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“We are our own counselor”: Resilience, risk behaviors, and mental health service utilization among young African American men

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Abstract

Despite risk for trauma, subsequent mental health concerns, and poor health outcomes, young Black/African American men (YBM) are less likely to receive mental health services than other racial/ethnic groups. Despite the growing literature on resilience, there is less information on relationships between resilience, risk behaviors, and use of mental health services. This study sought to examine resilience, trauma-related risk behaviors, and receipt of mental health services among a sample of YBM who experienced trauma. Focus groups and a brief survey were conducted with YBM (N = 55) who had been exposed to at least one traumatic event (e.g., witnessing violence, experienced serious injury or illness) and were recruited from urban community settings (e.g., colleges/universities, barbershops, churches). Participants were an average age of 23 years (SD = 3.9; range 18-30) and experienced an average of 2 to 3 traumatic events (SD = 2.2). Trauma exposure was a significant predictor of risk factors ($\beta = .513$, $p < .01$). However, resilience did not significantly moderate this relationship. Resilience also did not predict receipt of mental health services. Culturally relevant qualitative themes found to be related to resilience included maintaining resilience autonomously, preferred coping methods (e.g., friends, music), and habituating to adversity. This study has potential to inform the development of culturally tailored, relevant interventions to promote engagement in mental health services among YBM who’ve experienced trauma.

Keywords

trauma; African American; urban; community; mental health

Young Black/African American men (YBM) are at greater risk for experiencing traumatic events (e.g., witnessing violence, serious injury or illness, loss of a loved one) than their white peers.[1-3] Exposure to violence and trauma is also more likely for adolescents who spend more time in settings that are unstructured or unsupervised,[4] particularly in economically disadvantaged neighborhoods.[5-7] It is critical to address trauma among YBM,

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given the systemic, pervasive economic and social issues that burden the African American community and impact health outcomes.[8]

Exposure to trauma increases risk for developing mental health disorders.[5,9-14] Focus groups of YBM aged 18-30 who had experienced trauma showed that 65% of participants met criteria for PTSD.[7,11,15] Trauma exposure may also increase risk for depression among YBM.[16] Furthermore, YBM with greater trauma exposure were nearly three times as likely to report poor mental health compared to their peers with less trauma exposure,[9] which suggests that trauma may impact YBM differently than other chronic stressors.

Mental health screening is recommended by the National Institute for Mental Health for individuals who have experienced trauma, particularly when trauma is recurrent,[17] and is an important first step in the mental health continuum of care.[18] Supportive linkage to care (LTC) services are needed following mental health screening, when clinically appropriate. However, mental health care systems may not adequately engage with YBM to promote emotional recovery after trauma. YBM are less likely to report seeking mental health services compared to their female peers, young white men, and adult/older African American men and women,[19-23] even when they have had a psychiatric diagnosis.[24-26] Past research has found that YBM face a great number of barriers to seeking and receiving mental health services, including intersectional barriers such as stigma, lack of access, and cost.[27-31] Furthermore, African Americans have historically been mistreated by health care systems and often receive inadequate care, which may contribute to mistrust of mental health providers among YBM.[28,32,33] Finally, YBM in previous studies have discussed uncertainty whether symptoms are severe enough to warrant treatment[30] and difficulty describing symptoms,[34] with a different presentation of mental health symptoms compared to other racial/ethnic groups.[32,35] These factors may increase the likelihood for providers to underestimate symptoms or misdiagnose YBM[36-39] and may be a particular challenge for providers who are unfamiliar with the scope of negative experiences of YBM (e.g., economic disparities, racism and discrimination)[40,41] that have potential to exacerbate mental health concerns.[35,42-44]

