Health Disparities in Racial/Ethnic and Sexual Minority Boys and Men

AMERICAN PSYCHOLOGICAL ASSOCIATION

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CONTENTS

PREFACE

I n 2011, the American Psychological Association (APA) approved the support of a health disparities initiative as an activity of its recently adopted strategic plan. The purpose of the initiative was to increase support for research, training, public education, and interventions that reduce health disparities and promote health equity among underserved and marginalized populations. The initiative was based in the Public Interest Directorate, home to offices and programs that focus on the needs of underserved and vulnerable populations, including, for example, racial/ethnic minorities; women; lesbian, gay, bisexual, and transgender individuals; and persons with disabilities.

Health is viewed as a state of optimal physical, mental, and social well-being and not just the absence of disease. Health disparities are persistent, avoidable differences in health experienced by disadvantaged populations as a result of social injustices. Beginning with Secretary Heckler's (1985) report on Black and minority health, disparate gaps in health have been documented across a wide range of illnesses and health status indicators and within a number of population groups.

The initial scope of the initiative focused on three health problems: substance abuse, obesity, and stress. These conditions are significant health problems in their own right for many disadvantaged groups, and they are also correlates and predictors of other health outcomes and disparities. For example, drug use, including tobacco, alcohol, and illicit drugs and related behaviors, is the actual cause of death among the leading causes of death in the United States (Mokdad, Marks, Stroup, & Gerberding, 2004). Racial/ethnic minority populations experience more adverse consequences of drug use and addiction, have less access to quality drug treatment, enter drug treatment with more severe complicating problems, and have fewer abstinence-supporting resources (Marsh, Cao, Guerrero, & Shin, 2009).

Obesity is linked to at least 20 chronic diseases, increases the risk of premature death, and reduces overall quality of life (Khan et al., 2009; Robert Wood Johnson [RWJ] Foundation, 2010). Obesity is disproportionately experienced by racial/ethnic minority populations (RWJ, 2010).

Similarly, stress is linked to coronary vascular disease, obesity, diabetes, and autoimmune disorders (Djuric et al., 2008). A positive association has been found between health status and the psychological stress generated by racism and discrimination (Ahmed, Mohammed, & Williams, 2007) and unhealthy behaviors and Blacks who lived in chronically stressful environments (Jackson, Knight, & Rafferty, 2010).

Boys and men of color as well as sexual minority males, two groups of males especially vulnerable to sociocultural factors and structures that endanger their health, experience health disparities in high numbers. In recent years, there has been increased

attention to the needs of boys and men of color, particularly from philanthropic foundations such as the Kellogg and Ford foundations, professional organizations such as the Society for Research in Child Development, local governments, and the federal government.

A number of reports, articles, and books have been published detailing the educational, economic, social, and health status of vulnerable boys and men and describing steps to ensure better long-term outcomes for them, their families, communities, and society as a whole. They include, for example, the My Brothers' Keeper initiative (2014); two volumes of *Black American Males in Higher Education* (Frierson, Wyche, & Pearson, 2009); *Boosting the Life Chances of Young Men of Color: Evidence From Promising Programs* (Wimer & Bloom, 2014); *Advancing the Success of Boys and Men of Color in Education: Recommendations for Policymakers* (Center for the Study of Race and Equity et al., 2014), a report prepared by seven university-based centers that study the educational experiences of boys and men; *Development of Boys and Young Men of Color: Implications of Developmental Science for My Brother's Keeper Initiative* (Barbarin, Murry, Tolan, & Graham, 2016); and a special issue of the *American Journal of Public Health* on health disparities in boys and men (Boyce, Willis, & Beatty, 2012).

There is much work to be done to reduce health disparities and risks for negative life outcomes in boys and men highly vulnerable to social threats to health so they can obtain equity in health and access to opportunity. This work requires ongoing commitment by individuals and groups working collaboratively across disciplines and interest areas. APA and psychology are uniquely positioned to articulate the concerns of these boys and men and address the concerns with recommendations for action.

A call was issued requesting nominations from psychologists and other professionals to serve on a health disparities and boys and men working group. Outstanding scholars in the field applied. The Health Disparities National Steering Committee selected a diverse, multidisciplinary working group comprising professionals in psychology, social work, public health, and medicine. They are Wizdom Powell, PhD, MPH (Chair); Arthur Blume, PhD; Stephanie H. Cook, DrPH, MPH; Will Courtenay, PhD; Derek M. Griffith, PhD; Perry N. Halkitis, PhD, MS, MPH; Waldo Johnson, PhD; Eric S. Mankowski, PhD; Arik V. Marcell, MD, MPH; Randy Quinones-Maldonado, PhD; Roland J. Thorpe Jr., PhD; and Daphne C. Watkins, PhD.

The working group was charged with preparing a report that summarized critical factors contributing to health disparities in boys and men vulnerable to health disparities and making recommendations for action that APA and others, such as researchers, health care providers, community leaders, and policymakers, can take to eliminate health disparities more effectively and improve the overall health and quality of life of these boys and men.

The working group was asked to determine the health conditions that would be addressed. After reviewing the literature and engaging in much discussion, the group decided to focus on trauma, depression, violence, and substance use in boys and men of color and sexual minority males. These groups and issues were selected because the research base was fairly robust, the issues were considered critical, and psychology can play a leading role in addressing the issues. Producing an exhaustive review of the literature was not the goal of this working group.

EXECUTIVE SUMMARY

Racial/ethnic and sexual minority males are two of the most persistently unhealthy groups in the United States. In fact, health disadvantages are even more pronounced among groups of boys and men who have not fully enjoyed the socioeconomic power and privilege typically conferred to males in this country. These are boys and men at the intersections of social identities, communities, or groups that have historically been oppressed, marginalized, and stigmatized. Moreover, they are boys and men with lived experiences, occupations, or material circumstances that disconnect them from day-to-day society. Often, these males have some of the most negative health-related outcomes, including shorter lifespans, more threats to their safety and well-being, and less access to health care and social supports.

In 2011, the American Psychological Association (APA) approved the support of a health disparities initiative as an activity of its recently adopted strategic plan. A multidisciplinary working group was formed and charged with preparing a report that summarizes critical factors contributing to health disparities in boys and men vulnerable to poorer health and negative life outcomes. The report would include recommendations for action that APA and others, such as researchers, health care providers, community leaders, and policymakers, can take to eliminate health disparities more effectively and improve the overall health and quality of life of these vulnerable boys and men.

Why Racial/Ethnic Minority and Sexuality Minority Boys and Men?

Racial and ethnic minority boys and men and sexual minority males are the focus of this report. Each group has some common, long-standing patterns of social marginalization and stigmatization experiences that have uniquely compromised their health, safety, and well-being. Each group also has different health and well-being profiles that have been shaped by their lived experiences, coping styles, and access to opportunities for upward social mobility.

Racial and ethnic minority males generally exhibit worse health profiles than non-Hispanic White men (Arias, 2006; Bonhomme & Young 2009; Courtenay, 2003; Griffith, 2012; Griffith, Metzl, & Gunter, 2011; Plowden & Young, 2003; Thorpe, Bowie, Wilson-Frederick, Coa, & Laveist, 2013; Treadwell & Braithwaite, 2005; Treadwell & Ro, 2003; Williams, 2003). These disparities are most apparent in life expectancy trends. African American males, for example, consistently have a life expectancy that is approximately eight years shorter than that of Hispanic males (70.7 and 78.7 years, respectively) and about six years shorter than that of White males (70.7 and 76.3 years,

respectively) (Kochanek, Xu, Miniño, & Kung, 2011). African American and American Indian males have higher age-adjusted death rates than any other U.S. population group (S. L. Murphy, Xu, Kochanek, Curtin, & Arias, 2017). The high-profile killings of African American males (e.g., Tyre King, Keith Lamont Scott, Terrence Crutcher, Philando Castile, and Trayvon Martin) illustrate the high-threat conditions under which they live.

Moreover, boys and men of color are more likely to live in poverty, to have poorer education and educational opportunities, to be under- and unemployed, to be incarcerated, to be exposed to toxic substances, to experience threats and realities of crime, to live with cumulative worries about meeting basic needs, and to have discrimination influence their capacity to achieve and maintain good mental and physical health (Bonhomme & Young, 2009; Sabo, 2005; Treadwell & Braithwaite, 2005; World Health Organization, 2008; Xanthos, Treadwell, & Holden, 2010; Young, Meryn, & Treadwell, 2008).

Sexual minority boys and men remain at highest risk for acquiring HIV/AIDS (Halkitis et al., 2011). They have higher rates of smoking (J. G. L. Lee, Griffin, & Melvin, 2009) and suicide (Paul et al., 2002), are more likely to be bullied and harassed (Rivers, 2001; Stall, Friedman, & Catania, 2008), and in contrast to heterosexual men, are more likely to experience mental health problems (Cook & Calebs, 2016; Lick, Durso, & Johnson, 2013). Sexual minority boys and men are more likely to be the victims of hate crimes, such as those that claimed the lives of Matthew Shepard, Mark Carson, and others. More alarming are the heightened rates of mental health and traumatic childhood events experienced by sexual minority men of color (Cook, Valera, Calebs, & Wilson, 2016). The challenges involved in being both a racial/ethnic and a sexual minority male may explain these heightened rates.

The persistence of such disparities and the continuing increase in beliefs, practices, and policies that sustain and promote disparities within these groups (e.g., school suspension and expulsion rates, sentencing disparities, and incarceration rates) have sparked a deepening national interest in the well-being of these boys and men of color and sexual minority males. This deepening interest coincides with a growing recognition among scientific researchers that health disparities among this population create a significant burden not only for the boys and men themselves but also for their families, communities, and our nation.

Understanding Their Stress, Risks, and Resilience

Health disparities in boys and men of color and sexual minority men are viewed as being driven by myriad biological, social, psychological, behavioral, and structural factors but determined primarily by the social conditions in which these boys and men are born, grow, live, work, and age. Understanding the sources and consequences of health disparities in boys and men requires viewing them through a multisystems lens. To describe this complex web of determinants, this report relies principally on social ecological frameworks, which state that individual health and health behaviors are influenced by factors operating at multiple levels of their environments (e.g., individual, familial, structural, and cultural) (Bronfenbrenner, 1992; Stokols, 1992).

It is also important to recognize the profound influence of stress in the lives of these boys and men and its influence on health behaviors and outcomes and the multiple social roles they negotiate as they move through life or occupy different stages of normative development. It is equally important to discuss how life and role transitions shape risks and protections from health disparities, especially during sensitive periods of male development. Thus, we use the following conceptual frameworks to guide our understanding of health risks, behaviors, and outcomes:

- Life-course health developmental frameworks (Halfon & Hochstein, 2002; Thorpe, Duru, & Hill, 2015; Williams, 2003)

- The environmental affordances framework (Mezuk et al., 2010, 2013), which outlines a dynamic relationship between stress, biology, and individual motivation for, and availability to engage in, poor health behaviors

- Intersectionality theory, which helps to explain how social identities intertwine to produce compounded structural and individual vulnerability to health disparities (Cole, 2009; Crenshaw, 1991; Griffith, Ellis, & Allen, 2013; D. F. Warner & Brown, 2011)

- Theories of gender and power (Connell, 2012; Hammond, Fleming, & Villa-Torres, 2016), which describe how gendered structural arrangements produce inequities in exposures and risk factors and reinforce harmful norms that discourage positive health practices

- Resilience frameworks, which promote the ways boys and men might demonstrate positive development in the context of adversity and stress (Buttram, 2015; Masten & Wright, 2009)

Trauma, Substance Abuse, Depression, and Violence

We focus in this report on four outcomes impacting boys and men vulnerable to health disparities: trauma, substance abuse, depression, and violence. These outcomes were selected because of their prevalence and/or pronounced impact on health and their high association with other chronic diseases, psychological problems, and events and consequences that compromise health and life options of racial/ethnic and sexual minority boys and men (e.g., violence that leads to disability, death, or incarceration; addiction that increases other risky health behaviors; trauma that interferes with the ability to work or form meaningful personal relationships).

TRAUMA
We provide brief overviews of major types of trauma, including violence related to interpersonal violence (IPV) trauma in which males are victims; sexual assault–related trauma; combat-re-

lated trauma; historical trauma, a "macro-level temporal framework for examining how the life course of a population exposed to trauma at a particular point in time compares with that of an unexposed population" (Sotero, 2006); and race-based trauma, defined as exposures to racism that elicit profound emotional stress, fear, or physical harm (Bryant-Davis, 2007; Bryant-Davis & Ocampo, 2005). For example, estimates indicate that roughly 47% of males report IPV victimization (Kilpatrick et al., 2013). Sexual minority men are more likely to experience sexual violence victimization, such as childhood sexual abuse, sexual assault related to hate crimes; and intimate partner sexual assault, than are heterosexual men, with an estimated prevalence rate of 11.8–54% (Rothman, Exner, & Baughman, 2011). Moreover, compared with civilians, combat veterans present two to four times the rate of posttraumatic stress disorder (Richardson, Frueh, & Acierno, 2010).

SUBSTANCE ABUSE
Males in the United States tend to have higher rates of substance use than females and experience disproportionately greater consequences of substance abuse (Centers for Disease Control, 2014; Compton, Thomas, Stinson, & Grant, 2007; Kessler, Chiu, Demler, & Walters, 2005). Substance use is strongly influenced by masculinity beliefs (Blazina & Watkins, 1996). Use preferences and patterns vary across the lifespan by race/ethnicity (American Cancer Society, 2013; Substance Abuse and Mental Health Services Administration [SAMHSA], 2014), sexual and gender minority (J. Hunt, 2012), and stress (Martin, Tuch, & Roman, 2003; Zemore, Karriker-Jaffe, Keithly, & Mulia, 2011). Moreover, there are disparate health and social outcomes experienced by racial/ethnic and sexual minority males as a result of drug use (e.g., Barnes & Kingsnorth, 1996; Burt, Simons, & Gibbons, 2012; Chartier & Caetano, 2010, Hattery & Smith, 2007; Iguchi, Bell, Ramchand, & Fain, 2005; Kakade et al., 2012; Provine, 2007). These include but are not limited to imprisonment (Pettit & Western, 2004); HIV acquisition (Halkitis et al., 2011); overdose (Bird & Hutchinson, 2003); and social, emotional, and physical deterioration (Halkitis, 2009).

DEPRESSION
Although men are less likely to suffer from depression than women, researchers estimate that more than six million men in the United States have a depressive disorder—about one third of all adults living with depression in any given year (National Institute of Mental Health, 2017b). Estimates of diagnosed depression likely underestimate the burden of depression among males because they are least likely to seek help for depressive symptomatology (Rosenfield & Mouzon, 2013). Affirming the probability that male depression is underestimated are statistics indicating that when compared with females, males have higher rates of suicide completion (Joe, Baser, Breeden, Neighbors, & Jackson, 2006; Pittman, Osborn, King, & Erlangsen, 2014)—an outcome closely linked to depression. This gender paradox in mental health suggests that many more boys and men are suffering in relative silence from depression. Research indicates higher levels

of depression among gay/bisexual males when compared with heterosexual males (Cochran, Sullivan, & Mays, 2003). More research is needed to better understand depression in racial/ethnic and sexual minority males. Interestingly, racial and ethnic minority males appear to exhibit more resilience to depressive symptoms when they have a greater sense of control over social and political forces (Zimmerman, Ramirez-Valles, & Maton, 1999), access to culturally responsive interventions (Brave Heart, Elkins, Tafoya, Bird, & Salvador, 2012), healthy cultural identities (Cardoso & Thompson, 2010), and less rigid notions of masculinity (Iwamoto, Liao, & Lui, 2010).

VIOLENCE
Men represent more than 90% of the perpetrators of criminal violence in the United States and are also the victims of the large majority (78%) of that violence (Federal Bureau of Investigation, 2007; U.S. Bureau of Justice Statistics, 2008). The differences in exposure to violence that occur among men are due to complex interactions between race, sexuality, socioeconomic status, and geography. Boys and men from racial/ethnic and sexual minority populations are at increased risk for violence victimization and perpetration due in part to greater exposure to high-risk environments and less protection and support when violence is experienced. The following categories of violence are described in the report: physical fighting, weapon ownership and use, homicide, suicide, and intimate partner violence.

Approaches

We propose that health disparities can best be eliminated in racial/ethnic and sexual minority males by adopting upstream (i.e., policy), midstream (i.e., program/practice), and individual (i.e., downstream) approaches that (a) focus on strengths-based methods and those that emphasize optimal development as opposed to the mitigation of pathology; (b) address the social determinants of health, health disparities, and inequities; (c) improve cross-sector collaborations to maximize the impact of health-focused interventions; (d) apply interventions aimed at upstream, midstream, and downstream levels; (e) understand and appreciate the role of masculinity beliefs and norms on health behavior and outcomes; (f) address implicit racial and sexual orientations biases and the stress they induce; and (g) attend to the ways in which race/ethnicity, gender identity, and sexual orientation intersect.

RECOMMENDATIONS
FOR RESEARCH, PUBLIC POLICY, PRACTICE/EDUCATION/TRAINING, AND PUBLIC AWARENESS

RECOMMENDATIONS FOR RESEARCH

More research is needed on "normal" development and the socialization of boys and men of color and sexual minority males across the lifespan; how to prepare and improve the workforce that educates, treats, and provides services to boys and men of color and sexual minority men and their families; and development of strategies to keep them out of the criminal justice system. Additionally, better documentation of their experience of stress, trauma, and depression and the most effective coping and intervention strategies is crucial at the individual, family, and community levels. We encourage the use of community-based participatory methods in research with community stakeholders working in consultation with experts to develop quality prevention and treatment programs. We recommend that APA, research scientists, and other stakeholders:

Encourage increased funding and support for the National Institutes of Health (NIH) and other federal agencies to conduct more research on health disparities specific to boys and men from racial/ethnic minority populations.

Encourage increased funding and support for NIH and other federal agencies to conduct more research on health disparities specific to gender identity, particularly to health disparities faced by transgender and gender nonconforming individuals.

Continue to encourage funding for the Centers for Disease Control and Prevention to monitor gun violence and support firearm injury prevention research.

Conduct more research on normative and optimal development and the natural history of male role socialization of racial/ethnic and sexual minority males in families, within/across generations, and over the lifespan.

Investigate stress exposures (e.g., types of stress, chronic stress) experienced by racial/ethnic and sexual minority males, trauma (e.g., child sexual abuse), and their negative psychological consequences (e.g., depression) through methodologies that allow us to capture them in real-time.

Support studies addressing the preparation and improvement of the workforce that educates, treats, and provides services to racial/ethnic and sexual minority men and their families. These studies should address implicit bias and stereotyping in reference to racial, ethnic, gender, sexual minority status and the intersection of these identities and characteristics.

Conduct evaluation research that demonstrates the effects of programs and interventions.

Encourage and support research to determine the impact of proposed and current policies and programs likely to impact the health and well-being of racial/ethnic and sexual minority males.

Make funding available for research focused on the role of masculinity, chronic stress, trauma, depression, and substance abuse and their relationship to health status, health behaviors, and use of services in boys and men of color and sexual minority males across the lifespan; integrate these measures into the nation's Healthy People objectives.

Evaluate existing assessment measures of boys and men of color and sexual and gender minority males.

RECOMMENDATIONS FOR PUBLIC POLICY

Strong advocacy is needed to ensure that the health needs of racial/ethnic and sexual minority males are a priority agenda item (within APA and with policymakers) and to keep key political stakeholders aware of the impact of psychological factors on the long-term health and quality of life of these boys and men. We recommend that APA, research scientists, and other stakeholders:

Promote policies that reduce disparities and increase health equity among racial/ethnic and sexual minorities. Examples include expanding health insurance to include coverage for mental and behavioral health needs and providing civil rights protections, especially for sexual minority boys and men.

Develop policies that support holistic models of responsible fatherhood, family life, and sexuality. Such policies should emphasize economic and socioemotional contributions fathers make to family life.

Intensify adult and juvenile justice efforts to keep racial/ethnic minority males out of prisons and jails.

Identify existing levers within health care systems that can enhance access to care, improve processes of care, and minimize help-seeking barriers among vulnerable boys and men.

RECOMMENDATIONS FOR PRACTICE, EDUCATION, AND TRAINING

Psychologists, other health care providers, educators, and professionals who provide treatment and services to boys and men of color and sexual minority males can benefit from better understanding their clients' health care needs and barriers to providing care. We recommend that APA, research scientists, and other stakeholders:

Increase psychotherapeutic support for families in their efforts to promote optimal racial and gender socialization for racial/ethnic and sexual minority boys and men.

Address the stress-inducing implications of persistent exposure to implicit biases and the microaggressions they elicit in all the places racial/ethnic and sexual minority boys and men live, get educated, work, play, and acquire health care.

Integrate comprehensive assessments into clinical practice that include comprehensive screening for physical, medical, and mental health concerns during primary and specialty health care visits.

