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# Mental illness etiology beliefs among African American men with serious mental illness and their social support networks

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**ABSTRACT**

Semi-structured qualitative interviews were conducted with 26 African American men with serious mental illness who were consumers of community mental health services and 26 members of their social support networks. All participants were asked what they believed had caused the consumers' mental illness. Consumer participants most commonly identified chronic life stressors as a causal factor, while social supports most often identified intrinsic factors such as genetics or biology as causes of mental illness. Some support participants believed that unintentional drug use had precipitated the onset of mental illness or had no causal theories. The fact that some support participants could not identify a causal explanation may indicate failure on the part of mental health care systems to engage with consumers' social support networks and provide education about mental illness and its causes. The implications of etiology beliefs on mental health service utilization are discussed.

**KEYWORDS**
African American; etiology; mental health; serious mental illness; social support

African Americans experience disparities in all stages of mental health care (Carpenter-Song, Whitley, Lawson, Quimby, & Drake, 2011; Snowden, 2012; U.S. Department of Health and Human Services, 2001). The Surgeon General's seminal report on race and mental health care found that African Americans experienced less availability and accessibility of mental health services, lower service utilization, and poorer mental health outcomes (U.S. Department of Health and Human Services, 2001). In 2013, the National Survey on Drug Abuse and Health found that African Americans reported rates of mental health service utilization (8.9%) that were well below the national average (14.6%; Center for Behavioral Health Statistics and Quality, 2013).

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African Americans with serious mental illness are at particular risk of experiencing disparities in mental health care. Serious mental illnesses are diagnosable psychiatric disorders that result in significant functional impairment (Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 1999) and generally include schizophrenia and other disorders with psychosis, bipolar disorder, and severe depression (Department of Veterans Affairs, 2012). Research finds that non-Hispanic African Americans experience serious psychological distress at an almost 20% greater rate than non-Hispanic Whites (National Center for Health Statistics, 2012), yet: "African Americans with severe mental illness are less likely than Euro-Americans to access mental health services, more likely to drop out of treatment, more likely to receive poor-quality care, and more likely to be dissatisfied with care" (Whitley & Lawson, 2010, p. 508). There have been several comprehensive reviews of issues and concerns in African American mental health care including preventive approaches (Bell & McBride, 2012), microaggressions (Gómez, 2015), treatment disparities (Hankerson, Suite, & Bailey, 2015), service use (Holden, McGregor, Blanks, & Mahaffey, 2012), policy implications (Snowden, 2001), cultural mistrust (Whaley, 2001), and cultural lived experience (Williams & Williams-Morris, 2000).

Among African Americans who experience serious mental illness, additional barriers to mental health care exist for men. In their examination of African Americans in a nationally representative sample, Neighbors and colleagues (2007) found that of those experiencing severe psychiatric symptoms, only approximately half of African American men reported receiving any physical or psychiatric care within the last 12 months. African American men are also four times more likely to die by suicide than African American women (Kochanek, Xu, Murphy, Minino, & Kung, 2012). One important determinant of this disparity with serious mental illness may be related to gender role socialization, which can increase stigma around seeking mental health services. African American men are typically socialized to hegemonic masculine roles that define men as physically and emotionally tough and discourage overt expressions of vulnerability or emotions (Addis & Mahalik, 2003; Holden et al., 2012). This approach to masculinity may make it difficult for African American men to acknowledge mental health concerns and seek treatment when needed.

To address and reduce disparities in mental health service access and use for African American men with serious mental illness, it is critical that the mental health treatment community have a better understanding of the factors that contribute to disparities. Mental health service access and utilization disparities result from the interaction of consumer-, provider-, and system-level factors that influence providers' and consumers' beliefs, behaviors, interactions, and reactions (DeCoux Hampton, 2007; Smedley, Stith, & Nelson, 2003). One consumer-related factor that may be important for persons with serious mental illness is belief about the causes of mental illness.

Individuals make different attributions about the causes of mental illness—genetics, family environment, substance use—that have been found to influence individuals' reactions to people with a mental illness (Corrigan, Markowitz, Watson, Rowan, & Kubiak, 2003) and consumers' decisions to seek mental health care as well as the types of assistance sought (Chen & Mak, 2008). For example, research participants who viewed mental illness as the consequence of an individual's personal choices withheld helping behaviors and were less likely to personally consider seeking mental health care services in the future (Cooper, Corrigan, & Watson, 2003). In contrast, people who believed that serious mental illness stems from genetic factors were more likely to recommend hospitalization and medication (Phelan, Yang, & Cruz-Rojas, 2006). Ogden and Jubb (2008) examined the relationship between what people believed were the causes for three health problems (depression, sleep disturbance, and obesity) and what they suggested as appropriate interventions. When participants were influenced to change their opinions about the health problem cause, they also changed their beliefs about recommended treatment. For example, when participants were induced to believe the cause of a problem was psychological in nature, they more often recommended psychological treatment for that problem. Such findings illustrate the ways that etiology beliefs can influence help-seeking and suggest that education about the causes of mental health problems may impact consumers' willingness to accept treatment.

