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“Too Blessed to be Stressed”: A Rural Faith Community’s Views of African American Males and Depression

Keneshia Bryant, PhD, RN, FNP-BC [Assistant Professor],

Translational Research Institute KL2 Scholar College of Nursing University of Arkansas for Medical Sciences 4301 West Markham Street, Slot #529 Little Rock, Arkansas 72205 Phone: (501) 296-1896 Fax: (501) 296-1765 kjbryant@uams.edu

Tiffany Haynes, PhD [Instructor],

Translational Research Institute KL2 Scholar University of Arkansas for Medical Sciences 4301 West Markham Street Little Rock, Arkansas 72205 Phone: 501-257-1795 THaynes@uams.edu

Nancy Greer-Williams, PhD, MPH [Assistant Professor], and

Division of Research Practice and Improvement University of Arkansas for Medical Sciences 4021 West 8th Street Little Rock, AR 72205 Phone: (501) 686-7364 njgreerwilliams@uams.edu

Mary S. Hartwig, PhD, APN [Director of Nursing Education]

Area Health Education Center-Northeast University of Arkansas for Medical Sciences 223 East Jackson Jonesboro, AR 72401 Phone: (870)972-9603 X 254 Fax: (870)931-0839 mhartwig@uams.edu

Introduction/Background

According to the National Institute of Mental Health (2010), approximately 14.8 million American adults experience Major Depressive Disorder (MDD) in any given year. Although women are twice as likely as men to be diagnosed with depression, men experience markedly elevated rates of morbidity, disability, and mortality from depression than females, and African American men fare worse in comparison to their Caucasian counterparts (Rich & Ro, 2002). Additionally, in the past several decades suicide rates among African American men have steadily increased (U.S. DHHS, 2006). Despite this noted disparity in disease burden, limited research focuses on the gender- and/or race-specific experiences or perceptions of depression among African American males (Kendrick, Anderson & Moore, 2007; Bryant-Bedell & Waite, 2010). Greater understanding of the experiences and perceptions of depression of African American men could inform the development of effective, culturally appropriate interventions for depressed African American men.

It is well-documented that African American men experience high levels of psychosocial stressors (i.e., racial discrimination, neighborhood violence, increased levels of poverty, etc.) that may place them at greater risk for developing clinical levels of depressive symptoms (Outlaw, 1993). However, African American men are significantly less likely to be diagnosed with depression when compared to men of other ethnicities (Williams, 2007). Some research provides evidence that these disparities in diagnosis are not related to actual differences in prevalence rates, but rather are due to the under-diagnosis and/or misdiagnosis of depression among African American men (NMHA, 2004; Das, et al., 2006). Several factors are believed to contribute to the under-diagnosis or misdiagnosis of depression among African American men including cultural differences in clinical presentation of depression and the documented tendency of African American men to under-report depressive symptoms (NMHA, 2004; Das, et al., 2006).

Compared to men of other ethnicities, African American men are more likely to deny the seriousness of depressive symptoms and thus are less likely to report these symptoms to medical personnel (Cheung & Snowden, 1990). The tendency to under-report depressive symptoms is likely related to fears of stigmatization, fear of hospitalization or incarceration, and job discrimination due to mental illness (Porche, 2005; Ward & Besson, 2009). In addition to African American men under-reporting symptoms, medical professionals are often less likely to detect depression among African American men (Baker, 2001). This failure to diagnose could be related to cultural differences in clinical presentation among depressed individuals (Baker, 2001; Das et al., 2006). Depressed men, as a whole, are more likely to report experiencing increases in anger, aggression, substance use, impulsive behavior, inability to focus, memory difficulties, and decrease in sexual interest, but not decreased sexual activity (Cochran & Rabinowitz, 2003). These depressive symptoms commonly displayed by men are not always congruent with the diagnostic criteria for depressive episodes set forth in the Diagnostic and Statistical Manual (DSM) (Porche, 2005; Love & Love, 2006; Cochran & Rabinowitz, 2003; Foley et al., 2002). Given that the presentation of symptoms by depressed African American males may differ from the presentation that by men and women of other ethnicities, it is possible that depression in African American men is often undetected by medical personnel even when symptoms are being reported (Das et al., 2006). Clearly better approaches to detecting and diagnosing African American men are needed.

