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Black and Blue: Depression and African American Men

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A B S T R A C T

Depression is a common mental disorder affecting individuals. Although many strides have been made in the area of depression, little is known about depression in special populations, especially African American men. African American men often differ in their presentation of depression and are often misdiagnosed. African American men are at greater risk for depression, but they are less likely to participate in mental health care. This article explores depression in African American by looking at environmental factors, sigma, role, and other unique to this populations, such as John Henryism. Interventions to encourage early screening and participation in care are also discussed.

Depression remains one of the leading disabling and costly illnesses worldwide both directly and indirectly (World Health Organization, 2012). For the purposes of this paper, direct cost includes diagnosis, hospitalization and other examinations associated with depression and indirect cost includes loss of productivity and work related duties to include reduced employment, unemployment and other disabilities due to an impaired emotional state (Xue et al., 2015; Zarogoulidou et al., 2015). Direct cost for depression between 2005 and 2010 rose from $173.2 billion to $210.5 billion (Greenberg, Fournier, Sisitsky, Pike, & Kessler, 2015). This cost is probably higher due to other physiological diseases associated with depression, such as hypertension, obesity liver disease, and other physical disorders (Hankerson et al., 2011; O'Neil et al., 2012; Whooley & Wong, 2013). Depression is a treatable disorder, and proper primary and secondary interventions can be implemented to help reduce the cost of this illness.

The direct cost of depression has been discussed, but there are also indirect costs associated with depression. Depression has been associated with cognitive dysfunction, such as memory loss, irritability, and loss of concentration (McIntyre et al., 2013). Depression tends to present itself during the most productive period of life: 30–44 years of age (National Institute of Mental Health). An individual can lose up to 27.3 work days per year due to depression associated symptoms (Kessler et al., 2006). Other studies have shown that those who work while suffering from depression are less productive due to decreased energy, less interactive with co-workers, feeling less supported from management, and an overall decreased in the ability to perform tasks at work (Bertilsson, Petersson, Ostlund, Waern, & Hensing, 2013; Sallis & Birkin, 2014). The Bureau of Justice Statistics (BJS) (2006) reported that inmates 24 years or younger had the highest incidents of mental illnesses while incarcerated when compared to older inmates. The same study found that most men arrested with a mental illness were employed up to 1 month prior to their arrest. Unfortunately, very little work has been done to directly address depression in the work place. Two separate systematic reviews on depression in the workplace demonstrated that most interventions focus on stress in the workplace, which is a small component of depression (Dietrich, Deckert, Ceynowa, Hegerl, & Stengler, 2012; Furlan et al., 2012). This contributes to the organizational burden of depression. Therefore, more interventions are needed to address not just stress but other symptoms associated with depression in the workplace. This intervention would indirectly impact productivity.

Although much literature exists on the subject of depression and much progress has been made for the general population, little is known about it in African Americans, especially African American men. Depression in African American men was first brought to light in a study by Gary (1985) who identified the illness in this population and suggested rates of depression are higher in African American men than reported. It was suggested that African American men have unique characteristics that make them more vulnerable to depression and that these factors are often missed by most clinicians. The National Institute of Mental Health's "Real Men. Real Depression" campaign sought to expand the message of depression in men. Other literature also suggests that depression in men may be presented in ways not consistent with what is already known or expected, especially when race is a factor. This could lead to misdiagnosis and ineffective treatment. Due to these factors, the potential for treatment disparities exists (Hankerson, Suite, & Bailey, 2015). Therefore, more work in this area is needed to uncover the multiple layers of depression, especially in African American men.

As with most illnesses, there are disparities among depression in African American men when compared to other racial groups. A report in 1999 from the Surgeon General on mental health suggests that a disparity exists in the reporting and diagnosing of depression in African

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American men. For example, suicide is often associated with depression. The report and other studies suggest a disproportionate rate of suicide among African American men, which is often not diagnosed as suicide but often associate with reckless behaviors (Castle, Conner, Kaukeinen & Tu, 2011; Joe, Baser, Breeden, Neighbors, & Jackson, 2006; Kubrin & Wadsworth, 2009). The standard questions related to suicide may not be appropriate for African American men. A more thorough examination surrounding the circumstances of an injury qualitatively might be more appropriate for African American men.

