An initial exploration of what 'mental health' means to young black men

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Abstract

Background: A limited number of studies have examined the knowledge, attitudes, and beliefs of young Black men, particularly with regard to their mental health. This study used focus groups to explore the complexities of the Black male experience and capture young Black men's understanding of and comfort with discussing their mental health.

Methods: Forty-six Black male college students in a southern US state were recruited for this study. Participants were asked a series of mental health-related questions to determine their understanding of and comfort with discussing their mental health. Questions included: (1) *What is mental health?* and (2) *How comfortable do you feel talking about your mental health?* A taxonomy was created to organize results based on participant responses.

Results: Emerging themes included stigma in the Black community, the origin of stoic behaviors, and cultural stereotypes of Black Americans and mental health. During the discussions, participants articulated mental health in a way that they believed was suitable for the 'formal' focus group setting – that is, using mental health terminology familiar to that of health professionals. The men agreed that while they used 'formal' mental health terminology in the focus group setting, they were accustomed to using culturally-rich jargon, or slang to discuss their mental health in more informal settings. Participants also stated that they were comfortable discussing their mental health, however, their frequent use of slang may be undetectable and perhaps uncomfortable for health professionals.

Conclusions: Increasing our knowledge about the mental health of young Black men will help develop effective programs aimed at improving their health and overall quality of life. Findings from this study should be considered by health professionals during (1) the dialogue about culturally-appropriate, gender-specific health promotion programs tailored to Black men and (2) the design, implementation, and evaluation of these programs. © 2007 WPMH GmbH. Published by Elsevier Ireland Ltd.

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Introduction

What we know about the health of young Black men and women is largely derived from studies conducted at historically Black colleges and universities (HBCUs) [1]. While the number of studies that include Black college students is growing, prior research with this population has been limited due to the sampling methodologies implemented, and the absence of students who attended non-HBCUs. The health of Black college students is typically observed on a single campus, assessing the health of both Black college men and women,

with women largely over sampled [2]. Early research demonstrated that, unlike their White classmates, Black students attending predominately white institutions (PWIs) seldom utilized services designed to support the psychological and emotional health of the general student population [3]. Black men, in particular, may refuse to utilize mental health services because of their mistrust of the systems or due to culturally-appropriate and gender-specific needs that require specialized and innovative services.

Research has proposed a number of psycho-social factors that contribute to the limited

health-promoting behaviors of Black men. For example, a recent review identified psychosocial coping, economic status, and racism/discrimination as major factors that contribute to depression and depressive symptoms in Black men [4]. Furthermore, the transition to adulthood for young Black men may lead to increased levels of stress in early adulthood and maladaptive coping patterns that develop from an awareness of the limited opportunities they have in life [5]. For some Black men the transition to adulthood occurs in a college or university setting. While scarce resources have provided insight into the lives of Black college men, exclusively, an important segment of the literature examines the conditions of Black students who attend PWIs and HBCUs. Black college men in this literature are often understudied, especially with regard to their mental and physical health. Young Black men may encounter a number of daily hassles that can increase their risk for poor health. A recent study suggested that the mental health and health behaviors of Black college men are influenced by stressors germane to the institutions they attend [6]. In an effort to increase our understanding of young Black men, the present study will examine their knowledge, attitudes, and beliefs about mental health using qualitative research methodology.

A growing number of studies have demonstrated the value of using qualitative methods to identify the cultural context of Black men – oftentimes through exploratory research. For example, Diemer [7] used qualitative methodology to identify neglected aspects of Black male provider role identity while Royster and colleagues [8] used focus groups to examine the influence that male gender socialization and economic class have on the health of Black men. In that study, mental health emerged in the form of college-related stress and played an important role in the participants' self-reported health. Similarly, Ravenell et al. used focus groups to explore Black men's perceptions of health, health influences, and definitions of health [9]. Beliefs about health maintenance and influences on health were extracted from the study findings.