Given the context of these extensive barriers and stressors, it is important to understand coping outside of mental health care utilization. It is possible for individuals to experience positive changes after trauma (e.g., posttraumatic growth[45,46]), and YBM who have experienced a traumatic event may adopt a number of positive coping strategies, such as focusing on academic achievement, coming together with others, adapting to their environment, or engaging in activism.[7,47-49] However, strategies may also include carrying a weapon, retaliation, or hypervigilance, which have been perceived as important ways to prevent further injury, regain a sense of respect, protect one’s reputation, or maintain safety.[7,11,15,50-53] YBM may also use substances (e.g., marijuana, alcohol) to cope with previous trauma exposure[15,35,54] or subsequent mental health symptoms.[11] Studies have demonstrated the potential for these strategies to increase the likelihood of recurrent or escalating trauma[15] and other adverse outcomes (e.g. incarceration), which can negatively impact emotional well-being for YBM and further limit access to critical mental health services that could enhance resilience and recovery.[55]

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YBM have been found to demonstrate high levels of resilience, defined as the ability to effectively adjust to hardship.[8,56] Past studies have suggested that resilience among urban YBM is a complex, fluid construct that is influenced by contextual, sociocultural factors (e.g., community environment, street life).[57,58] However, the conceptualization of resilience has varied across studies,[59] particularly for Black men recovering from trauma.[46] Across studies with YBM specifically, resilience has been consistently characterized as self-reliance, particularly when reporting and coping with mental health concerns.[28,33,34,60-64] For example, focus groups with YBM aged 18-26 elicited beliefs that Black men should be strong enough to overcome mental health problems without talking to a mental health professional.[32] It has also been suggested that African American men may use alternative support networks, such as family, friends, or faith-based organizations, to cope with mental health issues.[20,28,47,49,60,62,65,66] However, there may be missed opportunities for mental health screening/LTC[24,67] and engagement in services that could be beneficial in addressing trauma, supporting emotional well-being, and promoting positive mental health outcomes.[17]

Prior research with YBM has identified several culturally-related factors associated with enhanced resilience, which include religion,[56,68] family,[8] racial identity,[69] and having a purpose in life.[46] Interventions have been developed to promote resilience among YBM, with training in goal setting, problem-solving, and skill building (e.g., assertiveness).[70,71] However, researchers have called for a deeper investigation of resilience among YBM[56] to inform culturally-tailored clinical care.[72] Less is known about the relationships between resilience, mental health screening/LTC, and coping behaviors that increase risk for trauma and related outcomes among YBM who experienced trauma.

Given the traditional conceptualization of resilience in effectively coping with stress, it was hypothesized that (1) resilience would moderate the relationship between traumatic events and risk factors (e.g., carrying a weapon, retaliation for violent injury, substance use). These behaviors were chosen from among the many possible coping strategies for YBM as culturally salient responses to trauma, with the greatest demonstrated likelihood of leading to negative health outcomes. The presentation of resilience among YBM has traditionally emphasized self-reliance in coping with mental health concerns, and resilience has been associated with lower psychological distress.[73] Thus, it was also hypothesized that (2) resilience would negatively predict receipt of mental health services. This study also sought to explore whether resilience, risk factors, and receipt of mental health services varied by number and type of traumatic events experienced. Finally, this paper highlighted qualitative, culturally relevant themes related to resilience among YBM.

Methods

Participants

The average age among participants ($N = 55$) was 23 ($SD = 3.9$; range 18 to 30). Many participants reported that they had graduated from high school or received their GED (38%; Table 1). Eligibility criteria included (a) self-identifying as African American and male, (b) being between the ages of 18 and 30, and (c) having experienced at least one traumatic incident, as defined by the DSM-5.[74] This includes exposure to actual/threatened death, serious injury, or sexual violence through direct experience, learning that the event occurred

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to a loved one, or experiencing repeated exposure to extreme aversive circumstances. Eligibility criteria also included d) having no active psychotic symptoms and (e) having no active suicidal/homicidal ideation (SI/HI). Individuals who were determined to be ineligible for the study were provided with feedback explaining why they were not eligible, and YBM with active SI/HI were referred to care at a community mental health center. Nearly all participants ($n = 54$) identified their sex at birth as male, and the remaining participant did not respond to the question.