African American men are typically not diagnosed with depression by professionals until they present in a venue other than a mental health setting, such as homeless shelter and correctional settings where care is limited. Head (2007) refers to this way of diagnosis as the back door method and remains a major means by which depression and other mental illnesses are identified and treated in African American men. The BJS (2006) reported that 56% of state inmates, 45% of federal inmates, and 64% of local jail inmates had a mental illness. Symptoms of depression were reported by 23% of state prisoners and 30% of jail inmates. The BJS does not provide data on specific races and mental illness, but given a large percentage of inmates are African American, it can be assumed that a significant number of them have some sort of mental illness. Inmates in all settings were more likely to have been homeless prior to arrest. Many of these facilities, such as homeless shelters and correctional facilities, are not adequately equipped to address mental illness. Sarteschi (2013) conducted a synthesis of mentally ill offenders in the criminal justice system and found that incarcerated individuals were more likely to encounter conditions such as long waiting time for mental health treatment, lack of mental health providers, neglect due to the ability to differentiate true mental illness from malingering, higher rates of behavioral disturbances, and suicide. The relationship between incarceration and mental illness is strong. There is an assumption that childhood experiences, mental illness and incarceration are highly related (Schnittker, Massoglia, & Uggen, 2012). Specifically, being poor, involved in violence, high school dropout, and being homeless were associated with being incarcerated and having a mental illness (Greenberg & Rosenheck, 2014). Environmental factors will be discussed later. Early identification treatment prior to reaching these back door settings might have an impact on other systems.

Sinkewicz & Lee (2011) reported a higher prevalence of depression in African American men when compared to the general population. This was supported by an extensive literature review conducted by Ward and Mengesha (2013) which demonstrated a high prevalence of depression among African American men. Although there is a high prevalence of depression, African American men are less likely to utilize mental health services (Ward, Wiltshire, Detry & Brown, 2013). This is partially due to the perceptions of mental illness in the African American community (Ward et al., 2013). Individuals are more likely to access their primary care provider initially with vague symptoms, such as fatigue, insomnia, and irritability. Many times depression is less likely to be detected because of these vague symptoms, cultural differences in presentation of symptoms, and lack of culturally qualified mental health providers (Noel & Whaley, 2012). The literature supports more understanding of depression in African American men in order to identify unique presenting symptoms in order to address this disparity in diagnosis and treatment.

ROLE EXPECTATION AND DEPRESSION

A number of structural and contextual factors among African American men make them more vulnerable to depression. These factors center on men's ability to demonstrate and fulfill their expected roles with minimal barriers. These factors can act as a facilitator or barrier to accessing needed resources, especially mental health services as discussed by Franklin (1999) and Anderson (1995). Manhood in African American men is defined by a number of factors, such as family, neighborhood, media and general societal expectation; each having conflicting requirements. This sometimes begins at the time of birth. These expectation can have a significant impact on the mental well-being of African American men as they try to negotiate and meet these different expectations (Castle, Conner, Kaukeinen & Tu, 2011a; Castle, Conner, Kaukeinen & Tu, 2011b; Franklin, 1985, 1999; Hartley, 1974). Many times, these expectations can conflict and affect the physical and mental health of these men (Plowden & Miller, 2000).

African American men are expected to conform to masculine roles while dealing with other social issues such as racism and discrimination. Roles such as dominant, independent and supplier have been identified as significant portrayal of masculinity for men (Plowden & Miller, 2000). Brannon (1976) used terms such as sturdy oak, Big Wheel, and No Sissy Stuff to describe masculinity in men. Other studies have identified similar role identification. When men are unable to function in these roles, they are perceived as less than a man, and it becomes a barrier to them caring for themselves. The literature has also shown that men's inability to live up to their expectations of manhood can act as a barrier to seek care (Plowden, 2000). Earlier studies have shown men, specifically African American men, will access health systems when internal and external conditions are sensitive to their need, and they feel accepted (Plowden & Miller, 2000; Plowden and Thompson-Adams, 2013). Therefore, access to health care can be enhanced by promoting factors that support their expected masculine role.

