EXPLORING MENTAL HEALTH SCREENING AND LINKAGE TO CARE AMONG YOUNG AFRICAN AMERICAN MEN

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ABSTRACT

Young Black/African American men are at greater risk for trauma compared to young non-Hispanic White males, which increases the risk of mental health concerns and risk behaviors. However, young Black/American men are less likely to seek mental health screening and linkage to care (LTC) services than other racial/ethnic groups. The purpose of the current study was to use a Theory of Planned Behavior (TPB)-guided framework to qualitatively explore attitudes, norms, control beliefs, and intentions related to seeking mental health screening/LTC among Black/African American men aged 18-30, who had experienced trauma. Participants (N = 55) had an average age of 23 years (SD = 3.9) and had experienced an average of two to three traumatic events (SD = 2.2), most commonly being threatened with a weapon and loss of a loved one. Focus groups elicited behavioral beliefs that there is a need to normalize mental health, services can be effective, and mental health providers can provide an objective perspective. However, participants also strongly believed that to engage in screening/LTC required individual effort and there is no guarantee that providers can help. Key normative referents were significant others, family, friends and peer groups, faith-based organizations, and employers. Participants endorsed greater motivation to seek screening/LTC with the support of others. Control beliefs ranged from individual and

interpersonal facilitators and barriers (e.g., knowledge of where to go, establishing a therapeutic relationship) and more systemic factors (e.g., availability of providers, cost, lack of access, disparities in incarceration). Findings have potential to inform development of culturally tailored, relevant intervention to promote engagement in mental health services among high-risk young adults. This study also could be a valuable resource for researchers and clinicians seeking to more effectively address trauma-related outcomes among urban youth.

APPROVAL PAGE

The faculty listed below, appointed by the Dean of the College of Arts and Sciences, have examined a dissertation titled "Exploring Mental Health Screening and Linkage to Care among Young African American Men" presented by Alexandria Gabrielle Bauer, candidate for the Doctor of Philosophy degree, and certify that in their opinion it is worthy of acceptance.

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CHAPTER 1

INTRODUCTION

The American Psychological Association (APA) has estimated that more than 65% of children and adolescents will experience a traumatic event (e.g., abuse, community violence, disaster) before they are 18 years old (La Greca et al., 2008; McLaughlin et al., 2013; Stein, Jaycox, Kataoka, Rhodes, & Vestal, 2003). Trauma can be differentiated from other stressful life events (e.g., divorce, job loss), as traumatic experiences center on those that are life threatening or involve risk of serious injury (Hatch & Dohrenwend, 2007; McLaughlin et al., 2013). Many studies of adverse experiences have defined traumatic events in accordance with the Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5; American Psychiatric Association, 2013) focusing on potentially injurious or fatal experiences happening to oneself or to loved ones (e.g., Boyraz, Horne, Armstrong, & Owens, 2015; Kilpatrick et al., 2013; McLaughlin et al., 2013; Roberts, Gilman, Breslau, Breslau, & Koenen, 2011; Salazar, Keller, Gowen, & Courtney, 2013).

Trauma Disparities

Studies have demonstrated greater risk of exposure to trauma for racial/ethnic minorities, although findings vary by study and type of trauma considered (e.g., Hatch & Dohrenwend, 2007). For instance, Whites were more likely to report experiencing any type of trauma compared to African Americans in adult samples (Roberts et al., 2011) and among young adults in foster care (Salazar et al., 2013). Overstreet and colleagues found no difference in frequency of overall trauma exposure between African American and White college students (2017), although other studies have documented higher rates for African

American students (74%) compared to White students (68%; Boyraz et al., 2015). Even greater disparities have been reported between African American adolescents and their White peers (75% vs. 63%, respectively; Andrews et al., 2015). Young adult African American males may be particularly likely to experience trauma. A sixteen-year review of the trauma literature conducted by Hatch and Dohrenwend (2007) concluded that trauma was most common among men, younger populations, and racial/ethnic minorities. Exposure to violence is also more likely for adolescents who spend more time in settings that are unstructured, unsupervised, and/or consist only of peers (Richards et al., 2004), which is a common occurrence for many young African American men from poor or urban neighborhoods (Butcher, Galanek, Kretschmar, & Flannery, 2015; Harrell, 2007; Seal, Nguyen, & Beyer, 2014).

For young Black/African American men, these traumatizing events tend to begin in early childhood and can repeat or escalate throughout development into young adulthood (Rich & Grey, 2005; Richardson, St. Vil, Sharpe, Wagner, & Cooper, 2016; Seal et al., 2014; Smith, 2015; Smith & Patton, 2016; Smith, 2014). For instance, studies of urban, adult African American men found that more than half of participants (58%) reported repeated hospitalization due to violent injury (Richardson et al., 2016). African American college students were more likely to report multiple instances of trauma than White students (66% and 61%, respectively; Boyraz et al., 2015). Furthermore, among African American students who experienced trauma, participants were more likely to report multiple experiences (66%) than a single traumatic experience (34%; Boyraz et al., 2015). Repeated victimization is particularly common for young African American men from low socioeconomic status (SES), urban communities, where rates of community violence and related crimes tend to be

highest (Davis, Ressler, Schwartz, Stephens, & Bradley, 2008; Harrell, 2007; Hatch & Dohrenwend, 2007; Herrenkohl, Jenson, & Catalano, 2014; Kearney, Harris, Jácome, & Parker, 2014; Papachristos & Wildeman, 2014; Royster, Richmond, Eng, & Margolis, 2006; Samuel, 2015).

Types of Trauma among Young African American Men

Younger African American men (below 24 years of age) are also at greater risk for exposure to several types of trauma than African American men aged 25 and older, or African American women (Harrell, 2007). Focus groups with 18-24 year old African American men from urban areas found that 100% of participants had witnessed a violent incident in their neighborhood (Smith & Patton, 2016). A nationwide survey reported that compared to White male high school students, African American male high school students were more likely to be threatened with a weapon on school property, in a physical fight on school property or elsewhere, and injured in a physical fight (Eaton et al., 2012). African American male college students were also more likely than White male students to report being threatened with a weapon, as well as being robbed or mugged, experiencing a serious injury or threat to one's life, and witnessing an assault or murder (Boyraz et al., 2015). Several studies have also reported on unexpected deaths of family members or friends as a frequent traumatic experience among African American adults, and young African American men aged 15 to 24 (Alim et al., 2008; Davis et al., 2008; Samuel, 2015; Smith, 2015; Smith, 2014), particularly compared to young White men of a similar age (Boyraz et al., 2015; Rheingold et al., 2003). In focus groups, African American men aged 18-24 reported knowing an average of three homicide victims, primarily peers (Smith, 2015). Early attention is needed to help young urban African American men who experience trauma, particularly

when experiences are recurrent or escalating, to manage the mental health impact of these life events.

Trauma and Mental Health

Exposure to traumatizing events increases risk for developing mental health issues (Voisin, Patel, Hong, Takahashi, & Gaylord-Harden, 2016; Wolff & Shi, 2012), including posttraumatic stress disorder (PTSD) and depression (Butcher et al., 2015; Myers et al., 2015; National Alliance on Mental Illness, 2017; Smith & Patton, 2016; Stimmel, Cruise, Ford, & Weiss, 2014). Prevalence of PTSD was over 50% among adult African Americans who experienced trauma (Alim, Charney, & Mellman, 2006), and recent studies have demonstrated a link between exposure to trauma and mental health concerns among diverse adolescents (Salazar et al., 2013), including distress and symptoms of depression and anxiety (Kilpatrick et al., 2013; Overstreet et al., 2017). Furthermore, African American boys aged 13-16 who had been exposed to violence were significantly more likely to report symptoms of depression and posttraumatic stress (Paxton, Robinson, Shah, & Schoeny, 2004), and focus groups of African American men aged 18-30 who had experienced trauma showed that 65% of participants met criteria for PTSD, particularly hypervigilance (Rich & Grey, 2005; Seal et al., 2014; Smith & Patton, 2016). Trauma exposure may also increase risk for depression among young African American men (Smith, 2014).

Mental Health Disparities

A recent review found that rates of diagnosed PTSD among adult African Americans (9%) were only slightly higher compared to Whites (7%; Sayed, Iacoviello, & Charney, 2015). However, adult African Americans with PTSD have also demonstrated greater severity and functional impairment compared to Whites with PTSD, and African Americans

with other anxiety disorders (Alegría et al., 2013; Benítez et al., 2014; Himle, Baser, Taylor, Campell, & Jackson, 2009; Roberts et al., 2011; Sayed et al., 2015). National studies have demonstrated that young African Americans aged 12-17 are more than twice as likely to be diagnosed with PTSD compared to their White peers, with risks increasing throughout young adulthood (Andrews et al., 2015; Kilpatrick et al., 2003). This is particularly true for African American adolescents and young adults in low-SES, urban environments (Alim et al., 2008), where young African American men aged 13-24 with greater trauma exposure were nearly three times as likely to report poor mental health compared to their peers with less trauma exposure (Voisin et al., 2016).

Similarly, rates of depression have risen across most racial/ethnic groups, but adult African Americans were more likely to rate their depression as severe or very severe compared to Whites (74% and 64%, respectively; Williams et al., 2007). Furthermore, 57% of African Americans with a lifetime mood disorder also met past 12-month criteria compared to 39% of Whites, representing greater duration of depression (American Psychological Association, 2018; Mays et al., 2018; Williams et al., 2007). Additional studies have shown that African Americans were less likely to report major depressive episodes, but more likely to report long-term dysthymia than Whites (Jonas, Brody, Roper, & Narrow, 2003). Compared to African American men aged 55 and older, young African American men aged 18-30 were more likely to experience depressive symptoms, serious psychological distress, and twelve-month major depressive disorder (MDD; Alim et al., 2006; Lincoln, Taylor, Watkins, & Chatters, 2011; Mouzon, Taylor, Nguyen, & Chatters, 2016).

Trauma, Mental Health Conditions, and Related Outcomes

Trauma and untreated mental health symptoms have been linked to poor outcomes for young African American men, such as substance use (Rich & Grey, 2005; Smith & Patton, 2016; Voisin et al., 2016). For instance, among focus groups of African American male college students (aged 18-25), several participants reported alcohol or drug use to cope with stress and depressive symptoms (Kendrick, Anderson, & Moore, 2007), with similar findings among trauma-impacted African American adults (Cross, Crow, Powers, & Bradley, 2015) and men aged 18-30 (Rich & Grey, 2005). Young African American men have also demonstrated more prevalent substance use comorbid with depression (19%) compared to similar age groups of non-Hispanic Whites (12%) and Hispanics (10%; Compton, Conway, Stinson, & Grant, 2006; Cross et al., 2015).

Trauma exposure and posttraumatic stress symptoms have also been linked to increased likelihood of acquisition of weapons, retaliatory attitudes, and perpetration of violence (Carter et al., 2013; Eitle & Turner, 2002; Rich & Grey, 2005; Rich & Stone, 1996; Richardson et al., 2016; Ruback, Clark, & Warner, 2014). African American men aged 30 and over who had experienced trauma in adolescence were nearly four times as likely to be involved in recent street violence and three times as likely to perpetrate interpersonal violence, both within the past six months (Reed et al., 2013). Several qualitative studies of African American men aged 18-30 have described these behaviors as a means of self-protection or to avoid looking weak or vulnerable, which has the potential to invite further assault or violence (Rich & Grey, 2005; Rich & Stone, 1996). Furthermore, these behaviors may be perceived as necessary, due to mistrust that police officers will assist in resolving escalating conflicts (Brunson, 2007; Rich & Grey, 2005). These outcomes may be

particularly difficult for young African American men who are unable to relocate from their current neighborhoods (Rich & Grey, 2005), which has been discussed in focus groups of young men and families in urban communities (Richardson, Brakle, & Vil, 2014; Smith, 2015).

Exposure to trauma and mental health concerns also contribute to involvement in the criminal justice system (Jäggi, Mezuk, Watkins, & Jackson, 2016; Richardson et al., 2016; White, 2016). Greater exposure to trauma has been associated with an increased likelihood of arrest and incarceration among African Americans (Jäggi et al., 2016), and the latter was more common for African Americans with PTSD (Jäggi et al., 2016). Young African American men with mental health concerns were more likely to be incarcerated than young White men with or without mental health concerns (White, 2016).

A Bureau of Justice Statistics report found that African American men are disproportionately imprisoned compared to White men, particularly in young adulthood (Carson, 2015). Furthermore, at 18-19 years old, African American men are more than ten times as likely to be in prison than White men of the same age. Although rates decrease throughout adulthood, from 30-39 years of age African American men continue to be nearly six times more likely to be incarcerated than White men in this age group. Juvenile incarceration has also been associated with increased risk of adult incarceration by age 25 (Kearney et al., 2014), and focus groups of African American men have elicited specific concerns about how incarceration could impact their future, including limited employment and stigma (Royster et al., 2006).

Trauma-related mental health symptoms are associated with increased risk of trauma re-victimization (Reed et al., 2013; Rich & Grey, 2005; Richardson et al., 2016), as well as

suicide and homicide. Recent studies indicate that African American adolescent and young adult males are less likely than non-Hispanic whites to die by suicide; however, they are more likely to attempt suicide before graduating high school (7.2% and 3.7%, respectively; Office of Minority Health, 2017) and to require medical attention after an attempt (Eaton et al., 2012). Suicide is the third leading cause of death for young African American males (Centers for Disease Control and Prevention, 2017), and they have a higher rate of suicide compared to African Americans at any other age (Crosby & Molock, 2006). Additionally, young African American men who have sex with men (MSM) are at particularly high risk for trauma, posttraumatic stress symptoms, and suicide (Fields et al., 2013; Koblin et al., 2006; Liu & Mustanski, 2012; Roberts, Rosario, Corliss, Koenen, & Austin, 2012).