In addressing disparities in mental health care, beliefs about the causes of mental illness may be especially important for African Americans with serious mental illness. As noted, causal beliefs impact people's reactions to those with serious mental illness and their assumptions about how to best treat these disorders. If etiology beliefs stress personal behaviors or attributes such as substance use or moral weakness as main causes, then one is more likely to both view serious mental illness as stigmatizing and question the benefit of seeking outside professional assistance. As noted by Compton and colleagues (2008) in their paper on this topic in schizophrenia: "… course and outcome for people with the illness may be indirectly influenced by beliefs about causes in the larger community" (p. 87). To date there has been little exploration of beliefs about the causes of serious mental illness among African Americans generally, or among African Americans with serious mental illness and their family members. Of the 13 articles published since 2000 that examined perceptions of mental illness etiology among African Americans, only one surveyed family members of consumers with serious mental illness (Esterberg & Compton, 2006) and only one focused on African Americans with serious mental illness (Maher & Kroska, 2002). Esterberg and Compton (2006) asked 61 family members of African American adults with schizophrenia to rate the likelihood of each of 30 options as a cause of schizophrenia. Biological causes were most commonly endorsed: 70.5% of participants rated disturbance of brain biochemistry and 52.2% rated hereditary factors as likely or very likely. Maher and Kroska (2002) surveyed a diverse sample of 144 participants with serious mental illness engaging in mental health care for the first time to identify variables that correlated with controllable explanations (such as personal effort, characteristics, and behaviors) versus non-controllable explanations (such as genetics or childhood socialization). Results showed that African American men differ from both White and African American women and White men in that they were the least likely to cite controllable sources as the cause of their serious mental illness. The authors' hypothesized that this intersectional race and gender difference was reflective of the disadvantage in social location experienced by African American men.

Other studies about etiology beliefs have been conducted with general members of the African American community who were not specifically selected for having a serious mental illness or family members with a serious mental illness. These studies have examined causal beliefs of mental illness both in general and also in specific psychiatric disorders such as depression or schizophrenia. Schnittker, Freese, and Powell (2000) utilized vignettes and surveys to assess variables that influenced etiological beliefs among a sample of 1,094 African Americans and Whites. They found that, when controlling for vignette features (such as diagnosis) and participant features (such as education) African Americans were less likely than Whites to support genetics or a person's upbringing as causes for mental illness and were more likely to cite bad character as a cause, though this was strongly impacted by participant education. There was no significant racial difference in endorsement of chemical imbalance in the brain or stress as causal explanations. Hamilton and colleagues (2006) utilized open ended questions to gather the views of 23 urban African American community members and found that older African Americans identified heredity or environmental factors such as stress or poverty as causes of mental illness, while younger participants focused on substance abuse, stress, and trauma as possible causes. In qualitative interviews with 15 African American women, Ward, Clark, and Heidrich (2009) found that the participants believed either general causes such as biology, trauma, and social relationships, or culturally specific causes related to racism as causes of mental illness. Women over 65 also cited aging as a cause of mental illness. Ward and Besson (2013) conducted in-depth qualitative interviews with 17 African American men living in urban settings about their mental illness causal beliefs. Participants endorsed multiple interactive causes of mental illness consistent with a biopsychosocial model. Compton et al. (2008) found that among 127 African American adults asked about the causes of schizophrenia in particular, over 40% of participants endorsed brain biochemistry, drug/alcohol abuse, hereditary factors, and brain injury as causal explanations for the development of schizophrenia.

This literature suggests that among African Americans living in urban communities there is significant nuance and variation in causal beliefs, although biological factors and environmental factors such as stress and trauma are frequently endorsed. To develop interventions and policies to improve help-seeking and outcomes among African American men with serious mental illness, it is important to have a more thorough understanding of the etiology beliefs endorsed by this population. It is also important to examine how consumers' significant others understand mental illness. According to the Network-Episode Model (NEM; Pescosolido & Boyer, 1999), which served as the theoretical framework for this study, research must examine the social structures that influence mental health treatment and how the social structures interact. The NEM argues that, "[h]ow people respond to illness is as much a process of social influence as it is a result of individual action" (p. 406). The NEM consists of four factors: individual social content, social support systems, the illness career, and the treatment system. Pescosolido and Boyer (1999) assert that individual factors associated with the client—such as gender, age, income, illness symptomology, and access to care—influence their social support system, illness career, and treatment system. In turn, these three systems influence each other. For example, the beliefs espoused by members of an individual's social support systems about health care professionals may influence when a client leaves treatment. In line with this model, research focusing on African American families suggests that the support and involvement of family has a greater impact on increased psychological functioning among African American men with serious mental illness than on White consumers (Guada, Brekke, Floyd, & Barbour, 2009; Rosenfarb, Bellack, & Aziz, 2006). In their review of the paucity of social work research on mental health of African American men, Watkins, Hawkins, and Mitchell (2015) stressed the need for future research to include members of African American men's communities in order to understand "the role of the Black family in the emotional health and well-being of Black men" (p. 247). A more thorough understanding of causal beliefs can help guide the development of evidence-based educational tools and resources that can be used to promote accurate perceptions of those with mental illness, thereby reducing stigma and enhancing individuals' willingness to accept treatment.

