

The Depressive Symptomatology of Black College Men: Preliminary Findings

Daphne C. Watkins

University of Michigan

Abstract

Black Americans have poorer health than the rest of the nation and are exposed to a wider range of social and environmental factors that adversely impact their health. Although it may be presumed that men who acquire a college education will also attain middle-class status, middle-class status does not provide Black men with the anticipated reductions for at least some health risks. This study presents preliminary findings from a study designed to assess the prevalence of depressive symptoms among Black college men (n=115) at a predominately white institution and a historically Black institution. Results suggest that although depressive symptoms for the Black college men in the sample were relatively low, participants from the predominately white institution reported slightly higher on individual depression items and had a higher total depression score than participants from the historically Black institution. Findings from this study have implications for the provision of adequate mental health services for Black college men as well as future research conducted with this population regarding their health and health behaviors.

© 2006 Californian Journal of Health Promotion. All rights reserved.

Keywords: African American, Black, men, college, depression

Introduction

Gender is one of the most important determinants of health behavior (Courtenay, 1998). Although a number of genetic and biological factors may contribute to the differences men experience, these factors do not explain them. Differences that are often acknowledged between men and women are not biologically inevitable but are shaped by social arrangements (Williams, 2003). Similarly, the health status of men is largely impacted by the social organization and the economic opportunities they are offered in society. Consider, for example, that the higher symptoms of depression and anxiety experienced by women are reversed when men and women are not in their traditional roles. Wives who are employed have lower depression scores than their husbands; subsequently, both women and men experience more symptoms of depression and anxiety when either earns less than their spouse. The living and working conditions of men in general, and the burdens of minority men, specifically, have adverse affects on their health. From birth, parents treat boys and girls differently (Courtenay, 2000a). Although boys

tend to be at higher risk, parents are often less concerned about the safety of their boys than they are about the safety of their girls (Courtenay, 2004). Likewise, boys are more likely than girls to be discouraged from seeking help, and are often punished for doing so. This differential treatment has been found to have both short-term and long-term effects on the health of men and boys (Courtenay, 2000a).

Men are expected to project strength, individuality, autonomy, dominance, stoicism, physical aggression, and to avoid demonstrations of emotion that could be mistaken for weakness (Courtenay, 2000a). These social orientations are prevalent among men of various cultures and are associated with an increase in their health risks. Despite the continual disadvantages that women experience on social proportions, and the multiple indicators of disparities that women of color face (Williams, 2002) recent reports suggest that Black men in the U. S. are falling ever further behind other groups in health among a number of other variables (Elsner, 2005). Black men live approximately seven years less than other racial

groups and experience higher mortality rates in every single leading cause of death (Arias & Smith, 2003).

Research shows that men engage in far fewer health-promoting behaviors and have less healthy lifestyle patterns than women (Courtenay, 1998). Men are more likely than women to engage in more than thirty behaviors that are associated with an increased risk of disease, injury, and death (Courtenay, 2000b). For instance, men take more risks with regards to driving, sexual activity, and drinking, and use more alcohol and other drugs than women. (Courtenay, 1998) Not only do men participate in more high-risk physical activities and physical fights, but they are also more likely than women to carry guns or other weapons and engage in criminal activity (Courtenay, 2003). Additionally, men are oftentimes more overweight; have less healthy dietary habits; are less likely to conduct self-examinations; have higher cholesterol and blood pressure; use less sun protection; wear safety belts less often; and use fewer medications, vitamins, and dietary supplements (Courtenay, 2003) than women.

Men sleep less, and less well than women, and they stay in bed to recover from illness for less time than women. When under stress, men respond in less healthy ways than women. Men are more likely to use avoidant coping strategies (e.g. denial, distraction, and increased alcohol consumption) and are less likely to employ healthy coping strategies and to acknowledge that they need help (Kopp, Skrabski, & Szedmak, 1998; Weidner & Collins, 1993). As a substitute, men may deny their physical or emotional distress, or attempt to conceal their illness or disabilities (Courtenay, 2001). Consider depression, for example, where men are more likely than women to rely on themselves, to withdraw socially, and to try to talk themselves out of feeling depressed (Courtenay, 2000a).