Procedures

This study was conducted as part of a larger, three-phase project that used a Theory of Planned Behavior (TPB) framework to explore mental health screening/LTC among YBM. The TPB consists of primary constructs of behavioral, normative, and control beliefs toward engaging in a behavior (e.g., seeking mental health screening/LTC), which together predict behavioral intentions.[75,76] The TPB has been used to explain health behaviors among African Americans in community settings.[77,78] The TPB approach first involves a qualitative elicitation phase to identify specific attitudes and beliefs relevant to a particular population. Findings then inform quantitative assessment of beliefs that are most predictive of the behavior or intention to engage in the behavior. Thus, Phase 1 of the project centered on qualitative elicitation of TPB constructs (e.g., attitudes, norms, and beliefs) related to mental health screening/LTC. Focus group findings were used to inform development and piloting of a TPB-guided survey instrument (Phase 2), which was refined and implemented with a larger sample in Phase 3. The data presented in this paper were collected during Phase 1, as a result of focus groups discussing themes over and above the intended TPB constructs.

Participants ($N = 55$) were recruited from diverse community sites in the urban metropolitan area of Kansas City, Missouri. Recruitment sites included colleges and universities, barbershops, churches, and community organizations that serve young urban African American men. To facilitate recruitment, the researchers partnered with community organizations (e.g., Calvary Community Outreach Network, Concerned Clergy Coalition, BlaqOut, Children's Mercy Hospital, and Metropolitan Community College). Participants were recruited using flyers, social media announcements, and church bulletin inserts, in addition to word-of-mouth. Individuals who were interested in learning more about the study and/or participation were screened for eligibility, signed informed consent and contact information, and assigned to a focus group. Participation in the study included a brief survey (approximately 15-20 minutes) completed just before a focus group discussion (60-90 minutes). Participants were compensated $40 in cash and provided a meal as part of the focus group session.

Six individual interviews and nine focus groups, consisting of 2 to 13 participants, were held in local community locations (e.g., barbershops, community colleges, churches, public library). Eligibility criteria were consistent across both interviews and focus groups, and individual interviews were conducted only when needed (i.e., only a single participant was available). The discussion guide was semi-structured and designed to elicit attitudes, norms, beliefs, and intentions about mental health services, with questions on perceived outcomes, sources of encouragement, and facilitators and barriers related to receiving mental health

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services. Focus groups and interviews were held as closed sessions to ensure participant confidentiality and privacy, and participants used pseudonyms to ensure anonymity. In addition to note taking, focus group discussions were digitally audio-recorded and transcribed for data coding.

Participants also completed a brief survey prior to the start of focus group discussions, which included measures for resilience, trauma exposure, risk behaviors, and receipt of mental health care. The brief survey was conducted to more fully understand and interpret beliefs and behaviors regarding mental health screening and LTC. This study was reviewed and approved by the University of Missouri-Kansas City Institutional Review Board.

Measures

Demographics—All participants were asked to report their age, sex at birth, socioeconomic status (i.e., education level, average monthly income), and health insurance coverage.

Trauma Exposure—Participants were asked whether they experienced any of ten traumatic events (e.g., “Being threatened with a weapon [knife, gun, etc.],” “Losing a loved one as a result of accident, suicide, or homicide,” “Life threatening illness,” “Being forced to have sex”). All ten events parallel items from the Stressful Life Events Screening Questionnaire-Revised (SLESQ),[79] and were the most commonly reported traumatic events in previous studies of young African American men.[2] Additionally, the SLESQ has demonstrated cultural validity and relevance among African Americans.[19] Checked responses were coded as 1 = yes, and unchecked responses were coded as 0 = No. Items were summed to create a total response for trauma exposure ranging from 0 (did not experience any of the ten events) to 10 (experienced all ten of the events). Cronbach’s $\alpha = .714$.