Duncan has argued convincingly that future research should examine problem severity, comfort in seeking help, and coping styles of Black college men [10]. In order for health professionals to provide appropriate services to these young Black men, they must first understand the unique aspects of their lives [6]. Despite the potential importance of young Black men's knowledge, attitudes, and beliefs surrounding their mental heath, there are relatively few studies that investigate this topic. It is difficult to contrast a model of Black male perceptions about mental health and their comfort with discussing it. Marshall & Rossman suggest that when no clear model exists, exploratory research in the form of qualitative methodology is applicable [11]. The present study uses qualitative methodology in the form of focus groups to identify and explore the general perceptions of young Black men and their mental health. This research is a first step in the formulation and analyses of robust and complex questionnaires for distribution to larger and more representative samples of Black men.

Methods

Study design

Focus groups can provide insight into a target audience's perceptions and motivations [12]. They can also capture the complexities of the thinking and behavior of a target audience in greater depth than a quantitative survey. Group interaction and dynamics can help elicit in-depth thought and discussion as well as brainstorming, because participants can build off one another's ideas. Focus group questions can be modified as information needs change; and barring unexpected recruitment difficulties, focus groups can be coordinated and conducted within a relatively short period of time [12]. The present study was guided by Lincoln & Guba's [13] naturalistic perspective and used focus groups as a data collection method to achieve the study goals.

Focus groups offer many advantages that were ideal for this study. First, they are best used to probe matters about which the target population is concerned. Second, focus group discussions are based on the premise that if theory is to be grounded in data, the data must first be located and analyzed inductively. Finally, several authors have advocated for qualitative methodologies in offering further insight into the meaning and experiences of Black men's knowledge, attitudes, and health

behaviors [8–10,14]. With qualitative inquiry comes issues of validity and reliability comparable to those in quantitative research. In concert with corresponding empirical procedures that affirm the trustworthiness of naturalistic approaches, substitute criteria such as credibility, transferability, dependability, and conformability [12] were implemented during all phases of this study. Additionally, the present study modeled the theoretical framework outlined by Ulin et al. [12] that demonstrated a methodological focus on complex relations between (1) personal and social meanings, (2) individual and cultural practices, and (3) the material environment or context applicable to the young Black men in the study.

A semi-structured, focus group protocol was developed to determine participants' comfort with discussing mental health, health behaviors, mental health knowledge, (individual) mental health, and mental health management. The protocol was pilot-tested with a convenience sample several weeks prior to the field test. During the protocol's pilot-testing, responses were recorded and suggestions for improvement were considered. The primary criterion that guided item inclusion in the protocol was scientific validity. Essentially, it answers the question: Is the instrument an appropriate one for what needs to be measured?

Participants

Young Black men enrolled in two southern US state institutions during the 2005–2006 academic year were eligible to participate in the study. The universities were located approximately 50 minutes apart, and centrally located almost equidistant from three metropolitan cities. At the time of recruitment, enrollment was approximately 10,000 at the smaller institution and 40,000 at the larger one. Recruitment efforts were made via email, direct person-to-person, and 'snowball sampling,' defined by Morgan & Krueger [15] as the process of asking people that have already been recruited for names of potential study participants. An honorarium was offered to all participants in the study.

Human subjects protection

The study was reviewed and approved by the Institutional Review Boards at each institution. Focus group participation was strictly voluntary and participants could withdraw from the study at any time without penalty. After reviewing the goals of the study, the focus group facilitator reviewed the consent forms with participants, informed them that the discussion would be audio-tape recorded, and obtained their signatures. Participants were advised to use only their first names or an alias during the discussions in order to maintain anonymity. All identifying information that could be traced back to the focus group participants was excluded from the final transcripts.

Data collection

Focus groups were facilitated by a trained, doctoral-level, Black female focus group facilitator. A total of five focus groups were conducted and the average number of participants per group was nine. Due to the depth and duration of the interviews five afforded data saturation, or the point where new data became redundant [16]. The major responsibilities of the facilitator included guiding the focus group discussions, periodically checking the recording equipment for proper functioning, and ensuring that all notes and tapes were appropriately labeled at the end of each focus group. The average length of focus group discussions was approximately 90 minutes; however, participants in the first and fourth groups were so engaged that they asked to continue their discussion past the allotted time. When this occurred, the focus group facilitator obtained permission from participants to continue audio-tape recording the discussion.