College Men's Health

Disease, injury and death rates are unavailable for college students specifically; however, a general profile of college men's health can be inferred from the risks of this age group. In the

15 to 24 age group, for example, more than 3 of 4 deaths each year are male (Courtenay, 1998). Even with this loss, policymakers and health professionals have paid little attention to men's health risks, or to their greater risk of premature death. When the health concerns of college men are studied, little is reported beyond the limited research addressing concerns such as STDs (Sawyer & Moss, 1993), testicular cancer (Neef, Scutchfield, Elder, & Bender, 1991), and men's mental health (Whitaker, 1987).

College men, specifically, engage in fewer health promoting behaviors than college women. Not only are college men's health-promoting behaviors scarce, but they have been shown to decrease overtime, while those of college women increase (Lonnquist, Weiss, & Larsen, 1992). In a review by Courtenay (1998) it was revealed that college men consistently score lower on an index of health-protective behaviors that includes safety belt use, sleep, health information, eating habits, and exercise. Furthermore, college men are significantly less likely to practice self-examinations for testicular cancer than college women are likely to practice self-examinations for breast cancer (Katz, Meyers, & Walls, 1995). Similar to men overall, college men have reported high risk-taking behavior. In an analysis of gender and driving risks among college students, men received significantly higher scores than women for problem driving, which included speeding or reckless driving, moving violations, arrest for driving under the influence, and license suspension or revocations (DeJoy, 1992). Among college students, men have been found to begin sexual activity earlier in their lives, have more sexual partners, and are more likely than women to have sex under the influence of alcohol or drugs (Wiley, James, Jordan-Belver, et al., 1996; Jadack, Hyde, & Keller, 1995). While being male is linked with poor health practices and a decrease in health-promoting activities, so is gender, or issues of masculinity.

A national study of nearly 2,000 men between the ages of 15 and 19 (including college men) revealed that traditional beliefs about manhood are linked with a variety of poor health behaviors, including drinking and drug use and

high risk sexual behavior (Pleck, Sonenstein, & Ku, 1994). Moreover, college men who adopt traditional attitudes about manhood experience higher levels of depression and are more vulnerable to psychological stress and maladaptive coping patterns (Eisler & Blalock, 1991; Good & Mintz, 1990; Sharpe & Heppner, 1991). These men complicate their risks because they tend to not seek help from others and underutilize professional services on campus (Good & Mintz, 1990). Among college students, traditional attitudes have been linked with a higher level of anxiety, greater cardiovascular reactions to stress, maladaptive coping, depression, poor health behaviors related to smoking, alcohol and drug use, safety, diet, sleep, and sexual practices (Courtenay, 2004). A major shock regarding the college population is that college men are successful at concealing their vulnerabilities. Compared to women, college men are less likely to confide in close friends, to express vulnerability, or to disclose their problems to others (Williams, 1985; Johnson, 1988). Among depressed college students, men are more likely than women to rely on themselves, to withdraw socially, and try to talk themselves out of depression (Courtenay, 2001, 2003). Research by Courtenay has also revealed that college men's self-reliance and denial of pain can play a part in the inattention of others to their health needs. For instance, the lack of information addressing the mental health of college men may be based on the limited number of men who will admit to experiencing depression and anxiety. College men's lesser response to depression promotes the widespread belief that college men do not get depressed. As a result, less intervention efforts are directed toward this population.

