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# Help-Seeking Experiences of African American Men With Depression

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Tiffany Monique Coleman

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Walden University
2019

Abstract

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MPH, Walden University, 2012

BS, Morris College, 2004



Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Public Health



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Abstract

Research indicated that depression is now the leading cause of disability globally. Depression and help-seeking experiences among African American men have not been adequately studied. The purpose of this phenomenological study was to explore the help-seeking experiences of African American men with depression. The theoretical framework was Andersen's Behavioral Model of Health Services. Purposive sampling was used to recruit participants. Inclusion criteria were (a) African American men, (b) aged 18 through 65, (c) having a medical diagnosis of depression or symptoms of depression, (d) not currently in treatment, and English speaking. Six African American men with depression or depressive symptoms were interviewed. Coding analysis of data generated two major themes: African American men's perceptions of factors that inhibit help-seeking and African American men's perceptions of factors that promote help-seeking. The 6 sub-themes identified were (a) African American men with depression tend to feel misunderstood and stigmatized; (b) some African American men admit to a degree of self-stigma; (c) some African American men deny their depression or any need for help; (d) African American men who had therapy found it helpful until the therapist was changed, causing feelings of mistrust and inadequate mental health care; (e) African American men fear guilt, fear being a burden to others, and feel they should be able to handle their problems; and (f) it is difficult being depressed and Black in America, which leads to stress, frustration, and perceived racism. Findings may be used by mental health professionals seeking to improve cultural competency, mental health and support services, and treatment regiments for African American men with depression.

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Dedication

First, I would like to give thanks and honor to God for directing my path throughout this journey and providing me with the wisdom, knowledge, and courage to remain steadfast and focused on my goal. You have blessed me beyond measure. This dissertation is dedicated to my late father, Eugene D. McBride. I hope I've made you proud, and I miss you with each passing day.

To my mom, there aren't enough words to express my gratitude. You instilled in me a love for God, family, all of humankind, and the importance of education. You fueled the fire to push myself beyond imaginable limits. You taught me to how to love myself, the importance of being a role model to others, and to always thank God in good and bad times. I love you dearly.

To my amazing husband, Markus, thank you will never be enough. You provided me with a constant flow of endless love, support, and encouragement during this process. You believed in me more than I believed in myself at times. You were the rock for me and our family, mom and dad to our children when I had to miss time with our family due to my studies and much more. I love you and am forever grateful.

To my dear children, Nadia, Ariana, Joshua, and Michaela, you all are my reasons. You all have been my constant source of inspiration to never settle for mediocrity. I will never forget your unwavering support, sacrifices, love, and patience with me during this journey. Always remember to keep God first, work hard, and pray without ceasing. Everything else will follow.  I love you all.

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This dissertation would not have been possible without the strong love and support from my family, co-workers, and friends. I will be forever grateful for each of you and I promise to make you all proud.

Finally, I want to express my sincere gratitude to the participants of this study. I am deeply moved and humbled by your courage, experiences, and dedication to the topic of this study. I have learned so much from all of you and am extremely appreciative of the opportunity to have shared with each of you. Stay in the fight. You are enough.

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Chapter 1: Introduction to the Study

Depression is one of many mental health illnesses that affect millions of individuals worldwide and is viewed as the most common diagnosable mental health illness (Centers for Disease Control and Prevention [CDC], 2016). Many organizations such as the CDC and the World Health Organization (WHO) have recognized the need for comprehensive mental health care, and many public health initiatives have been launched to address it, such as the Comprehensive Mental Health Action Plan 2013-2020, which is intended to reduce stigma and discrimination while promoting increased awareness (WHO, 2013). Significant research contributions have been made to the mental health field. However, mental health research regarding help-seeking behaviors and experiences of African American men is limited (Hammond, 2012).

The terms *mental illness* and *mental health* have been used interchangeably; however, there is an important difference between the terms. When referring to people's state of well-being and how they navigate the stressors of life, the term mental health is appropriate, whereas the term mental illness refers to a diagnosable mental condition (CDC, 2016). Analyzing the differences in mental health disorders among African American men including their personal, social, and environmental experiences with seeking help for depression is important because this group constitutes a considerable portion of the U.S. population (U.S. Census Bureau, 2013). Minority groups such as African American men have a tendency to have a higher incidence of depression compared to other ethnic groups (CDC, 2016). Therefore, it is important to understand

how varying factors can impact help-seeking among this group (Alegria, Woo, &

Takeuchi, 2010).

To understand factors that contribute to help-seeking behaviors in African

American men suffering from depression, I explored their experiences. Experiences may

impact help-seeking behaviors in a positive or negative way. In this qualitative

phenomenological study, I explored help-seeking behaviors among African American

men who were living with depression, including their personal, social, and environmental

experiences with seeking help for depression. Few studies had addressed the experiences,

coping strategies, and help-seeking behaviors of African American men who suffer from

depression.

This chapter provides an introduction to the study. I begin with a brief

examination of the literature on help-seeking behaviors among African American men

with depression. I then present the problem statement, purpose of the study, research

questions, and theoretical framework used to frame the study.  I also include the nature of

the study, definitions, assumptions, scope and delimitations, limitations, and significance

of the study.

## Background of the Study

Over six million men in the United States live with some form of depression

(National Institute of Mental Health, 2009). Improved treatment rates can be achieved if

help-seeking for mental health illnesses like depression is promoted and encouraged

among minority populations, such as African American men (Robinson, 2010). Research

has indicated that attitudes regarding mental health help-seeking differ among key

variables such as gender, age, and ethnicity; however, negative attitudes about help-seeking are more prevalent among males (Gonzalez, Alegria, Prihoda, Copeland, & Zeber, 2011). Few studies have addressed the experiences, coping strategies, and help-seeking behaviors of men suffering from depression, particularly African American men (Hammond, 2012).

The literature was inconsistent and limited regarding prevalence of depression and help-seeking behaviors among minority men, particularly African American men. A 12-month comparison of prevalence among African Americans and Whites with depression revealed values of 5.9% and 6.9% respectively; further analysis revealed that 56.5% of African Americans reported higher levels of disability and symptom severity compared to their White counterparts (Ward & Besson, 2013). Although prevalence rates of depression among African American men are 7% compared to 16% for White men, the severity of symptoms and disability is greater among African American men (Ward & Besson, 2013).

A dramatic increase in suicide rates among African American men in younger age groups has been associated with a lower likelihood of scheduling routine health examinations, preventive screenings, and consistent sources of care than among males in other ethnic groups (Ward & Besson, 2013). Some researchers have found that women suffer more from depressive episodes than their male counterparts, yet men are 4 times more likely to commit suicide (Hammond, 2012). Some of the factors that contribute to depression and lack of help-seeking in African American men are lack of access to care, improper diagnosis, and mediocre treatment options; other factors include culture,

poverty, economics, religious views, stigma, and family values (Dejesus, Diaz, Gonsalves, & Carek, 2011).

Other studies have indicated that men often experience restrictive emotionality, which is the suppression of emotion that increases depression (Wade, 2009). Restrictive emotionality is the fear of and difficulty in expressing how one feels, and difficulty in finding the verbiage to articulate innermost emotions and feelings (Wade, 2009). Although men of all ethnic groups are to some degree victims of restrictive emotionality and other masculine role norms that give rise to depression, African American men appear to be more affected than other groups (Wade, 2009). Restrictive emotionality can interfere with help-seeking behaviors and treatment options for depression, such as psychotherapy; certain emotions including fear, shame, and guilt, create the perception of vulnerability; as a result, males are more likely to restrict these emotions (Rogers, 2011).

Stigma is regarded as a mark of disgrace experienced by men and women. Stigma is commonly associated with depression and other mental illnesses (Hammond, 2012). Some masculine norms include being self-sufficient and impassible and having high levels of self-control (Vogel, Heimerdinger-Edwards, Hammer, & Hubbard, 2011). Theorists examining gender role socialization contend that beliefs rooted in gender pertaining to help-seeking are acquired from the culture and may contribute to the low use of mental health support services among men (McCusker & Galupo, 2011). Help-seeking, assessment, and treatment of depression in African American men are often impeded because these men are typically reluctant to discuss their emotional experiences and attitudes (McCusker & Galupo, 2011). Before researchers can begin to understand

why African American men may or may not engage in help-seeking behaviors, an understanding of their personal, social, and environmental experiences is necessary. According to Vogel et al. (2011), the lack of dialogue about African American men's feelings and coping mechanisms has become increasingly problematic as negative social perceptions of male mental health help-seeking have increased. The inconsistency of help-seeking has led men to suffer in silence (McCusker & Galupo, 2011).

Researchers have found that racism and discrimination contribute to racial disparities in mental health. Racial differences can impact depressive symptoms, suicidal ideation, and help-seeking behaviors in African American men (Jgaer, 2011). A comparison of ethnic groups revealed that all socioeconomically disadvantaged male populations are reluctant to seek help for mental health illnesses and disorders (Jgaer, 2011). African Americans as a whole do not appear to be at increased risk for developing clinical depression or other mental health disorders, but African American men who encounter personal, environmental, or social challenges are at increased risk for upward depressive symptomology, (Jgaer, 2011). This finding supported the need for a qualitative exploration of help-seeking behaviors of African American men who experience depression. Findings from the current study may help mental health practitioners and professionals develop culturally appropriate screening tools and design and implement comprehensive services aligned with the needs of the African American male population.

## Statement of the Problem

Reportable depressive episodes have increased in prevalence with nearly 16 million adults in the U.S. experiencing at least one depressive episode within their lifetime (CDC, 2016). Depression, once projected to be the second leading cause of disability globally by 2020, is now the leading cause of disability (WHO, 2017). Despite the growing number of studies that indicate the prevalence of depression and unmet needs for treatment, men's depression and help-seeking behaviors have not been adequately studied (Ramirez & Badger, 2014).  Part of the reason for the lack of research is that women are more likely to suffer depressive episodes than men (Hammond, 2012). However, men are more likely to be misdiagnosed or under diagnosed for depression and are 4 times more likely to commit suicide (Hammond, 2012). Few studies have addressed the experiences, coping strategies, and help-seeking behaviors of men suffering from depression, particularly African American men (Hammond, 2012).

According to Dejesus et al. (2011), men and women face similar challenges with depression, and these challenges may affect men's help-seeking attitudes in a different way. Although women tend to be more aware of problems and have positive care attitudes, men may experience more doctor distrust, higher substance and alcohol abuse rates, and higher levels of stress and anger (Himmelstein & Sanchez, 2014). Other gender differences include different ways of engaging with personal conflict, coping techniques, access to mental health care (McCusker & Galupo (2011).

## Purpose of the Study

The purpose of this study was to explore the help-seeking experiences of African American men with depression through their personal, social, and environmental experiences. The study contributed to the understanding of the mental health needs and experiences of African American men. The study revealed factors that could be instrumental in developing effective mental health programs and strategies for this vulnerable population.

## Research Questions

The purpose of this study was to gain an in-depth understanding of the help-seeking behaviors of African American men with depression by examining their personal, social and environmental experiences. The research questions for this study were the following:

1. What are the personal, social, and environmental experiences of African American men with depression as they relate to help-seeking?
2. How do personal, social, and environmental experiences help African American men navigate or overcome barriers that may prevent them from seeking help?

## Theoretical Framework

The theoretical framework for this study was the Andersen's behavioral model of health services. According to Gulliver, Griffith, Christensen, and Brewer (2012), several theoretical models have been used to understand help-seeking among individuals with a mental health illness or disorder. The behavioral model of health services provides a

framework for examining factors that influence individuals' decisions to utilize health services, notably the predisposing components, the enabling components, and need (Harris, McLean, & Sheffield, 2009). Predisposing components include age, ethnicity, and beliefs; enabling components include family structure, access to care or insurance, and the community/environment in which an individual resides or works; and need (in this case, for mental health care services) is exhibited in terms of perception and actuality (Harris et al., 2009).

The behavioral model of health services encompasses determinants of health services used on both the individual and organizational level. The behavioral model of health services is most commonly used when classifying mental health utilization determinants on an individual level (Harris et al., 2009). According to this model, help-seeking or mental health care utilization is determined by certain factors (Harris et al., 2009). Chapter 2 provides a more detailed discussion of the theoretical framework used to ground this qualitative study.

**Nature of the Study**

I used a qualitative approach with a transcendental phenomenological design. This method focuses on human experiences as they are lived to illuminate details within those experiences (Creswell, 2013). I explored experiences of African American men and identified factors that could protect their mental health as well as barriers they encountered and navigated. The phenomenological goal of my research was to illuminate the essence of experiences that African American men encountered and describe that

essence (see Creswell, 2013). This approach allowed for a smaller sample size and facilitated an in-depth personal exploration of the experiences with the phenomenon being studied. This approach also provides a way for researchers to bracket themselves out of the study by explicitly acknowledging their personal experiences or encounters with the phenomenon being studied (Creswell, 2013).

A small purposive sample of African American men between the ages of 18 and 65 was recruited using social media. Criteria for participation included a medical diagnosis of depression or depressive symptoms and not currently in treatment. Data were collected through in-depth one-on-one interviewing. Though the final number of interviews was decided by the point of data saturation, I estimated that approximately 6 to 8 interviews would be conducted. Interviews were face-to-face or via telephone in an effort to include African American men in varying geographical areas. The data were coded by hand.

## Definitions

For this study, the following terms were used and defined below.

*Depression*: A common mental illness or disorder that is characterized by symptoms such as sadness, loss of pleasure or interest, low self-esteem, sleep disturbance, poor concentration, and tiredness which can impact an individual's ability to function or cope with daily life (WHO, 2014).

*Emotional well-being*: The state of perceived satisfaction with life as well as perceived peacefulness, happiness, and cheerfulness (CDC, 2016).

*Mental health*: A state of well-being in which an individual realizes his or her own abilities, is able to cope with the normal stressors of life, is able to work productively, and able to make a positive contribution to his or her community (CDC, 2016).

*Mental Illness*: Collective diagnosable mental health conditions that are characteristic of changes in mood, thinking, or behavior that can cause distress and impair function (CDC, 2016).

*Mental health professionals*: Individuals who possess a degree in various fields including social work, psychiatry, counseling, nursing, or psychology and are licensed to practice and provide mental health and/or support services (National Alliance on Mental Illness, 2014).

*Psychological well-being*: The state of personal growth, self-acceptance, life's purpose, hopefulness, and control a person has over his or her environment and spirituality (CDC, 2016).

*Restrictive emotionality*: A suppression of emotion that increases self-reliance (Wade, 2009).

*Social well-being*: The state of social acceptance, societal beliefs, and personal self-worth (CDC, 2016).

**Assumptions**

This qualitative study included several assumptions related to the participants. The first assumption was that African American men would be reluctant to openly share their experiences, because the help-seeking literature suggested that men were less likely to divulge personal information than women (Hammond, 2012). However, I adopted a respectful, patient phenomenological approach that male participants would become more open, honest, and forthcoming when sharing their personal, social, and environmental experiences with depression. I assumed that this information would be provided willingly and voluntarily (see Creswell, 2013).

**Scope and Delimitations**

The scope of this study was African American men's experiences with depression and help-seeking in varying geographical locations. The environment of an individual has a direct influence on his or her behavior (Bronfenbrenner, 1979). This study focused on understanding the experiences and help-seeking behaviors of African American men who were not currently in treatment. Focusing on African American men who were not currently seeking treatment for their depression revealed barriers to help-seeking behaviors. Findings may be used to facilitate programs and services that will combat mental health disparities among minority male populations. This study addressed transferability through comprehensive descriptions of the experiences of the participants and exhaustive analysis of the processes of help-seeking behaviors (see Creswell, 2013).

**Limitations**

Using the phenomenological approach in qualitative studies is not without limitations. If the researcher does not bracket himself or herself out of the study, interference can occur when it comes to interpreting the data (Creswell, 2013). Another limitation was that those participating in the study would not be able to fully articulate their experiences due to issues such as embarrassment, language barriers, or not being comfortable. Creswell (2013) noted that the phenomenological approach is limited in that it may be difficult for the researcher to find participants who have all experienced the phenomenon that is being studied.

**Significance**

Findings added to the understanding of the mental health needs of African American men. By examining their experiences with depression, I identified the factors influencing their help-seeking behaviors. There is substantial evidence that men are reluctant to initiate mental health and support services, often as a result of masculinity norms, which can lead to attempts to self-manage symptoms (Whittenborn, Culpepper, & Liu, 2012). Because researchers had not delved into the experiences of men, particularly African American men, I began the process of filling that gap. I created a list of questions based on the literature and validated my questionnaire through pilot testing. The positive social change that could result from this study was providing knowledge that may be useful for community leaders, mental health professionals and practitioners, health

educators, researchers, and program developers who are seeking to improve the mental health of African American men. Findings may be used to increase awareness and use of mental health and support services among African American men to improve their mental health status.

