2008

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Community Ment Health J (2009) 45:272–284
DOI 10.1007/s10597-009-9186-7

ORIGINAL PAPER

Exploring the Mental Health of Black Men Who Have Sex with Men

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Received: 15 January 2008 / Accepted: 23 February 2009 / Published online: 17 March 2009

Absract Current research indicates that black men who have sex with men (MSM) are disproportionately burdened by depressive distress and anxiety disorders as compared to their white gay and heterosexual counterparts. This study utilizes focus groups to qualitatively explore issues surrounding the mental health status of this population in an attempt to shed light on potential influencing and determinant factors. Twenty-two self-identified black, or multiracial including black, MSM residing in Atlanta, Georgia participated in two focus groups—11 subjects each, respectively. Categories that emerged from data analysis include: knowledge/experiences, attitudes/beliefs, societal action/behavior, identity development, relationship functionality, and mental health status. Overarching themes for each category were delineated.

Keywords Depression · Anxiety · Men who have sex with men (MSM) · Gay · Black

This paper was presented at both the 2007, 78th Annual Meeting and Conference of the Georgia Public Health Association (GPHA), and the Our Common Welfare: MSM Health & Wellness Summit in Atlanta, Georgia (2007).

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Introduction

Prevalence of Primary Mental Disorders Among Black Men Who Have Sex with Men

To date, while there are no available sample statistics of mental illness prevalence among black men who have sex with men (MSM) in the US that can accurately estimate a population parameter, current research suggests that black MSM are disproportionately burdened by depressive distress and anxiety disorders as compared to their gay and black male reference groups. One study conducted by Cochran and Mays (1994) used the Center for Epidemiologic Studies-Depression scale (CES-D) (>15 cutoff score) to assess a point prevalence of depression among a non-random, nationally representative, with respect to geographic region, sample of black MSM ($N = 829$; from 41 states—25% west, 23% northeast, 19% mid-west, 15% south). Researchers found a 32.6% prevalence rate of depression among their sample, which is likely to be an underestimate given recent evidence indicating that the CES-D may not be an accurate screening tool for ethnic minorities (Perreira et al. 2005). Nevertheless, the mean score in this sample was 12.8, compared to 9.9 (Cochran 1987; Miller et al. 1990) and 9.8 (Vernon et al. 1982; Thomas et al. 1988) for gay men and black men, respectively in other previous studies using the CES-D. Further, other studies using the CES-D and same cut-off score have found 25.9% prevalence among blacks compared to 16.5% among whites (Frerichs et al. 1981; Gary and Berry 1985).

Contributing Social Determinants

While very little is known about factors that may influence the mental health of black MSM in particular, previous studies among black and MSM populations in general point to key areas for initial exploration among black MSM specifically. The brief literature review that follows has been organized in reference to the findings of the current study to more clearly present their relevance and implications for this study.

Identity Development

Racial and sexual identities are multifaceted concepts with many dimensions (Sell 1997). Crawford et al. (2002) used the minority ethnic identity measure (MEIM) to operationalize racial identity development among a sample of African American gay or bisexual men (AAGBM) in a study showing that AAGBM who possess more positive (integrated) self-identification as being African American and gay reported lower levels of psychological distress, and higher levels of life satisfaction and self-esteem than their counterparts who reported less positive African–American and gay identity development. The MEIM is based on the most prominent African–American identity development model proposed by Cross and colleagues which posits that as African Americans become aware that they are oppressed, their attitudes toward themselves, their own group, other ethnic minority groups, and members of majority cultures take shape in a way that leads to a central sense of self (Cross 1995). According to this model, the most psychologically healthy phase of functioning for African Americans is called Integration (Crawford et al. 2002). In this study, of the four modes of ethnic-racial acculturation (marginalization, separation, assimilation, and integration), those who had achieved Integration had a mean score of 3.26 on the Life Satisfaction Survey (LSS) (1–4) which was statistically significantly different from those who were categorized into marginalization with a mean LSS score of 2.74.

Stigma, Discrimination, and Victimization (SDV)

A mounting body of evidence on the relationship between social inequality and mental health outcomes suggests that certain social statuses related to race/ethnicity, sexuality and socioeconomic status, may greatly affect the probability of exposure to discrimination, abuse, and violence (Fife and Wright 2000) as a result of stigmatization (Krieger and Sidney 1996) which may influence acquisition of social and personal resources (Turner and Lloyd 1999). Experiences of stigmatization and discrimination have been shown to lead to greater susceptibility to depressive distress and anxiety (Finch et al. 2000; Kessler et al. 1999). Evidence in the literature is extensive regarding the associations between SDV and psychosocial health among blacks (Williams and Williams-Morris 2000). In the study by Crawford et al. (2002) referenced above, SDV was operationalized using the schedule of racist events (SRE), and authors found that racist events predicted 34% of the variability in life satisfaction—every one unit increase on the SRE corresponded to a 0.12 decrease in LSS.

Attitudes, Behaviors, and Beliefs: Homophobia and Heterosexism

Many individuals express negative attitudes toward homosexuality. Media-based surveys (Lacayo 1998) have found that many Americans believe that homosexual relationships are deplorable and are immoral, that homosexuality is subject to preference, and that gay men should not serve in the military, parent children, or instruct in schools. A Newsweek poll reported that approximately 50% of those polled believed homosexuality is a sin (Leland et al. 2000), and roughly 33% in another survey believed it to be a mental illness (Americans on Values 1999).

