

“We’re Going Through a Lot of Struggles That People Don’t Even Know About”: The Need to Understand African American Males’ Help-Seeking for Mental Health on Multiple Levels

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Michael A. Lindsey, PhD, MSW, MPH¹ and Arik V. Marcell, MD, MPH²

Abstract

Young adult Black males face challenges related to addressing their mental health needs, yet there is much more to know about their help-seeking experiences. Twenty-seven Black males, recruited from four community-based organizations, participated in four focus groups to explore perceptions of help-seeking for mental health. Identified themes, which function at individual, social network, community, and health care system levels, may facilitate or hinder Black males' mental health help-seeking. Themes included (a) “taking care of it oneself” as opposed to seeking help from someone; (b) issues engaging sources of help, including the ability to trust providers or the relationship closeness with social network members; and (c) “tipping points” that activate help-seeking to avert crises. Study findings provide initial evidence about the importance of addressing mental health interventions for Black males on multiple levels beyond the individual including engaging men's social supports, community, and the health care system.

Keywords

help-seeking, African American males, mental health

Black males are often reluctant to seek help for both health and mental health issues, despite the range and severity of health- and mental health-related problems affecting them (Tsio-A-Fatt, 2010). For example, Black males—relative to Black females, White males and females, and Latino males and females—suffer from more completely preventable diseases (Gadson, 2006; Williams, 2003; Wong, Shapiro, Boscardin, & Ettner, 2002) and face greater morbidity and premature mortality from these preventable, yet treatable conditions (Hammond et al., 2011; Jones-Webb et al., 2009). A pattern of lower service use relative to mental health also exists among Black males. For example, among Black adolescents, males account for more than 80% of suicides (Joe, 2006), which, in part, is due to their lower use of mental health services for issues like depression and anxiety (Lindsey et al., 2006). Young adult and adult Black males aged 25 years and older are also less likely to receive substance abuse services (Wells, Klap, Koike, & Sherbourne, 2001). Indeed, untreated mental health problems are the most formidable precursor to patterns of substance abuse for this group (Corcoran & Corcoran, 2001; Harris & Edlund, 2005; Khantzian, 2003; Oliffe et al., 2010). The lack of treatment of mental health and substance abuse problems among Black adolescent and young adult males

is particularly alarming because of the negative correlation between these untreated problems and other more serious physical health problems (e.g., diabetes, obesity, cardiovascular disease; Aarons et al., 2008; Chen et al., 2009; Cohen, Pine, Must, Kasen, & Brook, 1998; Goodwin et al., 2009).

Frameworks on health care use provide guidance for understanding factors that can potentially influence men's health care use, including the sociobehavioral (Andersen, 1995) and health belief (Becker, 1976) models. For example, these theories suggest that individual-level factors (such as personal knowledge and beliefs about health, income, and health-related need(s)), and health care system-level factors (e.g., service accessibility) can affect a person's use of health services. Specifically, as it pertains to Black males' mental health care seeking,

¹University of Maryland, Baltimore, MD, USA

²Johns Hopkins University, Baltimore, MD, USA

Corresponding Author:

Michael A. Lindsey, University of Maryland School of Social Work, 525 W. Redwood Street, Baltimore, MD 21201, USA
Email: mlindsey@ssw.umaryland.edu

theory on gender, culture, and social support can provide additional insight. For example, Addis and Mahalik (2003) discuss the role masculine ideology plays in understanding men's help-seeking and access to care, especially for emotional and psychological problems. Neighbors (1991) describes the role that environmental factors (e.g., socioeconomic), situational factors (e.g., discrimination), and intrapsychic factors play in causing Blacks' psychological distress. Neighbors also discusses the role that informal supports (e.g., family, church) play and how they may offer nontraditional solutions (e.g., prayer) instead of professional help. Rogler and Cortes (1993) describe the specific role that social and cultural influences have on help-seeking and emphasize that cultural norms may not prompt help-seeking unless a person views the issue as very undesirable by his/her cultural context. Finally, Pescosolido's (1991) social network-episode model, focusing on the role that social networks play in the help-seeking process, including network size, content, and structure, describes how social networks can influence sociocultural beliefs, attitudes, and perceptions about mental health care and, ultimately, care receipt. To improve our understanding of Black men's problem recognition and eventual help-seeking for mental health issues, however, we need to simultaneously examine the role that gender, social and cultural level factors play in addition to individual and healthcare system level factors.