## Summary

This chapter provided a brief overview of my qualitative phenomenological study. This study was conducted to explore the help-seeking behaviors of African American men with depression through their personal, social, and environmental experiences. The key to obtaining a clear understanding of the mental health disparities that are faced by African American males is to uncover and examine their personal, social, and environmental experiences with depression and help-seeking. Research has revealed that the experiences of African American men as well as depression among this group have been rarely studied for several reasons. I interviewed African American men from varying geographical locations to obtain a clear understanding of their experiences and help-seeking behaviors. Chapter 2 presents an exhaustive review of the literature that was used to frame this study.

Chapter 2: Literature Review

This phenomenological study focused on the personal, social, and environmental experiences of African American men regarding depression and help-seeking. Investigating this phenomenon required an in-depth look into factors that impacted help-seeking behaviors for depression among African American men. Although there was a wealth of literature on the phenomenon of depression and help-seeking, there was a lack of scholarly articles that addressed the experiences of African American men with depression and their help-seeking behaviors. Despite the growing number of studies that documented the prevalence and unmet treatment options for depression, understanding depression and help-seeking behaviors among men has been rarely studied (Ramirez & Badger, 2014). The purpose of this study was to gain an in-depth understanding of the help-seeking behaviors and experiences of African American men with depression.

African American men face many barriers related to mental health disorders such as depression (Klineberg, Biddle, Donovan, & Gunnell, 2011). Like men from other ethnic groups, African American men lack positive help-seeking behaviors and are reluctant to share their vulnerabilities (Pedersen & Paves, 2014). This has led to an increase in concern about help-seeking and mental health service utilization among African American men (Hammond, 2012). The literature related to this problem is reviewed in this chapter.

**Sources and Literature Search Strategy**

Information was gathered from scholarly articles that contained information about depression, the prevalence rate of depression, underestimation of the prevalence rates among African American men, help-seeking, restrictive emotionality, masculinity norms, gender differences, and racial differences, especially involving African American men. The databases used to identify scholarly peer-reviewed journal articles included BIOMED, CINAHL, PsychINFO, PubMed, Science Direct, EBSCO, and ProQuest Dissertations and Theses. I also used the Google Scholar search engine. Research literature specific to help-seeking behaviors, depression, and African American men were analyzed. Key words included *depression*, *African American men* and *depression, depression* and *restrictive emotionality, help-seeking, help-seeking* and *African American men, mental health care* and *men, stigma* and *depression, gender differences* and *depression, racial disparities and depression, underestimation, prevalence rates* and *men, prevalence* and *male depression,* and *masculinity norms.*

Although the word *help-seeking* was found in many of the abstracts or titles of articles, a formal discussion of help-seeking was not present within the body of those articles. As a result, further limitations were set to include not only help-seeking in the abstract or title, but to focus on help-seeking behaviors and depression. Most of the research on help-seeking and depression has been quantitative in design; few researchers used a qualitative methodology. Few qualitative studies are included in this review, and more are needed to provide a valuable contribution to the field of mental health and

underserved populations. In this phenomenological study, I explored the lived experiences of African American men with depression to understand the factors influencing their help-seeking behaviors.

## Overview of Depression and Prevalence

Affecting nearly six million men in the United States, depression is most commonly defined as a mood disorder that includes the loss of interest in activities that were once found pleasurable and may be accompanied by symptoms such as feeling helpless or hopeless, sleep and appetite disturbances, pain, and other symptoms (National Institute of Mental Health, 2009; Rochlen, Paterniti, Epstein, Duberstein, Willeford, & Kravitz, 2010). The factors contributing to depression include genetics, environmental stressors, chemical or hormonal imbalances, and situational crises (Perkins 2013).

Depression is measured using conventional, clinically appropriate definitions and symptomology (Kim, 2010). For example, the Center for Epidemiologic Studies Depression Scale is used in community settings to determine the severity and frequency of symptoms; however, this and other comparable scales were created for, and tested with Americans of European descent (Kim, 2010).

Previous population studies of depression have indicated the differences in experience and expression among men compared to women (Rochlen et al., 2010). Behaviors such as substance abuse, risk-taking, promiscuity, anger, and deliberate self-harm are more common among males than females (Brownhill, Wilhelm, Barclay, & Schmied, 2005; Kogan & Brody, 2010; Perkins 2013). Because of the focus on symptoms found among people of European descent, data on the prevalence of depression among

African American men are scant.  The reported lifetime prevalence rate of depression in the general population in the United States (17%) is low, while the prevalence rates for different ethnicities remains largely unknown (Griffith, Ober-Allen, & Gunter, 2011; Januar, Saffery, & Ryan, 2015).

The prevalence of depression and depressive symptoms among African American men has been estimated to range between 5% and 10%, which is similar to that reported for White men; (Ward & Besson 2013; Ward & Mengesha, 2013; Williams et al., 2010). Studies that suggest African American men are less likely to develop depression than White men should be cautiously viewed due to under-reporting among African American men (Breslau, Kendler, Su, Gasixola-Aguilar, & Kessler, 2005; Carr & West, 2013, Sinkewicz & Lee, 2011). Depression among African American men is often undiagnosed, misdiagnosed, and untreated, which contributes to factors such as suicide (Bryant-Bedell & Waite, 2010). This is one important reason why depression among men should be viewed as a dire health concern, not only in the United States, but globally, and why early detection, accurate reporting and diagnosis, and systematic intervention to mitigate the adverse effects of depression are important for men (Bryant-Bedell & Waite, 2010).

The Diagnostic and Statistical Manual, commonly known as the DSM, possesses limited criteria and a narrow scope of the depression phenomenon and is non-inclusive of issues that may be more prevalent among culturally diverse populations (Rochlen et al., 2009). Due to the atypical presentation of depression and depressive symptoms among African American men, it is imperative for healthcare practitioners and professionals to be vigilant when encountering African American men who are suspected of having

depression or depressive symptoms (Rochlen et al., 2009). The heterogeneous nature of depression results in different symptom profiles among individuals; men suffering from depression may also present in terms of economic stress, psychosocial stress, alcohol or substance abuse, difficulty coping with anger, or somatic symptoms that cannot be explained such as chronic stress (Bryant-Bedell & Waite, 2010).

### Utilization of Mental Health Services

Mental health treatments have improved significantly in recent years, yet mental health service utilization among underserved populations continues to be problematic as men, especially men from ethnic minorities, tend to shy away from seeking help from mental health services (Hammond, 2010). The most consistent finding among studies on the utilization of psychological services is that men are less likely to seek help than women (Woodward, Taylor, & Chatters, 2011). Although African American men may benefit from enrolling in mental health and support services, many do not comply with treatment regimens such as psychological counseling, therapy, medication, or a combination of treatment (Mills, Van Hooff, Baur, & McFarlane, 2012). A significant number of studies indicated that African Americans and other ethnic minority groups do not utilize psychological services or seek out psychological services when compared to Whites (U.S. Department of Health and Human Services Office of Minority Mental Health, 2016). Minimal research has focused on African American men and mental health disorders such as depression without additional social problems including incarceration, criminal behavior, unemployment, and HIV/AIDS (Woodward et al., 2011).

Research indicated there was a strong association between being African American and decreased mental health service utilization; further evidence revealed that African Americans utilized psychological health services at half the rate of Whites and were more inclined to seek help outside of the mental health arena (Griffith et al., 2011). Williams et al. (2010), used the behavioral model for vulnerable populations to look at mental health service utilization among African American adults. Findings revealed that 25% of participants utilized psychological services during their life course, and 9% of participants utilized psychological services within a 12-month span; also, men were twice as likely not to seek mental health services or treatment compared to women (Williams et al., 2010).

Mental health service utilization is a consistent problem among the African American male community for younger and older populations. Researchers identified barriers that prevent African American men from seeking help. One of the most troubling issues is the discomfort of African American men to talk about their mental health (Watkins & Neighbors, 2007). Watkins and Neighbors (2007) recruited 46 African American college students to participate in focus group discussions to assess their understanding of mental health and their comfort level with discussing their mental health. Emerging themes included, stigma, masculinity, and cultural stereotypes. Watkins and Neighbors (2007) considered the complexities that African American men often experience from the perspective of the participants, and findings revealed the strong need for mental health education and effective mental health promotion programs that are gender specific and culturally appropriate.

**Help-Seeking**

Woodward et al. (2011) examined the use of four options provided for help-seeking among African American men and Caribbean Black men who suffered from a mental disorder: formal or professional services, informal support, formal and informal support, or no support at all. In the sample, 371 African American men and 138 Caribbean Black men with a diagnosed mood disorder such as depression were recruited; multinomial logistic regression analyses were used to test the use of formal and informal support, controlling for variables such as socio-demographic, disorder-related, and family network (Woodward et al., 2011). The findings revealed that less than half of the Black male participants utilized both formal and informal support services, 24% relied on informal support, 14% sought formal services, and 29% did not seek help at all; findings also indicated that as men aged, their likelihood of using informal support services declined (Woodward et al., 2011).

In their quantitative study of informal and formal help-seeking, Scott, Curtis, & Snowden (2015) found that out of 97 black men, 10.9% sought help from formal sources such as trained mental health practitioners and professionals and 30.9% sought help from informal sources to include friends, family members, and clergyman; 5.5% sought help from informal and formal sources while 36.4% did not seek help at all. These statistics have led to the questioning of why mental health services are underutilized among minority populations. An extensive amount of current literature supports the assertion that African American men are less likely to seek help for mental health illnesses such as depression than women; this further explains the need to critically investigate the

complexity of issues that may impact help-seeking behaviors among African American men (Holden, McGregor, Blanks, & Mahaffey, 2012).

Statistical evidence also yields evidence that is indicative of how significant and problematic mental illness is among African American men and other minority populations. The United States Department of Health and Human Services, Office of Minority Health (2016) reveals African Americans are 30% more likely to receive improper diagnosis and treatment for mental health illnesses such as depression when compared to non-Hispanic Whites, leading to a greater decrease in functioning and disability. For example, when compared to non-Hispanic Whites, African Americans suffer from longer periods of depression and are less likely to seek and receive mental health services from a mental health practitioner (Bailey, Patel, Barker, Ali, & Jabeen, 2011).

A correlational survey study involving adult college students to examine attitudes toward help-seeking (Topkaya, 2014) found that self-stigma was a significant predictor of attitudes toward help-seeking rather than stigma alone. They also found that when compared to women, men were less likely to seek help. Preliminary research has indicated the attitude one has towards the concept of seeking help for psychological problems may be one of the best predictors. Sentinel research has also found that individual help-seeking attitudes is a reflection on whether a person sees the benefits of seeking help, whether positive or negative (Fisher & Turner, 1970).

A quantitative study (Vogel et al., 2011) suggests three factors that are critical for help-seeking are masculine norms endorsement, help-seeking attitudes, and self-stigma

can be barriers to help-seeking exist and may be difficult to navigate. Depending on the context in which they are viewed by African American men, these barriers may be perceived or real. Barriers to help-seeking may present as a result of lack of knowledge and awareness, lack of access to care, lack of trust in mental health providers, fear of being institutionalized, stigma, gender role socialization, and fear of confidentiality breach (Vogel et al., 2011, Mansfield et al., 2005).

A comparison among ethnic and gender groups on a national level supports the notion that men are less likely to seek help for psychological problems (Eisenberg, Downs, Golberstein, & Zivin, 2009; Mojtabai, 2007, Vogel et al., 2011). Researchers have presented several theories to explain why this discrepancy occurs. While many researchers attribute factors such as gender-role socialization conflicts, embarrassment, lack of positive help-seeking behaviors, and other things that may discourage help-seeking, research lacks in the area of how African American men and their experiences with depression while the focus remains on perceived negative attitudes (Tedstone & Kartalova-O'Doherty, 2010; Townes, Cunningham, & Chavez-Korell, 2009).

A strong connection may be present with the denial of mental health issues among the African Americans as this group shares a deeply rooted history of resiliency and self-reliance (Belgrave & Allison, 2010). Empirical evidence shows that African American men perceive certain elements that may increase their stress levels thereby limiting help-seeking and mental well-being (Scott et al., 2015; Townes et al., 2009). Interpersonal circumstances and impaired personal identity may lead to a psychological experience felt by African American men known as psychological invisibility (Franklin, 2004).

Psychological invisibility may be felt when African American men deal with factors such as discrimination; as such, their ability to foster adaptive behaviors may be hindered which in turn impacts their ability to cope with stressors on multiple levels (Franklin, 2004). The experience of psychological invisibility may cause an increase in mental and emotional distress.

Increases in mental and emotional distress and anguish can exacerbate other stressors, which can cause African American men to turn to non-traditional methods of dealing with mental health issues; adherence to formal mental health care treatment options such as therapy is also problematic among the African American male population. (Bell, Arcury, Snively, Golden, & Quandt, 2010; Townes et al., 2009). Within the process of disease, when medical treatment or intervention is sought early enough, the probability of survival increases (Hernandez, Han, Oliffe, & Ogrodniczuk, 2014; Noon & Stephens, 2008). The reluctance of help-seeking among African American men is particularly disturbing, especially within the context of mental health illness. Research has given useful insight into help-seeking among men; however, our understanding of the experiences men, especially African American men is quite limited (Hernandez et al., 2014).

## Traditional Masculinity Ideology

Research asserts that help-seeking is linked to two distinct masculinity variables which are traditional masculinity ideology and gender role conflict (Levant, Stefanov, Rankin, Halter, Mellinger, & Williams, 2013; Levant & Richmond, 2007; O'Neil, 2008). Viewed as the most dominant ideology in the U. S., traditional masculinity ideology

remained widely accepted until the 1960s and is defined as beliefs that focus on the importance of males to conform to traditional norms for their behavior (Levant et al., 2013). Traditional masculinity ideology can be measured through the use of the Male Role Norms Inventory – Revised or MRNI-R and outlines self-reliance, restrictive emotionality, dominance, and avoidance of femininity, negativity towards homosexual men, toughness, and non-relational sexuality which are considered seven traditional norms (Levant, Rankin, Williams, Hasan, & Smalley, 2010). Influenced by socialization processes, traditional masculinity ideology suggests that males are more likely to experience one or multiple types of gender role strain (Levant et al., 2013).

Researchers have utilized the strain paradigm to investigate cross-cultural masculinity ideology and men's mental health (Levant et al., 2013). The strain paradigm suggests that masculinity ideology influences processes that may promote or discourage male conformity to traditional male norms. Lynch & Kilmartin (2013) pose that because men may rely on traditional masculinity ideological principles, they will in turn develop coping styles or techniques that are considered masculine in nature to include rage, anger, and substance abuse. Research in terms of traditional masculinity ideology and African American men is limited. A quantitative study (Genuchi & Valdez, 2015) investigated adherence to traditional masculinity ideology and norms and their effects on depressive symptoms. Men that experience symptoms of depression may express those in ways that are highly influenced by traditional masculinity ideology (Genuchi & Valdez, 2015). Any type of emotion that alludes to sadness and vulnerability is socially unacceptable; men who adhere to traditional masculinity norms tend to express vulnerability in terms

that are consistent with masculinity and gender-role socialization (Genuchi & Valdez, 2015).

## Male Gender Role Conflict

Many theories have been utilized in hopes of offering a solid explanation for gender, masculinity, and their impact on mental health outcomes and help-seeking (Shepherd & Rickard, 2012). The Gender Role Conflict Scale (GRCS) and gender role conflict (GRC) were developed by O'Neil, Helms, Gable, David, & Wrightsman (1986). The operational definition of gender role conflict is tension that occurs between physical and mental health outcomes and gender role socialization when trying to conform to traditional masculinity norms; gender role conflict also postulates that when men adopt roles that are more rigid and masculine, they experience negative health effects (Levant et al., 2013; Shepherd & Rickard, 2012). Gender role encompasses an array of behaviors and attitudes that are attributed to members of a particular biological sex and can include behavior norms which can be classified as masculine ideology or traditional masculinity (Hammer & Good, 2010).

Societal views on male gender role have revealed prescribed ways for men behavior. The concept of Gender Role Conflict may shed some light on the subject on men, their experiences, and negative mental health outcomes (Shepherd & Rickard, 2012). Of the studies that have been conducted, it has been revealed that a positive correlation exists between Gender Role Conflict and negative mental health outcomes to include difficulties with interpersonal relationships, depression and other forms of psychological distress, substance abuse, and stress. A plethora of studies have been

conducted to help further our understanding of decreased help-seeking and gender role conflict (Shepherd & Rickard, 2012). From the 18 studies cited by O'Neil (2008), results indicated that a correlation exists between gender role conflict, negative help-seeking attitudes, negative attitudes toward the helpfulness of treatment, negative stimulus response to treatment options outlined in brochures, and a stronger preference for treatment options that are considered non-traditional (Shepherd & Rickard, 2012).