There is a paucity of mental health research on black MSM and studies that have been done are mostly quantitative and consider individual contributing factors singularly. There is an immense need for deeper and more holistic investigation of the issues affecting the mental health of black MSM. This study begins this work by exploring the mental health of black MSM through focus groups in an attempt to shed light on the ways in which the above, and potentially newly uncovered, factors may influence and affect each other and are interrelated with respect to the mental health of black MSM. A better understanding of mental health determinants among black MSM will advance psychosocial health promotion and protection tools and strategies that will ultimately lead to decreases in mental illness related morbidity and mortality. An enhanced understanding of mental health determinants among black MSM will aid in the improvement of quality of care, increased acceptability of services, and more targeted prevention efforts for this vulnerable population.

Methods

Research Participants

Eligibility criteria included being male, self-identifying as black, self-identifying as non-heterosexual, being $\geq$18 years of age, and providing both verbal and signed informed consent. While it is acknowledged that the sociocultural and historical backgrounds of groups comprising the racial designation ‘black’ differ to some degree, they all

share some common elements of black experiences both in relation to other racial designations and to each other, particularly concerning the constructs being considered; therefore, the study sample was not exclusive to solely African–Americans, although the vast majority of participants identified as such. Purposive sampling was employed to ascertain individuals representing diverse income levels, educational attainment, and backgrounds. Participants' HIV status was not ascertained so as to avoid both the dialog stifling affects of stigma surrounding HIV and in an attempt to circumvent centering the focus group conversations on HIV which can happen easily among this community that HIV affects so greatly and that is bombarded often with requests to discus HIV related issues. Participants were recruited from universities, churches, nightclubs, book stores, and other community venues via palm cards, flyers, online outreach, listservs, and word-of-mouth. Efforts were made to insure that the resultant sample was as accurate a representation of subgroups and communities as possible given resource constraints and the difficulty in accessing the target population.

Procedures

Development of focus group moderator's guide was in part informed by information gleaned from the literature on three core content areas delineated above: (1) mental illness prevalence among black MSM; (2) underlying contributing determinants of mental health and mental illness among black MSM; and (3) socio-cultural factors influencing the mental health of this population (Table 1). A semi-structured focus group format design was selected because it combines a highly structured framework with the flexibility to probe for further detail, which allows for focused, conversational, communication. This methodology can reveal key perspectives and nuances that researchers may not be able to foresee. Group interaction is an explicit component of this methodology. Rather than the moderator asking each person to respond to a question in turn, participants are encouraged to talk to one another, ask questions, exchange anecdotes, and comment on one another's experiences and perspectives.

A partnership with a local community-based organization (CBO) serving the target population was established to assist in the development of the moderator's guide, coordinate the recruitment of focus group participants, and administer facilitation training. The moderator's guide was crafted with careful consideration to wording, sequence, and content. Ten core focus group questions were designed to elicit insight and require the participants to describe what they think or perceive. All the questions were pretested to determine whether the questions and flow of questions encouraged thoughtful responses. The African American Gay Outreach division in the Education Department of the partnering CBO houses a program, which centers on the tremendous disparity of African American MSM residing in the greater Atlanta area, becoming infected with HIV and STI's. Their highly trained staffs, many of whom are part of the communities they serve, create and implement culturally appropriate and sensitive programs effective and efficacious in reaching African American MSM communities.

One moderator and one recorder including the Principal Investigator and staff provided by the partnering CBO were present at each focus group, which averaged 60–75 min. Each moderator participated in a required workshop prior to engaging participants. The workshop included training in research involving human subjects, effective facilitation skills, and the use of the focus group guide developed for this project. The training provided in-depth information that served as a guide for conducting the focus groups and appropriately handling any situations that arose. In Spring 2007, two focus groups of 11 participants each were conducted and digitally recorded, according to standard focus group research methodology, including the administration of an intake form to all participants collecting basic demographics as well as general information regarding participants' mental health help-seeking behavior. The institutional review board at a local medical school approved

Table 1 Focus group questions

1. What is unique about black MSM compared to MSM in general and black men in general?
2. What are some of the most difficult challenges, if any, you face as a result of your ethnic and/or sexual identity?
3. What is most stressful, if anything, about being a black MSM?
4. What does it mean to be a man?
5. What does it mean to be a black man?
6. What does it mean to be a man who is gay, SGL, or however you identify sexually?
7. If you have ever been depressed, please share about a time you were the most depressed you have ever been?
8. What lead to your depression?
9. How did you know you were depressed?
10. What did you do to deal with it?

this study and the authors certify responsibility for this manuscript.

Analysis

The recordings were transcribed verbatim to permit analysis using qualitative analysis software. NVIVO Software program was used in an open coding process for focus group content analysis. Data were analyzed by two coders and was cross referenced. Coding differences were reconciled by coders. Grounded theory, which relies on an inductive approach to data analysis, was used.

Rather than beginning the inquiry process with a preconceived notion of what was occurring, the approach focused on understanding a wide array of experiences and building understanding grounded in real-world patterns. Grounded theory was originally developed by Glaser and Strauss in the 1960s and is a complex iterative process whereby research begins with the raising of generative questions which help to guide the research but are not intended to be either static or confining. As researchers began to gather data, core theoretical concepts were identified and tentative linkages were developed between the theoretical core concepts and the data. Coding was used for both categorizing focus group data and for describing the implications and details of these categories.