Additionally, African Americans are six times as likely to be homicide victims than Whites (Cooper & Smith, 2011; Fox, 2006), and the Centers for Disease Control and Prevention (CDC) has estimated that African American males aged 15-24 were at greatest risk for homicide compared to younger ages and other racial/ethnic groups (David-Ferdon, Dahlberg, & Kegler, 2013; Lo, Howell, & Cheng, 2013). Furthermore, homicide is the leading cause of death for African American males, aged 18-30 (Centers for Disease Control and Prevention, 2017; Rich & Grey, 2005; Smith & Patton, 2016). Clearly, it is crucial to get young African American men early diagnoses and treatment services, as needed, in order to target trauma-related mental health outcomes.

African American Mental Health Treatment Disparities

Despite the mental health disparities and poor outcomes that burden African Americans, national studies have demonstrated that adult African Americans are less likely to receive mental health services compared to Whites (40% and 54%, respectively; González

et al., 2010). African American adults also perceived less need for mental health treatment (Breslau et al., 2017) and that those who did perceive need for services were significantly less likely to engage in services (Ault-Brutus & Alegria, 2016). Among African Americans with PTSD, only 13% received treatment (Davis et al., 2008). Also, as few as 37% of African American adults with mood and anxiety disorders received any kind of mental health treatment (Ault-Brutus & Alegria, 2016; Williams et al., 2007), and they were significantly more likely to receive inadequate depression treatment or no treatment at all compared to Whites (Alegría et al., 2013). African American men and women are also more likely to discontinue treatment compared to Whites (Fortuna, Alegria, & Gao, 2010; Mays, Jones, Delany-Brumsey, Coles, & Cochran, 2017). African American veterans show similar patterns of mental health care, with increased risk of mental health concerns but poorer access to care (Cohen & Glover, 2013; Jones et al., 2016).

African American men in particular are nearly 50% less likely to receive mental health treatment than White men (Ault-Brutus & Alegria, 2016; National Alliance on Mental Illness, 2017; Neighbors et al., 2007; Office of Minority Health, 2017; Ojeda & McGuire, 2006; Roberts et al., 2011), and they are less likely to seek mental health services than African American women (Alim et al., 2008; Holden, McGregor, Blanks, & Mahaffey, 2012; Plowden, Adams, & Wiley, 2016; Roberts et al., 2011). A recent study showed that among African American men who met criteria for a mood, anxiety, or substance use disorder in the previous year, only 27% sought mental health treatment (Mays et al., 2018).

Young African American men have displayed the least propensity toward use of mental health services compared to young African American women, and African American men and women of other ages (Green et al., 2014; Ward, Wiltshire, Detry, & Brown, 2013).

Young African American boys and men are less likely than their young White peers to utilize mental health services (Lu, 2017; Malhotra et al., 2015) including outpatient, school-based, residential, or general medical settings (Barksdale, Azur, & Leaf, 2009; Costello, He, Sampson, Kessler, & Merikangas, 2014) even when they had a psychiatric diagnosis (Costello et al., 2014; Cummings & Druss, 2011; Merikangas et al., 2011; Scott, Munson, McMillen, & Snowden, 2007). Furthermore, African American men aged 18-29 showed low perceived need for mental health services, and they were less likely to seek mental health services compared to African American females in this age group (Williams, 2014).

Barriers to Seeking Mental Health Services

Studies have identified several key barriers to seeking mental health services for adult men, including stigma and masculinity (Clement et al., 2015; Vogel, Heimerdinger-Edwards, Hammer, & Hubbard, 2011; Yousaf, Grunfeld, & Hunter, 2015). African American men face additional barriers, including cost and difficulty accessing services, lack of transportation, hesitation to discuss psychological concerns, others' negative experiences, racism or discrimination, and issues with therapeutic alliance (e.g., mistrust, poor communication, feeling misunderstood; Davis et al., 2008; Hankerson, Suite, & Bailey, 2015; Marsh & Wilcoxon, 2015; Powell, Adams, Cole-Lewis, Agyemang, & Upton, 2016; Sanders Thompson, Bazile, & Akbar, 2004; Ward et al., 2013; Ward & Besson, 2012). Similar barriers have been identified among diverse young adults, as well as fear of labels (e.g., "crazy") and difficulty recognizing or acknowledging mental health symptoms (Gulliver, Griffiths, & Christensen, 2010; Lannin, Vogel, Brenner, Abraham, & Heath, 2016; Vidourek, King, Nabors, & Merianos, 2014; Wilson & Deane, 2001).

Young African American men may face the greatest number of barriers to mental health services, including intersectional barriers typically faced by men, African Americans, and young adults (Lindsey, 2010; Lindsey, Barksdale, Lambert, & Ialongo, 2010; Lynch, Long, & Moorhead, 2018; Wallace & Constantine, 2005; Watson, 2014). In addition, systemic, multilevel barriers to mental health services exist for young African American men (Davis & Ford, 2004; Lindsey, Brown, & Cunningham, 2017; Lindsey & Marcell, 2012; Meyer, Saw, Cho, & Fancher, 2015; Seal et al., 2014; Watson, 2014). On an individual level, several studies have highlighted young African American men's preference for self-reliance for identifying and coping with mental health concerns (Al-Khattab, Oruche, Perkins, & Draucker, 2016; Holden et al., 2012; Kranke, Guada, Kranke, & Floersch, 2011; Lindsey, 2010; Lindsey, Joe, & Nebbitt, 2010; Lindsey et al., 2006; Matthews, Hammond, Nuru-Jeter, Cole-Lewis, & Melvin, 2013; Samuel, 2015). For instance, focus groups of African American men aged 18-26 elicited beliefs that Black men should be strong and tough enough to overcome mental health problems (Watkins & Neighbors, 2007), which has been shown to inhibit likelihood of mental health care among young African American men (Scott, McMillen, & Snowden, 2015; Scott et al., 2007). Other qualitative studies have described shame and embarrassment associated with mental health concerns (Lindsey et al., 2006). Other key barriers among African American men aged 14-26 include mistrust of mental health providers (Lindsey, 2010; Lindsey, Joe, et al., 2010; Watkins & Neighbors, 2007), difficulty determining whether symptoms are severe enough to warrant treatment (Watson, 2014), and inability to describe symptoms (Holden et al., 2012).

Interpersonal barriers associated with seeking mental health services include stigma from friends and family toward mental illness and professional mental health services

(Kranke et al., 2011; Lindsey, 2010), fear of being misunderstood by others (Watkins & Neighbors, 2007), and perceived cultural beliefs and norms that high emotionality is a sign of weakness (Lindsey, 2010; Lindsey, Joe, et al., 2010; Lindsey et al., 2006; Wallace & Constantine, 2005; Watkins & Neighbors, 2007; Watson, 2014). Systemic barriers include economic disparities, racial injustice, and racism or discrimination (Seal et al., 2014; Sellers, Caldwell, Schmeelk-Cone, & Zimmerman, 2003; Williams & Williams-Morris, 2000), which can inhibit ability to leave high-risk, low-SES environments (Richardson et al., 2014) and perpetuate continuous exposure to community violence (Brown, Payne, Dressner, & Green, 2010; Rich, Marks, Corbin, & Ashley, 2018).

It has been recommended that mental health interventions consider the complex, intersectional nature of treatment barriers, including age, gender, race/ethnicity, SES, and context (Watkins, Mitchell, Mouzon, & Hawkins, 2017). Furthermore, researchers have called for investigations into the mental health needs of African American men by conducting purposeful discussions with members of this population (Watkins, Mitchell, et al., 2017), particularly given the potential for persistent tension or conflict in urban neighborhoods (Rich et al., 2018).

Barriers to Effective Engagement in Mental Health Services

Restricted expression of emotions and greater acceptance of posttraumatic and depressive symptoms may present a challenge for engagement in care (Alim et al., 2008; Cox, 2016; Reed et al., 2013; Smith, 2015; Smith & Patton, 2016; Watkins, Walker, & Griffith, 2010). Studies have demonstrated that young African American men are less likely to express symptoms of depression in a way that is apparent to others, as well as accepting symptoms of depression and posttraumatic stress as a normal part of life (Kendrick et al.,

2007; Ofonedu, Percy, Harris-Britt, & Belcher, 2013; Perkins, 2013; Seal et al., 2014; Watkins & Neighbors, 2007). Young African American men have also described feeling that the presentation of depressive symptoms among African American men is different, partially due to cultural experiences, than symptoms seen among White men or typical clinical populations (Kendrick et al., 2007; Watkins & Neighbors, 2007), which is also recognized by African American women (Watkins, Abelson, & Jefferson, 2013). These perceptions of mental health symptoms are supported by ethnographic studies of African American adults (Alang, 2016) and evaluations of depression screening tools among African American adolescents (Lu, Lindsey, Irsheid, & Nebbitt, 2018), which suggest the need to consider a different conceptualization for mental health symptoms among young African American men.

Studies have also discussed the potential for providers to underestimate symptoms or misdiagnose when assessing African American men (Adebimpe, 2004; Hankerson, Suite, et al., 2015; Payne, 2012; Schwartz, Bradley, Sexton, Sherry, & Ressler, 2005). This may be a particular challenge for providers who are unfamiliar with the scope of negative experiences of young African American men (e.g., economic disparities, racism and discrimination; Copeland, 2006; Perkins, 2013) that have potential to exacerbate mental health concerns (Alang, 2016; Kendrick et al., 2007; Ofonedu et al., 2013; Rich et al., 2018).

Concerns about being misunderstood or misdiagnosed by mental health practitioners have been discussed in qualitative studies of young African American men (Lindsey, 2010; National Alliance on Mental Illness, 2017), in which participants expressed a preference to talk to a non-White provider (National Institute of Mental Health, 2012; Watkins & Neighbors, 2007) or concerns about treatment effectiveness (Samuel, 2015). However,

participants in similar studies have stated a preference for a mental health provider who is able to relate to them and understand the context of their experiences and symptoms, regardless of the provider's racial/ethnic background (Lindsey, 2010; Lindsey et al., 2006). This is supported by recent recommendations for mental health providers, which emphasized culturally competent, patient-centered approaches when working with African American patients (Stevens-Watkins & Lloyd, 2010). Furthermore, recent studies of adult African American men have noted support for mental health treatment (Hudson, Eaton, Banks, Sewell, & Neighbors, 2018), and studies have highlighted the perception that professional mental health services can be helpful (Kendrick et al., 2007; Lindsey, 2010), with community-based interest in mental health education to increase knowledge and improve ability to describe and discuss mental health concerns (Watkins et al., 2013; Watkins & Neighbors, 2007).

Use of Alternate Coping Strategies

Focus groups of trauma-exposed young African American men found that they were more likely to use coping strategies that increased risk of polyvictimization (e.g., intentional hypervigilance, aggression, retaliation) than to seek mental health services (Ault-Brutus & Alegria, 2016; Rich & Grey, 2005; Ruback et al., 2014; Smith & Patton, 2016). It has also been suggested that African American men may use alternative support networks, such as family, friends, or faith-based organizations, to cope with mental health issues (Blank, Mahmood, Fox, & Guterbock, 2002; Bryant-Davis, 2005; Dalencour et al., 2017; Gulliver et al., 2010; Hankerson, Suite, et al., 2015; Lindsey, 2010; Lindsey et al., 2006; National Alliance on Mental Illness, 2017; Samuel, 2015; Sharpe, 2015; Sharpe, Joe, & Taylor, 2013; Ward et al., 2013; Young, Griffith, & Williams, 2003), although use of religion may not be

equally common among young African American men (Lindsey et al., 2006). Yet, use of these support systems has been associated with lower likelihood of seeking professional mental health services (Neighbors, Musick, & Williams, 1998; Wallace & Constantine, 2005).

Although some studies have described these sources of support as beneficial mental health resources (Young et al., 2003), there is little empirical research to validate their effectiveness (Hankerson & Weissman, 2012). Researchers have acknowledged potential for community-based mental health screening interventions to help identify at-risk African Americans (Hankerson, Lee, et al., 2015), with continued need for partnership between personal or community (e.g., faith-based) resources and professional mental health services (Blank et al., 2002; Dempsey, Butler, & Gaither, 2016; Taylor, Ellison, Chatters, Levin, & Lincoln, 2000). Interventions to promote awareness of mental health symptoms, screening behaviors, and engagement in care among young African American males are needed.

Mental Health Screening and Linkage to Care

Mental health screening is the first step in the continuum of care model. In 2016, the U.S. Prevention Services Task Forces recommended depression screening for general population adults and adolescents with MDD (Siu, 2016). Yet, the National Institutes of Mental Health (NIMH) recognizes the gap in access to mental health care for minorities and the need to understand how to engage minorities in care (National Institute of Mental Health, 2012). Very little attention has been given to mental health screening among populations that are highly underserved, especially young urban African American males. A review of mental health treatments for trauma-impacted youth (e.g., Trauma-Focused Cognitive Behavioral Therapy) found that they are effective at reducing mental health symptoms and problem

behaviors (Cohen, Mannarino, Murray, & Igelman, 2006; Lindsey, Banks, Cota, Scott, & Joe, 2018). However, there is little research on how to effectively reach young African American men for initial mental health screening or linkage to care (LTC) into focused, evidence-based mental health treatment that are recommended for disorders such as depression, anxiety, or PTSD.