Limited literature and research exist on gender role conflict and African American men. Hammer and Good (2010) state that researchers have uncovered prescribed ways that society feels men should act, attitudes they should hold, and ways they should look; conversely society also have prescribed ways in which men should not act and attitudes they should not hold; these are centered on men of European decent. Traditional male gender roles suggest that men should not possess weakness and should always maintain control of their feelings and emotions, are the primary providers of the household while women are the primary caretakers and should be well kempt; men should not reveal feminine characteristics or emotional traits such as crying (Hammer & Good, 2010).

## Stigma and Traditional Masculinity Norms

Expressing emotion is strongly associated with making the decision to seek help for mental health issues such as depression (Vogel et al., 2011). Women are more inclined to recognize psychological distress than men. A study by Rose, Schwartz-Mett, Smith, Asher, Swenson, Carlson, & Waller (2012) found that even from the early ages of childhood and adolescent years, males were less likely to express their feelings and/or emotions; as such it is postulated that males are taught from young ages that expressing

their emotions is not the "manly" thing to do and are less likely to seek help. Stigma is often associated with depression and many other mental disorders; however, men may experience a stigma that is gender-specific (Hoy, 2012). Gender-specific stigma impacts help-seeking among men due to the perception that society is more willing to accept the lack of emotional control from a woman than a man.

Studies have found that traditional masculinity norms can influence behaviors, attitudes, and intentions of men to seek help (Hoy, 2012; Smith, Tran, & Thompson, 2008). Research has focused on mental health disorders such as depression and help-seeking among men and the relationship between help-seeking behaviors and masculinity, but few focus on their experience (Hoy, 2012). Within the paradigm of masculinity, men are portrayed as being unresponsive to emotional distress, unbothered by pain or minor depressive symptoms, and naturally strong; as a result, men are reluctant to reveal any vulnerabilities they may have and seek help (Chuick, Greenfeld, Greenberg, Shepard, Cochran, & Haley, 2009; Hoy, 2012; Scheid & Brown, 2010). Much of the existing literature on the psychological aspect of men and masculinity has focused on the challenges that may be encountered; the primary challenge that is often faced by men is the lack of awareness of the damaging effects of strangulated forms of masculinity, which can negatively affect psychological well-being (Kiselica & Englar-Carlson, 2010).

Yousaf, Popat, & Hunter (2014) conducted a study in which the relationship between masculinity and help-seeking attitudes were examined. The study supported existing research on help-seeking among men by showing a strong connection between masculinity norms and attitudes on seeking help for mental health illnesses such as

depression. Quantitative and qualitative studies have found that men are reluctant to seek help for psychological issues. This reluctance may be attributed to the attitudes men have regarding how they should behave and think (Smith et al., 2008; Yousaf et al., 2014).

## Restrictive Emotionality

Restrictive emotionality or the suppression of emotion, is often encountered by men and can increase depression and depressive symptoms (Wade, 2009). Fear of and difficulty in the expression of feelings, vulnerability, and difficulty in finding the appropriate words to articulate innermost feelings and emotions lays the groundwork for restrictive emotionality. Men across all ethnic groups are to some degree victims of restrictive emotionality and other masculine role norms that give rise to depression; this seems to affect African American men more than other groups (Wade, 2009). Restrictive emotionality can interfere with help-seeking behaviors and various treatment options for depression such as psychotherapy; certain emotions are viewed as "vulnerable": fear, shame, guilt; as a result, males are more likely to restrict these emotions (Rogers, 2011).

Social science literature expands on the concept of restrictive emotionality and suggests that an individual's emotional life shares a strong connection with social influences that can influence behavior and impact psychosocial functioning (Shields, 2008; Wong, Horn, Gomory, & Ramos, 2013; Wong & Rochlen, 2008). Social norms and individual perception pertaining to appropriateness, prevalence, and fervor of emotionality act as a guide and has the potential to constrain emotional well-being (Wong et al., 2013). Masculinity, gender role norms, and restrictive emotionality has been

applied in numerous studies, particularly Mahalik, Locke, Ludlow, Diemer, Scott, Gottfried, & Freitas (2003) study on gender role norms model; however, few studies have utilized African American men. The researchers in the above study proposed collection of masculine norms (predominantly White American) that influence help-seeking behaviors and the overall well-being of men with specific focus on emotional control and masculine norms (Wong et al., 2013).

Men who conform strongly to masculine norms that guide emotional control may not be willing to reveal what makes them vulnerable to others, which can lead to poorer psychological function and interpersonal relationships. Based on this research, it has been found that the emotional control of men is positively correlated with augmented levels of aggression, depression and depressive symptoms, negative attitudes toward help-seeking, lower levels of self-esteem, and overall poorer mental health well-being (Syzdek & Addis, 2010; Wong, Steinfeldt, LaFollette, & Tsao, 2011; Wong et al., 2013).

## Behavioral Model of Health Services

The theoretical framework for this study consisted of Andersen's behavioral model of health service. The behavioral model of health services has proven useful due to its flexibility as it allows researchers to choose independent variables that relate to a specific hypothesis (Babitsch, Gohl, & von Lengerke, 2012). The model has also been adapted to study various outcome variables pertaining to health care utilization and can be applied to qualitative studies; as such, the behavioral model of health services was one of the most widely used frameworks used to predict health care utilization (Babitsch et al., 2012). Developed by Ronald M. Andersen (1968), the behavioral model of health

services was created for the empirical testing of hypotheses regarding inequalities in health care access in the U.S. The model addressed matters that are of particular concern for ethnic minority groups that may receive less health care compared to the rest of the U.S. population (Andersen & Newman, 1973).

Viewing services access, the behavioral model of health services suggested that accessing care is the result of individual decision making; however, these decisions are often forced by service availability, socio-economic status, and other social inequalities (Babitsch et al., 2012). Predisposing, enabling, and need are three predictive factors contained within the behavioral model of health services; it is suggested that these factors determines health services utilization (Andersen, 1968). In the first study conducted by Andersen (1968), the unit of analysis and primary focus was family and as such, numerous variables on the family level were used; the model was later modified, and the unit of analysis became the individual (Andersen & Newman, 1973). Andersen (1995) revisited the model to review its development and application across various fields and argued that many of the concepts of the model developed in 1968 fit appropriately into the component of social structure. Within the component of social structure lies health beliefs. Health beliefs can include knowledge or attitudes an individual may have about health services and health, has the potential to influence perceived need, and may explain how social structure may impact perceived need, use, and resources (Andersen, 1995).

The 1968 model argued that predisposing factors focus on the assertion that an individual's inclination to utilize health services can be forecasted based on personal characteristics (social structure, health beliefs, and family composition) that predate the

illness; other variables include social class, gender, ethnicity, age, and family size

(Andersen, 1968). These variables often indicate the position of the individual on the

social ladder, which greatly influences their physical environment, lifestyle, and social

environment (Babitsch et al., 2012). Enabling factors are centered on the assumption that

even though a person may be predisposed to health service utilization, certain elements

must be present for them to access those services (Andersen, 1968). Enabling factors are

inclusive of health services availability, health insurance, and financial resources.

Need, the last of the factors, is an important factor in health service utilization.

Andersen (1968) outlined two types of need, response and illness, are often present. It

must be recognized that an illness is present, but the individual must also have the

appropriate response, which is to access services (Babitsch et al., 2012). Access is only

equitable if unalterable characteristics exist such as gender and age or by need (Andersen

& Aday, 1978).

Access is inequitable if prediction, whether entirely or partially, is based on

enabling factors, or ethnicity (Andersen & Newman, 1973). As such, the theoretical basis

is formed for using the behavioral model of health services to study health service

utilization to study ethnic minority populations that may face inequalities when utilizing

health services for mental health issues. Great efforts have been made to make the

behavioral model of health services an integrated model by incorporating elements from

behavioral and health belief models to explain utilization (Andersen, 1995).

The behavioral model of health services has been employed in studies involving

depression, help-seeking, and service utilization, particularly among women in the United

States. In a quantitative study by Keller, Gangnon, & Witt (2013) the behavioral model of health services was used to examine the relationship that exists between predisposing, enabling, and need factors as well as ratings of perceived communication between providers and female patients with depression. Additional studies have also found that individuals with depressive symptomology are less likely to have favorable communication with their personal providers (Martino, Elliot, Kanouse, Farley, Burkhart, & Hays, 2011). Using a nationally representative sample, women with depression were identified through the Medical Expenditure Panel Survey Household Component.

Predisposing factors were identified as age, race/ethnicity, education status, paid workforce participation, marital status, and geographical region; enabling factors were identified as socio-economic status, health insurance and type, primary spoken language, and having a consistent source of care; need factors that were investigated included health service utilization, chronic medical conditions and mental health comorbidity, quality of life, health status as rated by the individual, and functional limitation status (Keller et al., 2013). The results of the study found that African American women were more likely to report satisfactory ratings with provider education. This study's findings add to the growing amount of literature that suggests race plays a pivotal role in the perception of patients and communication behaviors of providers (Keller et al., 2013).

Maja, Nassar, & De Allegri (2013) conducted a qualitative study using the behavioral model of health services to investigate help-seeking behaviors among rural Palestinian women. As previously identified, the behavioral model of health services has been adapted and modified and can be done in order to fit the nature or purpose of the

research (Andersen 1995, Maja et al., 2013). The adaptability of the model also allows

for inclusion of additional factors that the researcher may deem important in contexts that

pertain to the study population. Evidence on help-seeking behaviors among the targeted

population was scarce, thereby causing the researchers to define the study as exploratory

or an attempt to understand the "how" and "why" of help-seeking in Palestinian women

(Maja et al., 2013). Three villages were selected and 10 women per village were

interviewed using semi-structured questions; individual interviews were chosen rather

than focus groups in efforts to focus on the experiences of individuals (Maja et al., 2013).

The results of study indicated that number of complex factors to include cultural norms,

geographical location, the structure of health systems, financial resources, and quality of

care influences the decision to seek help (Maja et al., 2013).

For the present study, the behavioral model of health services will be adapted to

examine help-seeking experiences and behaviors among African American men with

depression and how individual level factors may impact those experiences and behaviors.

Though the behavioral model of health services is employed primarily with quantitative

studies, it can be utilized as a theoretical framework in qualitative studies (Babitsch et al.,

2012; Hammond et al., 2012; Maja et al., 2013). African American men with depression,

their experiences, and help-seeking behaviors are rarely studied, yet researchers maintain

that variations are seen among ethnic groups in predisposing factors, enabling factors,

and need (Hammond et al., 2012, Babitsch et al., 2012).

In this study, the need factor is the presence of depression, a chronic mental

illness and disability, which connects with a need for support as well as need to share

their experiences when dealing with depression and help-seeking as an African American male. Predisposing factors such as age will consist of factors that predispose African American men to enabling factors or help-seeking behaviors. Finally, enabling factors such as access to mental health services, socio-economic status, and marital status will be incorporated. The explanation behind this is that African American men can have a need for support as well as predisposition, but if he is not empowered, he will not seek the support he needs.

## Summary

Studies revealed that depression among African American men is rarely studied and little is known of their help-seeking experiences. Chapter 2 included the introduction, literature search strategy and sources, overview of depression and prevalence, utilization of mental health services, help-seeking, traditional masculinity ideology, male gender role conflict, stigma and traditional masculinity norms, restrictive emotionality, and the theoretical framework. Due to personal, social, and environmental factors, it was possible they may influence help-seeking behaviors, augment, or diminish their experiences. The study provided significant insight into the help-seeking experiences of African American men with depression. Although studies have been conducted on minority populations and males, very little research looked at African American men dealing with depression. Chapter 3 will discuss the most appropriate method for utilization in this study in order to illuminate the personal, social, and environmental experiences as it pertains to help-seeking among African American men with depression.

Chapter 3: Research Method

I examined help-seeking experiences among African American men with depression using qualitative phenomenological methodology. The purpose of this study was to explore and describe the experiences of African American men with depression as it relates to help-seeking. Applying the phenomenological approach allowed me to gather details of the phenomenon that will contribute to the field of mental health concerning how African American men with depression navigate and overcome barriers to help-seeking. I explored the personal, social, and environmental experiences of African American men to understand their knowledge of depression and to describe how their experiences impacted coping and help-seeking behaviors. This chapter provides an overview of the research design and methodology, role of the researcher, target population, selection criteria for participants, data collection procedures, and ethical concerns associated with the research process.

**Qualitative Research Design and Rationale**

The central research questions for this study were the following:

1. What are the personal, social, and environmental experiences of African American men with depression as they relate to help-seeking?

2. How do personal, social, and environmental experiences help African American men to navigate or overcome barriers that may prevent them from seeking help?

The central phenomenon of the study was the personal, social, and environmental experiences of African American men. For the purpose of this study, *experience* was

defined as events or acts encountered, lived through, or undergone by individuals from a personal, social, or environmental perspective (see Creswell, 2013).

## Research Tradition

Creswell (2013) defined qualitative research as a process of inquiry in which researchers attempt to investigate and understand human or social phenomena that are subjective and impossible to quantify. Qualitative researchers collect empirical data and arrange them to form a picture and describe an individual's life or a phenomenon within a natural setting (see Creswell, 2013). Qualitative research design and methodologies are used to depict beliefs, attitudes, and motivations of a target population, which lays the groundwork for thematic analysis (Maxwell, 2012). Qualitative research provides intricate descriptions from a textual perspective and allows an in-depth view into human behavior, relationships, and emotions by including smaller sample sizes compared to quantitative approaches (Creswell, 2013). According to Maxwell (2012), the qualitative inquiry process involves the development of transferable theories and focuses on description and interpretation. Moustakas (1994) stated that the phenomenological approach calls for the skill to view and illustrate concepts as they are while understanding the essence of the experience.

## Transcendental Phenomenology

I used a transcendental phenomenological design in this study. A requirement of transcendental phenomenology is self-reflection, which involves awareness of the researcher's views and biases while examining the experiences of the participants

(Moustakas, 1994). Examining the experiences of African American men with depression from their point of view required a descriptive approach. Applying these techniques required reflection and description to comprehend the phenomenon. Obtaining data that illuminated the experience of the phenomenon was necessary to understand the experiences and behaviors being in this study. After considering other qualitative approaches such as ethnography, grounded theory, and hermeneutic phenomenology to examine the personal, social, and environmental experiences of African American men with depression, I concluded that the phenomenological approach was most appropriate. There was a gap in the literature regarding personal of African American men with depression. The phenomenological approach provided an appropriate means of understanding these experiences through semistructured interviews.

An ethnographic approach would have allowed me to describe behaviors and experiences, social interactions, and ideas from a cultural perspective over a period of time among a group (see Creswell, 2013). This approach would have allowed me to frame beliefs, attitudes, behaviors, or values within a community. However, I considered that some African American men would not have fully engaged with the community dynamic or utilized resources found in the community. As a result, this approach was not appropriate. Grounded theory focuses on the development of a theory that originates from collected data (Frambach, van der Vleuten, & Durning, 2013). Although grounded theory would have allowed me to observe participants, it did not permit the examination of lived experiences (see Moustakas, 1994). Developing a theory was not the purpose of this study; as such, this method was not deemed appropriate.

The hermeneutic approach would have enabled me to investigate and decipher the phenomenon meaning through the participants' expression and experience (see Gibson & Brown, 2009). The hermeneutic approach would have provided an overall understanding of the essences of experiences for African American men with depression; however, the intent was not to unearth what was hidden behind the phenomenon; it was also not the intent to merely decipher narrated text to try and ascertain the experience (see Husserl, 1970). The transcendental approach was most appropriate for this study to provide an extensive description and understanding of the lived experiences of African American men with depression from their perspectives. The approach for this study borrowed from Husserl's (1970) phenomenology of perception. Husserl (1962, 1970) asserted that value can be found in the experiences of humans as well as their perception, and researchers should not discount subjective information when pursuing understanding of what motivates human actions as these actions are guided by the perception of what is real. Exploring critical aspects of experiences from natural and cultural perspectives that are native to a subgroup of individuals can be done using a phenomenological approach.

### Rationale for Using a Qualitative Method and Core Practices

Qualitative methods, primarily transcendental phenomenology, allowed me to answer the research questions by gathering data to yield findings that were not predetermined, and to produce findings that could be applied beyond immediate boundaries of the study (see Creswell, 2013). This methodology provided an opportunity to interpret the complexity of help-seeking behaviors in African American men with

depression. A benefit of the qualitative approach was flexibility, particularly the ability to ask open ended questions. Open ended questions were designed to elicit responses from the target population that were relevant and not anticipated by me; open ended questions also presented favorable conditions for descriptions that were rich and substantial.