Even when depression is identified, traditional interventions may not be as effective for African American men, possibly due to conflict between treatment options and important cultural values of African Americans. Studies indicate that African Americans are more likely to endorse alternative methods of treatment such as prayer alone, or the reliance on self-management of depressive symptoms rather than treatment that emphasizes the need for external help such as pharmacotherapy, cognitive behavioral therapy, or talk therapy (Cooper, Brown, Vu, Ford & Powe, 2001; Holt & McClure, 2006; Jang & Johnson, 2004; Bryant-Bedell & Waite, 2010). Additionally, the importance of self-reliance, the stigma of depression, and limited mental health resources in rural communities may influence the behaviors and actions of African American males (Campbell, Gordon & Chandler, 2002).

Some researchers have theorized that adapting standard interventions to reflect these personal and spiritual coping values of African American men may be helpful in creating interventions that are more culturally acceptable and thus more effective (Ward & Collins, 2010). For example, faith-based depression interventions may be warranted for African American men who seek help from informal networks such as churches (Broman, 1996). It has been suggested that evidenced-based community outreach programs that address the specific needs of African American men and the faith community are needed (Brown & Gary, 1994; Ward & Collins, 2010). But prior to developing such an intervention, it is vital to know and understand the African American faith communities' views of depression among African American males. The purpose of this qualitative study is to better understand attitudes and perspectives about men and depression among a rural faith community with the ultimate goal of developing an evidence-based intervention that is optimally effective in this population.

Methodology

Setting and Participants

The study followed the principles of Community Based Participatory Research (CBPR) (Minkler & Wallerstein, 2008). Participants were recruited from a rural community located in Northeast Arkansas, near the borders of Missouri and Tennessee, in the Mississippi River Delta region. The target community has a larger population of African Americans than other

Arkansas counties (U.S. Census, 2010). Participants were recruited by a university community partner who was introduced to the lead researcher by a university liaison. The community partner is the director of a local non-profit organization affiliated with a local church. After completing *Protection of Human Subjects* training, the partner recruited potential participants for the study through personal contacts in the community. Participants comprised three cohorts: a group of pastors, a group of African American men who have a self-reported history of stress and/or depressive symptoms, and a group of parishioners interested in health (both men and women). To be included in the study's first cohort of pastors had to be the primary pastor of a predominately African American Christian church within the geographic recruitment area for a minimum of one year. The second cohort's inclusion criteria were: African American, male, 18 years or older and self-reported experience of either high stress or depression symptoms sometime in their life. The final cohort consisted of men and women, 18 years and older, who attended a predominantly African American Christian church in the recruitment area and who were self-identified as interested in improving the health of their community. To participate in the study, all individuals had to speak English.

Data Collection

In order to identify key issues and experiences important to the participants, focus groups were used as the primary source of data. The focus groups were conducted at various convenient locations in the community including a private room at a restaurant, church, and a business conference room. The first three focus groups (one with each cohort) were designed to collect initial data about the community and the beliefs of its residents. The initial focus groups followed a semi-structured format and the questions varied slightly based on the cohort. At the beginning of each session, participants were provided dinner, informed of their rights, and asked to complete the consent form and a demographic questionnaire. To maintain consistency, all focus groups and interviews were led by the lead researcher and digitally audio-recorded. After the completion of the initial focus group with each cohort, the succeeding focus groups and two interviews included preliminary results and the participants were asked to remark on them. Participants were thanked for their time and given a \$25 gift card as a token of gratitude at the conclusion of each session. Immediately following a focus group or interview the lead researcher summarized in written field notes what was discussed during the session, including interpersonal interaction. The digital recordings were transcribed excluding any identifying information and reviewed by the lead author for accuracy prior to analyses.