Addressing Trauma among Young African American Men

Interventions to address trauma have primarily been designed to reduce violent behaviors among urban youth, especially gun violence (Bushman et al., 2016; Spano, 2012). Programs such as Cure Violence and their national partners (e.g., Aim4Peace, CeaseFire, Safe Streets) have effectively reduced community violence by training community leaders to identify, mediate, and disrupt potentially violent situations (Butts, Roman, Bostwick, & Porter, 2015; Whitehill, Webster, Frattaroli, & Parker, 2013). Interventions have also aimed to disrupt cycles of violence and retaliation by reaching young minority men immediately after trauma occurs while they are in hospitals and emergency rooms (e.g., "golden opportunity"; Butts et al., 2015; Cooper, Eslinger, & Stolley, 2006; Jacobson, 2015; Purtle et al., 2013). Other violence prevention programs have included training in social skills, conflict resolution, anger management, and decision-making; building ethnic identity; reduced access to guns, alcohol, drugs, or violent media; and education on gun and gang violence and dating violence (Bushman et al., 2016; Griffin, 2005; Hammond & Yung, 1991; Regan, 2009; Thomas et al., 2012; Ward, 1995).

Despite the success of these programs at decreasing community violence, these prevention interventions often do not promote needed mental health services. Specifically, community- and hospital-based violence prevention programs for urban, trauma-impacted

youth often do not aim to screen young men for mental health disorders or provide LTC into focused therapy. Existing mental health programs targeted for young African American men have focused on improving social support and resilience, rather than screening/LTC (Brown et al., 2010; Watkins, Allen, Goodwill, & Noel, 2017).

Few empirical mental-health screening/LTC programs exist for young adults, particularly including young African American men. For example, a mental health utilization program conducted by Syzdek, Green, Lindgren, and Addis (2016) with diverse college men was not successful at improving rates of seeking professional mental health treatment using motivational interviewing strategies. Another mental health screening study was conducted to determine feasibility of screening for depression among African American adults in faith-based settings using validated measures (Hankerson, Lee, et al., 2015). Faith-based organizations have been identified as a key community organization to improve mental health outcomes for young African American men (Lindsey et al., 2017).

Researchers have also discussed school-based mental health screenings for children and adolescents (e.g., Dowdy, Ritchey, & Kamphaus, 2010; Weist, Rubin, Moore, Adelsheim, & Wrobel, 2007), recommending schools as key sites for monitoring depression symptoms, providing mental health education to children and families, and building social support networks to improve mental health outcomes (Lindsey et al., 2017). School-based interventions have used mental health screening to develop and refine service delivery, resources, and policies (Dowdy et al., 2015; Green et al., 2013). Additionally, interventions that promoted receipt of mental health screening/LTC compared to existing school-based services have been found to be effective at identifying a greater number of youth at risk for mental health concerns (Husky, Kaplan, et al., 2011; Husky, Sheridan, McGuire, & Olfson,

2011). However, school-based programs have not targeted young African American men, which is crucial given that they are less likely to receive mental health services across treatment settings, including schools (Barksdale et al., 2009; Costello et al., 2014). Additionally, school-based mental health screening interventions may miss opportunities to promote mental health screening/LTC among young adult African American men who are beyond school age, but still at risk for mental health symptoms and related outcomes.

Only one study has described a mental health screening/LTC intervention for African American youth, called the African American Knowledge Optimized for Mindfully Healthy Adolescents (AAKOMA) Project (Breland-Noble & Board, 2012; Breland-Noble & Burriss, 2010). This project used a brief motivational interviewing (MI) program to promote LTC among African American adolescents with depressive symptoms. Participants in this study were tested for depressive symptoms as part of inclusion criteria, so mental health screening was not a behavioral outcome. However, all of the participants who completed the full intervention attended at least one session for treatment of depression (LTC; Breland-Noble & Board, 2012). Despite this, there are no mental health screening/LTC interventions targeted for specifically for young African American men, particularly those in urban, community-based environments who have experienced trauma. Other programs that promote engagement in mental health treatment among high-risk, young minority men (e.g., Behavioral Health Juvenile Justice Initiative; Kretschmar, Butcher, Kanary, & Devens, 2015) occur only after they have been involved in the criminal justice system, which may miss opportunities to reach at-risk young African American men prior to negative outcomes. Thus, better understanding of depression/PTSD experiences, culture, beliefs (e.g., attitudes, norms, control) and intentions to seek/use mental health services among trauma-exposed young

urban African American men is crucial for designing interventions to improve access to appropriate mental health care, particularly with use of appropriate theoretical models to help explain contributions of these factors.

The Theory of Planned Behavior

The Theory of Planned Behavior (TPB), originally developed by Icek Ajzen (1980, 1991), is a proven health behavior change model that establishes a direct relationship between behavioral intentions and likelihood of actual behavioral engagement. The TPB posits attitudes, subjective norms, and perceived behavioral control influence intentions to engage in the behavior. Figure 1 illustrates the relationship between these TPB constructs, intentions, and behaviors. Attitudes refer to a person's appraisal of whether certain behaviors will lead to the behavioral outcome and whether the individual values the outcome. Subjective norms are perceptions of one's peer groups' (friends, family, church members, health providers) approval of the behavior and motivation to comply with their peers' opinions. Perceived behavioral control relates to control belief factors that may facilitate or impede behavioral performance (e.g., access to screening) and the perceived power of the factor to make the behavior difficult or easy. Prior to survey development, elicitation interviews or focus groups with the population of interest are recommended to facilitate shaping TPB constructs for the targeted behavior within the given population (Montaño & Kasprzyk, 2008).

The TPB has been used to explain intentions to receive health screenings, including intentions to obtain a Pap smear among African American women (Jennings-Dozier, 1999). Furthermore, the TPB has also been used to develop and evaluate interventions designed to

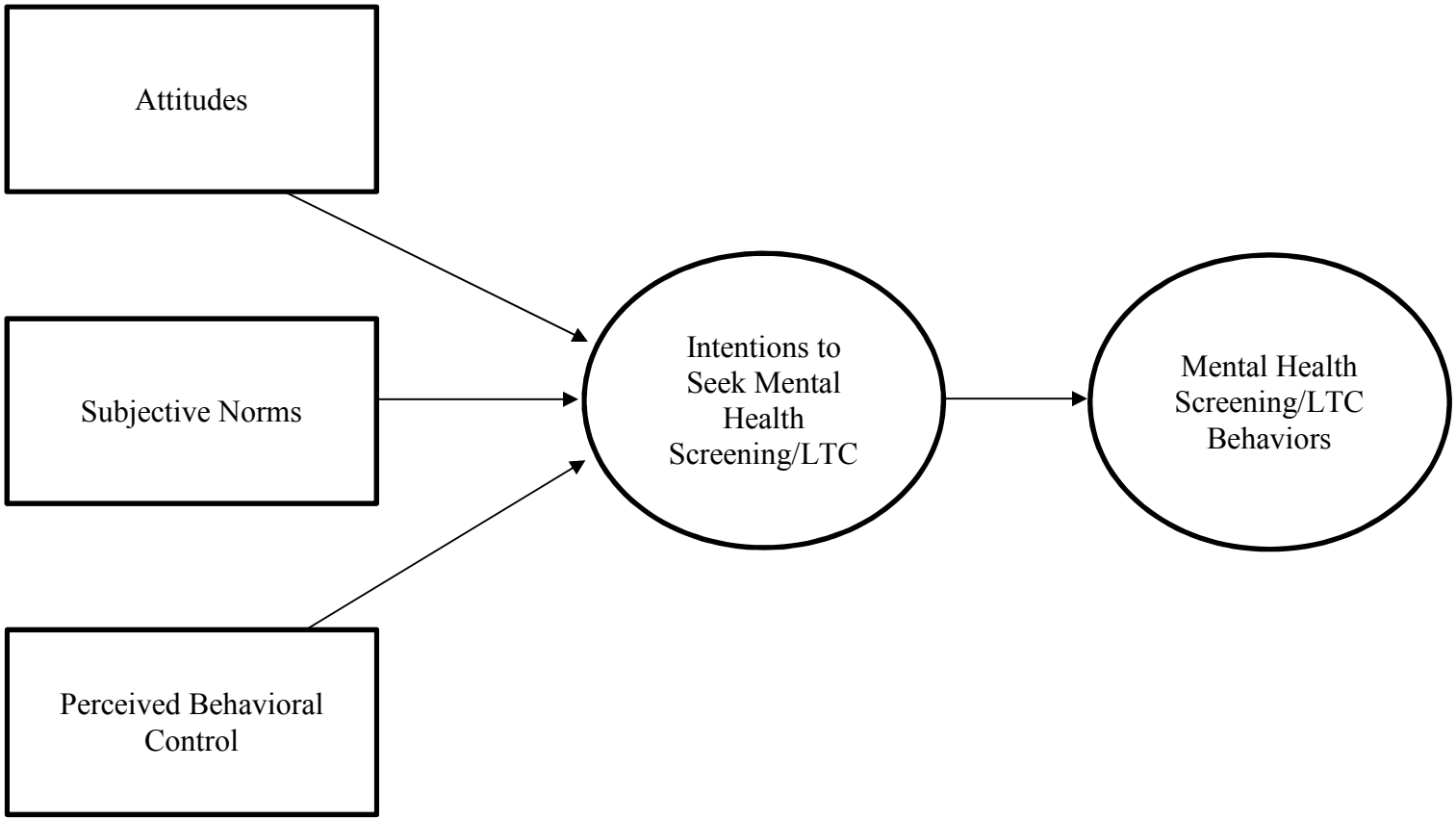

Fig 1. *The influence of higher-order TPB constructs on mental health treatment-seeking intentions and behaviors.*

promote HIV screening among African Americans in faith-based settings (Berkley-Patton et al., 2016), prostate cancer screening among international samples of Black and African American men (Parchment, 2004), and colorectal cancer screening among community-based African American men (Lucas, Hayman, Blessman, Asabigi, & Novak, 2016).

The TPB and Intentions to Seek Mental Health Services

A study by Bayer (1997) found that attitudes and subjective norms were predictive of intentions to seek mental health care among adults in community-based settings. More recent studies have focused primarily on attitudes toward mental health treatment seeking, in addition to psychosocial mediators (e.g., stigma, masculinity). For instance, a study of African American and White men and women reported that African Americans were more likely to have negative attitudes toward mental health treatment, and the relationship between race and attitudes was partially mediated by internalized stigma (Conner, Koeske, & Brown, 2009).

Similar patterns in attitudes are found in studies of adult men (Holden et al., 2012; Levant et al., 2013). Vogel et al. (2011) assessed attitudes toward mental health treatment seeking among African American and White men, demonstrating that attitudes are negatively associated with stigma and masculinity. Among White and African American college football players, greater gender role conflict and athletic identity were associated with greater stigma toward mental health services (Steinfeldt, England, Steinfeldt, & Speight, 2009). Masculinity was also negatively related to attitudes and intentions to seek mental health services among diverse male college students aged 18-26 (Smith, Tran, & Thompson, 2008). Another study of African American men found that a sense of control over one's life was

associated with fewer perceived barriers to mental health treatment (Lynch et al., 2018; Powell et al., 2016).

The TPB and Intentions to Seek Mental Health Services among Young Adults

A few studies have examined attitudes and other TPB components among youth, primarily college students. For instance, a recent study established direct relationships between attitudes, subjective norms, and intentions to seek mental health services among African American and White male and female undergraduates (Chen, Romero, & Karver, 2016). A TPB-based media intervention was designed to improve attitudes and intentions among diverse male and female undergraduates, which successfully improved attitudes toward mental health services but did not influence expectations or beliefs (Demyan & Anderson, 2012). In this intervention, intentions were only improved among students who had already engaged in mental health treatment. Furthermore, among African American and White undergraduate students in this study, females held more positive attitudes toward mental health services than male students. Another study demonstrated that White, African American, and Latino young adults aged 18-24 had worse attitudes toward seeking mental health services than older groups (Gonzalez, Alegria, & Prihoda, 2005). The diverse adolescent and young adult males aged 15-24 in this study were also nearly half as likely to endorse willingness to seek mental health services compared to young adult females aged 18 to 24. A study of male and female international and African American students found that intentions to seek mental health services were only predicted by perceived behavioral control, not attitudes or subjective norms (Mesidor & Sly, 2014). However, Barksdale and Molock (2009) determined that subjective norms among family and peers were negatively related to intentions to seek mental health services for African American male and female

students. TPB-based studies on use of mental health services among young adults have been primarily White (Demyan & Anderson, 2012; Gonzalez et al., 2005; Smith, Tran, & Thompson, 2008; Steinfeldt, England, Steinfeldt, & Speight, 2009), female (Barksdale & Molock, 2009; Chen et al., 2016), and/or limited to college students (Mesidor & Sly, 2014).

