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A Generic Qualitative Inquiry of the Challenges for Black African American Men who have Experienced Trauma

Randall Lee Maurice Shakir
University of Arkansas-Fayetteville

A Generic Qualitative Inquiry of the Challenges for Black African American Men who have Experienced Trauma

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by

Randall Lee Maurice Shakir
Wilberforce University
Bachelor of Arts in Rehabilitation Services, 2009
Wilberforce University
Master of Science in Rehabilitation Counseling, 2012

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University of Arkansas

This dissertation is approved for recommendation to the Graduate Council.

_____
Brent T. Williams, Ph.D.
Dissertation Director

_____
Keith D. Vire, Ph.D.
Committee Member

_____
Kristin K. Higgins, Ph.D.
Committee Member

Abstract

Black African American Men (BAAM) suffer disproportionately from trauma related challenges and have a higher risk of encountering trauma across the lifespan. The negative impact of trauma is a major public health concern in the United States, evidence suggests trauma negatively impacts the physical well-being, mental health, and mortality rate. BAAM have increased rates of trauma exposure and their traumatic experience is historically complex involving a variety of contemporary issues (i.e. Adverse Childhood Experiences (ACEs), depression, victimization and desensitization, stress). This research aims to explore the complex nature of their trauma-related challenges among a purposeful sample of BAAM participants in Arkansas using a generic qualitative inquiry. The study will use an adapted conceptual framework of Historical Trauma Theory (HTT) to anchor the researcher within the analyses of data to answer the question: "What are the challenges for BAAM who have experienced trauma?" Analysis of the descriptive data (e.g., interviews, observations, documents) aspires to expand the body of knowledge, to elucidate culturally congruent perspectives, and encourage improvement of trauma informed care among key stakeholders.

Keywords: Adverse Childhood Experiences (ACEs), Black African American Male (BAAM), historical trauma, mental health

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Dedication

I dedicate this opportunity to Yahweh, Yahushua and the gift of the Holy Spirit that empowers me, I am truly Shakir “Thankful” and “Grateful”. To my wife Angela, your reflection of light has kept me; thank you for being my blessing, and my best friend. I could not have borne the fruit of this labor without your love and support. To my son, Randall Lee Maurice Shakir Jr., you are my heir, what an honor it is to be your father and guide as you embark upon your quest through life. Last, but not least, I dedicate this dissertation to both past and future generations of BAAM who have been impacted by unremedied trauma.

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CHAPTER 1:

INTRODUCTION

This introductory chapter will contextualize trauma and the historical underpinnings relative to Black African Americans Males (BAAM) logistically presented in the statement of the problem, purpose of the study, research question, and significance of the study. Subsequently, the conceptual research design is described along with information germane to assumptions, limitations, and delimitations; followed by operational definition of terms and the chapter summary.

Trauma

According to the American Psychological Association (2019; 2020) traumatic experiences are events that threaten to cause: (a) physical harm or injury, (b) damage to the psychological integrity of self or others, and or (c) death. Traumatic experiences have demonstrated lasting negative impacts across racial, gender, and socioeconomic categories. It is not uncommon for people who encounter traumatic adversities to exhibit shock or denial, during or immediately after their initial exposure to the traumatic event; however, the onset of other negative effects may be more subtle, severe, and long-lasting (Center for Substance Abuse Treatment, 2014; Motley & Banks, 2018).

Repeated exposure to trauma across the lifespan poses significant risk to an individual's overall health, most often resulting in chronic physical health conditions, mental health dilemmas, lowered quality of life, and even early death (Center for Disease Control, 2019; Dube et al., 2010; Harris, 2018). Relevant literature identified trauma as a major public health issue for Black African American Males (BAAM) aged 18 and older, who demonstrated a noticeably higher risks for trauma exposure when compared to other racial groups (Davis et al., 2008;

Motley & Banks, 2018). Traumatic exposures have also been linked to maladaptive stress responses, including internalized problematic behaviors (e.g., anxiety, depression) and externalized problematic behaviors (e.g., aggression, violence) (Hunt et al., 2017).

In 2019, the U.S. Department of Health and Human Services Office of Minority Health reported that over half the adults who reside in the U.S. experienced trauma through adverse childhood experiences (ACEs); however, racial minority populations demonstrated increased risk for encountering one or more ACEs. The negative impact of early exposure to trauma has also been associated with mental and physical problems, such as: (a) lower self-rated health, (b) diabetes, (c) heart attacks, (d) diseases, (e) functional limitations (f) increased mortality rate and death (Dube et al., 2010; Gilbert et al., 2016; Gilbert et al., 2015; Huang et al., 2015).

The general assumption may have been that children were protected from the dangers and extreme circumstances to which adults are routinely exposed. However, current events reported in news media often highlight the fallacy in this thinking (Courtois & Gold, 2009; Singletary, 2022). Researchers found exposure to childhood trauma increased the risk for experiencing anxiety, depression, and aggression during middle childhood (Hunt et al., 2017). Children may also be affected by parental trauma exposure(s) that occurred before their birth, and possibly even prior to their conception due to the expression of epigenetic mechanisms within the DNA (Yehuda & Lehrner, 2018). Epigenetics is a well-documented science on how environmental pathology impacts cellular mechanics, with this in mind Crawford (2019) argued that Black people are essentially born traumatized.

Historical Trauma and Black African American Men

Historical trauma (HT) refers to a collective traumatic experience impacting subsequent generations of people who share an identity, affiliation, or circumstance (Brave Heart &

DeBruyn, 1998; Crawford, 2019; Evans-Campbell, 2008; Gone et al., 2019). HT has been used to describe the trauma as wounding shared by a group of people, rather than an individual's isolated experience. Sotero (2006) posits HT to be characterized by the following: (a) mass trauma deliberately and systematically inflicted upon another population by a subjugating, dominant population; (b) trauma not limited to a singular catastrophic event, but is continued over an extended period of time; (c) impact from the traumatic events extend throughout the population, creating a shared universal traumatic experience; and (d) the magnitude of the trauma derail subsequent generations resulting in a legacy of physical, psychological, social and economic disparities.

HT has been used as a reference point to examine outcomes across the life course of populations exposed to trauma at a particular point in time compared to unexposed populations (i.e. Native American Indians, holocaust survivors). For example, researchers conducted studies that involved subsequent generation of holocaust survivors to explore the transgenerational effects of the trauma on the family. Precedent research examined the intergenerational transmission trauma examining psychological effects of the German holocaust survivors' offspring (children born after the war) (Danieli, 1982). Thereafter, Nadler et al. (1985) reported that the surviving family members had an increased likelihood experiencing: (a) lowered self-esteem (b) psychological disorders, and (c) poorer physical health than their counterparts who did not directly experience the holocaust. Other recent investigations of HT have revealed that traumatic encounters which occur during childhood have the potential to cause neurobiological alterations which impact the mechanisms for coping with stressful stimuli and emotional regulation (Schore, 2009).

Of relevance, HT may also prove useful for exploring individual and community health related issues among racial and ethnic minority populations who have significant health disparities. Exposure to traumatic events has the potential to cause cognitive (i.e. depression, poor concentration and memory, lack of motivation, irritability, disinhibition, and aggression), emotional (i.e. sadness, hopelessness, worthlessness) (Singletary, 2020), and social impediments. BAAM suffer from HT and express concerns related discrimination and social injustice more often than other racial groups (Alegría et al., 2008; Ault-Brutus, 2012; Cook et al., 2007; Rich et al., 2020; U.S. Office of Minority Health, 2019). Slavery has been considered an American holocaust that can be associated with the traumatization of generations of BAAM and women (Crawford, 2019). Since the first ship from the U.S. sailed to Africa to forcefully take people as slaves up until today, this group of people has endured a legacy of trauma that is perpetuated again and again in different forms in this country (DeGruy, 2005). The historical dehumanization, subjugation, violence, and social disorganization endured by BAAM have perpetuated generational suffering and lifelong chronic stressors within the Black American community (Williams, 2018; Williams-Washington & Mills, 2018).

The negative impact of HT extends across multiple generations, such that contemporary members of the affected group may experience trauma-related symptoms without having been present for the prior traumatizing event(s) (Mohatt et al., 2014). It is impossible to imagine how and what it must be like to be stripped from your native soil, culture, and family, then be denied your basic human rights, devalued as three-fifths of whole person, as a slave to white oppressors. The process of dealing with feelings and thoughts related to HT, individual trauma, and visible mass traumas (i.e. COVID-19, unjustifiable police brutalities, and divisive political rhetoric)

compounds the complexity for BAAM attempting to responsibly manage these issues (Hawkins, 2022; Mingo, 2021; Reeves, Nzau & Smith, 2020; Singletary, 2022).

Moreover, the societal impact of HT has been particularly problematic for BAAM, who are disproportionately at-risk for additional trauma exposure(s) through witnessing and/or direct victimization (Galán et al., 2022). For BAAM, HT has resulted in a more discrete forms of traumatization and may be associated with several racially unique challenges (Motley & Banks, 2018). The negative impact of HT on the mind, bodies, souls, psyches, and spirits of Africans enslaved in the United States is often corroborated by conspiracies of silence. Dilemmas such as structural racism, discrimination, lower socioeconomic status, and systemic inequalities have been chronic stressors for generations of Black Americans (Clark et al. 1999).

Discussions about HT and the resultant racialized social ills may seem contentious as prior resolutions and social movements have fallen short in their ability to demonstrate sufficient sensitivity, cultural competency and remediation.

> In the wake of the social initiatives birthed by the Civil Rights Movement, significant changes occurred in the social sciences to address cultural variables in social and mental health care. Mental health care providers (i.e., psychiatrists, psychiatric nurse practitioners, psychologists, licensed counselors, social workers, school psychologists and counselors, marital and family therapists, certified alcohol and drug abuse counselors, and other allied professions) began to think about more effective ways to work with racial and ethnic clients whose value and worldview were different from their own. (Smith, 2015, p. 56)

History continues to manifest with artistic expressions (i.e. paint, theatre, literature, music and film) which have provided insightful bridges of communication and education about the social woes of time. For example, since the 1970's rap music (a form of hip-hop) has been used as powerful tool to convey indigenous perspectives about social grievances. As a genre, hip-hop was born out of the resistance movements particularly during the US civil rights era; it evolved

during a time of great destitution and has become a vehicle through which artists speak out against contemporary social issues (National Public Radio, 2003).

Fast forward, on May 30th, 2018, a BAAM hip-hop rap artist named Kendrick Lamar became the first rapper to earn a Pulitzer Prize; his oration was the first non-classical or jazz album to win this prestigious award since the awards began some 75 years ago. The 2017 album, titled *DAMN* provided contemporary BAAM perspectives about trauma and HT. His triple-platinum recording *DNA* revealed some of the trauma and systemic adversity laden within the DNA of BAAM (e.g., royalty, loyalty, war, peace, cocaine, murder, poison, pain, conviction). These lyrics transcend audible landscapes as Kendrick provided a glimpse of the unique challenges befalling BAAM. Since the release of *DAMN*, a growing number of notable voices from art and science have acknowledged the interaction between epigenetic factors and trauma laden within DNA, adding breath to Lamar's rhythmic vignettes (Crawford, 2019; Jones-Sawyer, 2018; Yehuda & Lehner, 2018).

Statement of the Problem

The posterity of BAAM is influenced by trauma and the negative impact of trauma related challenges encumber health and wellbeing. Existent research found traumatic experiences increase the risk of negative physical (i.e. adverse childhood experiences, victimization), psychological (i.e. desensitization, mental health diagnoses, depression, PTSD and anxiety), and social outcomes (i.e. structural racism, discrimination) (Chapman & Woodruff-Borden, 2009; Cougle Resnick & Kilpatrick, 2009; Hudson et al., 2018; Sotero, 2006). These men face complex racially unique circumstances, and despite numerous civic and social advancements many of their life-threatening dilemmas remain unresolved and under addressed. Expanding knowledge

about the challenges related to trauma is essential to understanding the complex issues that Black males experience on a daily basis (Singletary, 2020).

These men die earlier and with more frequency than other populations. When compared to other racial, ethnic, and gender groups BAAM maintained the lowest life expectancy, and highest mortality rate (Motley & Banks, 2018; Treadwell et al., 2012; U.S. Census Bureau, 2018; Watkins et al., 2010). BAAM suffer from an amalgamation of racially unique circumstances and factors including the psychophysiological burdens related to past and present trauma. The persistent disparities between physical health, mental health, social justice, and wellbeing among BAAM communities warrant additional research (Brooks & Moore, 2016). However, surfeit barriers contribute to the under recruitment of ethnic minorities in mental health-related studies (Brown et al., 2014; Spence & Oltmanns, 2011). A growing body of research has examined trauma among childhood and adolescence populations, however, there has been relatively little study of the unique experiences of Black males and the impact that past and current traumas have on their lives (Singletary, 2020; 2022).

Purpose of the Study

This qualitative research has been developed to expand the body of knowledge about the challenges of trauma in the lives of BAAM. The generic qualitative inquiry investigated personal reports, subjective opinions, attitudes, beliefs, and reflections about the challenges of BAAM who have been impacted by traumatic event(s). A collection of contemporary data (i.e. documents, fieldnotes, interviews etc.) was analyzed to answer the research question about topic. The study was designed to present descriptive information, in an authentic and meaningful fashion, to advance understanding about this complex topic among diverse populations of key stakeholders that include but should not be limited to: (a) BAAM and their families (b) public

service officials, (b) helping professionals, (c) social justice advocates, and (d) psychoeducational and researchers.

Research Question

This study will be guided by the following research question: "What are the challenges for BAAM who have experienced trauma?"

