabbed, stressed his desire for privacy.

I'm kinda personal, you know, first of all.

So I don't want to talk to nobody about it

Because I don't want nobody knowin' what I'm goin' through.

And, second of all, I have an attitude.

Nobody can help me with me, but me.

Like sittin' here talking to you.

I don't know you.

But I just opened up, you know, a can of worms for me.

You know by just relivin' it a little while.

This participant was not alone in the concern that talking about his problems might make the problem worse or began to trigger stress. Another participant, a 42-year old man who was stabbed, coped with his distress by using marijuana and alcohol. He recalled how a friend had gone into therapy after the death of his son. He believed that this friend ended up worse off because he continued to talk about his problems.

Like what better does it do for him?

Like I think it's worse, to me

'cause he gotta keep talkin' about it.

He likes to talk about it.

But I don't think it's doin' good for him

talkin' about it all the time.

Did not interpret need for help—A number of participants did not believe that they needed help. For example, a 20-year old gunshot injured man stated clearly:

Nothing really kept me from it.

I just didn't think that I really needed it.

He described feeling strong/independent and self-reliant.

No. I don't have to.

I think I'm a pretty strong individual.

For others, the violent event that caused their injury was viewed as inevitable or as a simple fact of life. A 33-year man who was shot in an attempted robbery did not feel the need to talk to a professional, explaining:

I think life is going according to plan

And just the way things are supposed to go.

So, I don't think I really need to talk to a professional.

Believing that counseling or other mental health services is not needed, is a powerful and logical reason not to seek help, whether that belief stems from one's own sense of strength or from a sense that there is a 'way things are supposed to go.'

Discussion

Participants in this study described a variety of perspectives about help-seeking for the psychological consequences of their traumatic injuries. Most perceived a substantial burden of symptoms and a desire for help at three months after injury. These perceptions were concordant with the extent of their clinical symptoms; near to 70% screened positive for a symptom burden indicating depression, and over 50% for a symptom burden indicating PTSD. Nonetheless, very few felt that they wanted or would be able to seek professional mental healthcare.

Through our inductive analysis of interview data, we found that participants' interviews could be divided into three themes that reflected their willingness to seek help in combination with perceived barriers to doing so. For some, severity of symptoms was enough to make them receptive to seeking help. For others, willingness to engage with professional mental healthcare was undercut by perceived barriers at the systemic, interpersonal, and individual level. Systemic barriers that participants identified were financial constraints, lack of health insurance, and limitations in access to mental health services. The most widely-endorsed interpersonal barrier was fear of the judgment by mental health professionals. Personal deterrents included a lack of perceived need for professional help and the sufficiency of familial, friend, and faith-based support networks.

The findings of this analysis support other recent studies of help-seeking for mental health concerns in uninjured urban Black Men. Hudson et al. (2016) identified stigma, perceptions of unaffordability, mistrust of healthcare providers, and norms around masculinity as major barriers to care for depression. Ward and Besson (2013) identified many of these same barriers as well as systems-level obstacles including the lack of health insurance and limited availability of local mental health services. Participants in this second study also perceived that open discussion and general awareness of mental illness was limited in Black communities and this, in turn, prevented help-seeking for psychological distress. This current analysis is also consistent with a recent study of help-seeking in men who experienced sexual violence. These men reported reluctance to identify as victims or take the chance that negative emotions would resurface in an encounter with a mental health professional; some struggled to find a professional who would understand them and provide what they perceived to be nonjudgmental support (Donne et al. 2018).

Research with Black men and women diagnosed with depression have identified how the stigma of being viewed as ‘weak’ or ‘crazy’ can diminish help-seeking behavior and encourage symptom concealment (Campbell and Mowbray 2016). In our study, we did not identify stigma. per se, as a salient barrier to help-seeking. We did, however, uncover how stigma interacted with perceived economic constraints (i.e. it would appear weak to go to therapy but if it was free I would go) in some participant’s intentions towards seeking professional help.