Provide graduate and continuing education (CE) training to all psychologists and other health care providers working with racial/ethnic and sexual minority males. Such training ensures that providers are highly competent and skilled in approaches proven to be the most effective in improving the health of these individuals and in treatment issues associated with gender, race, ethnicity, and sexual orientation, and in how their intersectionality impacts treatment process and outcomes.

Provide postgraduate and CE training to psychologists and other health professionals working with racial/ethnic and sexual minority males, particularly those working in elementary schools, high schools, junior colleges, universities, and communities.

Design youth mentoring programs that move beyond the establishment of bonds with role models toward those that also provide bridges to the social capital critical to accessing networks that enhance upward social mobility. Incorporate more reflexive examples of demonstrating manhood or masculinities into existing rites-of-passage mentoring programs to reflect a wider range of options for expressing masculinities.

Services are limited in rural and in low-income urban areas (SAMHSA, 2014). Treatment services for sexual minority and ethnic minority males are sparse and sorely needed (Healthy People 2020; U.S. Department of Health and Human Services, 2018). Provide quality and culturally appropriate assessment of trauma exposure and mental health needs as well as mental health and addiction care to vulnerable boys and men, especially incarcerated men, men from rural and low-income settings, and racial/ethnic and sexual minority males.

Increase access to interventions that assist vulnerable men in substance abuse recovery in the criminal justice system during the transition from incarceration and as they reintegrate in their communities and families. Increase and improve programs designed to ease reentry into society and the labor force.

Develop treatment services and modalities that attend to sexual identity and the complex interplay between persons and behavioral, psychosocial, and social stressors that place sexual minority men at risk and predispose the syndemic of substance use, HIV, and other sexually transmitted diseases, violence, and mental health concerns (Halkitis, Wolitski, & Millet, 2013).

Provide rehabilitative and supportive services to vulnerable boys and men who have been impacted by trauma and violence. Assure that such services attend to the unique ways in which such events impact masculine role identity. Integrate those services in spaces where racial/ethnic and sexual minority boys and men live, work, play, pray, are educated, and acquire health care. Provide support also for families and friends who are close to those who are impacted by trauma and violence.

Develop gender-based prevention programs and other interventions aimed at men involved in violence as perpetrators or peer bystanders (e.g., Coaching Boys Into Men).

Incentivize, expand, and support state and local programs to assist boys and men who are reentering communities from prisons and jails. In addition, develop and evaluate strategies to keep boys and men of color and sexual minority males retained and engaged in schools, family and community life, and the workforce.

RECOMMENDATIONS FOR PUBLIC AWARENESS

A well-informed, aware community is critical to improving the health of racial/ethnic and sexual minority males. We adopt a broad definition of community to include family, peers, teachers, religious leaders, schools, the media, civic associations, community groups, fraternities and sororities, and employers. Partnering with community-based organizations to plan strategic collaborative efforts to disseminate information on the mental and physical health of racial/ethnic and sexual minority males is needed. We recommend that:

APA work with other professional organizations (e.g., the American Public Health Association, American Medical Association) to develop and disseminate a variety of web-based materials and resources on topics pertaining to racial/ethnic and sexual minority men covered in this report.

APA and other professional organizations collaborate with community groups and stakeholders working with boys and men to provide technical assistance and expertise on the health of racial/ethnic and sexual minority males.

APA establish a systematic means to keep abreast of emerging needs and challenges facing vulnerable boys and men. We believe that what gets measured, gets done.

We believe that we need more than simple public narrative change to eliminate health disparities in racial/ethnic and sexual minority boys and men. Rather, we need narrative disruption to bridge the existing empathy gaps in our society for boys and men at the margins of opportunity. Our report was designed in many ways to bridge such gaps. We view this document as an initial effort by APA to ignite and sustain commitment among psychologists and other health care professionals to work collectively to eliminate health disparities in racial/ethnic and sexual minority boys and men.

INTRODUCTION

Men in the United States generally have greater socioeconomic power and privilege than women, as evidenced by higher earnings, greater representation in high-paying occupations, and fewer structural barriers to labor force participation (Haveman & Beresford, 2012; Reskin & Hartmann, 1986; Reskin & Ross, 1992; R. A. Smith, 2012). Yet they also experience worse health outcomes than women, including higher rates of suicide, substance abuse, and unintentional injuries (Centers for Disease Control [CDC], 2014).

Over the past three decades, only modest progress has been achieved in reducing sex differences in key health outcomes. For example, even as sex differences in life-expectancy gaps narrow, males in the United States continue to live shorter lives than women, and they have consistently lived shorter lives than their global peers since 1980 (Woolf & Aron, 2013). The life expectancy at birth of U.S. males is lower than that of males in 21 other highly developed countries (e.g., Australia, Canada, Japan, Sweden, the United Kingdom). Males in the United States also have a lower likelihood of survival to age 50 than males in 21 other high-income countries (e.g., Australia, Canada, Japan, Sweden, the United Kingdom, etc.) (Woolf & Aron, 2013).

Certainly, some of the health differences observed in boys and men can be explained by biological factors. For example, data suggest that males are more likely to be miscarried, to die shortly after birth, and to be susceptible to rapid biological aging (D. J. Barker, 2004; Chae et al., 2014; Kotrschal, Ilmonen, & Penn, 2007). However, if sex differences in health outcomes were solely explained by male biology, patterns of health disadvantage would be similar across all groups of males. This is not the case.

In fact, health disadvantages are even more pronounced among groups of boys and men who have not fully enjoyed the socioeconomic power and privilege typically conferred to males in this country. These are boys and men at the intersections of social identities, communities, or groups that have historically been oppressed, marginalized, and stigmatized. Moreover, they are boys and men with lived experiences, occupations, or material circumstances that disconnect them from day-to-day society. Often, these males have some of the most negative health-related outcomes, including shorter lifespans, more threats to their safety and well-being, and less access to health care and social supports. They are males who are the most socially vulnerable and at greatest risk for health disparities.

The Case for Focusing on Health Disparities

This report focuses on two groups of males who arguably may be at the highest risk of disparities in health and justice among all U.S. males and most other U.S. population groups: racial/ethnic minority and sexual minority males. We also recognize that gender identity is an area of great importance in the lives of boys and men and note the very limited body of research that considers the intersections of race/ethnicity, sexual orientation, and gender identity. Although we understand that other potentially vulnerable populations of boys and men exist, we chose these two groups because each has some common, long-standing patterns of social marginalization and stigmatization experiences that have uniquely compromised their health, safety, and well-being. Each group also has different health and well-being profiles that have been shaped by their lived experiences, coping styles, and access to opportunities for upward social mo-

Health disparities, especially among boys and men vulnerable to social threats, create a significant burden not only for the men themselves but for their families, communities, and our nation as a whole

bility. These groups share a significant proportion of the health disparities borne by men. Further, race, ethnicity, and sexual orientation have been found to be determinants of educational attainment, social class, economic status, income, and wealth (Kawachi, Daniels & Robinson, 2005; Mai, 2015).

Racial and ethnic minority males generally exhibit worse health profiles than non-Hispanic White men (Arias, 2006; Bonhomme & Young, 2009; Courtenay, 2003; Griffith, 2012; Griffith, Metzl, & Gunter, 2011; Plowden & Young, 2003; Thorpe, Bowie, Wilson-Frederick, Coa, & Laveist, 2013; Treadwell & Braithwaite, 2005; Treadwell & Ro, 2003; Williams, 2003). These disparities are most apparent in life expectancy trends: African American males, for example, consistently experience life expectancy that is approximately eight years shorter than that of Hispanic males (70.7 and 78.7 years, respectively) and about six years shorter than that of White males (70.7 and 76.3 years, respectively) (Kochanek, Xu, Murphy, Miniño, & Kung, 2011).

Compared with non-Hispanic White males, boys and men of color are more likely to live in poverty, to have poorer education and educational opportunities, to be under- and unemployed, to be incarcerated, to be exposed to toxic substances, to experience threats and realities of crime, to live with cumulative worries about meeting basic needs, and to have discrimination influence their capacity to achieve and maintain good mental and physical health (Bonhomme & Young, 2009; Sabo, 2005; Treadwell & Braithwaite, 2005; World Health Organization [WHO], 2008; Xanthos, Treadwell, & Holden, 2010; Young, Meryn, & Treadwell, 2008).

The high-profile killings of African American males (e.g., Tyre King, Keith Lamont Scott, Terence Crutcher, Philando Castile, Trayvon Martin, Freddy Gray, Eric Garner, Oscar Grant, Laquan McDonald, and others) have placed such inequities and the well-being of boys and young men of color at the center of public discourse. The public discourse is rooted in convincing scientific evidence that documents African American males' higher likelihood of being killed by police. Also

fueling this discourse are articles like the series produced by various media outlets on the estimated 1.5 million missing Black men in America (Wolfers, Leonhardt, & Quealy, 2015), which highlight the broader, population-level impacts of premature mortality and disproportionate incarceration rates. Recognizing the need for more focused attention on boys and young men of color, former President Barack Obama established My Brother's Keeper (2014), a national initiative designed to improve their life outcomes and access to opportunities.

Despite recent stability in new infection rates, sexual minority boys and men remain at highest risk for acquiring HIV/AIDS (Halkitis et al., 2011). Data also suggest that they have higher rates of smoking (J. G. L. Lee, Griffin, & Melvin, 2009), suicide (Paul et al., 2002), and reported bullying and harassment (Rivers, 2001; Stall, Friedman, & Catania, 2008). Researchers have found that in contrast to heterosexual men, populations of boys and men who occupy the intersection of sex and sexual minority status are more likely to experience mental health problems (Lick, Durso, & Johnson, 2013). Sexual minority boys and men are also victims of hate crimes that place their lives in unique peril. Like the high-profile killings of boys and men of color, crimes claiming the lives of Matthew Shepard, Mark Carson, and others make it clear that some health disadvantages (e.g., premature death) are not produced by individual behavioral choices but rather by larger social forces.

The persistence of such disparities and the continuing increase in beliefs, practices, and policies that sustain and promote disparities within these groups (e.g., preschool suspension and expulsion rates, school drop-out rates, sentencing disparities, and incarceration rates) have sparked a deepening national interest in the well-being of boys and men of color, in particular. This deepening interest coincides with a growing recognition among scientific researchers that health disparities, especially among boys and men vulnerable to social threats, create a significant burden not only for the men themselves but for their families, commu-

Some health disadvantages are not produced by individual behavioral choices but rather by larger social forces

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nities, and our nation as a whole. Effects on women and children, for example, can be far-reaching—affecting marriage rates and the high number of single-mother households (Ellwood & Jencks, 2004); instrumental support to households and adolescent psychosocial adjustment (Parent, Jones, Forehand, Cuellar, & Shoulberg, 2013); family processes and parental socialization (McLoyd, Cauce, Takeuchi, & Wilson, 2000); availability of male family members (Florsheitn, Tolan, & Gorman-Smith, 1998); and residential stability and behavior problems, especially in sons, as a result of parental (usually father) incarceration (Geller, Garfinkel, Cooper, & Mincy, 2009).

Moreover, in a recent analysis, Thorpe et al. (2013) estimated that costs between 2006 and 2009 associated with health disparities were nearly $448 billion for African American males for direct medical care expenditures and nearly $433 billion in indirect expenditures for African American and Hispanic males combined. Health disparities in boys and men have additional hidden economic costs. Premature male deaths hemorrhage talent and vital untapped human resources. Health disparities in boys and men exact a toll on labor force participation and organizational productivity and contribute to worker absenteeism—outcomes that are more likely to occur among vulnerable male populations (Bound, Waidmann, Schoenbaum, & Bin-

genheimer, 2003). Eliminating premature mortality and other downstream negative health outcomes among boys and men is essential to sustaining the nation's capacity to compete in the global marketplace. In other words, we all stand to gain when we address circumstances that limit racial/ethnic and sexual minority boys and men from living longer, healthier, and more socially productive lives.

Scope and Emphasis

We focus in this report on four outcomes impacting health disparities among racial/ethnic and sexual minority boys and men: trauma, substance abuse, depression, and violence. These outcomes were selected because of their prevalence and/or pronounced impact on health and their high association with other chronic diseases, psychological problems, and events and consequences that compromise health and life options (e.g., violence that leads to disability, death, or incarceration; addiction that increases other risky health behaviors; and trauma that interferes with the ability to work or form meaningful personal relationships).

We focus on two groups of boys and men: racial/ethnic and sexual minority males. We also draw upon our understanding of gender identity in this population when the literature permits. Racial/ethnic minority males include boys and men of color in group categories commonly used for federal data collection purposes and those most frequently used by researchers—namely, Black/African American, Hispanic/Latino, American Indian/Native American, Asian American, and Native Hawaiian and Other Pacific Islanders. Diversity within these groups (e.g., Mexican, Lakota) are presented when available. Data on the health concerns of this report are not equally available for each group.

Various terms are used to describe individuals with sexual and gender identities and orientations that vary from traditional societal norms. In 2016, the National Institutes of Health [NIH] designated SGMs (sexual and gender minorities) as a health disparity population

for research purposes; SGM is a term that is being increasingly used in federal public policy and may include transgender and gender nonconforming individuals. We use the term *sexual minority males* in this report because our focus is on individuals who identify as males. We acknowledge and make it clear that sexual orientation and gender identity are often overlapping yet distinct identities.

We were asked to consider addressing gender identity, but after careful consideration and advice from experts on gender identity, we decided not to include gender minority males as a major group of focus for the following reasons:

- Much of the research and many of the theories used in this report assume socialization as male since birth or early childhood, which is not the case for many trans men, precluding generalizations that would otherwise be assumed to follow.

- Unlike the populations of racial/ethnic minority men and sexual minority men, the population of gender minority men is composed of a substantively wide diversity of gender identity and expression along the gender continuum. This greater diversity of gender requires particular attention with regard to health disparities and the elements of minority stress that contribute to those disparities.

For these reasons, it is preferable that the population of gender minority men be addressed separately. For a more complete and nuanced treatment of issues regarding gender minority men, the reader is referred to the following documents: the *Resolution on Transgender, Gender Identity and Gender Expression Non-Discrimination* (APA, 2008b), the *Report of the Task Force on Gender Identity and Gender Variance* (APA, 2009), the *Resolution on Gender and Sexual Orientation Diversity in Children and Adolescents in Schools* (APA, 2014b), the *Guidelines for Psychological Practice With Transgender and Gender Nonconforming People* (APA, 2015), and the *Handbook of Sexual Orientation and Gender Diversity in Counseling*

We all stand to gain when we address circumstances that limit boys and men from living longer, healthier, and more productive lives

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and Psychotherapy (APA, 2016a). Please note that we provide brief definitions of terms related to gender identity in the glossary (see pp. 58–59), and when research is available and applicable to the topic under discussion, we reference it.

We use the term *vulnerable* to refer to a population's susceptibility to harm resulting from inadequate resources to meet challenges the group encounters (Mechanic & Tanner, 2007). A vulnerable population is a group with shared social characteristics that puts the population at a higher risk of risks (Frohlich & Potvin, 2008).

Consistent with APA's recent Stress in America survey (APA, 2016b), we recognize the well-established connection between stress and health disparities. Stress effects on health occur directly through physiological pathways and indirectly through health behaviors and practices (Wenzel, Glanz, & Lerman, 2002; Williams, 2003). Men generally respond to stress in less healthy ways than women.

Some men are more likely to use avoidant coping strategies (e.g., denial, distraction, and increased alcohol consumption), minimize the impacts of stress on their physical and mental health, and forgo help-seeking (Courtenay, 2001; Friedman, 1991; Kopp, Skrabski, & Szedmak, 1998; Vogel, Heimerdinger-Edwards, Hammer, & Hubbard, 2011; Weidner & Collins, 1993).

Our synthesis of the evidence in subsequent sections of this report draws attention to these potential life-course differences in demonstrations of masculinities. We felt it imperative to emphasize the ways in which boys and men also demonstrate positive masculinities or ways of being male that encourage health-promoting behaviors. We were implored to ignite a shift in research, policy, and practice away from the usual tendency to problematize and pathologize masculinities, especially those enacted by racial/ethnic and sexual minority boys and men.

The goal of this report is to synthesize rather than provide broad coverage

of the existing evidence base. For example, this report will not provide an exhaustive review of the evidence linking stress to health disparities (see APA, 2017). We envision this report as a tool for psychologists, physicians, public health practitioners, policymakers, advocacy groups, and community-based organizations who serve and advocate for boys and men vulnerable to societal threats and inequities.

The report is structured as follows: First, we present different ways of understanding the sources and consequences of health disparities among racial/ethnic and sexual minority males. We briefly review relevant theories and frameworks guiding our review of scientific evidence, including an overview of the significance of developmental issues. Second, we provide a brief summary of the evidence documenting disparities in depression, trauma, violence, and substance abuse among racial/ethnic and sexual minority males. Third, we outline proposed approaches and recommendations for addressing disparities in these selected outcomes.

Questions Addressed

Recognizing and drawing on existing scientific evidence, theories, and frameworks, we attempted to answer the following questions:

- What do we know from existing psychological, clinical, and public health research about health disparities in racial/ethnic and sexual minority males?

- How do we use what we know to inform research and policy more effectively as well as shape the public dialogue designed to impact health disparities among racial/ethnic and sexual minority males?

- How can we better equip and prepare health care professionals, advocates, and communities to eliminate health disparities in racial/ethnic and sexual minority males and to engage racial/ethnic and sexual minority males in their efforts to resolve health disparities?

Limitations

We were not able to fully explore all the intersectional identities and social determinants that shape and influence the health and well-being of racial/ethnic and sexual minority boys and men across their lifespan. Key among these are socioeconomic status (SES) and related variables (i.e., educational attainment, employment), disability status, immigration status and experiences, and geographic residence (rural, urban, suburban). Moreover, we did not attempt to fully describe and present data for each developmental age period from infancy to old age for each issue area addressed. Reasons for these exclusions varied.

Some topics like education and SES-related concerns have been well addressed previously and are available elsewhere (see, e.g., My Brothers' Keeper initiative [2014]; two volumes of *Black American Males in Higher Education*, edited by Frierson, Wyche, & Pearson [2009]; *Boosting the Life Chances of Young Men of Color: Evidence From Promising Programs* [Wimer & Bloom, 2014]; and *Advancing the Success of Boys and Men of Color in Education: Recommendations for Policymakers* [Center for the Study of Race and Equity et al., 2014], a report prepared by seven university-based centers that study the educational experiences of boys and men).

In addition, APA's Health Disparities Office has a working group on implicit bias and preschool suspensions pertinent to boys of color, with information and resources available online (see APA, n.d.-a). Other topics (e.g., research at each age range for the groups, rural populations, immigration status, biracial/multiracial vulnerable boys and men, English language proficiency) have limited or difficult-to-disentangle data for the populations and outcomes addressed in this report. We have included information on these factors, especially SES-related variables, when they are available and appropriate to the health outcomes identified.

WAYS OF UNDERSTANDING SOURCES AND CONSEQUENCES OF HEALTH DISPARITIES

IN RACIAL/ETHNIC AND SEXUAL MINORITY BOYS AND MEN

During the course of developing this report, the working group identified several frameworks and theories critical to understanding the complex sources and consequences of health disparities in vulnerable boys and men. Frameworks provide overarching ways of organizing ideas, evidence, and theories (Carpiano & Daley, 2006). Theories are a set of general propositions, explanations, or assumptions that describe processes leading to outcomes (Carpiano & Daley, 2006). Even when frameworks and theories are not explicitly acknowledged, we believe they are operating in ways that impact the kinds of strategies adopted to address health disparities. In this section, we briefly describe frameworks and theories that are especially helpful in understanding male depression, trauma, violence, and substance abuse.

There is strong consensus that while genetics and individual health behaviors contribute to disparities, health disparities are primarily determined by the social conditions in which people are born, grow, live, work, and age. These conditions are structurally determined by the distribution of money, power, and resources at global, national, and local levels. They are also influenced by political, educational, and health care systems primarily responsible for the distribution of social resources (Solar & Irwin, 2007; WHO, 2008). Thus, we assert that health disparities in vulnerable boys and men are driven by myriad biological, social, psychological, behavioral, and structural factors.

To describe this complex web of determinants, we rely largely on social ecological frameworks, which state that individual health and health behaviors are influenced by factors operating at multiple levels of their environments (e.g., individual, familial, structural, and cultural) (Bronfenbrenner, 1992; Stokols, 1992). Like Stokols and others, we assert that practice, research, and policies designed to eradicate disparities in vulnerable males should stem from a full consideration of the environmental contexts they navigate. Environments can be described in terms of their objective (actual) or subjective (perceived) qualities and their scale or immediacy to vulnerable boys and men (distal vs. proximal).

Applying a social ecological framework is helpful in unpacking interactions between various distal sociostructural systems and factors operating in more proximal environments and describing how they might lead to health disparities (Reifsnider, Gallagher, & Forgione, 2005). Also, just as environments can be described in terms of their relative scale and complexity, approaches to address their influence on the health of vulnerable boys and men should range from those aimed at individuals, small groups, and organizations to larger aggregates and populations.