Initially open coding was done, considering the data in minute detail while developing some initial categories. Following this, more selective coding was done where data were systematically coded with respect to a core concept. Memoing was used for recording the thoughts and ideas of the research team as they evolved throughout the study. The goal of the analysis was "to identify common themes" through the qualitative analytic technique of coding text. In the accompanying results, pseudonyms were used in place of true names to protect confidentiality.

Results

Demographics (Table 2)

Twenty-one self-identified black, or multi-racial including black, MSM and one self-identified black transsexual (m–f) participants, all residing in the greater Atlanta area (city proper and surrounding counties), participated in two focus groups—11 subjects each, respectively. All participants were "out" about their sexuality to someone; and 17 (77%) study participants identified as gay, 2 (9%) identified as bisexual, and 2 (9%) as same-gender-loving. Four (18%) study participants indicated that they were between the ages of 18–21 years old, 6 (27%) indicated that they were between the ages of 22–29 years old, and 11 (50%) were between the ages of 30–50 years old. Nine (41%) subjects reported an annual income less than $30,000, and 12 (55%) reported a formal educational attainment level beyond completing high school. Thirteen (59%) subjects reported a Christian religious affiliation, while 5 (23%) characterized their religious affiliation as spiritual.

Of those completing the intake form who reported age at first sex ($n = 20$), the average age of sexual debut was 14 years old; and the age at first sex ranged from 6 to 22 years old. Other relevant demographics collected at intake included assessment of voluntary or involuntary sexual debut, ever having received a mental healthcare referral, and ever having visited a mental healthcare provider. Eleven (50%) focus group participants indicated that their sexual debut was voluntary, and 13 (59%) indicated that they had never been referred to a mental healthcare provider. Similarly, 13 (59%) indicated that they have visited a mental healthcare professional, and 19 (86%) belong to or frequent some form of a support group for members of their sexual identity.

Focus Group Content Analysis

Focus group analysis revealed that a vast array of complex and interacting personal, interpersonal, cultural, and wider social factors may influence the mental health of participants. The following categories emerged from coding of transcript data: mental health status; knowledge and experiences; attitudes and beliefs; societal actions and behaviors; identity development; relationship functionality. The overarching theme within each category is presented.

Mental Health Status: The Struggle of Being a Black MSM Can Take a Toll on Mental Wellbeing

The category, mental health status, refers to the psychosocial state and mood in which individuals find themselves at any given point in time. The overarching theme within this category is that some black MSM often feel depressed and anxious. Many participants described themselves as having been depressed for many extended periods throughout their lives and perceived themselves as being more depressed more often than others. Participants characterized depression as feeling alone, lonely, unwanted, weird, abnormal, strange, broken, as if no one understands or relates, as if no one else is experiencing dysphoria, and suicidal ideation.

> I didn't feel comfortable with how I was handling myself and felt very depressed; because it started with this self-loathing. (group 2: Shawn)

Table 2 Focus group participant demographics and general mental health info

Characteristic variables	Focus group 1 (%)	Focus group 2 (%)	Total (%)
Sex			
Male	91 ($n = 10$)	100 ($n = 11$)	95 ($n = 21$)
Trans	9 ($n = 1$)		5 ($n = 1$)
Race			
Black	82 ($n = 9$)	100 ($n = 11$)	91 ($n = 20$)
Multiracial	18 ($n = 2$)		9 ($n = 2$)
Sexuality			
Gay	64 ($n = 7$)	92 ($n = 10$)	77 ($n = 17$)
Bisexual	9 ($n = 1$)	8 ($n = 1$)	9 ($n = 2$)
SGL	18 ($n = 2$)		9 ($n = 2$)
None	1 ($n = 1$)		5 ($n = 1$)
Age			
18–21	27 ($n = 3$)	8 ($n = 1$)	18 ($n = 4$)
22–29	36 ($n = 4$)	17 ($n = 2$)	27 ($n = 6$)
30–50	27 ($n = 3$)	75 ($n = 8$)	50 ($n = 11$)
>50	9 ($n = 1$)		5 ($n = 1$)
Annual income			
<$10,000	36 ($n = 4$)	8 ($n = 1$)	23 ($n = 5$)
$10,000–$29,000	27 ($n = 3$)	8 ($n = 1$)	18 ($n = 4$)
$30,000–$50,000	36 ($n = 4$)	42 ($n = 4$)	36 ($n = 8$)
>$50,000		42 ($n = 5$)	23 ($n = 5$)
Education			
<High school		8 ($n = 1$)	5 ($n = 1$)
High school graduate	64 ($n = 7$)	17 ($n = 2$)	41 ($n = 9$)
College graduate	36 ($n = 4$)	58 ($n = 6$)	46 ($n = 10$)
Terminal degree (masters, doctorate, etc.)		17 ($n = 2$)	9 ($n = 2$)
Religious affiliation			
Spiritual	36 ($n = 3$)	17 ($n = 2$)	23 ($n = 5$)
Christian	46 ($n = 5$)	67 ($n = 8$)	59 ($n = 13$)
Other	18 ($n = 2$)	8 ($n = 1$)	14 ($n = 3$)
None		8 ($n = 1$)	5 ($n = 1$)
Average sexual debut	14 (SD = 3.87)	14 (SD = 3.87)	14 (SD = 3.85)
Voluntary	64 ($n = 7$)	33 ($n = 11$)	50 ($n = 11$)
Have you even been referred to a mental health provider?	46 ($n = 5$)	33 ($n = 4$)	41 ($n = 9$)
Have you ever visited a mental health practitioner (psychologists, psychiatrists, pastor, etc.) for counseling or therapy?	64 ($n = 7$)	50 ($n = 6$)	59 ($n = 13$)
Do you belong to a support group or organization that caters to sexual minorities?	82 ($n = 9$)	83 ($n = 10$)	86 ($n = 19$)
Would you describe your sexual behavior as risky?	36 ($n = 4$)	50 ($n = 6$)	46 ($n = 10$)
Have you ever been sexually traumatized?	27 ($n = 3$)	58 ($n = 6$)	41 ($n = 9$)
If so, who was the perpetrator?			
Family member	9 ($n = 1$)	25 ($n = 3$)	18 ($n = 4$)
Stranger	9 ($n = 1$)	8 ($n = 1$)	9 ($n = 2$)
Clergy		8 ($n = 1$)	5 ($n = 1$)
Co-worker		8 ($n = 1$)	5 ($n = 1$)
Other	9 ($n = 1$)		5 ($n = 1$)