Resilience—Resilience was measured with the two-item Connor-Davidson Resilience Scale (CD-RISC2),[80,81] including “I am able to adapt to change” and “I tend to bounce back after illness and hardship.” Response options ranged from 0 = Not true at all to 4 = True nearly all the time. Items were summed to create a total resilience score, ranging from 0 (low resilience) to 8 (high resilience). The CD-RISC instrument was originally developed as a 25-item measure, although shorter measures have been validated for use among African American men.[73] The two-item measure previously demonstrated discriminant validity and correlated with longer versions of the CD-RISC scale, with equal predictive ability across age, race, and gender.[81] For this study, Cronbach’s $\alpha = .862$.

Risk Factors—Risk factors included carrying a weapon, substance use, retaliation, and previous incarceration. These were chosen due to the cultural salience across studies of YBM in response to trauma, while demonstrating increased risk for recurrent trauma or re-injury. It should be noted that recurrent trauma is also influenced by multilevel, environmental and social contexts (e.g., school achievement, economically disadvantaged or disorganized neighborhoods, being Black/African American or male).[5-7,15,82] Similarly, health care utilization can be impacted by individual, interpersonal, and community level

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factors. However, it is important to understand the impact of these individual-level risk factors on mental health help-seeking behaviors, in order to inform multilevel intervention strategies.

One dichotomous item asked whether participants usually carry a weapon (0 = No, 1 = Yes, 2 = Refuse to answer). Six items asked whether participants had used three substances (i.e., marijuana; crack, cocaine, or heroin; or 5 or more alcoholic drinks in one sitting) in either past 12 months or ever in their lifetime, respectively, with response options coded as 0 = No, 1 = Yes, 2 = Don't know, and 3 = Refuse to answer. One item asked whether participants had ever retaliated against someone for an insult or injury (0 = No, 1 = Yes, 2 = Don't know, and 3 = Refuse to answer). Participants were also asked if they had ever been incarcerated (0 = No, 1 = Yes). All risk items were summed to create a total risk score ranging from 0 to 9, with greater scores indicating more endorsed risk factors. Cronbach's $\alpha = .749$.

Receipt of Mental Health Services—Receipt of mental health services was measured with adapted versions of items used in previous African American screening/linkage to care interventions.[83-87] One item asked, "*Have you ever talked to a professional about mental or emotional problems?*" with response options no, yes, don't know, and refuse to answer. While previous studies of care utilization asked participants to indicate the type of professional,[87] this study simplified the item in order to broadly assess initial mental health screening. However, the survey included a question on type of professional visited for descriptive purposes, as shown in Table 1. A second item asked, "*How many times have you seen a mental health provider about mental/emotional problems?*" (once, two or more times, or don't know), which aimed to measure whether participants engaged in any mental health care beyond an initial visit or screening.

Data Analysis

A hierarchical linear regression was performed to test whether resilience moderated the relationship between trauma and risk factors. Trauma exposure and resilience were entered in Step 1, and an interaction term for trauma and resilience was added in Step 2. Bivariate correlational analyses were used to examine the preliminary relationship between resilience and receipt of mental health care, as well as relationships between resilience and number or type of traumatic experiences, respectively. All analyses were performed with IBM SPSS version 25.

Although the larger project was grounded in the TPB, codes related to resilience were analyzed with a phenomenological approach, with the goal of exploring how YBM experienced resilience after trauma. An independent research assistant first coded the data for themes related to resilience, which was reviewed by the first author (PI of the study). The first author then refined initial, broad codes to reflect major themes that arose across focus groups. Less common or relevant codes (e.g., how others have responded to community conflict) were removed from analysis. Final coding and major themes were finalized by discussion between the PI with the second and sixth authors, who were independent from initial coding.

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Results

Brief Survey Findings

Participants ($N = 55$) had experienced an average of 2-3 traumatic events ($SD = 2.2$), most commonly being threatened with a weapon or losing a loved one to accident, suicide, or homicide. The average resilience score was 6.9 ($SD = 1.7$), ranging from 0 to 8. Half of participants reported receipt of mental health care. More participants reported seeing a mental health care provider two or more times (36.5%) than only attended a single session (17%).