The present study used semi-structured qualitative interviews to examine mental illness etiology beliefs from a sample of 26 African American men with serious mental illness recruited from eight community mental health agencies in the Midwest (consumer participants), as well as 26 members of their social support networks (support participants). Both consumer and support participants completed semi-structured interviews that explored their views of the causes of serious mental illness. The use of qualitative methodology allowed participants to describe their views and beliefs in their own words, without the restriction of pre-designated categorical answers. The goal of this research was to learn about the beliefs of both African

American men with serious mental illness and members of their social support networks in order to articulate suggestions for how mental health service agencies might improve outreach to and services for this underserved population.

## Methods

### *Sampling and participant recruitment*

#### *Consumer participants*

Consumer participants were identified from a sample of 41 African American men with severe mental illness (SMI) who had previously participated in a study examining mental health care provider factors and racial disparities and had remained engaged in mental health treatment over the course of 6 months of data collection (Larrison, Schoppelrey, Hack-Ritzo, & Korr, 2011). Because of the difficulties experienced by African American men attempting to access and remain engaged in mental health care, these men represented an opportunity for atypical case analysis in order to learn more about potential facilitators of mental health care engagement (Creswell, 1998). Procedures for recruiting consumer participants were as follows. First, we attempted to reach all 41 individuals via phone calls and mailed letters to their previously known telephone numbers and mailing addresses. If there was no response, we provided letters to staff at mental health agencies and requested that they deliver them to consumers who were still receiving services there. For consumers who we still were unable to contact, we conducted home visits to attempt to speak with them in person. Via these methods, 10 (24%) remained lost to contact and two (5%) declined to participate. We learned that another three consumers (7%) had died. All of the remaining ($n$ = 26, 63%) consumers were interested in participating in this study.

Second, the 26 consumers who expressed interest in participating were scheduled for face-to-face meetings to further explain the study. Consumers were asked to pick a comfortable location in which to meet: most chose to meet in their homes ($n$ = 15, 58%) or at the community agency where they received mental health services ($n$ = 9, 35%); two (8%) chose to meet, respectively, in a fast food restaurant and in a relative's home. After discussion of the study, all 26 consumers were willing to participate and completed informed consent. The interviewer reviewed the informed consent form with each consumer and provided a copy for the participant to keep. As part of the informed consent process consumer participants were explicitly asked to consent to audio recording and were informed that they could decline to answer any questions, change their mind about participating in the study at any time, that declining would not impact the mental health services they received, and that their responses were confidential and would not be shared with their mental health agency or provider. Following informed consent the consumers completed demographic questions and the qualitative interview. Information about diagnosis and number of years in mental health treatment was obtained from consumers' mental health service providers with participants' consent via Health Insurance Portability and Accountability Act (HIPAA) release.

### Support participants

During the qualitative interview, consumer participants were asked to identify people they felt were key members of their social support network and to give their explicit permission for the researcher to contact these people and request an interview. Subsequently, social supports were contacted by phone or letter at the number or address provided by the consumer participant, and were provided a brief explanation of the research and how they were referred for participation. Social supports who expressed interest in participating were asked to pick a location to meet where a complete explanation of the research could be provided and, if they consented, the interview conducted. In the case of one consumer, the identified social support did not respond to multiple contact attempts so a second social support from another consumer was contacted and interviewed. All contacted social supports chose to meet in their homes except for one who was only available by phone. Informed consent procedures were similar to those used with consumer participants.

Most support participants were family members, including mothers ($n$ = 7, 27%), sisters ($n$ = 5, 19%), fathers ($n$ = 3, 12%), brothers ($n$ = 3, 12%), and aunts, cousins, and romantic partners ($n$ = 4, 15%). Support participants included biological relatives as well as step-, -in-law, and fictive kin relatives. Some support participants were friends ($n$ = 1, 4%) or mental health treatment providers of the consumer participant ($n$ = 3, 12%). In the three cases in which a mental health treatment provider was nominated to be a support participant, both the consumer participant and the mental health treatment provider stated that their relationship was characterized by a greater degree of closeness than a typical therapeutic relationship: they considered each other to be co-workers or to have a friend relationship.

