Barbers as community mental health advocates for African American men: A.D.A.A.M.-QR web design to address social determinants of depression and access to culturally-relevant resources

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Introduction

Depression is one of the costliest and most disabling illnesses worldwide (WHO, 2018). The World Health Organization (WHO) estimates that over 350 million people worldwide are affected by depression, leading to over 800,000 suicides each year (WHO, 2018). Major depression symptoms include memory loss, lack of focus, irritability and cognitive dysfunction, leading to substantial societal and economic costs (McIntyre et al., 2013; Probst et al., 2007). The direct cost of depression rose from approximately $173.2 billion to $210.5 billion between 2005 and 2010 (Greenberg et al., 2015), and the estimation is expected to be higher when chronic diseases related to depression are considered (Hankerson, Lee, et al., 2015; Hankerson, Suite, & Bailey, 2015; Penner et al., 2010). Individuals suffering from depression-associated symptoms are less productive at work and in their personal lives, have decreased energy, feel they receive inadequate support from supervisors, and have lower concentration when trying to perform job-related tasks (Bertilsson et al., 2013).

Although depression is a common mental disorder, little is known about depression in African American men (Powell et al., 2019). Approximately 6–7% of African American males will develop depression in their lifetime, with more debilitating effects than other ethnic groups (Blumberg et al., 2015). More than 15 years ago, the National Institute of Mental Health's Real Men, Real Depression public health campaign sought to bring greater awareness to depression in men (Rochlen et al., 2005). Despite the national attention brought to the urgent topic of mental healthcare, African American males continue to seek mental health treatment at a rate of approximately half of white males (Plowden et al., 2016).

In 2011, the leading cause of death for African American men aged 15 to 34 was homicide, followed by accidents and suicide (CDC, 2016). Out of all African Americans who died by suicide, African American males accounted for 80% of deaths in 2014 (CDC, 2016). Under the age of 12 years old, suicide rates among African American children, principally African American males, are 86% higher than Whites and Latinos (Joe et al., 2018). Suicide rates from 1960 to 1995 increased among African American males ages 10 to 14 years of age by 233% compared to an increase of 120% among whites during the same time period. Among African American children ages 10 to 19, males are 2.9 times more likely to commit suicide compared to females (CDC, 2016).

Undertreated mental health conditions, including depression, can result in disproportionately high rates of morbidity and mortality for African American men. Unfortunately, African American men have the lowest life expectancy and the highest mortality of any other racial/ethnic group in the United States (Hankerson, Lee, et al., 2015; Hankerson, Suite, & Bailey, 2015). Exposure to stressors, including racism and discrimination, are associated with disproportionately high rates of cardiovascular disease, cancer, HIV/AIDS, and homicide (CDC, 2016; Rich, 2000; Wayne et al., 2008). Some studies suggest Black men use maladaptive health behaviors, such as smoking, alcohol use, and poor diet, to self-manage depression and cope with the stressors of life (Kendrick et al., 2007). Researchers have identified associations between violence, depression, and aggression among young African American males (Thomas, Hammond, & Kohn-Wood, 2015). This psychopathology of major depression and anxiety in African American men has been further described via the Environmental Affordances (EA) Model (Mezuk et al., 2013, 2010). The EA postulates contextual environmental factors provide a source of stress and opportunities to alleviate the trigger of the stress. Secondly, cultural norms and contextual factors influences how one copes with these stressors. When compared to non-Hispanic whites, African Americans have a lower lifetime prevalence of major depressive disorder (Hankerson, Lee, et al., 2015; Hankerson, Suite, & Bailey, 2015; Mezuk et al., 2010), but African American men have a higher prevalence and debilitating effects of depression when compared to other ethnic groups (Ward & Mengesha, 2013).

Depression may be expressed differently in various ethnic groups, and the current symptom criteria may not reflect the symptoms and forms of depression in African American men (Jackson et al., 2011). Thus, reports on the prevalence of depression in African American men may be inaccurate because current diagnostic criteria do not reflect their specific contextual life experiences (Matthews, Hammond, Nuru-Jeter,

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Cole-Lewis, & Melvin, 2013). The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) characterizes the emotions and psychosomatic manifestations of depression (American Psychiatric Association, 2013). However, the social and structural determinants of health that African American men face (i.e., multiple sources of stress, racial discrimination, poverty, high rates of unemployment, and encounters with the criminal justice system) also should be considered when mental health providers evaluate them for depression. Some African American men do not identify with the label and conventionally defined symptoms of depression. Instead, they "chill and deal" with the stressors because these stressors are perceived as part of the typical life experience of being a black male (Kendrick et al., 2007). Questions have been raised to determine if the lower prevalence of depression in African American men is due to lower rates or misdiagnosis in this population (Keyes, 2009; Mezuk et al., 2013). Understanding the experiences and more accurate assessments of culturally-nuanced depressive symptoms in African American men may promote the development of culturally-appropriate assessment strategies and treatment interventions (Bryant et al., 2014).