Data Analysis

This study was designed to meet standards of rigorous qualitative research. Morse, Barrett, Mayan, Olson, and Spiers (2002) proposed that rigor in qualitative research includes investigator responsiveness, methodological coherence, sampling adequacy, an active analytic stance, and saturation. Investigator responsiveness was ensured in this study by having analysis conducted concurrently with data collection, driving increasing refinement of interviewing foci as data were crosschecked with the appearance of developing patterns. *Methodological coherence* in interviewing style and technique was supplied by having all of the focus groups and interviews being conducted by the lead author, an experienced qualitative researcher. Transcripts were reviewed by three additional experienced researchers, which provided *verification of concepts and categories*. Qualitative data collection, coding, analysis, and interpretation were integrated to ensure that interpretations of findings were grounded in the data. The verbatim transcripts of focus groups, interviews, and field notes were entered into a qualitative data analysis and management software package (Ethnograph 6.0). This process enabled the researchers to mark blocks of text with

codes, explore relationships among and between codes, and compare participants and groups. The lead investigator and an experienced qualitative researcher reviewed the transcripts and field notes and then developed an initial set of inductively derived codes with definitions. The study's leader and co-leader and a third researcher verified code words and definitions. The transcripts of the subsequent focus groups were jointly coded (leader, co-leader, and third researcher) to ensure that the definitions captured the meanings of the text and were mutually exclusive. This process also enhanced consistency in coding. Definitions were revised, as necessary. This process improves coding reliability and consistency. After completing the initial coding, codes were collapsed into more general and related constructs and were aggregated into four broad themes.

Results

A convenience sample of 24 African American faith community members participated in the study, including 16 men and 8 women. The three cohorts comprised: first cohort: 9 African American male pastors; second cohort: 4 African American men with a history of self-reported stress or depressive symptoms; and third cohort: 11 African American parishioners, 3 of whom were males (see Table 1). The age range of the participants was 24–70 years old (average 42.6 years). Most (62.5%) of the participants were married; a minority of the participants (8.3%) did not have college education. A majority of participants (60.9%) had household incomes below \$50,000/year. The Christian denominations represented were Baptist, Pentecostal, and Church of God in Christ (COGIC), while some participants were from non-denominational Christian churches. The average number of years at their current church for all participants ranged from 1–40 years (10.7 years average).

There were four explicit themes that were identified from the data in relation to the faith community's perceptions of depression among African American men. They included: (1) defining depression, (2) the etiology of depression, (3) denial of depression, and (4) effects of masculine roles on depressive experience. Though the first three themes could be applicable to either sex, each participant had a unique take on the African American male experience. And the final theme, masculine roles, explicitly revealed the role gender plays in depression.

THEME #1: DEFINING DEPRESSION

The participants described how they defined depression. Being “stuck,” “down,” or “unable to move” were the most often used terms. Descriptions of depression also included references to emotions, feelings, and moods.

Depression is basically a withdrawal process that happens slowly, but eventually it becomes where you get stuck and you need help coming out. (Pastor, Cohort 1)

I see depression as being, when you're in the state of loneliness, where you feel like there's no way out, and you be coming into another world. You feel like there's nothing anybody can do for you. It's always like you want to stay in a dark room all the time. You don't want a way out just because you feel like it's all over. (African American male, Cohort 2)

Participants described depression as a loss of hope that then impinges on one's drive and initiative. Some stated that when a person gets to such a point, they naturally develop defenses against the depression, while others may not know how to cope or manage the experience of hopelessness.

I don't relate to clinical terms either, but I view it as a person that's kinda lost hope, kinda lost their initiative, hadn't really been able to know how they're gonna get

from point A to point B, then the natural reflexes kick in. (African American male, Cohort 2)

The person got to the point where they ain't got a lotta hope, really don't know how to make things better. Just ain't no hope, and that affects their initiative. (African American male, Cohort 2)

THEME #2: THE ETIOLOGY OF DEPRESSION

Not only were definitions of depression discussed but also perceived etiologies of depression. Participants identified a variety of stressors that they believed could lead to depression. These stressors included a lack of finances, illness, life failures, family and life changes, and the environment. Financial problems and economic difficulties (e.g., loss of jobs, high costs of staples) were identified as key stressors that may lead to depression.