Much of what we know about help-seeking for mental health care among Black males (i.e., youth and adults) emanates from the perspective of those who have been diagnosed or who have received mental health services at some level. Prior research has identified a number of factors influencing mental health service use among Black males including fears of being labeled, confidentiality breaches and that health professionals will not understand unique ethnic-related challenges (e.g., harassment from law enforcement officials, negative interactions with school personnel); anticipating stigma from others, being misdiagnosed; and mistrust of health professionals due to past mistreatment of Blacks in the U.S. mental health system (Blank, Mahmood, Fox, & Guterbock, 2002; Chatters, Taylor, & Neighbors, 1989; Lindsey et al., 2006; Snowden, 2001). Examining perceptions of psychotherapy and psychotherapists among Black adults, Thompson, Bazile, and Akbar (2004) found that cultural norms, lack of knowledge about therapy, and mistrust to be major factors related to seeking help. Additionally, issues such as perceived social stigma, mistrust of White psychologists, and fear that the psychologist would not understand their unique cultural perspectives can lead to negative attitudes about help-seeking (Thompson et al., 2004). Duncan (2003) also found that Black college males with high levels of cultural mistrust reported more negative attitudes toward professional help. Whereas

prior research has found that Blacks, in general, report more positive attitudes toward seeking mental health services than Whites (Diala et al., 2000), other studies have found that Black males typically leave mental health treatment with higher levels of dissatisfaction and high premature termination rates (Nickerson, Helms, & Terrell, 1994; Ridley, 1984; Terrell & Terrell, 1981). These studies, however, focus mainly on mental health service use among persons with mental disorders rather than perspectives among community-based samples. Prior studies have also had a limited focus on Black male-specific help-seeking experiences. Finally, although many of the factors identified above represent barriers to mental health care seeking, few studies have also explored factors that might facilitate help-seeking in relation to mental health needs among Black males.

The purpose of this study was to broadly explore influences of help-seeking for emotional problems among an urban sample of Black men using qualitative methods. Our focus on a community-based population of Black males contributes to a greater understanding of the factors undergirding help-seeking precursor to a crisis or psychological breakdown. Such information can be invaluable for developing prevention strategies or stronger, early mental health problem identification opportunities for community samples of Black males and enhance the possible connections to mental health care for this traditionally underserved population.

Method

Black male participants were recruited from four community-based organizations, including three workforce development programs and one afterschool program, in a Northeastern city of the United States. Posted flyers, distributed handouts, and outreach was conducted with potential participants sharing that discussions would focus on men's health issues. Four focus groups of 5 to 8 participants were conducted to encourage involvement by all participants (Morgan, 1988). The number of focus groups was chosen to limit informational redundancy—the point at which no additional data can be gathered via interview (Lincoln & Guba, 1985).

All aspects of the study including consent and data analyses were approved by the investigators' institutional review boards. Participants received \$15 for transportation and meals. Two adult male facilitators conducted all focus groups.

Procedures

Data were gathered using the focus group technique. Although this technique has known limitations (Morgan, 1988), this method was chosen since it would allow

participants to broadly explore barriers and facilitators to help-seeking for mental health. A semistructured moderator guide was used emphasizing issues related to care seeking and guided by theories of health care use (see the appendix).

Each session consisted of a brief survey to assess participants' demographics followed by the focus group discussion. A brief 5-minute survey asked participants about their age, race/ethnicity, and theirs and their mother's highest level of education completed. Next, the focus group facilitators introduced the discussion using the moderator guide. As an "ice breaker" initial questions asked participants to talk about their perceptions regarding what it means to be a man in the context of their daily lives (masculinity ideology). The guide then asked participants to talk about their sources of help in general and for personal issues, as well as beliefs about how effective and important are the characteristics and sources of help. Focus group facilitators asked open-ended questions, followed-up participants' responses, sought clarification and elaboration as necessary, and engaged all participants in discussion. Discussions lasted approximately 1½ hours. All groups were audiotape recorded and transcribed.