Significance of the Study

As previously mentioned, traumatic exposure has been linked to costly physical and mental dilemmas (i.e. PTSD, depression, anxiety, diabetes, hypertension) that have a negative impact throughout the lifespan (Hertzman, 1994; Hudson et al., 2018; Metzler et al., 2017; Ortiz & Sibinga, 2017). The scope of traumatic burden has remained fiscally significant; expenditures for the remediation of trauma and associated challenges have cost the U.S. hundreds of billions of dollars. In their (2016) study Trautmann, Rehm, & Wittchen estimated the economic costs of mental health reporting:

> Between 2011 and 2030, the cumulative economic output loss associated with mental disorders is thereby projected to US$ 16.3 trillion worldwide, making the economic output loss related to mental disorders comparable to that of cardiovascular diseases, and higher than that of cancer, chronic respiratory diseases, and diabetes (p. 1245)

Resources must be used efficiently to properly address trauma related issues among vulnerable populations (Lee & Chen, 2017). Unfortunately, the underuse of therapeutic interventions and services is one of the most common, costly, and debilitating psychiatric disparities among BAAM (Hudson et al., 2018). The intergenerational impact of trauma is associated with subsequent cycles of risk for experiencing trauma as well as poor physical and psychological health outcomes across the lifespan (Bryant, Wicks & Willis, 2014; Conching & Thayer, 2019; Sotero, 2006). Research from Campbell et al. (2016) revealed that one in four

children experienced some form of childhood maltreatment trauma in their lifetime and that the estimated lifetime cost of childhood maltreatment exceeded $123,000,000,000.

Conceptual Framework

Frameworks have been described as "the map for a study" (Green, 2014 p. 2). Presumptions that theory construction should be the primary type of theoretical thought in qualitative research has been challenged by researchers (Gale et al., 2013; Saldana, 2015) who advocate for the use of frameworks to guide qualitative studies. This study adapted a conceptual framework from Sotero's (2006) Historical Trauma Theory (HTT) to operationalize the research design, illustrating how the purpose of the study and literature review complement each other to answer the research question (Collins & Stockton, 2018; Green, 2014).

To articulate further, this adapted conceptual framework of HTT stems from Sotero's (2006) work which built upon three existent theoretical frameworks: (a) the psychosocial theory, linking disease to both physical and psychological stress stemming from the social environment; (b) political/economic theory, which includes political, economic and structural determinants of health and disease such as unjust power relations and class inequality; (c) and the socio-ecological systems theory that considers the multilevel dynamics and interdependencies of present/past, proximate/distal, and life course factors involved with disease causation.

Prevalent research has deployed HTT to explore mental health, political and public health concerns. Historical Trauma (HT) has been referred to as "a disease of time" (Sotero, 2006 p.100). Influential studies such as the *Journal of Social Science Medicine,* Mohott et al. (2014) have discussed the centrality of HT as a contemporary perspective with personal and public representations of trauma in the present. HTT has appeared within literature about individual and community health of racial and ethnic minority populations, who have been known to experience

significant health disparities (Brave Heart et al., 2011; Gone et al., 2019). HTT has also been applied in research of colonized indigenous groups such as:

> African Americans, Armenian refugees, Japanese American survivors of internment camps, Swedish immigrant children whose parents were torture victims, Palestinian youth, the people of Cyprus, Belgians, Cambodians, Israelis, Mexicans and Mexican Americans, Russians, and many other cultural groups and communities that share a history of oppression, victimization, or massive group trauma exposure (Mohatt et al., 2014 p. 128)

For a myriad of reasons, this qualitative research does not forsake the impact of trauma befallen BAAM. Instead, the adapted HTT framework will assist the researcher in the exploration of challenges related to the extensive exposure to individual and group trauma. This conceptual framework will offer a glimpse of individual stories of suffering, identifying causes, valorizing the person's struggle, ascribing responsibility, and mobilizing effective responses (Kirmayer, Gone & Moses, 2014). Similar research has been conducted among other populations (i.e. Jewish holocaust survivors, Native American Indians) which revealed the intergenerational transmission of emotional (i.e. shame, guilt, distrust) and psychological wounding passed down to subsequent generations (Brave Heart, 2011; Sotero, 2006).

The adapted conceptual model of historical trauma included hereafter considers eight trauma related sub-categories that emerged from existent literature about the research topic. These sub-categories are listed as follows: (a) adverse childhood experiences (ACE), (b) victimization and desensitization, (c) behavioral stress, (d) help seeking, (e) depression, (f) post-traumatic stress and anxiety, (g) lifelong impact on opportunities, and (h) mental health, wellbeing and treatment. Overall, this model illustrates the impact of historical trauma on subsequent generations via physiological, environmental and social pathways that influence an intergenerational cycle of trauma response.

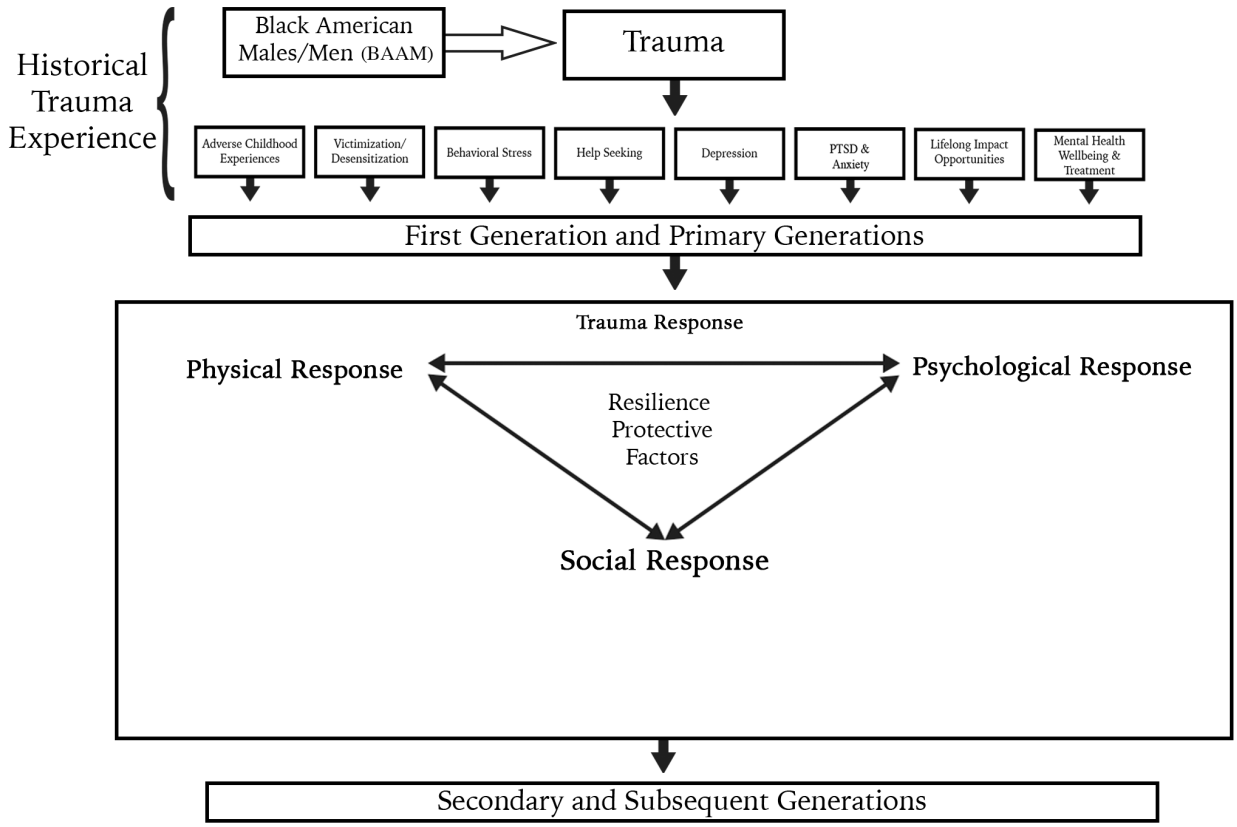

Figure 1.1. Conceptual adapted model of historical trauma.
Note. Adapted from "A Conceptual Model of Historical Trauma: Implications for Public Health Practice and Research" by M. Sotero, *Journal of Health Disparities Research and Practice, 1*(1), p. 98. Copyright 2006 by Center for Health Disparities Research School of Public Health

Assumptions

This research is premised upon the following assumptions: BAAM (a) are born traumatized by centuries of historic struggle (i.e. slavery, structural racism, discrimination, and persistent social injustice); (b) share similar historical and cultural experiences and beliefs about what it means to be Black; (c) must learn to navigate race-related stressors throughout their lifetime; (d) are nescient about historical trauma as an active impediment to their current posterity; and (e) are key stakeholders who require continued education and rehabilitation from the impact of trauma related challenges to improve their health and wellbeing.

Limitations

Potential limitations may include the barriers to recruitment of BAAM respondents who are willing and available to disclose information about their challenges with trauma. Typically, BAAM are reluctant about research involvement due to the history of stigma surrounding mental health topics, particularly in the Black community (Scharff et al., 2010; Ward et al., 2013). Although a small sample size is appropriate for this study, the generic qualitative research findings are not generalizable to the greater population of BAAM who currently reside within the U.S. (Dworkin, 2012; Robinson, 2014).

Delimitations

Delimitations aim to establish boundaries that narrow the scope of the study (Theofanidis & Antigoni, 2019). Recognizing generalization is widely considered a quality standard in quantitative research, but is more dubious in qualitative research; thus, individual studies that cannot be generalized may also be valuable (Patton, 2002; Ritchie & Lewis, 2003).

Hence, this study addresses conspicuous restrictions using purposive sampling to produce a rich, contextualized understanding of BAAM participant experiences of trauma (Robinson, 2014). Developing a meaningful understanding of collaborative information may serve as a beginning of community-based research about BAAM trauma in northwest Arkansas, that holds promise to inform practices and allocate resources to reduce the negative impact of trauma among BAAM families and communities.

Operational Definitions

ACEs: (a.) Encompass physical abuse, substance abuse, direct or indirect abuse exposure (emotional, physical, or sexual); household dysfunction (exposure to substance abuse, mental illness, parental separation, or divorce); physical and emotional neglect; other household

challenges (family member incarcerated); (b.) Refer to traumatic occurrences that may be experienced by individuals under the age of 18.

African American: The authors use the term "Black" and "African American" interchangeably throughout the paper to refer to a social, political, and culturally constructed ethnic group identity. The term "African American" conveys historic chronology, autochthonous lore, and miscegenation as it pertains to a negro, mulatto, mixed, colored. This term would more properly identify African-born people residing in the United States (James, 2017).

Black: Denotes both race and cultural affiliation and is often used synonymously with African American and Black within the literature; refers to the group of melenated racial minorities historically oppressed by the global system of structural racism.

Black African American Men (BAAM): Denote the Black African American man, male(s), or men and used interchangeably throughout to describe natural born melenated male descendants of the African diaspora who currently reside in the United States.

Coping: A person's volitional efforts to surmount their conscious or unconscious distress; and these subjective defense transactions are complex and evolving and serve as a buffer for emotion, cognition, behavior, and physiology in response to acute or chronic presentations of stressful events, circumstances, or environments.

Civic tenderness: An orientation of concern generated for people and vulnerable groups within our society; a certain kind of response that arises from a perceived vulnerability; more than a positive affective feeling state; and can also make people more physically tender in their motor behaviors.

Historical Trauma: The cumulative multigenerational psychophysiological suffering and harm experienced by a specific cultural, racial or ethnic group. This type of trauma exists as a

result of the catastrophic events which degraded groups of people through forced subjugation and oppression such as slavery.

Race-related stress: Refers to emotional, psychological, and physiological reactions of Black people facing systems of structural racism in America; pervasive and warrants subjective responses of motivation or inhibition. Responses triggered by one's awareness of their own minority status within a particular social context (i.e., vocational environment, community, or social context).

Racism: Used to denote with systemic/structural racism. Refers to the diabolical system prevalent within American history, culture, politics, and most markedly economics; and engineered to oppress, subjugate, and impede proclivities of melenated people. Diffuse system has routinely extended advantages to majority-Whites, specifically in the United States, while devising other more negative outcomes for populations with darker skin, specifically the Black male.

Trauma: Suffering caused by extreme, chronic, or prolonged activation of the body's physiological stress responses that is harmful to brain architecture and the body's systemic development and functioning.

Wellness: Refers to (a) maintaining one's subjective quality of life through successful aging; (b) living life without the interference of physical or cognitive impairment (e.g., distress, pain, disease, or chronic illnesses); and (c) maintaining inherent physical and mental powers associated with executive functioning survival and supporting one's ability to thrive without assistance from others.

Summary of the Introduction

This chapter presents an introduction of the research topic about BAAM who have experienced trauma. Next, the statement of the problem, significance of the study, and research question, and expound on the theoretical orientation are introduced. The section concludes with a presentation of assumptions, limitations, and delimitations; and lastly, the operational definitions. Chapter two will present a review of the literature.

Organization of the Dissertation

The chapters hereafter include: (a) literature review (Chapter 2) highlighting the current literature surrounding the topic of BAAM trauma and related challenges; (b) methodology section (Chapter 3) outlining the exploratory research design and procedures; (c) a chapter presenting the findings and data analysis (Chapter 4); and (d) presentation of study findings, discussion about recommendations and implications for the study's key stakeholders and other interested readers (Chapter 5).

CHAPTER 2:

REVIEW OF THE LITERATURE

Chapter two presents a review of robust literature pertaining to the challenges of BAAM who have experienced trauma. The researcher conducted the review using electronic databases from the University of Arkansas library system, Mullins Library, and Google Scholar to search articles, books, and journals about the topic. This chapter was also the impetus behind formulating the type of interview questions to ask prospective participants in determining the research question. This study was guided by the following research question: "What are the challenges for BAAM who have experienced trauma?"