### Sample comparison

Per the focus of the research, consumer participants were all self-identified African American men. Support participants were predominantly women ($n$ = 18, 69%) who self-identified as African American ($n$ = 22, 85%; White: $n$ = 4, 15%). The range of ages among the support participants was wider than in the consumer sample (36–86 years vs. 32–58 years) but on average support participants were 14 years older than the consumer participants. Support participants were more likely to be employed than the consumer participants. None of the

**Table 1.** Participant demographics.

| | Consumers<br>*M* ± *SD*<br>(range); *n* (%) | Social supports<br>*M* + *SD*;<br>*n* (%) |
|---|---|---|
| Age | 46 ± 7 (32–58 years) | 60 ± 11 (36–86) |
| Male | 26 (100%) | 8 (31%) |
| Race | | |
| African American | 26 (100%) | 22 (85%) |
| White | 0 (0%) | 4 (15%) |
| Any employment | 4 (15%) | 8 (31%) |
| Years in mental health treatment | 12 ± 7 (4–31 years) | — |
| Payment source | — | — |
| Medicare/Medicaid | 26 (100%) | — |
| Average annual income | $8,522 ± $1,266 | |
| Diagnosis | | — |
| Schizophrenia spectrum | 19 (73%) | — |
| Mood disorder | 5 (19%) | — |
| Dual MI/SA | 2 (8%) | |

*Note*. MI/SA = mental illness/substance abuse.

consumer participants worked full time though four (15%) worked part time. Among the support participants, six (23%) were employed full time and two (8%) worked part time. While consumer participants were willing to share information about their annual income ($M$ = $8,522, $SD$ = $1,266) the overwhelming majority of support participants declined to share such information, prohibiting a socioeconomic comparisons. Further descriptive information on all participants is provided in Table 1.

### Data collection and analysis

Interviews explored participants' views of mental illness onset and disease course, experiences with and opinions of mental health care services, social support involvement in services and treatment planning, and how mental health care for African Americans can be improved. Similar questions and interview structure were used across the interview guides to facilitate comparison of information from consumer and support participants. For the present study, findings from the question "What do you think caused your/[consumer's] mental illness?" were analyzed and compared. When needed, follow-up prompts were used to encourage participants to provide elaborative detail in their responses. Because the interview was semi-structured, if participants began to discuss causal beliefs the interviewer transitioned to the appropriate question in order to allow the participant to continue their line of thought. Interviews were coded using a qualitative thematic approach (Aronson, 1994; Boyatzis, 1998). The interviewer was a White, female, graduate student. In an effort to gather information and protect against interviewer bias or ignorance, both consumer and support participants were asked how they felt race and gender impacted experiences of mental illness. The interviewer's race and gender, in relation to the participants' race and gender, was also discussed in 27 (52%) of the interviews. This research was approved by the University of Illinois at Urbana-Champaign Institutional Review Board. All participant names are pseudonyms.

Overall, 25 out of 26 interviews were audio-recorded for both consumer and support participants; one consumer participant and one support participant declined to be recorded. Detailed notes were taken during the non-recorded interviews. Interviews were coded using thematic analysis, an approach which consists of three stages: observing a pattern, coding the pattern, and interpreting the pattern (Boyatzis, 1998). The first author used ELAN (EUDICO Linguistic Annotator; Lausberg & Sloetjes, 2009) to review each interview in its entirety and mark and code meaningful qualitative units. Rather than a line-by-line or paragraph-by-paragraph approach, coding used meaningful qualitative units, which may be any length but are characterized by their thematic consistency (Chenail, 2012). When a meaningful qualitative unit was identified, the author assigned a brief code that summarized the essential theme or message of the qualitative unit. For the two non-recorded interviews, interviewer notes were coded using the same approach. Once initial coding was complete, the first author compared all the relevant qualitative units and codes across all consumer interviews and grouped together codes which exhibited similar or related themes. These groupings of codes were examined to identify the overarching theme across interviews and a relevant category name was assigned. Finally, the first author reviewed the categories, themes, and qualitative units to ensure that each level of organization and coding was accurate and the most appropriately located. The same process was completed for the social support interviews. The final categories are presented in this article.

## Results

### *Causes of consumer participant's mental illness—Consumer participants*

Nearly half of consumer participants ($n$ = 12, 46%) identified chronic environmental stressors as the cause of their mental illness. Other common recurring responses were physical injury such as head trauma ($n$ = 3, 12%) or that mental illness was inherited ($n$ = 3, 12%). A small but important group of consumers ($n$ = 4, 15%) reported that they did not know what caused their mental illness ($n$ = 4, 15%); it was an inherited illness ($n$ = 3, 12%); or the mental illness was the result of physical injury such as head trauma ($n$ = 3, 12%). Two consumer participants (8%) believed their mental illness was the result of alcohol or drug abuse and another two (8%) asserted reported that they did not have a mental illness or disagreed with their diagnosis.

### *Chronic stress*

Chronic stress is “a negative emotional experience accompanied by predictable biochemical, physiological, and behavioral changes” that persists over time (Baum, 1990) and has been linked to mental illnesses such as depression and anxiety and physical illnesses such as obesity, heart disease, and high blood pressure (McEwen, 2008). Consumer participants frequently described “rough” childhoods or family conflicts that resulted in stress and caused their mental illness.