A number of African Americans come from diverse backgrounds. In addition to conforming to a general societal definition of masculinity, African American men must also negotiate expectations of masculinity from their country of origin or family expectation (Laubscher, 2005). The literature and media suggest African American masculinity as being different from general societal expectations (independence, family, etc.). The literature and social media also work to support cultural expectations of African American men. Many times, African American masculinity is portrayed in a negative way, such as a culture in constant chaos. African American men are also often portrayed as being in a constant struggle for survival. Given these expectation, African American men are often pulled in many direction in an attempt to meet the expectations placed upon them. For many African American men, they are judged based on their external appearance and not their internal value. Living up to the many expectations placed upon them could be the catalyst for stress and other depressive symptoms.

The negotiation of the many masculine expectation creates a sex–role strain for African American men (Pleck, 1981). Earlier studies have shown negative effects associated with sex–role strain, often described as hyper masculinity, increased criminal behavior, aggression, and other socially unaccepted social behaviors (Caldwell, Antonakos, Tsuchiya, Assari & De Loney, 2013; Levant, Stefanov, Rankin, Halter, Mellinger & Williams, 2013; Lincoln, Taylor, Watkins & Chatters, 2011; McCusker & Galupo, 2011; McFarlane, 2013; Oliffe, Kelly, Johnson, Gray, Ogrodniczuk & Galdas, 2010; Roberts-Douglass & Curtis-Boles, 2013; Thomas, Hammond, & Kohn-Wood, 2015; Valkonen & Hanninen, 2013). African American masculinity is often defined in a complex manner and expressed as a development of self and free will, leadership and responsibility, spiritual connection, success, and a bond with others outside of self (Roberts-Douglass and Curtis-Boles, 2013). Venues, such as barbershops, schools, sports arenas, and religious communities, serve as resources to enhance this exchange of values and expectations of the African American male roles (Plowden, 2000). The literature shows that the role of African American men is complex and needs further studying.

ECONOMICS

An essential factor associated with masculinity of any group is socio-economic position. Socioeconomic status involves factors such as education, income, and occupation and has shown to have an impact on an individual's mental well-being. Butterworth, Rodgers and Windsor

(2009) found a positive correlation between financial hardship and the likelihood of reporting depression. In order for a man to adequately perform identified sex roles, perceived financial support and stability must be in place and stable (DeNavas-Walt & Proctor, 2015) Socioeconomic data show that African American men fall short in the area of socioeconomic status, as determined by measures such as income and education. African Americans in general are more likely to live in the south, where poverty is higher than other areas of the country (US census bureau, 2015). African Americans tend to earn less than other racial groups. African American men are more likely to be unemployed (Rodgers, 2008a; Rodgers, 2008b; U.S. Department of Labor, 2014). African Americans are more likely to be incarcerated when compared to the general population, which affects income. Due to this increase in incarceration rates, there is a 30–40 percent reduction in earnings, reduced time on a job, and lower hourly wages (Western and Pettit, 2010). African American men are more likely to be single or absent from the household (U.S. Census Bureau, 2015). Ward and Mengesha (2013) conducted a meta-analysis of depression in African American men and found economic distress in the family as a strong stressful factor. The study showed an inverse relationship between income, employment, education and prevalence of depression. Hudson, Neighbors, Geronimus & Jackson (2012) defined unemployment as not being active in the workforce. These individuals who were unemployed were likely to meet the criteria for a major depressive episode over a lifetime. Kubrin & Wadsworth (2009) found that joblessness and poverty correlated positively with gun availability and suicide among young African American men. Gaines (2007) found that socioeconomic status had a strong effect on psychological distress in adult African American men. Although other factors influence mental well-being among African American men, the literature supports the strong influence of socioeconomic status and mood disturbance in this population. Therefore, socioeconomic status should be considered in assessing depression in African American men.

STIGMA OF MENTAL HEALTH

Stigma exists in the African American community towards metal health, especially with African American men. Most traumatic events are portrayed as having a mental health connection. When a violent crime occurs, most often the media turns to a mental illness as the cause. This influences the community perception of mental illness, especially depression. Individuals perceive depressed individuals as violent and dangerous and more likely to avoid these individuals (Conner et al., 2010). While many violent crimes are associated with mental illness, domestic crimes are more likely to occur in homes with firearms and no history of mental illness (Siegel, Ross, & King, 2013). Aggression is often associated with depression in African American men, but it is often seen as a sign of violence (Thomas, Hammond & Kohn-Wood, 2015). Discrimination and stigma are also magnified when other factors, such as race and sex, are added (Watson, Riffe, Smithson-Stanley, & Ogilvie, 2013). This could lead to further isolation, social deprivation, and economic distress. These factors are associated with increased risk for depression. African Americans are more likely to seek mental health care from their primary care doctor or rely on religion to deal with depression to reduce the stigma of being associated with a certain facility. African American men believe that individuals are labeled if they are seen at a particular facility (Plowden & Adams, 2013). Seeking care at a primary care facility is safer than going to a mental health facility. Therefore, efforts to reduce stigma publically and privately are needed. Nurses are in an ideal position to impact the public's perception of mental illness by providing outreach and education to correct misconceptions.