Chapter two is organized into eight interconnected themes that inform the understanding of the research topic. These themes will be presented as follows: (a) adverse childhood experiences (ACEs), (b) victimization and desensitization, (c) behavioral stress response, (d) help-seeking, (e) depression (f) Post-Traumatic Stress Disorder (PTSD) and anxiety; (g) lifelong impact on opportunities, and (h) mental health well-being and treatment. The following phrases and terms were searched individually and were also used in combination with one another as necessary to reveal information about research topic: *adverse childhood experiences (ACEs), African American male, anxiety, behavioral stress response, Black American Male Trauma, Black Males, Black Men, desensitization, depression victimization, post-traumatic stress disorder (PTSD), mental health, seeking help, trauma , well-being, treatment, health impact, and opportunity impact.*

Theoretical Orientation

Historical Trauma

Historical trauma refers to the collective traumatic experience impacting subsequent generations of people who share an identity, affiliation, or circumstance (Brave Heart & DeBruyn, 1998; Crawford, 2019; Evans-Campbell, 2008; Gone, 2013). While the negative effects of historical trauma on health are evident among historically disadvantaged communities, this concept has not received as much formal attention in public health literature (Conching & Thayer, 2019). A growing body of interdisciplinary research has employed HTT, making it deserving of further inclusion within research (BraveHeart & DeBruyn, 1998; Cook, Withy, & Tarallo-Jensen, 2003; DeGruy, 2005; Maxwell, 2014; Sotero, 2006; Whitbeck et al., 2004). Brown-Rice (2013) describe the phases of historical trauma as follows:

> The first phase of entails the dominant culture perpetrating mass traumas on a population, resulting in cultural, familial, societal and economic devastation for the population. The second phase occurs when the original generation of the population responds to the trauma showing biological, societal and psychological symptoms. The final phase is when the initial responses to trauma are conveyed to successive generations through environmental and psychological factors, and prejudice and discrimination (p. 118)

To reiterate, historical trauma consists of three core elements: (a) trauma or wounding; (b) the trauma is often shared by a group of people; (c) the trauma spans multiple generations, such that contemporary members of the affected group may experience trauma-related symptoms without having been present for the past traumatizing event(s) (Mohatt et al., 2014). Understanding how historical trauma influences the current health status of racial/ethnic populations in the U.S. may provide new directions and insights for reducing health disparities (Sotero, 2006 p. 94).

Historical Trauma (HT) has been referred to as "a disease of time" (Sotero, 2006 p.100). Influential studies such as the *Journal of Social Science Medicine,* Mohott et al. (2014) have

discussed the centrality of HT as a contemporary perspective with personal and public representations of trauma in the present. HT has been associated with issues such as survivor guilt, stressful life events, intergenerational grief and bereavement, post-traumatic slave syndrome, and cultural trauma (BraveHeart & DeBruyn, 1998; Cook, Withy, & Tarallo-Jensen, 2003; Danieli, 1998; DeGruy, 2005). Existent literature pertaining to the individual and community health of racial and ethnic minority populations also identified historical trauma as a pertinent topic (Brave Heart et al., 2011; Gone et al., 2019). HT has been applied in research of colonized indigenous groups who have been known to experience significant health disparities, these groups include but should not be limited to:

> African Americans, Armenian refugees, Japanese American survivors of internment camps, Swedish immigrant children whose parents were torture victims, Palestinian youth, the people of Cyprus, Belgians, Cambodians, Israelis, Mexicans and Mexican Americans, Russians, and many other cultural groups and communities that share a history of oppression, victimization, or massive group trauma exposure (Mohatt et al., 2014 p. 128)

Historical trauma functions as a contemporary narrative with personal and public representations in the present (Mohatt et al., 2014). Research that seeks to analyze how and why trauma is experienced must consider disparities and shifts in the broader social recognition of different forms of trauma and victimization (Maxwell, 2014). For example, in the United States 61% of Black African American children experience trauma through ACEs (Sacks & Murphey, 2018). Additionally, contemporary stressors may also take the form of public reminders of historical subjugation; confederate statues across the U.S. have recently been removed due to the divisive message the public commemoration of these individuals sends (Mohatt et al., 2014; NWA Democrat-Gazette, 2020).

Historical Trauma Theory

This dissertation will utilize a theoretical framework adapted from Sotero's (2006) conceptual model of historical trauma. Theoretical frameworks have been described as "the map for a study" (Green, 2014). Presumptions that theory construction should be the primary type of theoretical thought in qualitative research has been challenged by researchers (Gale et al., 2013; Saldana, 2015;) who advocate for the use of frameworks to guide qualitative studies. This study's theoretical orientation will operationalize the research design, illustrating how the purpose of the study and literature review complement each other to answer the research question (Collins & Stockton, 2018; Green, 2014).

To articulate further, this adapted conceptual framework of HTT stems from Sotero's (2006) work which built upon three existent theoretical frameworks: (a) the psychosocial theory, linking disease to both physical and psychological stress stemming from the social environment; (b) political/economic theory, which includes political, economic and structural determinants of health and disease such as unjust power relations and class inequality; (c) and the social/ecological systems theory that considers the multilevel dynamics and interdependencies of present/past, proximate/distal, and life course factors involved with disease causation.

For a myriad of reasons, this qualitative research does not forsake the impact of trauma befallen BAAM. Instead, this study will use an adapted HTT framework to assist the exploration of challenges related to the extensive exposure to individual and group trauma. This conceptual framework will offer a glimpse of individual stories of suffering, identifying causes, valorizing the person's struggle, ascribing responsibility, and mobilizing effective responses (Kirmayer, Gone & Moses, 2014). Similar research has been conducted among other populations (i.e. Jewish holocaust survivors, Native American Indians) which revealed the intergenerational transmission

of emotional (i.e. shame, guilt, distrust) and psychological wounding passed down to subsequent generations (Brave Heart, 2011; Sotero, 2006).

Explication of the comparatively poor physical, psychological, and social health outcomes among BAAM is convoluted by historic and contemporary digressions. For 21st century African Americans to attain freedom and move toward a greater future, they must first reclaim what was lost during the experience of "the most traumatizing mass human migration in modern history" (DeGruy, 2005 p. 25). Research about this population should endeavor to include an appreciation of the direct and indirect impact of historical, economic, and societal factors on the population (Halloran, 2019).

This generic qualitative research adapted Sotero's (2006) conceptual model of historical trauma theory (HTT), as a robust theoretical framework to explore the research topic. The adapted conceptual model of historical trauma included hereafter considers eight important trauma related subcategories or elements engrained within experiences of BAAM. These sub-categories are listed as follows: (a) adverse childhood experiences (ACE), (b) victimization and desensitization, (c) behavioral stress, (d) help seeking, (e) depression, (f) PTSD and anxiety, (g) lifelong impact on opportunities, and (h) mental health, wellbeing and treatment. This conceptual adaptation illustrates the impact of historical trauma on subsequent generations via physiological, environmental and social pathways that influence an intergenerational cycle of trauma response.

ACEs

Carl Hertzman (1994) examined the lifelong impact of childhood experiences on population health. His research explored the impact of early experiences among four different groups using two explanatory models: a) latency and b) pathways, to analyze the impact of

childhood experiences in later life. The latency model emphasized the importance of discrete events that occur early in life and have a strong independent effect later in life. Alternatively, the pathways model proposed the cumulative effects of life events and ongoing importance of life course conditions. These models conflicted with one another despite the conceptual complementarity. To resolve this conflict, Hertzman offered a pragmatic resolution that drew upon the strengths of each model writing:

> We need an approach to policy which builds towards a new working consensus, which stresses the importance of the life cycle. It should be action-oriented and grounded in social experimentation. And it should be receptive to the notion that there may be small answers to big questions. The latter may be the most important characteristic of all. Many of the most promising social interventions are rather modest in character: the value of positive mentors and good recreation programs for the young, a few opportunities at a 'second chance' to make a successful transition from childhood to adulthood, and a strong social support network to buffer the stresses of middle and late life. (p. 177)

In 1998, the *American Journal of Preventative Medicine* landmark research described the long-term relationship of childhood experiences to important medical and public health problems (Felitti et al., 1998). Prior to this, the relationship of health risk behaviors and disease in adulthood to the breadth of exposure to childhood emotional, physical, or sexual abuse and household dysfunction during childhood had not been described. The research was based at the Kaiser Permanente San Diego Health Appraisal Clinic where ACE researchers mailed questionnaires to members of the Kaiser health plan. Foundational data revealed that higher levels of exposure to ACEs were also associated with anxiety, anger, and depression. ACEs were also described to impact the likelihood of maladaptive coping strategies such as smoking, alcohol consumption, or drug use. Resultant findings also suggested a strong dose response relationship between the breadth of exposure to abuse or household dysfunction during childhood and multiple risk factors for several of the leading causes of death in adults (p. 251).

In 2006, a convergence of neurobiological and epidemiological evidence suggested that early life stressors, such as abuse and adverse experiences, cause enduring brain dysfunction that affects health and quality of life throughout one's lifespan (Anda et al.). This investigation included findings from the landmark Kaiser study where at least one ACE was reported by over half of the respondents. Epidemiological research purported that ACEs could impair, often permanently, the activity of major neuroregulatory systems, with profound and lasting neurobehavioral consequences. Their investigation also explained health-related correlates for ACES, which included: (a) substance use, (b) sexuality, (c) cardiovascular disease, (d) hypertension, (e) hyperlipidemia, (f) asthma, (g) metabolic abnormalities, (h) obesity, (i) infection, and (j) other physical disorders. Ultimately, the research described how multiple forms of abuse and stressors were cumulative, and the brain's vulnerability to stress during critical periods of development.

In *Future Medicine*, Anda and Brown (2007) explained how ACEs become a part of a person's social, emotional, and cognitive makeup. The researchers argued that if ACEs were the root of health-related problems in a country, then other social disadvantages such as racism, poverty, socioeconomic status, and the lack of access to healthcare were the soil in which these roots were embedded. Their editorial also reported associations between ACE's and the increased risk for developing maladaptive behaviors such as: (a) violence, (b) revictimization, (c) poor psychosocial functioning, (d) disease, and (e) disability. The researchers conclude placing a high emphasis on the importance of continued research about the effects of stress on neurodevelopment to further our ability to reduce the cumulative exposure(s) of children to activated stress response during critical periods of development.

In 2009, researchers Brown et al. conducted a survey among a prospective cohort who had been exposed to multiple traumatic stressors during childhood. Like other ACE studies, their research also exhibited graded relationships between ACEs and other health-related risk factors. These traumatic childhood experiences had a negative neurodevelopmental impact which increased the risk of other behavioral, health, and social problems. Results revealed that the people who had six or more ACEs died nearly 20 years earlier on average than those without ACEs.

A study conducted by Gilbert et al. (2015) used data from the Behavioral Risk Factor Surveillance System to investigate the pathology of adult morbidity and mortality among the most significant representative sample of American citizens to date. The researchers attributed the root of familial dysfunctions and abuses to ACEs as approximately 60% of respondents reported at least one ACE. Their investigation revealed a linear dose response relationship between the number of ACEs experienced and acquired health conditions (i.e. coronary heart disease, stroke, and diabetes). Additionally, after controlling for demographic variables, they found mental distress, disability, and fair or poor general health to be associated with ACE exposure.

> Over the life course, excessive stress induced inflammation increases allostatic load, providing a pathway whereby early life adverse environments predispose to poor health outcomes later in life. The findings of this study suggest that young men who reside in impoverished neighborhoods marked by violence may be at risk for future inflammatory disease. The impact of exposure, even if indirect, to neighborhood violence on stress reactivity has not previously been reported in the emerging adult literature, and this has particular health relevance for those who grow up in disadvantaged urban areas (Gilbert et al., 2015, p. 133).

During a systematic review of ACEs and the risk of suffering from type 2 diabetes Huang et al. (2015) reviewed seven articles, four cohort studies, and three cross sectional studies. Findings from their review confirmed research hypothesis that ACEs were associated with a

significantly elevated risk of type 2 diabetes in adulthood. According to Huang and colleagues, people who reported having ACEs had a 32% increased risk of developing type 2 diabetes later in life when compared to those study participants who reported no ACE exposure. Moreover, the study's findings reported the impact of childhood neglect was more prominent within the research than that of other types of abuse (i.e. physical and sexual).

A community-based research initiative was conducted in Florida by Salinas-Miranda et al. (2015) to investigate the impact of ACEs on health-related quality of life. The research team analyzed data collected from a group of economically disadvantaged group of predominantly Black participants. The methods used to assess the cumulative risk from childhood to adulthood included a community based participatory approach in combination with a Brief Family History Questionnaire (abridged from another ACE study). Their study took place over three years, confirming the researchers' hypothesis that adverse childhood events and health related quality of life were associated. The longitudinal data also suggested that childhood adversity could continue to affect the mental and behavioral health trajectory of adults over time.

A cross sectional analysis was conducted by Almuneef et al. (2016) to explore the retrospective prevalence of ACEs. The research considered the association between ACEs mental health, physical health, and risky behaviors. This study was unique in the exploration of a broad array of traumatic experiences among adult aged respondents from all 13 regions of the Kingdom of Saudi Arabia compared to traditional U.S. based ACE studies. Resultant data revealed that a threshold of two or more ACEs had a statistically significant impact on hypertension, mental illness, smoking, alcohol, and substance abuse among the study's respondents. Additionally, the data demonstrated findings similar to other ACE studies with

statistically significant graded relationships, as the ACE scores increased, so did the odds of the negative health related outcomes.