> I’m gonna say, number one, when I was in high school I had to raise my siblings under me. And they was, all together it’s 13 of us, but eight of them under me. And during high school you can imagine all the little ones that was under me. I had to raise them because parents was at work…. I had to get them up for school, do this, do that, make sure everybody go to school, I’m the last one to go to school. I have to come home from school, come straight home from school…. I’d never had a childhood because I was the dependent person for my sisters and brothers…. I had to be that father and mother until mom and dad got home. So, with all them different personalities plus me trying to squeeze in some childhood and be a child myself, I think that all had a combination of doing it. Too much stress. (Norman, 49 years old)

> I think that my mental illness it came from me not having a real father figure to point me in the right direction. I had a lot of stuff from my uncle. But I just needed [my father], in a bad situation. (Irving, 32 years old)

Consumer participants also discussed how poverty, military service, and incarceration caused stress, which led to initial onset of mental illness or hindered recovery.

> Not having no money. No money, no place to live, no transportation caused it. No transportation. No one to turn to. No place to really stay, stay for a long period. I’m not talking a week or a month, I’m talking about a year, so I can get back on my feet. No transportation and stuff. No money, that’s the cause of it all. (Joshua, 41 years old)

> A lot of stress and stuff. Worry. I didn’t take it too good in the service. But I got an honorable discharge, it wasn’t no bad discharge I got, it was a good discharge. (Yosiah, 55 years old)

### *Other causes*

Several participants responded that their mental illness was the result of other causes such as head trauma, inherited mental illness, or simply had no ready explanation.

> When I was a baby my Momma was in the kitchen and I fell on the hard floor and Momma didn’t catch me quickly, didn’t see me fall, and I busted my head wide open. They think it got off one of my senses. (Oliver, 53 years old)

> I inherited what my Daddy got. … I think so. (Floyd, 39 years old)

> I don't, I don't know. … I don't, I don't even know. (Zach, 50 years old)

### *Causes of consumer participant's mental illness—Support participants*

Support participants most often identified the following causal factors: naturally occurring factors such as heredity (*n* = 8, 31%), drug reactions (*n* = 6, 23%), chronic stress (*n* = 5, 19%), and no theory as to what caused the mental illness (*n* = 6, 23%). In addition, one support participant reported that his brother's mental illness had been caused by head trauma sustained from an assault.

### *Naturally occurring factors*

The most common explanation reported by support participants was that mental illness was an innate disorder that could not have been prevented. This theme took the form of references to nature, genetics, and simply being "born that way."

> I don't know if people feel that heredity plays a role or not but I think that was something that I've always thought was a real problem. … I think both of his parents had problems mentally. So I think that, I don't know if it's inherited or hereditary or what but I've often thought that maybe if he had lived in a different surrounding. … I just think he grew with a situation where there was history of medical problems and that caused him to have problems I think. (Preston, 68 years old, cousin)

> All I know is he was born with it. I can't really say. I know he was born with it. Genetic, that's all I know. (Belinda, 58 years old, wife)

> I guess he was born with that too. Cause pretty much he's been talking like that all his life. But he was pretty much born like that. (Helen, 52 years old, fictive kin sister)

To illustrate the hereditary nature of mental illness, some support participants also shared stories about a history of mental illness throughout the family.

> I thought that it just developed; I don't know what could have caused it, because I was told he was schizophrenic, so it developed over time. He grew up with loving grandparents. They did love him a great deal … so I don't think the way he was raised had anything to do with it. … It was just nature, things happen. You can't control everything. And actually, one of my aunts, my mom's sister, now that I'm thinking about it, was in a mental facility. … That's the only other person in the family that was diagnosed. My sister, I'll tell you honestly, she's acting very strange but she won't see a doctor. (Zora, 54 years old, sister)

### *Unknown causes*

Almost a quarter of support participants said they did not know what had caused the consumer's mental illness. Despite follow-up prompts, these support participants did not offer a causal explanation.

> That I don't know. … I don't know. I really don't know. (Carol, 52 years old, sister)

> I don't know. I've never even talked to him about it. … I wouldn't know. (Louis, 54 years old, brother)

One support participant did not have a causal theory but she did share that she had heard and rejected explanations from others in her community.

> I don't (pause) I don't know. I don't know what could have happened to him … [in response to a prompt about an earlier statement that a person in the community said son's mental illness was the result of substance abuse] No. They didn't have, when [he] was coming up as a kid, I didn't hear of no crack and meth and cocaine in the area. It was probably some of them that was smoking some marijuana or something like that but I didn't know any of them that was doing it. And it wasn't as plentiful as it is today. I had every child, all six of my kids, before I ever heard of it. (Esther, 68 years old, mother)

### *Reaction to use of an illegal drug*

It was also common for support participants to attribute their loved one's mental illness to a bad reaction to illegal drugs. Most social supports who offered this response believed that their loved one had unknowingly ingested drugs, except for Nate, the 74-year-old father of a consumer, who mentioned the possibility of his son's intentional drug use: "I've heard some rumors, I don't know if there's any truth to it, that [he and his friend] had their little drug experimental thing. You know [people in the community] were saying that years ago. I don't know if there's any connection there or not."