Facilitator notes were combined with the transcripts, which became a major component of the database used for analysis. The focus group protocol included 30 questions categorized into five sections: (1) health behavior; (2) general mental health; (3) comfort with discussion of mental health; (4) individual mental health; and (5) mental health management. This study reports the findings from questions asked during the 'general mental health' and 'comfort with discussion of mental health' sections of the protocol. Specifically: (1) *What is mental health?* and (2) *How comfortable do you feel talking about your mental health?* Following preliminary analyses, a participant from each focus group was randomly selected to

review the preliminary results from their focus group and to provide feedback on the facilitator's interpretation of their discussions. Results from these 'member checks' indicated that participant responses were accurately depicted by the focus group facilitator [15]. Member checks also helped to reduce researcher bias and *a priori* assumptions [17].

Data analysis

All focus group discussions were transcribed verbatim; three were transcribed by a local transcription service and two were transcribed by the focus group facilitator. Transcriptions occurred between October 2005 and December 2005. Each 90-minute focus group discussion took an average of 9 hours to transcribe. After transcriptions were completed, the data were entered into Microsoft® Excel for data reduction and analysis. Since Microsoft® Excel has been validated as reliable qualitative software for the management and organization of focus group data [18,19] it was used to manage and organize the focus group data in this study. Two primary goals of focus group analyses are to (1) reveal the important themes and their degree of emphasis that underlie participants' comments with regard to the study questions, and (2) to compare these themes across different types of groups [19].

Text patterns and narrative threads were used to develop codes that organized the content of the data into a classification system. First, the focus group categories were identified: comfort, frequency, weakness, good mental health, depression, anxiety, mental health concerns, stressors, coping, health behaviors, and closing statement. Next, units of information from these categories were sorted into relevant piles that were used to identify themes within each category. A total of 31 themes were identified. The theoretical plan that led to inquiry was used to assist in interpreting the categories and the findings. The focus group data were analyzed using multiple methods as suggested by Morgan & Krueger [15]: transcript-based analysis, tape-based analysis, note-based analysis, and memory-based analysis. An additional content analysis was also executed. Manning & Cullum-Swan define content analysis as a 'technique by which standardized measurements are applied to metrically defined units and are used to char-acterize and compare documents' ([20]: 464). In this study, content analysis was achieved by coding the text, and breaking it down into manageable categories. After the content analysis was completed, a data catalog was created to organize results based on responses to questions about participants' knowledge of and comfort with discussing their mental health.

Results

The 46 participants included Black men who attended either an HBCU ($n = 24$) or PWI ($n = 22$) during the 2005–2006 academic year. Ages ranged from 18–26 and there was representation from all academic schools/colleges (e.g. liberal arts, business, public health, etc) and university classifications (i.e. freshmen, sophomore, junior, senior, Masters, and doctoral). Participants at the HBCU were all undergraduate students and more than half of them were involved in on- and off-campus extracurricular activities. Those at the PWI included both graduate and undergraduate students and almost half were members of a fraternity. More than half were involved in extracurricular activities. Participant responses to (1) *What is mental health?* and (2) *How comfortable do you feel talking about your mental health?* are presented below.

Mental health knowledge, attitudes, and beliefs

What is mental health?
Focus group participants were asked a series of questions used to determine their knowledge, attitudes, and beliefs about mental health. Questions were open-ended and if participants provided one-word responses, the facilitator probed for more in-depth responses. When participants were encouraged to talk about their mental health, many of them offered personal accounts of their mental problems and concerns. Results suggested a consensus between the two campuses regarding perceived mental health status. Most participants reported fairly good mental health and noted that this was because they do not let their problems reach a point where they begin to 'feel down' and/or depressed. When asked: '*What is mental health?*' participants agreed that it is success in function, balance, and coping. They

also defined mental health as one's level of sanity and maintaining control over one's life. A doctoral student in political science noted:

'It's the ability to see past the present moment, to not allow your present situation to engulf you. I don't think it's necessarily bad mental health to be sad or depressed. If something bad happens? You know, you should be sad or whatever. But the ability to not let that circumstance overcome you [is good mental health].'