> To date, within the ACEs research field many studies have focused on the relative importance of ACEs scores of four or higher. However, when viewed from a public health perspective, the relative importance of lower ACE scores and their association with certain health outcomes may have been underappreciated (p. 15)."

Research from Cecil et al. (2016) described epigenetic signatures of childhood abuse and neglect and implied that those exposed to such abuse and neglect maintained a certain level of psychiatric vulnerability:

> Maltreatment types were also found to share a common methylomic signature, primarily enriched for processes related to neurodevelopment and organismal growth. This is consistent with a large body of evidence from animal and human studies documenting the impact of maltreatment and early life stress on brain structure, function, and development. (p. 191)

Children who experience maltreatment are at increased risk for a range of psychiatric problems, including anxiety, depression, PTSD, and antisocial behavior. Additionally, the research explained the theory of latent vulnerability as maltreatment exposure, which calibrates a range of biological and neurocognitive systems and causes a short-term and adaptive effect to a threatening and unpredictable early environment. Other biological correlates of maltreatment were also identified within the study, these included: (a) accelerated cellular aging, (b) neuroendocrine dysregulation, (c) heightened inflammatory response, and (d) altered brain structure and function. The researchers encouraged continued investigation of epigenetic processes like DNA methylation, which control the functional regulation of gene expression; as mounting evidence suggests that epigenetic processes can be modified by environmental factors (Cecil et al., 2016).

Research conducted by Janusek et al. (2016) evaluated the extent to which exposure to childhood adversity influenced one's psychological, cortisol, and proinflammatory response to

acute stress. Their research was conducted with a proinflammatory phenotype of African American male respondents from low-income neighborhoods in Chicago. The research methods included the use of pre- and post-Trier Social Stress Test instruments. Resultant data revealed that the salivary cortisol and IL-6 responses of 34 emerging adult African American males possessed a significant association between childhood trauma and indirect exposure to violence. These findings had particular relevance for disadvantaged African American men, who often demonstrated a disproportionately higher incidence and severity of inflammation-related diseases, most commonly cardiovascular disease (Janusek et al., 2016). Moreover, the data indicated that persons with chronic exposure to high psychosocial stress possessed higher rates of inflammation and increased rates of risk for diseases. Their research also suggested that adversity predicts higher levels of inflammatory markers in African Americans than Whites (Janusek et al., 2016, p. 126).

In 2017, Berens et al. conducted a meta-analysis of early life adversity (ELA). The Peer-reviewed analysis included an examination of academic literature pertaining to early life adversity from several databases, using cross-sectional animal studies where prospective human evidence was unavailable. Existent data about biological mechanisms thought to link ELA to later disease were organized across five impact domains: (a) brain structure and activity; (b) neuroendocrine stress regulation; (c) immune functioning; (d) metabolic health; and (e) the microbiome. Like other childhood adversity studies, their research regarded ELA as the soil which gives root to various manifestations of poor health across the life span. The researchers encouraged the use of disease prevention paradigms that transition from the proximal focus being on risk (e.g., diet and substance use) for experiencing specific diseases towards life course models which account for the early influence of lifelong health.

The review of ACEs literature revealed associations with a range of physiological, psychological, and sociological correlates found to lower life expectancy. Existent research revealed that ACEs have a profound impact on the regulation of biological and neurological systems across the lifespan. ACE exposure was also linked to increased rate of risk for negative health-related outcomes across the lifespan, with racial groups, most often black males demonstrating increased risk for exposure to ACEs. The impact of ACEs within the is lifelong and grievous.

Victimization and Desensitization

Ports et al. (2015). suggested a dose-response relationship between ACE scores and the likelihood of experiencing sexual victimization in adulthood. In this study the individuals who reported five or more ACEs demonstrated increased victimization when compared to those with no ACEs. This study's findings were not unlike that of the landmark CDC-Kaiser ACE study, describing that the prevalence of childhood sexual abuse had a significant impact on the likelihood of revictimization in adulthood. Their research also considered the interconnectedness of childhood sexual abuse and other adversities, revealing that adults who experienced one type of ACE are likely to have suffered multiple ACEs. Practitioners and researchers should include these linkages in their work as they develop and strengthen integrated services that acknowledge and incorporate the associations between early childhood experiences and health outcomes across one's lifespan.

Gaylord-Harden et al. (2017) explored the emotional and cognitive desensitization effects of community violence among a sample of male adolescents of color from urban communities. The research linked exposure to community violence with several maladaptive psychosocial outcomes. The study design used the pathologic adaptation model as framework for analyzing

data from youth who demonstrated responsivity to high levels of violence and emotional numbing as evidenced by lower levels of emotional symptoms and higher levels of violent behavior. Researchers noted that exposure to stress caused an initial increase in the behavioral response, followed by a decrease in responsiveness during repeated exposure to the same stimulus. The process of emotional desensitization appeared adaptive for decreasing depressive symptoms in the short-term; however, desensitization seemed to place youth at higher risk for callousness, violence perpetration, and additional violence exposure if the adaptation became chronic. In 2017, Gaylord-Harden et al. described desensitization as:

> One of the most dangerous consequences of violence exposure because it is believed to lead to violence perpetration and additional violence exposure as youth begin to experience emotional numbing, view violence as normative, and lose inhibitions about using violent behavior. (p. 464)

This section provided information about the relationship between trauma, victimization, and desensitization. The literature revealed that individuals who suffered from ACEs had a higher chance of experiencing revictimization and other adversity during adulthood. The review described linkages between traumatic exposures, violence, and maladaptive behaviors. Cognitive desensitization and emotional numbing were also introduced as maladaptive behaviors associated with traumatic exposure.

Behavioral Stress Response

Prospective research from Sellers and Shelton (2003) examined the direct and indirect relationships between racial identity, racial discrimination, perceived stress, and psychological distress among a sample of 555 African American Adults. The investigation hypothesized that racial centrality, racial ideology, and racial regard would moderate the mental health consequences of perceived racial discrimination. Their study purported that ideological differences exist about who Black people are, how they should behave, how they are treated,

these ideological mediate the psychological response to perceived racial discrimination among African Americans. This meant that some African Americans might be negatively affected by perceived discrimination, whereas others may be buffered from these consequences because of their ideological beliefs regarding the significance and meaning of race.

A 4-year longitudinal study examined the moderating influence of race/ethnicity on the relationship between child maltreatment, internalizing symptoms (e.g., affective and somatic problems) and externalizing behavior (e.g., rule breaking behavior and aggression) among African American and Caucasian children aged seven through 12 years old (Hatcher et al., 2009). Their research examined 151 youth who possessed a history of being maltreated or non-maltreated. Identifying how race/ethnicity influences the causal pathways that link child maltreatment to adverse child behavior or juvenile delinquency can help to identify characteristics of youth that are most at risk (p. 1043). Resultant data from the maltreatment study failed to yield a significant link between race and ethnicity and internalizing and externalizing behaviors; however, the researchers did note that African American youth's internalizing symptoms and externalizing behaviors were consistent and significantly higher than their Caucasian counterparts. These findings can also help service providers to develop culturally specific theoretical explanations that can be used to design or modify assessment and intervention strategies (p. 1043).

Myers (2009) conducted a selective review of stress exposure and other psychosocial and biobehavioral risk factors such as exposure to racism and discrimination, as contributory factors to diseases among African Americans. The epidemiologic study introduced a modified bio-psychosocial model for stress and disease risk to explain ethnic group differences about health and disease. Myers hypothesized that the interplay of these factors result in cumulative

biopsychosocial vulnerability over the life span, which accounts, at least in part, for the cross-generational persistence of the health disparities documented in the epidemiologic literature. The analysis revealed that the interactions between race and socioeconomic factors demonstrated an effect across the lifespan that was mediated through six pathways: (a) long-term chronic exposure to psychosocial adversities, (b) psychosocial reserve capacity, (c) cognitive-emotional processing, (d) clustering of health injurious behaviors, (e) biological, and (f) health care pathways. The literature also reported that African Americans exhibited higher rates of morbidity and mortality when compared to other racial groups.

Champagne's (2010) article on developmental psychobiology reported that environmentally induced changes in brain and behavior can influence offspring and grand offspring. The research described the epigenetic influence for maternal nutrition, physiology, and psychological state on the developing fetus; for example, the social and environmental experiences of the mother can lead to divergent developmental pathways of offspring. Champagne analyzed data from a stress exposure experiment conducted with rodents and reported, "Emerging evidence suggests that prenatal environmental exposures, postnatal mother–infant interactions, juvenile social rearing, and adult social stress can alter epigenetic processes such as DNA methylation (p. 2)". Resultant findings also indicated that higher rates of parental bonding were associated with elevated self-esteem, reduced trait anxiety, decreased salivary cortisol, and reduced activation within the rodents' ventral striatum in response to stress. The epigenetic study offered implications and broadened research perspectives about the inheritance of risk and resilience in response to social interactions:

> The quality of the social environment beyond infancy is capable of shifting patterns of gene expression with consequences for the functioning of the individual within their social context … Adult social interactions influence physiology and behavior and have

> been observed in humans, primates, as well as rodents implying the developmental plasticity among maturing organisms. (p. 2)

Using data from the 2010 Centers for Disease Control and Preventions' Brief Risk Factor Surveillance Survey, Fuller-Thomas et al. (2013) investigated association between ACEs, smoking initiation, and smoking cessation in men and women. Their research examined smoking association across six ACE categories: (a) parental separation or divorce, (b) problematic household drinking, (c) household substance abuse, (d) sexual abuse, (e) physical abuse, and verbal abuse. Researchers conveyed that the relationship between child maltreatment and smoking might be confounded by several risk factors, most notably other ACEs. Their study found that the males with environmental ACEs such as living with an alcoholic or drug abuser, parental divorce, and parental physical abuse demonstrated higher odds of ever smoking. Resultant data also revealed a graded relationship between the number of ACEs and the number of health risk factors that contributed to leading causes of death, such as: (a) smoking, (b) severe obesity, (c) physical inactivity, (d) depressed mood, (e) alcoholism, and (d) drug use.

In 2013, Wade and Rochlen explored psychosocial factors associated with health and well-being for African American men, they reported "Exposure to racial discrimination is a stressor that can adversely affect one's health" (p. 1). Their investigation identified associations between traditional masculinity and racial identity to the health and well-being of African American men. The researchers described that the masculine enactments of young African American men as the "Cool Pose," this was characterized by ritualized behaviors, scripts, physical posturing, impression management, and carefully crafted performances that deliver a single, critical message: pride, strength, and control (p. 2). Some of the historical formulations of traditional masculine ideology in contemporary American culture focused on standards and expectations which have resulted in negative consequences (i.e. anti-femininity, homophobia,

emotional restrictiveness). Data from this study revealed that variability exists about how masculine identities were conceptualized and negotiated among African American males. Racism and discrimination were described as significant common risk factors which have negatively affected the physical health and well-being of many African American men.

Research about African American men and women's attitude toward mental illness, perceptions of stigma, and preferred coping behaviors examined whether attitudes and preferred coping behaviors varied across gender and age (Ward et al., 2013). Their investigation exposed barriers for mental health service use to include: (a) stigma, (b) poor access to care, (c) receipt of poor-quality care, and (d) lack of availability of care associated with mental illness. Ward and colleagues also found that respondents seemed tentative about using informal supports. This was inconsistent with other existent literature, which had demonstrated that use of informal support such as family and friends are common among African American women and men. Resultant data also revealed that many of the respondents were concerned with the stigma related to disclosure of mental health service use; concerns about stigmatization were quite prevalent within the African American community.

Prospective research from Hunt et al. (2017), assessed and categorized adverse childhood experiences and behavioral problems that occur during middle childhood. The study explored longitudinal data drawn from a population-based, birth cohort: Fragile Families and Child Wellbeing (FFWCW). The assessment of child maltreatment used categories similar those of the CDC-Kaiser ACE study, these categories included: (a) emotional neglect, (b) physical neglect, (c) emotional abuse, (d) physical abuse, (e) parental domestic violence, (e) anxiety or depression, (f) substance abuse, and (g) incarceration. The investigation examined ACEs and behavioral problems for more than 3,000 children who had been exposed to ACEs by the age of 5 reporting:

> Children with problem behaviors have an increased risk of developing clinical level mental illnesses and physical health problems later in life. Adults are more vulnerable to depression if they were anxious or depressed in childhood and more likely to have anxiety disorders if they experienced childhood externalizing problem behaviors. p. 392)

The resultant data from Hunt et al. (2017) demonstrated that the internalizing behavioral problems such as anxiety and depression and externalizing behavioral problems such as aggression were more likely to emerge after exposure to childhood adversity. The data also found that the Black children reported the highest prevalence of each maltreatment type and were also much more likely to live with an adult who had spent time in jail or prison compared to individual from other racial groups.

In 2017, research about the role of mindfulness in reducing the adverse effects of childhood stress and trauma was reviewed by Ortiz and Sibinga. They aimed to identify the benefits of mindfulness-based interventions as a strategy for mitigating the negative sequelae of childhood trauma by summarizing relevant research in adult pediatric populations. The researchers explained that every human being has the capacity for mindfulness which was characterized to include: (a) nonreactivity, (b) awareness, (b) focus, (c) attention, and (d) nonjudgment. Their investigation found mindfulness practices were a viable strategy for intervention and acted as a buffer for the impact of childhood trauma and stress. Resultant data also found that toxic stress increased the body's allostatic load, caused neuroanatomical changes and increased inflammation, morbidity, and mortality both during childhood and across the lifespan into adulthood.