There are few theory-based studies of mental health screening/LTC attitudes and intentions among young African American men. However, several qualitative studies of young African American men have elicited attitudes, beliefs, or norms related to mental health screening/LTC. For instance, studies of African American adolescents (ages ranging from 12-26) described negative attitudes (e.g., stigma, shame, preference for self-reliance) toward seeking mental health services (Kranke et al., 2011; Lindsey et al., 2006; Watkins & Neighbors, 2007). African American adolescents and caregivers also endorsed negative attitudes toward the experience of seeking mental health services (Lindsey, Chambers, Pohle, Beall, & Lucksted, 2013). Negative attitudes were also elicited by focus groups of young African Americans (aged 15-17) recently released from juvenile detention, who had previously received mental health services (Samuel, 2015), including mental health is unimportant, mental health services are ineffective, and African Americans are rarely impacted by mental health concerns. This study also found that the influence of family, friends, and others (e.g., parole officers, social workers) on seeking mental health services was complex, with the ability to help or hinder help-seeking behaviors (Samuel, 2015). Studies have described perceived support from families, particularly mothers, to seek mental health care (Lindsey, Joe, et al., 2010; Lindsey et al., 2006), while other studies have reported negative perceptions about mental health service use from friends or family (e.g., feared antagonism, betrayal; Kranke et al., 2011; Lindsey, Joe, et al., 2010; Lindsey et al., 2006) and

considered how these norms would discourage seeking mental health services (Lindsey et al., 2013). Additionally, young African American men who were already in treatment reported willingness to talk to their friends about mental health, but also said they would not disclose that they were in treatment (Lindsey et al., 2006).

Only one TPB-based study qualitatively examined mental health service utilization among young African American boys and girls aged 13-18. This study used child/mother dyads (Thompson et al., 2013) and found that adolescents were less likely to report positive expectations of mental health services than mothers. Furthermore, over half of adolescent participants reported negative or ambivalent expectations toward mental health services, many with negative experiences and low intentions to seek mental health care.

Current Study

There are no studies that qualitatively examine mental health screening/LTC among only young African American men who: a) have experienced trauma as defined by the DSM-5, b) may not have received previous mental health services, and c) are recruited from broad, community-based locations. However, researchers have called for theory-based models to examine help-seeking (Vogel et al., 2011) and development of feasible, culturally tailored interventions to promote mental health screening/LTC among African American men (Holden et al., 2012). Given the multitude of poor health outcomes that can occur as a result of trauma, it is imperative to understand mental health screening/LTC among high-risk, underserved populations, including young adult African American men. The TPB has great potential to assist in serving this purpose.

The TPB approach first involves a qualitative elicitation phase to identify specific attitude, normative, and control beliefs relevant to a particular population. These findings

then inform quantitative assessment of beliefs that are most predictive of the behavior or intention to engage in the behavior. Thus, the purpose of the current study was to use a TPB framework to qualitatively examine mental health screening and LTC among young African American men exposed to trauma. Specifically, this study used focus groups and a brief survey to explore TPB-related attitudes, norms, facilitators/barriers, and intentions regarding receipt of mental health screening/LTC with young urban African American men who had experienced trauma.

CHAPTER 2

METHODOLOGY

Participants and Procedures

Participants ($N = 55$) were recruited from community-based, urban settings in the Kansas City metropolitan area. Eligibility criteria included: (a) self-identifying as African American and male, (b) being between the ages of 18 and 30, and (c) having experienced at least one traumatic incident, as defined by the DSM-5 (American Psychiatric Association, 2013). This includes exposure to actual/threatened death, serious injury, or sexual violence through direct experience, witnessing event in person, learning that the event occurred to a loved one, or experiencing repeated exposure to extreme aversive circumstances. Participants were assessed for trauma history using items drawn from the Stressful Life Events Screening Questionnaire-Revised (SLESQ; Goodman, Corcoran, Turner, Yuan, & Green, 1998), which has been used to measure potentially life threatening experiences among African Americans (Green, Chung, Daroowalla, Kaltman, & DeBenedictis, 2006). Eligibility criteria also included (d) having no active psychotic symptoms, and (e) having no active suicidal/homicidal ideation (SI/HI). Psychotic symptoms and SI/HI were determined by a screener adapted from subscales of the Mini International Neuropsychiatric Interview (MINI-7.0; Sheehan et al., 1998). Individuals with active SI/HI were referred to care at the Kansas City (KC) Care Health Center, a local community mental health center where free to low-cost behavioral health services (dependent on insurance coverage) were available.

In general, studies using focus group procedures in mental health research for young African American men have recruited 18 to 70 participants (e.g., Lindsey, 2010; Lindsey et al., 2013; Lindsey, Joe, et al., 2010; Lindsey et al., 2006; Samuel, 2015; Watkins &

Neighbors, 2007) to achieve "saturation" of results, whereby similar responses are elicited across multiple focus group discussions. The attained sample size of $N = 50$ also provided an opportunity to achieve balanced representation of multiple urban, community-based recruitment sites, with potential for saturation across settings.

Participants were recruited from diverse community sites, including colleges and universities, barbershops, churches, and community organizations that serve young urban African American men. Participants were recruited using flyers, social media announcements, church bulletin inserts, and word-of-mouth. Individuals who expressed interest in learning more about the study and/or participation were able contact the PI directly by phone or email. The PI provided further information, screened for eligibility, collected contact information, and assigned eligible participants to focus groups.

Each participant completed informed consent and a brief survey prior to the start of the focus group session. Surveys were designed to complement the qualitative findings, in order to more fully understand and interpret beliefs and behaviors regarding mental health screening and LTC. The brief survey also provided information outside of the primary scope of the focus group discussions, and beyond customary demographics, but central to understanding mental health services seeking (e.g., symptoms of depression and PTSD, attitudes towards mental health services). Survey completion took approximately 15-20 minutes, and all participants were compensated $40 and provided a meal for participation in the survey and a focus group. Study procedures were approved by the University of Missouri-Kansas City Institutional Review Board.

Focus Groups

Six individual interviews and nine focus groups were held, with an average of seven participants. Focus groups lasted up to 90 minutes. All discussions were held as closed sessions in local community locations (e.g., community colleges, churches) to ensure participant confidentiality and privacy. Participants used pseudonyms to ensure anonymity. In addition to note taking, focus group discussions were digitally audio-recorded and transcribed. A TPB framework was used to guide focus group discussions (see Appendix A). Participants were asked to discuss beliefs related to mental health screening/LTC, receipt of mental health screening/LTC, and additional needs and preferences regarding mental health care and services.

Survey Measures

Demographics and Trauma Exposure

All participants were asked to report their age, sex at birth, socioeconomic status (i.e., education level, average monthly income), and health insurance coverage (Appendix B). Participants were also asked to describe their history of trauma exposure, including whether any of ten potentially traumatic events (e.g., "Being threatened with a weapon [knife, gun, etc.]," "Losing a loved one as a result of accident, suicide, or homicide") happened to them, someone close to them, or neither. All ten events parallel items from the SLESQ, and were the most commonly reported potentially traumatic events in previous studies of young African American men (Boyraz et al., 2015). Checked responses were coded as yes (1), and unchecked responses were coded as (0), with Cronbach's $\alpha = .714$.

Receipt of Mental Health Screening/LTC

Receipt of mental health screening was assessed using adapted versions of items used in previous African American screening/LTC interventions (Berkley-Patton et al., 2016; Berkley-Patton et al., 2010; Berkley-Patton, Moore, Hawes, Thompson, & Bohn, 2012; Hankerson, Suite, et al., 2015; Hankerson, Lee, et al., 2015; Neighbors et al., 1998). Screening was considered any contact with a health care provider that includes report or evaluation of mental health symptoms. Receipt of mental health screening was assessed with a single item that asked, "Have you ever been asked by a professional about mental or emotional problems?" with response options including Yes, by a mental health provider (e.g., psychiatrist, psychologist, counselor); Yes, by my primary care doctor or another medical doctor; Yes; by a teacher or other school personnel; Yes, other person; No; and Don't know. One follow-up question asked about when they most recently talked to a professional about mental or emotional problems (Within the past 12 months, Within the past 13-24 months, More than 24 months, Don't Know).

LTC was defined as one or more follow-up visits with a professional mental health provider. One item asked, "How often did you see the same mental health provider about mental/emotional problems?" with response options Once, Two or more times, and Don't know. Participants also asked about to write in duration of services (i.e., how many years and/or months they had seen a mental health provider).

TPB Constructs

Beliefs about seeking mental health screening/LTC were assessed using the 24-item Inventory of Attitudes Toward Seeking Mental Health Services (IASMHS; Mackenzie, Gekoski, & Knox, 2006; Mackenzie, Knox, Gekoski, & Macaulay, 2004). The IASMHS has

demonstrated good internal consistency (Cronbach's α = .087) and test-retest reliability (ranging from .64 to .91; Mackenzie et al., 2006). This measure has been used in previous TPB-guided mental health studies with African American college students (Mesidor & Sly, 2014) and community-based African American adults (Ward et al., 2013). IASMHS items correspond with TPB components (Mesidor & Sly, 2014). Specifically, items from three IASMHS subscales (i.e., psychological openness, indifference to stigma, and help-seeking propensity) parallel TPB constructs of behavioral beliefs (e.g., "People should work out their own problems; getting professional help should be a last resort"), normative beliefs (e.g., "I would not want my significant other [spouse, partner, etc.] to know if I were suffering from psychological problems"), and control beliefs (e.g., "If I were to experience psychological problems, I could get professional help if I wanted to"), respectively. Response options ranged from Disagree (0) to Agree (4). Negatively worded items within the psychological help-seeking and indifference to stigma scales were reverse scored. Items within each subscale were summed to create total scores for behavioral, normative, and control beliefs. Each score ranged from 0 to 32, with higher scores reflecting greater beliefs.

Intentions were measured with a single Likert-type scale. Participants were asked to rate how much they agreed with the statement, "I intend to seek mental health services in the near future," with response options ranging from Strongly disagree (1) to Strongly agree (5).

Mental Health Symptoms

Symptoms of depression were measured using questions from the 9-item Patient Health Questionnaire (PHQ-9; Kroenke, Spitzer, & Williams, 2001), a widely used depression screening measure that has been effective at detecting symptoms of depression among African American adults (Cronbach's α = .86; Huang, Chung, Kroenke, Delucchi, &

Spitzer, 2006). The PHQ-9 asks, “Over the last two weeks, how often have you been bothered by any of the following problems?” followed by items including, “Little interest or pleasure in doing things,” and “Feeling down, depressed, or hopeless,” with response options including Not at all (0), Several days (1), More than half the days (2), and Nearly every day (3). Items were summed to create a total score, ranging from 0 to 27, with higher scores reflecting more severe depression symptoms. Scores were interpreted as indicative of mild (5-9), moderate (10-14), moderately severe (15-19), and severe depression (20 or greater; Kroenke et al., 2001).

Posttraumatic stress was measured using the Primary Care PTSD Screen for DSM-5 (PC-PTSD-5; Prins et al., 2016). The PC-PTSD-5 first asks about exposure to trauma using a dichotomous item ("Sometimes things happen to people that are unusually or especially frightening, horrible, or traumatic [like a serious accident, physical assault, natural disaster, seeing someone seriously injured or killed, or having a loved one die through homicide or suicide] Have you experienced this kind of event?). Five additional dichotomous items asked participants whether they experienced symptoms of PTSD over the past month (e.g., “had nightmares about the event(s) or thought about the event(s) when you did not want to”, “been constantly on guard, watchful, or easily startled,” “felt guilty or unable to stop blaming yourself or others for the event(s) or any problems the event(s) may have caused.”) The five symptom items were summed in order to create a total score, ranging from 0 (no posttraumatic stress symptoms) to 5 (greater posttraumatic stress symptoms). Previous research has suggested a cutoff score of 3 for identifying probable PTSD (Prins et al., 2016).

Data Analysis

Focus Group Data

Focus group discussions were transcribed and coded for analysis. Audio recordings provided to transcribers included only pseudonyms and responses from discussions and did not include any information that could be used to identify participants. Similarly, no sensitive or identifying information was available in focus group transcriptions.

Qualitative analyses used a deductive, TPB-grounded approach (Foley & Timonen, 2015), which has been used in several qualitative studies examining mental health treatment seeking (Thompson et al., 2013). The coding protocol began with "open-coding" of transcriptions (e.g., identifying within text key words, themes, description of behaviors), which was initially completed by the PI. A member of the research team reviewed the initial coding protocol to refine the coding framework by clarifying categories, identifying redundancies, and making recommendations for additions. The coding protocol was refined through discussion, with the final code map focusing on major themes within the TPB (e.g., perceived outcomes, sources of support, facilitators/barriers for mental health screening/LTC). The schema assisted with further grouping and retrieving factors on core coding categories (e.g., behavioral, normative, and control beliefs toward mental health screening/LTC), intentions to seek mental health screening/LTC, and past receipt of mental health screening/LTC. Core coding categories also included potential intervention strategies and needed resources that would promote engagement in mental health screening/LTC. Following initial development, the PI and a second independent rater each coded the data using the developed coding schema. Inter-coder agreement was assessed using the percentage of agreement and Cohen's kappa coefficient, which assesses reliability while also

considering chance agreement. The goal for consensus was 80%, with substantial agreement indicated by Cohen's $\kappa = .61$ or greater (McHugh, 2012). A third independent rater was consulted in order to provide further insight into reconciliation for areas of discrepancies.