COMMUNITY SUPPORT

The significance of social support and networks in promoting physical and psychological well-being has been extensively documented in the literature, especially among African American men (Baruth, Wilcox, Saunders, Hooke, Hussey & Blair, 2013; Franklin, 1985; Hurd, Stoddard & Zimmerman, 2013; Jackson, 2012; Lincoln, Taylor, Watkins & Chatters, 2011; Plowden, John & Vasques, 2006; Plowden & Young, 2003; Richardson, 2009; Thomas & Washington, 2012; Wang, Wu, Liu, 2003; Watkins & Jefferson, 2013; Yang, Latkin, Tobin, Patterson & Spikes, 2013). These networks can be formal, such as family and friends, or informal, such as media and music. Social support can be objective, such as formal emotional support from significant others, or perceived support, such as anticipatory support of others (Bandura, 2004; Rhodes & Lakey (as cited in Watkins & Jefferson, 2013). Community support remains an important part of the African American community. Ward et al. (2013) found that most African Americans turn to the church as an initial source of support when dealing with depression (Bryant, Haynes, Greer-Williams, & Hartwig, 2014). The level of actual and perceived social support suggests the level of concern and acceptance, which influences mental well-being.

Although independence is a component of masculinity, social support from others is essential to psychological well-being, especially depression. Lincoln, Taylor, Watkins & Chatters (2011) found the quality of social interaction processes contributed to the degree of depressive symptoms in African American men and women. Allen, Myers, & Williams (2014) found African American bisexual men who perceive decreased social support from family experience higher levels of depressive symptoms. There is also better psychological well-being with increased racial identity. Mair, Roux, Osypuk, Rapp, Seeman, & Watson (2010) found a positive correlation between higher concentrations of African American in a given neighborhood and the degree of perceived support. This includes neighborhood schools, especially during the early adolescent years. Adolescents from poorer socioeconomic communities with little social support were more likely to be depressed (Dunn, Milliren, Evans, Subramanian, & Richmond, 2015). Bryant et al. (2014) found that African American pastors believed that finances were the cause of depression in African American men. Lincoln, Taylor, Watkins & Chatters (2011) found a decrease in family interaction as a risk factor for suicide ideation among African Americans, suggesting a relationship between support and depression. It takes more than the individual to overcome depression. Therefore, any intervention targeting mental health in African American men must be at the individual and community levels, especially the church.

JOHN HENRYISM AND AFRICAN AMERICAN MEN

It has been established that African American men express depression differently than other groups. Therefore, no one tool can capture all of the characteristics associated with depression in African American men. Many characteristics of African American life are expressed in the arts, such as song, poetry, and dance. Legends have also been used to portray the life of African American men and their struggles. Most individuals from a certain period in time remember the legend of John Henry, the "steel driving man." Although no one knows for sure whether he was an actual person, individuals can identify with his struggle, especially as it relates to African American men. In short, John Henry was a man known for his strength and endurance in his work against a machine (Williams, 1983). This is a metaphor for the struggle of African American in society. While John Henry's perseverance won him the race, he died shortly thereafter from physical and mental exhaustion caused by stress. Like many individuals, he fought a good race unto his death. The prolonged struggle of coping with life stressors, contributed to his death. This could also be the case in African American men.

This analogy has been applied to African Americans, especially men and known as "John Henryism". James (1994) describes it as "prolonged, high-effort coping with difficult psychosocial environmental stressors" (p. 167). Within the African American community, it is thought that the early mortality associated with African American men is related to fatigue from the stressors of life. The phenomenon assumes that individuals, especially those from lower socioeconomic status, are exposed to

unique environmental stressors requiring great coping energy. Individuals will cope until biopsychosocial resources are depleted, making them vulnerable to many other conditions, such as depression and heart disease. The ultimate outcome is death, physically or psychologically. The phenomenon has primarily been studied in cardiovascular disease, but found a positive relationship between socioeconomic status and blood pressure. Lower socioeconomic individuals tended to have higher blood pressure due to environmental stressor (James 1994). This relationship was discussed earlier. Therefore, one could assume the same type of relationship between John Henryism and depression.