Sociohistorical factors also influence higher levels of stigma related to mental health care utilization among African American when compared to women and white Americans (Latalova et al., 2014; Wang, 2015). Socially determined cultural expectations of strength and independence among African American men may cause them to gravitate toward more dominant masculine gender norms, such as "boys don't cry" or "just deal with it," which only perpetuates this self-stigmatization and limits the utilization of mental healthcare services (Kendrick et al., 2007; Vogel et al., 2011). Sociohistorical factors also influence African American men's cultural distrust of mental healthcare providers (Hankerson, Lee, et al., 2015; Hankerson, Suite, & Bailey, 2015). Inadequate psychopharmacologic research on African American men limits information available to guide optimal medication management of mental health conditions in this population (Bailey et al., 2009). The underrepresentation of African American men in research results in inadequate evidence-based strategies for successfully connecting with this population to produce better outcomes (Bailey et al., 2009).

Despite the national attention focused on the urgency of mental healthcare in recent years, mental illness remains an underrecognized health challenge among many African American males in the United States (Powell et al., 2019). With lives at risk of succumbing to depression, there is an urgent need to break through barriers and strengthen efforts to get information on mental health to this community as expeditiously as possible.

Social determinants of African American men's health and the barbershop

Social determinants of health include a wide range of factors that contribute to the health status of individuals, families, communities, and populations, personal, social, economic, and environmental phenomena and structures (Centers for Disease Control and Prevention [CDC], 2018. Social determinants also include exposure to psychological stressors, discrimination, access to health care resources, and socioeconomic status (Artiga & Hinton, 2018). Determinants of health can either positively or negatively shape health conditions and are known contributors to health inequities across populations. By focusing on the determinants shaped by where people are born, where they grow up, where they work, and how they engage with social support networks and community resources, healthcare professionals and public health advocates can identify strategies for improving health for diverse groups (CDC, 2018; U.S. Department of Health and Human Services, 2020; World Health Organization, 2020). For many African American men, the barbershop is an important cultural institution and social support system that can influence health behaviors and health outcomes (Balls-Berry et al., 2015; Linnan et al., 2011; Linnan et al., 2014; Moore et al., 2016; Murphy et al., 2017; Victor et al., 2018).

With that in mind, this project was implemented in a barbershop in Durham, North Carolina to enhance mental health awareness among African American men. The project was designed to increase barbers' confidence in sharing information about mental illness with their African American male clients. The project, Against Depression in African American Men-Quick Response (A.D.A.A.M.-QR), provides evidence-based material about mental health, misconceptions about mental illness and community resources that are available for treatment of mental illness.

Barbers' presence in the African American community is highly regarded for reasons other than styling hair and trimming and shaving clients' mustaches and beards. Barbers routinely establish such a strong level of trust that their customers willingly disclose health concerns that they may hesitate to share healthcare professionals (Balls-Berry et al., 2015; Hood et al., 2012; Hood et al., 2018; Moore et al., 2016). This places them in a unique position to share information about mental health issues. Yet, barbers often do not have supportive resources to assist them in initiating conversations about and sharing information on mental health with their clients.

Methodology

Prior to implementation, the Office of Human Research Ethics at the University of North Carolina at Chapel Hill determined that this project met the criteria of a quality improvement, instead of human subjects research. This project was conducted with a barbershop located in Durham, North Carolina, which provides services to over 300 clients weekly and has ten barbers on staff. Though the customer base is predominantly African American men, multiple ethnicities and various sexes are served by the barbershop. The key stakeholders for the project were the barbers. The project director first sought support of the barbershop owner for this project by presenting information about the proposed DNP project at one of our introductory meetings. The barbershop owner expressed interest in hosting and invited his barbers to participate in the evidence-based web design A.D.A.A.M-QR project.

Eight staff barbers volunteered to participate in the project, which was conducted onsite, after business hours at the barbershop. The project director provided sandwiches and drinks to all participants after the didactic session as an expression of gratitude for their participation. The barbers completed a Quick-Response (QR) code link-accessible questionnaire to evaluate what they knew already about mental illness and their perceptions on depression. Following the delivery of a one-hour mental health education module on the A.D.A.A.M.-QR, a web-based resource with culturally relevant information on mental health for African American men, barbers completed a second questionnaire to evaluate the effectiveness of the website. The purpose of the evaluation was to determine if the web design on mental health increased barbers' confidence in sharing information about mental illness in a manner that supports the enactment of change to the stigma of mental health.

Procedure for project implementation

The project director asked the barbers to attend a one-hour session that had two evaluation components. During the first evaluation component, the barber's completed a pre-education assessment to evaluate what they knew already about mental illness and their perceptions on depression. During the pre-education assessment, the project director gave participants access to the web-based module by scanning a Quick-Response (QR) code using their personal cell phone. If barbers did not have the application on their phones to access QR code materials, they were taught how to download the application by the project director. Following the delivery of a one-hour mental health education module on the A.D.A.A.M.-QR, a web-based resource with culturally relevant information on mental health for African American men, the barbers completed the second evaluation component. A web-based questionnaire was used to evaluate the effectiveness of the A.D.A.A.M.-QR website. The purpose of the evaluation was to determine if

the web-based one-hour module on mental health increased barbers' confidence in sharing information about mental illness in a manner that supports the enactment of change to the stigma of mental health.