Data Analysis

Data were entered from the brief surveys into a spreadsheet to generate frequencies. Two research staff trained in qualitative research methods independently coded interview transcripts for content and proposed categories using established constructs from the theories of health care use as applicable (Crabtree & Miller, 1999). Construct building was done in an iterative process. First, the coders identified quotes from the group transcripts that linked to the constructs of the aforementioned models of mental health service use. The coders then analyzed the transcripts again to identify themes not included within these models. This involved scrutinizing the data to discover recurrent patterns of similar and different meanings, expressions and practices, and tracing back to raw data to ensure data credibility and emergence of theme patterns (Miles & Huberman, 1994). Transcripts were coded using this final common list of codes. The two researchers compared the codes with agreement 95% of the time. When codes were not agreed on, there was a discussion and a mutually agreed on code was used. Themes are presented that demonstrate commonality across all four focus groups. Quotes were selected for presentation to illustrate identified themes.

Steps were taken to corroborate study findings, a concept in qualitative research similar to reliability and validity in quantitative research (Miles & Huberman, 1994). These steps included using independent investigators to code transcripts, systematic checking of themes against

supporting quotations by a second analyst, and an independent review of transcripts, categories, frequency tables, and themes by a third investigator.

Results

A total of 27 Black males (mean age = 20.4 years [$SD = 6.4$]) participated in four age-appropriate focus groups: 6 middle adolescents (15.7 [1.2]), 5 older adolescents (17.6 [0.9]), 8 young adults (20.1 [3.0]), and 8 adults (26.1 [8.9]). Participants' last completed grade was reported by 29.6% ($n = 8$) as 9th grade or less, 37% ($n = 10$) as 10th/11th grade, 22.2% ($n = 6$) as 12th grade/high school equivalency (GED), and 11.1% ($n = 3$) as some college or more. Participants' mother's highest level of education was reported by 12% ($n = 3$) as 9th grade or less, 8% ($n = 2$) as 10th/11th grade, 44% ($n = 11$) as 12th grade/GED, and 36% ($n = 9$) as some college or more with 2 males reporting not knowing.

Themes

Participants' discussions revealed three major themes as related to men's mental health help-seeking: (a) taking care of it oneself, (b) issues engaging potential sources of help, and (c) "tipping points."

Themes were discussed by participants in the context of growing up in communities plagued with poverty, drugs, and violence; deficient in jobs and resources; and lacking in positive male role models and family/community cohesion. Participants also discussed perceiving gender inequities in community resources for men compared with women and in interactions with the law. Participants also discussed positive and negative attributes about what it means to be a man in their community, including the need to be strong mentally and emotionally and not just physically; be responsible (e.g., taking care of oneself, family, children); show and get respect; demonstrate loyalty; have integrity; persevere through struggles; and be smart, successful, and a leader. Whereas older participants supported more flexible male role expectations and goal-oriented expectations (e.g., having goals, being accountable), younger participants emphasized strength and materialistic notions of masculinity. It is within this context that emergent themes about men's mental health help-seeking should be considered.

Theme 1: Taking Care of It Oneself

When down or sad, all participants discussed "keep[ing] to oneself," "tell[ing] nobody," and "tak[ing] care of it [one]self" related to their perceived "responsibilit[ies] of being a man":

Young Adult 1: I thought that was a part of being a man, dealing with your problems on your own. You feel me? Finding [the] solution on your own.
 Young Adult 2: I keep it to myself and try to work [it out], figure out a way to get out of the problem, whatever the problem may be, [and then] move on with it.

However, when probed participants did not believe asking for help would be perceived as “embarrassing” or viewed as “being weak.”