We return to these points later in this report. Because, as social ecological models imply, most primary causes of health disparities are socially and behaviorally, as opposed to biologically, driven (Featherstone, Rivett, & Scourfield, 2007), we believe they are also modifiable. We also think it is critical to communicate that vulnerable boys and men are also agentic and self-determined. In other words, even in the face of sociostructural barriers, they mount proactive strategies in their everyday lives to define themselves in healthy and positive ways and to improve their health and well-being.

In this report, we draw attention to life-course health developmental frameworks (Halfon & Hochstein, 2002; Thorpe, Duru, & Hill, 2015; Williams, 2003) and root many of our recommendations in the following assumptions about health disparities in racial/ethnic and sexual minority boys and men:

- They take shape early in life and establish chains of risks or resilience later in life.

- They are timed and sequenced (i.e., they emerge most significantly at turning points and during both critical and sensitive periods).

- They result from a synergistic effect of biological, social, psychological, behavioral, and social exposures.

We acknowledge the importance of focusing on the multiple social roles vulnerable boys and men negotiate as they move across the life course or occupy different stages of normative human development. It is equally important to address how life and role transitions shape health risks and protective factors, especially during sensitive periods of development. For example, emerging adulthood is the developmental period between 18 and 25 when youths, who are out of adolescence but not yet adults, gain new social skills and are learning how to negotiate adult demands (Arnett, 2000). Emerging adults have one of the highest prevalence rates of sexually transmitted infections (STIs) in the United States (Eaton et al., 2008; Weinstock, Berman, & Cates, 2004; Workowski & Bolan, 2015) because many engage in sexual behaviors that increase their risk of STI/HIV during this phase of life (Lefkowitz & Gillen, 2006). This transition period is a time when peer networks change and

many emerging adults begin to consolidate and refine social identities (Arnett, 2000, 2014). Equally important role and life-course transitions occur as men become fathers or confront aging-related threats to their physical, cognitive, and social integrity.

It is also important to have a framework for understanding how environments might uniquely condition health behaviors over the life course for vulnerable boys and men. We think it is especially vital that researchers, practitioners, and policymakers have a way to understand processes by which stress and social disadvantage accumulate and become embodied by racial/ethnic and sexual minority boys and men. To address this vital need, we rely on the environmental affordances framework (Mezuk et al., 2010, 2013). This framework suggests a dynamic relationship between stress, biology, and individual motivation to engage in poor health behaviors. Further, it frames negative health

behaviors as stress-coping or self-regulation strategies broadly influenced by social structures and contexts (e.g., poverty, segregation, access to goods).

In addition to the frameworks described previously, we draw on theories from psychology, sociology, and public health. We focus explicitly on theories that explain how the social identities boys and men value influence their stress response, health behaviors, and ways of negotiating social disadvantage.

Racial/ethnic and sexual minority boys and men often face compounded disadvantages because they are marginalized in multiple social identity domains. For example, racial and ethnic minority males can also experience social disadvantage associated with low-income status. Similarly, sexual minority males can experience additional social disadvantage stemming from belonging to a racial/ethnic minority group. Intersectionality theory helps explain this kind of compounded disadvantage be-

Vulnerable boys and men are in a precarious social position because they are marginalized in one social identity domain (race/ethnicity and sexual orientation) and presumed to be privileged in another (gender)

cause it describes how social identities intertwine to produce structural and individual vulnerability to health disparities (Cole, 2009; Crenshaw, 1991; Griffith, Ellis, & Allen, 2013; D. F. Warner & Brown, 2011). Researchers investigating the health of boys and men and disparities among males need to consider how sexual orientation, sexual identity, racial identity, ethnic identity, religiosity and spirituality, and other factors intersect with gender to create unique biopsychosocial contexts and points of intervention for males. It is critical to highlight and illustrate how identities, social and economic statuses, and group memberships other than gender affect the health of boys and men (Griffith, 2015).

Intersectionality provides a systematic way to explore how sex and gender affect the health of boys and men, yet these determinants of health also rely on other identities, characteristics, and categories for meaning as determinants of health (Gilbert et al., 2016; Griffith, 2012, 2015). It is necessary to move beyond identifying proxies for determinants of the health of boys and men. Identifying how gendered mechanisms and pathways affecting men's health intersect and are shaped by nongendered ones (e.g., SES, education) will advance progress in reducing health disparities in the United States and globally. It is critical for intersectional approaches to be applied not only to research and practice but also to policies that affect these populations. It has become increasingly apparent that

the determinants of the health of boys and men are not just rooted within each nation but are global in nature, and the interdependence of countries has important implications for economic, social, and political determinants of health (Griffith, 2015; Sabo, 2005).

Vulnerable boys and men are in a precarious social position because they are marginalized in one social identity domain (e.g., race/ethnicity and sexual orientation) and presumed to be privileged in another (e.g., gender). Occupying discrepant social positions can lead vulnerable boys and men to respond to environmental stress, depression, and trauma by engaging in health-damaging behaviors that symbolically restore power and control (Hammond, Fleming, & Villa-Torres, 2016). Often these behaviors are the very ones that put these males at greater risk for health disparities. This possibility is supported by the theory of gender and power (Connell, 2012), which describes how gendered structural arrangements produce inequities in exposures and risk factors and reinforce harmful norms that discourage positive health practices.

Research regarding factors that increase risk for negative health and social outcomes is very clear, but research is not as clear regarding factors that protect those who are vulnerable. We think it is critical to incorporate resilience frameworks into our ways of understanding health disparities in boys and men. Traditional discussion about vulnerable populations, but especially

those concerning men, tend to center on resilience, operationalized in terms of a psychological model. Resilience has been theorized and conceptualized as a dynamic process describing the ways individuals demonstrate positive development in the context of adversity and stress (Buttram, 2015; Masten & Wright, 2009). Resilience is posited as positive adaptations to threats to an individual's life or function (Buttram, 2015; Masten & Wright, 2009). Individuals who are able to overcome great odds against them by using assets, resources, and other protective or enabling factors in their environment are defined as resilient (Masten & Wright, 2009). We assert that the majority of vulnerable boys and men are resilient and inherently oriented toward personal growth.

We acknowledge that other ways of understanding health disparities in boys and men exist. For example, syndemic theory (Singer, 2010; Singer & Clair, 2003; Singer & Snipes, 1992) presents another useful framework for understanding trauma, depression, substance abuse, and violence. This theory suggests that such outcomes are enmeshed, working in concert with harmful social and physical conditions to increase health vulnerability.

We present these various ways of understanding as viable options for contextualizing the often disparaging epidemiological data documenting health outcomes in vulnerable boys and men. We also hope that by doing so, we encourage researchers, practitioners, and policymakers to consider factors operating within and outside boys and men that contribute to health disparities. We firmly believe that broadening the aperture through which we view the fundamental causes of male health disparities will enhance our collective capacity to improve health equity among our nation's most vulnerable boys and men.

Male trauma is mutually constituted of biobehavioral, interpersonal, and environmental factors that may differentially impact men's health over the life course

TRAUMA

Summary of the Evidence on Male Trauma

Trauma is a potent and prevalent catalyst for health disparities in boys and men. The term *trauma* has been applied to many contexts with different definitions, sometimes used to describe negative events that produce significant psychological distress or to describe distress itself. According to the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*; American Psychiatric Association, 2013), trauma refers to the threat, exposure, or direct witnessing of death, injury, and/or sexual violence. Posttraumatic stress disorder (PTSD) is considered present when individuals have been exposed to actual or threatened death, serious injury, or sexual violence (American Psychiatric Association, 2013), resulting in a constellation of symptoms (i.e., hypervigilance, reexperiencing, hyperarousal, intrusive memories, avoidance, and negative mood changes).

Nationally representative studies estimate lifetime trauma exposure rates of up to 90% in the general population (Breslau, 2002; Breslau et al., 1998; Gillespie et al., 2009; Kilpatrick et al., 2013). Rates of exposure to traumatic events vary across subgroups of men according to their race (Brewin, Andrews, & Valentine, 2000; Roberts, Gilman, Breslau, Breslau, & Koenen, 2011) and other sociodemographic characteristics (Breslau et al., 1998). Based on the 2011/2012 National Survey of Children's Health, nearly 50% of U.S. children 17 years and younger have experienced one or more types of trauma (U.S. Department of Health and Human Services [DHHS], 2014).

Data consistently show that men experience more traumatic events than women even though fewer men meet *DSM-5* criteria for PTSD (Tolin & Foa, 2006). Most recent lifetime prevalence estimates indicate that 5.7% of men compared with 12.8% of women have PTSD (Kilpatrick, 2013). This finding might suggest that men are at reduced risk for PTSD. However, it is also likely that fewer men disclose or seek help for symptoms in the aftermath of trauma. It is clear that events do not need to satisfy current *DSM-5* criteria for PTSD to be considered traumatic

(Maier, 2007). For instance, there is a large body of research positing that divorce, parentification (i.e., the expectation that children will fulfill a caregiving role), and parental loss may be considered traumatic and have lasting consequences across different developmental stages (Markese, 2011). Boys and men have varying thresholds for adverse events. Consequently, a better determinant of trauma following adverse events is whether they overwhelm the psychological, familial, or social resources that boys and men have.

Trauma researchers routinely focus on understanding the social, psychological, and behavioral impacts of traumatic events on the health and well-being of girls and women across the life course, and with perhaps the exception of combat-related trauma, have largely examined males as perpetrators of trauma-inducing acts. In this section we focus specifically on evidence that sheds light on the ways in which traumatic events or experiences influence the health and well-being of vulnerable boys and men across the life course. Our core assumption is that male trauma is mutually constituted of biobehavioral, interpersonal, and environmental factors that may differentially impact men's health over the life course. These factors form the ecological contexts in which trauma occurs and collectively impact how males perceive, respond to, and seek help for trauma.

Boys and men can display a wide range of psychological, cognitive, and behavioral responses to trauma. PTSD—one of the most commonly described psychological responses to traumatic events—has been linked to increased risk of medical conditions affecting cardiovascular, gastrointestinal, and musculoskeletal systems (Pietrzak, Goldstein, Southwick, & Grant, 2012; Scott et al., 2013) and to neurobiological abnormalities (Sherin & Nemeroff, 2011). Trauma exposure can also result in seemingly unrelated behavioral changes, such as difficulty concentrating, hyperactivity, aggression, relationship dysfunction, and social withdrawal.

Types of Trauma Exposures Among Males

There is significant variation in the types of trauma individuals experience. Here we provide brief overviews of major types of trauma impacting vulnerable boys and men.

INTERPERSONAL VIOLENCE-RELATED TRAUMA

Interpersonal violence (IPV) includes "physical violence, sexual violence, stalking and psychological aggression (including coercive acts) by a current or former intimate partner" (Breiding, Basile, Smith, Black, & Mahendra, 2015). Trauma stemming from IPV exposure is an important, albeit a scarcely attended to, contributor to male health disparities. The topic of males as potential perpetrators as well as victims of interpersonal violence is covered in other sections of this report. Here, we call attention to the potential for male victims to experience IPV trauma. We view IPV as a source of significant stress among males that requires continuous psychological adaptation. Accordingly, coping processes play a critical role in shaping IPV-related outcomes, including the development of PTSD or symptoms. The scientific evidence-base addressing male IPV-related trauma is notably thin. Consequently, less is known about the potential health consequences of this trauma exposure. Recent estimates indicate that roughly 47% of males report IPV victimization (Kilpatrick et al., 2013).

According to additional national data sources, approximately 60% of males who report experiencing IPV also report clinically significant posttraumatic stress symptoms (Douglas & Hines, 2011). However, this number likely underestimates IPV trauma, since males may be less likely to disclose posttraumatic symptomatology to others (Purves & Erwin, 2004). Linkages have also been found between IPV and chronic disease in both women and men (Coker et al., 2002).

Males, particularly vulnerable males, suffer from a disproportionate amount of chronic disease. In a systematic review of the literature on partner abuse in ethnic minority and LGBT populations, West (2012) found that sexual and gender minority groups reported higher rates of IPV than heterosexuals. Stults, Javandi, Greenbaum, Kapadia, and Halkitis (2015, 2016) reported a high correlation between perpetration and victimization and a high level of association of IPV with condomless sex and drug use in sexual minority men; fewer gender differences in rates of physical and psychological aggression among African American, Hispanic, Asian, and Native American men and women; and varying IPV risk factors across race and gender, with environmental factors a key determinant.

SEXUAL ASSAULT–RELATED TRAUMA

According to the National Intimate Partner and Sexual Violence Survey (Breiding et al., 2014; CDC, 2014), racial/ethnic minority men experience more sexual violence during their lifetimes than do White men. For example, 1.7% of White men experienced rape, compared with 31.6% of multiracial non-Hispanic men and 26.6% of Hispanic men. Sexual and gender minority men are more likely to experience sexual violence victimization (e.g., childhood sexual abuse, sexual assault related to hate crimes, intimate partner sexual assault) than heterosexual men, with an estimated prevalence rate of 11.8–54.0%, respectively (Rothman, Exner, & Baughman, 2011). Such violence contributes significantly to a range of trauma-related health outcomes.

COMBAT-RELATED TRAUMA

Combat veterans present PTSD rates two to four times higher than those of civilians. While the PTSD rate among civilians is 5–6%, veterans of Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) have point prevalence rates of 2–17% and lifetime prevalence rates of 6–31% (Richardson, Frueh, & Acierno, 2010). In one study, Latinos were found to report more combat-related PTSD (Ruef, Litz, & Schlenger, 2000). Research on race/ethnicity differences in the experience of PTSD among veterans, however, is complex, with studies reporting no differences in overall severity but some differences in specific symptomatology (Monnier, Elhai, Frueh, Sauvageot, & Magruder, 2002). Males are still disproportionately represented among active military and combat veterans (Office of the Under Secretary of Defense, 2014). Further, some evidence from subsets of the military population suggests higher PTSD rates among male OEF/OIF veterans (Haskell et al., 2010).

HISTORICAL TRAUMA

Historical trauma is a "macro-level temporal framework for examining how the life-course of a population exposed to trauma at a particular point in time compares with that of unexposed populations" (Sotero, 2006). There are three phases of historical trauma: (a) the intentional perpetuation of mass trauma by a dominant population on a target population that results in cultural, social, and economic devastation; (b) the biological, societal, and psychological response to the trauma; and (c) the transmission of the responses to successive generations through environmental and psychological factors (Brown-Rice, 2013).

Historical trauma has been most frequently proffered to explain the experiences of American Indians who, as a result of deliberate actions perpetrated against the group (e.g., forced relocation, broken treaties), have low income, high poverty, high morbidity and mortality, and low educational attainment (Brown-Rice, 2013). Taking Native American children from their families and sending

> **Trauma stemming from interpersonal violence exposure is an important contributor to male health disparities**

Research affirms that trauma among boys and men can be compounded across the life course in ways that complicate and compromise normative development

them to residential schools to "kill the Indian and save the man" is one example of the extent to which their families and culture were subjugated and devalued (Gone, 2013). Posttraumatic slavery syndrome, a form of historical trauma, posits that the Middle Passage, slavery, and racism created a collective trauma that has impacted the health of African Americans (DeGruy, 2005).

RACE-BASED TRAUMA
Mere exposure to racist events/incidents does not mean that individuals experience them as traumatizing. In general, race-based trauma refers to exposures to racism that elicit profound emotional stress, fear, or physical harm (Bryant-Davis, 2007; Bryant-Davis & Ocampo, 2005). Such trauma often involves vicarious exposures or witnessing the endangerment of significant others or members of one's racial or cultural group(s).

How Trauma Varies Across the Male Life Course

Examining trauma among boys and men requires a multilevel, life-course developmental and transdisciplinary approach. Trauma exposures in childhood, particularly those characterized as adverse childhood experiences, have been linked to a range of poor health outcomes later in adulthood. For example, a strong relationship has been found between childhood sexual trauma and mental health and health behaviors in adulthood (Molnar, Buka, & Kessler, 2001; Schoedl et al., 2010). Among boys exposed to trauma during childhood, it is estimated that between 1% and 6% will develop PTSD. Developmental transitions are particularly sensitive periods for trauma exposure. Trauma during periods in which identity development and consolidation are occurring and capacity to self-regulate are being crystallized may have enduring health

Black boys are often perceived as older and less innocent than non-Hispanic White males, which places them at greater risk for racial profiling by police officers

impacts. For example, Cook (2013) found that multiple forms of trauma in childhood were associated with depression during emerging adulthood. Taken together, research findings affirm that trauma among boys and men can be compounded across the life course in ways that complicate and compromise normative development.
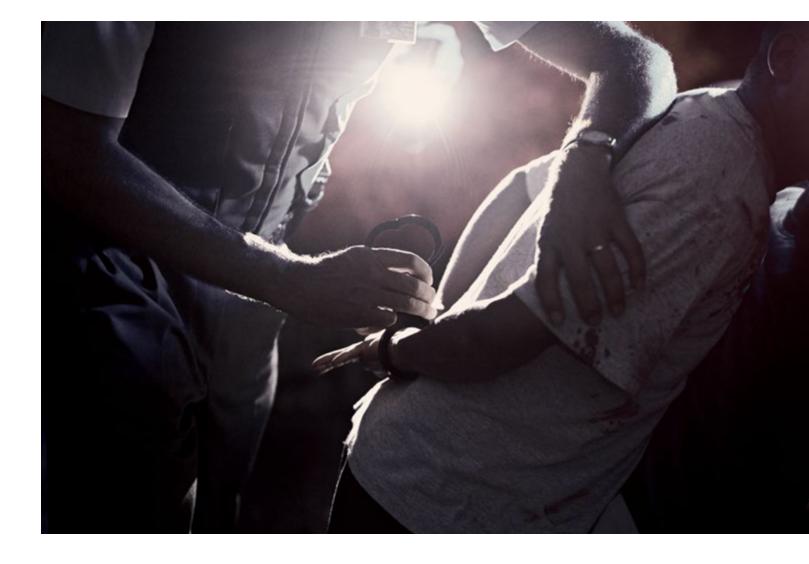
How Masculinities Influence Trauma Exposure and Response

Trauma among boys and men is a silent epidemic fueled by traditional masculine gender role norms (i.e., social constructionist perspectives about toughness and emotional control). Traditional notions of masculinity encourage restrictive affectionate behavior, aggressiveness, and identity assertion through risk-taking behaviors (Courtenay, 2000a, 2000b). Masculinity prescribes emotion suppression or masking distress, and boys learn to suppress or hide their feelings very early in life (from as young as 3–5 years of age). Males are more likely than females to use emotion suppression to regulate negative (and in some cases positive) emotions. Although emotion suppression is not always problematic and may decrease emotional distress in the short term, this style of affect regulation has been associated with less willingness to seek help (Hoge et al., 2004), more aggressive behavior, higher levels of PTSD symptomatology (Tull, Jakupcak, Paulson, & Gratz, 2007), and increased heart rate (Campbell-Sills, Barlow, Brown, & Hofmann, 2006; Feldner, Zvolensky, Stickle, Bonn-Miller, & Leen-Feldner, 2006). The admission of being emotion-

ally affected by an event may represent a threat to masculinities.

Trauma can coincidentally induce shame and a sense of powerlessness, which contradict societal expectations that boys and men display unabated physical strength and invincibility. The societal value placed on men's ability to demonstrate self-reliance can make seeking help feel like a sign of weakness. In fact, delayed help-seeking among boys and men might best be viewed or understood as a byproduct of masculine gender socialization or as a way to restore a sense of control (Addis & Mahalik, 2003).

Since beliefs about masculinities vary by race and ethnicity, we might also observe similar differences in the ways they impact male trauma response. For example, some African American boys and men might respond to trauma with the kind of masculinity-informed, high-effort coping that is characteristic of what psychologists refer to as John Henryism (S. A. James, 1994; see definition of this term in Glossary). This coping style or disposition can often provide acute symptom relief. However, long-term deployment of John Henryism in response to trauma may not be as health advantageous, since it hinges on displaying emotional stoicism. Also, data suggest that the health impacts of John Henryism vary among African American men by SES.

For example, John Henryism has been associated with hypertension and negative health outcomes in lower class African American men (Bennett et al., 2004) and better physical health in high-SES African American men (Bonham, Sellers, & Neighbors, 2004). These mixed results suggest that there are costs and benefits to coping with trauma

in this way that warrant consideration. Similarly, high endorsement of machismo ideology (related to restrictive emotional expression and "traditional" notions of masculinity) might make it more difficult for Hispanic/Latino boys and men to disclose trauma, especially if doing so might disrupt their sense of identity as strong fathers or providers. It is important to note that it is possible for machismo ideologies to positively impact trauma response, especially when coupled with high endorsement of caballerismo (positive Latino ideology), which has been related to positive coping, such as use of humor, positive reframing, and planning (Ojeda & Liang, 2014).