The Mental Health of Black Men

The legacy of slavery and discrimination continues to influence the social and economic standing of Blacks in the United States (USDHHS, 2001). To understand the mental health of this population, the historical context must be considered. A large number of the U.S. Black population can trace their ancestry to the slave trade from Africa. As a result of the mental and physical abuse that many of the slaves received during their oppression, it is believed

that some of these legacies have continued to evolve in the minds of Black Americans. The Report of the Surgeon General on Mental Health notes that "through mutual affiliation, loyalty, and resourcefulness, African Americans have developed adaptive beliefs, traditions, and practices" (USDHHS, 2001). Black Americans have survived and accomplished many things, sometimes against enormous odds. Despite their ability to overcome hardships and sustain a high degree of mental health (USDHHS, 2001), Blacks have poorer health and are exposed to a broad range of social and environmental factors that adversely affect their health (Williams, 2003). Although the health of Blacks is influenced by biological factors as well as social determinants, many Black leaders have traditionally blamed the legacy of slavery, institutional racism and poverty for the problems that Blacks face, especially Black men.

Black men are more likely than men of other groups to endorse traditional attitudes about masculinity (Courtenay, 2001, 2002). A common social orientation is that men are to be the model of strength and power in comparison to the lesser, weaker female sex. Similarly, men are also projected to be the physically and mentally stronger of the two sexes. This has not always been the case in the traditional Black community. Although the Black man may have a presence in the household as the bread-winner and male influence, in many cases, the Black woman has assumed control of the household. Recent data illustrate that Black women are forced to assume the lead role in the household due to the absence of the male (Williams, 2003), resulting in the economic marginalization and increased mental problems among Black males. The presence of Black men at institutions of higher learning may indeed resemble their presence in the household. Black men may not benefit from the positive engagement that the university's social and educational experiences nurture which may also result in their economic marginalization and increased mental problems. The acclamation of Black men to the college environment undoubtedly influences their mental health. The purpose of this study is to examine the depressive symptomatology among Black college men at a predominately white

institution (PWI) and a historically Black college/university (HBCU). Furthermore, this research seeks to generate scholarly discussion about Black college men and the factors that influence their health.

Methods

The study was reviewed and approved by the Institutional Review Board at each study site. Survey methodology was employed to assess the depressive symptomatology of Black college men. The convenience of an online survey is that respondents can complete it at a location and time of their choice. The majority of survey respondents completed the online survey; however, paper versions of the survey were distributed in focus groups (a separate phase of this study) conducted at the PWI and HBCU. Since paper versions of the survey were completed by members of the focus groups, the focus group facilitator (a Black, female doctoral student) read the focus group consent form to participants once they were assembled at the site. Respondents to the online survey were presented with an informed consent page. Their decision to complete the assessment (which was determined by selecting the option to "Begin Questionnaire") served as their consent to participate in the study. To maintain participant confidentiality, no identifiers linking the information to the respondents were collected.

Sample Selection

Eligible participants were Black college men who were enrolled at the PWI and HBCU, both located in a southern U.S. state, during the 2005-2006 school year. The investigator recruited the men from the PWI and solicited the help of a faculty member to recruit the men at the HBCU. Respondents at each institution were contacted via email, direct person-to-person, and 'snowball sampling' (Morgan & Krueger, 1998). 'Snowball sampling' is the process of asking people that have already been recruited for names of other potential participants. Participants in the focus groups completed a paper version of the questionnaire while all other respondents completed the questionnaire online. No incentive was provided for completion of the questionnaire.

Measures

Data were collected using the General Health Assessment (GHA), which contains 22 questions, all derived from the Health Information National Trends Survey (HINTS). The investigator pilot tested the instrument with a mock group at one of the study sites. Three primary criteria guided item inclusion for the GHA. These criteria included scientific validity, data utility, and implementation. The criterion of scientific validity involved the following: (1) the questions were well-established for assessing general health-related information, (2) the questions could be self-reported accurately by the target population, and (3) the sample size was adequate to produce reliable estimates in analyses. Data utility encompassed priorities such as selecting and retaining items that would support the investigator's research agenda and program efforts in mental health status and health behaviors. Finally, the instrument had to meet implementation criteria. Examples of this criterion for the study included: (1) an item being able to be administered online, (2) an equitable distribution of questions among topics, and (3) respondent burden reduced as much as possible. For the purpose of this study, only responses to items related to the participants' demographics and prevalence of depressive symptoms are reported.