Across groups, participants discussed personality characteristics that may facilitate (e.g., “self-assurance”/confidence) or hinder (e.g., “ego,” “pride”) help-seeking and described that in lieu of help-seeking for assistance with emotional struggles, they did things for themselves as a means for problem solving including engaging in (a) hobbies, (b) introspective activities, and (c) drugs.

Subtheme 1.1: Engage in Hobbies. Across groups participants discussed the importance of “do[ing] something [they] like,” including playing music, playing a game, writing, journaling, eating, or going for a walk, that typically did not involve another person:

Older Adolescent: I ain’t going to tell nobody ’cause I might not want nobody to know. I know if I were to hit that point, where I’m like down just like damn depressed, . . . I would do something I’d like. That’ll get me back up and then I’d be alright.

Subtheme 1.2: Engage in Introspective Activities. Across groups participants discussed the role of spirituality and use of meditation-like activities, such as “chill[ing] out,” “laying low,” and “mellowing out,” when feeling down or sad:

Adult 1: If something going wrong with me and I don’t know what to do about it, I’m going to Jesus first before I go to anybody. I tell you, I’m hittin’ that Bible.

Adult 2: I . . . sit by the water just to clear my head. You get that good breeze by the water, lay back, . . . some time to think. A nice little quiet spot where I got this little picture in my head where I’m on this island by myself, some Bud Light . . . away from everybody else.

Subtheme 1.3: Engage in Drug Use. Participants discussed using drugs, especially marijuana (and alcohol in the above quote), as a way to “ease”/“help forget” one’s problems with varying beliefs about the benefits:

Adult 1: When I feel as though my back is against the wall and I got a lot on my mind, . . . this may sound crazy, but I smoke weed.

Adult 2: I was just getting ready to say [the same thing].

Adult 1: It just . . . allow[s] me to talk to my girl, . . . just vent. You know what I’m saying? . . . If I got a lot on my head, I smoke and vent.

Older Adolescent: “You know what a lot of people do? A lot of people go get some drugs to make it go [away or] ease . . . their problems. But, it’d come right back. There’s not too many people you can talk to out here about your problems. You gotta deal with it yourself. . . . A lot of people, they see drugs as a way. But, drugs ain’t a way.”

Overall, participants believed marijuana use is calming, widespread among peers, and not a problem for the community.

Theme 2: Interacting With Potential Sources of Help

Within the context of participants’ disjointed support systems (e.g., limited male role models and family/community cohesion), participants discussed that interacting with sources of help depended on (a) qualities about the source of help and (b) the type of problem. Participants’ potential sources of help, if or when seeking help, included immediate (e.g., parent, sibling) and extended (e.g., grandparent, cousin) family members, close male/female friends, partner (e.g., girlfriend/wife), and teachers.

Subtheme 2.1: Qualities About the Source of Help. Participants discussed who they go to for help in the context of feeling down or sad depends on trust and thus assurances regarding confidentiality and closeness of the relationship.

2.1a: Trust/confidentiality. Across groups participants discussed the role trust and confidentiality play in decisions to going to a source of help (e.g., parent, friend, teacher, and mental health professional) for emotional struggles. Younger participants discussed not trusting teachers as a source of help since this is not part of their job: “Teachers don’t really like to talk to anyone. [They] just do their work and go home.” Concerns of mistrust stemmed from participants’ past breaches in confidentiality and thus concerns for future breaches.

Middle Adolescent 1: A lot of teachers run their mouths off.

Middle Adolescent 2: Yeah, I [agree] . . . Even though you think you cool with them, they still let your business out.

Middle Adolescent 3: Lot of time.

Facilitator: What do you mean when you say “run your mouth”?

Middle Adolescent 1: Talk to other students or other teachers.

Middle Adolescent 2: You be thinking when you talk to one teacher it's confidential [but] when you talk to another teacher, you know, it's out there.

Older Adolescent: "To be honest . . . I ain't telling my homeboys my problems because they ain't gonna be there to help me. I am sure of that. . . . They might be your homeboys one minute, [but] the next minute [they'll] turn around and put your business out on the street".

Some participants also described "test[ing]" potential sources of help before sharing personal information.