The review of behavioral stress response literature contained information about problematic behaviors associated with exposure to trauma and adverse experiences. The research selected for inclusion in this section described: (a) African Americans' possessed an increased likelihood for experiencing the psychological toll of trauma and stress; (b) factors such as stigma

and discrimination limited access to healthcare mental health service use; (c) psychosocial factors were linked to maladaptive stress-related behaviors such as smoking, emotional restrictiveness which have been known to negatively impact health and well-being across the lifespan.

Help-Seeking

Ward (2005) explored the experiences of 13 African American parents who sought counseling services from a community mental health center in the midwestern United States. The study used grounded theory to analyze the subjective perceptions of the respondents. Historically, mental health treatment for African Americans had been characterized by: (a) lower rates of outpatient care, (b) high rates of inpatient care, premature termination, (c) psychological misdiagnosis, (d) cultural mistrust, and more recently, (e) spirituality and religiosity. Resultant data identified three dimensions that influenced the clients' counseling experience client-therapist match, safety in therapy, and counselor effectiveness. Ward's research also revealed that African American clients appeared to monitor and manage self-disclosing along a continuum:

> When these clients perceived their counselor to be effective, they felt safe, which enabled them to engage in open disclosing, possibly leading to more positive counseling processes such as working alliance. On the other hand, assessing sometimes led to negative outcomes, such as apprehension about counseling and superficial disclosing, when participants perceived that the issues salient to them, such as client-counselor match and safety, were not addressed. (Ward, 2005, p. 479)

De Maynard (2007) used grounded theory to analyze the critical elements of mental health for visibly Black African and African-Caribbean men who became mentally ill in London, England. The study provided qualitative data about the context in which mental illness appeared to originate. Most participants demonstrated social rather than psychological problems and were therefore less likely to make use of psychological and psychiatric interventions. Qualitative

ethnographic data indicated that the Black men had "their own ideas about what might be wrong with them; culturally derived explanations for why they feel, think, and act the way they do" (p. 39). Similarly, the Black males' explanation for a presenting behavior often failed to concur with explanations offered by health and social professionals. De Maynard argued that "Presenting symptoms, when taken out of context, lose their meaning, and, therefore, any treatment offered cannot address the cause of the apparent mental illness because the cause as yet remains hidden" (p. 42).

In a study about the avoidance factors that inhibited individuals from seeking professional help Vogel et al. (2007) used multidimensional information about psychological help-seeking barriers within counseling, clinical and social psychology, social work, and psychiatry. The research suggested that seeking professional help is an approach-avoidance conflict where the approach factors increased the likelihood and avoidance decreased the likelihood of individuals initiating help-seeking behavior. Several avoidance factors were identified which stifled the help-seeking process: (a) social stigma, (b) treatment fear, (c) fear of emotion, (d) anticipated utility and risk, (e) social norms, and (f) self-esteem. Other avoidance factors, such as "the risks of being perceived as crazy," (p. 410) decreased the likelihood that individuals would seek help. Avoidance factors varied in their intensity and importance depending on individual characteristics (i.e. sex, age, type of problem), the environment, as well as social and cultural influencers. The researchers also found it common for minority populations to use family and friends rather than counselors when they needed help.

Research from Davis et al. (2008) identified several treatment barriers among a sample of low-income African Americans with undiagnosed PTSD**.** The study assessed the frequency of trauma exposure and PTSD symptoms using screening tools to collect data about respondent

lifetime history of traumatic events. Their study conveyed that low-income African Americans exhibited higher rates of PTSD when compared to the general U.S. population. Additionally, low-income respondents who reported fewer barriers were more likely to receive mental health services and more prone to seek mental health care via emergency services or primary care providers. Findings also revealed fear of family and community disapproval exist as significant barriers resulting in inadequate treatment and more severe outcomes for PTSD. Several other treatment barriers were found to exist at the individual level (e.g., insufficient finances and extremely stressful lives) and institutional level (e.g., unfamiliarity with clinical services and ineligibility).

In 2011, Murry et al. investigated perceptions about mental health care and help-seeking among rural African American families. To accomplish this goal qualitative data from mothers of children with mental disorders who expressed feelings related to cultural mistrust, stigma, and barriers associated with the involvement of mental health professionals in their family business. The study was guided by a conceptual model of health service use adapted to recognize the role of community factors in help-seeking and service use. Researchers described that help-seeking required: (a) clinical need (i.e., the patient's clinical status), (b) predisposing factors (i.e., family history of mental illness and service use), and (c) enabling factors (i.e., family beliefs about help-seeking and knowledge of relevant resources). The results described social, political, and economic marginalization to be a culminate disadvantage which exerted a powerful influence on medical care and access to service, ultimately perpetuating poor health and health disparities. Similar to other existent literature about the topic, this investigation found that depression, anxiety, attention deficit disorder, attention deficit hyperactive disorder, and other emotional and behavioral problems were concentrated and prevalent for African American children, particularly

those living within impoverished rural communities. Resultant data also revealed that self-referral for mental health care never occurred; participants reported never seeking mental health services directly. Instead, primary health care providers and social institutions, such as schools or the juvenile court system, had referred participants to mental health services.

In 2012, Ault-Brutus examined disparities among a sample of white-black and white-Latino Americans using two of the largest nationally representative service use surveys, the 1990–1992 National Comorbidity Survey (NCS) and the 2001–2003 National Comorbidity Survey Replication. The epidemiological research sought to investigate adequacy, accessibility, and acceptability of mental health services. The study revealed: (a) White-black and white-Latino disparities in the use of mental health care increased between 1990 and 2003 (b) Black and Latino respondents were less likely than Whites to use antidepressants (c) Blacks and Latinos had a limited availability of high-quality providers and treatments in the communities in which they reside.

Grande et al. (2013) interviewed a random selection of 20 African Americans ages 18 to 35 to characterize brotherhood and understand the nature of brotherhood as it relates to wellness and health-seeking behaviors among African Americans. Their investigation revealed five aspects as being essential for both brotherhood and healthcare use among African American men: (a) trusting, which lessens individual barriers to action, (b) identification, which unites men through a process of authentication, (c) generational leadership established by example, (d) approaching life as a shared learning experience, and (c) social pressure and ridicule, which uphold the need for collective action. Their study also explained that lack of trustworthy relationships disproportionately affected African Americans, particularly African American men, who were found to respond positively when they have trusting relationships.

Using a qualitative design, Thompson et al. (2013) examined the experiences, expectations, and intentions of African American mothers and their youth who sought mental health services. Ultimately, this descriptive analysis highlighted disparities about the mental health treatment of African Americans. The researchers maintained that African American parents' expectations about mental health treatment for their children were influenced by: (a) the parents' prior experiences with clinical outcomes of treatment (direct and indirect), (b) the relationship quality with the treatment provider, and (c) the autonomy afforded to parents during treatment. When asked about seeking mental health services, many mothers and youth reported that they had positive expectations, positive experiences, and positive intentions . In contrast, a smaller portion of the respondent mothers reported negative expectations but also had positive intentions to seek mental health services. Some of the mothers also expressed concerns about patient privacy and reported challenges with medication management.

This section described that the help-seeking behaviors of Black men in America were influenced by factors such as: trusting relationships, generational leadership, brotherhood, and shared learning. Some racial disparities were presented along with several other barriers that were identified to impede the adequacy, accessibility, and acceptability of mental health services for Black men. The perpetuation of these and other help-seeking challenges is a result of the social, political, and economic marginalization of Black men, which exerts a powerful influence on access to services.

Depression

Alegría et al. (2008) investigated disparities in depression treatment among racial and ethnic minority populations within the United States. Evidence showed African American respondents who used services in the prior year had appreciably lower odds of receiving

adequate depression care when compared to non-Latino Whites. Pooled data from the National Institute of Mental Health Collaborative Psychiatric Epidemiology Surveys found that regardless of race or ethnicity, most people who accessed services for depression treatment received inadequate care; African Americans were particularly less likely to receive adequate care.

Research from Siegrist (2008) highlighted associations between work-related psychosocial stress and depression. Proper identification of modifiable risk factors could help with the design and implementation of preventive strategies to reduce the high burden of disease and related costs. Evidence also pointed to risks of depression elevated as a function of exposure to psychosocial stress related to work. Substantial evidence indicated a prospectively established associations between psychosocial adversities in the work environment (i.e. high demand and low control; high effort and low reward) and depression.

Lindsey and Marcell (2012) examined individual, sociocultural, social network, and system-level factors that impacted Black males' mental health help-seeking behavior. Their qualitative research emphasized the importance of understanding how multiple complex factors influenced help-seeking behaviors for emotional problems among an urban sample of Black men. The study design provided insight into the interactions between Black male socioeconomics, social support, and perceptions regarding mental health help-seeking and care accessibility. Resultant data offered three significant themes related to men's mental health help-seeking behavior: (a) taking care of it oneself, (b) issues engaging potential sources of help, and (c) tipping points. Lindsey and Marcell also reported:

> Across groups, participants discussed personality characteristics that may facilitate (e.g., "self-assurance"/ confidence) or hinder (e.g., "ego," "pride") help-seeking and described that in lieu of help-seeking for assistance with emotional struggles, they did things for themselves as a means for problem-solving including engaging in (a) hobbies, (b) introspective activities, and (c) drugs. (p. 357)

Ward and Mengesha (2013) reviewed existent studies to investigate the prevalence of depression related risk factors, treatment-seeking behaviors, and barriers among African American or Black men. The review included 19 empirical studies that investigated depression among African American men. The research revealed associations between depression and issues such as work-related stress, employment earnings and job stability. Findings identified income as a significant protective factor against depressive symptoms among African American men and that being married and having a higher level of income served as a potential protective factor for improved mental health among African American men. Additionally, as retirement decreased depressive symptoms in some other racial groups, it increased depressive symptoms in African American men. Resultant data also revealed that the Men who had been divorced, separated, widowed, and never married reported significantly greater odds of major depression when compared with married men.

Historically, African American males have demonstrated lower rates of participation as well as unsuccessful recruitment within depression studies; thus, Bryant et al. (2014) sought to fill this void by investigating how African American men recognized and expressed major depression disorder. Their research revealed that African American males had a higher chance of experiencing major depressive disorders that impacts their quality of life and daily functioning. Deleterious psychosocial stressors and adverse life events were also linked to higher levels of depression and placed many African American men at greater risk for depressive onset when compared to majority population. In their study, Bryant et al. described some challenges with the recruitment of depressed African Americans participants:

> Researchers typically experience challenges in recruiting African Americans who have been diagnosed with depression. Factors contributing to this situation include lack of awareness of the importance of health care research and, more specifically, mental health research, mistrust of researchers by African Americans, and the stigma associated with

> mental health disorders as a medical diagnosis and research topic. These challenges have led to an overall under-representation of African Americans in mental health research in general in the U.S. (p. 18)

Mitchell et al. (2017) reported that "More than 7% of all African American men will develop clinically diagnosed depression during their lifetimes" (p. 1366). Their mental health research analyzed self-reported responses about correlates for downheartedness from older African American men about. The nature of depressive disorders among African American seemed to stem from an intersection of factors such as individual behavior and the interpretation of depressive symptoms. Resultant data confirmed that 23% of the older African Americans had experienced at least one lifetime mental health disorder. The researchers also reiterated that the mental health needs of aging African American men have been understudied, overlooked, and underdiagnosed.

Hudson et al. (2018) reported that studies about African American male depression has lacked and only a scarcity of data existed about treatment-seeking experiences. To bridge this literary gap, researchers recorded the perceptions of depression and depression care among a sample of adult African American males in St. Louis. The research sought to unveil information about the appropriateness, acceptability, or effectiveness of depression care.

> What things stress you the most? What does the word "depression" mean to you? How would you feel if one of your friends told you that he was depressed? How do you deal with stress or negative feelings? Would you be open to talking to a professional, such as a counselor, to help you deal with stress? Would you be open to talking to clergy, like a pastor or priest, to help you deal with stress? What do you think prevents men, particularly Black men, from seeking depression treatment? What resources would be helpful to you if you were feeling stressed or depressed? (Hudson et al., 2018, p. 129

Identifying African American men who could be suffering from depression could be challenging because many men choose not to discuss their feelings, particularly with mental health providers (Hudson et al., 2018). Resultant data revealed that approximately half of the

sample reported being unemployed, with most of the participants describing a great deal of stress due to their unemployment or underemployment.

In 2018, Lindsey et al. analyzed randomly controlled trials to determine the most efficacious depression treatments among young Black men (YBM). The research examined 12 studies with a total of 2,586 respondents (61% confirmed to be male). Data from the randomly controlled trials suggested that YBM: (a) demonstrated a lower likelihood to receive treatment for depression, (b) were significantly less likely to receive care for depressive disorders when compared to their White counterparts and (c) were likely to have untreated or undertreated depression due to the impact of negative social network influence.

To that end, this section highlighted studies pertaining to depression which revealed the following: (a) it is not uncommon for Black men to suffer from higher rates of depression when compared to other racial groups, (b) BAAM suffered from a higher prevalence of underdiagnoses for depression, (c) Black men have to navigate complex interacting factors to remedy depression, and (d) there has been a lack of efficacious rehabilitative resources for depressed BAAM.

PTSD and Anxiety

A sample of African Americans were included in an investigation that explored the expression of PTSD and other related psychological problems such as depression (Alim et al., 2006). The study revealed that individuals who reside in urban at-risk communities experienced an increased likelihood to be exposed to violence and PTSD. Resultant data identified risk factors for PTSD to include: (a) exposure to violence, (b) race-related stress, (c) lack of support, and (d) decreased use of mental health services. The researchers also reported, “Violent traumas such as homicide, physical assault, and rape are perpetuated more frequently against African

Americans … however, this appears secondary to being more likely to reside in poverty-level urban communities" (p. 803).