Demographics. Survey respondents were asked seven questions about their personal characteristics. Respondents were asked to indicate their classification (undergraduate versus graduate student); if they are involved in extracurricular activities (i.e. fraternity, student-athletes, on- or off-campus activities); their perceived health status (excellent, very good, good, fair, or poor); their age; their marital status (married, separated, divorced, never been married, widowed, or a member of an unmarried couple); their race (American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or other Pacific Islander, or White); and their annual income (less than \$15,000, less than \$20,000, less than \$25,000, less than \$30,000, less than \$35,000, less than \$40,000, less than \$45,000, or \$46,000 or more).

Depression. Respondents were asked to indicate how often they experienced depressive symptoms in the past 30 days using the following five-point Likert scale: 5 (all of the time), 4 (most of the time), 3 (some of the time), 2 (a little of the time), and 1 (none of the time). The six depressive symptoms included feeling: so sad that nothing could cheer you up, nervous, restless or fidgety, hopeless, that everything was an effort, and worthless. If respondents answered “all of the time,” “most of the time,” or “some of the time,” to any other depression items, they were prompted to answer question number nine: “Altogether, how much did the abovementioned feeling interfere with your life or activities?” To this question, respondents could have answered: 4 (A lot), 3 (Some), 2 (A little) or 1 (Not at all).

Results

Demographics

Respondent characteristics are presented in Appendix A. A total of 115 Black college men responded to the survey. The majority of respondents were undergraduate students (80.9%) and participated in extracurricular activities (80%). The average age of respondents was 21.64 (SD= 2.661) and the age range was 18 to 33. Approximately 92% of the men had never been married and almost half of the men reported that their health was “very good” (46.1%). Ninety-nine percent of the respondents identified themselves as Black or African American and over half attended the HBCU (69.6%) and earned less than \$15,000 annually (60%).

A large portion of the total number of respondents were men from the HBCU (n= 80). The mean age of respondents from the HBCU was 21.34 (SD= 2.08) and most (88.8%) were undergraduate students and had never been married (91.3%). These respondents participated in extracurricular activities (72.5%) and over half earned less than \$15,000 a year (57.5%). Almost half of them perceived their health to be “very good” (48.8%). A small number of respondents were from the PWI (n=35). The mean age for these men was 22.15 (SD=2.176) and more than half were undergraduate students

(62.9%). The men at the PWI reported their health to be “excellent” (31.4%), “very good” (40%) and “good” (25.7%), respectively. A large number of the respondents at the PWI had never been married (94.3%) and participated in extracurricular activities (97.1%). More than half had annual incomes less than \$15,000 (65.7%).

Depressive Symptoms

Participants were asked to respond to how often they felt: so sad that nothing could cheer you up, nervous, restless or fidgety, hopeless, that everything was an effort, and worthless in the past 30 days. Although more than half of the respondents said that they felt so sad that nothing to cheer them up none of the time (60.9%); they identified feelings of nervousness (41.7%) and restlessness or fidgetiness (36.5%) a little of the time. The majority of respondents also reported feelings of hopelessness (73%) and worthlessness (85.2%) none of the time. When asked if they felt that everything was an effort, participants had mixed responses. Although most reported that everything was an effort none of the time (28.7%); feelings of effort some of the time (27%) and a little of the time (26.1%) closely followed.

Also noteworthy is the large number of men at the PWI (71.4%) compared to that at the HBCU (56.3%) who reported feeling so sad that nothing could cheer them up none of the time. The majority of men at the PWI (62.9%) reported that they felt nervous a little of the time versus those at the HBCU who reported that they felt nervous none of the time (33.8%). Additionally, the most frequently reported responses for men at the PWI were feelings of restlessness (34.3%) and that everything was an effort (40.0%) some of the time. Overall, the men at the PWI reported feeling nervous a little of the time and reported feeling restless and like everything was an effort some of the time compared to the men at the HBCU where the majority of respondents only reported feeling restless a little of the time and reported experiencing the other depressive symptoms none of the time. The most frequently reported depression items are presented in Table 1.