Moreover, conceptions of masculinity and their potential impact on the health of sexual and gender minority males require much more attention. The impact of hegemonic conceptions of masculinity must be considered historically and in light of sociopolitical contexts across generations that have affected these men and their health, including during the height of the AIDS crisis (Connell, 1992; Halkitis, 2001, 2016; Hamilton & Mahalik, 2009). Whether and how masculinities affect the response to trauma might also be determined by the type, chronicity, and severity of the exposure to trauma. More stigmatizing and shame-inducing traumatic events such as those resulting from sexual assault, chronic stigmatization, or race-related stress exposures uniquely threaten masculinity (Hammond et al., 2016). Homophobic preoccupations, such as the perception of being perceived as homosexual, and male rape myths, such as the belief that "tough" men cannot be sexually assaulted, are additional issues that serve as barriers to care among sexually assaulted males (Turchik et al., 2013).

Trauma Among Racial/Ethnic Minority Males

Racial/ethnic minority males face wide-ranging exposure to trauma. Evidence suggests that African American males in civilian and veteran populations have the highest lifetime prevalence of

Resilient male survivors of child sexual abuse renegotiate traditional masculinity norms in ways that create alternatives to violence and allow them to establish healthier intimate relationships

PTSD (Alegria et al., 2013; Koo, Hebenstreit, Madden, & Maguen, 2016; Roberts et al., 2011). Compared to Whites, African American men are also at an increased risk of experiencing interpersonal violence (McGruder-Johnson, Davidson, Gleaves, Stock, & Finch, 2000) and more severe types of trauma (Ai et al., 2011). African American and Hispanic/Latino males are disproportionately exposed to trauma induced by community violence. Historical trauma is also more common in this group, especially among American Indian/Alaska Native boys and men. For example, Lakota men with boarding school experiences report more life-course and historical trauma (Brave Heart, 1999). Given the traditional masculine role expectancies to protect and provide for their families, historical trauma may be an even more potent catalyst of high emotional distress, depression, and ineffective behavioral coping such as substance abuse, violence, and suicide in males.

The rash of recent police-related killings of African American males has ignited new interest in public health impacts of race-based trauma. Emerging evidence suggests that African American men and boys have the highest likelihood of being killed by police. The viral circulation of videos capturing these tragic killings increases opportunities for vicarious exposure to trauma. Emerging perspectives suggest that symptoms akin to those presented in cases of PTSD can appear among witnesses of these killings. Black boys are often perceived as older and less innocent than non-His-

panic White males, which places them at perhaps greater risk for racial profiling by police officers. Also, Black and Hispanic/Latino boys are seen as more culpable, which increases the likelihood they are viewed as crime suspects (Goff, Jackson, Di Leone, Culotta, & DiTomasso, 2014).

Trauma Among Sexual and Gender Minority Males

Trauma among sexual minority males has received less empiric attention, and for gender minority males, this area of research is only beginning to emerge. However, mounting evidence suggests that this group disproportionately experiences adverse events typically associated with increased trauma in both sexual minority and gender minority (Mizock & Lewis, 2008), including gender nonconforming, males (Wyss, 2004). Microaggressions toward both sexual and gender minority males have been linked to trauma (Nadal, 2013) and may be heightened for those who are also migrants (Alessi, Kahn, & Chatterji, 2016). Data suggest that sexual and gender minority youth are at increased risk of experiencing physical dating violence, compared with minorities who are not sexual minorities (Luo, Stone, & Tharp, 2014). Sexual minorities also report higher rates of sexual coercion (Breiding et al., 2014). Approximately 32.3% of gay men, 21.1% of bisexual men, and 10.8% of heterosexual men reported unwanted sexual contact during their lifetime.

Trauma exposure among sexual and gender minority males may also increase risky sexual practices (e.g., inconsistent condom use, concurrent sexual partnerships), which compound risk for HIV/AIDS and other STIs. Sexual minorities had a higher risk of PTSD onset and were more likely to have experienced childhood maltreatment, interpersonal violence, and the unexpected death of someone close (Roberts, Austin, Corliss, Vandermorris, & Koenen, 2010). The 2016 massacre in Orlando, FL, on Latinx night at the Pulse nightclub that killed 49 people, most of whom were Latino and Black men, suggests that the risk for direct exposure to trauma inflicted on sexual minority males warrants consideration (Acosta, 2016) and the need for ongoing vigilance to ensure the safety of gay and bisexual men in their social contexts (Stults, Kupprat, Krause, Kapadia, & Halkitis, 2017).

Relationships Between Stress and Trauma

As noted in previous sections, stressful life events are associated with a wide range of psychiatric and physical health outcomes and traumatic events. Men of low SES and racial/ethnic minority groups are more likely to experience traumatic, life-threatening events (Hatch & Dohrenwend, 2007). Racial/ethnic boys and men and sexual minority males routinely encounter both chronic and acute stressors that can escalate to trauma. As we have highlighted earlier, racial/ethnic males are at higher risk of being victims of violence and affected by historical trauma. Sexual minority males who adopt traditional constructions of masculinity are more likely to engage in risky health and sexual behaviors (Hamilton & Mahalik, 2009). Understanding the triggers and mechanisms that determine the progression of stress to trauma in vulnerable boys and men across the life course is critical to prevention and treatment interventions.

Trauma Resilience

Even as vulnerable boys and men are negatively impacted by trauma, they also have the capacity to exhibit resilience and growth in the face of trauma. There are relatively few empirical studies focusing specifically on trauma and resilience in vulnerable boys and men. However, there are notable findings in the existing evidence base. For example, resilient racial/ethnic minority and sexual and gender minority male survivors of child sexual abuse renegotiate traditional masculinity norms in ways that create alternatives to violence and allow them to establish healthier intimate relationships (Kia-Keating, Grossman, Sorsoli, & Epstein, 2005). Studies among African American college students suggest that race-based trauma may be offset by racial socialization messages, which provide explicit and implicit perspectives about one's culture and strategies for encountering bias (Brown &

Tylka, 2011). Similar findings exist for racial/ethnic minority transgender individuals who are exposed to traumatic events (Singh & McKleroy, 2011).

Posttraumatic growth (PTG), or the positive changes and benefits stemming from trauma exposure (Calhoun & Tedeschi, 2014; Tedeschi, Park, & Calhoun, 1998), is also a possible way that resilience manifests among vulnerable boys and men. When PTG occurs, vulnerable boys and men can experience changes in their self-perception, philosophy of life, and interpersonal life that can alter the trajectory of health-related risk taking (e.g., increased substance abuse/misuse and violence engagement) that can ensue after exposure to trauma. Relatively few studies have explored PTG in vulnerable boys and men. However, extant research on boys and men suggests that males exhibit more resilience than females following traumatic exposure, and such resilience has demonstrable impacts on mental health (Bonanno & Diminich, 2013).

Summary

The traumas that vulnerable boys and men face are complex and reflect exposures presented in their families, schools, and broader social environments. Traumas among vulnerable boys and men are often the consequence of marginalization, discrimination, and race-related events. Masculinities play an important but varied role in how vulnerable boys and men cope with and respond to trauma. Stress is a critical factor in trauma onset and can set the stage for the adoption of behavioral coping strategies that can place the health of vulnerable boys and men at greater peril.

Males tend to have higher rates of substance use than females and therefore suffer greater consequences

SUBSTANCE USE/ABUSE

Summary of the Evidence on Male Substance Use/Abuse

Substance use—the consumption of alcohol, tobacco, marijuana, and other illicit drugs—is a major public health problem in the United States associated with significant and expensive consequences to health, well-being, and productivity (Healthy People 2020; U.S. DHHS, 2018). Substance use is directly or indirectly associated with the top seven causes of death in the U.S. (CDC, 2014), which include heart disease, cancer, unintentional injuries, COPD, strokes, diabetes, and suicide. Moreover, addiction has direct or indirect links with the three leading causes of death for males under 25: unintentional injuries, homicide, and suicide (CDC, 2014).

Researchers have found that U.S. males tend to have higher rates of substance use than females and therefore disproportionately greater consequences of substance abuse (CDC, 2014; Compton, Thomas, Stinson, & Grant, 2007; Kessler, Chiu, Demler, & Walters, 2005). Males are more likely to smoke than females (CDC, 2016a), and adult males are three times as likely to drink and drive as women, with young adult, Native American, and White males at particular risk (Chou et al., 2006). Males under 25 years of age are at particular risk for substance use problems (Substance Abuse and Mental Health Services Administration [SAMHSA], 2012).

Co-occurring substance use and severe mental disorders place boys and men at risk for poor health and well-being. For example, untreated impulse control and attention disorders create stressors for boys such as poor school performance (e.g., Borland & Heckman, 1976). Among male adolescents, these disorders have been linked to violence (Dalteg & Levander, 2017; Krakowski, 2003; Nagin & Tremblay, 1999) and, if untreated, may lead to work instability and financial insecurity (Matza, Paramore, & Prasad, 2005). Abuse of stimulants may mask the manifestation of attention deficit disorders, and elevated use of these substances has been noted among males who are untreated for these conditions (Halkitis, 2009).

In the *DSM-5* (American Psychiatric Association, 2013), substance abuse is diagnosed if use has contributed to aversive behavioral, cognitive, and physiological consequences that impair level of function and disturb quality of life. A recent change in the *DSM* diagnostic criteria accounts for greater heterogeneity in the presentation of substance abuse, with less focus on physical dependence. However, the new *DSM* criteria continue to highlight individual-level variables and not to account for important group differences in the presentation of substance abuse (including gender, age, race, ethnicity, and sexual orientation) or important life-course or social ecological considerations. We address these factors in the next section.

How Substance Use/Abuse Varies Across the Male Life Course

Substance use patterns often vary as a function of accessibility to particular substances during age-related developmental stages (e.g., Jones-Webb et al., 1997). Young males are influenced by peer behavior with regard to substance use. Researchers have found that young males engaging in social comparisons tend to overestimate the substance use of peers and underestimate their own substance use (Lewis & Neighbors, 2004). This particular style of social comparison tends to perpetuate substance abuse, since young males generally conclude their substance use occurs less and is less risky than that of their peer group.

While substance abuse is concerning across the male life course, there are developmental periods when the onset and steep escalation of substance abuse are most likely. For example, a particularly vulnerable period for the development of substance abuse is when adolescent males enter early adulthood, between the ages of 18 and 29 (Arnett, 2000, 2005). During this time, adolescents may move away from home, experiment, and develop personal identities, including masculinities, a process

that may be more threatening for some young men to navigate, including sexual and gender minority men.

Moreover, this period continues to be associated with plasticity in neuronal structures, creating the possibility of lifelong neural and cognitive deficits if substances are abused during this developmental period. Novelty seeking is important for brain maturation in humans (Chambers, Taylor, & Potenza, 2003), contributing to risk-taking and sensation-seeking behavior, which are heightened during emerging adulthood and have been linked to substance abuse in males (Halkitis et al., 2014; MacPherson, Magidson, Reynolds, Kahler, & Lejuez, 2010) and condomless sexual behavior during this time (Halkitis et al., 2015). Alcohol and tobacco advertising targeted to emerging adult men increases likelihood of substance use initiation. Lax enforcement of drinking laws, state sanctioned alcohol use at age 21, and immersion in fraternities, clubs, and bars create vulnerabilities for emerging adult men with regard to the use and potential abuse of alcohol and other substances, including tobacco.

Emerging adult males are significantly more likely to abuse steroids than females (Bahrke & Yesalis, 2014), and sexual minority adolescent males are significantly more likely to abuse steroids than non-sexual-minority adolescent males (Blashill & Safren, 2014). Steroids are instrumental in physique and strength building and in illusions of increasing personal power, which appeal to males for whom hypermasculinity is an important value (Halkitis, Moeller, & DeRaleau, 2008; Kanayama, Barry, Hudson, & Pope, 2006). The emergence of masculine identities may be complicated by steroid use and abuse, believed to enhance masculinity, appearance, and strength. This circumstance is further complicated by high-profile allegations of steroid abuse among prominent athletes.

As men enter middle age, changes in metabolism, immune response, and sexual performance, among others, create stressors that impact physical, emotional, and social well-being (Lakka et al., 2002). This developmental period is also one of great vulnerability to substance abuse because of increased reliance on psychoactive medications for health conditions, as well as the lack of attention within the medical establishment to substance abuse among older adult populations. Health challenges may be heightened in sexual minority men, are highly interrelated, and may be directed by social, environmental, and psychosocial factors (Halkitis et al., 2013).

Adults over age 65 and males, in particular, are at risk for alcohol abuse (Moos, Schutte, Brennan, & Moos, 2009). For this particular age group, addictions are directly or indirectly associated with most of the 10 leading causes of death (CDC, 2014). Alcohol abuse is problematic, but the greater availability of prescribed medication by health care providers to older men may also lead to high rates of abuse. This may be particularly true for psychotropic and analgesic substances that may be overprescribed to older men for symptoms of aging, including the evolution of chronic pain (Craft, Mogil, & Aloisi, 2004; Roe, McNamara, & Motheral, 2002).

How Masculinities Influence Substance Use/Abuse

Masculinities have powerful influences on substance use behavior in boys and men (Blazina & Watkins, 1996). Masculinities may exert their most powerful influence over substance abuse among boys and men when discrepancies exist between who they are and who they believe society expects them to be. Although data are mixed, there is general agreement that these kinds of discrepancies can create internal conflicts and strains, setting the stage for reliance on substances to cope. Heightened alcohol and drug use is directed by male gender stress, and for some, this stress derives from socialization to the expectations of male roles. These substance use phenomena may be heightened by conformity to the male role among heterosexual racial and ethnic minority groups such as Asian and Pacific Islanders (Liu & Iwamoto, 2007). For sexual minority men, the greater rate of substance use is influenced by the socially produced hypermasculine conceptions espoused by some sexual minority men (Halkitis, Moeller, & DeRaleau, 2008; Hall, Logan, et al., 2008) and have been associated with the impact of the AIDS epidemic on male body conception in gay men (Halkitis, Zade, Shrem, & Marmor, 2004).

Substance Use/Abuse Among Racial/Ethnic Minority Males

Manifestation of substance use and abuse is not monolithic but rather presents in nuanced ways among subgroups of the population. Groups may differ in age of first drug use, progression to problem use, patterns of use, and drug preferences. For example, data suggest that African American youth are late-onset users of substances. One explanation offered for this later age of initiation is the presence of family and cultural protective factors such as high religiosity and authoritarian parenting (Gibbons, Pomery, & Gerrard, 2010). Risk factors—ranging

Masculinities may exert their most powerful influence over substance abuse among boys and men when discrepancies exist between who they are and who they believe society expects them to be

from family history and dynamics to societal and community variables such as unemployment and homelessness—can also differ by group.

Homelessness is a serious concern regarding boys and men of color; recent government estimates suggest that over 70% are male. African Americans and Native Americans experience homelessness more than twice as frequently as would be expected—and Pacific Islanders approximately six times as frequently—given the current proportion of the U.S. population by race (Henry, Watt, Rosenthal, & Shivji, 2016).

Racial/ethnic groups differ in the extent to which they use substances and in the impact of those substances on their health. Smoking is the leading cause of preventable illness and death. American Indians have the highest rate of tobacco use (40.1%), followed by persons of mixed race (31.2%), Whites (27.7%), Blacks (27.1%), Hispanics (18.8%), and Asians (10.1%) (SAMHSA, 2014). American Indians also have the highest rate of nicotine dependence (SAMHSA, 2014). African Americans are at the greatest risk of tobacco-related diseases and deaths (American Cancer Society, 2013), including those who do not smoke because of the high number of African Americans (71% or more) exposed to secondhand smoke (Giovino, Garett, & Gardiner, 2016). Exposure to secondhand smoke may be higher for males given their higher rates of smoking and the increased likelihood that smoking occurs at venues and settings where males gather.

Estimates of current alcohol use among males by race/ethnicity show that drinkers are more likely to be White (74.27%), followed by Hispanics (69.99%), Native Americans (65.48%), African Americans (62.62%), and Asians (61.51%). Daily heavy alcohol users, however, are more likely to be Hispanics (40.48%), Whites (30.74%), Native Americans (29.34%), African American (25.81%), and Asians (18.84%) (SAMHSA, 2014). Latinos were found to have a 21.5% incidence of binge alcohol use (five or more standard drinks) in the last month, significantly higher rates than either White or African American men.

Both Latinos (6.7%) and African American males (5.2%) had higher rates of current alcohol dependence than White males (3.5%). Latinos binged on alcohol at rates approximately six times that of Latinas and were four times more likely than Latinas to meet criteria for current alcohol dependence. African American males were almost four times as likely as African American females to have binged on alcohol and over three times more likely than African American females to meet criteria for alcohol dependence (Witbrodt, Mulia, Zemore, & Kerr, 2014; Zemore, Karriker-Jaffe, Keithly, & Mulia, 2011). In an earlier study, Native American men reported binge rates of 23.9% in the past month and were nearly three times more likely

than Native women to binge on alcohol (Denny, Holtzman, & Cobb, 2003).

The most commonly used illicit drug is marijuana (19.8%) followed by psychotherapeutics (6.5%), cocaine (1.5%), hallucinogens (1.3%), inhalants (0.5%), and heroin (0.3%). In 2013, the rate of current illicit drug use was 3.1% among Asians, 8.8% among Hispanics, 9.5% among Whites, 10.5% among African Americans, 12.3% among American Indians or Alaska Natives, 14.0% among Native Hawaiians or Other Pacific Islanders, and 17.4% among persons reporting two or more races (SAMHSA, 2014).

In comparison to Whites, racial/ethnic minority groups experience greater disparities in medical and social problems as a result of their substance use, even when their rates of use are lower than those of Whites. The medical and social consequences of alcohol consumption by racial/ethnic males include higher rates of liver disease in Hispanics and African Americans, higher rates of esophageal cancer and pancreatic disease in Black men, and higher rates of intimate partner violence (IPV) in all groups. Native Americans are at particular risk for alcohol-related trauma, including suicides and alcohol-related motor vehicle accidents. Moreover, nearly 12% of all Native American deaths are attributable to alcohol (Chartier & Caetano, 2010). There is still much to be learned about the effects of alcohol use and stress on various groups over the life course (Keyes, Hatzenbuehler, & Hasin, 2011).

African American, Latino, and Native American male youth have documented disparities in substance abuse treatment (Alegria, Carson, Goncalves, & Keefe, 2011). Racial/ethnic minority males also have higher rates than females of violence, incarceration, and suicide due to the consequences of substance misuse (Cottler, Campbell, Krishna, Cunningham-Williams, & Ben Abdallah, 2005; Greenfield et al., 1998; National Center on Addiction and Substance Abuse, 2010). African Americans are six times more likely than Whites to be imprisoned most often for drug-related charges, although they use drugs at similar rates. Moreover, African Amer-

ican and Latinos constituted over 56% of the prison population in 2015 even though they accounted for only 32% of the U.S. population (NAACP, 2016).

These disparities in incarceration rates are likely related to racial profiling, institutionalized bias in the criminal justice system, and unfair sentencing guidelines for substances such as crack cocaine or due to three-strikes laws (Barnes & Kingsnorth, 1996; Burt, Simons, & Gibbons, 2012; Hattery & Smith, 2007; Iguchi, Bell, Ramchand, & Fain, 2005; Kakade et al., 2012; Provine, 2007). These disparities are not limited to imprisonment (Pettit & Western, 2004) but also include HIV acquisition (Halkitis et al., 2011); overdose (Bird & Hutchinson, 2003); and social, emotional, and physical deterioration (Halkitis, 2009).

Substance Use/Abuse Among Sexual Minority Males

Gay and bisexual men are more likely to engage in substance use and abuse than their heterosexual peers (Kelly, Davis, & Schlesinger, 2015), a situation complicated by the high prevalence of HIV and other STIs in sexual minority men (Halkitis et al., 2011). Smoking rates are high among sexual minority individuals; one report found that nearly a third (32.8%) smoke (U.S. DHHS, 2008) and another that sexual minority individuals are one-and-a-half to two times more likely to smoke than heterosexuals (J. G. L. Lee et al., 2009). In addition to the usual health outcomes associated with tobacco use, smoking carries increased risk when health is compromised by HIV (Crothers et al., 2009). In comparison to the general population, gay and bisexual men, lesbian, and transgender individuals are more likely to use alcohol and drugs, have higher rates of substance abuse, not withhold from alcohol and drug use, and continue heavy drinking into later life (CDC, 2016a, 2016b).

Even before the emergence of the AIDS epidemic in 1981, gay and bisexual men were at high risk for the abuse of alcohol and other drugs (Halkitis et al., 2011). However, the intimate link between non-

Disparities in incarceration rates are likely related to racial profiling, institutionalized bias in the criminal justice system, and unfair sentencing guidelines

injection substance use and the potential transmission of HIV through unprotected sex has garnered much attention in the past three decades (Halkitis et al., 2011). For gay and bisexual men, the synergies that exist between substance abuse and HIV are representative of the diminished health outcomes for these men and, more important, the multiple epidemics (referred to as a syndemic) that coexist within this population. The coexistence of substance abuse, HIV risk, violence, and mental health stressors in the population is well-documented, compromising the health of these men (Halkitis, 2010; Halkitis, Wolitski, & Millet, 2013). For example, substance abuse has also been linked to high suicide rates among gay and bisexual males (King et al., 2008).