Let me tell you what make folk depressed. You ain't got no money. We ain't got any money. (Pastor, Cohort 1)

Although some participants described depression as being caused by sickness, the causation was always expressed in relation to other illnesses, such as cancer or diabetes. Participants did not describe biological causes of depression, such as chemical imbalances.

Sickness will cause depression; not only finance but not even having somebody to talk to aside from church. You've got a lot of different aspects of depression that could show up. (Pastor, Cohort 1)

Past failures and disappointments in life were acknowledged as causes of depression as well. This factor was thought to impact men in a variety of ways including those who had left the rural community to join the armed forces, but then returned to their communities upon discharge with the expectation of having accomplished more than what they had. This etiology was also described as applicable in cases of elderly men who looked back on their lives and did not feel as if their lives had been successful.

Some are stressed or depressed by the past and failures of their past and things they did not feel like they accomplished, should have accomplished in the past. Now they're older they're looking back over it. (Parishioner, Cohort 3)

Family life issues including struggles with death, marriage, parenting, and single parent households were mentioned as stressors leading to depression as well.

My daddy was never around. I've been depressed about it for 15 years. (Pastor, Cohort 1)

A death in the family, that at that moment it 'causes you to be depressed. (Pastor, Cohort 1)

Problems at home or could be just family problems or it could be problems at work. (African American male, Cohort 2)

Divorces and separations depress families just about more than anything else. (Pastor, Cohort 1)

A person's environment was also identified as a potential cause for depression. This category included the physical environment and a lack of resources. Some participants stated that their environment could make them depressed because there was "nothing to do," no activities, and minimal job opportunities, which impacted quality of life. Additionally, the influences of society in general were thought to have an impact on mental wellness in African American males. This included stereotypes, negative images of African American men, and social structures.

The community sometime creates some of that depression....the community has to change. It has to make that switch. You know? People want a quality of life, things like that. If the quality of life changes, then they feel like the mentality will change. (Pastor, Cohort 1)

The societal environment was also described and perceived as being a particular challenge for African American men because of how society views them. A large number of male participants stated that African American men experience stressful lives, even more stressful than African American women or men in other ethnic and racial groups.

Many participants believed that depression is a problem in society in general that needs to be addressed.

Black men, invariably, they [society] make them feel bad about themselves. (Pastor, Cohort 1) [Black] Men go through a lot of abuse, mental and physical abuse. (Parishioners, Cohort 2)

Society has mastered in making us [Black men] feel worthless. (Pastor, Cohort 1) Sometimes it seems like the world system is against them, and this causes them to depress. (Pastor, Cohort 1)

THEME #3: DENIAL OF DEPRESSION

Denial defined as the lack of acceptance of MDD and depressive symptoms by African American males was the third theme identified by the participants. The major reasons mentioned by participants for African American males to deny they are depressed were social stigma and a lack of understanding about depression. The stigma of depression based on the belief that depression is a sign of weakness makes it difficult for men in general to admit to feeling depressed, according to several participants. Participants noted that many men believe that to be masculine is to not show signs of weakness. Some expressed that within the African American culture a Black man is expected to not show signs of weakness, vulnerability, or failure.

Yeah, I know how it is for them [depressed Black male] to admit depression; it's to them in their mindset that they're weak. (Pastor, Cohort 1)

We can't take the load of the world, and there are times that we fault weakness to many things, but the stigma has to be put off, that if you're a Black man and you're depressed, it don't mean that you're weak. (Pastor, Cohort 1)

Admitting depression for a man, especially a Black man, is admitting weakness. (Pastor, Cohort 1)

Participants also mentioned a sense of loss of pride if a Black man admitted to being depressed and that until the stigma of depression is removed, men will continue to deny, suppress, or cope with depression independently.