In the same focus group, a Masters student in public health offered a philosophical perspective:

'I've come to the realization that life is like a roller coaster, man. You have your highs and your lows. If you're not too high with your highs and don't get too low with your lows, but you try to find that median for life? Once you find that median, that's good mental health, in my opinion.'

During the discussions, participants were not only asked to define mental health, but also to expound upon how they formed these definitions. Some referred to terminology used by their family members, while others insisted that examples from their daily lives were used to form their definitions of mental health. For example, a student-athlete at the PWI defined mental health as the practice of self-concealment, or the tendency to actively conceal one's feelings and emotions. His explanation of this proudly exuded the 'mental toughness' he maintains as a Black male athlete in a predominately white environment:

'It also goes with what kind of person you are inside. Because I feel [I am] a real strong person and, somebody might come up to me, white people might come up to me everyday, might smile in my face. I don't worry about that, you know?...because I've got mental toughness. If you're tough and you don't let people see on the outside what is getting to you, [that is good mental health]. . .. Well, I might be sad, I might be crying on the inside right now, but you can't tell. . .'

Other responses to the question included: *'stability and making good decisions;' 'whether you're crazy or not;'* and *'making smart choices about your health.'* One undergraduate psychology student reflected on how much power the mind has over the body. He felt that the health of an individual is determined by their thinking pattern (*'If you think you're going to get sick, you'll*

get sick but if you think healthy, then you'll stay healthy.'*) Interestingly, other participants in this focus group defined mental health by highlighting specific mental illnesses and disorders, such as schizophrenia and bipolar disorder. Others defined mental health by talking about self-esteem and depression. For example, one participant stated:

'Depression can get drastic. Low self-esteem leads to depression, but it doesn't necessarily have to go to the low points that depression does.'

Overall, participants were very open to discussing mental health and kept their definitions clear and concise (e.g. *'I think mental health is just your state of mind'* or *'I think mental health is who you become after the world changes around you'*). Quite a few were psychology majors and demonstrated their comfort with discussing some of the same topics that emerged in their classrooms. While discussing mental health, participants frequently mentioned 'depression,' as many of their definitions for the two were synonymous. Although the facilitator probed the participants to talk about depression *and* anxiety, their knowledge, attitudes, and beliefs about depression dominated the discussions.

What is depression?

When participants were asked *'what is depression?'* some provided a definition of the word while others identified signs and symptoms. Responses were frequently tied to their attitudes about society's image of Black men, and the role of social support in combating depressive symptoms. An undergraduate kinesiology major said:

'Depression could be a disease; it could be treated. I wouldn't call a guy weak [if he felt depressed] I would just think that he is at one of his weaker moments. That is why we need a support group. If I saw somebody depressed, or thought they were depressed, you know, I'd try to help them. If they didn't want to talk, I'd try some sort of way to get them help. I mean, people who are depressed they don't always think they're depressed. They just think, "Yeah, well you know, I'm just kind of dealing with some things. Let me be." So you being a black man, you know you gotta be macho. You gotta be strong, got to handle all this...it's the attitude that we've been raised to have. Society has only verified that, but that's just kind of how we are.'

In another focus group, an undergraduate biology major defined depression as something that encompasses all of one's emotions and behaviors:

'When I think about depression, you know, I think about something that kind of supersedes all of your emotions...when you're depressed, you can't sleep well...sometimes you don't eat.... I know when I'm depressed I really don't pay that much attention to stuff....'

While several participants shared periods of their lives when they believed they may have experienced depression, many affirmed that they do not let things 'get to that point.' A Masters student in biology shared a time when he believed he was challenged with depression:

' [W]hen I first went to college and had a real serious athletic injury, they wanted me to go see a psychologist because they thought I was depressed...come to find out, I really was depressed. I think what helped me to get over my depression was the support that I got from one of my coaches and some of my friends on the football team.'