Survey Data

The brief survey was used to complement focus group discussions by providing additional data not captured during discussions. Thus, quantitative analyses were limited to descriptive statistics and appropriate parametric and non-parametric tests.

CHAPTER 3

RESULTS

The average age among participants ($N = 55$) was 23 years ($SD = 3.9$; range 18 to 30). Demographics from the brief survey are presented in Table 1. Nearly half of participants reported education level of high school/GED or lower. The majority of participants had health insurance. Half of participants reported receipt of previous mental health care, primarily from a mental health provider or pastor or spiritual leader. Of participants who had talked to a mental health professional, more participants reported seeing a mental health care provider two or more times (61%) than only attending a single session (28%). Participants also commonly reported seeing a provider within the past year (56%) or more than two years previously (33%).

The final percentage agreement between coded pairs was 86% after secondary coding (i.e., discussion and reconciliation) and 97% after review by a third party. Cohen's kappa reflected substantial agreement between coders, which improved between the initial coding cycle ($\kappa = .753$, $p < .001$) and secondary coding ($\kappa = .793$, $p < .001$). Analyses of focus group discussion transcripts yielded several thematic categories. Participants reported extensively on trauma exposure and chronic stress experiences and subsequent mental health symptom and linkage to care, as well as themes aligning with the TPB. Key themes aligning with behavioral beliefs included need to normalize mental health, potential effectiveness of services, gaining an outside perspective, and factors that impact effectiveness (e.g., individual effort). Key referents to support normative beliefs included significant others, family, friends and peer groups, and faith-based organizations. The factors discussed that

Table 1. Demographic characteristics of participants.

	N	%
Education		
High school graduate/GED or less	26	50
Post high school technical training	1	1.9
Some college (but no degree)	18	34.6
Associates degree (AA) or technical school certificate	3	5.8
Bachelors (BA, BS)	2	3.8
Some graduate school or graduate degree	2	3.8
Health insurance		
Medicare or Medicaid	14	25.5
Private insurance	17	30.9
Other	5	9.1
No insurance	18	32.7
Average monthly household income		
$0 - 1,000	7	12.7
$1,001 - 2,000	6	10.9
$2,001 - 3,000	4	7.3
More than $3,000	15	27.3
Don't know	21	38.2
Refuse to answer	2	3.6
Trauma Exposure		
Life threatening illness or accident	19	34.5
Robbery or mugging	18	32.7
Being threatened with a weapon	23	41.8
Witnessing someone be seriously injured, assaulted, or killed	15	27.3
Losing a loved one to accident, suicide, or homicide	23	41.8
Serious injury or threat to life	15	27.3
Physical harm from a parent or caregiver as a child	7	12.7
Being physically harmed or beaten as an adult	8	14.5
Forced sexual activity	8	14.5
Previous receipt of mental health screening	27	50.0
Mental health provider	23	41.8
Medical professional	10	18.2
Teacher or other school personnel	10	18.2
Pastor or spiritual leader	18	32.7

impact control beliefs ranged across all social ecological levels, including barriers and facilitators at the individual, interpersonal, organizational, community, and policy levels.

Exposure to Trauma and Chronic Stressors

Across focus groups, participants discussed a wide range of traumatic experiences, such as experiencing the loss of close friends and family members to suicide or gun violence. For example, participants reported, "I lost my brother to the streets. I lost my big brother to the streets when I was a young kid," "my little brother got killed at 14," and "I've seen somebody die like right in front of me or in the same car with them." Focus groups also discussed personal history of experiencing robbery, assault, physical and sexual abuse, domestic violence, or gun violence (e.g., "I got shot in crossfire a couple of years ago coming out of the Sprint Center"). This was supported by survey findings, in which participants endorsed an average of 2-3 traumatic events (*SD* = 2.2), most commonly being threatened with a weapon or losing a loved one to accident, suicide, or homicide. Furthermore, 62% of participants endorsed two or more traumatic events.

Focus groups also elicited other stressful experiences such as homelessness, being bullied by peers, and racial discrimination. Theo discussed the impact of being openly gay, including being bullied by classmates. He described the effect on his mental health, including suicidal ideation, and persistent family strain:

> "I use to literally have thoughts of killing myself. It was hard at one point to tell my father… So, every time he called, I reject his call because of all the pain, the frustration, getting whoopins with extension cords, that is the reason I don't really talk to my father."

Participants experienced racial discrimination as "just everyday living in Kansas City." Kitty explained, "I live up north where I feel like it is predominantly White and just walking past people's cars, you kind of get locked doors and stuff like that." Participants also felt that

racial discrimination from "usually White Americans" kept them from becoming successful (e.g., getting to "the top of the totem pole"). These themes were echoed by discussion of chronic stress that pervades their communities, with mentions of "being woken up by gunshots in the middle of your sleep" and perpetual mistrust of other young men on the street:

> "Like, we live in a natural war zone, like growing up Black especially, you know, we live in a natural war zone. We ain't got no choice but to be stressed, because we don't know if he is going to kill you, you don't know if he is going to kill you, or if he is going to kill you."

Mental Health Symptoms and Screening/LTC After Trauma

Survey results for measures on depression and PTSD symptoms are displayed in Table 2. Participants commonly endorsed feeling down, depressed, or hopeless on several days (35%) or more than half the days (20%) over the past two weeks. Similarly, many participants endorsed difficulty sleeping for several days (40%) or more than half the days (26%). More than half of the sample (57%) endorsed three or more symptoms of PTSD, most commonly avoidance (65%); feeling numb or detached from people, activities, or surroundings (63%); and hyperarousal or hypervigilance (58%). The latter was supported by focus group comments, such as "You might end up hurting somebody else because you are so traumatized by it you might get paranoid, thinking everybody is out for you." In a separate focus group, Ace described:

> "I mean what made me kind of get posttraumatic stress stuff… because when I sleep, you know, I don't feel safe all the time. I expect the worse to sometimes happen… And I'm more watchful, you know what I'm saying, watch more of my surroundings, people around me, but even though, like it could be the people you least expect."

Table 2. Help-seeking attitudes and symptoms of depression and anxiety among focus group participants.

	M	*SD*	Range
IASMHS scores	53.00	11.7	17 - 73
Behavioral beliefs subscale (psychological openness)	14.98	5.2	0 - 26
Normative beliefs subscale (indifference to stigma)	19.08	6.3	2 - 30
Control beliefs subscale (help-seeking propensity)	18.65	7.5	3 - 32
Intentions	2.98	1.1	1 - 5
PHQ-9 scores	8.85	6.2	0 - 21
PC-PTSD scores	2.75	1.8	0 - 5

care and few resources available to them, particularly as students. Fernando discussed how a classmate passed away, and there were no grief counselors available at school to support students. John agreed with this experience:

> "I grew up in an inner-city school system, but I went out to like the suburbs some and we lost somebody in our class there. Exactly what he said, like they had grief counselors and they had that day of school where you had your people to talk to … where we will just come and all come into the auditorium and sit down … grieve together as a school or as a community."

Fernando elaborated that he continued to experience reminders of this loss: "When that girl died in Central, the next day we were at school, like I walked over that girl's blood, like they didn't even clean the blood up."

Behavioral Beliefs

Positive Beliefs and Outcomes

Behavioral beliefs scores from the brief survey are displayed in Table 2. Participants described "respect for people in the mental health field" who are "noble" and that "they care about people." Qualitative positive beliefs were encompassed by the overarching concept that "you don't have to do it yourself." Within this concept, key themes included (1) need to normalize mental health, (2) effectiveness of services, and (3) gaining an outside perspective.

Need to normalize mental health. Participants noted that in general, "We have this attitude that we can do it ourselves, and we have to do it ourselves, because no one else is

Table 3. Key focus group findings on behavioral, normative, and control beliefs.

TPB Construct and Major Themes	Key Subthemes	Example responses
Behavioral beliefs		
Need to normalize mental health	Changes in mental health status	• Normal thing, like hunger • Treated the same way we would treat any other illness
	Process of talking to a provider	• What to expect, since it can be intimidating • Looks like any other office building
Effectiveness of services	Coping strategies	• Make the right choices, keep the situation from escalating • More active than "dealing with it"
	Comparison to religious coping	• Faith in God as first-line strategy • More to just praying about issues • Can get the ball rolling instead of hoping for solution to just be magical
Gaining an outside perspective	Trained professionals	• Provide an unbiased opinion • Without a provider you intrinsically think you are right • Friends and families have their own biases
Requires individual effort	Resistance to engagement	• Some people don't take things serious enough • Just put in your time for court-mandated therapy • Could lead to self-conflict
	Need to maintain barriers	• Read them before they get a chance to read you • I'm going to keep certain details to a minimum, so you don't get the full story
	Cultural mistrust	• Barriers are a defense mechanism, due to mistrust

		• Perception of mistrust has gone down through the generations
No guarantee that services will be beneficial	Mental health care may not be able to help	• They can only pay so much attention to you • Potentially misdiagnosed, labeled, institutionalized
	Providers may not understand	• Can't get to the key points to fix you and help you out with your life situation
	Providers rely too much on medication	• Give them some medicine because that is all they know; there are no natural remedies • Talking about it and getting things off your chest… is enough medicine for some people
	Not enough mental health research	• Some things can't be understood • Data is skewed to White people
Normative beliefs		
Significant others	Supportive	• She helped me see the progression I was going through
Family	Varies in level of support	• Sometimes your parents have been going through something themselves, so they know that mental services do work • Parents ain't really supportive when it comes to stuff like that • Key referent for help-seeking behaviors
Friends and peer groups	Varies in level of support	• That is what a friend does • Only discuss mental health with "certain friends" • 'Man you are crazy, don't go there'
Faith-based organizations	Varies in level of support	• Depends on if they view mental health as a conflict

		with religion • ‘Go and pray about things’ • Potential for gossip or ulterior motives
Employers and supervisors	Not supportive	• They might be able to give you a little leeway • Don’t interfere with company time
Willingness to comply with norms	More likely to seek services with support of others	• If someone else is motivating me to go do it, I’d definitely be more motivated to go
Control beliefs		
Individual level		
Facilitators	Personal beliefs and knowledge	• Belief that it will help • Personal motivation • Education on how to navigate the system
Barriers	Personal limitations	• Not knowing where to go • Hesitance to try something new • Maintaining motivation • Lack of priority
Interpersonal level		
Facilitators	Establishing therapeutic relationship	• Meeting with one provider consistently • Establishing a personal connection
Barriers	Justification for needing services	• Prove that you are actually crazy, that you need to be there
Organizational level		
Facilitators	Provider availability	• Having providers available • Extended availability to account for work hours • Counselors at school that are really counselors

Barriers	Financial obstacles	• Cost • Health insurance
	Lack of access	• The stuff that we actually need, we have to go out on highways to get it • Recommendations of home visits or making services available in community centers
	Uncertainty of confidentiality	• Could increase risk of backlash from gangs or others in community
	Lack of Black/African American providers	• I would feel more comfortable with a Black person • They can identify with you personally • They are not in the neighborhoods
Community level		
Facilitators	Acceptance and modeling	• Growing awareness around mental health • Seeing a local, Black public figure modeling screening/LTC behaviors
Barriers	Same problems within neighborhoods	• Going to see providers and go back home to what I just came from to begin with
Policy level		
Barriers	Changes needed	• Allocation of additional funding
	Disparities in punishment and incarceration	• Not going to make it affordable for you to do those things unless you get in trouble • More likely for young Black men to go to jail for life than to receive mental health care

there for us." This was echoed by a participant in another focus group, "We just get so used to, keep it to ourselves and just not trusting anyone." Despite these traditional attitudes, Josiah expressed that "I feel there is such a negative stigma tied to it and there doesn't really need to be," with participants echoing need to recognize changes in mental health as a "normal thing like hunger" and "treated the same way we would treat any other illness" (Table 3). Participants also discussed the need to normalize the therapy process and "what to expect," since talking to a provider can be "kind of intimidating at first." As Jay explained:

> "Some people automatically assume like if I tell people I'm going to therapy, oh like are you going to the hospital, so you are talking to, what do they call them, a shrink, and I'm like no, I'm going to an office inside of a building that looks like any doctor's office or a dentist's office. It looks like any other office."

Effectiveness of services. Participants across focus groups endorsed the attitude that mental health services can be effective and that, "There is stuff out there that could, and is made to help." One participant observed, "I have seen suicidal people … and then I will see them a month later or six months later and they are flourishing or appear to be flourishing." In particular, focus groups discussed effectiveness of mental health care at providing coping strategies, which would help young Black/African American men in "making the right choices," and "more knowing, understanding, and doing what you got to do to get past that." Participants also said that coping could include identifying "what triggers for them to act a certain way" with alternative strategies to keep the situation from "escalating." Notably, the idea of "coping" was an active response, differentiated from more passive strategies (e.g., "dealing with it"). Jay described:

> "'Dealing with it' is seeing a brick wall and looking at it like fuck, you know, just like, damn. And then coping with it is like getting that shovel or whatever and digging at that brick wall. So it is like the action in it."

Participants also discussed the effectiveness of mental health services compared to religious coping and prayer. Some participants discussed how they "strayed away" from church and that "there is more to just praying about issues … to solve them, than what the church traditionally speaks about." Similarly, Jay described:

> "If somebody did give us the option instead of just saying pray, like go talk to this person… to put it all out there and then you actually do get feedback. Instead of like hoping for something just to be magical … you can just have that get the ball rolling kind of attitude."