Phenomenology can be used when researchers wish to describe the how and what regarding individuals' lived experiences as they relate to a concept or phenomenon (Creswell, 2013). Phenomenology can be used to study what emerges from an individual's mind and may also be used to study how different types of experiences such as thoughts, perceptions, and memories are framed (Creswell, 2013). Creswell (2013) asserted that emphasis is placed on the phenomenon that the researcher wishes to explore.

Transcendental phenomenology as introduced by Husserl (1962, 1970) and was later adapted by Moustakas (1994), yielding six core practices. The first core practice allowed me to employ bracketing, the process of setting aside personal experiences, preconceived notions, and biases (see Moustakas, 1994). Bracketing prior to interviewing and during the data collection and analysis assisted me in withholding my attitudes, bias, and judgement regarding existing ideas to ensure objective findings. The second core practice enabled me to use the interviewing process for data collection; participants who had experienced the central phenomenon were interviewed.

The third core practice allowed me to capture and describe an authentic depiction of the phenomenon using the perspective of the participants. Horizontalization was the fourth core practice in which all collected data had equal value (see Moustakas, 1994).

This process provided a clean perspective that added to the understanding of experiences. The fifth core practice allowed me to use textural descriptions. Analysis of textural descriptions is used to reveal themes from the data (Moustakas, 1994). The textural descriptions were representative participants' experiences. The sixth core practice provided an opportunity to take an in-depth look at emerging themes and examine the meanings behind them.

## Role of the Researcher

In this phenomenological study, I explored the help-seeking experiences of African American men with depression from their perspective. Bracketing was used to set aside my beliefs, knowledge, and personal experience with African American men with depression. Bracketing allowed me to understand the phenomenon that was being studied from the viewpoint of participants. Creswell (2013) asserted that bracketing allows for multiple layers of interpretation to be unfolded for the phenomenon to be unveiled.

My goal was to bracket my experience through constant assessment of inquiry, prevention of influence on the objects being studied, and neutralization of preconceptions and biases (see Husserl, 1970). I was the designated point of contact for any questions pertaining to the study. I was also responsible for giving instructions to study participants, conducting interviews, collecting data, and analyzing data. In addition, I was responsible for recording interviews and taking notes to promote objectivity and mitigate bias. I did not have any personal or professional relationships with the participants.

## Methodology

The target population for this study were African American men between the ages of 18 and 65 who resided in varying geographical locations within the United States. Results from the study conducted by Edwards, Green, Wellington, & Muhammad, (2009) revealed that mid 20's was the average age of African American men diagnosed with depression. Previous research revealed that depression in African Americans persists for extended periods of time (Gibbs, Okuda, Oquendo, Lawson, Wang, Thomas, & Blanco, 2012).

Purposive sampling was used to recruit participants. Purposive sampling relied on my judgment when participants were selected (see Creswell, 2013). Compared to probability sampling, purposive samples are small (Creswell, 2013). One of the main reasons for using purposive sampling was to avoid random selection from a population to generate a sample. The range of purposive sampling was wide and allowed me to focus on certain traits of a population of interest which allowed the research questions to be answered (Patton, 2002).

Criteria for participation included being an African American man, aged 18 through 65, a medical diagnosis of depression or experienced symptoms of depression, not currently in treatment, and English-speaking. Participants met criterion based on responses received from a demographic and screening questionnaire that was administered (See Appendix B). Qualitative methods are known for small sample sizes; keeping the sample size small allowed for in-depth exploration of the experiences of the

participants. The targeted number of participants for the study was 8- 10; however, the final number of interviews (6) was decided by the point of data saturation.

## Recruitment of Participants

An invitation for participation occurred upon notification of authorization from the Institutional Review Board and was done through purposive sampling (See Appendix A). Electronic flyers were distributed through social media sites such as Facebook and through oral communication. Prospective participants underwent an interview conducted by telephone to ensure eligibility for study participation.

## Data Saturation and Sample Size

A tool that is utilized in qualitative research is data saturation. Data saturation includes processes such as data collection and analysis to the point in which no new observations occur. Data saturation is considered meaningful because it addresses whether a study has a sample size adequate enough to establish validity (Francis, Johnston, Robertson, Glidewell, Entwistle, Eccles, & Grimshaw, 2010). In a review of 18 peer reviewed articles, France et al., (2010) found that at least fifteen researchers stated data saturation was met. Although the working definition of data saturation was consistent among the articles, new concepts, findings, problems, or themes were not evident.

**Instrumentation and Data Collection**

An instrument used throughout qualitative research and data collection is the researcher (Patton, 2002). As recommended by Creswell (2013) and Maxwell (2012), I conducted interviews using self-created, semistructured questions. Open ended along with a few closed questions were used to obtain participant's perspectives and experiences. A self-created 10-minute demographic questionnaire was also used (see Appendix B). An interview guide was developed for the purpose of narrowing interview questions that allowed the participants to reflect on how their experiences with depression impact help-seeking behaviors (see Appendix D). Before interviewing participants, a pilot study was conducted with two African American men that met the criteria for the study.

In-depth qualitative interviewing was employed to explore the perspectives, attitudes, beliefs, and experiences of the study participants and each interview was recorded and transcribed. Patton (2002) explained that the interviewing process in qualitative research is important when collecting data. Interviewing techniques depended on the types of questions that were answered and the interview focused on practicality and what yielded the most relevant answers to the research questions. Qualitative interviewing allowed me to obtain meaningful and rich descriptions of the personal, social, and environmental experiences of African American men with depression as it relates to help-seeking.

Each participant chose a date, time, and method that was convenient for interviewing. According to Maxwell (2012), informal conversational interviews are beneficial in establishing a rapport with participants and can be viewed as a mechanism for establishing trust and connections. Prior to beginning interviews, the purpose of the study and research design was reviewed prior to obtaining the signature of the participant on a consent form (See Appendix C).

## Procedures

Prior to collecting data, the National Institute of Health (NIH) Office of Extramural Research Human Research Protections training was completed and approval was granted (approval number 09-22-16-0202016) from Walden University's Institutional Review Board (IRB). State and federal guidelines were complied with and included informing study participants of the level of confidentiality. Once participants were identified and selection criteria was confirmed, they were informed by email, phone, face-to-face interaction, or social media. An invitation letter was also given to the participants (see Appendix A). I informed study participants of their right to ask any questions about the study, which was done by face to face, phone, or email. I did not include anyone in the study with whom I had a personal relationship to include professional colleagues, academic colleagues, friends, family members, or coworkers.

Upon receipt of the invitation letter and demographic questionnaire, each prospective participant received the consent form which required their signature. Prospective participants were given a copy of the consent form for their records. Upon

receipt of the signed consent form, each participant was contacted to schedule an interview that was most convenient for them. Interviews took place via telephone or face to face at the Round Rock Public Library located at 216 East Main Street, Round Rock, Texas 78664 and were audio recorded. This study did not cause acute emotional or psychological discomfort; however, to protect participants from psychological distress, they were informed of local resources in their areas if they experienced any negative side effects or discomfort from their participation.

**Data Analysis Plan**

Data analysis software is a tool that researchers could use when working with various types of data such as multimedia or data that is rich in text; software programs have been proven useful when researchers wish to perform a thorough analysis for small quantities of data or when large amounts of data needs to be analyzed (Hutchison, Johnston, & Breckon, 2010). Qualitative data is not numerical and can often lack structure; NVivo can assist the researcher with managing and organizing data (Hutchinson et al., 2010). Hutchison et al., (2010) states that NVivo can also help the researcher with data classification and can also take an in-depth look at existing relationships among the data; as a result, existing trends or themes may be identified for cross-reference. For this study, data were analyzed and coded by hand.

Thematic analysis, pre-coding, first cycle coding, and second cycle coding were used to analyze data. Thematic analysis is an adaptable method that enables themes and patterns to be identified, described, analyzed, and reported (Miles, Huberman, & Sladana,

2014). I familiarized myself with the data by reading the contents of the transcribed interviews to become familiar with the contents. I generated labels through coding so that I could uncover important features found within the data that would be helpful in answering the research questions. Uncovered themes were reviewed against the data set to determine if they answered the research questions. During this phase, themes were defined, refined, and named after a detailed analysis.

Coding is a process that is necessary in qualitative methods and involves assigning a label that has significant meaning to data that is collected when conducting a qualitative study (Creswell, 2013). Coding included of several processes such as analysis, condensing data into meaningful matter, and was a pathway for discovery. Coding was categorized into two stages which were first cycle coding and second cycle coding. First cycle coding can be inclusive of 25 different approaches, each complete with their own unique purpose (Miles et al., 2014). For this study, descriptive coding was used. According to Miles, Huberman, and Saldana (2014) when researchers utilize first cycle coding processes, the data that is obtained is congregated into codes that are often recurrent to see if different themes will emerge as well as summarize different segments of data.

For descriptive coding, I looked at basic passages of the interviews and assigned labels, short phrases, or a word to summarize the data. Descriptive coding yielded a list of topics that were indexed and categorized as codes. The words or phrases from the participant's interviews were placed in quotation marks which set them apart from the

codes I generated. Repetitive words or phrases from the participants led to patterns.

Second cycle coding involved taking the summaries of data segments obtained from first

cycle coding and breaking them down into smaller segments or themes; this was also

considered pattern coding (Miles et al., 2014). I used pattern coding to take large amounts

of data and condensed it into smaller units. I was able to analyze collected data which

helped me understand interactions, incidents, and laid the foundation for cross-case

analysis (Miles et al., 2014).

## Issues of Trustworthiness

Creswell (2013) stated that two elements of conducting research are validity and

reliability. Reliability and validity have been widely argued between the two research

traditions, quantitative and qualitative and it is often argued as to which tradition is the

greater source (Creswell, 2013). For this study, validity and reliability were established

through various channels: credibility, transferability, dependability, and confirmability.

Credibility pertained to how credible the results of the research were from the

perspective of those participating in the research (Lincoln & Guba, 1985; Elo,

Kääriäinen, Kanste, Pölkki, Utriainen, & Kyngäs, 2014). To establish credibility, member

checks were performed by emailing the participants a copy of the interview transcripts so

they could be reviewed for accuracy. I also established credibility by using iterative

questioning and probes in order to obtain detailed information from participants. This

method enabled me to uncover discrepancies in the data (Elo et al., 2014). Transferability

focused on whether the results of the study could be transferred to other settings or

situations (Elo et al., 2014). Transferability was established by providing detailed accounts of the personal, social, and environmental experiences of the participants which could be transferred to other situations, settings, or people (Lincoln & Guba, 1985; Elo et al., 2014)).

Dependability addressed the issue of whether the findings of the study were consistent and repeatable (Miles et al., 2014). Dependability was established by audit trails. Audit trails provided a description records of how the study was conducted. Confirmability focused on whether others can confirm or corroborate the results of the study (Miles et al., 2014, Tracy, 2010). Confirmability was established and enhanced through member checking through the duration of the study.

## Ethical Procedures

Approval was granted by Walden University's Institutional Review Board (approval number 09-22-16-0202016) and informed consent was obtained from participants. A consent form was given to the participants for signature (see Appendix C). Project identification, purpose of the study, procedures, risks, benefits, confidentiality, and an explanation of participant's rights were included on the consent form. Participants were advised of all rights to include withdrawal from study participation and the right to ask questions. If participants showed signs of agitation or distress, the interview ceased. All participants received a list of available resources in the area if they needed further assistance.

**Summary**

This chapter provided a brief overview of the research design, rationale, methodology, data collection, and data analysis procedures. The purpose of this study was to explore and describe the experiences of African American men with depression as it relates to help-seeking. Semistructured interview questions were used and each interview was analyzed and transcribed. This study was conducted according to guidelines set forth by Walden University's Institutional Review Board to ensure the ethical and humane treatment and protection of the participants. Upon receipt of signed informed consent (see Appendix C), each prospective participant was contacted to schedule a date and time that was convenient for interviewing. All data obtained were kept secured. This chapter also included my role as the researcher, methods for establishing validity and reliability, and ethical procedures. Chapter 4 will discuss the results, participant demographic profiles, data collection, data analysis, themes, and sub-themes.

Chapter 4: Results

The purpose of this phenomenological study was to explore the help-seeking experiences of African American men with depression. I focused on the personal, social, and environmental experiences of African American men with depression as they related to help-seeking. The following research questions guided the study:

1. What are the personal, social, and environmental experiences of African American men with depression as they relate to help-seeking?

2. How do personal, social, and environmental experiences help African American men to navigate or overcome barriers that may prevent them from seeking help?

Chapter 4 includes a description of the pilot study, setting, demographics, data collection and analysis, evidence of trustworthiness, results. I explain how data were obtained, recorded, and analyzed to identify themes representing the experiences of African American men with depression. I used a transcendental phenomenological method to explore and describe the experiences of African American men with depression as they relate to help-seeking. Transcendental phenomenology afforded me the opportunity to gather data, and produce findings that were not predetermined and that could be applied beyond immediate boundaries of the study to gain a deeper understanding of the essence of the phenomenon (see Moustakas, 1994). I was responsible for data transcription as well as data verification, editing, and analysis. Data collection instruments included a demographic questionnaire (Appendix B) and interview

questions that were semistructured and open ended (Appendix D). Each African American participant was interviewed for approximately 60 minutes.

The purpose of the study was to answer two central research questions through data collected from open ended, semistructured interviews. The interview questions addressed the personal, social, and environmental experiences of the study participants (Appendix D). The first central research question was developed to gain a better understanding of the experiences of African American dealing with depression, especially in relation to help-seeking. The second central research question focused on how African American males believed they could overcome barriers that prevented them from seeking help. I analyzed pertinent phrases and passages from the interview transcripts to classify meanings and themes that are presented as tables.

## Pilot Study

The pilot study consisted of two African American men who met the criteria of the study. Consent forms and demographic questionnaires were given and administered before the participants could participate. The pilot study interviews were conducted at a public library. The interview questions were tested for feasibility by looking at several factors such as the ease of comprehension. I determined whether the interview questions would yield responses that were relevant to answering the research questions. Participants' responses indicated whether they understood the questions. Pilot testing was also useful in determining how much time the participants would need to complete the interview. The pilot study also allowed me to assess any possible triggers or side effects

that could impact the emotional state of the participants while they recalled unpleasant situations, memories, or outcomes.

Each interview question was answered appropriately, and the two participants agreed that each question was easily understood, clear, and concise. The participants were able to recall their experiences and did not show any visible signs of emotional disturbance, distress, or discomfort. The pilot study's results revealed that the interview questions did not need to be changed and the questions were found to be appropriate for the main study. Conducting the pilot study also shed light on the time needed to conduct interviews in the main study. In addition, the pilot study reinforced the two most critical elements of research, which are validity and reliability (see Creswell, 2013). Validity refers to whether the findings are consistent and applicable, and reliability refers to whether the research will produce the same findings if repeated (Creswell, 2013). The pilot study showed that the interview questions were comprehensible and would elicit relevant responses from the participants.

**Setting**

Purposive sampling was used to recruit study participants. When using purposive sampling, researchers can focus on certain traits of the population of interest (Creswell, 2013). In-depth semistructured interviews were conducted with 6 African American men who had a medical diagnosis of depression or had experienced symptoms of depression. The interviews took place in a private conference room at a public library were conducted

by telephone. At the time of the study, no organizational conditions that could influence the participants' experiences or the study's results were present.

## Demographics

The original target number for study participants was 8 to 10; however, data saturation was reached with 6 participants. Criteria for participant selection included (a) African American men, (b) aged18 through 65, (c) having a medical diagnosis of depression or symptoms of depression, (d) not currently in treatment, and (e) English speaking. All participants were recruited through social media, agreed to participate in the study, and signed the informed consent.

Participants were given a demographic/screening questionnaire to ensure they were eligible for the study. The findings from the demographic screening questionnaire revealed that all participants identified their ethnicity as not Hispanic or Latino and their race as African American. The age ranges on the demographic and screening questionnaire were 18 to 29 years old, 30 to 49 years old, 50 to 64 years old, and 65 and older. All 6 participants fell into the age range of 30 to 49 with the youngest being 33 years of age and the oldest being 44 years of age. One participant reported being single, one participant reported being divorced, and four participants reported being married. Regarding levels of education, one participant had some college experience, two reported having an associate's degree, two reported having a bachelor's degree, and one reported having a master's degree. Of the 6 participants, five were full-time employees and one was not employed.