This personal account was well-received by others in the focus group, as evident by their nods in agreement. It was particularly acknowledged by the undergraduate students in the group as they then discussed the importance of social support for Black men. Facilitator notes revealed that when the undergraduate participants appeared uncomfortable during discussions about depression at the PWI, the graduate students provided verbal and physical support for them, in the form of words of encouragement and pats on the back, respectively. For example, in a different focus group a Masters student in health education reassured the others in his group that depression is very common with statements such as, 'I guarantee everybody in here has experienced a mild case of depression.' Similarly, a Masters student in environmental health offered his support with more encouraging words:

'I think depression can be beaten, honestly. I don't think you have to be in a depressed state if you think about all the good things that are happening to you. A lot of people tend to focus on the negative....'

Several participants defined depression as feelings of 'sadness;' 'loneliness,' 'hopelessness,' 'guilt,' 'worthlessness,' 'pity,' 'fear,' and 'worry,' and agreed these terms not only derived from personal experiences, but television commercials.

'I've known some depressed people and I've seen some of the symptoms that they show on the commercial. You see them crying or trying to look for someone to build them up. They're always looking for someone else's opinion or someone else to approve of them.'

Participants in this group defined depression as '...always feeling down and never being able to build yourself back up on your own.' They described ways in which they have tried to overcome their depression so that others would not recognize it as a problem. According to one psychology major, this reaction is innate for Black men, as he admitted to instinctively concealing his depression from time to time. *'I think everybody has done something to cover up their depression. Nobody wants to walk around showing that type of emotion on their sleeve.'* Likewise, another interesting topic that emerged was that of depressive symptoms in Black men compared to those in men and women of other races/ethnicities. For example, participants at both institutions believed that symptoms experienced by Black men are different than those of White men. An undergraduate kinesiology student noted:

'Our depression is not the same as everybody else's depression. You don't have time to be sad, because you have too much to worry about. You're supposed to be the Black man, take care of everything. You can be depressed but not have the symptoms of depression that a normal person would [have]. I guess that "standard" of depression is not the same standard of depression that a Black man goes through.'

Comfort and frequency of discussions: searching for insight

There was a consensus regarding how comfortable the participants felt discussing their mental health and the frequency at which their mental health was discussed. While the men reported feeling very comfortable talking about their mental health, they admitted that they do not discuss it often because they fear others may think that they are weak or 'soft.'

Participants reported that although they do not talk about their mental health often, when it *is* discussed it is expressed in culturally-rich jargon, or slang, such as their need to be 'straight,' 'hard,' 'come real,' 'hold it down,' and not be 'messed up.' While several participants used formal mental health terminology (or, terminology common to mental health professionals) during the discussions, they admitted that they were only using this verbiage because they were in a 'formal' setting with the focus group facilitator; and that ultimately, they do not use this language in their everyday lives. Common day-to-day phrases used to describe their poor mental health are 'turning back,' 'getting beat,' and 'letting the "man" have the upper hand.' Furthermore, men disclosed that they do not talk about their mental health often because expressing their mental health challenges to another individual may place them at a point of vulnerability, much like the men who participated in the USPHS Syphilis Study at Tuskegee (formerly known as the Tuskegee Syphilis Study) from 1932–1972. A Masters student in environmental health stated:

'I think it stems from the Tuskegee experiment. Are ya'll familiar with that? How they mislead the Black man with the whole experiment. [Black men] don't feel comfortable speaking about [mental health], even amongst ourselves because we've been mislead altogether as far as health goes.'