In contrast, other participants described a preference for religious coping. Willinaire stated:

> "My first outlet is always my faith in God and that has never let me down or caused me to like spiral in a bad state of mental health or anything like that. So, I mean until that kind of like fails, which it never will, I mean I don't see a point in seeing like a therapist personally."

Gaining an outside perspective. A third major theme was the importance of gaining an objective perspective from trained professionals, particularly compared to relying on themselves, friends, or family. As a participant explained, "I guess professional help would just be better, because, you know, they are trained in the field and they know [what] they are doing." Mental health providers can "figure out if you need to get clinically diagnosed or something, or maybe you need to see a specialist." Participants also expressed that mental health providers "can be objective," and help give "a professional unbiased opinion." Bosh further explained that mental health providers are in a unique position to be unbiased because "they don't [know] your situation and they don't know all the different outliers, but like you are telling them straight up, this is what is bothering me."

An outside perspective was particularly important because of an individual's personal biases in dealing with mental health symptoms. One participant, Kitty, commented that without a mental health provider, "you don't really have anyone outside of yourself to make

you question it" and "you think just intrinsically, you are right." Key further explained the potential for a mental health provider to help overcome these personal biases:

> "If you can get that from a trained professional who went to school for 10 years and knows how to do it and can be objective about it, can be fair and can rationalize with you when you can't, and your emotions are taking the best of you, then it definitely can be beneficial."

Participants also discussed limitations of family and friends in helping to address mental health concerns, compared to an objective provider. Notably, family "don't have time" while friends may say, "just hit me up whenever, and they never answer the phone or something." Furthermore, participants strongly endorsed that "when you talk to people that you are close to" they are unable to help to address mental health concerns, particularly if friends "are all kind of going through the same issue." As Key explained, "I'm feeling bad or feeling down, all the people say is damn or that's crazy." In the same focus group, Kitty agreed with this sentiment and elaborated that "they can't be that person for you. They are in your life on a daily basis, they don't know how to separate the two and two." Finally, Bosh explained:

> "You are going make them feel better, but you are not necessarily relieving the situation, you know, like you are not fixing the problems that they are going through. You are not actually helping them with the problems, you are just telling them what they want to hear."

Negative Beliefs and Outcomes

Attitudes about individuals. Despite these positive beliefs, participants discussed pervasive negative attitudes toward mental health services among young Black/African American men. First, participants felt that mental health screening/LTC would require a significant level of individual effort. Responses included that "the only way you can really help somebody is if they want help," and that people must "stick to a plan" to see a benefit

from mental health care. Draco stated, “Some people don’t take things serious enough. It is a waste of time to them, and they are not going to be tuned in mentally, and they already have a mindset build that this is some bull crap.” This was also true of court-mandated therapy, in which participants would “just put in your time.” For some young Black/African American men, mental health care was associated a sense of “self-conflict… what am I doing, why am I here, I’m stronger than this. They can’t tell me how to feel.”

Another salient negative attitude was the perceived need to maintain barriers between individuals and mental health providers. Participants described pressure to “read them before they get a chance to read you.” Participants also worried about finding “the catch” in therapy and feeling that in sessions “you give too much, and you are just like shit hold up, I wasn’t ready for all of that.” One participant described how this process had taken place for him and others:

> “Yea, they will say and think they want to get the help, they will go to the therapist and everything, but then … this wall stays up, and they tell like a half truth or they tell their spin on what they help with, almost like manipulating the therapist, you know, telling them what they want to hear. Because I mean honestly, the first time I ever went to therapy, I was like yea, you are not about to get nothing out of me. Like, yea I’m here, but you are not going to get anything out of me. Like I’m going to tell you what I want to tell you, and that is it, and I’m going to keep certain details to a minimum, so you don’t get the full story.”

However, one participant discussed how these barriers were a persistent issue, which mental health services had potential to change:

> “I mean because we are often really closed off. We are loners typically even though we have a small group of friends and small communities, we are still alone a lot of the time. So, getting the mental health allows us to actually have a community.”

Participants also commented on how cultural mistrust of health care providers relates to development and maintenance of these barriers. For instance, interpersonal barriers were described as a “defense mechanism, because you didn’t trust them.” Mistrust of providers

stemmed from the Tuskegee Syphilis Experiment and other historical instances of mistreatment of the Black community. One participant stated, "From [a] generational standpoint, there are a lot of reasons why people don't trust … I feel like a lot of Black people's perception of, can I really trust healthcare professionals, has gone down through the generations."

Attitudes about providers. Negative attitudes extended to mental health providers, including how sometimes "not even they can help" and "there ain't no guarantee" that mental health care will be beneficial. This perception was partially due to the impression that mental health providers "have so many patients and clients… They can only pay so much attention to you." These attitudes led to the perception that mental health care would be a waste of money, which exacerbates already limited resources. Furthermore, engagement in therapy could lead to being misdiagnosed, being labeled, or providers "locking you up" in a mental institution.

In contrast to positive beliefs about an outside perspective, participants expressed concerns that mental health providers "can't relate" or "can't really get to the key points to how to fix you and help you out with your life situation." Ezekiel described,

> "I never really believed in it, that somebody can tell me how to really cope with what I go through, unless they have actually been in the exact same situation that I've been in. They can't really tell me how to deal with it basically… I mean some people can understand as they go through situations in their life, but I don't see how they can fully understand the situation that I'm in and how I feel about it."

Because of their inability to understand what young Black/African American men have experienced, mental health providers were perceived to rely too much on medication:

> "It is not there to help us, like so if we go to this White man and this White lady, they are so intrigued by the stuff that we've that we've gone through and the stuff that we've seen, then it is like well what do I do, and what do I say, well give them some

> medicine because that is all they know. There are no natural remedies. There are no other things for us."

In contrast, a participant in the same focus group expressed that, "Sometimes really talking about it and getting things off your chest, clearing your mind, you know, I think that in and of itself is enough medicine for some people." Several participants discussed being wary of medications and their side effects (e.g., being "like a zombie"), believing that benefits may be temporary, they may not help at all, or they may "hurt you more than help you." Finally, one participant explained that when considering mental health medications, some people "just act like they need it" in order to "supply the neighborhood with it."

Attitudes about system. More broadly, participants discussed limitations of therapy, as "there are just some things that can't be helped because we are not that advanced yet." This was especially true for young African American men: "I think like with a lot of stuff in like any health field, like all the data and everything is skewed to White people, so we don't have anything to really help us."

Normative Beliefs

Significant Others and Family

Key normative referents included significant others and family members. Participants exclusively discussed significant others in a supportive role, noting that they were in a unique position to notice changes in mental health because "she is right there" and "she helped me kind of see the progression of what I was going through." However, the perception of norms among parents and families varied considerably. For instance, some parents were encouraging: "Sometimes your parents have been going through something themselves, so they know that kind of mental services do work sometimes if you find the right people." Other participants described support from fathers who had been through combat experiences

and had their own mental health concerns, or that "I didn't really grow up with a dad, so my mom was there. My mom has been there."

Other participants reported less support or being discouraged from seeking mental health services. Comments included being told to "man up" by fathers and that "parents ain't really supportive when it comes to stuff like that. Like I got momma, like she's stressful, like I can't talk to her about nothing." Furthermore, some participants felt that "they have enough of their own problems" and "they don't even go get help and things like that, so I wouldn't expect them to understand." However, parents played a crucial role for participants, with the likelihood of seeking mental health services highly dependent on feedback from parents. "Everybody in the world could tell you do it, but if your parent is sitting here saying 'that is for crazy people'… I live under their house, I'm not about to put myself in that predicament."

Friends and Peer Groups

Similar mixed responses were stated for friends. Participants said that they would expect friends to be supportive, even when family members were not, "because that is what a friend does." While participants felt that "White friends" would be supportive of mental health care, some participants "felt more taken care of" when surrounded by their African American peers "because those same people that struggle with you, they are going to get you. White people don't understand that." However, an important aspect of this expectation was discussing mental health only with a small circle comprised only of "certain friends" or one's "closest friends." One participant discussed this further:

> "I don't keep a lot of them, because friends, you know, you don't tell everybody your business. Like I said, you tell them your business and they will tell your business. You have to be careful what you discuss between your friends. You have to find them and evaluate your friends and basically test them before you have a trust in them."

Other participants noted that their peers might discourage them from seeking care, saying "'Man you are crazy, don't go there, like don't believe in nothing they say.'"

Faith-Based Organizations

Church members were perceived by some participants to be supportive of mental health care, and participants said that they might seek encouragement from male congregants or church leaders, deacons, or ministers. Kitty stated that his church was "next level as far as support with anything that is going on." Other participants were less certain about receiving support from churches, particularly since it "depends on if they view mental health as like a conflict with seeking religion, or if they [see] it as like a tool that God can give you." As Josiah described:

> "If you are sick, you go to a doctor, so if you are mentally ill, you go to a therapist. So, trying to reconcile the two. I don't know how people, traditional people, who have been in church a long time and kind of from a different era, would see mental health professionals."

Although one participant acknowledged that "sometimes you have pastors that are actually counselors who are there to help you," other participants questioned why "churches offer therapy, so I'm like, why can I come to you for it, but I can't go to a professional psychologist?" Furthermore, participants discussed being taught to "go and pray about things" rather than seeking mental health services. Finally, some participants discussed more definitive beliefs that the church would not be supportive, because people may gossip or because at some churches, they are more concerned with having "money and their bills paid."

Employers and Supervisors

Employers were exclusively discussed as not being supportive of mental health care. Participants felt that "they might be able to give you a little leeway," but that their

supervisors “don’t really want it to interfere with company time.” Furthermore, a mental health diagnosis may prevent advancement in one’s career:

> “They might say they want you to get better, but if they notice that you are like taking medicine or whatever, then when it comes time for a promotion or whatever, it is like well, are you sure you are ready for it?”

Willingness to Comply with Norms

Participants’ ratings of willingness to seek mental health screening/LTC with the support of referents ranged primarily from five to ten, with several participants rating around a seven. Furthermore, participants’ comments reflected more willingness to seek mental health services with the support of others, such as “If someone else is motivating me to go do it, I’d definitely be more motivated to go,” “Like I really don’t believe I need to do it, but if my mom says so, then that boosts it up to about a 7.” One participant stated that it would involve both personal motivation and encouragement from others:

> “I guess it would all depend, like if I think it would help, I guess yea, I would talk to I guess a few people that I’m close to and see what they thought about it and kind of go from there.”

Control Beliefs

Individual and Interpersonal Factors

Participants perceived barriers and facilitators were multilevel and complex. At the individual level, participants’ perceived facilitators to mental health care were the belief that it will help, “being comfortable around the person”, having a loved one or trusted person to go with you, personal motivation, and education on how to navigate the system. Similarly, barriers to mental health care included not knowing where to go, hesitancy to try something new, and maintaining motivation for engagement. Participants also stated that “usually mental health usually gets pushed to the bottom” of priorities. Omar further explained:

> "Your circumstances would really hinder it, because like if you are going through some stuff real deep and you are real deep into it, you know, like life is crashing down on you, you are not going to be worried about no psychiatrist, you would be worried about how to get through the next day."

Interpersonal facilitators to mental health care included being able to meet with one person consistently, establishing a personal connection with the provider, and providers being able to share a bit about their background. However, barriers included the pressure to prove to a provider that "you are actually crazy… that you need to be there."

Organizational Level

Facilitators at the organizational level included having more providers available, existing providers offering additional availability for people with longer work hours and having "counselors at school that are really counselors." Primary barriers, reported in nearly every discussion, were cost, health insurance (e.g., obtaining coverage, mental health providers being out-of-network), and lack of access. Participants strongly perceived that mental health services are only offered in distant neighborhoods or certain parts of town: "All the negative stuff, we can find next door, but it is just like the stuff that we actually need, we have to go out on highways to get it." To address this, participants recommended home visits, providing transportation to mental health care facilities, and making services available in local community centers. Furthermore, mental health providers coming to participants' neighborhoods could "make me feel like you care, instead of me always having to come to you."

An additional barrier was concern about confidentiality. One participant stated that a breach of confidentiality could lead to backlash from a gang or others in the community, and "I don't care about my mental health if I know I'm not safe." Finally, focus groups also described a lack of Black and African American mental health providers as a barrier to care.

Participants commented that, "I probably would feel more comfortable with a Black person" because "they can identify with you personally." Malcom discussed his personal experiences with a therapist and why this might be important:

> "I mean my counselor is not African American right now, but fortunately we clicked really well, but I think that for a lot of people, you know, when you first see someone and they look like you, that is the first thing and you are like okay, you know, you don't have to have that guard up."

Furthermore, participants noted an additional issue that providers of color "are not in the neighborhoods."

Community Level

Participants commented on a growing awareness around mental health as a facilitator for seeking services. Additional facilitators included being able to see another Black person, particularly a local public figure or "somebody who has been through that shit" be willing to talk to a mental health provider. However, participants stated that it would be difficult to discuss mental health while the same problems persist in their neighborhoods. For example, Omar explained:

> "I'm not fitting to worry about working, catching the bus across town to go see this man and talk to him and hear what he got to say to say to see if I would want to, you know, believe what he has to say and actually accept and then go back home to what I just came from to begin with."