With regard to military service, 5 participants had previously served in the U.S. Armed Forces. All participants reported that they were previously diagnosed with depression or suffered from depressive symptoms, were not under mandatory in-patient psychiatric observation, were not currently seeking treatment for their depression or depressive symptoms, spoke English fluently, had health insurance to cover any needed treatment, and did not reside in a facility such as group homes, or nursing facilities. Regarding geographical location, 1 participant resided in South Carolina, 1 participant resided in North Carolina, 1 participant resided in New York, 1 participant resided in Indiana and 2 participants resided in Texas. Five participants reported having children, and one participant reported not having children.  During the course of the interviews, I did not guide or direct responses and did not offer any personal accounts, comments, or experiences to the participants. Participant demographic information is presented in Table 1.

Table 1

*Demographics of Participants*

| Participant | Age | Educational level | Type of interview | Marital status |
| --- | --- | --- | --- | --- |
| 1 | 35 | Bachelor's degree | Telephone | Married |
| 2 | 36 | Bachelor's degree | Face to Face | Married |
| 3 | 33 | Master's degree | Telephone | Married |
| 4 | 34 | Associate's degree | Face to Face | Single |
| 5 | 44 | Some college | Face to Face | Single |
| 6 | 35 | Associate's degree | Telephone | Married |

**Data Collection**

Data collection tools included a demographic questionnaire and an interview guide that consisted of interview questions, possible follow-up questions, probing words, and transitional phrases to explore the personal, social, and environmental experiences of African American men. The study participants were each given the demographic questionnaire to ensure eligibility for participation. The interview protocol consisted of open ended questions that were semistructured with a few close-ended questions. The interview questions addressed factors surrounding depression and help-seeking such as (a) experiences when seeking support for depression, (b) the effect of depression on personal and social relationships and work environment, (c) experiences with the mental health system as well as prior or existing knowledge about depression and help-seeking, (d) structure of support systems, (e) stigma associated with depression and help-seeking, (f) and societal views and expectations of African American men. The interviews were scheduled at a date and time that was convenient for each participant, were digitally recorded, and took approximately 60 minutes to complete.

To manage and track data, I used a filing and logging system. All files were maintained digitally through the use of Microsoft Word, and hard copies were kept locked in a filing cabinet for security and confidentiality. Documentation regarding interview appointments, interview outcomes, and research activities was kept confidential. I also kept a journal of my reflections and thoughts on the research process. Printed and electronic copies were filed including the NIH training certificate, proposal,

IRB documentation, ethics feedback, recruitment flyer, consent forms, demographic

screening tools, interviews, transcripts, digital recordings, and data analysis.

**Data Analysis**

A phenomenological approach was used to analyze data obtained from the

interviews; this allowed for themes to be revealed. The data analysis process included

coding, classifying, and interpreting information obtained from interviews. It is

customary to use data analysis software packages such as NVivo in qualitative research

data analysis. I deviated from this by manually arranging data using chart paper, colored

tabs, colored highlighters, pens, and markers. With these tools, I color coded data,

constructed codes, established themes, created charts, established a connection between

themes, and reported data (Creswell, 2013). The names of the participants were not

revealed during data analysis.

I transcribed each audio interview and sent a copy of the transcription to each

participant so it could be viewed for accuracy. Each interview was listened to without

interruption and I took basic notes. This allowed me to annotate and describe participant

vocal intonations, inflections, and note any pauses or hesitations when responding to the

interview questions. In order to isolate the data into meaningful sections, I listened to

each interview three additional times.

When the interviews were played a second time, I paid close attention to

participant responses to the first and third questions listed on the interview protocol

which were "Please tell me how you came to realize you might be depressed and how

you felt about that" and "What has been your experience when seeking help for your depression"? The first sheet of chart paper was titled depression and the second experience. As the participants responded to the questions about realizing when they were first depressed and their experiences with help-seeking, all descriptive words were recorded.

The third round of listening to interviews consisted of focusing my attention the participant responses on their experiences of being an African American man with depression or depressive symptoms and their personal, social, and environmental experiences with help-seeking. Because the names of the participants were not revealed, each participant was given a unique identifier. Each participant was allotted a sheet of chart paper with their identifier in the top right corner. As I listened to each participant interview, detailed notes, words, and phrases were recorded on his chart to describe how his experiences of having depression impacted help-seeking on a personal, social, and level. The first round of coding analysis revealed codes and a table was created to represent those codes and the number of participants that experienced each code; the codes were used to develop themes and sub-themes. The digital recordings of the interviews were listened to a fourth and final time to verify my accuracy in the identification of the experience, significance, and terminology as stated by the participants during their interviews.

The study focused on the experiences of being an African American man with depression or depressive symptoms and help-seeking. Themes were developed that

corresponded with seeking help and as a result, a chart called themes and sub-themes was developed. Coding the data by hand was valuable as it allowed me to systematically classify and analyze the data.

Table 2: *Developed Codes from Participants*

| Codes | # of participants that experienced code |
|---|---|
| Guilt | 5 |
| Frustration | 6 |
| Anger | 3 |
| Role reversal | 1 |
| Denial or avoidance | 2 |
| Faith | 2 |
| Mistrust | 5 |
| Substance abuse | 2 |
| Weakness | 4 |
| Stress | 6 |
| Racism | 6 |
| Inadequate mental health care | 6 |
| Isolation | 4 |
| Family and support | 5 |
| Burden | 6 |
| Stigma and judgment | 6 |
| Sadness | 5 |
| Avoidance | 3 |
| Inferior | 4 |
| Suicide | 5 |
| Therapist | 6 |

Table 3

*Themes and Subthemes*

| | Major Theme 1: African American men's perceptions of factors that inhibit help-seeking | Major Theme 2: African American men's perceptions of factors that promote help-seeking. |
|---|---|---|
| **Sub-Theme 1** | African American men with depression tend to feel misunderstood and stigmatized. | Understanding that talking with a therapist can be very helpful. |
| **Sub-Theme 2** | Some African American men admit to a degree of self-stigma. | A support system or safety net will help a person get through it. |
| **Sub-Theme 3** | Some African American men deny their depression or any need for help. | |
| **Sub-Theme 4** | Those who had therapy found it helpful until the therapist was changed, causing feelings of mistrust and inadequate mental health care. | |
| **Sub-Theme 5** | Most believe that African American men fear guilt, fear being a burden to others, and should be able to handle their problems. | |
| **Sub-Theme 6** | It is difficult being depressed and black in America, which leads to stress, frustration and perceived racism. | |

**Evidence of Trustworthiness**

As outlined by the ethical considerations that are set forth by Walden University, the data collection process was followed as described in my approved proposal by the Institutional Review Board (approval number 09-22-16-0202016). Evidence of trustworthiness in this study was demonstrated by credibility, transferability, dependability, and confirmability. As discussed in Chapter 3, credibility was established by the member checks. Each participant was emailed a copy of their interview transcript so it could be reviewed for accuracy. Each participant responded via email confirming the accuracy of their interview transcript. I also established credibility by using iterative questioning and probes to gain detailed information from the participants.

Transferability was established through the use of detailed accounts of participant demographics and notes during the research process. This study could be replicated to other settings, people, or situations. Dependability was established through the use of audit trails. Dependability is supported in by audit trails or detailed records of why and how the study was conducted, how the data were obtained, why and how the participants were chosen, and the data analysis processes that produced research findings. Confirmability was established by performing data checks throughout the duration of the study and keeping documentation of those checks for the recommended time frame as outlined by Walden University.

**Results**

To explore the personal, social, and environmental experiences of African

American men with depression as they relate to help-seeking, I asked each participant

interview questions, followed by a series of supporting questions that provided me with

data to answer the research questions. I also asked each participant interview questions

that helped to identify how African American men believe they might better overcome

barriers that prevent them from seeking help. Each participant was given adequate time to

reflect upon and explain their experiences while I paid attention and notated key phrases

and words that could further describe their experiences. Several codes were used by 5 or

6 of the participants. Three of the participant's described their experiences as

disappointing. Two major themes and 5 subthemes were developed regarding the factors

that prevented the participants from seeking help for their depression. The major themes

were (1) African America men's perceptions of factors that inhibit help-seeking and (2)

African American men's perception of factors that support help-seeking.

**Major Theme 1: African American Men's Perceptions of Factors That Inhibit Help-Seeking**

Five sub-themes supported theme 1: (1) African American men with depression

tend to feel misunderstood and stigmatized, (2) some admit to a degree of self-stigma, (3)

some deny their depression or any need for help, (4) those who have had therapy found it

helpful until the therapist was changed, (5) most believe that African American men fear

guilt, fear being a burden to others, and should be able to handle their problems, and (6) it

is difficult being depressed and Black in America, which leads to stress, frustration, and perceived racism.

**Sub-theme 1: African American men with depression tend to feel misunderstood and stigmatized.** This was the most dominant of the sub-themes. All of the participants described their experiences in relation to being black and depressed as a disheartening struggle in the face of social judgment. For example:

- For me, it has always been the perception of other people, especially the ones that are supposed to be helping you. It is really sad that society makes you feel dirty when it comes to illness such as depression for an African American man; it's a 'me against the world' battle. (P5)

- Some days though, I almost lose the battle. I am really close to the edge and I don't know what keeps me from going over, but I haven't yet. I'm a Black man; no one understands what this is like, except another Black man that goes through it. (P6)

- Yeah. A lot of people have actually discouraged me from seeking help without even realizing it. Because when they hear of mental health, they think 'Oh, you're crazy' and then they just put the stigma on you. They back off; they label you; they treat you different. I'm no different. I am the same person on an average day. It's just that I deal with stuff in the head that you don't. That's it. (P2)

- So with my immediate family, you're still my brother, you're still my

  son, you're still my dad, but you begin to notice when people don't

  come around or they don't even want to talk to you because you still

  have the same topic or you're still the 'Debbie Downer' so to speak. I

  can still see that. I still see how society and even family members

  judge you for having depression and not being able to simply figure it

  out. It affects every single conversation and every relationship. (P3)

**Sub-theme 2: Some African American men admit to a degree of self-stigma.**

The second sub-theme to emerge resulted from the participant views on judging

themselves, or self-stigma.

- In my situation, I think I judged myself because it seemed like life

  just picked up and moved on and I couldn't; or the one that hurt me

  or in my opinion, the one who helped put it there – put me into

  depression seemed to have the most help. (P3)

- I think it's a constant fight with myself, how I judge myself, how I

  view myself, who I see myself as, and what life holds for me.

  Depression just adds an added layer to an already difficult fight.

  Then again, I don't remember feeling any different. It's not a

  matter of if I will have another episode, but when. (P6)

- I can't believe that I'm actually here; battling this thing

  (depression) that I'm not supposed to have. I don't believe I can

get out of it; and when I do get out if, those who have experienced

me go through it, sometimes that's all they see, 'Oh poor  so and

so'. Well, that's what I see. That may not always be the case, but

sometimes it is. (P1)

**Subtheme 3: Some African American men deny their depression or any need for help.** Participants shared their experiences of denying they were depressed and denying the help they needed to help them with their depression. "It's sad, but I have come to the conclusion that this is my cross to carry." (P6).

- Society always has the mindset that, if you're seeing a therapist, that's one thing, but if you're seeing a psychiatrist, then you're crazy. That's the dark cloud that society puts on us (African American men) and I don't want that label or it hanging over me. In order to not have this (label), I'll find other ways to deal with my depression or bury it. I don't need any help. (P1)

- I really didn't know what was going on; I didn't know what was going on inside of me. We only give the highlights; we don't give the low lights. The highlights are 'oh I'm doing well', but you wouldn't get that 'oh, I'm sitting here with a bottle of pills or I'm thinking about suicide today'. (P2)

- At first, I thought something like this (depression) could never

    happen to me. When I realized how much it was affecting me and

    my family, I had to swallow my pride and seek assistance. (P4)

When asked what kind of therapist they would prefer and if that played a role in them making the choice to deny help, one insisted that only an African American man could understand him; he did *not* want a female.

I didn't have much of a father figure growing up. I'm not saying I was looking for

him (medical provider) to be my dad, but someone that could relate to what a

good man is, was, characteristics of what this should look like. I've wanted my

providers to be African American men because I feel we would relate better, but

that's not the norm in mental health. (P3)

**Subtheme 4: Those who had therapy found it helpful until the therapist was changed, causing feelings of mistrust and inadequate mental health care.**

Several participants had a positive experience in therapy, only to have the process collapse when the therapist or provider was changed.

- I did see a therapist; I did talk at one point and that's all because I was

    forced to. Eventually, I did open up to the person, began talking, and

    dealing with it, but two months later, I received a phone call from the

    clinic that the provider I was working with no longer worked there. That's

    what did it for me. How am I ever supposed to get through this, when I

don't have consistency? I'm not starting over with someone I don't know and have to relive everything all over; it's not worth it. (P1)

- He didn't prescribe anything. He just talked. I went to him every Tuesday and we talked. That was pretty much what I needed. That felt good. I was getting stuff off. I was facing things. I was dealing with stuff. I felt *good* for what felt like was the longest time in my life. I was having good days. Then all of a sudden, he is now no longer working in that department. He said, 'Well I could refer you to…' No! We built a rapport and I'm not about to start over with someone that I don't even know and have to take the time to get them up to speed or take the chance of him barely going over my previous history. (P2)

- My life is so busy and hectic; it takes time for me to open up and I hate when I have to do it repeatedly because providers leave. Everyone leaves. (P3)

- As an African-American man with depression, it affects you personally, but you can see it in the work setting too. With work, I already know going into it that I already have a strike against me because I am African American. If I have to leave work to deal with my depression issues, it's a hassle in itself, but it's a different thing when I have to constantly rehash what's going on with me to a different face that won't even last in that capacity for a full year or more. (P4)

**Subtheme 5: Most believe that African American men fear guilt, fear being a burden to others, and feel they should be able to handle their problems.** A fifth inhibiting factor that emerged as a theme was the belief that African American men should be able to handle his problems without being a burden to others.

- Lots of things have gotten in my way over the years, myself personally, if anything. My own thought processes. For example, I feel like I don't want to be a burden on anybody so that's why stuff kept piling up and building. (P2)

- For fear of being a burden, I don't talk about much now anymore. I think I made a mistake in talking about it with my son because the way it comes out, the way it's communicated would come across as has mom being the reason I was depressed. No child wants to or should hear that. Although he's 22 now, he's still kind of young in life. I've burdened him once; I don't want to do it again. (P3)

- I became extremely sad and upset. I would be upset because I have this plate of stuff to do and it didn't feel like anything was being accomplished even though I'm working through a list of things to do. It made me feel sad and I guess a little upset because I'm supposed to be the one getting up and going to work. I'm not saying my wife shouldn't work, but I am the one who is supposed to wake up, go to work, and make sure the bills are paid; it's how I grew up. It makes me feel like I'm a burden to my wife and family because of this. (P1)

- For a while, I was able to hide it (depression) because I didn't have the stable family life (due to being single), so when you're single, it's seen as a young man

just acting out. Once my family became my foundation, I had to adapt due to changes and didn't want to be a burden to my wife or my kids. (P5)

**Subtheme 6: It is difficult being depressed and Black in America, which leads to stress, frustration, and perceived racism.**

- Just the stress of being an African American man is scary enough. Without the depression, I have dealt with so much. I have been watched, I have been followed; I have been asked 'why am I in this neighborhood'? I have been questioned about what I'm doing on my own property. I have been threatened; I have witnessed instances of police brutality. That's just being African American. Being an African American man that is gay is an abomination to just about everybody. Now add depression on top of all of that! I am surprised I am still breathing. If you're not a Black man, you won't understand it because you choose not to acknowledge that we suffer from mental illnesses too. To not be validated just causes feelings and emotions to build and build and eventually you take that entire bottle of pills, you try to drink yourself to death, or you contemplate leaping into traffic or off of that bridge. That's when you wake up the next day and thank God you don't own a gun. That's my reality; that's my day, that's my night. (P2)

- In this day and age, it's stressful and scary. We have to worry about walking outside and being arrested for just what our skin looks like. We

can't shop. We can't talk to the police the way others can because all people are going to see is the color of your skin. But, I don't think they look at or see a man that may be going through something. It's not just the same stressors; it's the added stress of because I am African American. So, it's a dangerous place already, just to need mental health help, but then you add on more of a danger of not being just a Black man in America, but one that has a mental disorder. It makes you feel very low, especially when you've got to hope that the people that already look at us as unstable, has our best interest at heart. (P3)

- It (depression) affects your entire life and African American men already are portrayed in a negative light. Appointments eat up a lot of time; when you leave them, you don't feel like talking to anyone so now I'm anti-social. You have other medical issues going on and you can't do some of the things you used to; that's ok for other men, but not Black men. I'm a day behind, I'm missing time, so much in fact that I had to quit because of the issues I was dealing with. It's all just too stressful to handle at times. (P1)

- The honest answer is it sucks! I know that's not the most professional sounding, but it is how I feel. It's beyond stressful being Black, depressed, always having to remain strong, and never showing your weakness. (P5)