Several support participants reported the belief that their loved one had been surreptitiously drugged. The phrase "slipped a mickey" was used by several support participants to describe this phenomenon. The saying "slipped a mickey" is slang that originated in Chicago in reference to local bartender Mickey Finn, who surreptitiously drugged his customers in order to rob them (Asbury, 1940). In interviews, support participants described their belief that their loved one unknowingly consumed a drink that had been laced with a drug.

> He got hooked to some PCP. … He likes to dance, he likes to party, but somebody put something in his drink. That's what the doctor told me. … He has two kids. I think the oldest son is about 22 and [the daughter] is about 19. I saw her this morning. Something's going on with her. They slipped her something. It's really going on with her. (Violet, 58 years old, sister-in-law)

The stories about drug use and surreptitious drugging carried similar themes that reflect universal touchstones about mental illness and stigma, namely jealousy and immorality (Abdullah & Brown, 2011; Patel, 1995). Consumers were exposed to drugs while drinking at parties or clubs, behavior that can be framed as immoral and inviting problems, and the catalyst for the drugging usually involved women, either "bad" women or men who were jealous of the consumer's relationship with a woman.

> Ok, I'm gonna tell you what happened to [him]. [He] went out to a party and he was with one of his best friends. They went to this party and somebody slipped a mickey in his drink and that's when the problems started. After they did that I started noticing change in him. … He said he went to the bathroom. He told his best friend to watch [his drink] so I'm thinking his best friend had something to do with it too, because of a female. The female that [the consumer participant] was dating. His buddy started dating her too and they was trying to keep it a secret. … [The drug] never wore off. I don't know how much he had in his system. I mean it just unbalanced him. And to this day, you know, he's focused now, but for how long? What will trigger him off? (Quiara, 53 years old, mother)

Some stories harkened back to the concept of mental illness as the result of an "evil eye," with one participant explicitly blaming witchcraft:

> Well I'll tell you what my son told me when he came back from Atlanta. He said he met this girl. … And when he came back, he took me to the park and said, "I need to talk to you." I said, "Ok, what's going on?" He said, "Me and her used to get into it all the time and she took me around a witch." I said, "What!" He said, "Yeah, I was sitting there and this witch gave me something to drink and something wrong with me up in here." Now that's what he said, "Something is wrong. I think she had me witchcrafted because I started to find out she wasn't the right one and I was getting ready to leave her and stuff." And he said, "I'm just sitting up there talking and stuff and all of a sudden the woman said, "I'm a witch. I'm a witch doctor." And he was already drinking whatever they had gave him. He said, "I think they put something in my drink. I don't feel right up in here." And about a year later he started to deteriorate. (Xarah, 58 years old, mother)

One support participant no longer believed her brother's mental illness was caused by "being slipped a mickey," but she explained how she had initially believed that scenario. She felt that being slipped drugs or experiencing brain trauma were popular explanations for adult onset mental illness in the African American community and were perpetuated by fear of stigma.

> I found out a lot of things through that [meeting with the mental health provider]. It wasn't a class for me but I just sat in. I wanted to know and I took my time to find out. But I really thought someone had mickied my brother so it upset me. Not that I was racist or anything but he had been going with bi-racial women and, one of the young ladies, her father did not care for my brother. … We didn't understand how you go from graduating from barber college to like a week or two being schizophrenia so we thought maybe her father mickied or did something to him. It's a common thought. Nobody tells you nothing different. Nobody offers the family support or help to figure out what is the cause or what is the matter. … Literally, people think that people mickied him or that he got into some accident

> and maybe he had a brain aneurism that he suffered from. The number one answer is that they were mickied. And when I sat in the class I quite didn't understand … so after I sit in, and [the clinician] diagnosed him with being schizophrenia I did my own research to find out it was hereditary. And she said it's a gene that come from you don't know what side of the family, who it's from, but a lot of time it comes out at an age 24, 25, and then they start acting weird. And so people want to say it's from being mickied because they don't want to think nobody in their family is crazy. (Ada, 36 years old, sister)

### Chronic stress

Chronic stress was identified by several support participants as a cause of their loved one's mental illness. While support participants were less likely than consumer participants to view mental illness as a result of ongoing environmental stress, when they did discuss stress, they often touched on negative childhoods or military experiences, similar to explanations provided by the consumer participants.