Lindsey and Marcell (2012) explored the factors that influenced help-seeking for mental health symptoms in Black adolescent and adult men and identified preferences for isolation and introspection over professional help. Participants questioned whether health professionals would be able to relate to their lives. To these men, health professionals were ‘strangers’ and therefore regarded with a level of skepticism and mistrust. Professional mental healthcare was only endorsed for catastrophic life events that would potentiate a ‘tipping point,’ after which professional help might be necessary. These findings are supported by our analysis. The few participants who would seek professional care and did not interpret major barriers to doing so, described feeling like they reached a threshold after which they were no longer able to live with the severity of their psychological symptoms.

The majority of participants attempted to cope with their psychological symptoms on their own or through reliance on their existing support network. Studies of other Black men living with mental health disorders in US cities suggest that they are more likely to depend on informal support networks of family and friends (Woodward, Taylor, and Chatters 2011) and faith-based organizations (Young, Griffith, and Williams 2003; Hankerson, Suite, and Bailey 2015). Black patients are also more likely to seek help for psychological distress in emergency departments (EDs) (Snowden, Catalano, and Shumway 2009) and primary care settings (Holden et al. 2012). Use of these care settings may be ideal for screening and referral. However, exclusive reliance on emergency and primary care can limit treatment retention and effectiveness, which is optimal when facilitated by a mental health professional (Fortuna, Alegria, and Gao 2010). It may be that perceived barriers to professional mental healthcare are overcome at a threshold which prompts use of urgent and easily accessible, rather than specialized, mental health services. Nonetheless, any source of

treatment and support might be preferable to no support. If existing social networks or formal treatment options are not available or effective, unresolved psychological distress can lead to harmful coping strategies like substance use which can potentially contribute to chronic substance abuse (Rich and Grey 2005; Liebschutz et al. 2010) and other long-term health problems.

All of the participants in our study were Black men and we are therefore unable to compare them to similarly injured men of different races or to other genders to understand how health disparities manifest in the care of the injured. We can, however, highlight areas where race and masculinity may have influenced how participants viewed professional mental health care. The impact of perceived racial bias in healthcare encounters may be evident when participants expressed their concerns about being labelled as 'crazy,' particularly in light of their view that providers would not share their lived experiences. The legacy of racism and racial bias in mental health diagnosis is supported in the literature and participants may be reflecting how they observe these biases playing out in their lives and communities; a review of empirical research related to race and the diagnosis of psychotic disorders found that African Americans are diagnosed with psychotic disorders or Schizophrenia three to four times more frequently than Euro-Americans (Schwartz and Blankenship 2014). Other studies show that diagnostic disparities exists without evidence that African Americans demonstrate more severe symptoms or higher prevalence rates of psychosis (Neighbors et al. 2003). Some participants also offered the perspective that mental health care was not culturally normative among Black communities and that seeking such care is discouraged. In addition, threats to masculinity may underpin participants' concerns about appearing weak or having to depend on others for care and support.

Facilitating better psychological outcomes after injury may require specific efforts to diminish barriers and lower the threshold at which injury survivors are referred to or receive professional care for psychological symptoms. First and foremost, there is need to enhance the awareness of the relationship between injury and psychological symptoms (Richmond et al. 2003; Corbin et al. 2013; Love and Zatzick 2014) across the continuum of injury and professional mental healthcare. Approaching all injured people using a trauma-informed approach would enhance the opportunity to recognize psychological symptoms and prevent healthcare encounters that add to the psychological trauma of physical injuries. Healthcare providers and institutions that use a trauma-informed framing in their work: 1) realize that psychological trauma is widespread, 2) recognize the signs and symptoms of trauma in patients and their larger social support system including families, friends, and staff in the healthcare system, 3) respond by integrating knowledge about trauma in policies, procedures, and practices, and 4) attempt to identify and resist re-traumatization (Hopper, Bassuk, and Olivet 2009; Substance Abuse and Mental Health Services Adminstration 2015; Damian et al. 2017).