Trauma exposure had a significant preliminary relationship with risk factors ($r = .536$, $p < .001$) and was a significant predictor of risk factors in a linear regression ($\beta = .513$, $p < .01$). A hierarchical multiple regression was performed to test the hypothesis that resilience moderated the relationship between trauma and risk factors. In Step 1, the centered variables of trauma and resilience independently accounted for a significant amount of the variance in risk factors, $R^2 = .412$, $F(3, 35) = 5.96$, $p < .01$. An interaction term was created with trauma and resilience and added to the regression model in Step 2, but it did not account for significantly more of the variance in risk factors, $R^2 = .176$, $F(1, 35) = 3.06$, $p = .09$. Thus, the relationship between trauma exposure and risk factors did not vary across levels of resilience. Furthermore, resilience was not significantly associated with receipt of mental health care (Table 2) or number of times talking to a professional. There were no significant relationships for number of traumatic experiences or type of trauma with resilience.

Focus Group Findings

Key themes related to resilience were elicited during focus groups, including (1) maintaining resilience autonomously, (2) preferred coping methods, and (3) habituating to adversity.

Maintaining Resilience Autonomously—Participants across focus groups discussed the need to "deal with things" independently. For instance, one participant (under pseudonym of Draco) stated, "You really just got to cope through it. You got to get through it and keep moving." Several participants discussed cultural expectations about why it was important for young men to be resilient and "deal with your problems yourself." As a participant called Joe described, "In the Black community, I feel like we are taught at a young age to keep everything held in… If you go to somebody and tell your business, you are not a man, or you are looked at differently."

Maintaining resilience without help from others contributed to participants' reluctance to seek mental health services. One participant, Jessie, explained: "And dealing with it, I probably should, you know, talk to somebody about it, but yet we try to deal with stuff on our own, like we are our own counselor." Another participant stated, "…When it comes to getting help, it is always one of the things that we always are told, that we have to kind of deal with this, like a part of being strong is more self-reliability and everything."

Focus group discussions also elicited the perception that YBM are better prepared to handle their own problems than anyone else. As Joe reported, "You don't even want to be open or

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talk about that shit for real, because it is like, that's some personal shit, you don't understand that shit." This was particularly true for Ezekiel, a graduate student. His ability to handle problems on his own convinced himself and others that he did not need help, despite some interest in seeking mental health services:

> I thought about in undergraduate and I thought about it in a master's program but just didn't do it just because of resiliency, you know, just the ability to just under pressure, under anxiety, under all of that, to still just get results that are above what others would be anyway. When you are the person off here getting master's degrees and when you are just, you know, performing so well, it is just like oh well, you know, there is no need to worry about that person. They are doing so well.

Finally, managing on one's own was viewed by some participants as beneficial. For example, Josiah described using his problems as motivation:

> I use what I went through more as fuel. Say I went through that, I wouldn't tell anybody, that was more fuel, just that inner feeling of okay. Like, I'm dealing with this and I can do it myself, but instead of like feeling it, I will use it as fuel to get what I need and it felt weird in a sense when I would tell people my problems, because in a sense it was like I was getting rid of the fuel I needed to kind of propel me forward.

Importantly, this participant felt that talking through his problems with others would be detrimental to his success. However, he went on to acknowledge that this was not a feasible long-term solution:

> I realized maybe that wasn't the healthiest thing to do. […] I guess somewhere along the line I stopped doing that and I tried to replace it with more peace and understanding of myself rather than just complete. I don't really know, I can't really understand it was. I just never would have been the kind of person to talk about my problems and I always hated doing it until like about a year or two ago.

This was echoed by other participants, who also mentioned that it can take time to realize that self-reliance may not be sufficient for well-being.

Preferred Coping Methods—Participants across focus groups mentioned strategies that they or others typically use to cope, including positive strategies. A participant with pseudonym of Sam stated, "I found many of ways to cope with stress and it is not always bad ways. I can play a game with friends or something… and I will be alright eventually." Several participants agreed that music can be helpful. As Draco stated:

> If you listen to a lot of rappers though, listen to a lot of their music, that is therapy right there. A lot of people say a lot of crazy shit in their music and then a lot of the people really actually live their life, you know what I'm saying, that is a therapy in its own.