Table 2 continued

Characteristic variables	Focus group 1 (%)	Focus group 2 (%)	Total (%)
Are you currently in a romantic, intimate relationship?	46 ($n = 5$)	42 ($n = 4$)	41 ($n = 9$)
The last time you had sex, did you use protection?	36 ($n = 4$)	58 ($n = 6$)	46 ($n = 10$)
Do you talk to your partners about using protection before having sex?	91 ($n = 10$)	83 ($n = 9$)	86 ($n = 19$)

When the depression set-in I started to ask myself why am I here; no body wants me around so I'll fix that for you. (group 2: Marcus)
It came to a point where I did try to kill myself. (group 1: Kim)
At one point in time I was depressed. When I was depressed I was always trying to get out the house. I was super rebellious and whatever I wanted to do I did. (group 2: John)
I was depressed for four or five years. It got so bad that I did not want to exist in the world anymore. I thought about killing myself. My brother and my sisters teased me too; I even tried to kill myself in front of them. (group 1: Chris)

Throughout all of the categories and corresponding themes to follow, mental health issues surface and are intimately related. We now turn to relationship functionality.

Relationship Functionality: For Black MSM, Relationships of Support Sometimes Become Relationships of Shunning and Ostracism

The category relationship functionality refers to the degree to which individuals are able to build, grow, and maintain healthy relationships with family, friends, and romantic partners. The overarching theme within this category is that some black MSM may develop and sustain unhealthy relationships in which identity plays a prominent role. Some participants felt betrayed by their families and communities whom they felt were supposed to be their protectors, their place of refuge, the place were if know one else understood them, they could be understood as it related to their identity. Participants also reported feeling unloved by friends and family who in some cases abandoned them emotionally if they came-out or did not conform to mainstream ideals of masculinity.

That's when I thought I didn't belong in the family and places like school; I was feeling isolated and not loved by those who should love me. (group 2: Charles)
Before I told my mother I was gay she trusted me more. Like before she knew, I could go out and everything was fine, I just had a certain time to be home. Now every time I go out or go to school she thinks I'm talking to some little boy. (group 1: Linert)
So at every family event or any function you are the person they all look at like that is the gay boy; and you just have to deal with it. (group 2: Daniel)
I think that coming up your parents need to get an understanding on how you feel because it plays a part in depression. (group 2: Mike)
Everybody looks for acceptance in your family and when your family shuns you [], turn[s] you away or purposely says they don't like you or whatever, that will lead someone into depression. So I think your environment and family [] does play a part on it. (group 1: Mark)

These adversarial family and friend relationship dynamics led to some participants feeling angry, short-tempered, and becoming violent.

The violence just escalated. (group 1: Carl)
I was being violent and it escalated to depression to the point where I was suicidal. (group 2: Lindsey)

The above quote speaks both to violence and other mental health issues such as depression and suicidality.

Knowledge/Experiences: Masculinity and Sexuality Teachings and Shaping

The category knowledge and experiences refers to the information participants learn from their family and through mass media, and interactions and experiences with friends and community institutions (i.e. church, school, etc.) regarding gender, race, and sexual identities. The overarching theme within this category concerns message transference about masculinity and sexuality. The message given to young black males is that men are expected to be "manly" and heterosexual. How participants were raised, TV/music/movie star role models, and cues (verbal and non-verbal) from immediate family, friends, and community authorities appear to have played a significant role in shaping and informing how participants understand and orient themselves to masculinity, ethnic culture, and sexuality. Participants recounted childhood rules and regulations instituted by their guardians that spelled out a code of conduct by which they were to live by given that

they were black males presumed to be heterosexual. Participants explained that there were consequences for being, behaving, or feeling in an unacceptable manner in the sense that their identities were policed and governed with rewards and punishments sometimes by friends, sometimes by authorities in schools, churches, and other community institutions.