Clinicians who care for men of color after injury should also be aware of identified barriers, like the fear of being labelled crazy or skepticism of professional mental healthcare that inhibit help-seeking and self-advocacy for mental health services. Many victims of traumatic events avoid treatment due to their fear of re-visiting or re-experiencing traumatic memories (Kantor, Knefel, and Lueger-Schuster 2017). Counseling literature also describes a multitude

of a reasons why Black men, in particular, may approach mental healthcare with suspicion or hostility (Suite et al. 2007). These include socialization processes that discourage Black men from opening up to people outside of their family or social community and extend to personal and community histories which tie counseling to punishment or rehabilitation for crimes or other social offences (Lee 1999). Despite these barriers there are professional mental healthcare strategies which may facilitate more responsive and acceptable counseling for Black men after injury; examples are outreach counseling in homes, schools, and community centers to establish rapport, decrease mistrust, and initiate the counselor-client relationship (Harper, Terry, and Twiggs 2009) and approaches that acknowledge the dynamic of racism clients' lived experience and perception of mental healthcare (Lee 1999).

Interpersonal interventions are essential, but intervening at the system level and in a way that incorporates the needs of healthcare disenfranchised populations, is likely to have the largest impact (Ruzek and Rosen 2009). System-level barriers identified by participants in this study could be minimized through facilitated access to health insurance in patients who are uninsured, and/or referral to low-cost and free of cost professional mental health services that are accessible where patients live and recover. Integrating injury rehabilitation services with social services for enhanced economic and social support could be especially valuable for highly vulnerable populations (housing unstable, unemployed, and formerly incarcerated men) who present with injuries (Holden et al. 2012). Our study and others suggest that existing social networks are also foundational in creating support and encouraging professional mental care for Black men. Health systems should build on and mobilize these networks, beginning with specific inquiries to ask patients about their social support and faith-based activities, and using these networks to identify ideal partners in community-based efforts to enhance recovery after injury.

The findings of this study should be interpreted in the context of its limitations. Qualitative data collection was directed by open-ended interview questions that permitted participants to interpret 'professional help' in a variety of ways. Participants may have interpreted very different modalities of mental healthcare and professional healthcare providers. Our analysis and coding schema was limited by our conceptualization of 'professional' as a mental health provider or person who by education, training and experience is qualified to assess and diagnosis mental health conditions and provide counseling interventions (National Alliance on Mental Illness 2017). The participant who described seeking care from a Deacon from his church identifies a different but important cadre of professional help providers (Harper, Terry, and Twiggs 2009; Holloway 2017). Future studies may address ways in which trauma-informed education and training for faith leaders and other community-based professionals could offer pivotal opportunities for identification, referral and/or treatment of psychological symptoms that integrates the existing strengths of familial and community resources (Bell-Tolliver, Burgess, and Brock 2009; Young, Griffith, and Williams 2003).

Finally, the pointed focus on help-seeking after injury in a single race and gender group may oversimplify help-seeking in injured Black men in a way that belies their unique, lived experiences. With recognition that race and gender identities are socially constructed - this is not our intent. Rather, we believe that specific focus is warranted in order to bring greater voice to the experience of a group of patients with heightened vulnerability to psychological

distress after injury, limited attention in trauma care research, and for whom future in-depth research and intervention is essential.

Conclusions

Specific research is needed to inform interventions that can diminish the impact of potent barriers to care and identify from whom, where, and how professional mental health help might be effectively offered to injured Black men. By strengthening our understandings of help-seeking in this population and others living at high risk for poorer outcomes, we will be better positioned to create individually-responsive but widely-effective recovery programs that are seeded within the continuum of trauma care.