Policy Level

Focus groups acknowledged need for change at the policy level, including more funding (e.g., use of tax funds) to facilitate access to mental health care. Furthermore, perceived barriers included having to get in legal trouble (i.e., "catch a case") to have access to mental health care. Participants commented, "I think they are not going to make it affordable for you to do those things unless you get in trouble," and "a person can't even put

themselves in anger management… but you will find out real quick if you get an assault charge." Disparities in punishment and incarceration were also a barrier, with Black adolescents and young adults "going to jail for life" more often than receiving mental health care. Another participant agreed and noted that these disparities can also be fatal: "You got that right. They are going to give you 30+ years or they are going to kill you."

Intentions

The intentions item on the brief survey, regarding intentions to seek mental health care in the near future, showed an average rating of 2.98 (*SD* = 1.13). Within focus groups, ratings of intentions to seek mental health screening/LTC varied widely. One participant explained his motivation for seeking care for persistent problems:

> "I'm probably going to seek some help in some areas, because I just haven't got there myself… I feel like you need to get to know yourself all the way, so you can thoroughly explain the problems to a doctor or a professional … You have to figure it out for yourself first, then seek out the right and correct help for those problems."

CHAPTER 4

DISCUSSION

This study was among the first to qualitatively examine mental health screening/LTC among community-based, young Black/African American men with trauma exposure, who are at risk for mental health concerns (e.g., depression, posttraumatic stress). This study was unique compared to previous TPB-based studies on mental health service use among young Black/African American men, which have primarily consisted of young men from colleges and universities (e.g., Mesidor & Sly, 2014) or those involved in the justice system (Kretschmar et al., 2015). Participants in this study represented a broad community sample that was recruited from several sectors including barbershops, churches, men's organizations, and local colleges. The sample also represented a range of income and education levels.

Most participants reported exposure to multiple traumatic experiences, with an average of two to three events. More specifically, 42% had been threatened by a weapon. Forty-two percent had also experienced loss of friends or family members to accidents, suicide or gun violence; nearly one-third had personal history of getting robbed/mugged; and more than 25% had a serious injury/life threat or witnessed someone being seriously injured, assaulted, or killed. These findings are consistent with previous literature that has demonstrated great risk for trauma among young Black/African American men (Boyraz et al., 2015), particularly assault and traumatic loss (Alim et al., 2008; Davis et al., 2008; Samuel, 2015; Smith, 2015; Smith, 2014), which may escalate throughout development and young adulthood (Richardson et al., 2016; Smith, 2015; Smith & Patton, 2016; Smith, 2014).

Despite all participants having been exposed to trauma, only half of the participants reported receipt of previous mental health screening. Among participants who had talked to a

mental health provider, 61% had engaged in two or more sessions, while 28% of participants attended only a single session. Although these rates are greater than previous studies of African American adolescents (Williams, 2014) and African American men (Mays et al., 2018), it is likely that not all participants who may have benefitted from mental health services received needed screening/LTC. Measures of current depression and posttraumatic stress symptoms reflected mild depression and probable PTSD among participants, respectively, yet participants endorsed very low intentions to seek mental health care in the near future. A study by Mesidor and Sly (2014) demonstrated moderate intentions to seek mental health care among African American college students, which highlights the low likelihood that young African American men in broad, urban community settings will seek mental health care, even when needed.

Intentions are a key factor for engagement in health behaviors, as described by the TPB (Ajzen, 1991; Ajzen & Fishbein, 1980) and studies of men's mental health service utilization (e.g., Sagar-Ouriaghli, Godfrey, Bridge, Meade, & Brown, 2019). The low intentions ratings in the current study were possibly driven by the participants' attitudes that indicated low perceived need for mental health care. Their comments suggested that "dealing with" chronic mental health symptoms was common among young African American men and not severe enough to warrant treatment-seeking, especially given the significant barriers they would have to overcome to access services. Furthermore, their responses point to the need for culturally relevant, tailored interventions to promote intentions to receive mental health screening/LTC and engagement in services for young Black/African American men by addressing individual, cultural, and systemic barriers to mental health care. Using the TPB as

a guiding framework for focus groups, this study highlighted key viewpoints of young Black/African American men regarding mental health care.

Focus group participants endorsed beliefs in the potential for mental health services to be effective for themselves and other young African American men. This supports positive beliefs from previous qualitative studies of young adult African American males about mental health services being able to help (Kendrick et al., 2007; Lindsey, 2010; Ward & Besson, 2012; Watkins & Neighbors, 2007) which were especially prevalent among African American adolescents who continued to engage in therapy (Samuel, 2015). Participants across focus groups also expressed the belief that mental health services could provide training in methods to actively cope with mental health problems and ongoing stressors (e.g., identifying triggers, making the right choices, de-escalating conflict). This suggests willingness to take an active role in managing mental health, with interest in learning skills that could be used in their daily lives. However, participants also acknowledged negative beliefs related to mental health care, such as requiring a substantial amount of personal effort that not all young African American men would invest. Furthermore, participants endorsed a cultural mistrust of providers, which contributed to the need to maintain interpersonal barriers between oneself and provider throughout the course of therapy. Notably, participants also described mental health providers' perceived inability to understand the problems of young African American men. Similar beliefs have been persistent among African American men in the qualitative mental health literature (Hankerson, Suite, et al., 2015; Lindsey, 2010; Lindsey, Barksdale, et al., 2010; Sanders Thompson et al., 2004; Ward & Mangesha, 2013; Watkins & Neighbors, 2007; Watson, 2014). Furthermore, behavioral belief scores were lower among participants compared to a previous study consisting of African American

college students (Mesidor & Sly, 2014). Interventions designed to promote mental health screening/LTC among urban, young men of color should make focused efforts to build behavioral beliefs, with focused attention on addressing mistrust of mental health providers and medical systems and concerns about negative outcomes from seeking services (e.g., loss of confidentiality; being misdiagnosed, labeled, prescribed unhelpful or harmful medication).

Normative beliefs regarding support from others is also a key construct of the TPB. Participants endorsed moderately high normative beliefs and willingness to comply with key referents if encouraged to seek screening/LTC. Key normative referents identified by participants included significant others and parents/family. Significant others were exclusively discussed as being supportive, while the level of support from family members varied among focus groups. As described by Lindsey and colleagues (2010; 2006), families may be a primary source of influence for mental health help-seeking and may exert an even greater influence on mental health treatment-seeking than peers. For instance, African American adolescents with parental support were more likely to report receipt of mental health care, and parents were a crucial link for adolescents to follow through with LTC after mental health referrals from teachers (Lindsey et al., 2006). In contrast, stigmatizing attitudes toward mental health care from family and friends may be a significant deterrent for young Black/African American men considering mental health care (Kranke et al., 2011; Lindsey, 2010; Lindsey, Joe, et al., 2010; Lindsey et al., 2006). Researchers have recommended the inclusion of family norms in mental health care promotion interventions for African American young adults (Barksdale & Molock, 2009), and the current findings suggest that significant others may also be a key influence in increasing intentions and care-seeking behaviors among young African American men. Thus, interventions should consider how

close family members and significant others can be activated to promote positive norms regarding mental health for young African American men, in order to foster care-seeking and use of mental health services.

Participants also discussed the role of faith-based factors in terms of behavioral and normative beliefs. While some participants described relying on faith in God before seeking professional help, others perceived professional mental health care to be more effective than prayer or religious coping. Although Ward et al. (2013) found that young African Americans were more likely to prefer religious coping than professional mental health care, qualitative studies have found that religious coping may be less likely among young Black/African American men compared to the larger African American community (Lindsey et al., 2006). Despite the high religiosity and frequency of church attendance among adult African Americans, particularly African American women, young African American men are less likely to report a religious affiliation or engage in religious behaviors (e.g., pray, attend church services; Diamant & Mohamed, 2018; Pew Research Center, 2009; Taylor, Chatters, & Brown, 2014). Participants also discussed faith-based referents, with less acceptance for mental health services among individuals with greater religiosity and more established connections to the church. However, a study by Kranke and colleagues (2011) demonstrated that faith-based organizations exerted less influence on mental health help-seeking among African American male adolescents compared to African American adults. Faith-based organizations have been recommended settings for mental health promotion interventions broadly (Hays & Aranda, 2016), but mental health promotion programs designed to reach young Black/African American men may be more feasible and effective if implemented in broad community settings (Lindsey et al., 2017). However, tapping into faith-based settings

could provide opportunities to promote positive norms about mental health care among significant referents for young African American men (e.g., parents, significant others). Programs to promote mental health screening/LTC could also examine the impact of incorporating religious tailoring with other culturally relevant themes, to more effectively reach a broad audience of young minority men. Finally, although African American college students demonstrated an interest in incorporating religious beliefs into mental health treatment (Mesidor & Sly, 2014), clinical researchers and providers should work with young African American men to determine whether religious values are a relevant consideration for treatment.

Control beliefs were moderate, although lower than African American young adults in a study by Mesidor and Sly (2014). Participants' responses related to control beliefs included complex, multilevel systemic barriers to mental health screening/LTC. Primary systemic barriers that limit personal control identified in focus groups were cost, insurance, and lack of access (e.g., availability of providers, services not being available within their communities), which was consistent with other studies with young African American men (Davis & Ford, 2004; Lindsey, 2010; Lindsey, Barksdale, et al., 2010; Lindsey et al., 2017; Lindsey & Marcell, 2012; Lynch et al., 2018; Meyer et al., 2015; Seal et al., 2014; Wallace & Constantine, 2005; Watson, 2014). In the current study, suggested solutions to overcome these barriers included home visits, transportation assistance, provision of mental health services in community centers, and allocation of funding for community mental health programs. Although focus groups did not elicit telehealth as a way to increase use of mental health services, this is a growing area within the mental health field, with potential to increase access to care for young minority men and should be tested with this population

(Perle & Nierenberg, 2013). Community-based interventions to address trauma and violence have enlisted community leaders to mediate conflict (Butts et al., 2015; Whitehill et al., 2013). It may also be helpful to enlist trusted community leaders to share their personal stories about receipt of mental health care.

Some participants emphasized the importance of having a Black/African American mental health provider who would be more likely to understand one's problems and more easily establish rapport and trust. However, the emphasis of race concordance between patient and provider varied among participants, as it has in previous studies (Lindsey, 2010; Lindsey et al., 2006; Watson, 2014). While training programs have made efforts to recruit and retain diverse providers (e.g., Dovidio, Penner, & Pachankis, 2016), recommendations have also been made across the field for providers to use culturally competent approaches when working with diverse populations (Stevens-Watkins & Lloyd, 2010). The National Institute of Mental Health has recognized the importance of ensuring availability of culturally-adapted care and mental health professionals who are representative of underserved populations, and it has developed initiatives to increase diversity among mental health professionals (National Institute of Mental Health, 2019). Furthermore, it has been recommended that mental health providers understand and address cultural considerations and related factors (e.g., religious coping, social support) when working with young Black/African American men, during both assessment and throughout a treatment protocol (Bryant-Davis, 2005; Comas-Díaz, 2016; Scurfield & Mackey, 2008). For instance, as part of culturally competent care, providers should be able to recognize the presentation of mental health symptoms among young minority men, which may differ from the general population by emphasis on stress, irritable mood, or somatic symptoms (e.g., insomnia, changes in

appetite or weight; Bailey, Blackmon, & Stevens, 2009; Das, Olfson, McCurtis, & Weissman, 2006; Hankerson et al., 2011; Kendrick et al., 2007; Payne, 2012; Watkins & Neighbors, 2007). Additionally, providing validation for their willingness to address symptoms, acknowledging both adaptive and maladaptive coping strategies, and discussing factors impacting the therapeutic relationship may help to improve engagement in services and therapy outcomes (Bryant-Davis, 2005; Hankerson, Suite, et al., 2015; Sanders Thompson et al., 2004).

There were some limitations to the current study. The brief survey did not include measures of sexual orientation or gender identity. Self-report measures of receipt of screening/LTC depended on participant recall for number, timing, and duration of treatment sessions, and it is unclear how many sessions participants attended with a mental health provider. However, this study provides insight into participants' experiences with initial mental health screening/LTC, which is an important first step to engagement in mental health services. It is also possible that participants did not recognize when providers were attempting to complete mental health screening or link them to mental health services; therefore, it is possible that frequency of screening/LTC may be higher than reported. The qualitative nature of the study and the potentially stigmatizing topic may have resulted in some bias (e.g., social desirability), but the young men were highly engaged in focus groups and commented on the need to have opportunities to openly share their opinions and experiences. Finally, the sample represented a young, urban African American population, which may have different needs, perspectives, and experiences compared to rural or suburban young African American men or young men in other settings (e.g., incarcerated). However, recruitment from multiple urban sectors is a strength of this study and the participants

represented a wide socioeconomic range. Overall, this TPB-guided study has potential to inform interventions to increase mental health screening/LTC for high-risk urban youth with trauma exposure, as well as provide insight into the mental health care needs and preferences of this priority population.

Mental health promotion interventions should make efforts to address behavioral beliefs around mental health screening/LTC, with a particular focus on cultural mistrust and negative outcome expectations, and with promotion of positive norms of mental health care among significant others and parents. Faith-based elements should be used in conjunction with other tailored strategies to provide the broadest reach for populations of young African American men with variable levels of religiosity. Finally, interventions must address the systemic barriers to care that limit access to mental health care for high-risk young African American males, while ensuring that providers are able to provide culturally competent care.