Older Adolescent 1: You can . . . make something up real quick [and] test them. . . . Like you [can] go to your homeboy and [say] "hey man I got burned last night." Then . . . if you told them to tell nobody—you're not going to tell something that you're not supposed to do—they're your homeboy. . . . Your homeboy is supposed to be there for you. And, if they're [not], then they ain't your homeboy, you're gonna leave them alone. Because honestly, he gonna be the one to get you.

Older Adolescent 2: To me, honestly I ain't gonna lie. I ask questions. I ask personal questions and I ask [a lot of] questions. . . . If you answer it and I like [your answer] I'm gonna keep on asking you questions. And then [you] gain [my] trust.

2.1b: Relationship closeness. When sad or down, participants discussed being more comfortable asking for help from someone they have "known . . . awhile," have "bond[ed]" with, are "used" to, or "know well" including immediate and extended family members. However, participants discussed relationship closeness is necessary but not sufficient to garner trust:

Older Adolescent 1: Like you say, there're snakes in the family. There's always a snake in the family for real. They only think about themselves.

Facilitator: A snake?

Older Adolescent 1: Snakes would talk to everybody [about your problems].

Some participants discussed needing to get "objective" and "unbiased" feedback; participants identified lack of relationship closeness and trust and confidentiality issues when talking to a mental health professional:

Older Adolescent 1: Honestly, I can't handle counselors 'cause I'm not just gonna go ahead and tell a

stranger everything about me. . . . It might take me about (thinks and mumbles) . . . 20 sessions for them to . . . get into my head. I'm not going to go in there and tell you "Oh I'm feeling down about this and this [is] wrong [with me]." 'Cause counselors will get you for real. Counselors will get your parents locked up. I've seen it . . . cuff your parents—locked up. They may ask "You been beat at home?" And you like "Why you worried about that? We're supposed to be worried about MY problems."

Facilitator: So you don't trust them because of past experiences and [concerns about] put[ting] your family business out there?

Older Adolescent 2: It's not even that. It's just the point. . . . Like you ain't gonna tell nobody your business if you don't know [them]. . . . Like if somebody coming to you [and say] "I see you're down. I want you to talk to this counselor." You gonna look at them like, nah, plus I don't even know this person. Mostly it is you don't know that person.

Young Adult: "I wouldn't go talk to no old head professor type dudes. . . . I would talk to somebody [who has] been through the same situation that I've been through . . . so he knows the same mindset I'm going through right now or maybe been through the same mindset; you feel me? . . . We go through a lot of struggles right now that people don't even know about."

Adult participants discussed how a lack of mental health knowledge contributes to urban Black men's discomfort "go[ing to] talk to somebody":

Adult: New age Blacks will talk to a psychiatrist [or] a therapist. But Blacks in the inner city—to them it's not being a man talking to somebody, a doctor . . . 'Cause it comes from back in the older period. They didn't have a lot of . . . help for Blacks at that time, so it wasn't pushed through as much. It's not . . . caught up as much [as is] . . . physical [health]. . . . With the new age Black man, they went through college and they know this knowledge and they have the Internet, so they can read up on it and they know they have to go for the mental thing. But as [for] the inner city, they don't have as much knowledge as somebody . . . that goes to higher education. . . . So then they . . . don't feel as strong because a lot of them scared, so they not gonna talk to somebody.

Participants discussed that a health professionals' ability to "relate" to young Black males, "make a connection"

with this group, be “down to earth,” and exhibit “respect” may diminish the influence of gender or race as a barrier to this population’s engagement in care. Participants’ discussions about “respect” referred to how a health professional talks to you, if they can be themselves and if they can understand your “slang.”

Subtheme 2.2: Help-Seeking Varies by Type of Problem. Participants discussed that a source of help can vary based on the problem. For example, participants discussed going to females for girlfriend-related problems and emotional issues (“Mostly I go to one of my home girls. ‘Cause a lot of girls, they know about them emotional problems,” Middle Adolescent) and going to males for “guy issues” (e.g., pubertal development):

Middle Adolescent: [If] you going through a man phase, I talk to my father; . . . something female wise, I talk to my mother.