Acknowledgments

We wish to thank Andrew Robinson and Tara Fernandez for their administrative and technical contributions to this research.

Funding

This research was funded by grant: NIH R01NR013503, (PI: Richmond). Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the National Institute of Nursing Research/ National Institutes of Health.

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Key Messages

- Black men may be more susceptible to psychological symptoms after serious injuries
- Study participants identified multiple interpersonal and systems-based barriers to seeking professional mental healthcare
- Mental health interventions tailored to diminish barriers to mental healthcare utilization in injured Black men may improve psychological outcomes

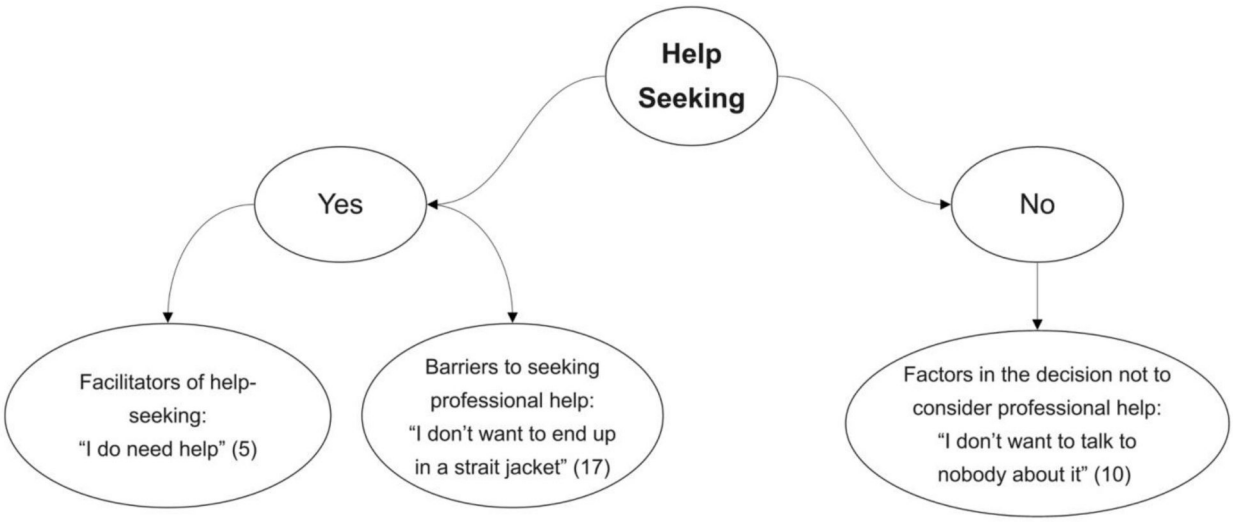

Figure 1:
Schematic of key themes

Table 1.

Sample Demographics

Variable	Mean (range) or Frequency
Age (years)	38.7 (18-67)
Annual income	
Less than $20k	59.4%
$20k −39,999k	12.5%
$40k −59,999k	9.4%
More than $60k	3.1%
Don’t know/not sure	15.6%
Is there a time in the past 12 months when needed to see a doctor but could not because of cost?	46.9%
Is there a person you think of as your doctor or your healthcare provider?	
One person	43.8%
More than one person	3.1%
No	53.1%

Table 2:

Pre-injury history of psychological disorders and post-injury screening for depression and PTSD

Variable	Frequency
Pre-injury history of diagnosis for	
Depression	
Yes	18.8 %
No	81.3%
Not sure	0%
Post-traumatic stress disorder	
Yes	6.3%
No	87.5%
Not sure	6.3%
Anxiety disorder (GAD, panic disorder, social anxiety, OCD)	
Yes	25%
No	71.9%
Not sure	3.1%
Positive screening assessments for symptom severity at 3 months after injury indicating	
Depression (≥11QIDS)	68.8%
Post-traumatic stress disorder (>33 PCL5)	53.1%