Pre-intervention questions

The following are questions participants were asked to answer as "Agree" or "Disagree" before they attended the education session on mental health.

1. I feel comfortable discussing mental illness.
2. Depression is not that serious.
3. Depression is a sign of weakness.
4. Depression is a sign of not trusting God.
5. Depression is used by the white man as a way to hold a black man down.
6. Most of the time, you can 'shake' depression without medication.
7. When African American men feel 'down and out,' they don't talk about it.
8. A sign of depression includes feeling a lack of energy to get out of bed.
9. Most African American men are willing to take medication for depression.
10. Many African American men would feel ashamed if anyone knew they had depression or mental illness.

Educational module discussion points

The following topics were covered during the one-hour session with barbers after they completed the pre-intervention questionnaire.

1. explanation of A.D.A.A.M.-QR
2. definition of mental illness;
3. myths about depression;
4. explanation of mental illness;
5. startling statistics about African American men and mental illness explained;
6. understanding depression;
7. treatments for depression;
8. understanding mental health hygiene;
9. community resources available to assist with mental health; and
10. evaluation of A.D.A.A.M.-QR.

Results

All the participants (eight total) at the barbershop completed the questionnaires on mental health as well as participated in the A.D.A.A.M.-QR educational session. In sum they reported a) an increased confidence in sharing knowledge on mental health care, and b) they found A.D.A.A.M.-QR was a beneficial tool for barbers to share information about mental illness, including misconceptions of mental health. Barbers expressed confidence that they could discreetly share the QR code with clients at their barbershop to provide mental health resources.

Discussion

Given the sparse representation of African American men in literature on mental health interventions, a more creative approach is needed to reach this underserved population. This project demonstrated the potential benefit of targeting the social determinants of African American men's lives, with a specific emphasis on social support networks and resources found at the barbershop. Strategies that reach African American men where they congregate and disseminate information may generate success in enhancing access to mental health information for this group. Barbers recognize they are trusted and perceive a responsibility when it comes to the African American community, and those who participated in this project desired to be equipped with information they could to share with their clients.

Overall, participants expressed having a web-based educational tool gave them adequate support and materials on mental illness to share with their customers. Sixty-three percent of the participants felt utilizing the web-based design provided the customers with privacy to read about the stigma of mental health and locate community resources in a convenient, discreet manner using the QR code. The barbers expressed A.D.A.A.M-QR would be beneficial to other barbers and barbershops nationwide because the tool would give barbers easy access to information on mental health as well as suggestions for resources to treat mental illness. Of significant importance to the barbers is that the web-based design A.D.A.A.M-QR provided ease of access, with readily available resources and discretion for their clients. However, barbers targeted in this project revealed a one-hour education session was not enough time for them to get the full benefit from this unique training.

Healthcare providers should keep in mind that African American men are less likely than other groups to volunteer to come to clinics or participate in research; subsequently their voice is inadequately represented in the literature on mental health. It is critically important to follow through with any opportunity, to bring attention to the mental healthcare of African American men—even if this means presenting information in a locale where they feel safe and in a format which they are more likely to trust the information provided.

Limitations and implications for future studies

Potential weaknesses of the project include the fact that the educational session was delivered in a 60-minute time frame and for one time only. This meant the information had to be condensed for a group of barbers who were already at a disadvantage with minimal to no knowledge of mental health, and the information was presented in a limited amount of time, leaving the participants with little opportunity to engage in lengthy discussions on what they heard and viewed. Therefore, participants were not given ample time for a question and answer period that would further allow them to explore their concerns on mental healthcare.

Demographic information and the pre-intervention questionnaire and post-intervention questionnaire on mental health were completed by barbers who worked in a barbershop located in suburban Durham, North Carolina, the home of major learning institutions such as Duke University, North Carolina Central University and the nearby University of North Carolina at Chapel Hill. The questionnaire about mental illness that was given prior to the educational session might have been answered differently if the educational session had been presented to barbers who worked in rural and urban areas of the city. More information on medications should be included as part of the resources to dispel myths concerning medications and alternative treatments for depression that should be addressed in a sensitive, accurate manner. Lastly, the sample group of eight barbers could be increased to include more barbers across a spectrum of geographic locations to capture more feedback about the web design and to equip additional barbers with a tool that can help them initiate conversations about mental illness with their clients.

Conclusion

The education session targeted barbers' confidence in sharing knowledge about mental health using the A.D.A.A.M.-QR web design to increase awareness of mental disorder in African American men. Fostering awareness of mental illness and providing resources to address it are the first steps to reducing the stigma of depression in African American culture. The initial stages of designing A.D.A.A.M.-QR established a web-based design module that could be used to increase barbers' confidence in sharing knowledge to eliminate discomfort when discussing mental illness, the stigma of mental illness and myths associated with it among African American males. The findings from this project highlight the potential value of targeting barbers as key

stakeholders and social support determinants for African American men's mental health and well-being.

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