In 2008, an investigation of adolescent coping and stress adaptation revealed evidence to support the influence of coping for counteracting the effects of stress among a sample of low-income urban African American youth (Gaylord-Harden et al.). Their study considered conscious volitional efforts used to regulate: (a) emotion, (b) cognition, (c) behavior, (d) physiology, and (e) the environment in response to stressful events or circumstances. Using information from the Children's Coping Strategy Checklist the researchers found that exposure to stressful life experiences increased dramatically during adolescence, and adolescents are expected to manage stressors with increasing independence. The study's resultant data revealed two coping groups:

> Self-reliant avoidant copers and diversified copers. Self-reliant avoidant copers were characterized by high levels of avoidant coping strategies, moderate levels of active coping, and low levels of support seeking coping. Diversified copers showed moderate use of all coping strategies, with very few differences among strategies (p. 19)

Cougle et al. (2009) used 8-year longitudinal data to investigate whether individuals who were exposed to potentially traumatic events (PTEs) had an increased risk for PTSD after subsequent exposure to trauma as an adult. Their research suggested that specific individuals were more prone to the experience of both PTE and PTSD due to underlying factors such as psychological vulnerability. Resultant data also found: (a) childhood abuse as a predictor for PTSD in response to post-traumatic events (b) dose-response relationship with the frequency of previous trauma increasing the risk for experiencing PTSD. Conversely, respondents that had been exposed to trauma but did not develop PTSD demonstrated psychological resilience.

> Even though most people do not develop PTSD following exposure, the prior exposure/no PTSD group is by definition "resilient" in that they did not develop PTSD following exposure … Evidence that this group is not more likely to develop PTSD

> following an additional PTE does not necessarily suggest that prior PTE does not act as a risk factor for PTSD in response to a subsequent PTE; it may, instead, suggest that this group possesses certain characteristics such as hardiness that help buffer the effects of PTEs. (p. 1016)

In 2009, Chapman and Woodruff-Borden used a structural equation model to analyze the impact of familial functioning on anxiety symptoms. Their study examined data collected from African American and European American young adults using the 3 anxiety assessments the Becks anxiety inventory, State trait inventory and The McMaster family assessment device. Though researchers noted that the differences in resultant data between the two groups, the dimensional nature of anxiety and psychological distress was implicated within the experienced function or dysfunction anxiety between both groups. Additionally, the data revealed associations between anxiety, family dysfunction and maladaptive child outcomes. Conversely, the impact of family functioning also demonstrated some positive child outcomes such as post-divorce adjustment, academic achievement, and emotional and social adjustment.

Research from Smith and Patton (2016) explored the trauma responses for exposure to violence and homicide deaths among a group of Black males from urban neighborhoods. Their investigation revealed: (a) more young Black men are killed annually than young men of any other racial-ethnic group in the United States (b) the experienced exposure to violence for Black youth growing up in economically disadvantaged contexts was comparable to that of youth who survived in war zones (c) Symptoms of post-traumatic stress—such as intrusive images of a loved one's death, nightmares, and anxiety—have also been evidenced in surviving family members, with many demonstrating the criteria for PTSD. Smith and Patton's effort to increase understanding about the impact of traumatic stress symptoms among urban Black males exposed to community violence included descriptive data, narratives from young Black male victims of violence. The narratives were collected and analyzed using the phenomenological variant of

ecological systems theory. The model was empirically grounded in the developmental experiences of youth of color and included five central tenets: (a) risk contributors, (b) stress engagement, (c) reactive coping strategies, (d) emergent identities, and (e) coping outcomes. In response to their finding, Smith and Patton suggested the following:

> Perhaps some responses to Traumatic stress offer situational and temporary relief from the physical and emotional pain resulting from a violent experience (e.g., avoidance). In this way, avoidant symptoms ("just don't think about it") and hypervigilance ("stay on point") may be adaptive coping strategies that promote resilience in the context of chronic threats to physical and psychological safety and well-being. (p. 220)

A group of 75 predominantly African American male veterans with comorbid substance use disorders and PTSD were included in a study to understand the connection between distress tolerance (DT) and PTSD (Vinci et al. 2016). Their investigation sought to identify trans-diagnostic characteristics that explain the risk for PTSD and related conditions. The study defined (DT) as the perceived or actual ability to tolerate negative emotional or physical states. Data from the study associated lower levels of DT with increased PTSD symptom severity. The researchers posited that this type of research could have important implications for the treatment and the ongoing assessment of PTSD.

Research from Gebre and Taylor (2017) explored the effects of perceived stress and self-esteem on the associations of poor relations with kin, psychological distress, and college adjustment. The data was gathered using online surveys that were completed by a sample of African American college students in the midwestern United States. The research proffered a link between the quality of kin relations essential for the psychological well-being of emerging adults.

> Just as supportive social interactions can promote physical and psychological well-being, aversive interactions can be detrimental to health. In fact, some researchers suggest that negative social relations may be a stronger predictor of psychological functioning than the presence of supportive social relations … Positive social interactions may have an

> immediate impact on positive feelings; negative social interactions have longer-lasting effects on negative emotions. (p. 217)

Research from Badour et al., (2017) described 3 key features associated with PTSD as: (a) intrusive recollections from past traumatic events, (b) heightened emotional or physiological arousal, and (c) attempts to avoid internal and external cues related to a traumatic experience. Their study examined information about worsening emotions using data from men and women respondents who were asked to describe each emotion they had experienced (i.e., fear, anger, guilt, shame, or horror) following an affirmative response to having experienced worsening emotions. Resultant data revealed: (a) men and women confirmed problems with negative emotions at similarly high rates, (b) problems with shame were more strongly associated with assault-related (AR-PTSD) among women, (c) problems with fear were more strongly linked to AR-PTSD among men, and (d) individuals with AR-PTSD reported a higher incidence of anger, shame, fear, guilt, and horror.

In summation, PTSD and anxiety literature included in this review illustrate that urban at-risk communities experienced an increased likelihood of exposure to PTSD and anxiety. The research also validated associations between familial dysfunction, exposure to traumatic events (i.e. violence, ACEs), distress tolerance, coping strategies, and PTSD. The prevalent research also suggested that the use of adaptive coping, positive social interactions, and functional familial supports can mitigate the detrimental effects of stress.

Lifelong Impact on Opportunities

Dube et al.'s (2010) study about the health-related outcomes of ACEs examined self-reported data about smoking, obesity, and general health using the 2002 Texas Behavioral Risk Factor Surveillance System. Their scientific inquiry revealed: (a) almost one-third of adults who experienced both childhood abuse and household dysfunction reported current smoking; (b) the

prevalence of obesity was higher among those who experienced both household dysfunction and childhood; and (c) fair or poor general health status was more frequently reported among people who grew up in a dysfunctional household. The study also found that children who were exposed to serious family dysfunction or abuse were more likely to have an overactive stress response and suffered from anatomic, functional, and neurologic changes which have been known to cause developmental disruption of nervous, immune, and metabolic systems.

Metzler et al. (2017) revealed that ACEs increased the likelihood of adults living in poverty, subsequently putting their children at higher risk for remaining in poverty and experiencing lower attainment of life opportunities as adults. Using data collected from the Behavioral Risk Factor Surveillance System, researchers analyzed how childhood adversity negatively impacted adults' educational, vocational, and income opportunities. Their research hypothesized that individuals who suffered from ACEs would exhibit an increased likelihood of reduced educational outcomes, unemployment, and low income.

> Health conditions and indicators associated with early-life adversity include: chronic disease; cancer; sexually transmitted diseases; frequent mental distress and depression; intimate partner violence; suicide attempts; health risk behaviors such as smoking, alcohol abuse, substance abuse, sexual risk-taking, and youth violence and increased risk for premature mortality by as many 19 years. (p. 142)

Resultant data from Metzler et al.'s (2017) research revealed that the intergenerational effects of ACEs are more significant for some racial and ethnic groups. Resultant data also revealed that respondents who reported four or more ACEs were more likely to have reported high school noncompletion and household poverty. Additionally, those who reported three or more ACEs were more likely to report periods of unemployment. Their research provoked questions about the mainstream American narrative, which has traditionally viewed the disposition of poverty to be the result of individual characteristics such as lack of intelligence,

lack of ambition, or laziness without consideration of ACEs or broader structural or institutional factors.

In 2017, Searcy and Hines used the historical persecution reaction complex (HPRC) to explain the connection between racial identity and poor leadership. The study defined leadership as a dynamic, process-driven activity that involves a role, goals, and influence between a person and a group. The ethnographic research was hinged upon the premise that Black individuals possessed a tacit understanding of their history of oppression and the perception of continued marginalization by a dominant identity group. Critical race theory was used as a framework to analyze evidence pertaining to HPRC among Black American leadership through three case examples. Each example demonstrated limited public criticism of leadership by those who shared the same identity group. Their investigation also revealed the reluctance of oppressed populations (who had a history of persecution) to publicly criticize the recognized shortcomings of leaders within their population. Leaders who do not challenge the status quo narrative of Black educational, political, or cultural leadership dysfunction are systematically allowed to be maintained by dominant groups. Searcy and Hines argued that due to the strategic persecution and execution of Black leaders (i.e. targeted or persecuted by lynch mobs, local police task forces, and governmental organizations), a number of Black people have defended Black leadership regardless of the leader's performance.

This section detailed how childhood adversity impacts one's opportunities throughout their lifespan. Prior research described how chronic stress impacted opportunity as a contributor to poorer general health, functional and neurologic damage to the nervous, immune, and metabolic systems. The literature also highlighted that exposure to childhood adversity and trauma increased the likelihood of several maladaptive health behaviors, smoking, alcohol abuse,

substance abuse, sexual risk-taking, and obesity. Historical oppression and hyperactive stress response, anxiety and depression were also described to impact lifelong opportunity.

Mental Health, Wellbeing and Treatment

Wells et al. (2001) studied ethnic disparities in unmet mental health care needs and found that African Americans had higher rates of mental disorders and perceived need for substance abuse treatment when compared to Whites. Researchers found some consistent ethnic differences that resulted in a greater unmet need for African Americans that included: (a) less access to care, (b) poor quality of care, (c) alcoholism, (b) drug abuse, and (e) mental health treatment. Moreover, their mental health research offered suggestions for remediation of mental health disparities stressing the importance of implementing educational, medical, and psychiatric interventions for improving the quality of care provided to ethnic minorities.

Salloum (2008) conducted a secondary analysis investigation of the effectiveness of a time-limited, school-based grief and trauma group intervention for elementary age survivors of homicide victims. The study data came from the Project Loss and Survival Team program in New Orleans, Louisiana, which provides therapeutic services to survivors of homicide victims and children who have been exposed to violence. Eighty-nine of the 102 children respondents reported that at least one person close to them had died because of a homicide. Salloum hypothesized that the children who witnessed homicide would sustain a more significant post-traumatic impact compared to the non-witness child group. The research also found that African American children from low-income urban contexts who participated in the school-based grief and trauma-focused intervention experienced fewer symptoms of post-traumatic stress at the end of the intervention. Several unknown factors influenced treatment outcomes among the children exposed to homicide; for example, children who had witnessed homicide had additional

environmental factors that may contribute to more chronic symptoms. Factors such as: (a) media coverage, (b) criminal justice proceedings, (c) social stigma, (d) changes in caregivers, homes, neighborhoods, (e) peer associations, (f) surrounding traumatic reminders, (g) familial stress, and (h) other additional losses were found to have a significant psychological and behavioral effect on the children post homicide exposure.

A meta-study of Black males' mental health and well-being revealed that Black men demonstrated lowest life expectancy and are not afforded the full benefit of societal resources (Watkins et al., 2010). Their investigation examined intersections between culture, race, and gender revealed the following: (a) historical context of race impacted Black males' mental health outcomes, (b) health behaviors attitudes, and beliefs of Black men may not differ when compared to other men despite the significance of both social and racial factors, and (c) higher socioeconomic status and education buffer the adverse effects of racism on mental health and well-being for Black men. The resultant analysis also noted behavioral responses (coping) such as tobacco, alcohol, comfort food, and illegal drugs as that were perceivably beneficial for helping with the management of stress among male respondents.

Maulik et al. (2011) explored the various ways that adolescent African American youth and young adults from Baltimore, Maryland sought supportive services for their mental health issues. Their investigation reported that for the appropriate mental health services to be delivered to any population, it would be imperative to identify the factors that are associated with the use of such services, so that those factors can be strengthened or promoted. In this study a revised version of the Behavioral Model of Health Services was used as a guide to identify the factors related to mental health service use within 5 service sectors that included:

> [a] Formal mental health services are characterized by service delivery from mental health professionals or specialty clinics … [b] Social services are characterized by the

> receipt of community-based mental health services provided by non-formal mental health providers, including staying in group homes, foster homes, or emergency shelters during the night … [c] Correctional facilities services included staying overnight in a detention center, prison, or jail, or seeing a probation officer, juvenile corrections officer, or a court counselor during the day, for problems related to behavior, feeling, drugs, or alcohol … [d] Other human services included consulting a priest, shaman, acupuncturist, or crisis hotline … [e] School-based services included using school counseling and therapy for behaviors, feelings, drugs, or alcohol problems from school or classroom, including additional tutoring and training. (p. 209)

Maulik et al.'s research revealed that enabling factors such as health insurance, access to service providers, and social support were not significantly associated with the type of service used. Their results showed that depression and anxiety were associated with significantly increased use of formal mental health services, social services, or correctional facility services. Researchers also expressed concern about the significantly increased use of correctional facility services as a medium for mental health services among low-income, at-risk populations within the literature.