Adult: “I say the reason why I go to my homeboys and talk, instead of a female, because a man is the only one who understands a man. A woman not gonna understand what you dealing with.”

Younger participants also discussed needing to say things differently to peers than parents and needing to avoid parents altogether if it would get them in trouble.

Theme 3: “Tipping Points”

Participants discussed “tipping” into help primarily after experiencing major and mainly negative life events as illustrated in the following quotes.

Young Adult 1: When you at the point where you know you ‘bout to hurt somebody.

Young Adult 2: I was just suspended . . . until I realized, cause everybody would tell me—my mother, . . . uncles, teacher—“I need counseling.” Once I finally seen that it was a problem, [that] it would stop my education, I finally realized that I need[ed] to do something about me. I didn’t see it when it first started though; but I did eventually though.

Adult: “It took me going to jail a couple times. It took me seeing my friends get killed. . . It just took all that for me to realize, and the birth of my son, . . . that [selling drugs] ain’t for me.”

Participants’ discussed delays in help-seeking resulted from Theme 1’s “taking care of it on one’s own” that led

to “forget[ing] about [one’s problems]” and thus worsening of symptoms.

Older Adolescent: If you . . . forgot about it . . . eventually it’s gonna come back. And if it comes back, 9 out of 10 . . . it’s gonna be worse than what it was before because you needed to work it out before. Now you gonna struggle with how to work this problem out. That’s when honestly. . . I’d ask somebody what to do. Because I don’t know what to do. I forgot about it and it came back and it’s worse. So what to do now?

Delays in help-seeking also resulted from waiting for other people to figure out that something is wrong rather than self-initiating help:

Young Adult: When I’m feeling sad or down, somebody gonna notice it in me, [will] want to talk to me. I’m not gonna like, Oh, I’m down ‘cause of this and this. Like I’m a cheerful guy; they gonna know when something wrong with me. They gonna want to talk [to me]. I’m not . . . gonna be like, “Man I need to talk to you yo.” Nah, that ain’t me.

Marijuana Use and Care Seeking

Secondary to the significant use of marijuana in the community and by participants as part of their help-seeking strategy, we also explored issues related to help-seeking for drug use. Participants discussed care seeking for marijuana abuse was different than care seeking for issues related to mental health, primarily because marijuana is not seen as a problem.

Young Adult 1: I know for sure a lot of dudes ain’t trying to hear . . . like smoking weed is a problem for real.

Young Adult 2: I mean, if you go to like sniffing coke and all that like that, I mean that’s a problem there.

Participants emphasized a person’s first step in help-seeking would need to be that he recognizes he has a problem and that this can be very difficult for marijuana given its pervasive use and normative community perception.

Facilitator: So what about somebody who’s using and is interested in getting help? Would you think it’s easy or difficult?

Young Adult 1: Difficult.

Young Adult 2: Difficult getting help cause first they gotta admit they need help.

Participants discussed not knowing many places or people to go to for help given marijuana's illegal nature and the risk of getting in trouble with parents and/or the police: "If you go to your parents, it's a possibility you will be cut off, probably punished; never see daylight" (Middle Adolescent). Participants also discussed the limited role of peers as a source of help given their own drug use and the role addiction may play in hindering help-seeking and staying clean.

Young Adult 1: You can't go to your home boys saying, "Man, I want to stop smoking weed. Can you help me?" He probably the one who turned you on to the weed.

Young Adult 2: Marijuana ain't gonna have you all addicted like hey you're scratching your skin waiting the line, waiting for the man.

Finally, participants discussed how facilitators/barriers to help-seeking for marijuana may be linked to economic realities especially for people who are using and dealing drugs.

Young Adult 1: Dudes just don't know, boy, if you can stay clean at least 45 days, you got you a job.

Young Adult 2: How would you feel if . . . can't eat? You can't go to school because the kids cracking on you cause you got holes in your shoes or you wearing LA Gears some light up shoes or something, dirty t-shirts that look brown. And, then you see these, the neighborhood drug dealer. He fresh . . . he got the tennis shoes. He got the clothes. . . . So a lot of kids who sell drugs, I think they make the choice, not because they want to, it's because they have to because that, sometimes drugs, selling drugs will help you survive in the long run because as much as people don't like to admit it, it's the truth, money makes the world go 'round, and you can't do nothing without it.