Until we get the stigma off, if you depressed, there got to be something wrong with you. If you can pull that off, people will start to talk, especially Black men, cuz we got pride boy, we got pride. (Pastor, Cohort 1)

I'm going to suppress it [depression]. I'm going to find a way get it [depression] fixed. That's admitting I'm weak, and I can control it [depression]. As black men, we don't do it [admit depression]. (African American Male, Cohort 2)

One pastor also identified a stigma of depression among clergy. There is a belief that, if you are a man of God and living a righteous life, then you should not have problems, and therefore you should not have depression. Several pastors stated that they often hear the

problems and tribulations of their parishioners, but they in turn do not have anyone with whom to talk about their problems. Some of the pastors felt that they needed someone to talk to at times, but were apprehensive because they are in the leadership role and everyone expects them to “have it all together” and to not experience depression or depressive symptoms.

But it’s taboo for us to be depressed, ‘cuz we men of God and we preachers, and we don’t have problems. We sit on the left hand of God and Jesus on the right hand, and we just...it don’t happen. (Pastor, Cohort 1)

One participant stated that men who suffered from depression may be weak.

Maybe the person actually saying it [that they are depressed], that he might be the weak one. (African American Male, Cohort 2)

It was noted by several participants that many members of the community lack an understanding of depression.

They probably can’t define that and probably been that all their life but probably don’t understand the definition. (Parishioner, Cohort 3)

A lot of people really don’t know what depression is. A lot of people just think they got symptoms and think its depression. But I think it’s really not [depression]. I think it’s mostly [they] want to have a pity party. (African American Male, Cohort 2)

As previously stated under theme three, the participants felt that societal pressures impacted the etiology of depression. It was explicitly expressed that societal pressures lead to denial, but participants believed that the strain of societal pressures leads to increased depressive symptoms among African American men. Because some men do not possess the coping mechanisms or do not have support to manage these stressors, they do not deal with their emotions properly.

With depression, as well as anything else, what’s not said is acted out...That’s why a lot of men, when you look in prison, and they go through these things, if you ever got down to the root problem, they was depressed and they acted, just like children. (Pastor, Cohort 1)

So what we do as men is we bottle that [depression] in. (African American Male, Cohort 2)

My personal opinion, the reason why most black men that are sitting in jail right now, leads all the way back to some form of depression. The reason they acted out and did what they did that got them in there. (Pastor, Cohort 1)

The idea that depression can lead to criminal and abusive behavior was endorsed by numerous participants. Depression as causative of criminal behavior was largely attributed by participants to the belief that African American men experience more stressors than men from other ethnic backgrounds, and the lack of management of reactions to these stressors leads to “acting out.”

THEME #4: MASCULINE ROLES

The final theme was masculine roles. Many of the men participating stated that showing or expressing feelings is not part of the expectations of men. They are raised to believe that a “real” man does not show his emotions, and depression falls into that realm.

I’m guilty, I told my son, ‘Don’t you cry,’ told him, ‘Stand up there like a young man,’ and stuff like that. I wouldn’t let him cry. (Pastor, Cohort 1)

One female participant felt that a lack of a father or father figure could have negative effects on males as they get older.

They can't express their self this is what's wrong with a lot of black men because some of them have fathers to tell them, to teach them, we as women can do so much and tell our sons so much. (Parishioner, Cohort 3)

Several participants discussed the difficulties African American males have in admitting to depression or depressive symptoms:

So admitting that I'm depressed about a certain issue whether it's my job, my finances, my marriage or you know the state of position with my kids, I'm not going to do that. (Pastor, Cohort 1)

We're not gonna' admit any kind or form of depression. We've got clichés like "I'm too blessed to be stressed." (Pastor, Cohort 1)

I believe people know what depression is; I just don't think they know how to go seek help. (Parishioner, Cohort 3)

Multiple participants believed that men need to be able to openly discuss their problems, which would aid them in seeking help in coping with their stressors and depression.

I'm talking about the Black male community. We don't do a lot of discussing. We'll cover it up and sweep it under the rug, stuff like that, and we just really don't do a lot of discussing. (Pastor, Cohort 1)

Because most men want to make sure that they don't lose their masculinity. (Pastor, Cohort 1)

Even with men, we have issues, and we have to be able to deal with them and be able to deal with them openly. (Pastor, Cohort 1)

But some participants believed that the comfort level of men in discussing depression is impacted by the setting in which the discussion occurs (or by whom they are talking to). In this study, the gender of other participants in the focus groups and/or the presence of church leaders may have affected what men divulged. The participants suggested that some men may feel more comfortable talking to their pastor, but others (likely dependent on the subject manner) may prefer talking with their friends.