> Well, my dad was a real manly man you know. He was like, 'as a black man they gonna judge you, you gotta always make sure you pull the seat belt back for ladies when they're getting in the back seat, you gotta always pump the gas…' I remember this one time I let my sister pump the gas and he got pissed, and started yelling at me at the gas station trying to embarrass me and shit… Take out the trash, blah, blah, blah. (group 1: Chris)
>
> When my cousin came out, my mom was saying he was possessed by demons; she prayed over him and came into his bedroom and said she saw demons on the ceiling – that kind of thing; I didn't want to be in his shoes. (group 2: Shawn)
>
> When I first came out in 1996 and I was 17 years old, Melissa Etheridge and all these people on TV; it was wild because everyone was coming out. Now young kids who are coming out are talking about they want to be Carrie from Sex in the City, Will on Will and Grace, or Noah on Noah's Ark. But when I was little before I came out, we had Warren G, Tupac, and them. I wanted the house, the car, the wife and kids, the man who didn't take no shit. I think it's a big difference. (group 1: Anthony)
>
> You know how it is. When I first started out, I wasn't all into sports and stuff; but when your friends call you sissy and gay enough and tease you 'cause you wear tight pants with a belt that your mom bought you, then I just started to try and dribble a little bit and got better and stuff. (group 1: Kyle)
>
> At vacation bible study, the teacher would say, 'he is a mama's boy'; and I didn't like the way I was treated, so I knew I had to man up. (group 2: Lindsey)

While the majority of participants shared similar experiences expressed in the above quotes, it should be noted that a few participants shared that their guardians and community leaders took a more hands-off approach in terms of prescribing and dictating their behavior and feelings. They expressed that they did not feel as pressured and restricted as many of the other study participants in terms of their experiences with friends and other community members. Overall though, the knowledge gained from family and popular media, and experiences with friends and in community institutions seems to have prescribed and dictated masculinity, race, and sexuality ideals and cultural norms that may affect and influence and may be affected and influenced by attitudes and beliefs held regarding these identities.

Attitudes/Beliefs: Non-traditional Masculinities and Sexualities are Viewed Negatively

The category attitudes and beliefs refer to feelings toward and conceptions of gender, race, and sexuality designations. This category is closely related to knowledge/experiences, but differs in that rather than referring to specific and direct action and processes used to promote and shape the growth and maturation of participants into certain desirable conceptions of black manhood, this category reflects the general disposition participants' families and communities have toward specific identities, particularly non-traditional masculinities and sexualities. In essence, the distinction is the difference between what families and communities did to guide the development of young boys versus how they feel about other versions of masculinities and sexualities. The overarching theme within this category is that deviations from traditional masculine and heterosexual ideals are judged harshly. This theme is closely tied to the previous theme and derives from groupings of knowledge and experiences that may have similar foundations or undergirds. These attitudes and beliefs may inform the knowledge and experiences of participants or the knowledge and experiences aforementioned may be built on these attitudes and beliefs.

The attitudes and beliefs participants alluded to include heterosexist and homophobic ones, and encompass hegemonic gender conformity expectations. Participants spoke generally and descriptively about the accompanying negative attitudes and beliefs.

> Because mainstream society operates off of a masculine-feminine dynamic most people are not open to a different type of dynamic. (group 2: John)
>
> When I told people I was gay they looked as if they were shocked and thought I had gone crazy. (group 1: Anton)
>
> Black people are like you going to hell fire and brimstone baby… (group 2: Marcus)
>
> Because you automatically loose your power, masculinity, or love; so now that I have more power than you I have to judge you. (group 1: Marvin)
>
> My dad would say I have three sons and I decided I would give you my name. I wish I would have named you [Rob] and gave [Mark] to somebody else because I would not have wanted a fag named after me. And he told me if you want to be a fag you need to get out and be a fag somewhere else. I was put out at 17. (group 1: Mark)

While the above quotes represent the majority of participants' perceptions regarding attitudes and beliefs that either they or those close to them held, it should be noted there were also some participants that described attitudes and beliefs regarding sexuality and gender that they perceived as more positive, validating, and welcoming. Additionally, as seen in the above quotes, attitudes and beliefs often accompany or lead to some form of action: "I was put out at 17."

Societal Actions/Behavior: Black MSM Mental Health is Negatively Affected by Discrimination and Violence

The next category that emerged, societal actions and behavior, refers to events or dealings targeted toward black MSM that participants seemed to perceive as society-wide occurrences and are likely influenced by overarching attitudes and beliefs. The overarching theme within this category reveals participants' shared experiences of being victimized and discriminated against due to their sexuality.

> Being in high school you don't want kids to know because you don't want to fight. (group 1: Chris)
> She asked me if I had a girlfriend and I told my mom I didn't like girls. And my dad would want to do the whole beating thing. (group 2: Charles)
> During the time I was in middle school, I got jumped and teased, but I didn't really know if I was gay or not. I really wasn't comfortable with it then. (group 2: Mike)
> I had a rainbow bracelet on, she said you gay, and she spit in my face. I was hurt about that incident. (group 2: Shawn)

Many participants reported that the threat of violence and discrimination caused them more anxiety as they felt constantly on guard and compelled to take heightened precautions for safety.

> …When I walked around I would have to watch everything I did: The way I walked, talked, the things I said, the way I hold my hands; and then all of a sudden I became stiffer and I realized that I am not like that. I'm more like my dad, and it makes you very uncomfortable in your own skin. Then all of a sudden you don't know who you are because you are to busy trying to be what everybody wants you to be instead of being who you really want to be. (group 1: Mark)

In addition to pointing to the tedious steps taken to assure safety, this quote also alludes to the potential affects of violence and discrimination on identity development and overall mental health.