The abuse of substances by gay and bisexual men is also affected by the contexts of socialization for members of this population, as substance use is an expectation of engagement in some circles, such as circuit parties (Greene & Halkitis, 2006; Halkitis, Greene, & Mourgues, 2005). Such environments facilitate the use and abuse of numerous types of substances, but in particular, club or party drugs such as ketamine, methamphetamine, and GHB, among others—substances also associated with high sexual risk-taking within the population (Halki-

tis & Parsons, 2002). The sexualized environments of circuit parties (e.g., bathhouses, bars, and the like) incubate the abuse of substances and fuel the drug–sex link. For emerging and young adult gay men who are coming of age, immersion in such environments may engender substance abuse and other risks, including the risk of unprotected sex.

Substance Abuse Among Rural Boys and Men

Opioid abuse among boys and men in rural America has become of significant concern over the past decade, resulting in spikes of opium-related overdoses (Hall et al., 2008; Levy et al., 2016; Meiman, Tomasallo, & Paulozzi, 2015). The typical demographic profile of people at risk in rural America includes White middle-aged men of low income who may have comorbid mental health concerns (Paulozzi, 2012). However, Native Americans in rural America have also experienced significant increases in drug overdoses, including opioids (CDC, 2017; T. Murphy et al., 2014; Shiels et al., 2017). Although there has been increased attention to these disturbing trends in rural America, much more needs to be done to address the problems.

How Stress Influences Substance Abuse

Substance abuse as a psychological and behavioral phenomenon does not exist in isolation. For males, a variety of psychosocial stressors occur in tandem with substance use, functioning as antecedents/facilitators and outcomes/consequences of substance abuse. To fully address substance abuse among vulnerable males, we must consider the psychosocial stressors that coexist with the use and abuse of substances and develop holistic interventions that fully address the intersectionality of substance abuse and stress faced by males.

Elevated rates of substance abuse among racial/ethnic and sexual minority males require that we attend to the man-

ifestations of substance use in these groups and acknowledge the particular stress-related challenges they face—challenges that may be heightened in light of intersectional identities (e.g., ethnic sexual minority males). Abuse of substances by males may serve as a means for self-medicating negative psychological states that accompany stress exposure, although the body of research suggests that self-medication activities often exacerbate rather than ameliorate symptoms (Blume, Schmaling, & Marlatt, 2000). For sexual minority males, intersectionality must also include the role of gender identity as it relates to sexual orientation and race (L. R. Warner & Shields, 2013), as well as how intersectional identities explain the preponderance of HIV infection among young Black sexual minority men (Halkitis et al., 2013).

A number of stress-related exposures may place racial/ethnic minority males at increased risk of substance abuse. Victimization by bullies places youth at increased risk of substance use (Ringwalt & Shamblen, 2012). Discrimination and prejudice are also linked to increased risk of substance abuse among young adults of color (Martin, Tuch, & Roman, 2003; Zemore et al., 2011). Racial/ethnic minority men are often victims of race-related microaggressions that have been linked to binge drinking and other substance abuse (Blume, Lovato, Thyken, & Denny, 2012; Johnson-Jennings, Belcourt, Town, Walls, & Walters, 2014; Skewes & Blume, 2015). For example, Latino binge drinking has been associated with acculturative stress (Vaeth, Caetano, & Rodriguez, 2012).

Stereotypes often depict racial/ethnic minority males unfavorably in the

context of substance use. Stereotyping of minority males places them at risk for experiencing a stereotype threat situation in which group-based negative stereotyped behavior and outcomes are expected. In such circumstances, the individual experiences distress that may hinder performance and contribute to negative outcomes (Steele, 1997). For example, Native American males are often stereotyped by the firewater myth that expects out-of-control drinking, and there is concern that stereotype threats related to the myth may be associated with increased risky alcohol use by male American Indians and Alaska Natives (LaMarr, 2003).

Sexual minority males have been severely oppressed, marginalized, and discriminated against in the United States, including through state-sanctioned policies and laws (Halkitis et al., 2013). Homophobia permeates the culture and is linked to the health disparities in the gay and bisexual population and to negative health outcomes, including but not limited to HIV transmissions, diminished mental health, and substance abuse (Institute of Medicine, 2011). Gay youth and gender nonconforming youth, in particular, are subject to hostile environments in schools that place them at risk for marginalization. Stereotyping and microaggressions are daily occurrences and place sexual minority males at risk for substance abuse (Bontempo & d'Augelli, 2002; DuRant, Krowchuck, & Sinal, 1998; Rivers & D'Augelli, 2001).

Research on the relationship between SES and substance use is equivocal (Patrick, Wightman, Schoeni, & Schulenberg, 2012), although certain economic factors have been linked to substance abuse. Economic stressors are associ-

Homophobia is linked to health disparities in the gay and bisexual population and to … HIV transmissions, diminished mental health, and substance abuse

ated with increased risk of substance abuse (e.g., Henkel, 2011; Richman et al., 2012). Males are generally socialized to associate work and work-related accomplishments with self-esteem, so economic challenges such as underemployment or unemployment tend to negatively impact male self-worth (C. Lee & Owens, 2002).

Unemployment and economic disadvantage have been linked to greater alcohol abuse among males (Berg et al., 2013). Males have higher rates of unemployment than women (U.S. Bureau of Labor Statistics [BLS], 2014), increasing the likelihood they will not have the financial resources necessary for quality treatment. Indeed, males have tended historically to be at the top of the uninsured list in the United States (C. James et al., 2012), and racial/ethnic minority males are more likely to be uninsured across the lifespan (Wilson-Frederic, Wendt, Dorsey, & Gunja, 2014). African American and Hispanic males are more likely to be unemployed and have lower weekly earnings than White and Asian males (U.S. Bureau of Labor Statistics, 2007, 2016). According to the Movement Advancement Project (2015), gay and bisexual men experience a wage penalty and earn less than heterosexual men, and LGBT persons of color are more likely to be unemployed, at high risk of poverty, homeless, and raising children.

Substance Abuse and Misuse Resilience

Many vulnerable boys and men demonstrate resilience in the face of substance abuse risk factors (C. Smith, Lizotte, Thornberry, & Krohn, 1995). A number of studies suggest that family functioning plays a considerable role in promoting resilience (Caldwell, Sellers, Bernat, & Zimmerman, 2004; Marsiglia, Miles, Dustman, & Sills, 2002; C. Smith et al., 1995). For example, research conducted among Native American adolescents suggests that positive family and peer relationships are key to the resilience involved in resisting substance abuse/use (Waller, Okamoto, Miles, & Hurdle,

2003). Similarly, the later onset of drug use observed in African Americans, in comparison to White youth, has been attributed to protective factors related to family and self-regulation (Wills, Gibbons, Gerrard, & Brody, 2000) and to the negative attitudes of African American youths toward drug use as a result of witnessing the consequences of drug involvement in their communities (J. M. Wallace & Muroff, 2002).

Evidence further suggests that racial/ethnic pride may be a source of resilience (Austin, 2004; Castro, Stein, & Bentler, 2009; Elmore & Gaylord-Harden, 2013; S. A. Wallace & Fisher, 2007). Research on resilience to substance abuse and misuse among sexual and gender minority males is relatively nascent. A great deal of the literature on resilience in this vulnerable population focuses on HIV/AIDS and sexual risk-taking. However, there is promising evidence from research conducted in the broader sexual and gender minority population indicating that supportive peer networks promote resilience (Bockting, Miner, Swinburne Romine, Hamilton, & Coleman, 2013). In addition, the broader evidence base on resilience in transgender youth suggests that positive self-esteem, a sense of mastery, and other sources of social support might reduce the risk of substance abuse/misuse (Bariola et al., 2015; Grossman, D'augelli, & Frank, 2011).

Summary

Boys and men are at risk for substantially greater substance use and misuse than girls and women. Substance misuse is linked to a number of other health and mental health problems, intersects with the other disparities discussed in this report in destructive ways, and likely is a significant contributor to lower life expectancies among males in American society. In particular, smoking and binge alcohol use are significant threats to the health and well-being of boys and men. Boys and men are more vulnerable to experiencing substance abuse when they have other severe comorbid mental disorders. Substance abuse among boys and men is greatly influenced by eco-

Positive family and peer relationships are key to the resilience involved in resisting substance abuse/use

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nomic stressors and by unrealistic societal expectations of masculine behavior.

Adolescence and early adulthood are developmentally risky periods for substance abuse among boys and men, although risks remain greater for males throughout the life course. In addition, there is growing concern about increased substance abuse among older men. Racial, ethnic, and sexual minority males are subject to bias, stereotyping, and discrimination that are linked to increased substance use and to difficulties accessing and completing treatment for substance abuse. Racial and ethnic minority males are significantly more likely to be incarcerated because of substance abuse than are White males and are therefore subject to the negative consequences of incarceration, including high rates of relapse and recidivism.

Focusing on the factors that promote resilience among vulnerable boys and men is essential to mounting more effective substance abuse prevention interventions. Sexual minority males experience disproportionately high rates of substance abuse and have few options for specialized care, circumstances that are exacerbated for sexual minority males of color. Addressing the specialized needs of boys and men, with attention to the unique circumstances of those at high risk for difficulties with substance misuse, would substantially improve overall health outcomes and quality of life for males in American society.

Men's depression is often masked by alcohol or drugs or by the socially acceptable habit of working long hours

DEPRESSION

Summary of the Evidence on Male Depression

Depression is a mood disorder characterized by a constellation of disruptive symptoms including persistent sadness, feelings of hopelessness, irritability, loss of interest in activities, appetite changes, decreased energy/fatigue, and thoughts of death or suicide (U.S. DHHS, 2015). Depression varies in its severity and impact on individual functioning. The most recent *DSM-5* divides depression into categories designed to distinguish between symptoms that present nearly every day (depressive disorders) and those that present for shorter intervals (depressive episodes) (American Psychiatric Association, 2013). Roughly 16 million adults in the United States have experienced a major depressive episode (National Institute of Mental Health [NIMH], 2017a).

Depression has been identified as one of the most serious health problems in general populations around the world. In a WHO report, depression was ranked fourth among leading diseases, after respiratory infections, diarrheal disease, and conditions during the perinatal period (Alegria & Canino, 2000). By the year 2020, depression is expected to be the most serious health problem (second only to heart disease) affecting the world population (Saez-Santiago & Bernal, 2003). Major depression can be treated successfully, yet only one in three individuals who suffers from depression seeks treatment for the disorder (U.S. DHHS, 2001).

Depressed individuals tend to be female; to have low levels of education; to be separated, divorced, widowed, or to never have been married; and to be unemployed (Blazer, Kessler, McGonagle, & Swartz, 1994). Findings from the 2005–2008 National Health and Nutrition Examination Survey showed that depression was associated with functional impairments in life (e.g., difficulty at work, difficulty getting along with other people) and that rates of depression were higher in women, non-Hispanic Black persons, and individuals with low SES (Pratt & Brody, 2008). Men and boys typically report symptoms of depression less often—and are diagnosed with depression less often—than

women and girls (Kessler et al., 2003; Rosenfield & Mouzon, 2013; Scholz, Crabb, & Wittert, 2014). For example, in the United States, 8.5% of men reported feeling daily depressive symptoms (Blumberg, Clarke, & Blackwell, 2015). Not only are men less likely to recognize, acknowledge, and seek treatment for depression, but doctors are also less likely to suspect it.

Although men are less likely to suffer from depression than women, researchers estimate that more than six million men in the United States have a depressive disorder—about one third of all adults living with depression in any given year (NIMH, 2018). Estimates of diagnosed depression likely underestimate the burden of depression among males because men are least likely to seek help for depressive symptomatology (Rosenfield & Mouzon, 2013). Affirming the probability that male depression is underestimated are statistics indicating that when compared to females, males have higher rates of suicide completion (Joe, Baser, Breeden, Neighbors, & Jackson, 2006; Pitman, Osborn, King, & Erlangsen, 2014)—an outcome closely linked to depression. This gender paradox in mental health suggests that many more boys and men are suffering in relative silence from depression.

Boys and men may show signs of depression that are different from those typically observed in girls and women. For example, depressed boys and men may display more irritability, aggression, and social withdrawal. Depression typically shows up in men not as feelings of hopelessness and helplessness but as irritability, anger, and discouragement; hence, depression may be more difficult to recognize and diagnose in men than in women (NIMH, 2017b). These depressive symptoms can be misinterpreted as displaced anger, especially when they are displayed by vulnerable boys and men. Not surprisingly, when vulnerable boys and men display such symptoms in schools, the workplace, and social spaces, they also receive more serious social reprimand (e.g., higher numbers of school suspensions and expulsions) (A. A. Ferguson, 2001; Thomas & Smith, 2004; Wingfield, 2010).

Not only are men less likely to recognize, acknowledge, and seek treatment for depression, but doctors are also less likely to suspect it

Male depression also plays a role in other health outcomes that disproportionately affect boys and men. Although depression is associated with an increased risk of coronary heart disease in both men and women, only men suffer a high mortality rate (Ferketich, Schwartzbaum, Frid, & Moeschberger, 2000). Even though women experience depression about twice as often as men (Blehar & Oren, 1997), men's depression is often masked by alcohol or drugs or by the socially acceptable habit of working long hours.

How Depression Varies Across the Male Life Course

The onset, severity, and symptom characteristics of depression vary over the life course and at different ages. For example, according to data from the most recent National Survey on Drug Use and Health, more adults between the ages of 18 and 25 had a major depressive episode in the past year (SAMHSA, 2014). In contrast, major depressive disorders were least common among older adults (those 50 and older). Estimates of depression among children and adolescents indicate that 11.4% of individuals between the ages of 12 and 17 had a major depressive episode in the past year (SAMHSA, 2014).

Vulnerability to depression likely ebbs and flows as boys and men age or transition to different stages of their lives. Boys may be vulnerable to depression because early in the life course they are still acquiring developmental capabilities to detect or successfully manage difficult emotions. In contrast, depression vulner-

ability during late adolescence and early adulthood could result from challenges associated with the new assumption of adult responsibilities and greater isolation within their social networks, especially among men, who report having smaller social networks and fewer close individuals with whom they might share personal information—a potential contributor to lower rates of help-seeking (Möller-Leimkühler, 2002; Pescosolido, 1992).
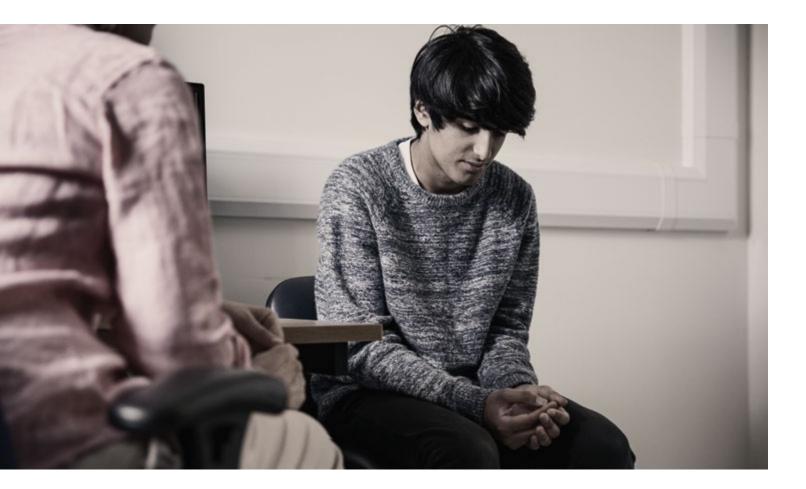
Later life depression may result from challenges stemming from the adjustment to aging. Such life-course variability in depression is especially important to consider when developing programs and policies. Vulnerable boys and men are even less likely to seek help for or report depression, which suggests that they may suffer greater health consequences when experiencing depression. In fact, recent evidence detects an upsurge in suicide among younger (8–11-year-old) Black boys (Bridge et al., 2015). Similarly, data indicate that in 2014, American Indian/Alaska Native males had the highest rates of suicide among all racial/ethnic groups, a rate 60% higher than in 1999 (Curtin, Warner, & Hedegaard, 2016). These findings underscore the pronounced suicide vulnerability among these male populations.

How Stress Influences Depression

Stress is a significant predictor of depression (Miroswsky & Ross, 2003). Although women report higher levels of stress than men (APA, 2011), coping responses are gendered, and vulnerable boys and

men are disproportionately impacted by stress-related health outcomes (e.g., violence/homicide, interactions with law enforcement, education barriers) resulting from more maladaptive coping behaviors. Males generally respond to stress in less healthy ways than women. Some males are more likely to use avoidant coping strategies (e.g., denial, distraction, and increased alcohol consumption) and are less likely to employ healthy coping strategies and to acknowledge they need help (Iwamoto, Liao, & Liu, 2010; Kopp et al., 1998; Magovcevic & Addis, 2008; Maremmani et al., 2015; Weidner & Collins, 1993); they may also deny their physical or emotional distress (Courtenay, 2001). With depression, some males are more likely than females to rely on themselves, withdraw socially, and try to talk themselves out of feeling depressed (Courtenay, 2000, 2011).

There has not been a completely satisfactory explanation for the cause and definition of stress, but researchers have made various attempts at understanding the term. Early scholars have characterized stress or distress as a lack of enthusiasm, problems with sleep (e.g., trouble falling asleep or staying asleep), feeling downhearted or blue, feeling hopeless about the future, and feeling emotional (e.g., crying easily or feeling like crying).

Vulnerable boys and men, in particular, face greater psychosocial stressors (e.g., unemployment, suicide, and violence) than many other groups, placing them at greater risk for stress. Specifically, vulnerable boys and men may encounter numerous daily hassles that can directly or indirectly influence their health (Watkins & Neighbors, 2012). For instance, the transition to adulthood for vulnerable boys and men may be associated with heightened awareness of restricted opportunities and may lead to increased levels of stress in early adulthood and maladaptive patterns of coping (Watkins, Hawkins, & Mitchell, 2015; Watkins & Neighbors, 2012; Williams, 2003). Overall, there has been sparse research on how stress factors influence the mental health of boys and men and even less research has been conducted with vulnerable boys and men.

How Masculinities Influence Depression

Males deny or hide the kinds of symptoms that typically characterize depression largely because they are socialized to do so. Masculinity norms that influence depression are socially constructed, communicated, and reinforced by messages received from parents, teachers, peers, and the media (Addis, 2008; Kilmartin, 2005; Rochlen, Whilde, & Hoyer, 2005). From an early age, boys hear messages that prescribe ways of feeling and behaving that discourage the disclosure of depression. Some of the most common messages include "boys don't cry," "walk it off," and "take it like a man." Such messages are part of masculine role socialization—the process by which boys learn gender norms, rules for relationship engagement, and the consequences of stepping outside of gender role boundaries (Hammond, 2012; Oliffe, Kelly, Bottorff, Johnson, & Wong, 2011).

Some masculinities may exacerbate depression, while others do not. For example, many studies document a relationship between masculinity norms that encourage boys and men to restrict or suppress emotion. Findings related to the role of masculinity norms that encourage autonomy or self-reliance are less consistent, with some research finding that they decrease the likelihood of depression (Oliffe & Phillips, 2008). These findings suggest that the impact of masculinities on depression among boys and men will depend on which aspects are at play. Some researchers suggest that depression among boys and men may be more a consequence of the stress, strains, and conflicts they experience while trying to live up to ideals of masculinity (Rochlen et al., 2005).

Traditional masculine norms are more difficult to adopt when men are confronted with serious chronic health conditions, like depression, that require professional attention. The quest for strength, independence, and self-sufficiency among men, along with their unwillingness to reveal any sense of vulnerability, are not aligned with asking for help (Addis & Mahalik, 2003; Griffith, Gunter, & Watkins, 2012). The dilemma is exacerbated for vulnerable boys and men: How do they confront mental health problems if the traditional masculine norms from which they derive a sense of efficacy, control, and self-esteem also devalue help seeking? Given societal pressures to fulfill gender and cultural norms (Wester, Vogel, Wei, & McLain, 2006), vulnerable boys and men who are reluctant to ask for help when needed may face a resounding challenge.

Studies have described the needs of some subgroups of vulnerable boys and men who experience depression in the context of their masculine identities (Hammond, 2012; Hammond & Mattis, 2005; Watkins & Neighbors, 2012), though more is needed to understand how masculine norms and identities influence

the distressing experience for vulnerable boys and men. Unfortunately, because so many vulnerable boys and men underutilize mental health services (Hammond et al., 2011; Watkins et al., 2015), much work remains to determine how to reach them with the message that it is acceptable and appropriate to discuss their emotional and psychological health with others.

Depression Among Racial/Ethnic Minority Males

Providers have greater trouble detecting depression among racial/ethnic minority patients (Borowsky et al., 2001, Harman et al., 2001; Noël & Whaley, 2012). Most data affirm that racial and ethnic minority males are diagnosed less often with depression than non-Hispanic White males (Blumberg et al., 2015). National studies examining the prevalence and persistence of depression have found that while prevalence rates of lifetime depression were higher among non-Hispanic Whites (17.9%), followed by Caribbean Blacks (12.9%) and African Americans (10.4%), the persistence (or chronicity) of depression (the percentage of those with lifetime depression who also have 12-month depression) was higher for African Americans (56.5%) and Caribbean Blacks (56%) compared to non-Hispanic Whites (38.6%) (Williams et al., 2007). This implies that the long-lasting effects and course of depression may be more severe within and across Black American ethnic groups than they are for Whites. In other words, though Black groups have a lower lifetime prevalence of depression overall, compared to Whites, they have a higher risk of persistence for depression.