They'll sit in a group with their buddies with beers and smoke, and they'll talk about their problems while they're there, and feel like it's okay there. But, they're scared to talk about it with us [clergy] as if we're going to dishonor their trust, and then their buddy turns around and will carry it out. (Pastor, Cohort 1)

Discussion

Specific themes about depression among African American males were identified by both men and women participants within a rural African American faith community. From the data extracted from focus groups and one-on-one interviews, four themes were identified: defining depression, the etiology of depression, denial, and masculine roles. Overall, the participants defined and described depression in terms of emotions, feelings, and behaviors, but the participants did not describe depression in terms of physical symptoms or according to the medical model. The responses did not support previous findings among African American pastors and older African Americans who defined depression in spiritual terms such as "hopelessness resulting from a lack of trust in God," "loss of touch with God or spiritual core," or "loss of faith" (Wittink et al., 2009; Payne, 2009).

Most of the causes of depression identified by the participants were based on social and environmental factors. These included financial problems, past failures, and family life challenges such as divorce and death. These findings strongly mirrored depression etiologies identified by Kramer et al. (2006) among a sample of primarily African American clergy. However, Kramer's results also included lack of self care, high professional and personal expectations, and societal emphasis on material wealth as potential causes of depression. Although sickness and poor health were identified as stressors in our study, those participants who mentioned these connections did not directly relate depression to known biological causes of depression such as thyroid hormone or serotonin levels. Because the participants were more likely to attribute depression etiology to social causes, this could potentially impact their help-seeking behaviors. This may explain why African American males are more likely to seek help from informal sources (Broman, 1996). It may also lend some credence to why intervening in churches may be more effective for African American men, because churches have a long standing history of helping with social and economic issues.

There was a perception among a portion of the study respondents that African American males experience more stress in general than African American women and men from other racial backgrounds. This perception has been studied previously and supports the correlation between increased stressors such as racism and the impact of psychological well-being among African American men (Weaver & Gary, 1993; Utsey, 1997). Also, a previous study showed that African American men experience markedly elevated rates of morbidity, disability, and mortality from depression in comparison to their Caucasian counterparts (Rich and Ro, 2002). This is of particular importance because despite the reported low prevalence rates of depression in African American men, the participants in our study believed that African American men have stressful lives that could lead to more depression. If this is so, that would lend support to devising interventions for depression in this population despite the relatively low prevalence rates.

Several participants suggested that some men naturally develop defenses against depression. Some participants identified the defense as denial or lack of effective coping, thus implying that some African American men recognize depression, but they expect to be able to cope independently or by other means. The identification of this belief supports the need for treatments that help individuals develop positive coping behavior, such as self-management strategies. It also suggests that traditional methods of intervention (i.e., drugs or behavioral therapy) may not be effective within the African American male population because 1) they are less likely to recognize depression as a medical disorder but more likely to view depression as a consequence of societal pressures, and 2) they expect that "real men" should be able to deal with it on their own.

Masculine roles have been explored by other researchers. The phenomenon of shielding depression has been defined in the past as some have hypothesized that men engage in such shielding when facing depression (Bryant-Bedell & Waite, 2010; Hart, 2001; Lynch & Kilmartin, 1999). Some have noted that men hide their emotional pain through juvenile, aloof, selfish, or cruel behaviors (Hart, 2001; Lynch & Kilmartin, 1999). Alcoholism or other substance abuse, frequent job changes, or family abuses are other mean through which men often hide emotional pain. Some experts have noted that because it is so difficult to see the pain behind the mask, people tend to deal solely with the outward appearance of the problem behavior and fail to address its underlying causes (Lynch & Kilmartin, 1999). This observation directly links to the participants' beliefs in this study regarding MDD as related to "acting out" and criminal behavior. The connection of mental illness and African American males was also identified in a previous study (Ward & Besson, 2012). Yet, in another study African American men were described as wearing a mask, pretending that

everything is fine, and actively shielding their depression (Bryant-Bedell & Waite, 2010). This discrepancy in how African American males manifest and perceive depression needs to be examined in future studies. It is important to consider the effects of male gender roles when developing intervention programs for African American men with depression, particularly within faith organizations where the majority of institutions are led by males.