Identity Development: Black MSM are Challenged in Developing a Healthy Identity

The next category that emerged, identity development, refers to the process whereby one comes to clearly understand and conceptualize who he is with respect to others who are like him and others who are not regarding gender, race, and sexuality. Identity development in this context is further defined as the degree to which one is comfortable and confident in oneself and is able to establish meaningful connections and interactions with others given gender, race, and sexuality. The overarching theme within this category is that some black MSM have a difficult time achieving a healthy identity because of societal pressures regarding manhood and sexuality combined with being black. While most participants communicated that they were almost completely comfortable and confident in their identity as black people, there seemed to be much less positive identity achievement with respect to gender and sexuality. Many participants expressed the difficulty in integrating these three components of their identity seamlessly.

Participants further conveyed that sometimes they embrace masculine qualities that they learned and that are expected of them by society at large, and consequently feel that they do not always behave authentically in the sense that they play-up hegemonic masculine qualities and down play their sexuality if they disclose true sexual orientation at all. Moreover, they described feeling tired of not being able to be themselves all of the time and feeling that the more time they spend with their sexual minority friends, the less and less successful they become at meeting traditional expectations and therefore they have to work harder at it. This appeared to be a source of stress for many participants. All of the participants were out to someone, however, less than half of the participants were out to everyone or are out all of the time. In sum, these identity issues perceived by participants as problematic, can be conceptualized as unhealthy identity development characterized by feelings of having to choose between racial and sexual identities, perceiving a compromised manhood if/when participants come-out, feeling compelled to conform to mainstream ideals of masculinity, attempting to "pass" as heterosexual (closeted), and difficulties coming-out.

> Sometimes you can be so gay you forget you're black. (group 1: Carl)
> There are issues when you openly say you are gay; it is different when someone just finds out, then you don't have that masculinity. Society will take that from you because you say you are sleeping with men. (group 1: Marvin)

> Some people don't see you as a man because you are gay. (group 1: Anthony)
> Then I had to hide again, so I said I am going to have [to] shed this gay image [], get a girl friend, and join a sports team. [I] did the whole nine yards with shedding that image. You can't go everywhere acting like that. Some places you will get your butt kicked and some places, sometimes it's just embarrassing. Sometimes you don't want everyone knowing you are out and have people looking at you like you are a freak. Sometimes you want to be in. Sometimes you want to be like everyone else and be able to hide. (group 1: Kyle)
> So I found myself trying to change for my mom. I even tried to get a girlfriend and I had no interest in girls. Eventually, she began to accept who I was but she was not supportive. (group 1: Lonnie)

Probing further and more concretely into the struggle participants elucidated regarding identity integration, participants were asked to depict and typify men in general, black men, and gay men. Participants described and characterized men as being strong, aggressive, competitive, mean, unemotional, and that they should not cry and should perform such duties as taking out the trash.

> He [(men)] is the decision maker; he is the person that stands up when everyone else is afraid to stand up. (group 1: Anton)
> He [(men)] is the person that fights for the people that are weak. He is the person that keeps justice when there is not any. (group 2: Michael)

Participants described and characterized black men as thugs, urban, violent, feared, fashionable, sexually experienced, and as having large penises.

> They have this persona like the Mandingo complex with big dicks; you are always supposed to be the strong black warrior kinda like how thugs try to be. (group 2: Charles)
> The black man has to be strong and the bread winner and you're supposed to take care of your wife and she is a female and not a boy, you know. (group 2: Daniel)

Participants described and characterized gay men as weak, fashionable, independent, and smart.

> I think when black men in the south say that they are gay they are assumed to be weak or less than a straight guy. But people just don't know how much we have to go through by ourselves; we are very independent that way. (group 1: Mark)
> When you are gay you are automatically associated with femininity; even when talking about smarts. (group 2: Lonnie)

While all participants identified as male, most made a distinction between the manly qualities that they were taught (and believe society at large holds) and their personal manhood which did not always encompass or include all of the mainstream traits ascribed to men generally.

> You know we have to be like that; but we should also be interdependent on people in the sense that you understand connectivity, you understand community, and you understand relationships and the importance of relationships. (group 1: Mark)
> It's like… but for me, I believe [being a man is also] having a spiritual connection. (group 1: Linert)

While all participants identified as black, most made a distinction between how whites and society at large view black men and how they see themselves which does not always encompass or include the traits sometimes ascribed to black men.

> Sometimes people say we don't take care of our kids, but a black man has to learn how to take responsibility for your own actions. (group 1: Bill)
> I believe that a strong black man is able to take care of himself. (group 1: Kert)

Also, while all participants identified as having had sex with men, most made a distinction between how heterosexuals and society at large views MSM and how they see themselves, which does not always encompass or include the traits sometimes ascribed to them.

> They think that we're weak, but we'll cut you in a minute. (group 1: Kert)

Participants expressed the complexity of the affects of attitudes and beliefs regarding gender, race, and sexuality on their identity in conveying the dissidence between those attitudes and beliefs that they may have been taught or that may have been ingrained through experience, and how they may actually perceive or want to perceive themselves. This to, is compounded by how others view them, both insiders with respect to their gender, race, or sexual designation as well as outsiders. Attitudes and beliefs may bear on identity development encompassing the degree to which they are internalized, deconstructed, reconstructed, and newly constructed, and may also influence relationship functionality and mental health status directly.