John Henryism was first identified by James (1994), which led to the development of a 12 item scale named "The John Henryism Scale for Active Coping" based on the premise of mental and physical strength, dedication to hard work, and the determination to overcome any barrier. The phenomenon has been measured in a number of studies and shown to be inversely related to socioeconomic status. James (1994) first identified this relationship in a rural African American with hypertension. Socioeconomic status was inversely related to hypertension. Other studies have shown a correlation between psychosocial variables, such as depression social support, and discrimination and John Henryism (Lehto & Stein, 2013; Matthews, Hammond, Nuru-Jeter, Cole-Lewis & Melvin, 2013). John Henryism is a means of understanding the impact of environmental stressors and traditional African American role expectations on coping. Little work has been done to correlate this phenomenon with mental illness specifically in African American men.

IMPLICATIONS FOR PRACTICE: HEALTH CARE FOR ALL

As this article shows, depression in African American men is unique in several ways. This presents significant health care issues, such as misdiagnosis and mistreatment. Wilson (2010) found a significant number of psychiatric nurses lacked appropriate cultural knowledge of African American clients, and nurses are the largest health care providers in the system. This supports the need for cultural diversity in health care, as suggested by the 1999 Surgeon General's Report on Mental Health (U.S. Department of Health and Human Services 1999). Additionally, the Institute of Medicine recently released a report calling for changes in the health workforce, especially in the area of cultural diversity. This is also significant given the recent changes in health care law allowing for more individuals to access to physical and mental health treatment services. Individuals who may not have been able to access mental services will now have these services, such as those who may not have qualified for Medicaid services or may have had a pre-existing health condition. An estimated 32 million individuals will gain access to health care services with the changes in law (Pating, Miller, Goplerud, Martin & Ziedonis, 2012). With nursing having a major impact on the health of society, greater access has several implications at the individual and system levels. As mentioned earlier, the need to deliver culturally sensitive care is essential.

The need to provide culturally appropriate care to at risk individuals is essential, especially during the assessment of symptoms. Love & Love (2006) found that components of the Center for Epidemiological Studies Depression (CED-D) Scale, a widely used measure for depression, may not be applicable to older urban African American men. Torres (2012) studied a larger group of African American men and found that the 12-item version of the 20-item CES-D demonstrated a low alpha score when all items were used. When certain items were eliminated, the alpha score increased in African American men. This suggests that a widely utilized tool may not be reliable in some populations. Hankerson et al. (2011) found African Americans present with different descriptions of depression from Caucasians which may not be captured on standard tools. For examples, terms unique to the African American community might not be included in these tool, which could lead to misunderstanding of items. This is significant because symptom characteristics of depression in African Americans might be missed (Hankerson et al., 2011). Although the John Henryism scale has shown to be reliable in African American men, few of the factors within the scale are found in many frequently used depression measurement tools utilized in the African American population. This calls for more nurses and other mental health workers to be more involved in psychiatric scholarship through research and to increase the number of valid and reliable instruments that are culturally appropriate.

Cultural sensitivity also involves being aware of factors that influence relationships between individuals and care providers to encourage health seeking behaviors. The relationship between African Americans and the American health care system has been less than perfect and has created an atmosphere of mistrust between the two. Numerous scholarly writings have exposed the health care inequalities over history and, at times, the exploitation of African Americans by the health care system. Therefore, a discussion of cultural sensitivity with African Americans would not be complete without discussing the issue of trust.