**Major Theme 2: African American Men's Perceptions of Factors That Promote Help-Seeking**

**Subtheme 1: African American men understand that talking with a therapist can be very helpful.**

- The provider I saw for my issues spoke to me and treated me with respect. He gave me breathing exercises that helped to calm me down, so I could try to clearly express what I was feeling; I think it was a pretty decent experience. He treated me the way I would hope he would treat anyone else. I feel like I have a say and active role in my care. I'm a better husband, a better father, a better son; all because of getting help. The positive relationships I have are just one of the many benefits of getting the help I needed and deserved. (P1)

- When I was doing the therapy thing, I was told that in addition to keeping all of my scheduled appointments, one of the best things I could do when I was in between sessions was to call a friend and talk. Two ladies, as a matter of fact I call them my sisters (even though we aren't related), told me that I could call them day or night. They are very encouraging and supportive. We even check in with each other at least 2 weekends out of the month to have dinner together. I like the fact that the medical professional's answers weren't always 'take this pill or that pill'. I am not able to maintain many positive relationships. Sometimes, that's the added

benefit of seeking help; to get that unbiased perspective from someone else. (P2)

- When I sought help for my depression, it affected every aspect of my life in a positive way, from my work habits and ethic, to my personal relationships (I'm now engaged to a wonderful woman with whom I can be transparent with), and my social relationships. (P3)

- At first, I thought that my issues were not worth a doctor's time. I felt that there were others who probably needed it (help) more than me so I was hesitant in seeking help. I discovered quickly that my issues were something I could not handle without the assistance of others. My church, wife, family, close friends, and professionals have been very supportive. Being a police officer can be very stressful at times. My wife has been very supportive all of the time. I try not to bring work home, but on some occasions, things I deal with on the street hit too close to home. I also work with an outstanding group of people at work. Most times, we will stay after work for a while to talk things over. My department is also good at providing counseling after every major event and providing us with the necessary resources to get help. (P4)

**Sub-Theme 2: A support system or safety net is important to help a person get through.**

- My support system are the faces I see every morning, my wife and my kids. They have been there with me through everything I've had to deal with and they are the reason I keep pushing. It's my family. (P1)

-  I would say I like who's in my corner. I know that if I need to, I can talk to them. If there is anything that needs to change, it would be me actually opening up to them more. Instead of relying on my mom so much (which isn't a problem), I need to utilize them more on that. If they needed me, of course, I'd drop anything for them. I've been told that if I'm ever having a bad day, they are there for me. Maybe, I just need to listen more and do it. (P2)

- God, my wife, my mom, brothers, and sisters. I have a dream team of support and it's pretty amazing. I look back and see how incredibly blessed I am. My wife is a star player. (P3)

- My support system can be kind of tricky, but it's one that works well. My wife is a major staple in my support system, but she has her own problems to battle. My feeling is how she can handle my problems when she has her own? She does it with patience though. I used to be able to talk to my mother and father, but since their passing a few years ago, it can be hard to open up. I don't feel like at times I can share my true feelings without

hurting someone's feelings because I think about situations differently, but

I do thank my wife and my in-laws for being there for me when I need it.

(P5)

## Summary

The purpose of this study was to explore the personal, social, and environmental

experiences of African American men with depression as they relate to help-seeking.

Chapter 4 discussed the experiences of 6 African American men with depression or

depressive symptoms related to help-seeking through the use of phenomenological

analysis. The first part of the data collection process required me to build a rapport with

the participants so they felt comfortable to share their experiences with me. Participants

were able to speak freely and were not rushed to complete interviews that extended

beyond the anticipated 60 minutes. All data obtained from the interviews provided rich

information that was hand coded and analyzed. The themes identified were African

American men's perceptions of factors that inhibit help-seeking and African American

men's perception of factors that support help-seeking.  The 6 sub-themes that were

identified were (1) African American men with depression tend to feel misunderstood

and stigmatized, (2) some African American men admit to a degree of self-stigma, (3)

some African American men deny their depression or any need for help, (4) those who

had therapy found it helpful until the therapist was changed, causing feelings of mistrust

and inadequate mental health care, (5) most believe that African American men fear guilt,

fear being a burden to others, and should handle their own problems, and (6) it is difficult

being dressed and Black in America, leading to stress, frustration, and perceived racism. The findings from the interviews enabled the research questions to be answered, which will be discussed in Chapter 5. With regard to the help-seeking experiences of African American men with depression, findings indicated that their experiences were predominantly negative, therefore greatly impacting their ability to seek help.

Chapter 5: Discussion, Conclusions, and Recommendations

An estimated six million men in the United States have experienced or live with some form of depression (National Institute of Mental Health, 2009). A review of the literature indicated the characteristics of depression and an increase in reportable depressive episode prevalence, and indicated that depression is now the leading cause of disability globally (WHO, 2017). Although the number of studies that have documented depression prevalence and unmet treatment needs has increased, there was a gap in the literature about understanding men's depression and help-seeking behaviors, particularly African American men. The purpose of this qualitative, transcendental phenomenological study was to explore and understand the help-seeking behaviors and experiences of African American men regarding depression and navigating barriers to mental health care.

A transcendental phenomenological approach was used to examine the help-seeking experiences of 6 African American men with depression from personal, social, and environmental perspectives. Transcendental phenomenology is a qualitative research method used to understand human experience (Moustakas, 1994). This method allowed me to examine the phenomenon by extracting the essence of the experiences of African American men with depression. Andersen's behavioral model of health services was used to guide this study.

The behavioral model of health services, (Andersen,1968) established a framework for examining factors that influence an individual's choice to utilize health

services with a focus on predisposing factors, enabling factors, and need. Using this model, I examined the ways in which negative help-seeking behaviors influenced African American men with depression on a personal, social, and environmental level and explored the need, inhibiting, and supporting factors related to African American men's experiences.

Data were collected through the use of a demographic questionnaire and semi-structured, open ended interviews in a neutral environment to increase the comfort level of the participants. The interview data were used to answer two central research questions: What are the personal, social, and environmental experiences among African American men with depression as they relate to help-seeking? How do personal, social, and environmental experiences help African American men to navigate or overcome barriers that may prevent them from seeking help? The rich descriptive data provided an in-depth look into the perceptions of African American men with depression and how they view help-seeking.

With the use of an interview guide, I was able to focus on the topic of depression and help-seeking. The use of open ended, semistructured interviews produced rich data with detailed information regarding the perceptions of depression, help-seeking, and its impact on participants' personal, social, and environmental experiences. Each of the 6 interviews were digitally recorded and transcribed verbatim. Thematic analysis was used to gain understanding from the data obtained from the interviews. After the review of each transcript, I used short phrases and/or words to develop themes. The participants

perceived help-seeking as either having a positive or negative impact. The participants described how their lived experiences impacted the personal, social, and environmental aspects of their daily lives. The participants verbalized the ways in which they seek help or bypass help. Although each participant's experience was different, help-seeking will continue to be an on-going learning process to navigate the challenges associated with having depression as an African American man.

The final stage of thematic analysis was dedicated to verifying the accuracy of identified experiences including terms used by the participants to indicate themes that emerged from their responses. The major themes that emerged were (a) African American men's perceptions of factors that inhibit help-seeking and (b) African American men's perceptions of factors that support help-seeking. The interpretation of findings provides a more detailed description of each major theme, the supporting sub-themes, and their connection to the literature.

## Interpretation of Findings

The literature reviewed in Chapter 2 supported some of the findings from the study which focused on factors of help-seeking to address the needs of African American men with depression. The following sections include a discussion of the connection between the literature review, themes, and sub-themes.

**Major Theme 1:  African American Men's Perceptions of Factors That Inhibit Help-Seeking**

**Subtheme 1:  African American men tend to feel misunderstood and stigmatized.** The existence of the stigma attached to depression has a significant impact on the African American man and is often augmented by other factors such as race (Watson, Riffe, Smithson-Stanley, & Ogilvie, 2013). Some African American men have a higher tendency to isolate themselves or rely on other means to deal with their depression. African American men believe that where they seek treatment is directly related to the stigma associated with having depression (Plowden & Thompson-Adams, 2013). In the current study, some participants reported that if presented with the option to seek mental health care from a psychiatric facility, primary care facility, or clergyman, they would rather not be seen at a psychiatric facility. Participant 2 stated,

> As soon as you're seen walking through the door of a psych clinic, you're automatically labeled as being 'crazy'. No. I'm not crazy. I have a hard time coping with certain issues that come up in my life just like the next person. For that reason alone, I wouldn't be caught dead walking into a psych clinic. I would rather be seen by my primary care doctor or go and talk to my pastor.

Participant 1 stated,

> It's a 'me against the world' battle and there's no winning side. I already have to deal with the fact that I am a Black man suffering from depression.

I should be able to be the man my family needs and not be weak; but to have society look down on me as if I'm just the typical 'angry disorderly Black man' or if my problems aren't real is an entirely different blow. What's the point of reaching out to get help when this is the general consensus, no one understands, and I'm going to be judged anyway, especially if I'm seen frequenting psychiatric facilities?

Participant 4 stated,

You're a lost cause. People don't believe you can get out of it. You may not believe you can get out of it. When you do get out if, those who experienced you go through it, sometimes all they think is 'Oh poor so and so'. That may not be the case, but sometimes it is. There can be a self-initiated stigma, but I do feel it's a societal one as well because of Facebook, other social media outlets, and everything else. You just see it. You feel it. I would rather just go to my personal doctor to cut down on all of the judgement from others.

Participant 5 stated,

I am my depression and society has shown me that because of the way I am treated. I have been called 'crazy', 'unstable', and 'irrational' just because I have a form of mental illness that has requires me to go to a psych clinic. I've been excluded by some of those closest to me in my family and professional life because of being depressed.

This finding supports how African American men feel misunderstood when it comes to their depression and shapes their beliefs when it comes to making decisions in terms of seeking help for the management of their depression.

**Sub-theme 2: Some African American men admit to a degree of self-stigma.**

Topkaya (2014) described self-stigma as a significant indicator of attitudes toward help-seeking and that men were less likely to seek help compared to women. In the current study, some participants reported experiencing some form of self-stigma associated with having a mental health disorder in varying facets such as fearing they were not qualified enough for positions at their places of employment due to their depression, being excluded, being avoided by family members, or not feeling competent in their intimate relationships.

- I judged myself the most I think. Life is going to move on whether you're ready or not and the person or people that can bring it (depression) on seem to be unaffected or get the most help. I wasn't successful at work, or in my relationships. It was all me; it's what you think people are thinking about you until you get to the point where you don't give a damn. (P2)
- I judge myself for being this way. There are a lot of people that tell me that depression is nothing to be ashamed of, but I am very ashamed. I think that's part of the reason why it's so hard for me to be consistent with getting help and why I avoid those I love. I

struggle with even walking into a psych clinic because I'm not

supposed to be there. I'm not supposed to have this problem. I'm

not supposed to struggle in this way. (P3)

- Trying to wrap my head around all of this is depressing on top of

the depression. It's so pathetic not to be control of my own

emotions and being on this constant rollercoaster. I'm ashamed of

myself and sometimes it feels like there's no getting out of this.

(P4)

- My self-esteem is at an all-time low and I know that. It's like

there's this constant voice inside of my head that constantly

reminds me that I'm not worth a damn and that I'm not good

enough so whey even try? I know that failure is inevitable so why

even bother looking for help? (P5)

The findings support that self-stigma is one of the many barriers to help-seeking

that exist as well as one of the most difficult to navigate (see Vogel et al., 2011).

**Sub-theme 3: Some African American men deny their depression or any need for help, especially if providers do not look like them.** Vogel et al. (2011),

Mansfield et al. (2005), and the National Alliance on Mental Illness (2016) indicated that

fear of a breach in confidentiality is a barrier to help-seeking in African American men.

In the current study, each participant reported feeling that he could not trust his mental

health provider, especially mental health providers that were not Black, and cited this as a

reason for denying help or denying his depression altogether. The negative attitudes and beliefs toward White mental health professionals arose from the perceptions of some of the participants that the mental health system was not designed for African American men and lacks culturally sensitive and culturally competent providers. Participant 1 stated,

> Don't get me wrong. I am proud of my heritage, culture, and skin color, but it is a double-edged sword that I wouldn't wish on my worst enemy. How can a White man help me overcome my struggles when he doesn't know nor can begin to relate to what my struggle is as a Black man? More than likely, he's just going to tell me I need to take some pill, give it time to work, and sit down with someone to talk about my problems. Guess what? That person will more than likely be White. It's a never-ending cycle so it's just easier to deny having depression in the first place.

Boulware, Cooper, Ratner, LaVeist, & Powe, (2016) supported that a relationship exists between race and health. Some participants in the current study stated that if stronger efforts were made to recruit providers who reflected them, they would have a greater trust in the mental health system and sustain contact with mental health providers. Studies have found that the perception of the African American man regarding the attentiveness and communication skills of his provider are strong indicators of trust (Cooper, Roter, Carson, Beach, Sabin, Greenwald, & Inui, 2012). The findings from this study are consistent with the

literature that African American men will continue to experience denial and help-seeking barriers due to the lack of African American men represented in the mental health field. Sadly, many African American men are unable to adequately articulate their psychological and emotional needs for a host of reasons such as pride or lack of trustworthy individuals to talk to. Belgrave & Allison (2010) suggested that a strong correlation may be present with the denial of mental health issues among African Americans due to the fact that this group shares a deeply rooted history of resiliency and self-reliance, which was also confirmed by the findings of this study.

**Sub-Theme 4:  Those who had therapy found it helpful until the therapist was changed, causing feelings of mistrust and inadequate mental health care.** The fourth sub-theme that emerged from the thematic analysis was the evidence of a phenomenon related to help-seeking behaviors among African American men with depression in terms of therapist changes. Mills, Van Hooff, Baur, & McFarlane (2012) asserted that African American men could significantly benefit from enrolling in mental health programs and support services; however, many do not comply with treatment regimens. Additionally, it was found that African American men were less likely to seek and receive mental health services from a mental health practitioner (Bailey, Patel, Barker, Ali, & Jabeen, 2011).

A change in therapists can be devastating for some African American men, and a major inhibiting factor to seeking further help. Sentinel research by Maslach (1982)

suggests that therapist changes in mental health care can be contributed to factors such as

burnout, depersonalization, and ineffectiveness among providers. Burnout occurs when

mental health providers experience the depletion of emotional energy due to the demands

of the organization in which they work, patients, or those in leadership roles. Burnout

directly lends itself to depersonalization or emotional detachment from job

responsibilities and/or patients which ultimately impacts physician effectiveness

(Maslach, 1982). As one participant 3 stated, "By the time I am comfortable enough with

a doctor to let my guard down, I am informed that they no longer work in that department

or have transferred someplace else. What's the point"? The findings from this study

suggest that lack of consistency among mental health providers is consistent with the

literature in terms of African American men not adhering to treatment regiments as well

as being less likely to seek help from a mental health practitioner.

**Sub-Theme 5: Most believe that African American men fear guilt, fear being**

**a burden to others, and feel they should be able to handle their problems.** The fifth

sub-theme that emerged from thematic analysis was the belief that African American men

fear guilt, fear being a burden to others, and feel they should be able to handle their

problems. It was reported by participants that the structure of the African American

household suggests that the African American man must have everything in order and

must take on his own troubles as well as the burdens and issues of everyone else. This is

consistent with the findings of Genuchi & Valdez (2015), who reported that men who

experience depression or depressive symptoms tend to express it in ways that are highly

influenced by traditional masculinity ideology; thus, any type of emotion that reflects sadness and vulnerability may be socially unacceptable.

- I don't want to feel like a burden. I mean, just imagine if I was your friend and I had this mental breakdown for six and a half weeks straight. You have a family and a life. Here I am calling you every day, not knowing what you have going on with your career, your school, your life. Everyday. I'm in a dark place today. I can't get these voices in my head to shut up. I'm hurting just because I'm awake every day. I'm a man; a Black man at that. I should be able to handle this myself. I don't want to be a burden to somebody. (P2)

- Everyone else has their own issues to deal with. What I have going on in my life is incessant; it doesn't feel like it ever lets up. I'm not going to my wife with all of my problems or constantly tell her that I'm in this rut that I can't get out of and that life's not worth living most days. It has nothing to do with her or my kids. It has everything to do with me. I'm a man. I should know how to handle this. I'm not going to burden her or anyone else with this. It just isn't fair. (P3)

- I am the head of the household. I'm very much a man; there's nothing feminine about me. It's acceptable when women cry and when they are vulnerable. It's not acceptable for me to do that. I'm

going to man up and take care of what I have to. This depression is

my burden to bear; not my family's. I feel guilty though. I know

my wife can sense when something is wrong, but how can I tell her

that I feel like I'm in a black hole or that I feel like dying today?