Other evidence supports the finding that depression may be more severe for boys and men of color. The most recent national data on mortality in the United States identifies suicide as the sixth leading cause of death for American Indian and Alaska Native males and the eighth leading cause of death for Hispanic and Asian/Pacific Islander Americans (CDC, 2013). For Native American males, suicide accounts for 4.3% of all reported deaths, a higher rate than for any other racial/ethnic group, male or female (CDC, 2013). One particular study examined various demographic predictors (including race, ethnicity, and gender) of suicide rates aggregated by state level data and found that being male and Native American was significantly and positively associated with rates of suicide in various states (Tondo, Albert, & Baldessarini, 2006).

Studies find that African American men define depression based on their personal accounts and what they see on television. Similarly, the origin of their response to depression was mainly described in the context of their families and communities (Bryant-Bedell & Waite, 2010; Head, 2004; Kendrick, Anderson, & Moore, 2007; Watkins & Neighbors, 2007; Watkins, Walker, & Griffith, 2010). Studies further suggest African American

men use prescribed terminology adopted from the media and rely on signs and symptoms to conceptualize their knowledge, attitudes, and beliefs about depression. Also noteworthy is that the culturally rich jargon used by African American men might go undetected by health professionals or make them uncomfortable (Bryant-Bedell & Waite, 2010; Kendrick et al., 2007; Watkins & Neighbors, 2007). These findings have important implications for the training of mental health professionals who may lack the competency needed to assess, diagnose, and treat the depressive symptoms some African American men display.

Compared with their female counterparts, African American men have reported daily life experiences, such as racism, violence, homicide, and invisibility, that present more barriers and antecedents to depression (Watkins, Abelson, & Jefferson, 2013; Watkins & Neighbors, 2007). Among Latino American males, perceived discrimination was found to be significantly and positively predictive of suicidal ideation (Ai, Pappas, & Simonsen, 2015). In a study of Latino university students, acculturative stress had a significantly greater impact on depression symptoms among men than among women (Castillo et al., 2015). In a study examining depression among Asian American males, Iwamoto and colleagues (2010) found that conformity to masculine norms such as winning (in a negative direction) and dominance (in a positive direction), along with avoidant coping (in a positive direction), were associated with depressive symptoms. Another study found that suicidal ideation among Asian American men, but not women, was associated with having chronic health problems (Cheng et al., 2010).

Depression Among Sexual and Gender Minority Males

Some researchers find a higher likelihood of experiencing mental health issues, including poor psychosocial development, depression, anxiety, and suicidal ideation, among gender nonconforming youth (Plöderl & Fartacek, 2009).

Some research also indicates higher depression among gay-bisexual males than among heterosexual males (Cochran, Sullivan, & Mays, 2003). Higher depression among sexual and gender minority males is likely attributed more to the stigma, discrimination, and stress associated with unfair treatment. For example, the negative valuation of same-sex orientation causes excess stress in persons with those orientations above and beyond general stress. I. H. Meyer (1995) labeled this "excess" stress as sexual minority stress. The minority stress model posits that stress occurs because of objective external events and conditions (I. H. Meyer, 2003).

The expectations of stressful events, as well as the vigilance this expectation requires, may lead to the internalization of negative social attitudes and the concealment of one's sexual orientation, all of which represent stressors that increase mental health concerns (I. H. Meyer, 2003). For instance, Hatzenbuehler, Nolen-Hoeksema, and Erickson (2008) found in a cohort of 74 bereaved gay men that experiences of stress from occupying a minority status was associated with increased depression.

Depression Resilience

Depression resilience among vulnerable boys and men is dependent on a mix of biological and social factors (Silk et al., 2007; Southwick, Vythilingam, & Charney, 2005). Such factors include the capacity to regulate emotion and manage stress reactivity, as well as positive pa-

Racial and ethnic minority males exhibit more resilience to depressive symptoms when they have a greater sense of control over social and political forces

rental support (Silk et al., 2007; Skrove, Romundstad, & Indredavik, 2013). Racial and ethnic minority males appear to exhibit more resilience to depressive symptoms when they have a greater sense of control over social and political forces (Zimmerman, Ramirez-Valles, & Maton, 1999), access to culturally responsive interventions (Brave Heart et al., 2012), healthy cultural identities (Cardoso & Thompson, 2010), and less rigid notions of masculinity (Iwamoto et al., 2010). Spirituality and religiosity might also bolster resilience in vulnerable boys and men (Barbarin, 1993; Christian & Barbarin, 2001; Kasen, Wickramaratne, Gameroff, & Weissman, 2012).

Summary

Depression produces a burden for racial/ethnic and sexual minority boys and men that is often not well recognized. A comprehensive understanding of the similarities and differences at the intersection of gender, race, ethnicity, and sexual orientation can improve our existing capacity to capture the epidemiology, etiology, and risk factors for major depressive disorders among vulnerable boys and men. Such an understanding would also help move us closer to tackling some of the health conditions associated with depression disparities in vulnerable boys and men.

Men represent more than 90% of the perpetrators of criminal violence in the United States and are also the victims of the large majority of that violence

VIOLENCE

Summary of the Evidence on Male Violence

In the United States, violent deaths from suicide and homicide are the third leading cause of premature death (defined by years of potential life lost) before age 65 (M. Anderson et al., 2001; CDC, 1994, 2010). Men represent more than 90% of the perpetrators of criminal violence in the United States and are also the victims of the large majority (78%) of that violence (Federal Bureau of Investigation, 2007; U.S. Department of Justice [DOJ], 2008). Men account for the majority of felons convicted in state courts and nine out of 10 of those convicted for violent offenses (U.S. DOJ, 2004). In U.S. district courts, men account for nearly nine out of 10 (87%) people convicted of any crime, and most people sentenced for violent crimes, including murder (88%), manslaughter (82%), kidnapping or hostage taking (92%), sexual abuse (98%), robbery (90%), assault (90%), and arson (90%), are men (U.S. DOJ, 2007).

Between 1995 and 2006, male youth 10–24 years of age were arrested for violent crime at significantly higher rates than were females (CDC, 2011). The cost of child abuse in the United States has been estimated to be $94 billion; the cost of IPV, $12.6 billion (Waters et al., 2004). In addition, the government absorbs 56% to 80% of the costs of care caused by stabbing or gun injuries in some form of uncompensated care financing and higher payment rates (Waters et al., 2004).

Violence takes on many forms, which differ in prevalence across diverse groups of men. Disparities exist among boys and men in the prevalence and impact of violence experienced and perpetrated. Differences in exposure to violence occur among men due to complex interactions between race, sexuality, SES, and geography. Understanding how and why such disparities occur can help us develop more effective strategies for eliminating these inequalities through intervention at the individual, organizational, and institutional levels of violence.

Boys and men from vulnerable populations, particularly racial/ethnic and sexual minorities, are at increased risk for violence victimization and perpetration due in part to greater exposure to high-risk environments and less protection and support when violence is experienced. Boys and men are at elevated risk for certain disabilities, including autism (Rivet & Matson, 2011) and learning disabilities (Child Trends Databank, 2016). In addition, boys and men with disabilities are at significant risk for victimization (Bones, 2013; Mitra & Mouradian, 2014; Simpson, Rose, & Ellis, 2016; Sobsey, Randall, & Parilla, 1997). Moreover, disability may result as a consequence of violence.

PHYSICAL FIGHTING

There is consistent evidence that in the United States, men express significantly more aggression than women—particularly physical aggression (Archer, 2004; Benenson, Carder, & Geib-Cole, 2008; L. D. Cohn, 1991; Côté, 2007; Eagly & Steffen, 1986; Knight, Guthrie, Page, & Fabes, 2002; Maccoby, 1988; Morgan & Kena, 2017). For example, males are much more likely than females to be both the perpetrators and the victims of violence (FBI, 2015; Loeber et al., 2005; Morgan & Kena, 2017), which remains true among youths (Courtenay, 1999). Nearly half of men nationally have been punched or beaten by another person (U.S. DOJ, 1994). Each year, one in five men is physically assaulted (Morgan & Kena, 2017).

Among adolescents, national data have consistently shown that about half of all male students have been in a physical fight during the course of any one year (American School Health Association, 1989; CDC, 1992a, 1992b; Kann et al., 1998). Differences exist in reports of fighting at school over the past year, with males engaging at much higher rates (15%) than females (7%) (CDC, 2010). Fighting is the most immediate antecedent behavior for a great proportion of homicides and is often considered a necessary, if not a sufficient, cause (CDC, 1992b; Gelles & Straus, 1988). Fighting is also predictive of suicide attempts in adolescent males (Nickerson & Slater, 2009).

The common denominator in teen homicides is boys killing boys with guns

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WEAPON OWNERSHIP AND USE

A person must own or obtain a gun to be able to commit gun violence. Substantial sex differences exist in access to and carrying a gun. Males are roughly two to four times as likely as females to have access to a gun in the home or to possess a gun (Swahn, Hammig, & Ikeda, 2002; Vaughn et al., 2012). In the United States, nearly three times more men (17%) than women (6%) carry a gun for defense, and almost twice as many men carry a knife for defense (16% and 9%, respectively) (U.S. DOJ, 2007). Far more men (49%) than women (31%) have a gun in their home (Hepburn, Miller, Azrael, & Hemenway, 2007), and more than twice as many men live in households with loaded firearms (Powell, Jacklin, Nelson, & Bland, 1998).

In turn, gun carrying is a key risk factor for gun violence perpetration and victimization. For example, gun carrying is associated with dating violence victimization among adolescents, with boys more likely to be victimized than girls (Yan, Howard, Beck, Shattuck, & Hallmark-Kerr, 2010). In children under age 14, boys sustain four out of five firearm-related injuries, and boys are the victim in three out of four firearm deaths; male relatives are the cause of the majority of these injuries (80%) (Eber, Annest, Mercy, & Ryan, 2004).

HOMICIDE

Most homicide deaths in the United States occur among males. Gun use has been implicated in a recent surge in homicides among young African American males—including juveniles—who are disproportionately both victims and perpetrators (Fox & Swatt, 2008). A disproportionate number of gun homicides occur in urban areas. Men are most likely to be killed in a public place by an acquaintance (U.S. DOJ, 2008).

School shootings get headlines. Yet the truth is that school shootings account for less than 1% of all homicides among school-age children (M. Anderson et al., 2001; CDC, 2008). According to the Office of Juvenile Justice and Delinquency Prevention, boys account for 94% of all known juvenile killers (Poe-Yamagata, 1997). The common denominator in teen homicides is boys killing boys with guns. Guns symbolically represent some key elements of hegemonic or dominant masculinity—power, hardness, force, aggressiveness, and coldness (Connell, 1995; Stroud, 2012).

SUICIDE

Even more common than homicide is suicide, another leading cause of death in the United States and the eighth leading cause of death for men (Kann et al., 2015). The suicide death rate is four times higher among males than females. Depending on the age group, roughly four to six times as many men as women kill themselves with firearms (CDC, 2013). Firearm suicide was generally at least twice as high among Whites than among Blacks and other racial groups from 1980 to 2010 (CDC, 2013). Associations between unemployment and psychological problems are stronger among men, and rates of suicide are linked with unemployment and times of economic depression for men but not for women (Bambra, 2010; Courtenay, 2000a, 2000b, 2011).

A disproportionate number of firearm suicides occur in rural areas (Branas, Nance, Elliott, Richmond, & Schwab, 2004). In American jails and state prisons, suicide rates are 12 times higher than the rates for individuals in the general population, and nearly all of these deaths are male (CDC, 2010; Mumola, 2005). In American jails, suicide was the leading cause of death during the 1980s. While these rates have decreased somewhat, suicide remains the cause of death in one third (32%) of the jail population (Mumola, 2005).

Gun ownership significantly increases the risk of suicide (Nickerson & Slater, 2009; Wintemute, Parham, Beaumont, Wright, & Drake, 1999). Findings from two population-based case-control studies indicated that gun ownership is independently associated with a higher risk of suicide, increasing the risk of suicide almost five times (Kellermann et al., 1992). National data also indicate that gun ownership is associated with an even greater risk for suicide than for homicide (Kaplan & Geling, 1998). Over half of all firearm-related deaths are suicides (CDC, 2010; National Safety Council, 1998).

INTIMATE PARTNER VIOLENCE

Gender differences in rates of IPV perpetration are subject to considerable debate (Field & Cataeno, 2005; Kimmel, 2002). Most often, decontextualized behavioral survey measures find lesser or no disparities, whereas qualitative data and criminal justice records indicate greater disparities, particularly in more severe forms of violence. Data on male victims of male IPV perpetration is scarce.

Rates of fatal IPV victimization and perpetration differ among men and women. Women are killed by current or former intimate partners four to five times more often than men (J. C. Campbell, Glass, Sharps, Laughon, & Bloom, 2007). Tellingly, this sex difference does not appear to hold in the limited data available on same-sex intimate partner homicide; it

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Research reveals an association between viewing television violence and subsequent violent and aggressive behavior

is more common for men to kill their male partners than for women to kill their female partners (J. C. Campbell et al., 2007).

Disproportionately higher rates of male violence do not occur in a vacuum. Rather, violence is proliferated in the structures and contexts that boys and men navigate. For example, the mass media is a structure that presents and represents male violence in ways that contribute to health disparities. Men and boys on television are also more likely than women and girls both to initiate violence and to get away with it (e.g., Glascock, 2008; Larson, 2001; McGhee & Frueh, 1980; Signorielli, 1993). Violent and antisocial behaviors are often portrayed as effective means for male characters to meet their objectives; typically, these behaviors are rewarded and have no negative consequences (Heintz-Knowles, 1995; Sege & Dietz, 1994; Signorielli, 1993). Boys are 60% more likely than girls to be portrayed using physical aggression (Heintz-Knowles, 1995). Toy commercials demonstrate similar gender differences in aggressive behavior (Sobieraj, 1998; Zuckerman, Singer, & Singer, 1980).

Research consistently reveals an association between the viewing of television violence and subsequent violent and aggressive behavior; there is also some evidence that this association is causal (Glymour, Glymour, & Glymour, 2008; Sege & Dietz, 1994; Signorielli, 1993). Men of color are overrepresented in media images of violence as well as in the criminal justice system (Entman 2006; Steffensmeier & Demuth, 2000; U.S DOJ, 2018).

Like the effects of television exposure, excessive gaming has been associated with lack of attention, poor sleeping patterns, and deteriorated verbal cognitive performance in children and adolescents (Chan & Rabinowitz, 2006; Dworak, Schierl, Bruns, & Strüder, 2007) and dysfunctional coping in adults (Hussain & Griffiths, 2009). The sudden increase in the prevalence of excessive Internet gaming and its negative consequences have led to the recent inclusion of Internet gaming disorder in the *DSM-5* (American Psychiatric Association, 2013). Considerable evidence links violent video gaming to aggressive and violent behavior (C. A. Anderson et al., 2010), though some analyses have reached more modest conclusions (C. J. Ferguson & Olson, 2014), suggesting that cognitive desensitization from gaming is linked to lower empathic concern and prosocial behavior toward strangers (Fraser, Padilla-Walker, Coyne, Nelson, & Stockdale, 2012).

How Violence Varies Across the Male Life Course

Disparities in violence are also linked to the dynamic contexts of human development across the lifespan. Male high school students (Grades 9–12) reported carrying a weapon over the past month (27%) or a gun (10%) at a much higher rate than girls (7% and

Male suicide increases dramatically in adolescence and early adulthood, precisely the years during which young men's sense of manhood is developing

2%, respectively) (CDC, 2010). Among 10–24-year-olds, boys (86%) are much more likely than girls (14%) to be victims of homicide (CDC, 2010). Male suicide also increases dramatically in adolescence and early adulthood, precisely the years during which young men's sense of manhood is developing. Although suicide rates among young adults declined during the 1990s, rates have been increasing significantly since 1999 among young men (and women) at all age groups under 75 years (Curtin et al., 2016). For this approximate age group (15-24), suicide is now the second leading cause of death (Curtin et al., 2016).

White males over the age of 65 have suicide rates that far exceed all other major age–gender–racial demographic groups. Men's historic role as economic providers in heterosexual families typically ends with their retirement from the workforce. Suicide rates increase dramatically at precisely this point in the life course (i.e., age 65 and older), whereas they decrease

among women of this age. The increase in suicide rates among White men at age 65 and older does not occur nearly to the same degree among Black men, who as a group have much higher levels of unemployment throughout their lives and consequently may not experience the same sense of loss of meaning or entitlement.

How Masculinities Influence Violence

Physical dominance and violence are often easily accessible resources for structuring, negotiating, and sustaining masculinities, particularly among vulnerable boys and men who, because of their social positioning, lack less dangerous means of doing so. Men often associate physical aggression with controlling others (A. Campbell & Muncer, 2008; Sijtsema, Veenstra, Lindenberg, & Salmivalli, 2009) and with what it means to be male (Krug, Dahlberg, Mercy, Zwi,

Men appear to struggle with contradictions between their lived experiences of manhood and social norms, and may rely on violence to display masculinities

& Lozano, 2002). Just as men exercise varying degrees of power over women, they exercise varying degrees of power among themselves. Status as a man, relative to women, is structured through patriarchal systems of power that support the (re)production of dominant or hegemonic masculinity through gender socialization. Such status is also achieved through the exaggerated display of stereotypically masculine characteristics (i.e., hypermasculinity).

Males who fail to demonstrate the culturally specific codes of masculine behavior have their status as a man questioned, or more extremely, are assaulted or killed. For example, some men denigrate and physically attack other men perceived to be gay as a means of establishing membership among groups of heterosexual men (Parrott, 2008). Socially vulnerable men might report being personally opposed to violence but willing to use physical violence "if necessary"—fearing that they will be victimized by other men if they appear weak or transgress masculinity and believing that the display of some degree of violence (or, at least the threat of retaliation) will protect them from harm by other men (Rich & Stone, 1996).

Men appear to struggle in their daily lives with contradictions between their lived experiences of manhood and real or perceived social norms of masculinity. These contradictions can heighten reliance on violence as a means of displaying masculinities. Thus, it is useful when explaining differences in violence to consider how vulnerable boys and men differ substantially in their access to opportunities to fulfill ideals and expectations of manhood in

socially accepted ways. For example, men with less formal educational and economic opportunity, who in the United States are disproportionately African American and Latino, experience greater challenges in fulfilling expectations to be successful breadwinners in socially acceptable ways (e.g., paid, legal employment).

Adherence to masculinity ideology is associated with abusive behaviors (Senn, Desmarais, Verberg, & Wood, 2000), interpersonal violence and aggression (A. Cohn & Zeichner, 2006), relationship violence (Jakupcak, Lisak, & Roemer, 2002), and hostile attitudes toward women (Rando, Rogers, & Brittan-Powell, 1998; Senn et al., 2000). Beliefs in traditional masculinity are also related to suicidal thoughts, although differently across age cohorts (K. Hunt, Sweeting, Keoghan, & Platt, 2006). Masculinity is related to men's use of violence in intimate relationships (Moore & Stuart, 2005). Specifically, men's gender role, stress, and conflict are directly associated with interpersonal aggression and violence, including the perpetration of IPV and suicide (Feder, Levant, & Dean, 2010; Moore & Stuart, 2005; O'Neil, 2008).

Social expectations and norms for stereotypic masculinity are supported by social and organizational systems and practices of privileged boys who reject or avoid in themselves anything stereotypically feminine. These expectations/norms include the following: act tough and aggressive, suppress emotions (other than anger), distance oneself emotionally and physically from other men, and strive competitively for power. For example, social norms endorse reckless behaviors from boys and men (G.

Barker, Ricardo, Nascimento, Olukoya, & Santos, 2010; Courtenay, 1998; Courtenay, 2000a, 2000b; Courtenay & Keeling, 2000; Duck, 2009; Eisler, Skidmore, & Ward, 1988; Tomsen, 1997; Williams, 2003). Men with more restricted emotionality and affection with other men are more likely to be aggressive, coercive, or violent (O'Neil, 2008). These dimensions of masculinity are also related to a number of other harmful behaviors that are, in turn, associated directly with gun violence and other forms of aggression (see O'Neil, 2008, for a review).

Violence Among Racial/Ethnic Minority Boys and Men

There are stark racial/ethnic differences in the patterns, types, and opportunities to enact violence. Homicide is the leading cause of death for African American males between the ages of 15 and 34 (CDC, 2014). In these same age groups, homicide is the second leading cause of death for Hispanic/Latino males, the third for American Indian/Alaska Native males, and the fourth among Asian and Pacific Islander males (CDC, 2014). Further significant disparities exist in police killings of Black males, who were more than three-and-a-half times as likely to die during arrest than Whites between 2003 and 2009 (Burch, 2011); this inequity may be much higher among young Black men.