The stories and narrative of study participants above suggests that the aforementioned themes may all influence and affect the mental health of black MSM in someway and are likely to be related: knowledge from family and popular media, and experiences with friends and communities regarding identities may inform and may be informed by attitudes and beliefs regarding gender, race, and sexuality that may be internalized by black MSM and may inform

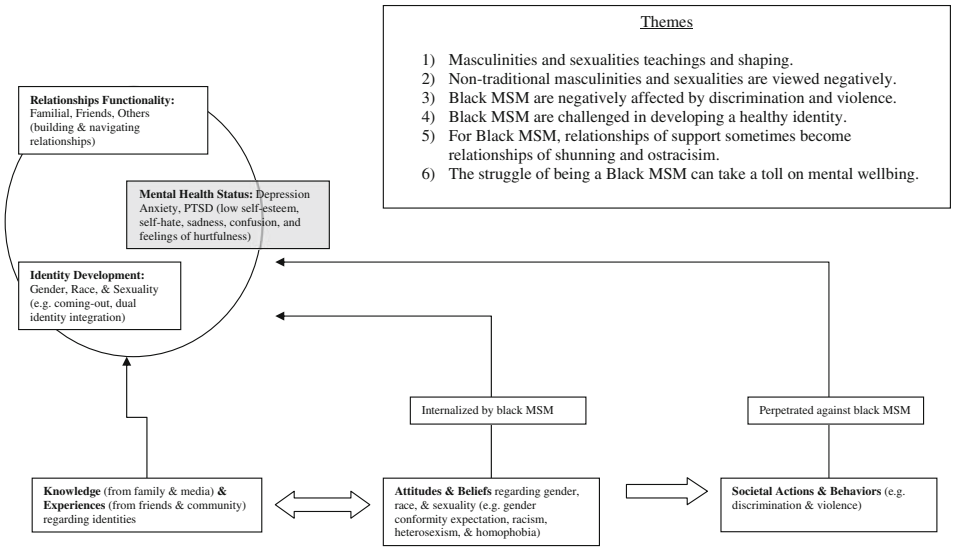

Fig. 1 Mental health of black MSM—preliminary thematic domains

societal actions and behaviors targeted at black MSM, which when coupled, may inform the identity development, relationship functionality, and mental health status of black MSM. The following depiction is a preliminary graphic representation of the ways in which the themes delineated above may influence and affect the mental health of black MSM (Fig. 1), however, additional investigation and evidence is needed before this graphic display could be considered or evaluated as a model.

Discussion

Very little is known about the determinants, onset, and sequelae of depressive distress and anxiety disorders among black MSM. This study contributes to early-stage exploration of mental health influencing factors among this population by qualitatively formulating preliminary categories and thematic domains, many of which have to some degree been alluded to in the literature for either black populations or MSM populations, but very few for black MSM in particular. Findings of this study, in large part corroborate previous studies concerning discrimination, violence, and identity development (Fife and Wright, 2000; Finch et al. 2000; Kessler et al. 1999; Mays and Cochran 2001; Sell 1997; Cross 1995; Helms 1993; Schmidt and Nilsson 2006; Cass 1979; McCarn and Fassinger 1996). Additionally, this study adds new evidence to the scant knowledge base of attitudes, beliefs, relationship dimensions, and mental distress presentation among this population. Two potentially key findings concern the relatively high percentage of early and involuntary sexual debut of participants, and the seemingly disparate way in which participants described their mental distress compared to men and black populations in general.

Findings suggests that black MSM appear to learn and became aware of what it means to exemplify manliness, blackness, and gayness from their families, friends, through popular media, and in community institutions, which seem intimately related to attitudes and beliefs surrounding identity designations, including heterosexism, homophobia, and hegemonic gender conformity expectations that may be both internalized by black MSM and lead to societal actions and behaviors perpetuated against black MSM, such as violence and discrimination. Similarly, this corroborates Dian et al. (2001) findings that experiences of social discrimination with respect to race, sexuality, and class predicted 11% of the variability in psychological symptoms (depression, anxiety, suicidal ideation) among a sample of Latino MSM. Data analysis suggests that these categories and themes there within, knowledge/experiences, attitudes/beliefs, and societal actions/behaviors can influence and affect black MSM's core sense of self, the degree to which they are able to sustain healthy relationships, and their mental health status; where there may exists bi-directional relationships between these three categories and themes: identity development, relationship functionality, and mental health status. This is in accordance with Crawford et al. (2002) which conclude that the more AAGBM are able to integrate and embrace positive self-attitudes toward their racial-ethnic and sexual identities, the more likely they are to value themselves, safeguard their health, and experience higher degrees of personal satisfaction.

In terms of knowledge/experiences, participants realized early on in their lives what to be, do, and feel, and consequently what not to be, do, or feel concerning manliness, blackness, and sexual orientation—in essence, the characteristics of manhood and blackness that are good (which includes heterosexuality) and those that are bad (which

includes homosexuality). They were often able to witness first-hand the consequences of those who, for example, did not conform to mainstream masculinity or heterosexuality versus those who did. Underlying much of the knowledge/experiences category appears to be attitudes and beliefs from which the specific information and instances originate and/or perpetuate. The category attitudes/beliefs, in essence, represents an attempt to categorize and organize the vast array of knowledge and experiences shared by participants that seem very important in informing later themes, namely those within identity development and societal actions/behaviors categories.