No. I'm going to handle this myself. (P4)

The traditional male gender role implies that men should not show weakness and must always maintain complete control of their feelings and emotions all while being the primary providers of the household; they should also refrain from revealing feminine characteristics or emotional traits such as crying (Hammer & Good, 2010). Hammer and Good (2010) have pointed out that most research on gender roles has focused on men of European descent. My findings show that in this respect, African American men seem to be no different.

**Sub-Theme 6: It is difficult being depressed and Black in America, which leads to stress, frustration, and perceived racism.** Hammond (2012) revealed that African American men are more likely to be misdiagnosed, undiagnosed, or untreated for depression; diagnoses of conduct disorder or oppositional defiant disorder are often applied. Factors such as these contribute to men being 4 times more likely to commit suicide versus women (Bryant-Bedell & Waite, 2010). Though numerous studies have been conducted which suggest that African American men are less likely to develop depression than White men, this should be viewed with caution due to under-reporting (Carr & West, 2013; Sinkewicz & Lee, 2011).

Hammond (2012) indicated that few studies describe the experience, coping strategies, and help-seeking behaviors of men suffering from depression, particularly African American men. Some of the participants reported that having depression is like a less traveled road or a double-edged sword. Even though they are physically strong, they are also mentally weak. The expectation of production is still high; there is no room for self-care or compromise. Vogel et al. (2011) and Tedstone and Kartalova-O'Doherty (2010) suggested the lack of dialogue about how African American men feel and their coping mechanisms has becoming increasingly problematic; very little research has examined the experiences of African American males with depression.

Some participants reported that their experiences of being an African American man in America with depression is incomparable to other ethnicities as they are often viewed as non-conforming rather than depressed.

- These are scary times. We have to worry about being a target because of the color of our skin. We can't do things that most people who don't look like us do. We have to be very careful how we interact with the police because the first thing they see is a Black man. I really don't think people see that as a Black man, I'm going through something that is hard to deal with. Our stress is a different level of stress. There's an added stress because I am a Black man. This country is already a dangerous place for me and

to be a Black man that needs mental health care is an added danger. (P1)

- It is dangerous enough being Black in America, but when you're a Black man and you've got a mental unsteadiness, if you will – it makes you feel very, very frustrated and low. You've got to hope that the people that look at us as being Black and unstable – which is a very dangerous combination, see a man that's going through a tough time. (P2)

- Racism is alive and well. Just being a Black man in America is deadly without being depressed. I have been stopped on suspicion because I'm not supposed to drive my luxury car, I have been followed while shopping, and I have been asked "do you live in this neighborhood?" Things like this just don't happen in one location, but any place that I've been. That's what it means to be Black in America. So, now that depression is thrown into the mix, I am surprised that I am even still alive. The color of my skin creates a level of stress and frustration that I wouldn't wish on my worst enemy. (P4)

Some of the participants believe that simply being an African American man puts them in a position in which they have no choice but to press on with life. Without the presence of healthy support systems, several of the participants found

it difficult to move forward with the personal, social, and environmental aspects

of their lives.

The depression as experienced by the participants manifested itself in many

different forms such as anger, anxiety, promiscuity, isolation from loved ones, and their

lives being in total chaos behind the security of closed doors. Empirical evidence

referenced by Scott et al. (2015) suggested that African American men perceive certain

elements that may increase their stress levels which limits help-seeking and mental well-

being. Franklin (2004) spoke of a phenomenon known as 'psychological invisibility'

which may be felt by African American men when they deal with interpersonal

circumstances, impaired personal identity, and a number of other factors which impacts

their ability to foster adaptive behaviors and ability to cope with stressors on multiple

levels.

Some of the participants expressed that attempting to share their problems or

attempting to seek mental health support either formally or informally is unfortunately

viewed as being less than a man and a sign of weakness; African American men don't

discuss their problems; African American men don't cry; African American men never

wear their distress. Sociocultural norms and negative attitudes surrounding depression

and help-seeking are what inevitably traps African American men into a harmful cycle of

suffering in silence. Our understanding of the experiences of African American men is

limited (Hernandez et al., 2014). The findings from the current study may increase the

understanding of the experiences of the African American male population.

**Major Theme 2: African American Men Perceptions of Factors That Promote Help-Seeking**

Subtheme 1: **African American men understand that talking with a therapist can be helpful.** The first sub-theme of Major Theme 2 was understanding that talking with a therapist can be very helpful and is a benefit of seeking help. All participants reported numerous benefits to receiving help for their depression to include improved relationships, increased awareness of mental health support programs and services, increased self-confidence, improved mental health status, and the development of appropriate coping strategies and techniques. Derksen (2010) found that policy, physical, and social environments can influence human behavior. One participant reflected on how his knowledge and awareness of his depressive symptoms improved once he realized the good outweighed the bad.

> I finally began to realize that I would be on a continued downward spiral
> that would probably lead to me taking my own life. I've got a wife and
> kids that need me around to protect and support them. I started paying
> attention to programs that were being offered in the local or neighboring
> areas and I was honestly surprised at how much was out there; it was up to
> me take advantage of them if I wanted to get better. Now that I have, I'm
> doing better on my job, my personal and social relationships have

improved, and I just feel better overall. I just wish that I saw the benefit

sooner. (P4)

Help-seeking behaviors in African American men, as acknowledged by Derksen

(2010), may improve if keen efforts are placed upon their individual choices and factors

that may impact those choices. It is thought that decreasing stigma alone is not sufficient

to empower individuals to adopt affirming attitudes (Corrigan, Druss, & Perlick, 2014).

Comprehensive mental health services and support programs also need to promote

benefits of help-seeking such as prolonged recovery, empowerment by being active

decision makers in health treatment plans, and self-determination (Corrigan et al., 2014).

Drake, Deegan, & Rapp (2010) outlined three components that are critical in

understanding the benefit of seeking help which are education, analyzing cost-benefit,

and support. Examining the cost and benefit of seeking help is of utmost importance and

could ultimately encourage African American men to identify and make sense of the pros

and cons of certain services for specific problems such as depression. The education

process is one that must be fluid, meaningful, and a combination of sources that are user-

friendly or easy to interface with. Consistent with the literature, the findings from this

study has shown that teaching agents with whom the patient has a similarity are most

likely to have the greatest impact (Calhoun, Whitley, Esparza, Ness, Greene, Garcia, &

Valverde, 2010).

**Sub-Theme 2: A support system or safety net is important to help a person**

**get through it.** The second sub-theme that emerged was that a support system or safety

net is important to help a person get through it. Bopp, Baruth, Peterson, & Webb (2013) highlighted the importance of networks, social supports, and the impact they have on mental health well-being among African American men. Support networks can be formal such as individual or group sessions or informal such as clergy, family friends, and social networks. Support from the community is also an integral component of the African American community (Ward et al., 2013).

Bryant and colleagues (2014) found that churches in the African American community are an initial source of support that African Americans turn to when dealing with depression. Some participants expressed having some form of support system in place (formal or informal) that ranged from clergy members, family members, spouses/significant others, social groups, individual, and group counseling. This supports the literature that the Andersen's behavioral model of health services can be successfully employed in qualitative studies to examine relationships that exist between predisposing, enabling, and need factors (Keller et al., 2013). Dejesus (2011) suggested that while men and women face similar challenges in light of depression, the challenges may affect men's help-seeking attitudes and the way they seek prevention. African American men must have a need for support as well as predisposition. However, if he is not empowered and an active participant in his mental health care regiment, he will not achieve the support he needs. Pollak, Alexander, Tulsky, Lyna, Coffman, Dolor, & Ostbye, (2011) suggested that if African American men feel that their providers are more empathetic to their needs, they would feel more supported. The findings from this study support the

importance of informal and formal support systems as African American men will likely utilize both.

The findings of this study were interpreted through the use of Andersen's behavioral model of health services which was used to frame the study. The behavioral model of health services is comprised of three core components: enabling factors, predisposing factors, and need factors. The behavioral model of health services was used to explore factors that inhibited or promoted help-seeking in African American men with depression. The model maintained that enabling factors, predisposing factors, and need can explain or predict health behaviors such as help-seeking and the use of mental health services (Magaard, Seerlalan, Schulz, & Brutt, 2017).

In this study, there was an established connection between each core component (enabling, predisposing, and need factors) in terms of help-seeking. The study's findings showed the enabling factors to be access to a source of regular mental health care and family and community resources which encouraged or discouraged help-seeking among the African American male participants with depression when seeking mental health care services.

- People think it's easy for me to just go out and get help for my depression. It's not that simple. Being from relatively small area, I have to travel at least an hour one way to get to a provider. God forbid there's construction going on or an accident which makes the drive even longer. Mental health care here just isn't easily accessible so I try to manage things on my own. (P2)

- There was a psychiatrist and psychologist in a practice in my immediate area, but they didn't take my insurance so I wasn't able to get any type of mental health care there. I eventually found a general practitioner that I was able to establish care with. As far as medication goes, the doctor was able to prescribe that, but I was out of luck in terms of going to any type of therapy. (P3)

- There was a time where I was uninsured due to losing my job. It's not like my benefits were super great, but at least they were decent enough for me to be able to go to the doctor or therapist if I needed to. Because I didn't have health insurance, I had to pay for all services out of pocket. That's kind of hard to do when you're unemployed. My family (especially my mom; my dad on the other hand didn't feel I had a legitimate problem) helped out as much as she could, but it became too expensive so I had to stop going to therapy, which was a major setback in my opinion. (P4)

- You know, when you think about it, there are support groups and resources in the community for all sorts of things – recovering alcoholics, drug addicts, or survivors of some type of violence. I haven't seen nor heard of any type of community outreach or support program for people that suffer from depression, let alone a black man that suffers from depression. I think if there were more

visibility with this, it would definitely encourage us to get the help

we need and deserve. (P5)

From the perspective of the behavioral model of health services, the predisposing factors identified were the perceptions about depression and mental health beliefs of the participants. The behavioral model of health services was developed to gain an understanding of why individuals may utilize health services. Perceptions, attitudes, and mental health beliefs contributed to the help-seeking behaviors of African American men with depression. Some of the participants noted that the predisposing factors of their perceptions about depression and mental health beliefs interfered with them seeking help for their depression.

- Men, especially Black men, just do not get depressed. I'm not

  saying we don't experience stress of any type, but if you were to

  ask me, women are more likely to be depressed than men, simply

  because they are more emotional than we are (P1)

- I have always found myself in culturally diverse situations and

  environments and to be honest, depression is something that I see

  in my White male and female counterparts, not among my own

  kind; not Black men. That just does not happen. (P4)

- I know getting help is the common sense thing to do. I know

  getting help is the right thing to do. I know getting help is what I

  need to do in order to keep everything in perspective, but it's

  complicated and time consuming. I don't always want to talk or

share what's going on with me, especially if I don't know you like that or if I am not comfortable with you. How can someone else who doesn't know my struggle help me with my problems? (P5)

- The system is not equipped to deal with mental health in African American men. I firmly believe that most people feel like depression is a myth among Black men and because of this, we don't have what we need to be able to get through the dark times. (P6)

The last of core elements in the behavior model of health services were need factors. In this study, the identified need factors were the presence of depression or depressive symptoms, severity of depressive symptoms, and duration of symptoms. According to the model, need factors can influence an individual to seek care. Some of the participants noted that the presence of these need factors were the catalyst behind seeking help for their depression.

- There was something that was off. I just couldn't put my finger on it. I began to slow down on doing some things that I once enjoyed doing. I started drinking more than usual and becoming less and less and patient with those that were close to me. I knew I had to get to the bottom of what was going on so I made the decision to bring it up with my primary care. After telling him what was going

on with me and filling out a few questionnaires, I was told I was

depressed. (P3)

- I just remember hitting rock bottom. I wasn't performing well on

  my job anymore, my marriage was starting to suffer, and I felt like

  I was losing myself little by little. It got to the point where I started

  to question my life and why I was here. I started gaining weight,

  couldn't sleep, and just felt completely hopeless and worthless.

  Death seemed like my own viable option. (P4)

- For about three months, I just remember feeling my absolute

  lowest. I didn't want to do anything or be bothered with anyone. I

  was in a constant state of low; there were no high moments for me.

  Sometimes I would cycle out of it, but then I would easily fall back

  into a slump that could last for weeks or months on end. (P6)

**Research Question 1 and Relevant Themes**

**Research Question (RQ) 1:** What are the personal, social, and environmental
experiences of African American men with depression as they relate to help-seeking? Six
themes were generated from the responses of the participants to address RQ1:

1. African American men with depression tend to feel misunderstood and

   stigmatized.

2. Some African American men admit to a degree of self-stigma.

3. Some African American men deny their depression or any need for help.

4. Those who had therapy found it helpful until the therapist was changed, causing feelings of mistrust and inadequate mental health care.

5. Most believe that African American men fear guilt, fear being a burden to others, and should be able to handle their problems.

6. It is difficult being depressed and Black in America, which leads to stress, frustration, and perceived racism.

Participants spoke of different types of experiences from multiple perspectives to address the personal, social, and environmental factors that either encouraged or discouraged them from seeking help for their depression. Though some of the participants expressed their feelings more or less than the others, the majority conveyed the feeling of depression being misunderstood among themselves, within their personal relationships, and their communities. While depression is considered to be the leading cause of disability worldwide, African American men are often misdiagnosed and viewed as having emotional angst and not depressed (CDC, 2016; Hammond, 2012). A lack of education on the cause and effects of depression, the benefits of proper mental health treatment, or access to adequate programs within the community give way to fear and stigma that is often attached to depression. These results support the findings of Hammond (2012), Holden et al., (2012), and McCusker and Galupo (2011) that African American men encounter various socio-cultural, psychosocial, and environmental experiences that influences help-seeking and are often misdiagnosed or categorized as being disorderly or defiant.

Some of the participants admitted to experiencing self-stigma or being in denial of their depression or depressive symptoms which discouraged them from seeking help for their depression which align with the findings of Topkaya (2014) who argued that self-stigma was a significant predictor of attitudes toward help-seeking. The participants used a variety of phrases and words to explain their experiences of being in denial about their depression and self-stigma. For example, one participant explained the experience of denial as, "…at first I refused to believe that I was suffering from depression because everyone has their moments of not feeling their personal best". In terms of self-stigma, another participant explained the experience as "…I think I judged and criticized myself more than anyone in my circle that knew exactly what I was dealing with". The participants in this study commonly referred to self-stigma and denial when explaining their experiences with each.

For the participants that sought formal help-seeking such as seeking therapy from mental health professionals found it helpful until their provider was changed, which align with the findings of Vogel et al. (2011) who argued that barriers to help-seeking may present as a result of lack of trust in mental health providers. Having a provider changed during therapy was viewed as detrimental to some of the participants that were already reluctant to seek formal help for their depression. Some of the participants shared their experiences of having a provider change and used words or phrases such as *inconvenient* or *frustrating*. For instance, participant 3 viewed his experience as

The word that comes to mind is frustrating. It affects me in more than one way because on one hand, if I don't get the help I need, it will cause problems in my relationship. If I do take the time to get the help I need, it affects me at work because now I have to miss time to make all of my appointments. If there isn't going to be any consistency in who I see, what's the point of seeking out the help? I'm just going to have to repeat my whole life story over to someone else who only knows what's going on by notes left in my file, which I'm not too sure if the doctors are even fully documenting everything I am saying.

Participant 5 shared a similar experience of provider mistrust and described it as being *inconvenient*.

Nothing says 'inconvenient' more than getting used to talking with a therapist for a few months only to go into your appointment one day to find out that they are no longer working there. It would be nice to get some sort of advanced notice so that I can mentally prepare myself for having to relive and retell my hell.

Some of the participants felt that most believe that African American men should be able to handle their own problems, fear guilt, and being a burden to others. These findings align with the findings of Watkins and Neighbors (2007) who argued that discomfort is experienced among African American men which prevents them from talking about their mental health as well as the findings from

Genuchi and Valdez (2015), who argued that men that experience depression may express symptoms in ways that are highly influenced by traditional masculinity ideology and norms. This study revealed that experiences of the participants varied. Participants expressed that it is a misconception that they always have the capability to navigate and handle problems without the assistance of informal support through family and friends or formal support through mental health professionals. The study conducted by Hammer and Good (2010) argued that researchers have found that there are ways in which society feels men should act, attitudes they should hold, and that they should not possess weakness, which also confirmed the findings of this study.

The participants disclosed their experiences from personal, social, and environmental perspectives which uncovered the final theme in this study that it is difficult being depressed and Black in America, which leads to stress, frustration, and perceived racism. The study conducted by Dejesus et al. (2011) argued that several factors contribute to depression and lack of help-seeking to include culture, poverty, religious views, economics, and family values. In a study by Jgaer (2011), it was found that racism and discrimination contributed to racial disparities in mental health and impact depressive symptoms, suicidal ideation, and help-seeking behaviors, which support the findings of this study. The participants shared varied responses of their experiences of being Black and depressed in America.