Another common coping strategy was focusing on work: "If I'm bored in my life, I would go get a job or something… And then I'm not thinking about like depression and all that other stuff." One participant agreed that to deal with stress, he would "go make some money." Sam elaborated on how working helped to distract him:

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> I just basically I worked a lot. I went to job corp when I was 16… After 16 I went straight to house jobs, I wasn't even allowed to work for house jobs because I wasn't old enough, I was suppose to be 18, but like my uncles and people got me jobs, so working helped me out, moving, lifting stuff. I wouldn't say I was a body builder but I just worked out a lot.

Prayer was also discussed as a common coping strategy. However, not all participants perceived it to be helpful. One participant, Bosh, stated:

> I also think that religion plays such a big part in the Black community so like a lot of people are like oh you need to pray about it… Like you don't need to seek help, you just need to pray about it. And it is like okay that can help, but like at the end of the day, like praying is not going to get rid of a mental, you know… If something is like wrong with your brain, like praying really isn't going to do that much for you. Like yeah it can give you peace of mind, but… like me personally I don't think it is going to really like change the whole outcome of the situation.

Several participants also mentioned substance use (e.g., "smoking [marijuana] or drinking") as a coping strategy. However, many acknowledged that this was a poor long-term solution: "It didn't benefit me when I was doing it, so that is when I knew that I just had to figure the problem out myself." Jessie elaborated:

> As I got older, I was like no, that is not the best way for me to cope with it, because it is actually making me think that I have to deal with those thoughts after, you know, the medication or drinking or whatever goes away. Those thoughts still arise again, so I have to deal with that. So as I got older, I was like it is not helping me. It is just putting it to the side. It is just pushing it off and it is going to come back again.

Habituating to Adversity—Across focus groups, several participants discussed the need to adjust to ongoing stress, including recurrent trauma. Several participants described the process as becoming "numb." As one participant, Jimmy, reported,

> I've seen somebody die like right in front of me or in the same car with them though. And it really just turned you numb and cold to face your life like that… It is what it is, I've got to live life like this… this is what life comes down to.

Another participant, Sean, elaborated:

> Me personally I haven't seen someone die in a long time, but I feel more sad that I'm not sad. You know what I'm saying, I hear somebody on the news then I'm actually like damn, but inside I actually feel sad, like some tears, that I'm dealing with this person.

When prompted, this participant continued to say that he felt "numb, like it is normal. Dang that is messed up, and it happens, and it happens, and it happens." Jimmy agreed, saying, "It is just so normal, like my momma can tell me this person was just shot and like it is normal."

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Participants also commented on how habituating to adversity went beyond their communities, particularly in response to the media. As one participant (Elton) mentioned, "I heard about a murder on Facebook… it was like some cartel dude and I was just like, crazy, and now you see that on Facebook and everybody is just like scrolling past." Another participant echoed this attitude when discussing reactions to the shootings in Christchurch, New Zealand:

> It is publicized. It is everywhere on social media and that type of stuff. Even like something happened over there in New Zealand and then they posted a video and he made it seem like it was Call of Duty, he was just going around just killing them and shit like that. I mean, it's like you see and you are like damn this is messed up, but you don't feel it because you've been so desensitized to that shit.