Table 1
Responses to the depression items by school (*most frequently reported*)

Item	Predominantly White Institution (PWI) (n=35)	Historically Black College/University (HBCU) (n=80)
So sad that nothing could cheer you up	None of the time (71.4%)	None of the time (56.3%)
Nervous	A little of the time (62.9%)	None of the time (33.8%) ^b
Restless or fidgety	Some of the time (34.3%) ^a	A little of the time (40.0%)
Hopeless	None of the time (71.4%)	None of the time (73.8%)
That everything was an effort	Some of the time (40.0%)	None of the time (32.5%) ^c
Worthless	None of the time (88.6%)	None of the time (82.5%)

^a responses for 'a little of the time' (28.6%) and 'none of the time' (28.6%)

^b responses for 'a little of the time' (32.5%) and 'some of the time' (30.0%)

^c responses for 'a little of the time' (28.8%) and 'some of the time' (21.3%)

Spearman's rho correlations for the depression items and the total depression score are presented in Table 2. All depression items proved to be positively associated with one another and negatively associated with health. This indicates that the higher a respondent scored on an individual depression item, the higher their total depression score. While all depression items were positively correlated with the total depression score, three variables presented exceptionally high associations. The variables most highly correlated with the total depression score were restlessness ($r_s = .753$; $p=.000$), hopelessness ($r_s = .727$; $p = .000$), and feeling that everything was an effort ($r_s = .717$; $p=.000$). This suggests that respondents who scored the highest on restlessness, hopelessness, and effort were also more likely to report a higher total depression score. The relationship between the total depression score and perceived health was calculated to assess the probable association between how Black college men perceived their overall health and their depressive symptomatology. The total depression score was negatively correlated with perceived health ($r_s=-.371$; $p=.079$) which suggests that the men who reported that they had 'excellent' or 'very good' health also had lower total depression scores.

Discussion

In 1994 when the Journal of American College Health devoted its March issue to diversity, Black students, and the college campus,

Reginald Fennell recommended that a national study be conducted to measure the health status of Black college students- "both health disparities and the positive healthful behaviors." One of the most comprehensive studies on Black college students was by Fennell (1997), who used the National College Health Risk Behavior Survey (NCHRBS) to survey 996 African American students attending HBCUs in seven different states. Of the respondents, 678 (68.3%) were female and 314 (31.7%) were male. Approximately eighty-two of the respondents were sexually active and most (59.6%) had used a condom during their last sexual encounter. Seventeen percent of the students used no form of birth control during their last sexual encounter and the men in the study were more likely than women to have used alcohol or other drugs before engaging in sexual intercourse (Fennell, 1997). Studies such as this have provided some imminent results regarding Black male students; however, the number of large and adequately-sampled research studies that specifically address their mental health is sparse.

The aim of the present study was to compare the depressive symptomatology of Black college men at a predominately white institution (PWI) and a historically Black college/university (HBCU). Results from this study suggest that there is not a major difference between the depressive symptomatology of Black college men at a PWI and those at a HBCU, although differences do exist. For example, men at the

PWI scored higher than men at the HBCU on individual depression items, and had a higher (although not immensely) total depression score. Effort, nervousness, and restlessness were the highest scores on individual depression items for men at both institutions. Additionally, respondents with feelings of restlessness, hopelessness, and effort reported higher total depression scores. Findings from this study suggest the possibility of alternative symptoms of depression experienced in Black college men,

as identified in Black adults from previous studies (Myers, 1993; Baker, Espino, Robinson, & Stewart, 1993; Baker, 2001; Ayalon & Young, 2003). When attempting to explore depressive symptoms in Black men, researchers should not discount the importance of how depression is expressed in this population. Future studies should also consider the expression of depressive symptoms in college men and women of other races, ethnicities, and cultures.