- Being Black and depressed in America is a lethal combination. It's stressful walking out of my front door everyday knowing that I have an automatic strike against me because of the color of my skin. It's also frustrating that because of the color of my skin, it is assumed that I am every diagnosis except depressed. (P2)

- According to society, my life doesn't matter. I'm expendable at the hands of law enforcement and any other individual that feels it's ok to eradicate my race. I have problems just like the next person. I struggle just like the next man. I am more than what others perceive my culture to be. We are taught in our families that we are descendants of warriors and that if they can endure unfathomable events, then everyday life in modern society should be a cake walk. There were plenty of days that I thought about ending it all. I wish it were that simple. (P4)

**Research Question 2 and Relevant Themes**

**Research Question (RQ) 2:** How do personal, social, and environmental experiences help African American men to navigate or overcome barriers that may prevent them from seeking help? Two themes were generated from the responses of the participants to address RQ2:

1. Understanding that talking with a therapist can be very helpful.
2. A support system or safety net will help a person get through it.

The personal, social, and environmental experiences of the participants enabled them to uncover ways to navigate and overcome barriers to help-seeking. The two main themes were understanding that talking with a therapist can be very helpful in helping to manage their depression and developing a support system to help a person get through times were formal support methods are not utilized. Robinson (2010) argued that improved treatment rates can be achieved if help-seeking for mental illnesses like depression is promoted and encouraged among minority populations. The findings of this study align with the findings of Robinson (2010) in that the participants have uncovered the benefit of having a sound support system that encourages them to seek the necessary help they need to overcome the challenges associated with depression.

- I have family and friends that have become like family who have been supportive of me since I've revealed that I suffer from depression. I was almost taken aback by how encouraging they were. Some of them even shared their own personal accounts with their struggles and how they wouldn't be where they are without the help of mental health professionals. To see them be successful, have solid relationships, good jobs, and a tribe of great friends encouraged me to do my own research on therapists in my area so I can get help. (P1)

- Once I finally got over all of the denial and shame of being depressed, I got into therapy. It was good to have a person I could talk to that wasn't my wife or family members who could offer an

unbiased perspective on things. It also helped me to be a better spouse because I am now in a place where I can be more emotionally available to my wife if she's dealing with any kind of stress. It was one of the best decisions I could have made for myself and ultimately my family. (P2)

- This thing called 'depression' is one hell of an opponent and the knock down battles are enough to make anyone throw in the towel, but the one thing I've found is that you've got to have a team of supportive people on your side. For me, my pastor and spouse are the head coaches and my family and friends are my teammates and cheerleaders on the sidelines. With them on my side, I feel like I can get through anything. (P4)

- I tried to battle depression on my own and I ended up on the losing side every time. I commend the ones who can muster through and handle it all on their own, but my saving grace has been the support given to me by my family, friends, and co-workers. I had some pretty rough days at home and on the job and when I did, I had someone there to remind me that I could overcome and get through it. (P6)

Overall, the results from the responses of the participants helped to answer the two central research questions and aligned with the literature that was reviewed to support this study. The varied responses and perceptions of the

participants in terms of their personal, social, and environmental experiences with depression have potentially addressed the gap, which are the few studies that describe the experiences and help-seeking behaviors of African American men.

## Recommendations

After examining the perceptions of African American men with depression in the United States and reviewing the literature, I recommend that future research on the attitudes and perceptions of African American men with depression encompass a wider range of geographical locations within the United States, other minority male populations, and older men with depression. Researchers from other countries with high prevalence or incidence rates of minority males with depression could also conduct such studies for the purposes of international comparison, and to promote increased mental health awareness and improved mental health programs.

Very few studies focus on help-seeking among African American men with depression. It is recommended that further quantitative research be conducted with larger sample sizes. Several participants expressed concern that their providers and practitioners provided them with antiquated treatment techniques, that they did not feel like they played a role in their treatment plan, and that their providers lacked cultural sensitivity. This reinforces the need for providers that are culturally competent and realize the importance of being able to provide culturally competent care. Consistent training in the area of cultural competence must be ongoing in order to best meet the needs of minority populations such as African American men.

While the findings from this study are valuable, some of the participants in the sample did not have insurance. A future study should be done to examine and compare the help-seeking behaviors of African American men who are insured versus those who are not. Yet another line of inquiry could examine the opposite end of the spectrum and take an in-depth look at the differences in provider diagnosis of depression in African American men. As previously highlighted in the literature, African American men are often misdiagnosed (Hammond, 2012).

Stigma has been found to play a significant role in whether African American men seek help for their depression or forego treatment altogether. Further research is needed to examine how African American men experience stigma and how it directly relates to their attitudes, adherence to treatment regimens, and if they experience multiple types of stigmas. Connor and colleagues (2010) further assert that research focused on stigma needs to diverge from only addressing one single stigma and begin to identify and address how multiple stigmas impact mental health treatment, help-seeking behaviors, and attitudes. Several participants expressed concerns regarding the presentation of their symptoms, racism and the perception of other agencies such as law enforcement.  It is recommended that further quantitative and qualitative studies be conducted to examine how other agencies can be educated on depression and its presentation among African American men to reduce perceived racism.

**Implications**

Positive social change can occur on many levels. At the individual level, positive social change includes an increased awareness about depression and depressive symptoms and utilization of mental health programs in an effort to better understand and manage their symptoms. Understanding the experiences and perceptions of African American men with depression in terms of help-seeking can create positive change at a family level in the development of a sustainable support system. At the organizational level, positive social change may result in providing information to help create programs that might be more culturally appropriate, highlighting the need for more African American male therapists, improved policies and mental health reform at the local, state, and national levels.

The dissemination of this study's findings can add to our understanding of the mental health needs of African American men to create culturally appropriate screening tools and comprehensive mental health support programs as well as reduce societal stigma and biases in terms of mental health disorders. Possible dissemination includes furnishing the manuscript and study results to mental health care administrators, mental health and support services, families, mental health, and men's journals. This study may address the gap in the research, namely the few studies conducted on help-seeking among African American men with depression, by expanding the literature. This can be achieved

through dissemination in peer-reviewed journals. The extent of this transcendental, phenomenological, study focused on potential transferability as the findings from this study could be applied to other ethnic minority male populations with similar experiences. The targeted population for this study were African American men with depression in the United States.

## Conclusion

This phenomenological study explored the lived experiences of help-seeking among African American men with depression. With depression being the leading cause of disability globally, it was imperative to explore the experiences of help-seeking among African American men depression and ways that may help them navigate barriers to help-seeking. Treatment rates among minority populations can vastly improve if help-seeking behaviors are encouraged and promoted (Robinson, 2010). In order for further understand why there is inconsistency in help-seeking or lack of positive help-seeking behaviors among African American men, their experiences must be understood. African American men with depression need to be more adherent to the treatment options that are available to them. This is inclusive of utilizing mental health resources that are made available to them, such as mental health and wellness programs. In doing so, there will be an increase in awareness that can be sustained for African American as they successfully navigate the mental health system.

The key findings from this study provide meaningful insight into the help-seeking behaviors of African American men with depression. The lived experiences of African

American men can lend insight into adjustments that may be needed to promote their help-seeking behaviors to improve overall mental health, enable them to actively participate in their mental health care, and to accurately define their needs. This study found that each of the participants benefited from some type of support, whether it was formal or informal. This knowledge may offer individuals, families, and employers the tools needed to create positive environments and stable support systems through coalition building on multiple levels for the common purpose of having equitable mental health care. Each participant in this study encountered self-stigma as a barrier to help-seeking. The results may provide the public with increased knowledge and awareness to mitigate the self-stigma that is often associated with mental health illnesses and disorders. Adhering to treatment plans has been problematic among African American men with depression and depressive symptoms. The administrative system in mental health care may benefit from this study as the results could potentially increase adherence mental health treatment services and programs, defray the costs associated with mental health care, offer additional maintenance strategies to improve optimal mental health, and encourage positive help-seeking behaviors among minority populations in addition to focusing on the policy environment to provide evidence-based justification for needed programs.

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Appendix A:  Invitation for Participation

Dear **[Name will be inserted here]**,

My name is Tiffany M. Coleman and I am currently a doctoral student at Walden University.  I am investigating the personal, social, and environmental experiences of African American men with depression as it relates to help-seeking in various geographical locations within the United States.

Your participation will be greatly appreciated.

Participation will involve completing a brief demographic questionnaire which will take approximately 10 minutes as well as participating in an interview which will take approximately 60 minutes.  For local participants, interviews will be conducted in a private conference room at the Round Rock Public Library located at 216 East Main Street, Round Rock, Texas 78664.  The interviews will be conducted during a time that is most convenient for you.  For participants across the United States, interviews will be conducted by telephone, electronic mail, or Skype.

All information obtained from the demographic questionnaire and interviews will be kept strictly confidential.  Those who choose to participate will not be identified in any findings from the study or prepared reports.

Should you have any questions about the study, please feel free to contact me at **[insert email address]** or **[insert Google voice phone number]**.

If you are interested in participating in the study or would like to recommend another African American male who suffers from depression or experience depression symptoms, please complete the following questions and email responses to the email address listed above.

Thank you in advance for your consideration and assistance with my research.

Sincerely,

Tiffany M. Coleman

Appendix B:  Demographic and Screening Questionnaire

1.  Are you willing to participate in this study?

    a)  Yes

    b)  No

2.  What is your full name?



3.  What is your age?

    a)  18-29 years old

    b)  30-49 years old

    c)  50-64 years old

    d)  65 years and older

4.  What city and state do you live in?



5.  What is your highest level of education?

    a)  Some high school

    b)  High school graduate

    c)  Some college

    d)  Trade/Technical/Vocational Training

    e)  College Graduate

    f)  Some Post Graduate Work

    g)  Post Graduate Degree

6. What is your race?

    a) White

    b) African-American

    c) Asian

    d) Pacific Islander

    e) Native American

7. What is your ethnicity?

    a) Hispanic or Latino

    b) Not Hispanic or Latino

8. What is your employment status?

    a) Full time

    b) Part time

    c) Not employed

    d) Retired

9. How many people live in your household, including yourself?

10. What is your marital status?

    a) Single/Never married

    b) Married

    c) Separated

    d) Divorced

    e) Widowed

11. What is your annual household income?

    a) $20,000 - $29,000

    b) $30,000 - $39,000

    c) $40,000 - $49,0000

    d) $50,000 - $74,000

    e) $75,000 - $99,999

    f) Over $100,000

12. Have you ever been diagnosed with depression or suffered from symptoms of depression?

    a) Yes

    b) No

13. Are you currently seeking treatment for your depression or symptoms of depression?

    a) Yes

    b) No

14. Is English your primary language?

    a) Yes

    b) No

15. Do you have health insurance?

    a) Yes

    b) No

Please provide your contact information below:

Name_____

Email address_____

Phone Number_____

Appendix C: Consent Form

You are invited to take part in a research study of personal, social, and environmental experiences as it relates to help-seeking. The researcher is inviting African American men between the ages of 18 and 65 who have been diagnosed with depression, suffer from depression symptoms, and are not currently in treatment. This form is part is part of a process called "informed consent" to allow you to understand this study before deciding whether to take part.

This study is being conducted by a researcher named Tiffany M. Coleman, who is a doctoral student at Walden University.

**Background Information:**

The purpose of this study is to explore and describe the experiences of African American men with depression as it relates to help-seeking.

**Procedures:**

If you agree to be in this study, you will be asked to:

- Complete a 10-minute demographic survey
- Complete a 60-minute face to face, electronic mail, or Skype interview

Here are sample questions:

1. How do the stressors you encounter in your daily life influence your help-seeking, coping techniques, and strategies?
2. How do you navigate or overcome barriers that may prevent you from obtaining mental health care?
3. What encourages or discourages you from seeking mental health help?

**Voluntary Nature of the Study**

This study is voluntary. Everyone will respect your decision of whether or not you choose to be in the study. No one will treat you differently if you decide not to be in the study. If you decide to join the study now, you can still change your mind later. You may stop at any time.

**Risks and Benefits of Being in the Study**

Being in this type of study involves some risk of the minor discomforts that can be encountered in daily life, such as fatigue, stress, or becoming upset. Being in this study would not pose risk to your safety or well-being.

Anticipated benefits of being in this type of study include increased awareness are mental health disorders, improved policies through legislature, and increased mental health programs and support services.

**Payment:**

No compensation is offered to participants.

**Privacy:**

Any information you provide will be kept confidential. The researcher will not use your personal information for any purposes outside of this research project. Also, the researcher will not include your name or anything else that could identify you in the study reports. Data will be kept secure in a locked file cabinet and password protected computer where in which only the researcher will have access. Data will be kept for a period of at least 5 years, as required by the university.

**Contacts and Questions:**

You may ask any questions you have now. If you have questions later, you may contact the researcher via [enter Google phone number and email address]. If you want to talk privately about your rights as a participant, you can call Dr. Leilani Endicott. She is the Walden University representative who can discuss this with you. Her phone number is 612-312-1210. Walden University's approval number for this study is **[IRB will enter approval number here]** and it expires on **[IRB will enter expiration date]**.

For those participating in face-to-face research, the researcher will give you a copy of this form to keep. For those participating in online research, please print or save this consent for your records.

**Statement of Consent:**

I have read the above information and I feel I understand the study well enough to make a decision about my involvement. By signing below or replying to this email with the words, "I consent", I understand that I am agreeing to the terms described above.

Printed Name of Participant                     _____

Date of consent                              _____

Participant's Signature                      _____

Researcher's Signature                      _____

Appendix D:  Interview Guide

**Study**:  Exploring Help-Seeking Experiences among African American Men with

Depression

**Date:** _____

**Time:** _____

**Location:** _____

**Interviewer:** _____

**Interviewee:** _____

**Consent form signed?** _____

**Introduction**

- Provide introduction and welcome participant to the interview

- Provide a general overview of the study and why participant was chosen to

  participate

- Discuss the interview process and purpose

- Provide an explanation of why recording equipment is present and will be used

- Discuss general guidelines and expectations for interview

- Reassure the participant of confidentiality

"Hello.  My name is **[insert researcher's name**] and I am a doctoral student

currently attending Walden University.  I would first like to thank you for taking the time

out of your schedule to participate in this study about help-seeking experiences of

African American men with depression.  You were chosen for participation in this study

because you met the requirements.

"Your perception and experiences are very important and will add to our

understanding of help-seeking behaviors of men.  Your experiences may help us to make

improvements to mental health and support resources and programs.  The results of this

study may improve mental health and support service utilization, inform policies, and

increase awareness.  Ultimately, I hope the results of this study will improve the

experiences of African American men in order to help them successfully navigate any

barriers to help-seeking".

"I would like to remind you that you can withdraw from this study and interview

session at any time; any information that you share with me during this interview will be

kept strictly confidential.  The interview will last for approximately 60 minutes and will

be digitally recorded.  I would also like to remind you that I will also be taking notes

during the interview.  When the interviews are transcribed, your name will not be

included or disclosed.  Do you have any questions?  Are you ready to proceed?  Let's

begin".

**Demographic questions**

- "Please tell me your name, age, and marital status."
- "Please tell me your highest level of education."

**Interview Questions**

- "Have you ever been formally diagnosed with depression or experienced symptoms of depression?"

- "Are you currently seeking treatment?"

- "How do the stressors you encounter in your daily life influence your help-seeking, coping techniques, and strategies?"

- "How do you navigate or overcome barriers that may prevent you from seeking help for your depression?"

- "What encourages or discourages you from seeking mental health help?"

- "How does depression affect your personal relationships?"

- "How does depression affect your social relationships?"

- "Does your depression affect your work environment?"

- "How do these experiences influence your help-seeking for depression"?

- "Do you a support system in place when seeking help for your depression"?

- Have you experienced any barriers in developing a support system?"

- "How would you describe your overall experience of being an African American man with depression?"

**Possible follow-up question topics**

- Prior or existing knowledge about depression and help-seeking

- Stigma associated with depression and help-seeking

- Societal views/expectations of African American men

**Probing Words/ Transitional Phrases**

- "Can you please share an example of a time where you felt you were unable to seek help"?

- "Please tell me more about your experiences of being an African American male with depression"

- "What do you mean by…"

- "Such as…."

- "Why do you think that is…."

- "How did that make you feel…."

- "Is there anything else you would like to share before we move on?"

**Conclusion**

"Is there anything else you would like to share on this before we conclude this interview?  Do you have any questions for me at this time?  Again, I would like to thank you for participating in this interview.  I appreciate your time and most importantly your thoughts and views."