Landmark research and opportunities to strengthen the foundation for mental health treatment using political measures to close the gaps within mental health provision were highlighted in Snowden (2012). Lower treatment rates for African American populations coupled with higher rates of exposure to adverse life circumstances and severe and disabling mental illnesses have contributed to the African American populations' high rate of mental-illness-related disability. His study came as a 10-year follow-up to the U.S. Surgeon General's report on "Mental Health: Culture, Race and Ethnicity," which acknowledged the undeniable indications that ethnic minority populations received less and lower quality health care than White Americans. Resultant analysis described some of the historical and contemporary inequities about mental health care among African Americans as the result of a myriad of factors, stating that "African Americans sometimes reject mental health treatment because of the considerable stigma associated with mental illness" (p. 526). Snowden also described some institutional

commitments and policy initiatives such as the Affordable Care Act and how they helped to demonstrate a greater society-wide notice of mental health treatment disparities.

A study found that individuals with low health literacy levels were 12 to 18 times more likely to lack the ability to adhere to their health care regimens (Ivanov & Ingram, 2013). The descriptive research used a correlational design to examine the association between the health literacy and health behaviors of African American older adults diagnosed with hypertension. The study was conducted among sample of 121 African American older adults; approximately half of these participants were nonadherent to their prescribed regimens for hypertension. Factors associated with adherence to antihypertensive regimens to included: (a) respondent demographic characteristics, (b) knowledge, (c) awareness, (d) beliefs and attitudes about antihypertensive regimens, (e) depression, and (f) side effects associated with medications. Ivanov and Ingram went on to explain factors related to health literacy and adherence reporting:

> Health behaviors are influenced by predisposing, reinforcing, and enabling factors; these factors were explored as determinants affecting health literacy and adherence. Predisposing factors were age, educational level, and understanding of health information and were considered factors that manipulate health behaviors. Reinforcing factors were defined as the self-determination of an individual's overall health status. Enabling factors are operationally defined as factors that support individuals' ability to maintain their health, such as income level, access to health care, comorbidities, and the frequency with which health information is read. (p. 24)

An investigation of whether conventional ACEs sufficiently measured adversity was undertaken by Cronholm et al. (2015). This study was one of the first to describe the prevalence of conventional ACE scores among a socioeconomically and racially diverse urban adult population. Researchers explained that to only rely upon conventional ACEs in this study would have caused a considerable underrepresentation of the prevalence of adversity experienced among the sample. Given the current understanding about health disparities, researchers

presumed that other unmeasured ACEs also may impact health outcomes, particularly in more diverse and minority populations.

> Qualitative data from African American and Latino youth support expanding the concept of childhood adversity to include community-level indicators such as: experiencing racism, witnessing community violence, living in an unsafe neighborhood, experiencing bullying, and a having a history with foster care. (p. 355)

More than a quarter of Cronholm et al.'s study respondents reported a combination of being a witness to community violence, experiencing racial discrimination, or growing up in an unsafe neighborhood. The urban community-based sample showed higher rates of exposure for six of the nine conventional ACEs. The study's data also revealed a stepwise, dose-dependent relationship for developing at-risk behaviors such as: (a) substance abuse, (b) multiple sexual partners, (c) smoking, and (d) early initiation of sexual activity and (e) pregnancy. Additionally, when the researchers compared results from the predominantly White, fully insured Kaiser study population to their diverse urban sample they found that the urban sample reported higher rates for physical abuse, substance-abusing household members, mentally ill household members, emotional abuse, incarcerated household member, and witnessing domestic violence.

In 2015, Wade et al. examined the effect of household and community-level ACEs on health outcomes among a socioeconomically diverse population. Their study explored associations between conventional ACEs (related to family dysfunction) scores, expanded ACEs (related to community-level stressors) scores, and health outcomes such as: sexually transmitted infections and substance abuse, cardiovascular disease, asthma, and fractures. Researchers posited that given the complex relationships between socioeconomic status and ACEs, exploring the moderating effect of socioeconomic status on the relationship between ACEs and adult health outcomes may elucidate mechanisms to guide future interventions. Resultant data revealed that the risk for experiencing health risk related behaviors and mental health problems for both

conventional and expanded ACE increased as the ACE score increased. At the same time, Wade et al. suggested that the impact of ACEs on adverse health outcomes may differ somewhat based on socioeconomic status.

This section detailed some factors that have impacted the mental health and well-being of Black men. Prior research discussed how social and racial factors are contributory to the health behaviors, attitudes, and beliefs of Black men. This review contained information about the risk behaviors and mental health problems associated with conventional and expanded ACEs. Data also conveyed racial and ethnic disparities about health care use and provision. The impact of trauma and ACEs has been resulted in significant detriments to mental health, well-being, and treatment within Black communities.

Summary of the Literature Review

The Chapter two review of the literature was included as strategy to increase sensitivity and rigor about the research topic, as recommended within qualitative research (Maher et al., 2018). The research included within this chapter offered compelling evidence about how exposure to trauma and adverse conditions increases risk for psychological, mental, and physical distress. A plethora of scholarly articles were included to explore conjectural gaps about the challenges that Black men who have experienced trauma encounter across the lifespan. This section included eight salient themes that were pertinent to the research topic, these themes included: (a) ACEs; (b) victimization and desensitization, (c) behavioral stress response, (d) help-seeking, (e) depression, (f) post-traumatic stress disorder [PTSD] and anxiety; (g) lifelong opportunities impact, and (h) mental health well-being and treatment.

Each category demonstrated interconnectedness and was essential for helping to answer the research question. Next, chapter three will present this study's methodology, research design, sample selection, data collection process, and data analysis.

CHAPTER 3:

METHODOLOGY

Chapter three presents the qualitative research design that will be used to answer the research question. The chapter will provide an overview of the generic qualitative inquiry followed by a description of the population and sample. Then, the research procedures, data collection, analysis and trustworthiness will be discussed. Next, the chapter will detail the ethical considerations and conclude with a summary.

Research Design and Rationale

The aim of this study was to shed light on the difficulties encountered by Black African American Men (BAAM) who have undergone traumatic experiences, utilizing a generic qualitative inquiry methodology. Qualitative research is a comprehensive range of methods that offer researchers numerous choices based on several factors, such as the study topic, research query, participant attributes, and research context (Austin & Sutton, 2014; Yadav, 2022). This methodological approach was particularly appropriate for exploring the fundamental aspects of experience from the viewpoint of those directly involved (Yin, 2014).

Generic qualitative inquiry is useful for topics relatively new, poorly understood; or when a phenomenon cannot be fully explained by another qualitative methodology (Kahlke, 2018). The generic qualitative approach is also advantageous when a qualitative research question does not fit within parameters of traditional or focused qualitative methodologies (i.e. phenomenology, ethnography, grounded theory, case study) “for one reason or another” (Caelli, Ray & Mill, 2003; Liu, 2016; Percy, Kostere & Kostere 2015 p.76).

This study, employed a generic qualitative inquiry to construct a theoretical pathway to answer the research question about BAAM challenges with trauma. Salient features of this

research approach included: (a) intentional rejection of allegiance to a single focused qualitative methodology; (b) goal of developing understanding from the participants point of view; (c) researcher as the primary instrument for data collection and analysis; and (d) presentation of the resultant findings (Bradbury-Jones, Taylor & Herber, 2014; Cooper & Endacott, 2007; Patton, 2002; Percy, et al., 2015).

This generic qualitative inquiry utilized a combination of qualitative methods; however, this did not mean that the approach lacked logic (Liu, 2016). For example, the purpose of the study, research question, and corresponding methods were cohesive and congruent (Caelli et al. 2003; Kahlke, 2014; 2018). The organization and illumination of the research topic involved iterative, non-linear methods that shifted the researcher back and forth using thematic analytical lens (Braun & Clarke, 2006; 2012; 2021; Percy et al. 2015). Moreover, the researcher adapted a relevant theoretical framework (historical trauma theory) to assist with the conceptualization of themes to answer the research question (Bradbury-Jones, Taylor & Herber, 2014).

The researcher used the semi-structured interviewing method to capture the essence of the participants "lived experience", a strategy common to phenomenological research. However, this generic qualitative study used the interviewing to elucidate the point-of-view data from participant based upon lived experience (Auta, Strickland-Hodge, & Maz, 2017). The research was designed to explore the participant's perceptions and feelings about research topic, rather than the "inner-essence" and "pre-reflective conscious experiencing" (p. 77) of the traumatic phenomena (Percy et al., 2015) thus should not be confused with phenomenology.

This generic qualitative inquiry does not seek to develop theory, instead, the approach seeks to illuminate the topic by organizing prevalent themes within the data (Liu, 2016). Like grounded theory which uses heuristic guidelines for data-driven theory construction, coding and

analyzing, (Braun & Clarke, 2006; Timmermans & Tavory, 2012) this generic inquiry elicited the researcher's pre-knowledge/pre-understanding about the topic to develop codes/themes from which to categorize the data (Percy, et al., 2015). The resultant themes do not exist separate from the researcher, each theme is mediated by the study's theoretical orientation and all that the researcher brings to this process (e.g. their research values, skills, experience and training) (Braun & Clarke, 2021). The partnership established between the researcher and participants has generated a repository of genuine data that can be utilized to collaboratively construct a resolution to the research inquiry (Crabtree & Miller, 1992; Mills, Bonner & Francis, 2016; Patton, 2002).

The generic qualitative research approach is depicted across three stages in the figure below: (1) development, (2) fieldwork and analysis, and (3) conclusion. The preliminary stage outlines the research process, this includes selecting the research topic, literature review, theoretical framework, and methodology. Stage two illustrates the process of data collection and analysis. Finally, Stage 3 concludes with final steps that will be used to construct the study's themes, writing, coding, organizing and presenting findings to answer the research question.

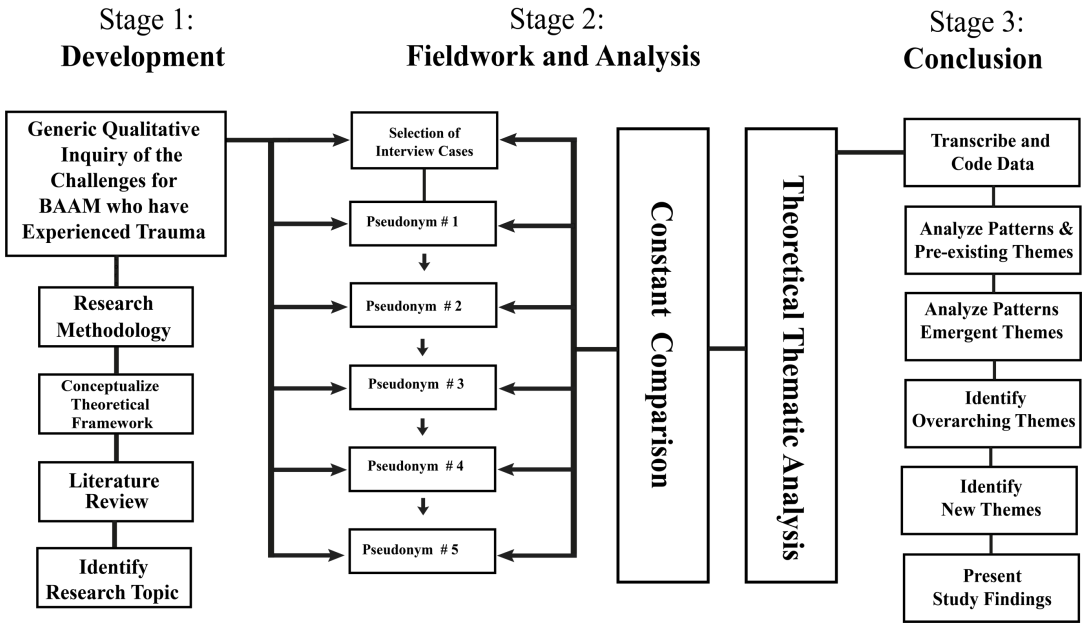

Figure 2.1. Research design for generic qualitative inquiry.

Population and Sampling

Population

The study population included BAAM between the ages of 24 and 58, residents of northwest Arkansas and have experienced trauma in their lifetime. The negative effects of trauma can be devastating; with costly transgenerational impacts, negative physical, psychological, social outcomes for BAAM and their families, (Chapman & Woodruff-Borden, 2009; Cougle Resnick & Kilpatrick, 2009; Hudson et al., 2018; Yehuda & Lehrner, 2018). This study collected and analyzed data about the challenges of trauma among a purposeful sample of BAAM.

Sample

Purposeful sampling was used to recruit five BAAM participants who have information rich experiential knowledge to illuminate the topic (Palinkas et al., 2015; Robinson, 2014; Tellis, 1997). The exploration of perspective participant data among a small sample of participants sought maximize what could be learned in the period available for this research. Dworkin, (2012)

argued that researchers may learn a great deal more by focusing on understanding the phenomena within a small sample size.

According to Patton (2002), purposeful sampling ensured that participants would be able to provide informational data strategically. Each participant was selected intentionally based on predetermined criteria generated by the researcher (Patton, 2002; Suri, 2011). Sampling from participants who know other BAAM who have similar characteristics that meet the inclusion criteria, also known as snowballing, would have been used if there was a need for a secondary means of identifying additional participants who could offer contributory information (Palinkas et al., 2015).

Inclusion Criteria

Participant selection was determined by their individual responses to the screening material (see Appendix D), (see Appendix E). The study's inclusion criteria is as follows: (a) ≥ 18 years of age; (b) identify as cisgender BAAM (Black and/or African American) male; (c) live in Arkansas; (d) not actively experiencing PTSD or depressive symptoms; (e) have access to a self-identified support system; (f) self-report that they have experienced a traumatic event in their lifetime (g) ACE score ≥ 3 or more (h) give written consent to participate in the study (i) agree to participate in a recorded one hour interview.