Table 2
Bivariate Nonparametric Correlations: Depressive Symptoms, Depression Total, and Perceived Health (N= 115)

Spearman's rho	Depressive Symptoms						Depression Total	Health
	Sadness	Nervous	Restless	Hopeless	Effort	Worthless		
Sadness	1.000	-	-	-	-	-	-	-
Sig. (2-tailed)	.							
Nervous	.288	1.000	-	-	-	-	-	-
Sig. (2-tailed)	.002	.						
Restless	.392	.251	1.000	-	-	-	-	-
Sig. (2-tailed)	.000	.007	.					
Hopeless	.591	.432	.503	1.000	-	-	-	-
Sig. (2-tailed)	.000	.000	.000	.				
Effort	.223	.232	.393	.392	1.000	-	-	-
Sig. (2-tailed)	.017	.012	.000	.000	.			
Worthless	.545	.260	.408	.578	.346	1.000	-	-
Sig. (2-tailed)	.000	.005	.000	.000	.000	.		
Depression Total	.600	.601	.753	.727	.717	.567	1.000	-
Sig. (2-tailed)	.000	.000	.000	.000	.000	.000	.	
Health	-.189	-.395	-.255	-.298	-.178	-.185	-.371	1.000
Sig. (2-tailed)	.043	.000	.006	.001	.057	.047	.000	.

Note: All correlations are statistically significant at the 0.01 level with the exception of health * sadness, effort * sadness, and effort * nervous which are statistically significant at the 0.05 level.

One way to further explore depressive symptoms of Black college men is to first assess their mental health, specifically their stressors. A study by Watkins and colleagues (In press) reported the results from a qualitative study conducted at a PWI and a HBCU that addressed the major stressors of Black college men and how these stressors influence their mental health

and health behaviors. Findings from this study revealed stressors at the PWI that were more 'school-related' and stressors at the HBCU that were 'non-school-related.' Future studies should consider formative research as a means to build on specific variables to further examine Black college men and mental health. Findings from the present study also uncover beliefs about the

factors that lead to depression among black men, in general. Findings from a review affirm that prior to the year 2004, the majority of studies published about depression and Black men identified racism/ discrimination, socioeconomic status, and psychosocial coping as major factors that lead to depression in Black men (Watkins, et al., 2006).

Prior research on Black college men's health provides a foundation on which future research endeavors can be formed. Due to the dynamics of the college/university, more research on the mental health of Black college students can be conducted, as collecting larger samples of students have been found to be convenient at colleges and universities (Patton, 1991). This paper serves as a step toward understanding depressive symptoms in Black college men. Blacks are disproportionately affected by a

variety of health problems, including leading causes of death, cardiovascular disease and cancer. These and a number of other health problems can be reduced, and in some cases eliminated, by education and improvements in health-related behaviors. The influence of others can increase the chances of college students engaging in healthy behaviors. In fact, the probability that a college student will change their health behaviors increases if the health issues are perceived as relevant and of concern to them or their peers (Ford & Goode, 1994). More emphasis needs to be placed on the mental health of Black college men in order to improve their health and reduce the prevalence of disease. One of the ways to reduce/eliminate the disparities of Black men is to address their mental health and mental disorders early, and for some Black men, many health issues could be addressed during their college years.