Gang violence is also a growing problem in the United States, and it is largely concentrated among racial/ethnic minority males (National Gang Center, 2016). More Hispanic/Latino males in large cities are gang members. African American males have higher gang membership in rural areas (National Gang Center, 2016). Gangs may provide racial/ethnic minority males with a sense of belonging, pseudofamilial affiliation, and protection from violence; however, data indicate that members of gangs are many times more likely to be both victims and perpetrators of interpersonal violence than are nonaffiliated persons.

Although suicide rates are relatively low among African American males, recent evidence suggests an increase

among boys ages 5 to 11 (Bridge et al., 2015). Alaska Native/American Indian boys and men have some of the highest suicide rates in the United States; among those ages 10–35, it is the second leading cause of death (CDC, 2013).

Rates and forms of IPV appear to differ among diverse ethnocultural groups (Caetano, Field, Ramisetty-Mikler, & McGrath, 2005). Reasons for such differences are complex and contested. Among U.S. immigrant Latino populations, higher acculturation is often positively associated with IPV (Caetano, Schafer, Clark, Cunradi, & Raspberry, 2000; Firestone, Lambert, & Vega, 1999; Harris, Firestone & Vega, 2005; Ingram, 2007; Kantor, Jasinski, & Aldarondo, 1994; Mankowski, Galvez, Perrin, Hanson, & Glass, 2013), but some studies have found that acculturation is negatively associated with IPV (Champion, 1996). One recent study demonstrated a positive relationship between IPV perpetration and acculturation among Latinos, but this relationship was weaker among those with greater incomes (Galvez, Mankowski, & Glass, 2015). Highly acculturated Latinos may experience greater stress due to increased exposure to conflicting ideals, norms, and values and may be more aware of their limited access to social, educational, and economic opportunities (Caetano et al., 2000; Firestone et al., 1999; Ingram, 2007; Jasinski, 2001; Kantor et al., 1994).

Violence Among Sexual Minority Boys and Men

There is considerably less aggregated data on violence among sexual minority males. This data gap likely exists because sexual minority males get lumped into other sociodemographic groups (e.g., racial and ethnic minority males). Males are more likely to be both victims and perpetrators of violent hate crimes than females. Gay males are more likely to experience violence, threatened violence, and verbal abuse than other sexual minorities (Herek, 2009). Gay youth are more likely than heterosexual males to attempt or commit suicide (Kann et

al., 2015; Russell & Joyner, 2001). Men who have sex with men are disproportionately victimized by homophobic violence, whose perpetrators may be motivated by a desire to demonstrate heterosexual masculine identity (Mason, 2001; Tomsen & Mason, 2001).

How Stress Influences Violence

Stress and trauma have direct and indirect influences on violence among vulnerable boys and men (Rich, Harris, Bloom, Rich & Corbin, 2016; Williams & Jackson, 2005). Exposure to traumatic violence in the family, school, or community is related to chronic stress and in turn to violence victimization as well as perpetration. The perpetration of violence also can be traumatizing. For example, a majority of males who have completed homicides at schools had trouble coping with a recent major loss, and many also experienced bullying or other harassment (Vossekuil, Fein, Reddy, Borum, & Modzeleski, 2002). Conversely, sexual minority males who experience higher minority stress are more likely to report IPV victimization (Finneran & Stephenson, 2014).

Violence Resilience

Vulnerable boys and men forgo engaging in violence even when they face enormous psychosocial pressures. The factors that promote resilience to violence are similar to those that afford protection from trauma, substance abuse, and depression. For example, re-

Adolescents show resilience when they display self-control over their emotions, talk with parents or friends, seek help, and have positive relationships with adults

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search indicates that adolescents who are exposed to violence demonstrate resilience when they display self-control over their emotions, are able to talk with parents or friends about violence, seek help to avoid violence, and have positive relationships with adults (Kassis, Artz, Scambor, Scambor, & Moldenhauer, 2013; Luthar & Goldstein, 2004). Taken together, this body of literature suggests factors promoting violence resilience exist in the social, school, and familial environments navigated by vulnerable boys and men.

Summary

In the United States, men represent the majority of perpetrators and victims of interpersonal violence. Significant disparities in violence exist and are linked to the complex and transactional family, community, institutional, and developmental contexts in which individual boys and men are situated. These disparities in exposure to violence, victimization, and perpetration have a particularly profound impact on the stress, trauma, quality of life, psychological well-being, and longevity of boys and men of color and sexual minority boys and men. Vulnerable boys and men have inherent strengths and untapped capacities for violence resilience that warrant further attention. Continued research and intervention, informed by an appreciative understanding of these psychological processes, resilience factors, and social conditions, are urgently needed to enhance and improve the lives of boys and men in this country.

As we work to eliminate health disparities, we also have to improve the social conditions that give rise to them

APPROACHES TO WORKING WITH RACIAL/ETHNIC AND SEXUAL MINORITY MALES

Racial/ethnic and sexual minority males have high rates of disparities in overall health (e.g., physical, psychological, and social) that result primarily from social determinants of health. We posited ways of understanding health disparities in vulnerable boys and men as driven by factors operating at the individual and system levels. Moreover, we reviewed evidence illustrating how stress and masculinity norms and expectations underlie and contribute to illness and mortality among vulnerable boys and men that must be actively addressed to produce significant, long-lasting improvements in their health and optimal development. We are particularly concerned with the rates of trauma, depression and suicide, violence, and substance use in these populations because of the tremendous impact these conditions have on their lives and the lives of those closest to them.

We focused on each of these issues separately, but many men experience comorbidities of risk during stages of their life or cumulatively across their lifespan. Left unnoticed and untreated, these conditions lead to other serious comorbid conditions, unhealthy coping strategies, and grim, debilitating social consequences (e.g., incarceration, unemployment) that are difficult to overcome and negatively impact men's role in society; in their communities, families, and relationships; and as fathers.

Review of Existing Approaches

There is consensus that the most effective approaches to eliminating health disparities are those designed to improve the social determinants of health (Koh et al., 2010; Solar & Irwin, 2007). Most health interventions are aimed downstream at individuals, but research suggests that upstream approaches are most effective in the long-term. To eliminate health disparities in vulnerable boys and men, we need interventions at the upstream (policies that affect large populations), midstream (programs and practices within organizations), and downstream

(individual behavior) levels (Brownson, Seiler, & Eyler, 2010). Cross-sector collaborations are essential to maximizing the impacts of health-focused interventions.

Thus, as we work to eliminate health disparities, we also have to improve the social conditions that give rise to them. Providing better housing has been shown to improve overall health, decrease substance abuse, and reduce violence exposure (Williams, Costa, Odunlami, & Mohammed, 2008). Providing stress management programs to low-SES groups has reduced hypertension, cortisol levels, and height decreases in the elderly as well as increased involvement of stakeholders in community-level health promotion programs, resulting from resiliency building in racial/ethnic communities (Davis, Cook, & Cohen, 2005).

Approaches to working with racial/ethnic and sexual minority males have often relied on pathological or deficit models of culture and behavior and the premise that there is something inherently wrong with the individual, group, or community that should be changed or corrected (e.g., Harper, 2010; Hill, Billingsley, Engram, Malson, & Rubin, 1993). The boarding school experiences of American Indians (Gone, 2013) and the conversion therapies purported to cure homosexuality (Haldeman, 2002) are examples of interventions based on deficit models and the assumption of inferiority of the group and culture. Approaches are also influenced by the biases and stereotypes held toward vulnerable boys and men. For example, research on implicit bias shows the unconscious biases that many people have for racial/ethnic minority groups and the negative outcomes of holding such biases in areas such as employment decisions and health care provision (Godsil, Tropp, Goff, & Powell, 2014).

Vulnerable boys and men are more susceptible to unconscious biases and negative stereotypes. For example, African American boys are more likely to be viewed as older and less innocent (Goff et al., 2014). These biases and beliefs may lead to harsher interventions such as high rates of school expulsion starting in prekindergarten (Gilliam, 2005) and higher rates of incarceration (Alexander, 2010). Students of color and LGBT students

Research on implicit bias shows the unconscious biases that many people have for racial/ethnic minority groups and the negative outcomes in areas such as employment decisions and health care provision

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are more likely to be caught in the school-to-prison pipeline—that is, they experience more school disciplinary incidents and are more likely to be suspended from school, pushing them into the criminal justice system. Black boys are over three times more likely to be suspended than White students (Redfield & Nance, 2016).

These "fix him" approaches endorse treatments or interventions that change often developmentally appropriate behavior to conform to a prevailing norm or standard of behavior and punish him for not doing so. Punitive disciplinary approaches are too frequently applied to vulnerable boys and men.

It is beyond the scope of this report to fully summarize the types of interventions that have been used to address these concerns, but a brief description of some existing approaches follows.

MENTORING PROGRAMS

Providing mentoring programs to racial/ethnic minority males is a popular approach to addressing challenges associated with becoming successful, productive men in the community. Manhood development and rites-of-passage programs typically offer comprehensive curricula covering major aspects of personal, family, and community life (e.g., Watts, Abdul-Adil, & Pratt, 2002). Expectations about what it means to be a man in one's racial/ethnic culture and in the majority culture are usually explored. Other mentoring programs may target a specific problem such as school achievement and retention. Youth mentoring programs have been shown to be effective (DuBois, Portillo, Rhodes, Silverthorn, & Valentine, 2011).

FAMILY SOCIALIZATION

Families are the first source of information about race, bias, and discrimination. Hughes et al. (2006) reviewed the literature on the ethnic/racial socialization practices of parents, looking particularly at cultural socialization, preparation for bias, egalitarianism, and promotion of mistrust. They noted the complexity of the construct and the need for more research. They did find that most parents engage in such socialization; however, their messages differed, and there may be gender differences.

SUPPORT GROUPS

Another approach is support groups for boys and men, which enable individuals with the same problems to help each other cope (e.g., C. W. Anderson, Maton, Burke, Mankowski, & Stapleton, 2014; Mankowski & Silvergleid, 2000; Maton et al., 2014). They can be led by trained professionals or peers who have had the same experience as members of the group. For example, in-person and online support groups and communities are available for sexual minority individuals to deal with the stress associated with stigma, discrimination, and coming out. In a qualitative study to assess the impact of belonging to a high school Gay/Straight Alliance, Lee (2002) found positive results in academic performance, school/social/and family relationships, comfort level with sexual orientation, development of strategies to handle assumptions of heterosexuality, sense of physical safety, increased perceived ability to contribute to society, and an enhanced sense of belonging to the school community.

VIOLENCE PREVENTION

Some programs strive to reduce boys' or men's adherence to hegemonic or dominant masculinity in an effort to decrease violent behaviors (e.g., Karp, 2010; Schrock & Padavic, 2007). Other interventions attempt to change how masculinities are defined and socialized in a community to create adherence to an alternative set of masculine ideals that are not linked to violence. Some programs draw on the strength stereotypically associated with masculinity but attempt to associate it instead with nurturing behaviors—for example, the "Our Strength Is Not for Hurting" campaign. The "Real Men. Real Depression" campaign encourages men to recognize vulnerable emotions within themselves and to reduce stigma associated with help seeking among men (Fleming, Lee, & Dworkin, 2014).

TRAUMA PREVENTION AND TREATMENT

Comprehensive trauma prevention and intervention strategies include approaches that address macro (environmental) risk factors that place vulnerable boys and men at risk for traumatic exposure and experience while incorporating (micro) individual differences that differ among boys and men who are trauma survivors. A communal approach to addressing trauma in vulnerable boys and men acknowledges that the impact of trauma is not restricted solely to those who have been personally exposed or victimized but also to the network of individuals with whom they are affiliated.

Program examples include Healing Hurt People, an emergency room–based, trauma-informed, community-focused program designed to intervene in the lives of injured patients at the life-changing moment of violent injury (Corbin et al., 2011), and Sexual Health Intervention for Men, a program to lower sexual risk-taking among HIV-positive African American and Latino men who have sex with men and who have unaddressed histories of childhood sexual abuse (Williams et al., 2008).

APA's Safe and Supportive Schools Project is an example of a program that works to promote safe and supportive environments

to prevent HIV and other sexually transmitted infections among adolescents. Part of the program focuses on lesbian, gay, bisexual, and transgender youth who are at disproportionate risk of being intimidated, taunted, harassed, and bullied. The project works with state education agencies to help school districts create safe and supportive school environments for all students and staff by implementing clear policies, procedures, and activities designed to prevent bullying and violence and promote health and safety. In addition, the project partners with five professional organizations to promote the leadership of school-based counselors, nurses, psychologists, and social workers in establishing safe and supportive school environments for all students and staff (see APA, n.d.-b).

SUBSTANCE ABUSE PREVENTION AND TREATMENT

Prevention programs could have broad impact in reducing substance-related disparities for boys and men, but prevention efforts tend to be greatly underfunded when compared to treatment provided after the development of an addictive disorder (e.g., Pentz, 1998). School-based programs have been most frequently used to discourage children and adolescents from using drugs, including alcohol, tobacco, and illicit drugs. Some of these have not proved to be effective, but others report mixed success.

Table 1 provides a summary of major risk and protective factors linked to the experience of trauma, substance use, violence, and depression in racial/ethnic and sexual minority boys and men. The table is not exhaustive; rather, it highlights key factors identified in the extant evidence base. Please note that many risk and protective factors overlap across health conditions and age groups. In particular, we observed that many factors associated with unaddressed childhood trauma also influence depression, violence, and substance use across the life course.

Suggested Approaches

We propose that health disparities can best be eliminated in racial/ethnic and sexual minority males by adopting upstream, midstream, and individual approaches that (a) are strengths-based and recognize and capitalize on the deep legacy of resiliency that exists within the families and communities of these individuals; (b) address the social determinants and ecological factors that determine their health and well-being; (c) understand and appreciate the powerful role masculinity beliefs, norms, and expectations have on health at the individual, provider, and system levels; (d) attend to the unique stress these individuals experience related to their race/ethnicity, gender identity, and sexual orientation; and (e) understand how intersectionality of identities and experiences contributes to their health.

SUMMARY

- Focus on strengths-based methods and those that emphasize optimal development as opposed to the mitigation of pathology.

- Address the social determinants of health, health disparities, and inequities.

- Improve cross-sector collaborations to maximize the impact of health-focused interventions.

- Apply interventions aimed at upstream (policy), midstream (program/practice), and downstream (individual) levels.

- Understand and appreciate the role of masculinity beliefs and norms on health behavior and outcomes.

- Address implicit racial and sexual orientations biases and the stress they induce.

- Attend to the ways in which race/ethnicity, gender identity, and sexual orientations intersect.

TABLE 1

MAJOR LIFE-COURSE DEVELOPMENTAL STAGE FACTORS ASSOCIATED WITH HEALTH DISPARITIES IN RACIAL/ETHNIC AND SEXUAL MINORITY BOYS AND MEN

	HEALTH DISPARITY OUTCOME: **TRAUMA**	
LIFE-COURSE DEVELOPMENTAL STAGE	RISKS/CHALLENGES	STRENGTHS/PROTECTIONS
CHILDHOOD	**Inadequate, underresourced systems such as schools, family disruption, and negative peers** impact identity, emotional, social, cognitive, and physical health development in African American youth (APA, 2008a). **Masculine gender role socialization** that stifles trauma recognition and response (i.e., exposure to parental modeling or messages that encourage emotion suppression like "boys don't cry") (Hammond, 2012; Vogel et al., 2011). **Adverse childhood experiences** that induce trauma (Molnar et al., 2001; Schoedl et al., 2010). **Childhood maltreatment and sexual abuse**: significant race differences in occurrence appeared for first time in research in 2010, with Black children reported as more likely to be maltreated, which was attributed to increasing poverty (Lanier et al., 2014). **Neurobiological changes** attributable to adverse childhood experiences (Nemoroff, 2004) that increase likelihood of negative behavioral responses to trauma. **Developmental disabilities or special needs** can heighten risk for abuse and maltreatment (Child Trends Databank, 2016). **Black boys seen as older, less innocent, dehumanized** (Goff et al., 2014).	**Higher childhood socioeconomic status—not living in poverty** (Child Trends, 2016). **Resilience**, including critical mindedness, active engagement, flexibility, and communalism (APA 2008a); positive development in context of adversity and stress (Buttram, 2015). **Positive masculine gender role socialization** that encourages emotion expression (Vogel et al., 2011). **Early childhood development and support programs** for infants, toddlers, and parents (e.g., Head Start) (Love et al., 2005).
ADOLESCENCE	**Masculine role identity negotiation and consolidation** peaks during adolescence and can strongly emphasize male behavioral risk-taking. **Intimate partner violence victimization** as males begin to form more intense romantic connections (Kilpatrick et al., 2013; West, 2012). **Maladaptive emotion/affect regulation** that can emerge as stricter reliance on emotional suppression and anger (Hoge et al., 2004). **Greater exposure to community and race-based violence**, especially among African American and Latino males. **Delayed help-seeking** (Addis & Mahalik, 2003). **Increased experience of microaggressions and higher sexual coercion among sexual minorities** (Mizock & Lewis, 2008; Nadal, 2013; Walters et al.,2013).	**Resilience-building strategies** such as those provided during racial socialization, which can impart positive messages about one's self/culture and serve as stress buffer (Brown & Tylka, 2011). **Posttraumatic growth**—the experience of positive psychological changes following trauma (Singh & McKleroy, 2011).
ADULTHOOD	**Rigid reliance on high-effort coping** (e.g., John Henryism) (Bennett et al., 2004; Bonham et al., 2004). **More pronounced trauma severity** and higher PTSD rates among African American men (Ai et al., 2011). **Historical trauma** among American Indians (Brave Heart, 1999; Gone, 2013) and African Americans (DeGruy, 2005). **Frequent life-threatening events** among racial/ethnic minority men (Hatch & Dohrenwend, 2007).	**Greater resilience** such as purpose in life, active coping, and optimism among African American males (Alim et al., 2008).

HEALTH DISPARITY OUTCOME: **SUBSTANCE ABUSE**		
LIFE-COURSE DEVELOPMENTAL STAGE	RISKS/CHALLENGES	STRENGTHS/PROTECTIONS
CHILDHOOD	**Boys more likely than girls to state they intend to use substances** (Andrews et al., 2003). **Adverse childhood events/trauma exposure** that set the stage for externalizing behaviors, including adolescent alcohol use (Dube et al., 2006). **Exposure to racism and discrimination** (Gibbons et al., 2004).	**High religiosity and authoritarian parenting in African Americans** (Gibbons et al., 2010). **Family functioning** that promotes resilience (Caldwell et al., 2004).
ADOLESCENCE	**Sensitive developmental period for risk taking and sensation seeking** (Arnett, 2000; Halkitis et al., 2014). **Masculine gender role stress** (Blazina & Watkins, 1996; Liu & Iwamoto, 2007). **Normative community and peer expectations** regarding substance use (Oetting & Donnermeyer, 1998); factors may vary by race/ethnicity (e.g., normative environment for American Indian youth differ from White adolescents) (Dieterich et al., 2013). **Social and residential instability** (e.g., homelessness) (Henry et al., 2016). **Bullying exposure** (Ringwalt & Shamblen, 2012). **Higher drug-related incarceration rates, violence, and suicide among racial/ethnic minority males** (Cottler et al., 2005: National Center on Addiction and Substance Abuse, 2010).	**Greater resilience** (Smith et al., 1995). **Protective factors that encourage positive self-regulation** (Wills et al., 2003). **Positive self-esteem, a sense of mastery, and other sources of social support** decrease likelihood of substance misuse among transgender youth (Bariola et al., 2015; Grossman et al., 2011). **Positive/supportive family and peer influences** are key resilience factors for American Indian adolescents (Waller et al., 2003).
ADULTHOOD	**Gay and bisexual men engage in more substance use than heterosexual peers** (Kelly et al., 2015). **Challenges with independent, productive living** (e.g., homelessness, unemployment, lack of insurance) (Berg et al., 2013; Wilson-Frederick et al., 2014). **Comorbid medical and social problems** (e.g., Chartier & Caetano, 2010).	**Employment is associated with less problematic drug use in male**s (Berg et al., 2013). **Having insurance increases access to care and treatment** (e.g., see Wilson-Frederick et al., 2014, on lack of insurance among minority males). **"Maturing out"**—older age is associated with less problem drinking (O'Malley, 2004).