So as to not place themselves at a point of vulnerability, participants at both campuses acknowledged that they try to maintain the reputation that precedes them, that 'Black men are tough.' According to the participants, this reputation is one that is instilled in them during childhood and reinforced by society during adulthood. Many of them indicated that they do not want society to know their weaknesses because society can use these as weapons against them. Participants also noted that due to the image Black men have, they are less likely to seek help for their mental health problems and concerns. Participants at the PWI stated that Black students who attend a PWI, especially, should have mental health resources available to them and utilize these resources, as challenges may arise for a Black student at a predominately white university. Although they admitted to actively concealing their emo-

tions, the participants stated that Black people *'shouldn't keep things bottled up'* and agreed that it is important for everyone (not just Black men) to have access to healthcare professionals. They stated that Black men do not seek help because of the stigma attached to seeking medical care in the Black community as well as the pride that is instilled in Black men by their communities. Interestingly, a political science major disclosed that he sought professional help for his problems; however he quickly provided rationale for why he chose this avenue:

'I'm not going to lie, my sophomore year I had a therapist. You tell people you have a therapist and you're Black, that's unheard of. But I'm still seeing a therapist today because [there is] a lot of stuff you can't go see your boys about. . .. I guess what I'm looking for is an objective opinion; like that ambiguity of someone I don't know. And that's why a lot of people do choose a therapist. I think it's starting to become more popular among Black people. But still, you don't tell people you see a therapist.'

Others in this focus group agreed that seeking help was important but, unlike the young man above, were not aware of the help available to them. Participants noted that Black men should seek professional help for mental problems, but discount the importance of professional help because they have been taught to handle problems on their own, a strategy that may be inoperative for some Black men. While the men entertained counseling as an option, they also noted that having someone to talk to (particularly a non-White individual) would be most helpful to them. Several graduate students in the study agreed that a major problem with Black people is that they do not know when to seek help, if it were ever needed. Paternal influence emerged as a theme during this discussion with many of the participants referencing their fathers and grandfathers as the individuals after which their behaviors are modeled. For instance, if a Black man's father encouraged him to express his feelings to others then he is more apt to do so. Or as a Masters student in health education explained,

'Let's say your dad, for instance, was very open with himself. . .then you'll probably be more prone to do so with some of your homeboys. I think it might have been one time that I've seen

[my dad] cry…he was off in the corner doing it then. When I went up to him, he shook it off like it was nothing. From that [moment] I adopted that whole [tough man] mentality.'

Findings from both institutions were comparable, as participants agreed that Black men do not seek professional help as often as they should; however, the men noted that seeking professional help is a challenge for Black men because it is not a 'typical' approach to handling problems in the Black community. Instead, non-verbal coping mechanisms were identified (e.g. participation in music, art, sports, etc…) as ways in which the Black men in this study deal with their problems. Likewise, participants identified self-concealment as a more characteristic approach for Black people.

To probe deeper into the comfort Black men have discussing their mental health, focus group participants were asked to talk about the frequency at which they converse about their mental health with others. When the question '*how often do you talk about your mental health with others?*' was posed to the participants, there were mixed responses. Respondents affirmed that they do not discuss their mental health often because: it places them at a point of vulnerability; their families did not encourage them to discuss it; they do not want their peers to think that they are 'soft;' and they do not believe others will understand them. Furthermore, participants reported that they do not talk about their mental health however, they would like to increase their mental health knowledge so that they could discuss it more often. One advanced psychology student noted that although he feels comfortable talking about his mental health, the conversation never transpires:

'*[Shoot]. Nobody ever asks me.*'

Similarly, another participant in the same focus group said:

'We don't express it a lot because we feel like we are already on the bottom because we're Black and so showing everyone in the world that you may not be stable in your mind is just out of the question. You can't let them think that something is wrong with you because you already got so many things against you because you're a Black man.'

Participants at both institutions reported that Black men are not 'open' about their emotions. Some participants believed that this is due to the media's role in creating negative images of Black men; moreover, they agreed that coping with stress is a learned behavior that Black people must endure and have endured for decades. This behavior is almost innate, or as one participant explained, it is passed down from generation to generation:

'It's roots. The point of the Black culture is this: we're still here after everything, we've survived…. Black people don't have that level of weakness.'