> [His mental illness] was caused by what happened in Vietnam. He was a Marine and in Vietnam and he described seeing people on fire. And he said nobody should have to die that way. And it was some of his guys from his platoon. I think that really had a lot to do with it. Some of the things he told me were just so bad. (Yvette, 58 years old, staff/friend)

> I do know from talking with him that family had a lot to do with it. Things that happened in the family had a lot to do with it. So I guess I'd have to say from what I've heard probably family issues are what started it. It may have been deeper seated than that but it's what brought it to the surface. (Irene, 45 years old, staff/coworker)

Although some support participants based their opinions about past stressors on reports from the consumers themselves, others had their own observations and theories about stressful events in the consumer's life:

> Maybe feeling that he was different his whole life, you know, being gay. And he wasn't sure how to handle it or how to channel the feelings. You know a lot of times I think other kids pick up on it long before parents see anything and they might have teased him. (Tabitha, 62 years old, mother)

## Discussion

The objective of this research was to allow African American men with serious mental illness and members of their social support networks the opportunity to share their own explanations about the causes of mental illness through participation in qualitative interviews and to utilize those responses to develop recommendations to improve service outreach. Consumer participants primarily endorsed stressful life experiences as the cause their mental illness; other causal explanations identified by consumer participants were intrinsic factors such as heredity or external experiences such as head injury. Support participants offered a wider variety of explanations for mental illness including being born predisposed to mental illness, being drugged, or experiencing chronic life stress; some support participants could not name any possible explanations. These findings suggest that African American men with serious mental illness and the individuals who provide support to them may benefit from both framing mental health services as a means of coping with stress and being offered psychoeducational services that provide evidence based information in the causes of serious mental illness and the recommended treatments.

In this study we asked African American men with serious mental illness to describe their perceptions of the causes of their own mental illness. Similar to research conducted with African American community members, some participants endorsed causal explanations such as heredity, past trauma, and stress (Hamilton et al., 2006; Ward & Besson, 2013). The frequent endorsement by consumer participants of stress as a cause of mental illness is noteworthy in light of research about the interaction of increased stress sensitivity and psychosis. Aiello, Horowitz, Hepgul, Pariante, and Mondelli (2012) conducted a systematic literature review examining the relationship between psychosis vulnerability and the hypothalamic-pituitary-adrenal (HPA) axis, which is the primary component of the human stress response system. Their review of 44 studies found that enhanced stress response and HPA axis hyperactivity were prodromal indicators of psychosis. DeVylder and colleagues (2013) compared stress sensitivity and life events in 65 clinically high-risk (CHR) participants and 24 healthy controls and found that stress exposure experiences were comparable across both groups but that CHR participants had impaired stress tolerance. Furthermore, stress sensitivity in the CHR group was associated longitudinally with numerous positive and negative symptoms of psychosis. These findings suggest that early experiences of stress and anxiety prior to development and diagnosis of SMI have had an impact on consumers' beliefs and understanding of the causes of their mental illness.

It is clinically relevant to note that in their narratives, consumer participants were aware that they were experiencing unusually high levels of stress and saw this as detrimental to their mental health. Mental health agencies attempting to reach African American men who may be at risk for developing SMI may consider using language around stress, burden, and coping to encourage these individuals to seek mental health care. This may speak to emotional experiences to which these individuals can relate and avoids stigma associated with diagnostic labels. The protective factor in such an approach is illustrated by Yang et al.'s (2013) research with college students, which found that a label of psychosis risk, as compared to a nonpsychotic mental health disorder, was significantly associated with less willingness to help and greater social distance, status loss, and discrimination.

Support participants most commonly reported that intrinsic factors such as genetics were the cause of consumers' mental illness. Some also believed that SMI was a reaction to using drugs or being surreptitiously drugged. These findings are in line with others in the field (Broussard, Goulding, Talley, & Compton, 2010; Esterberg & Compton, 2006) but since the present results are based on qualitative interviews it allowed for discussion of details in similarly themed responses. For example, while many social supports reported drug use as a cause of SMI, the nature of the interviews allowed for a more detailed understanding that "drug use" includes both intentional use and surreptitious drugging, a distinction that can change the categorical meaning of this explanation from one of personal actions to one in which the consumer was not at fault.

Despite being highly invested in consumers' lives and mental well-being, as evidenced by long-standing relationships with the consumer participants prior to and during mental illness onset, diagnosis, and treatment, many support participants either had no explanation for mental illness or held belief in some outside negative influence as the cause. Such responses may reflect a lack of information that could be better provided by mental health care agencies. After excluding the three support participants who were employed by the community mental health agency, only five of the 23 non-provider support participants in the sample were in contact with consumers' mental health providers or otherwise involved in the consumers' mental health services. This is despite reports from support participants that they were willing to be involved and interested in learning about mental illness and consumers' affirmation that they would welcome family involvement. This lack of collaboration between mental health providers and families may have limited the opportunities for consumers' most trusted social supports to receive psychoeducation about serious mental illness. Because they had little contact with mental health care services or providers, support participants were reliant on community beliefs, independent information seeking, and personal observations to formulate hypotheses about the etiology of their loved one's mental illness. It is a common belief across cultures that an outside malevolent force is the antecedent of mental illness (Bever, 2000). Without alternative explanations from a trusted source, support participants may rely on such beliefs to explain their loved ones' experience, or may give up trying to understand that experience altogether. These findings highlight the need for mental health treatment providers to reach out to and engage with members of their clients' social support networks, and for community mental health agencies to provide information and education to interested family members.