Discussion

In this exploratory study, a community-based sample of Black men identified influences of help-seeking for mental health at individual, social network, community, and health care system levels. Commonly shared barriers to help-seeking included engaging in coping activities in isolation (individual level), engaging in negative coping mechanisms such as drug use (individual level), maintaining heightened concerns about trust and confidentiality when interacting with others (social level), and perceiving negative community beliefs about mental

health care (community level). Commonly shared facilitators to help-seeking included the role that relationship closeness and quality interactions play in garnering trust and confidence from one's social support (social level) and opportunities for interventions during crisis events (individual and health care system levels). Future work should continue to examine the role that gender, social and cultural factors simultaneously play in Black men's help-seeking behaviors and access to mental health care.

Few past studies have sought to understand the interplay between Black men's socioeconomics, social support, and perceptions regarding accessing of mental health help-seeking and care. Findings from this study are consistent with a prior qualitative study that identified influences of mental health at individual (e.g., masculine ideology beliefs), individual-provider interaction (e.g., provider comfort), and cultural (e.g., mental health stereotypes) levels (Watkins & Neighbors, 2007). However, our study differs from the findings of Watkins and Neighbors by explicating the specific mental health help-seeking perceptions of Black males. Modifications to current mental health help-seeking frameworks that conceptualize influences of Black men's care seeking on multiple levels (e.g., individual, sociocultural, social network, and system levels) may thus contribute to a better understanding of mental health help-seeking for this population.

In this study, Black men discussed specific barriers to mental health care seeking when feeling sad or down at the individual, social, and community levels. If future work confirms that our study findings hold for larger samples of Black men, intervention approaches at multiple levels may be needed to engage this population in care seeking for mental health. For example, at the community level, approaches may need to involve increasing community awareness of mental health signs, symptoms, and commonly associated comorbidity (e.g., drug use, externalizing behaviors). At the social level, targeting professionals who frequently interact with this population (e.g., teachers, law enforcement, and health care providers) about screening for early signs of mental health problems and comorbid conditions may also be necessary. Also, at the social level, a better understanding of Black males' trust issues and discomfort in sharing personal or emotional-laden information with people in their social network is also needed. Consistent with this proposition, Pederson and Vogel (2007) found that men with high levels of discomfort in self-disclosure reported more negative attitudes toward psychological services and thus less willingness to seek help. At the individual level, intervention approaches may want to find ways to engage men in health promotion through organized activities around sports, music, or mindfulness-based strategies

(Grossman, Niemann, Schmidt, & Walach, 2004; Stevenson, 2003) rather than leaving them to rely on individual-based and potentially isolating activities.

Conversely, our study also identified facilitating factors for Black men's mental health care seeking including factors at individual, social, and health care system levels. For example, leveraging men's social support relations may be an approach to facilitate men's care seeking. In fact, Ayalon and Alvidrez (2007) found among seriously mentally ill Black consumers that having supportive social environments including family and friends and supportive relationships with mental health providers facilitated access to services. Black males' social network support system has been underutilized as a strategic partner with mental health professionals to increase service utilization opportunities for this group (Lindsey et al., 2006). Black males are sons, fathers, partners, and friends who co-reside with networks that they are likely to turn to in times of emotional distress, as discussed by participants in this study. Increased caregiver support has also been found to buffer the negative effects of stigma on mental health distress among young Black males (Lindsey, Joe, & Nebbitt, 2010). Thus, our study's findings are consistent with earlier research regarding the role of social networks as facilitators to mental health promotion and service use opportunities for Black males. Future work should also consider whether engaging men during times of disequilibrium in mental health screening and treatment contexts can be successful as has been found for other populations (Auerswald & Eyre, 2002).