Also noteworthy is a comment made by an advanced psychology student who believes that Black people are comfortable discussing their mental health because '*they do not have mental problems*' like other races. On several occasions this participant denied that Black people have mental problems, and used this as a response to six different questions posed by the facilitator. He began this advocacy when the focus group facilitator asked if the participants agreed with the idea that Black men do not seek help because they do not want people to know their weaknesses and continued to use this response for other questions during the discussion. Other members of the focus group agreed with this participant and added that everyone has problems so they, as Black people, should not complain. '*Why not just deal with it?*' one participant shrugged. It was avowed that if Black men begin to reveal their problems then they may '*let too much out.*' If this occurs, then there is a chance that they will get hurt. Another participant simply said '*If you come off being too kind then someone will try to take advantage of you.*'

Discussion

Previous studies have highlighted the barriers that prevent Black men from having positive therapeutic outcomes, specifically, cultural mistrust, unwillingness to self-disclose, counselors' insensitivity to Black male issues, and inadequate training [21]. Providing services for Black men will continue to present challenges unless health professionals strive to ensure that Black men are comfortable with discussing their mental health in a safe and secure

environment. The present study extends this research by examining young Black men's knowledge, attitudes, and beliefs about mental health. This study also fills a gap in the literature by exploring Black men's comfort with discussing personal issues related to their mental health.

First, the present study examined how young Black men define *mental health* and *depression*. Participants defined mental health as having *'sound peace of mind,' 'the ability to see past the present moment,' 'making smart choices about your health,'* and being *'crazy.'* The men provided definitions for mental health and depression based on their personal accounts and provided the origin for their stoic responses to stressors, mainly described in the context of their families and communities. When participants were asked to define depression, responses were *'when you let your circumstances get the best of you,' 'being unproductive,'* and *'sadness, loneliness, guilt, and pity.'* Black male participants defined depression using prescribed terminology adopted from the media and relied on signs and symptoms to conceptualize their knowledge, attitudes, and beliefs surrounding the illness. The men reported that their understanding of depression and many other mental illnesses and disorders were ascertained from personal experiences and television, a mechanism that has increased the exposure of mental health issues to the public [22]. Exposure to mental health topics that are more openly discussed on television, radio, and the Internet may be responsible for the ease with which the men in this study shared their mental health knowledge and beliefs. Future studies should consider this hypothesis and the effectiveness of the Internet in providing mental health information to young Black men just as Cousineau et al. [23] highlighted the importance of using the Internet for nutrition education among college students.

Second, this study sought to understand the level of comfort and frequency of mental health discussions among the Black male participants. Though participants at both institutions attempted to define depression based on the media's characterization of the word, they also reported that Black men experience depression differently than White men. Participants believed that how Black men define and express depression may manifest itself in

terminology and behaviors that are unfamiliar to health professionals. Despite this discussion, focus group participants still attempted to articulate their knowledge about mental health in a way that they believed was suitable for the focus group setting – that is, using 'formal' mental health terminology. While participants expressed their understanding of mental health using verbiage comparable to that of the DSM-IV criteria, they also acknowledged that when they talk about mental health amongst themselves, they use culturally-rich jargon, or slang. Findings from this study revealed alternative expressions of mental health used by young Black men that may be overlooked by the mental health researchers and practitioners who study and provide services to them. For example, Black men in this study expressed poor mental health as *'getting beat'* and good mental health as *'holding it down.'* Participants believed that this culturally-rich jargon may be undetected by and uncomfortable for health professionals. These findings also raise important questions about how the mental health terminology used by participants in the focus group setting compares to the slang they use during more informal settings. This notion, as well as the effectiveness of mental health programs grounded in the 'Black male articulation' of mental health, should be explored in future research. Davis [24] recognized the need for culturally-appropriate, gender-specific health promotion programs and disease-specific interventions for Black men. Likewise, Rich affirmed that 'the development of health education messages that are culturally appropriate and empower young men to care for their health, coupled with accessible healthcare services, are important steps toward improving the health of college-aged African American men' ([25]:186).