Greater access to psychoeducation, especially culturally informed psychoeducation programs tailored for African American consumers and families (Kranke, Guada, Kranke, & Floersch, 2012), is critical for people living with and caring for consumers with serious mental illness. Lack of knowledge about mental illness or framing mental illness dichotomously as sick versus healthy, with change triggered by an external, uncontrollable force, disempowers individuals and diminishes the perceived usefulness of mental health care (Chen & Mak, 2008; Ogden & Jubb, 2008). Failure to frame mental health as a continuum on which all people exist encourages stigmatizing labels while discouraging healthy behaviors such as preventative or early intervention help-seeking (Corrigan, 2007). It may also lead to greater dissatisfaction with mental health care services when providers are not able to simply flip the switch back from sick to healthy. This is illustrated by the experience of Ada, a support participant and the sister of a consumer participant, who stated that being "slipped a mickey" or experiencing head trauma were common explanations for mental illness in her local African American community. She described how she had only rejected the idea that her brother had been surreptitiously drugged after observing a session between her brother and a mental health provider, hearing the therapist's assertion that schizophrenia has genetic roots, and conducting her own online research. Ada remarked: "Nobody tells you nothing different. Nobody offers the family support or help to figure out what is the cause or what is the matter." Ada's story illustrates the frustration and isolation experienced by some African American families who are not provided information about the causes of SMI.

## Limitations

A limitation of this research is the use of a single coder to identify meaningful units and qualitative themes. It is possible that use of and discussion with an additional coder may have resulted in different conceptualization of the themes. However, peer debriefing via in-depth discussion and feedback on the interviews, coding process, and themes was provided by the second author, who served as dissertation chair. Another possible limitation was the lack of racial and/or gender concordance between the interviewer and the participants. While some race-focused researchers have argued that researcher-participant racial matching oversimplifies culture and rapport building (Gunaratnam, 2003), Mizock, Harkins, Ray, and Morant (2011) did find that when the topic of discussion was race and racism, interview themes differed depending on the racial pairing of the participant and researcher. In an attempt to address the lack of race, and in some cases gender, concordance, the interviewer invited discussion on this topic. In the 27 interviews where interviewer race or gender was discussed, five participants acknowledged discomfort or stated that they would have interacted differently with a different interviewer: One participant noted that an African American interviewer would understand her life experiences better, two participants stated that as men they would have spoken differently with a male interviewer, one felt that having the same socio-economic status would have facilitated the interview, and one participant simply stated that he would be hesitant with any interviewer who was a stranger. Additionally, the qualitative methodology, one interview per participant as opposed to a more in-depth approach such as ethnography, did not allow for a comprehensive cultural and individual understanding of each participant's socialization so we were unable to speak definitively to the process by which participants arrived at their etiological beliefs. Finally, the sample size of 26 consumer participants and 26 support participants provided rich data for qualitative analysis and was well-suited to the exploratory nature of this research project. However, this sample size, limits the transferability of the findings.

## Conclusion

African American men experience internalized and environmental barriers to mental health care access due to race and gender. One way to better understand how African American men engage with mental health care services is to learn what they and their social support networks perceive as the origin of mental illness, which in turn may influence their decisions to seek treatment. This research provides an initial exploration of the views of African American men with SMI and members of their social support networks.

Findings from this study indicate that a focus on the role of stress in mental health well-being may be a useful outreach strategy and appealing early stage screening and intervention approach for this population. Mental health agencies may also consider using structured tools such as the Cultural Formulation Interview, either the consumer or social support informant version, provided in the DSM-5 (American Psychiatric Association, 2013) in order to assess cultural context as it impacts mental health and treatment. Use of such tools can assist providers in eliciting the salient components of mental illness etiology beliefs and assist with rapport-building by engaging in collaborative partnerships which capitalize on clients' own illness narratives and motivations. These findings also highlight how accurate information often does not get to those who need it and that failing to educate consumers and family members is a missed opportunity to support consumers in the process of health decision making. Reaching family members of those with SMI, through evidence-based practices such as family psychoeducation, is a critical step in fully educating consumers and social supports about the causes of mental illness

(Dixon et al., 2001). The results of this research signal that programing that addresses community-identified questions and needs may represent opportunities for mental health care clinicians and agencies to engage productively in partnerships with African American communities and potential consumers. Further research is needed to determine if such targeted educational outreach, cultural tools, and interventions can increase understanding of mental illness, provider–client collaboration, and likelihood of service engagement among African Americans when implemented on a large scale.

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