Study Limitations

Though many of the concerns shared by the participants of this study mirror those in other studies, participants were all derived from a few churches in one rural community recruited by one community partner.

Implications for Future Research

The conduct of a study that specifically addresses the concerns and barriers described by the rural African American faith community regarding the recognition of depression and how to seek care for depression is important in the development of an effective intervention. In addition, the role mental health literacy plays needs to be explored within this population.

This study indicates that the rural African American, faith community identifies depression among Black men as a major health issue and is open to intervention. However, community members' perceptions of the causes of depression and the stigma of depressive symptoms among men may negatively impact their decisions to seek help when facing depression. Findings suggest that faith community outreach programs to address and alleviate the problems experienced by African American men with depression should include efforts to reduce the stigma of depression as well as education regarding the illness, including recognizing the symptoms. In addition, skillful training in self-management techniques may promote effective, positive coping strategies. While this study and others have identified existing community and gender-specific issues with depression, additional information is needed to determine the most effective and culturally acceptable ways to deliver these interventions in the community. Further research with urban as well as rural populations is needed to explicate the social stressors of being an African American male. In particular, the relationship of race-specific social stressors to depression needs to be studied, as well as the short- and long-term sequelae of depression among African American men.

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Biography

Dr. Keneshia Bryant is an Assistant Professor at the University of Arkansas for Medical Sciences (UAMS) in the College of Nursing and a UAMS Translational Research Institute KL2 Scholar. She is also a board certified family nurse practitioner. Dr. Bryant's research expertise includes working with the faith community to develop depression interventions with a focus on the needs of African American males.

Dr. Tiffany Haynes is a faculty member at the University of Arkansas for Medical Sciences (UAMS) in the Department of Psychiatry and a UAMS Translational Research Institute KL2 Scholar. She is a trained psychologist with a research expertise in health services research.

Dr. Nancy Greer-Williams graduated from the Western Michigan University with a PhD in Higher Education Administration (2004). In 2011, Dr. Nancy Greer-Williams received from Benedictine University, a MPH in Public Health and a PCHC in Health Education & Promotion. Dr. Greer-Williams's experiences upon graduation spans higher education administration, research and public health concentrations. Dr. Greer-Williams is an Assistant Professor in College of Medicine and Assistant Director for Research and Practice Improvement at the University of Arkansas for Medical Sciences (UAMS).

Dr. Mary S. Hartwig graduated with her Ph.D. in Nursing in 1993 from the University of Tennessee-Memphis. She is currently faculty with the University of Arkansas for Medical Sciences-College of Nursing & Area Health Education Center-Northeast where she works as a Board Certified Family Nurse Practitioner (ANCC), certified as in Advanced Diabetes Management (AADE), Director of Nursing Education, and faculty research chair in Family Medicine Residency program.

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Table 1

Participant Demographics

Variable		N=24
Gender	Male	16
	Female	8
Age	18-25	3
	26-45	13
	46-65	7
	66-older	1
Marital Status	Never married	6
	Married	15
	Divorced	3
Education	High school diploma	2
	Some college/trade school	13
	Associate degree	4
	Bachelor's degree (BS, BA, etc.)	3
	Graduate degree	2
Employment	Employed full-time	15
	Employed part-time	3
	Unemployed	1
	Retired/Veteran	1
	Disabled	4
Household Income	Less than US \$20,000/year	8
	US \$20,000-50,000/year	6
	US \$50,001-100,000/year	8
	Greater than US \$100,000/year	1
	Did not answer	1
Religion	Baptist	8
	Pentecostal	5
	Church of God in Christ (COGIC)	3
	Non-denominational	6
	Other/Did not answer	2