The degree to which traditional gender roles and beliefs about what it means to be a man may also contribute to comfort in men's discourses on personal issues (Addis & Mahalik, 2003; McKelley, 2007; Thompson et al., 2004; Witty, White, Bagnall, & South, 2011). This study did not explicitly develop themes around male role expectations or masculinity, since focus group discussions were influenced by an ice breaker about men's role in the community and thus coding for male role expectations would introduce study bias. However, Witty et al. (2011) argue that influences of individuals' help-seeking behaviors are diverse and complex and are more than just about holding traditional beliefs about masculinity. In fact, Black males in their study were willing to seek medical help from a variety of sources (the pharmacist, friends, family, the Internet) and some males used masculine ideas of independence to promote their help-seeking behaviors (Witty et al., 2011). Another study by Johnson, Oliffe, Kelly, Galdas, and Ogrodniczuk (2011), which explored discourses of seeking help among adult men with

depression, found linkages between discourses of men's help-seeking for depression and discourses of masculinity. They argued that challenges around reconciling masculinities with seeking professional medical help and accessing mental health care services is complicated by depression. Future work should examine how male role expectations play out in the context of a larger framework of men's help-seeking for mental health.

Finally, participants conceptualized help-seeking for substance use as being more restrictive than that for mental health. Smoking marijuana and drinking beer was discussed as a positive way to emotionally cope with one's problems in lieu of seeking help. Whereas, persons addicted to "hard" drugs such as crack cocaine or heroin may have more difficulty handling their life pressures and stressors and have even more limited social network support. Moreover, getting help for drugs was viewed by study participants as even more stigmatizing than help-seeking for mental health, secondary to its intricate linkage to the community's social economy and greater levels of resultant vulnerabilities, including financial and criminal outcomes. Future research is needed to better understand Black males' help-seeking for drug abuse and its intersection with mental health using a similar multilevel framework.

This study has a number of limitations. Focus group participants were drawn from mainly community-based job readiness programs in one urban area. Future work should explore whether study findings hold for other populations. This study did not assess for mental health symptoms or illness among participants. However, this study's goal was to gain a better understanding of the factors influencing decision making to get help among a community-based sample and not among people with mental health problems. Strengths of this study include the use of qualitative methods to generate consistent themes across all groups related to Black males' mental health help-seeking. Future work should consider how themes might vary by others in the community including parents, partners, and professionals.

Study findings highlight the importance of understanding how factors on multiple levels, including individual, sociocultural, social network, and system level factors, may hinder and/or facilitate Black males' mental health help-seeking. Future work should examine whether addressing mental health help-seeking for Black males beyond the individual level, such as engaging men's social supports, community, and the health care system, especially during times of equilibrium, can successfully engage this population in mental health care.

Appendix

Focus Group Moderator Guide

Ice Breaker

How do you define manhood, or what it means to be a man?

Getting Help in General

What do you do for help when you experience any personal issues?

Probe: Is a guy weak if he asks for help?

Who do you talk to/go to for help for these kinds of issues?

Probe: Ask about gender, age of person, places where go for help

Getting Help Specific to Feeling Down or Sad

What do you do or see others do for help when feeling down or sad?

Who do you or others talk to/go to for help when feeling down or sad?

Probe: Ask about gender, age of person, places where go for help

Is it okay for a person to get or seek help if they feel down or sad?

Probe: Why or why not?

At what point is it okay to ask for help?

How helpful/not helpful are certain people in your lives about times that you may feel down or sad.

Probe: Family members, friends, the community where you live, others (as generated from group)?

Does it matter if the person who you see for this type of issue is the same gender as you?

Does it matter to you if the person who you see for this type of issue is the same race as you?

Would you recommend going to a place that works specifically with young people when they feel sad or down? Why or why not?

If you went to one of these places, what kind of experience are you looking for? Or, what would you expect?

Is there anything else that we did not discuss that might prevent someone from getting help if they are down or sad?

Probe: What makes it difficult/easy for someone to get help?

Probe: How difficult/easy is it to find a place where you can go for help?

Probe: Do you know places where you could go?

Probe: How difficult/easy is it to get to these places?

(Parallel probes were then asked about drugs and getting help for drug use)

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