Discussion

This study was among the first to examine the impact of resilience on risk behaviors and mental health screening/LTC among YBM who experienced trauma, and it represents an important opportunity to further understand the experience of resilience after trauma for this group. Similar to other studies, participants commonly reported multiple traumatic events including high rates of being threatened with a weapon and losing a loved one,[2,62,88] and a large proportion endorsed risk factors (e.g., drug or alcohol use, retaliation).[15,50]

Exposure to trauma was significantly positively related to engagement in risk factors (e.g., substance use, retaliation, incarceration), which is consistent with past studies.[15,89] YBM who have been exposed to trauma or violence may be more likely to engage behaviors that increase risk of re-injury, in part because these behaviors can serve as coping strategies and are perceived to be effective at maintaining safety and control.[35,54] Furthermore, some risk behaviors (e.g., retaliation) are supported by cultural expectations and norms[11,15] and may be seen as necessary for survival. Efforts have been made to reduce these behaviors, such as preventing cyclical violence in urban communities,[90-95] with promotion of resilience and social skills.[70,71] However, resilience did not moderate the relationship between trauma and risk factors in this study, which contradicts the first hypothesis and suggests that the traditional concept of resilience may not be a sufficient protective factor against engagement in behaviors that increase risk of re-injury.

Half of participants reported at least one previous visit with a mental health care provider, and resilience scores were moderately high. However, resilience was not associated with previous receipt of mental health care, so the second hypothesis was not supported. Past studies on community mental health programs for YBM have not explored the impact of resilience on mental health engagement.[96] More research is needed to determine psychosocial factors that are related to mental health screening and LTC among YBM exposed to trauma.

Some violence and trauma interventions have demonstrated greater impact by targeting the community as a whole (e.g., promotion of healthier norms), rather than focusing solely on individual resilience and behavior change.[92,93,97] For example, the Cure Violence model includes involvement of trusted members of the community as violence interrupters and

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outreach workers, who are trained to implement individual-level mediation and promote healthier group norms. A review of programs based on the Cure Violence model demonstrated fewer shootings and homicides in many of the study sites across the country. Thus, interventions that are targeted for YBM should explore inclusion of family members, significant others, friends, and other trusted members of the community in promotion of mental health screening/LTC to improve effective coping and recovery.

Our focus group findings provided contextual information on how participants characterized resilience and their experiences with using mental health services. They reported it was better to handle things on one’s own than to talk about problems, especially with a professional mental health care provider. This was particularly true for how they would be viewed by others (e.g., not seen as a man) and their ability to achieve personal success. Despite the potential benefits of mental health care for individuals exposed to trauma or violent injury,[17,18] and the acknowledgment among participants that self-reliance was not a viable long-term solution, few participants expressed interest in seeking out further mental health screening/LTC. Further research is needed to understand willingness to utilize mental health screening/LTC among YBM and to address the multilevel barriers to mental health care that burden this population.[7,27-31,98,99] Additionally, it is critical to promote culturally competent, informed clinical practice, in order to ensure that trauma-based therapies and intervention strategies are effective at improving emotional recovery for YBM.

Previous studies have shown that religion, family, and racial identity contribute to resilience among African American men.[8,56,68,69] Participants discussed preferred coping strategies that maintained resilience and self-reliance, including both positive strategies (e.g., seeking social support, occupational achievement) and negative strategies (e.g., substance use). This supports the idea that YBM are able to engage in positive behaviors despite continued adversity and stressors, but additional resources may also be beneficial.[48] Prayer and religion appeared to play a complex role in participants’ coping. Participants reported being encouraged to pray and turn to God, but some participants commented that this would not change anything in their lives. Although religiosity and spirituality have long been key cultural factors within the African American community,[100] they may be less salient in enhancing resilience or recovering from trauma for YBM.[60]

It is important to understand resilience among YBM, as it may be protective against negative health outcomes (e.g., gang involvement).[101] In this study, resilience did not vary by number of traumatic experiences or type of trauma, which contrasts with previous studies.[46] However, participants also described habituating and becoming “numb” to adversity, including witnessing violence or death, which seems to reflect the concealment of emotions described in the literature.[47] Given the fluidity and context-dependent nature of resilience among YBM,[58] together with the persistent disparities in trauma and related outcomes, it may be even more important for researchers and policy makers to address the multilevel, systemic stressors (e.g., racism, discrimination, recidivism, employment, housing) that impact mental health among YBM.[102-104] To accomplish this, researchers should consider partnerships with schools, community organizations, and health organizations. Additionally, national policy should reflect the ongoing needs of YBM with continued efforts to address the significant burden of trauma and violence in urban African American communities.