Findings from this study also raise important questions about the mental health literacy of young Black men. The need for mental health education was apparent through the focus group discussions. Participants expressed interest in learning more about mental disorders so that they can easily identify them in their family and friends. Participants also stated that while they feel comfortable talking about their mental health, they rarely engage in these conversations because it places them at a point of vulner-

ability in society. This concern emphasizes the need for more work with mental health stigma, particularly in Black Americans. Another theme that emerged during focus groups was the role of the Black family unit in the health knowledge and behaviors of young Black men. Several participants revealed that they model their health behaviors after the men and women in their families. Specifically, the men stated that they were not encouraged by their families and friends to express their knowledge, attitudes, and beliefs about mental health to others. This theme has implications for future studies that highlight the influence of family health practices on the individual health behaviors of young Black men and women. The idea that Black people do not have mental health problems because they are 'stronger' than individuals of other races also emerged from this study and is present in the mental health stigma literature [26,27]. Similarly, participants illustrated a strong behavioral predisposition to cope actively with psychosocial environmental stressors, or characteristics of the John Henryism hypothesis [28]. These findings are aligned with those of Black Americans and high-effort coping [29,30] and have implications for future work conducted with young Black men and the John Henryism hypothesis.

Issues of masculinity emerged from the focus group discussions. For example, participants reported that Black men think that they are 'super tough' and have the responsibility of being 'hard,' 'holding it down,' and not being 'messed up.' Research [31–33] has demonstrated that Black men are more likely than men of other groups to endorse traditional attitudes about masculinity, therefore, issues of masculinity and young Black men should be the topic of future studies. While the language used by Black college men may be unfamiliar to health professionals, it should not be overlooked during the assessment, design, implementation, and evaluation of health promotion programs for this population. Our understanding of the vernacular used by Black men will provide health professionals with the insight to help improve the communication between Black men and health services staff. Our goal should be to ensure that young Black men not only feel comfortable discussing their mental health, but that they also become more receptive to the appropriate services that improve and maintain their mental health.

This study used qualitative methodology to consider the complexities of the Black male experience that larger studies do not afford. The qualitative methodology in this study also offers the perspective of the participants and what they deem important, rather than what the researchers deem important *a priori*. Although results from this study are not conclusive, they do offer access to the cultural and gendered context of Black men. A logical next step in this research is the formulation and analysis of questionnaires that include more representative samples of Black men. While young men are probably not in need of as many health services as young women, they are still less likely than women to seek health care [34]. Thus, any encounter between a health professional and a young man has been noted as a vital opportunity for assessment and intervention [35], as these encounters are limited over time. Studies suggest that health professionals who ask, educate, and counsel people about their personal health behaviors are more likely to attract individuals in need than those who perform physical examinations or tests [31]. Therefore, college health professionals are placed in an imperative position to impact the lives of young Black men.

Limitations

Findings from this exploratory study are useful in that they build on the knowledge, attitudes, and beliefs of Black men with regard to their mental health. Despite the importance of these findings, its limitations should be noted. First, several focus group participants were psychology majors so the psychological terminology used in this study may have been more familiar to some than it was to others. Another limitation involves the prevalence of mental health/mental illness stigma in the Black community, which may have led to participants' limited willingness to disclose more information in a group setting. The use of focus groups in this study evokes limitations that are common with this method of research. For example, the participants may be influenced by each other or be reluctant to disagree with opinions put forth during the discussions. Also due to the nature of focus group research, participant responses may not necessarily represent their

individual opinions. Future qualitative and quantitative studies with Black men will help reduce the likelihood of presenting biased group responses as homogeneous. Finally, participants may have been a biased sample of young Black men at each institution and generalization beyond this study may present challenges. Apart from its limitations, the findings from this study should be considered a valuable contribution to the body of literature.

Conclusions

Establishing successful relationships with Black men begins with increasing our knowledge about their understanding of mental health and their comfort with discussing it. The present study presents a foundation upon which other studies that address similar issues with Black men can be constructed. Several themes that emerged from this study were consistent with existing literature, though a few areas have not been addressed or raised questions about prior research. Efforts made toward providing information and services to

Black men will not only benefit their health during their college years, but also subsequent years following their post-secondary education. As we continue on a path to improve the overall quality of life of Black Americans, the Black college-aged population should not be overlooked in our efforts. If we increase our knowledge about the mental health of young Black men our programs aimed at improving their health and overall quality of life will be more effective.

Acknowledgements

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