HEALTH DISPARITY OUTCOME: **VIOLENCE**		
LIFE-COURSE DEVELOPMENTAL STAGE	RISKS/CHALLENGES	STRENGTHS/PROTECTIONS
CHILDHOOD	**African American and Latino male youth who are repeatedly exposed to violence** experience emotional desensitization, depressive symptoms and aggressive behaviors (Gaylord-Harden et al., 2017). **Having a disability** (e.g., a learning disability) (Bones, 2013; Child Trends Databank, 2014). **Adverse childhood experiences** that induce trauma (Molnar et al., 2001; Schoedle et al., 2010). **Exposure to traumatic violence and chronic stress** (e.g., Rich et al., 2016).	**Better housing improves health, reduces substance abuse, and reduces violence exposure** (Williams et al., 2008). **Parenting programs can protect children from adverse experiences, such as APA's ACT Raising Safe Kids Program** (http://www.apa.org/act/about/evaluation/index.aspx; Knox & Burkhart, 2014).
ADOLESCENCE	**Hopelessness, depression, previous victimization, corporal punishment** (Song et al., 1998). **Rigid adherence to masculine ideology** (e.g., sustaining masculine belief of physical dominance and power) (Campbell & Muncer, 2008; Krug et al., 2002); social norms that endorse reckless behaviors (Barker et al., 2010; Courtenay, 1998). **Gang involvement**, especially for racial/ethnic and rural males (National Gang Center, 2016). **Hate crime victimization**: **Gay males more likely to be victims of violence/hate crimes** (Herek, 2009). **Lack of protection and support** when violence is experienced.	**More pronounced emotion control** (Kassis et al., 2013; Luthar & Goldstein, 2004). **Reducing adherence to hegemonic masculinity** to decrease violent behaviors in boys and men (Karp, 2010; Schrock & Padavic, 2007). **Reducing bullying and other violence/trauma against youth, including LGBT youth**, through school-based programs, training, and policies (APA Safe and Supportive Schools Project, APA, n.d.-b).
ADULTHOOD	**For males between 15 and 34, homicide is leading cause of death for African Americans, 2nd for Latinos, 3rd for American Indians/Alaska Natives, and 4th for Asian/Pacific Islanders** (CDC, 2014). **African American males are 3.5 times more likely to be killed by police during arrest/encounter than White males** (U.S. DOJ, 2011). **Unemployment/limited economic opportunities** (My Brothers' Keeper Task Force Report to the President, 2014; Spaulding et al., 2015).	**Providing comprehensive intervention in emergency room at time violence is experienced** (Healing Hurt People) (Corbin et al., 2011).

HEALTH DISPARITY OUTCOME: **DEPRESSION**		
LIFE-COURSE DEVELOPMENTAL STAGE	RISKS/CHALLENGES	STRENGTHS/PROTECTIONS
CHILDHOOD	**Vulnerable to depression as males learn to manage difficult emotions** (Pescosolido, 1992). **Increase in suicide among Black boys** (Bridge et al., 2015). **Childhood maltreatment increases lifetime risk of depression** (Nanni et al., 2010).	**Positive parental support** (Silk et al., 2007). **Having access to health/mental health services,** discussed in the Surgeon General's *National Action Agenda on Children's Mental Health* (Olin & Hoagwood, 2002).
ADOLESCENCE	**Chronic stress associated over time with depression,** anxiety, ineffective coping among African American adolescents (Schmeelk-Cone & Zimmerman, 2002). **Under-/misdiagnosed depression** (Kessler et al., 2003): **Symptoms of depression in vulnerable boys and men misinterpreted,** leading to social reprimand (A. A. Ferguson, 2001). **Strict use of avoidant coping strategies** (Iwamoto, Liao, & Liu, 2010; Kopp, Skrabski, & Szedmak, 1998), including withdrawal (Courtenay, 2011). **Racism, invisibility, perceived discrimination** (Ai, Pappas, & Simonsen, 2015; Watkins & Neighbors, 2007). **Acculturative stress in Latinos** (Castillo et al., 2015).	**Well-trained professionals** who can properly assess and treat depression in vulnerable boys and men (e.g., Bryant-Bedell & Waite, 2010).
ADULTHOOD	**Increased psychosocial stress such as unemployment and violence** (Bambra, 2010; Spaulding et al., 2015). **Delayed or nonexistent help-seeking** (Rosenfield & Mouzon, 2013). **Lack of or diminished social support** (Moller-Leimkuhler, 2002).	**Having greater sense of control over social and political forces,** especially among racial/ethnic minority males (Zimmerman, Ramirez-Valles, & Maton, 1999). **Having less rigid conceptualizations of masculinity** (Iwamoto, Liao, & Liu, 2010).

RECOMMENDATIONS

Research

Research on the health and well-being of racial/ethnic and sexual minority males has grown in recent years. For racial/ethnic minority males, earlier research was characterized by deficit models that focused on high-risk problem behaviors such as violence, including street and IPV, drug use, and irresponsible sexual activity. Early research on sexual minority males was sparse and often limited to the study of homosexuality and sexual preference itself. Recent research has broadened its scope to include more cultural strengths-based approaches for both groups.

More research is needed on "normal" development and the socialization of boys and men of color and sexual minority males across the lifespan; better documentation of their experience of stress, trauma, and depression and the most effective coping and intervention strategies at the individual, family, and community levels; how to prepare and improve the workforce that educates, treats, and provides services to boys and men of color, sexual minority men, and their families; and development of strategies to keep them out of the criminal justice system. We encourage the use of community-based participatory methods in research with community stakeholders working in consultation with experts to develop quality prevention and treatment programs.

We recommend that APA, research scientists, and other stakeholders:

Encourage increased funding and support for the National Institutes of Health and other federal agencies to conduct more research on health disparities specific to boys and men from racial/ethnic minority populations. NIH has a mandatory strategic plan on health disparities administered by the National Institute on Minority Health and Health Disparities (NIMHD), which requires participation by all NIH institutes and centers. Solicited research specific to boys and men of color has been limited and most often seen in work related to HIV/AIDS. There have been some notable exceptions, including work supported by the National Institute on Nursing Research under its "Health Promotion Among Racial and Ethnic Minority Males" funding opportunity announcement and the Omega Psi Phi fraternity's "Brother, You're on My Mind" initiative addressing mental health in African American males and supported by NIMHD.

Encourage increased funding support for NIH and other federal agencies to conduct more research on health disparities specific to gender identity, particularly the health disparities faced by transgender and gender nonconforming individuals. In October 2016, the director of NIMHD announced the formal designation of sexual and gender minorities (SGMs) as a health disparity population for NIH research.

Continue to encourage funding for the Centers for Disease Control and Prevention to monitor gun violence and support firearm injury prevention research. APA passed a resolution on firearm violence research and prevention in 2014 in which the need for federal legislation was discussed (see APA, 2014a).

Conduct more research on normative and optimal development and the natural history of male role socialization of racial/ethnic and sexual minority males in families, within/across generations, and over the lifespan.

Investigate stress exposures (e.g., types of stress, chronic stress) experienced by racial/ethnic and sexual minority males, trauma (e.g., child sexual abuse), and their negative psychological consequences (e.g., depression) using methodologies that allow us to capture them in real time.

We need more than public narrative change . . . we need narrative disruption to bridge the empathy gaps in our society for boys and men at the margins of opportunity structures

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Support studies addressing the preparation and improvement of the workforce that educates, treats, and provides services to racial/ethnic and sexual minority men and their families. These studies should address implicit bias and stereotyping in reference to racial, ethnic, gender, and sexual minority status and the intersection of these identities and characteristics.

Conduct evaluation research that demonstrates the effects of programs and interventions. Use this information to determine best practices and evidence-based prevention and treatment interventions effective with racial/ethnic and sexual minority boys and men in schools, workplaces, juvenile facilities, prisons, neighborhoods, clinics, and other relevant contexts that can help males overcome gender norms that discourage help-seeking and transform socially constructed definitions of manhood based on demonstrations of toughness and violence.

Encourage and support research to determine the impact of proposed and current policies and programs likely to impact the health and well-being of racial/ethnic and sexual minority males. This could include policies regarding eligibility for health insurance and public housing or HIV criminalization.

Make funding available for research focused on the role of masculinity, chronic stress, trauma, depression, and substance abuse and their relationship to health status, health behaviors, and use of services in boys and men of color and sexual minority males across the lifespan; integrate these measures into the nation's Healthy People objectives.

Evaluate existing assessment measures of boys and men of color and sexual and gender minority males. The field lacks uniformity in its measurement of masculinity, gender role conflicts, and other psychosocial factors impacting the health of vulnerable males. Evaluations of such measures and establishing a publicly available compendium of measures would provide guidance for researchers and practitioners seeking to design gender-informed interventions.

Public Policy

Health disparities, by definition, are the result of long-term inequities in health and wellness experienced by certain marginalized population groups, including access to appropriate, quality care. The solution to achieving health equity relies to a great degree on having policies in place requiring that quality care is available and accessible to all. Strong advocacy is needed to ensure that the health needs of racial/ethnic and sexual minority males are a priority agenda item (within APA and with policymakers) and to keep key political stakeholders aware of the impact of psychological factors on their long-term health and quality of life.

Many of the disparities observed among racial/ethnic and sexual minority males, however, are fundamentally driven by policies and practices that place them on the periphery of the opportunity structure. Hence, efforts to reduce health disparities among vulnerable boys and men also have to address factors operating outside the health care system. It is also not always necessary to create new policies. Opportunities exist to leverage existing policies to improve health outcomes for vulnerable boys and men.

We recommend that APA, research scientists, and other stakeholders:

Promote policies that reduce disparities and increase health equity among racial/ethnic and sexual minority boys and men. Examples include expanding health insurance to include coverage for mental and behavioral health needs and providing civil rights protections, especially for sexual minority boys and men.

Develop policies that support holistic models of responsible fatherhood, family life, and sexuality. Such policies should emphasize economic and socioemotional contributions fathers make to family life.

Intensify adult and juvenile justice efforts to keep racial/ethnic minority males out of prisons and jails.

Identify existing levers within health care systems that can enhance access to care, improve processes of care, and minimize help-seeking barriers among vulnerable boys and men. Incentivize federally qualified health centers that expand services designed to increase use of preventive health services among vulnerable boys and men.

Practice, Education, and Training

Psychologists, other health care providers, educators, and professionals who provide treatment and services to boys and men of color and sexual minority males can benefit from better understanding their health care needs and barriers to providing care.

We recommend that APA, research scientists, and other stakeholders:

Increase psychotherapeutic support for families in their efforts to promote optimal racial and gender socialization for vulnerable boys and men. Such support is especially warranted at this time in our nation when families are grappling with rearing boys in a climate rife with racial division.

Address the stress-inducing implications of persistent exposure to implicit biases and the microaggressions they elicit in all the places vulnerable boys and men live, get educated, work, play, and acquire health care. Deliver training in school and community settings that incorporates an understanding of how gendered stereotypes of vulnerable boys and men intersect with implicit racial bias to shape disciplinary approaches and responses.

Integrate comprehensive assessments into clinical practice that include comprehensive screening for physical, medical, and mental health concerns during primary and specialty health care visits. Where possible, utilize health navigators to assist with the gathering of psychosocial data and use these data to improve processes of care.

Provide graduate and continuing education (CE) training to all psychologists and other health care providers working with racial/ethnic and sexual minority males. Such training ensures that providers are highly competent and skilled in approaches proven to be the most effective in improving the health of these individuals and in treatment issues associated with gender, race, ethnicity, and sexual orientation, and in how their intersectionality impacts treatment process and outcomes.

Provide postgraduate and CE training to psychologists and other health professionals working with racial/ethnic and sexual minority males, particularly those working in elementary, high school, junior college, universities, and communities.

Design youth mentoring programs that move beyond the establishment of bonds with role models toward those that also provide bridges to the social capital critical to accessing networks that enhance upward social mobility. Incorporate more reflexive examples of demonstrating manhood or masculinities into existing rites-of-passage mentoring programs to reflect a wider range of options for expressing masculinities.

Accessible services are limited in rural and low-income urban areas (SAMHSA, 2014). Treatment services for sexual minority and ethnic minority males are sparse and sorely needed (Healthy People 2020; U.S. DHHS, 2018). Provide quality and culturally appropriate assessment of trauma exposure and mental health needs as well as mental health and addiction care to vulnerable boys and men, especially incarcerated men, men from rural and low-income settings, and racial/ethnic and sexual minority males.

Increase access to interventions that assist vulnerable men in substance abuse recovery in the criminal justice system, during the transition from incarceration, and as they reintegrate in their communities and families. Increase and improve programs designed to ease reentry into society and the labor force.

Develop treatment services and modalities that attend to sexual identity and the complex interplay between persons and behavioral, psychosocial, and social stressors that place sexual minority men at risk and predispose the syndemic of substance use, HIV and other STDs, violence, and mental health concerns (Halkitis et al., 2013).

Provide rehabilitative and supportive services to vulnerable boys and men who have been impacted by trauma and violence. Assure that such services attend to the unique ways in which such events impact masculine role identity. Integrate those services in spaces where vulnerable boys and men live, work, play, pray, get educated, and acquire health care. Provide support also for families and friends who are proximal to those who are impacted by trauma and violence.

Develop gender-based prevention programs and other interventions aimed at men involved in violence as perpetrators or peer bystanders (e.g., Coaching Boys Into Men). Knowledge about masculinities in community settings with diverse groups of men is developing (Mankowski & Maton, 2010) and can be used to prevent and respond to violence among boys and men.

Incentivize, expand, and support state and local programs to assist vulnerable boys and men who are reentering communities from prisons and jails. This includes providing support to those offering masculinity- and trauma-informed care and services. In addition, develop and evaluate strategies to keep boys and men of color and sexual minority males retained and engaged in schools, family and community life, and the workforce.

Public Awareness

A well-informed, aware community is critical to improving the health of racial/ethnic and sexual minority males. We adopt a broad definition of community to include family, peers, teachers, religious leaders, schools, the media, civic associations, community groups, fraternities and sororities, and employers. Partnering with community-based organizations to plan strategic collaborative efforts to disseminate information on the mental and physical health of racial/ethnic and sexual minority males is needed.

APA has created resources (e.g., videos, webinars) to help the public understand the needs of racial/ethnic and sexual minority males, dispel myths about men's health, and reframe how this nation defines the culture of masculinity. We suggest amplifying, scaling up, and disseminating such efforts to reach a broader audience. In addition to creating links between them, mass media campaigns can be designed that break down associations between socially derived notions of "real men" and violence. Such an approach could reduce violence in men, encourage help-seeking, and improve their emotional well-being. This would also include culturally responsive or centered approaches that take into consideration values and beliefs that may be unique to racial/ethnic and sexual minority populations.

We recommend that:

APA work with other professional organizations (e.g., the American Public Health Association, American Medical Association, and others) to develop and disseminate a variety of web-based materials and resources on topics pertaining to racial/ethnic and sexual minority men covered in this report.

APA and other professional organizations collaborate with community groups and stakeholders working with vulnerable boys and men to provide technical assistance and expertise on the health of racial/ethnic and sexual minority males.

We believe that what gets measured, gets done. Thus, we also recommend that **APA establish a systematic means to keep abreast of emerging needs and challenges facing vulnerable boys and men.**

We believe that we need more than simple public narrative change to eliminate health disparities in vulnerable boys and men. Rather, we need narrative disruption to bridge the existing empathy gaps in our society for boys and men at the margins of opportunity structures. Our report was designed in many ways to bridge such gaps. We view this document as an initial effort by APA to ignite and sustain commitment among psychologists and other health care professionals to work collectively to eliminate health disparities in vulnerable boys and men.

GLOSSARY

Definitions are provided to ensure clarity in some of the terms and concepts used in this report.

Caballerismo refers to "a code of masculine chivalry" that generally includes a focus on family connection and social responsibility (Arciniega, Anderson, Tovar-Blank, & Tracey, 2008, p. 20).

Coping is an organizational construct used to encompass myriad actions individuals might use to deal with stressors (Skinner, Edge, Altman, & Sherwood, 2003).

Depression is a mental disorder, characterized by sadness, loss of interest or pleasure, feelings of guilt or low self-worth, disturbed sleep or appetite, feelings of tiredness and poor concentration. The *DSM-5* (American Psychiatric Association, 2013) defines clinically diagnosable depression as major depressive disorder. Major or clinical depression is diagnosed when these symptoms persist every day for at least two weeks. Individuals may have depressive symptoms such as anxiety and feelings of hopelessness and helplessness in response to some stressful event. Although having depressive symptoms does not mean one meets criteria for major depression, depressive symptoms can interfere with coping and are sometimes associated with other health conditions.

Gender identity refers to how boys and men see, understand, and experience their sexual identity.

Gender nonconforming males are those males who do not follow stereotypes about how they should look or act based on the sex they were assigned.

Health disparities have been defined in a variety of ways. Healthy People 2020 (U.S. DHHS, 2018) defines health disparities as "a particular type of health difference that is closely linked with social, economic, and/or environmental disadvan-

tage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion."

We define health disparities as avoidable, unjust differences in health status seen between population groups caused primarily by long-standing, persistent social systems and policies. There is consensus that while genetics and individual health behaviors contribute to disparities, they are primarily determined by the social conditions in which people are born, grow, live, work, and age. These conditions are structurally determined by the distribution of money, power, and resources at global, national, and local levels. They are also influenced by political, educational, and health care systems primarily responsible for the distribution of social resources (Solar & Irwin, 2007; WHO, 2008).

Although we use the term disparities, we also recognize that eliminating health disparities is a necessary condition for achieving health equity or "the absence of systematic disparities in health (or in the major social determinants of health) between social groups who have different levels of underlying social advantage/disadvantage—that is, different positions in a social hierarchy" (Braveman & Gruskin, 2003). "Health equity is the principle underlying a commitment to reduce—and, ultimately eliminate—disparities in health and in its determinants, including social determinants" (Braveman, 2014).

John Henryism refers to the "strong behavioral predisposition to cope actively with psychosocial environmental stressors" (S. A. James, 1994, p. 163). In accordance with the legend of John Henry—the famous Black steel driver of American folklore—

John Henryism can be understood as a cultural statement about how Black Americans must often attempt to control behavioral stressors through hard work and determination (S. A. James, Hartnett, & Kalsbeek, 1985). Syme (1979) indicated that individuals of lower SES require higher levels of coping to deal with the psychosocial stressors they experience.

Machismo refers to a cultural standard of behavior exhibited by some Mexican men (Arciniega et al., 2008). Such behaviors can be positive (e.g., nurturance, hard work, honor, and responsibility) or negative (e.g., violence, aggression, hypermasculinity, and sexualized behaviors).

Manhood refers to a social status and aspirational identity that is defined by the intersection of age, race/ethnicity, and other identities and perpetually needs to be proven; it reflects the embodiment of virtuous characteristics and traits, performance of certain social roles, and the fulfillment of gendered expectations associated with being an adult male (Griffith, 2015; Vandello & Bosson, 2013).

Men's health disparities are differences in health outcomes that are determined by cultural, environmental, and economic factors associated with socially defined identities and group memberships. These patterns reflect the ways in which masculinities are related to health; how gender is constructed and embedded in social, economic, and political contexts and institutions; and how culture and subcultures influence how men develop their masculinities and how they respond to health issues (Griffith et al., 2011).

Racial/ethnic minority males refers to boys and men belonging to the following U.S. racial/ethnic groups: Black/African American, American Indian/Native American, Asian American, Hispanic/Latino, Hawaiian, Other Pacific Islander. We recognize the diversity within each of these groups (e.g., Korean, Puerto Rican, Cherokee). Data are mostly available by the broad group category.

Sexual minority males refers to boys and men whose sexual identity, orientation, or practices differ from those of the majority in the surrounding society. This group includes gay and bisexual individuals.

Stress is defined as an environmental demand that taxes an individual's resources, resulting in psychological or biological changes that can put that individual at risk for disease. A stressor is any physical, social, environmental, or psychological event or condition that causes the body to make an adjustment (Cohen, Kessler, & Gordon, 1995; Wenzel et al., 2002).

Substance abuse refers to the harmful or hazardous use of psychoactive substances, including alcohol, tobacco, and illicit drugs. We also rely on the definition provided in the *DSM-5*, which describes it as a "maladaptive pattern of substance use

manifested by recurrent and significant adverse consequences related to the repeated use of substances" (American Psychiatric Association, 2013).

Substance use refers to the consumption of any psychoactive substance, including alcohol, tobacco, and illicit drugs. It captures persons who exhibit no harmful effects related to use and those who exhibit adverse consequences related to use.

Transgender males refer to boys and men whose gender identity differs from the sex they were assigned at birth.

Trauma refers to "experiences or situations that are emotionally painful and distressing and that overwhelm people's ability to cope, leaving them powerless. Trauma has sometimes been defined in reference to circumstances that are outside the realm of normal human experience. Unfortunately, this definition doesn't always hold true. For some groups of people, trauma can occur frequently and become part of the common human experience" (National Center for Nonviolence and Social Justice, 2014). Trauma includes the threat, exposure, or direct witnessing of death, injury, and/or sexual violence.

Violence is "the intentional use of physical force or power, threatened or actual, against oneself, another person, or a group or community that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation" (Krug et al., 2002). Violence includes that directed at the self, others, and groups.

Vulnerable population. "A vulnerable population is a subgroup or subpopulation who, because of shared social characteristics, is at higher risk of risks. The notion of vulnerable populations refers to groups who, because of their position in the social strata, are commonly exposed to contextual conditions that distinguish them from the rest of the population. As a consequence, a vulnerable population's distribution of risk exposure has a higher mean than that of the rest of the population" (Frohlich & Potvin, 2008).

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