References

- Arias, E., & Smith, B. (2003). Deaths: Preliminary data for 2001. *National Vital Statistics Reports*, 51 (5). Hyattsville, Maryland: National Center for Health Statistics. Retrieved February 20, 2006, from http://www.cdc.gov/nchs.data/nvsr/nvsr51/nvsr51_05.pdf
- Ayalon, L., & Young, M. A. (2003). A comparison of depressive symptoms in African Americans and caucasian Americans. *Journal of Cross-Cultural Psychology*, 34(1), 111-124.
- Baker, F. M., Espino, D. V., Robinson, B. H., & Stewart, B. S. (1993). Assessing depressive symptoms in African American and Mexican American elders. *Clinical Gerontologist*, 14(1), 15-29.
- Baker, F. M. (2001). Diagnosing depression in African Americans. *Community Mental Health Journal*, 37(1), 31-38.
- Courtenay, W.H. (1998). College men's health: An overview and a call to action. *Journal of American College Health*, 46(6), 279-90.
- Courtenay, W. H. (2000a). Teaming up for the new men's health movement. *Journal of Men's Studies*, 8(3), 387-392.
- Courtenay, W. H. (2000b). Constructions of masculinity and their influence on men's well-being: A theory of gender and health. *Social Science Medicine*, 50, 1385-1401.
- Courtenay, W. H. (2001). Counseling men in medical settings. In G. R. Brooks & G. E. Good (Eds.), *The new handbook of psychotherapy and counseling with men: A comprehensive guide to settings, problems, and treatment approaches* (Vol. 1, pp. 59-91). San Francisco: Jossey-Bass.
- Courtenay, W. H. (2003). Key determinants of the health and well-being of men and boys. *International Journal of Men's Health*, 2(1), 1-30.
- Courtenay, W. H. (2004). Making health manly: Social marketing and men's health. *Journal of Men's Health & Gender*, 1(2-3), 275-276.
- DeJoy, D. M. (1992). An examination of gender differences in traffic accident risk perception. *Accident Analysis and Prevention*, 24(3), 237-246.
- Eisler, R. M., & Blalock, J. A. (1991). Masculine gender role stress: Implications for the assessment of men. *Clinical Psychology Review*, 11, 45-60.
- Elsner, A. (2005). New studies point to crisis among U.S. black men. *Reuters Health*, Retrieved September 1, 2006, from <http://www.aegis.com/news/re/2005/RE050302.html>

- Fennell, R. (1997). Health behaviors of students attending historically black colleges and universities: results from the national college health risk behavior survey. *Journal of American College Health*, 46 (3), 99-101.
- Ford, D. S., & Goode, C. R. (1994). African-American college students health behaviors and perspectives of related health issues. *Journal of American College Health*, 42, 206-210.
- Gary, L. E. (1985). Correlates of depressive symptoms among a select population of black men. *American Journal of Public Health*, 75(1), 1220-1222.
- Good, G. E., & Mintz, L. B. (1990). Gender role conflict and depression in college men: Evidence for compounded risk. *Journal of Counseling and Development*, 69(1), 17-21.
- Jadack, R. A., Hyde, J. S., & Keller, M. L. (1995). Gender and knowledge about HIV, risky sexual behavior, and safer sex practices. *Research in Nursing and Health*, 18(4), 313-324.
- Johnson, T. M. (1988). Physician impairment: Social origins of a medical concern. *Medical Anthropology Quarterly*, 2(1), 17-33
- Katz, R. C., Meyers, K., & Walls, J. (1995). Cancer awareness and self-examination practices in young men and women. *Journal of Behavioral Medicine*, 18(4), 377-384.
- Kopp, M. S., Skrabski, A., & Szedmak, S. (1998). Why do women suffer more and live longer? *Psychosomatic Medicine*, 60, 92-135.
- Lonnquist, L. E., Weiss, G. L., & Larsen, D. L. (1992). Health value and gender in predicting health protective behavior. *Women's Health*. 19(2-3), 69-85.
- Mizell, A. C. (1999). Life course influences on African American men's depression: Adolescent parental composition, self-concept, and adult earnings. *Journal of Black Studies*, 29(4), 467-490.
- Morgan, D. L., & Krueger, R. A. (1998). *The focus group kit*. Thousand Oaks, CA: Sage Publications.
- Myers, H. F., Bastien, R. T., & Miles, R. E. (1983). Life stress, health, and blood pressure in Black college students. *Journal of Black Psychology*, 9, 1-25.
- Neef, N., Scutchfield, F. D., Elder, J., & Bender, S. J. (1991). Testicular self-examination by young men: An analysis of characteristics associated with practice. *Journal of American College Health*, 39(4), 187-190.
- Patton, M. J. (1991). Qualitative research on college students: Philosophical and methodological comparisons with the quantitative approach, *Journal of College Student Development*, 32, 389-396.
- Pleck, J. H., Sonenstein, F. L., & Ku, L. C. (1994). Attitudes toward male roles among adolescent males: A discriminant validity analysis. *Sex Roles*, 30(7-8), 481-501.
- Sawyer, R. G., & Moss, D. J. (1993). Sexually transmitted diseases in college men: A preliminary clinical investigation. *Journal of American College Health*, 42(3), 111-115.
- Sharpe, M. J., & Heppner, P. P. (1991). Gender role, gender-role conflict, and psychological well-being in men. *Journal of Counseling Psychology*, 38(3), 323-30.
- U. S. Department of Health and Human Services (USDHHS). (2001). *Mental health: Culture, race, and ethnicity- a supplement to mental health: A report of the surgeon general*. Rockville, MD: Office of the Surgeon General.
- Watkins, D. C., Green, B. L., Goodson, P., Guidry, J., & Stanley, C. A. (In press). Using focus groups to explore the stressful life events of black college men. *Journal of College Student Development*.
- Watkins, D. C., Green, B. L., Rivers, B. M., Rowell, K. L. (2006). Depression in black men: Implications for future research. *Journal of Men's Health & Gender*, 3(3), 227-235.
- Weidner, G., & Collins, R. L. (1993). Gender, coping, and health. In H. W. Krohne (Ed.), *Attention and avoidance* (pp. 241-265). Seattle, WA: Hogrefe and Huber.
- Whitaker, L. C. (1987). Macho and morbidity: The emotional need vs. fear dilemma in men. *Journal of College Student Psychotherapy*, 1(4), 33-47.
- Wiley, D. C., James, G., Jordan-Belver, C., Furney, S., Calsbeek, F., Benjamin, J., & Kathcart, T. (1996). Assessing the health behaviors of Texas college students. *Journal of American College Health*, 44, 167-172.