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There were some limitations to this study. First, a brief measure of resilience was used. Although shorter (i.e., 10-item) versions of the CD-RISC scale have been validated for use among African Americans, is unclear whether this extends to the two-item scale. Second, the mixed methods of brief survey and focus group were conducted concurrently. However, this study was part of a larger project that will build on qualitative findings to inform development of a TPB-guided measure. This study did not allow for subdividing by age or other demographic factors. Finally, analyses focused only on individual-level contributors to resilience, risk factors, and mental health care utilization, although findings may help to inform future multilevel, community-based interventions.

Conclusions

In this study, trauma exposure was significantly and positively related to YBM risk factors (e.g., substance use, retaliation, incarceration), which was not moderated by resilience. However, resilience was not related to engagement in mental health services. As is recommended by national trauma and violence prevention programs,[92] much more exploratory and intervention research is needed to address cultural norms and systemic issues (e.g., access to care, media portrayals of violence) in order to reduce unhealthy coping behaviors and promote engagement in mental health screening and LTC among trauma-exposed YBM.

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Table 1.

Demographic characteristics of participants.

	N	%
Education		
11th grade or less	6	11.5
High school graduate or GED	20	38.5
Post high school technical training	1	1.9
Some college (but no degree)	18	34.6
Associates degree (AA) or technical school certificate	3	5.8
Bachelors (BA, BS)	2	3.8
Some graduate school or graduate degree	2	3.8
Health insurance		
Medicare or Medicaid	14	25.5
Private insurance	17	30.9
Other	5	9.1
No insurance	18	32.7
Average monthly household income		
$0 - 1,000	7	12.7
$1,001 - 2,000	6	10.9
$2,001 - 3,000	4	7.3
More than $3,000	15	27.3
Don't know	21	38.2
Refuse to answer	2	3.6
Trauma Exposure		
Life threatening illness or accident	19	34.5
Robbery or mugging	18	32.7
Being threatened with a weapon	23	41.8
Witnessing someone be seriously injured, assaulted, or killed	15	27.3
Losing a loved one to accident, suicide, or homicide	23	41.8
Serious injury or threat to life	15	27.3
Physical harm from a parent or caregiver as a child	7	12.7
Being physically harmed or beaten as an adult	8	14.5
Forced sexual activity	8	14.5
Other	0	0.0
Risk Factors		
Carrying a weapon	9	17.6
Marijuana use (past 12 months)	30	56.6
Marijuana use (lifetime)	36	72.0
Crack, cocaine, or heroin use (past 12 months)	0	0.0
Crack, cocaine, or heroin use (lifetime)	3	6.8
Five or more alcoholic drinks per sitting (past 12 months)	14	28.6
Five or more alcoholic drinks per sitting (lifetime)	22	47.8

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	N	%
Previous retaliation	25	47.2
Previous incarceration	13	24.5
Previous receipt of mental health care	27	50.0
Type of provider		
Mental health provider	23	41.8
Medical professional	10	18.2
Teacher or other school personnel	10	18.2
Pastor or spiritual leader	18	32.7

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Table 2.

Bivariate correlational relationships between resilience and receipt of mental health care, number of times talking to a professional, and number or type of traumatic experience.

	r	*p*
Receipt of mental health care	.252	.071
Number of times talking to a professional	.078	.588
Number of traumatic experiences	.063	.655
Type of trauma		
Life threatening illness or accident	−.152	.277
Robbery or mugging	.258	.062
Being threatened with a weapon (knife, gun, etc.)	.119	.395
Witnessing another person being seriously injured, assaulted, or killed	.112	.425
Losing a loved one as a result of accident, suicide, or homicide	.096	.494
Serious injury or threat to life	−.040	.775
Physical harm from a parent or caregiver as a child	.191	.171
Being physically harmed or beaten as an adult	−.135	.333
Forced sexual activity	−.199	.152
Other event	.008	.955