With respect to identity development, in accord with a study by Crawford et al. (2002), many participants shared that they sometimes feel that their black selves and sexual orientation compete; that is, they feel that they have to choose to either be black or a sexual minority, and that they can not be both at the same time. They feel torn between fidelity to black communities in general and the predominantly black sexual minority communities of which they are also apart. This may intern delay successful identity achievement integration. Considering the category, relationship functionality, participants expressed that their struggles with the aforementioned issues may affect their relationships with family and friends, and given reports on average age of sexual debut and first sex voluntary status, may affect their romantic relationships as well.

The average age of sexual debut for participants is 14 years old and 50% of participants' first sexual experience was not voluntary. Interestingly, this did not come up during the focus group conversations possibly because no questions were directly aimed at this topic and it is likely not a topic participants would feel comfortable discussing in a group. This issue may be better explored through individual interview. The average age of sexual debut for MSM in general, as reflected in the literature, is estimated to be around 15–16 (Levina et al. 2001).

The reported prevalence of childhood sexual abuse among MSM in general has ranged from 11 to 37% (Doll et al. 1992; Bartholow et al. 1994; Lenderking et al. 1997; Jinich et al. 1998; Paul et al. 2001; Traden et al. 1999; Kalichman et al. 2004), and a study conducted in Minneapolis/St. Paul found a 20% prevalence rate among African–Americans (Brennan et al. 2007); however, the African–American sample size was too small to conduct meaningful significance tests. Another study with a similarly modest sample of MSM youth found a 54% prevalence of childhood sexual abuse where 35% of participants were Latino and 34% were African–American (Rosario et al. 2006). Additional research is needed to acquire good robust sexual debut and involuntary sex data among Black MSM. However, if the data from this study and that of others are indeed accurate in the early sexual debut and high prevalence of involuntary sex among Black MSM, their relationships with family and friends could be affected, particularly if family or friends were perpetrators or if they did not or could not prevent or help in any way.

Black MSM's identity development may also be affected in reference to how they view themselves as a result of the violation or whether or not they blame themselves. In addition to affecting mental health directly, it may also be affected by way of the abuse's affects on their relationships or identity development. It is unknown whether or not the abuse was/is chronic and was/is accompanied by physical violence which could worsen the mental health effects. Moreover, early sexual debut and sexual abuse have strong implications for poor sexual health outcomes.

Another potentially interesting finding within the mental health category relates to mood and mental distress description. It is well documented that men typically report fatigue, irritability, loss of interest in work or hobbies, and sleep disturbances when characterizing depressive symptomology rather than feelings of sadness, worthlessness, and excessive guilt as has been found among women (DHHS 2003). It is also well documented that black populations often report more somatic complaints and more sleep and appetitive disturbances, while whites consistently report cognitive disturbance, anxiety, and core depressive feelings (Garlow et al. 2005). Participants in this study reported low self-esteem, self-hate, sadness, confusion, and feelings of hurtfulness. Mental distress among black MSM in this study appears on the surface to present differently from men and black populations in general. While the focus group discussions are in no way a substitute for qualified psychiatric or psychological evaluation of official symptomology, participants' descriptions of their mental distress is suggestive and may be pointing to important differences in the presentation of depressive distress among this group compared to their reference populations, and if nothing else calls for further investigation. While it is acknowledged that these qualitative data may not be directly or explicitly comparable to other studies documenting symptomology (especially given that no other focus group studies have been conducted among this population concerning these issues), from a triangulation perspective, this finding is interesting and should be followed-up.

In sum, all of the aforementioned factors seem to bear on the participants' mental health status. It is likely that many of the participants had at some point in their lives suffered from a diagnosable mental disorder (e.g., depression, anxiety, PTSD) as nearly half of the participants had previously been referred to a mental health professional. Consequently this particular group's insights may be especially relevant in providing key information to assist in the exploration of potential mental health determinants among this population.

Historically, black MSM have been identified as a target population very difficult to reach as individuals in this group do not always live in the same geographic locale and these communities are often not as visible or easily identifiable as other similar minority populations. Consequently only two focus groups were conducted, which limits the power and generalizability of the findings. Both additional qualitative and quantitative studies are needed to further define, describe, and operationalize thematic domains, as well as to expand or contract the overall scope of categories. Previous studies, for example, suggests that coping (Peterson et al. 1996; Leserman et al. 1992) and sexual health (Ryan and Futterman 2001; Stokes and Peterson 1998; Rotherman-Borus et al. 1995) issues may also affect the mental health of black MSM and may need to be included in the categorical configuration; although these issues did not surface in this study.

Further quantitative investigation is needed to develop measures for implied variables, as well as to determine whether any specific statistical relationships exist between categories and thematic domains in a more generalizable and broadly representative group of black MSM as some experiences and perspectives may be more commonplace than others. Overall, particular areas that need further combined or joined qualitative and quantitative study include teasing out the nuances in the identity development theme related to the idea of unacceptable or incongruent identities (e.g., black-gay, gay-man), the role of black gay communities in the mental health status of black MSM, coping and resiliency, severity of depressive symptomology in relation to the aforementioned themes, and the effects of sexual health on mental health. This study significantly adds to the dearth of research on psychological challenges facing black MSM. Overall, this investigation helps shed light on an important facet of the health of black MSM that ultimately affects both their general wellbeing and the general health and wellness of communities at large. These findings may assist providers in better tailoring more appropriate services for this subpopulation and may contribute to the development of additional intervention strategies targeted at this subgroup to decrease morbidity and mortality resulting from mental distress and illness.

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