Williams, D. G. (1985). Gender, masculinity-femininity, and emotional intimacy in same-sex friendship. *Sex Roles*, 12(5-6), 587–600.

Williams, D. R. (2002). Racial/ethnic variation in women's health: The social embeddedness of health. *American Journal of Public Health*, 92, 588-597.

Williams, D. R. (2003). The health of men: Structured inequalities and opportunities. *American Journal of Public Health*, 93, 724-731.

Acknowledgements

The author would like to acknowledge the following individuals who provided feedback regarding research methodologies and earlier drafts of this work: B. Lee Green, PhD, Patricia Goodson, PhD, Jeff Guidry, PhD, Christine A. Stanley, PhD, and Derek Wilson, Ph.D. This research project was supported by the Center for the Study of Health Disparities, Texas A&M University, College Station, Texas.

Author Information

Daphne C. Watkins, Ph.D.
National Institute of Mental Health Postdoctoral Fellow
Institute for Social Research
University of Michigan
402 Nob Hill Court 3
Ann Arbor, MI 48103
Ph.: 734-369-4204
E-Mail: daphnew@umich.edu

Appendix A

Respondent Characteristics (N=115)

Respondent Characteristics	N	Percent
University		
Predominantly white institution (PWI)	35	30.4
Historically black college/university (HBCU)	80	69.6
Classification		
Undergraduate	93	80.9
Graduate	22	19.1
Extracurricular activities		
Yes	23	20.0
No	92	80.0
Health status		
Excellent	28	24.3
Very good	53	46.1
Good	30	26.1
Fair	4	3.5
Poor	*	*
Marital status		
Married	3	2.6
Not married	16	13.9
Annual income		
Less than \$15,000	69	60.0
Less than \$20,000	16	13.9
Less than \$25,000	12	10.4
Less than \$30,000	*	*
Less than \$35,000	4	3.5
Less than \$40,000	3	2.6
Less than \$45,000	10	8.7
\$46,000 or more	1	0.9

* no response