Conclusions

Despite all participants having a history of trauma exposure, a large proportion had not received mental health screening or needed care. Furthermore, participants endorsed low intentions to seek mental health services. Participants described belief in the effectiveness of mental health services and potential to gain skills for ongoing management of mental health, but they also acknowledged negative expectations and cultural mistrust of mental health services. They identified key normative referents as significant others and parents/family and recognized a great number of multilevel influences on control beliefs, primarily reflecting lack of access and availability of services. It is imperative that researchers make concerted efforts to promote mental health care among young African American men in urban communities, particularly given the grave trauma disparities that burden this population.

APPENDIX A
Focus Group Discussion Guide

Prior to beginning with the welcome for the focus group, participants will be asked to:

- Help themselves to dinner, which will be available in the meeting room.
- Complete the focus group survey and to put it in an unmarked envelope after completion.
- Write whatever first name they would like to use on a table tent.

Focus group moderator and assistant will: mingle with participants, encourage participants to get a plate of dinner and find a seat where they are comfortable, and ask participants to write a pseudonym on the table tent in front of them.

Welcome Statements

Good afternoon/evening! Thank you for taking time to talk with us about community mental health. My name is Alex Bauer and assisting me is [*name of study staff*]. We're with the University of Missouri-Kansas City School of Medicine. Our study is trying to figure out how to develop mental health screening and linkage to care initiatives tailored for young African American men in urban communities. You've been invited because we are interested in getting your input on the facilitators and barriers to developing and implementing community-based mental health programs.

We'd like your help to learn more about things that would motivate young African American men in the community to participate in mental health screening and linkage to care (e.g., referral to services), as well as potential challenges that they would need to overcome to address mental health. There are thousands of African Americans in the Kansas City metro area who are affected by potentially traumatic events (e.g., serious injury, abuse, witnessing violence), and what you share with us today can be used to help improve community mental health. We are having meetings like this one with several groups of community members here in the KC area.

You are the expert(s), so what you have to share is very important to us. Please make sure to respect the opinions of others, but you should feel free to share your opinions even if it differs from what others have said. While you may have different opinions, there are no wrong answers to these questions. We want to hear from everyone -- even when you may not agree with others. We have about 8 questions that we want to discuss over the next 1 1/2 to 2 hours. To make sure that we hear from everyone on these questions, there may be times when I move the discussion along.

You've probably noticed the digital recorder. We are recording the session, because we don't want to miss any of your comments. People often say very helpful things in these discussions, and we can't write fast enough to get them all down. We will be using these pseudonyms, and we won't use any names in our reports. The report of this discussion will be used with our research group and community partners to help plan future efforts in the area of community-based mental health programming. You may be assured of complete confidentiality. Okay, let's get started. The name cards on the table in front of you are to help us remember each other's fake names. Let's find out some more about each other by going around the table.

Opening question
Tell us your *fake* name and one thing you enjoy doing in your spare time (e.g., reading, movies, sports).

Transition question

1. Let's begin by talking about some of the experiences people have that could make them want to seek mental health care. Have you ever had any especially difficult experiences or times in your life, or emotional problems? Did it make you think about seeking mental health care?

<u>Focus group questions related to TPB constructs</u>

Attitudes/behavioral beliefs toward mental health screening/LTC

2. How could young African American men benefit from receiving mental health services?
   - Describe any negative outcomes and/or bad things that could happen to you or other community members from receiving mental health services
   - What positive outcomes and/or advantages could you and other community members receive from mental health services?
   - What would you want or expect to happen if you sought out mental health services?
   - What else comes to mind when you think about mental health screening and care?

Normative beliefs related to receipt of mental health screening/LTC (Relevant referents)

3. Now let's talk about who would be supportive or not so supportive of you seeking mental health services.
   - What people, groups, or organizations *would not* be supportive of you and other community members receiving mental health services?
   - What people, groups, or organizations *would be* supportive of you and other community members receiving mental health services?
   - On a scale of 1 to 10, how motivated would you be to receive mental health screening or care with the support of others?

Behavioral control over receiving mental health screening/LTC

4. If you or others desired to get mental health screening or care, there may be some things that could make it harder or easier to be seen.
   - What personal and community factors/circumstances would make it harder or impossible to seek mental health services (e.g., lack of access, cost of tests, not a priority compared to other things going on in life)?

- What personal and/or community factors would make it easier to use mental health services (e.g., availability, assuredness that your disclosures would not be shared with others)?

- Do you know what kind of symptoms would make you seek mental health care? What are they?

Intentions to receive mental health screening/LTC

5. On a scale of 1 to 10, how likely are you to seek mental health care in the near future?

History of mental health screening/LTC

6. How many of you have spoken with a doctor or health care provider about mental health concerns?
   - How were you linked to mental health care (e.g., referred by a doctor, found it on your own)?
   - How long ago did you see a provider?
   - What is a positive or negative experience?
   - Did you engage in services long-term?

Intervention Strategies

7. What potential strategies or resources would help you get mental health care, if you wanted it? For instance, are there any places such as church, community centers, or school, where you think mental health should be discussed? Who should talk about mental health, and when would it be helpful to have these conversations?

Wrap-up question

8. If resources were not an issue, what other tools or support would your community need to fully participate in implementing mental health screening and linkage to care services?

Focus Group Closing

That's all of the questions we have for this focus group meeting. Take a moment and think about what's been discussed. Now we'd like to take a few moments to summarize what's been discussed. [Do a brief summary]. Did we miss anything? Does anyone have any questions about what was discussed or how this information will be used?

We really appreciate the time you have taken to help us better understand how you to develop and implement community-based mental health screening and linkage to care interventions for young African American men. We hope you were comfortable and felt like you had an opportunity to share your thoughts and opinions. Please feel free to give us feedback on the questions asked, this meeting space and time, or anything else you think we should know.

Thanks again.

APPENDIX B
Brief Survey Measures

Demographics

1. **How old are you?** Write in age _____

2. **What was your sex at birth?**
   ☐ Male
   ☐ Female

3. **Do you identify your ethnicity as being of Hispanic or Latino origin?**
   ☐ No, not of Hispanic or Latino origin
   ☐ Yes, Mexican, Puerto Rican, Cuban, or another Hispanic, Latino, or Spanish origin
   ☐ Unknown
   ☐ Refuse to answer

4. **What is your highest level of education completed?**
   ☐ 11th grade or less
   ☐ High school graduate or GED
   ☐ Post high school technical training
   ☐ Some college (but no degree)
   ☐ Associate's degree (AA) or technical school certificate
   ☐ Bachelor's degree (BA, BS)
   ☐ Some graduate school or graduate degree

5. **Do you have health insurance or coverage that helps pay for part of your medical bills?**
   ☐ Yes, Medicare or Medicaid
   ☐ Yes, Private insurance (e.g., Blue Cross/Blue Shield, United Healthcare)
   ☐ Yes, Some other insurance
   ☐ No, I do not have health insurance

6. **For the past 12 months, please estimate the average monthly income of your household.** Include all the sources of income from all members of your household. *(Check one)*
   ☐ $0 - $1,000
   ☐ $1,001 - $2,000
   ☐ $2,001 - $3,000
   ☐ More than $3,000
   ☐ Don't know
   ☐ Refuse to answer

Exposure to Trauma

Which of the following have happened to <u>you or someone close to you</u>? *Check all that apply.*

	Happened to me	**Happened to someone close to me**	**Neither me or someone close to me**
7. Life threatening illness or accident	☐	☐	☐
8. Robbery or mugging	☐	☐	☐
9. Being threatened with a weapon (knife, gun, etc.)	☐	☐	☐
10. Witnessing another person being seriously injured, assaulted, or killed	☐	☐	☐
11. Losing a loved one as a result of accident, suicide, or homicide	☐	☐	☐
12. Serious injury or threat to life	☐	☐	☐
13. Physical harm from a parent or caregiver as a child	☐	☐	☐
14. Being physically harmed or beaten as an adult	☐	☐	☐
15. Forced sexual activity	☐	☐	☐
16. Other (please describe): _____	☐	☐	☐

17. **Have you ever talked to a professional about mental or emotional problems?** *(Check one)*
    - ☐ Yes
    - ☐ No
    - ☐ Don't know
    - ☐ Refuse to answer

18. **Who have you talked to about mental or emotional problems?** *(Check all that apply)*
    - ☐ A mental health provider (e.g., psychiatrist, psychologist, counselor, social worker)
    - ☐ A medical professional (e.g., primary care doctor, or another doctor or nurse)
    - ☐ A teacher or other school personnel
    - ☐ A pastor or spiritual leader
    - ☐ Other: _____

19. **When was the last time you talked to any professional about a mental/emotional problem?** *(Check one)*
    - ☐ Within the past 12 months
    - ☐ Within the past 13-24 months
    - ☐ More than 24 months
    - ☐ Don't know

20. **How many times have you seen a mental health provider about mental/emotional problems?** *(Check one)*
    - ☐ Once
    - ☐ Two or more times
    - ☐ Don't know

21. **How long did you see a mental health provider about a mental/emotional problem?** *(Write in number of years and months). If never or don't know, write in "0")*
    _____ years and _____ months

22. **Where have you received support for mental or emotional problems?** *(Check all that apply)*
    - ☐ Clinic or health center
    - ☐ Doctor's office
    - ☐ Hospital outpatient department
    - ☐ Community center
    - ☐ Emergency room
    - ☐ School
    - ☐ Church
    - ☐ Correctional facility (e.g., jail, prison)
    - ☐ Not applicable (never received support)
    - ☐ Other: _____

Inventory of Attitudes Toward Seeking Mental Health Services (IASMHS)

	Disagree				Agree
23. There are certain problems which should not be discussed outside of one's immediate family.	0	1	2	3	4
24. I would have a very good idea of what to do and who to talk to if I decided to seek professional help for psychological problems.	0	1	2	3	4
25. I would not want my significant other (spouse, partner, etc.) to know if I were suffering from psychological problems.	0	1	2	3	4
26. Keeping one's mind on a job is a good solution for avoiding personal worries and concerns.	0	1	2	3	4
27. If good friends asked my advice about a psychological problem, I might recommend that they see a professional.	0	1	2	3	4
28. Having been mentally ill carries with it a burden of shame.	0	1	2	3	4
29. It is probably best not to know everything about oneself.	0	1	2	3	4
30. If I were experiencing a serious psychological problem at this point in my life, I would be confident that I could find relief in psychotherapy.	0	1	2	3	4
31. People should work out their own problems; getting professional help should be a last resort.	0	1	2	3	4
32. If I were to experience psychological problems, I could get professional help if I wanted to.	0	1	2	3	4
33. Important people in my life would think less of me if they were to find out that I was experiencing psychological problems.	0	1	2	3	4
34. Psychological problems, like many things, tend to work out by themselves	0	1	2	3	4
35. It would be relatively easy for me to find the time to see a professional for psychological problems.	0	1	2	3	4
36. There are experiences in my life I would not discuss with anyone.	0	1	2	3	4
37. I would want to get professional help if I were worried or upset for a long period of time.	0	1	2	3	4
38. I would be uncomfortable seeking professional help for psychological problems because people in my social or business circles might find out about it.	0	1	2	3	4
39. Having been diagnosed with a mental disorder is a blot on a person's life.	0	1	2	3	4

40. There is something admirable in the attitude of people who are willing to cope with their conflicts and fears without resorting to professional help.	0	1	2	3	4
41. If I believed I were having a mental breakdown, my first inclination would be to get professional attention.	0	1	2	3	4
42. I would feel uneasy going to a professional because of what some people would think.	0	1	2	3	4
43. People with strong characters can get over psychological problems by themselves and would have little need for professional help.	0	1	2	3	4
44. I would willingly confide intimate matters to an appropriate person if I thought it might help me or a member of my family.	0	1	2	3	4
45. Had I received treatment for psychological problems, I would not feel that it ought to be "covered up."	0	1	2	3	4
46. I would be embarrassed if my neighbor saw me going into the office of a professional who deals with psychological problems.	0	1	2	3	4

Patient Health Questionnaire (PHQ-9)

Over the last two weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
47. Little interest or pleasure in doing things	0	1	2	3
48. Feeling down, depressed, or hopeless	0	1	2	3
49. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
50. Feeling tired or having little energy	0	1	2	3
51. Poor appetite or overeating	0	1	2	3
52. Feeling bad about yourself or that you are a failure or have let yourself or your family down	0	1	2	3
53. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
54. Moving or speaking so slowly that other people could have noticed (or the opposite, being so fidgety or restless that you have been moving around a lot more than usual)	0	1	2	3
55. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3

Primary Care PTSD Screen for DSM-5 (PC-PTSD-5)

Sometimes things happen to people that are unusually or especially frightening, horrible, or traumatic (like a serious accident, physical assault, natural disaster, seeing someone seriously injured or killed, or having a loved one die through homicide or suicide).

56. **Have you ever experienced this kind of event?**	☐ Yes	☐ No

IF YES TO #63: In the past month, have you…	**Yes**	**No**
57. Had nightmares about the event(s) or thought about the event(s) when you did not want to?	☐	☐
58. Tried hard not to think about the event(s) or went out of your way to avoid situations that reminded you of the event(s)?	☐	☐
59. Been constantly on guard, watchful, or easily startled?	☐	☐
60. Felt numb or detached from people, activities, or your surroundings?	☐	☐
61. Felt guilty or unable to stop blaming yourself or others for the event(s) or any problems the event(s) may have caused?	☐	☐

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VITA

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