The goal of any client/provider relationship begins with the development of a trusting and caring relationship. Early research literature supports a relationship between race, trust and health. (Hood, Hart, Belgrave, Tademy, & Jones, 2012; Plowden, 2003; Plowden, Fletcher & Miller, 2005; Plowden & Miller, 2000; Plowden & Young, 2003). Meghani et al. (2009) conducted a comprehensive review of the literature and found patient provider race-concordance was associated with a sense of trust and other positive health outcomes for minority individuals. Numerous articles have discussed the relationship between care, trust and health seeking behaviors based on patient/provider race concordance (Plowden, 2003; Plowden & Miller, 2000). This takes place at the individual and system levels. A stronger effort should be in place to enhance trust and caring, such recruitment of individuals who reflect the populations served and other factors to facilitate entry and sustained contact with health systems. For example, the Office of the Surgeon General (2001) reported that only 2% of psychiatrist, 2% of psychologist, and 4% of social workers identified as African American. This compared to a much larger percentage of African Americans with mental illnesses. This is significant since most African American providers are more likely to practice in areas that served a larger number of African American clients (Komaromy et al., 1996). Therefore, efforts should be made to recruit more minorities in the area of mental health treatment.

In addition to providing culturally sensitive care, efforts must be made to reduce the stigma of mental illness and assist individuals with feeling comfortable with mental illness in general and accessing needed services. Although much progress has been made to reduce stigma in the area of mental health treatment, there remains much to be done. Laws, such as Education for All Handicapped Children Act [EAHCA] of 1975 and The American with Disabilities Act (ADA) have reduce discrimination and stigma on the federal level, but stigma and discrimination around mental illness continues More remains to be done to protect individuals with mental illness to reduce barriers associated with stigma.

The Affordable Care Act (ACA) opened the door for increased mental health treatment, but there are barriers to access associated with the ACA. Insurance companies are required to cover mental health illness the same as physical illness. The Medicare Improvement for Patient and Providers Act (MIPPA) was passed in 2008 that increased payments for mental illness from 50% to 80%, but clients with mental illness are still limited to 190 life time days for inpatient treatment (Golden & Vail, 2014). If severe depression presents at an early age, it is easy to use up these life time days. While this law reduces the burden of physical care, there continues to be a burden associated with drug cost. A recent law by Medicare and Medicaid attempted to pass a rule to limit coverage for antidepressant and other drugs. While Medicare and Medicaid cover many of these drugs, many clients reach their drug coverage limited, referred to as the "Donut Hole", and often cannot afford their medication. The ACA's impact will not affect drug coverage until 2020 (National Alliance on Mental Health, 2014). The ACA has improved care for individuals with mental illness, but there continues to be a gap in care.

Reducing mental health disparity also involves working with medical providers. Access to primary care settings has shown to reduce emergency room visits (van Loenen, van den Berg, Westert & Faber, 2014), but several barriers prevent access to primary health care. There has been a decline in the number of physicians who accept government assisted health programs. The percentage of psychiatrist who accept government assisted programs, such as Medicare and Medicaid, was found to be significantly lower when compared to other fields of medicine (Bishop, Federman, & Keyhani, 2011; Bishop, Press, Keyhani & Pincus, 2014; Cummings, 2015). The greatest dissatisfaction was found among psychiatrist who worked in practices that accepted Medicare clients (Demello & Deshpande, 2011). These same physicians were more likely to prefer practice in an environment where fee for service was expected directly from clients. The main reason for not accepting insurance was the low reimbursement associated with office visits. When compared to other disciplines, psychiatrists often provide not just medical services, such as medication management, but they also provide psychotherapy. In solo practices, reimbursement for these services can be low. The cost for these services is often passed onto the client. Most individuals, especially on fixed incomes, cannot afford to pay privately to see a psychiatrist as well as pay for their medications. Strategies that will increase the number of psychiatrist or advance practice are needed. More importantly advance practice nurse should be allowed to practice at their level of education as recommended by the report from Institute of Medicine (2011). There are states that continue to restrict practice of advance practice nurses and groups with great political action supporting these actions. Another approach is to adopt a patient medical home concept where psychiatry is a part of a much larger team of health care providers (Alakeson, Frank, & Katz, 2010).

CONCLUSION

This article focused on the unique characteristics of depression in African American men. Statistically, depression rates remain low among African American men when compared to other ethnic groups due to the difficulty in reaching these men. However, the negative effects and long term outcomes remain or are intensified in African American men. With appropriate evidence based interventions, barriers to seeking mental health care will be reduced. African American men will more likely seek not just somatic illnesses care but also mental health problems. The need to understand and provide culturally appropriate care is essential in order to reduce the effects of this devastating disease among this population at the individual, community, and policy level. Nurses remain in an ideal position to not only identify but provide quality care to individuals in order to reduce the disparity of depression in African American men.

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