Participants who volunteered and met the inclusion criteria received a confirmatory email with details about what participation in this research would involve along with a mental health resource packet (i.e. web-links, and therapeutic information and materials). The researcher scheduled a date and time to conduct ZOOM interviews with selected participants. Potential participants who did not meet the inclusion criteria were also offered mental health resource packets.

Procedures

As previously acknowledged, the study utilized a purposeful selection of participants to obtain a comprehensive understanding of the topic within the limited timeframe. The recruitment, data collection, and analysis were carried out using systematic procedures. The purposeful recruitment and screening process of BAAMs participants, semi-structured interviews, theoretical thematic analysis, and trustworthiness were described in a step-by-step manner. These procedures were interdependent and had to be executed in a specific sequence. The sampling method was designed to identify individuals with extensive experiential knowledge relevant to the subject matter. However, it is important to note that this study was not conducted as a case study research, as indicated by Palinkas et al. (2015) and Tellis (1997).

Participant Selection

Informational flyers were posted in public locations frequented by BAAMs such as Black owned barbershops, Black churches, urban community centers. The recruitment flyers contained information about the purpose of the research, inclusion criteria, information about confidentiality, interview details and the researcher's contact information. Respondents contacted the researcher to confirm their willingness to participate in the study.

Prospective participants reviewed and received a copy of the informed consent form prior to participation in the study. The informed consent document described what the study involved, what to expect, risks, confidentiality, the participants rights, use of the information, and the agreement to be video and audio recorded. Next, each participant had an opportunity to ask questions about the research and documentation prior to signing the consent. If a participant was unclear about the research agenda, intentions or consenting, the researcher addressed each concern until the participants were comfortable moving forward or decided to discontinue. Each

participant was informed of their right to withdraw from the study at any time, without any penalty.

Eligibility and inclusion was determined purposefully using the predetermined criteria and participants responses to the screening instrument (see Appendix D) and ACE questionnaire (see Appendix E). Screening materials were provided to potential participants during or following the initial researcher contact. The researcher emailed and presented prospective participants with a copy of the informed consent document, the screening instrument and a link with instructions to complete ACE questionnaire online.

Eligible participants received a confirmatory email with details about what their participation in this research involved. Then the researcher scheduled a date and time to conduct their ZOOM interview. As previously mentioned, the researcher's contact information was provided to allow participants to ask questions pertaining to the study and participation was voluntary.

Participant Safety

Participants met at their scheduled time via a secure ZOOM link. The researcher did not record audio or video data until the participants reported that they were ready to proceed with their interview. Once the participant was ready, they entered the ZOOM room and the recording devices were turned on. To protect the participants personal information pseudonyms were assigned for use on all data (consent forms, recordings, transcripts, etc.). Then, the researcher identified the participant by their assigned pseudonym, thanked them for their involvement and reminded them that they could discontinue the interview at any time during the interview session.

The use of ZOOM recording made it difficult to de-identify participants. For this reason, all participants knew and consented to their images being recorded. As previously discussed, each participant signed and received a copy of the informed consent document containing crisis hotline information (see Appendix B) and access to the mental health resource packet (see Appendix C) prior to inclusion within the study. The participants were also made aware that video recordings would only be handled by the principal researcher and their transcripts reviewed by a secondary observer.

The emotional safety of the participant was also considered within this study. Researchers who discuss sensitive topics with participants may encounter emotional experiences in the field (Hubbard et al., 2001). As a precautionary measure each participant was provided with a resource packet that included supportive materials and referral information about mental and physical healthcare services (see Appendix G). These mental health resource packets included local clinicians and counseling resources, materials, mindfulness practices, and suicide prevention information.

The researcher's ability to manage his emotions and feelings throughout the study were paramount to this generic qualitative research. Additional precautions were taken to protect the researcher from experiencing vicarious traumatization from working with multiple participants who have experienced trauma. This type of traumatization occurs when a person is "listening to and working with participants who have experienced trauma, and they begin to experience the effects of trauma themselves" (Dickson-Swift et al., 2009, p. 72). During the course of the study, the researcher engaged in reflexive inquiry by reflecting on personal life experiences that may have elicited emotional distress. To mitigate the potential impact of these stressors, the

researcher employed multiple self-care strategies including peer debriefing, maintenance of a researcher's journal, and seeking counseling services as needed.

Privacy and Confidentiality

To maintain confidentiality of the study's participants the researcher assigned pseudonyms. This strategy helped to ensure the protection of their identity especially during interviews as participants may disclose personal private information. These pseudonyms were used throughout the research process, and each eligible participant was notified of their pseudonym after they agreed to participate in the study (i.e. P1, P2, P3, etc.). The participants pseudonyms were also used as labels for distinguishing identifiable information within the research documents (i.e. informed consent, screening instruments, interviews, transcriptions and audit trail).

Table 1.1. *Participant Screening and Demographic Information.*

Participant (P)	Age	Employment Status	Marital Status	ACE
P1	33	Employed	Married	9
P2	53	Employed	Divorced	5
P3	29	Employed	Married	4
P4	41	Employed	Married	4
P5	39	Employed	Married	5

Data Collection

Interviews

The overall purpose of using semi-structured interviews was to gather information from the key informant's personal experiences, attitudes, perceptions and beliefs related to the topic of interest (DeJonckheere & Vaughn, 2019). This generic qualitative study used five semi-structured interviews to gather firsthand information from BAAM about their challenges with trauma. The interviews provided descriptive audio-visual information to help answer the research question from the participants perspective (point-of-view), their opinions, values, judgments, and emotions related to the research topic (Auta, Strickland-Hodge, & Maz, 2017; Patton, 2002).

The researcher encouraged the participants to fully communicate their perspectives, which brought out a wide variety of thoughts and feelings about the topics related to trauma. As previously mentioned, each participant received a resource packet to help safeguard the emotional stability of the participants; and participants was advised on where and how to obtain additional support if talking about their trauma caused any distress. The resultant data assisted with conceptualizing the challenges for BAAM who have experienced trauma using the participants perspectives. The collection of interview data was analyzed in combination with other data to reveal the study's patterns and themes.

Each participant was scheduled between one and two hours to complete their interview (each interview may vary in length from about one to two hours), and the participants were allowed to complete their interviews in two sessions (if necessary). If a participant had questions, concerns or was unclear about the research documentation, the researcher would address each concern prior to moving forward with the study. Prior to the start of each interview, the researcher reviewed the signed materials (informed consent, and screening instruments)

completed by the participant. After the review, each participant was offered an opportunity to ask any additional questions that they had about the study, documents and interviewing process. The participants were also reminded that their participation was voluntary and they were not forced to participate and could opt-out at any time during the interview.

Upon participants' confirmation of their readiness to proceed with data collection following a thorough review and agreement to the informed consent documents, the researcher commenced the interview process. Drawing on expertise gained from certification as a rehabilitation counselor and doctoral-level training, the researcher conducted the interviews. Additionally, the researcher received training in the use of semi-structured interview techniques during previous employment at a behavioral health hospital.

Interview dialogue was encouraged using a set of guiding questions developed by the researcher, potential/prospective participants and the assistance of BAAM professional peers actively involved in the counseling profession who have experience working with people suffering from trauma. The semi-structured interview questions helped the researcher collect rich in-depth information from each participant about their experiences related to the research question. This investigative technique promoted a conversational flow as the researcher listened attentively to determine appropriate times to explore the participants experience in greater detail, or when to transition to the next question (Hardy, 2019).

The researcher remained attentive, actively listening to the experiences of the research participants. During each interview, the researcher asked the semi-structured questions, then asked for additional clarification if necessary, allowing relevant information to emerge naturally throughout the interview. The guiding interview questions presented later in this chapter were used to prompt each participant to reflect upon their experience with trauma. The researcher did

not ask the participant to detail their traumatic experiences, instead the researcher remained focused on how those experiences affect them in their lives today. It was left up to the participant to determine if they would like to discuss specific traumatic events or not. Throughout the interviewing process the researcher assessed the need to utilize therapeutic techniques and approaches based upon the emergent data in as the interview developed. It was important for the researcher to include moments of therapeutic silence, which are considered powerful tools for the establishment of rapport (Sharpley, Munro, & Elly, 2005).

After the interview was completed, the researcher asked the participant if they had any questions or concerns. Again, if a participant had questions, the researcher would address their question, and if there were no more questions, the researcher concluded the interview session and stopped the recording. Afterwards, the participant was thanked for their time, participation and for sharing their experiences.

The researcher reminded the participant that they would receive an email copy of their transcript to review and confirm the accuracy of the data collected within their interview session within two weeks of the interview. Member checks provided an additional level of credibility regarding the accuracy of emerging themes; improve the dependability of the study data (Bellini & Rumrill, 2009; Koelsch, 2013). Thomas (2006) described member checks as useful validation technique to ensure that participants agree that findings constructed by the researchers adequately represent the reality that participants will report.

Observations

Observation of social interactions and body language was important to capture BAAM responses; therefore, the researcher used the ZOOM video to collect the observational interview

data. Video recording enhanced the richness of the study, allowing the interactions between the researcher and participants to be observed. Video recording/data enabled the researcher to:

1. go back and observe facial expressions, tone of voice, posture changes, and movements of the participant (Garcez et al., 2011);
2. capture the essence of thoughts, beliefs, emotions and impressions of others and oneself during the decision-making process (Henry & Fetters, 2012); and
3. analyze data such as smiles, frowns, hand gestures, shrugs, and other nonverbal cues (Sullivan, 2012).

Movements were considered important and play an integral part in successful interaction between the researcher and participant (Sullivan, 2012). Though some concern has been voiced about the influence of recordings on participants, scant evidence suggests little change in participant behavioral response (Henry & Fetters, 2012). The video data that was captured from the study participants did not reveal significant evidence to answer the research question, and was not included within the thematic analysis.

Video Recording

For video recording to play its role effectively in investigative contexts, the researcher needed to be familiar with the equipment (Garcez, Duarte & Eisenberg, 2011). The researcher utilized the internet based tele-communication software "ZOOM" in a private, secure location (i.e. University of Arkansas Counseling and Psychological Services Center). The electronic software and computer equipment were checked prior to each interview to ensure that was recording and working properly prior to starting the interview.

Participants were met at their scheduled time via a secure ZOOM link. The researcher did not record audio or video data until the participants reported that they were ready to proceed with

their interview. Once the participant was ready, they entered the ZOOM room and the recording devices were turned on. To protect the participants personal information pseudonyms were assigned for use on all data (consent forms, recordings, transcripts, etc.). Then, the researcher identified the participant by their assigned pseudonym, thanked them for their involvement and reminded them that they could discontinue the interview at any time during the interview session.

Documents

The collection of documents was crucial for building a case to answer the research question. According to Lincoln and Guba (1985), documents are "singularly useful sources of information" (p. 276). Data from this generic qualitative inquiry was generated from a combination of descriptive documents. These written documents will assist the researcher in extending the study data beyond the limits of recorded interviewing. The researcher examined documents that included but was not limited to: screening instruments, questionnaires, field notes, brochures, pamphlets, reports, newsletters, and other printed materials—such as, textbooks, articles, and training materials relating to the research topic.

Focus Group

In order to gather data on the experiences and perspectives of Black African American Men (BAAM) who have undergone trauma, the research incorporated a focus group. Focus groups are a qualitative research technique that involves conducting a group interview with participants, aimed at obtaining data through their interactions and communication (Kitzinger, 1995). The focus group was conducted in-person and the focus group volunteers were invited based on their expressed interest in the research topic, as outlined in the recruitment materials and word of mouth.

It is important to reiterate that the participants in the focus group were voluntary and their personal information was not recorded. This ensured that their privacy was protected and that they could share their experiences and perspectives without fear of being identified or judged. By creating a safe and non-judgmental space, the participants were able to freely express their thoughts and feelings on the research topic. This approach was essential to obtaining rich and detailed data on the experiences and perspectives of BAAM who have undergone trauma.

The focus group was particularly useful for exploring the BAAM knowledge and perspectives on the research topic. The interactive nature of the focus group allowed the participants to share their experiences and provide detailed information that would have been difficult to obtain through individual interviews. The group dynamic also helped to validate the responses, as participants were able to build on each other's comments and generate new insights.

Data Analysis

Theoretical Thematic Analysis with Constant Comparison

This generic qualitative inquiry provides a unique contribution to professional knowledge and awareness of the participant's experiences in a fair and effective way (Braun & Clarke, 2006; 2019; Koch et al., 2014; Percy et al. 2015). The researcher selected theoretical thematic analysis with constant comparison as a method to identify the patterns, categories and resultant themes within the data (Aronson, 1995). Again, the conceptualization of these themes involved iterative procedures shifting the researcher back and forth between a collection of data. The collaboration between the researcher and participants produced a collection of authentic data that helped to mutually construct and answer the research question (Crabtree & Miller, 1992; Mills et. al., 2006; Patton, 2002).

According to Mills et al. (2016), regularly comparing research findings to the relevant field will ensure that a researcher's final theoretical conclusions are firmly grounded in the actual experiences of the participants. To achieve this, a rigorous immersion within the data is required, which involves transcribing verbatim each participant's interview and carefully reviewing the data multiple times. Qualitative data analysis techniques such as open coding and theoretical thematic analysis with constant comparison were employed to identify recurring patterns and themes in the data (Percy et al. 2015).

Open coding organized the data into meaningful segments, assigning each segment a unique code. Meanwhile, theoretical thematic analysis involved identifying the emergent patterns and themes in the data. During this process, open coding was used to create an all-inclusive list of codes that capture the most significant features of the data. These codes were then grouped into patterns to identify key themes. This iterative process facilitated the emergence of new codes and themes as the researcher gained a more profound understanding of the data. By using open coding in theoretical thematic analysis, the researcher developed a conceptual theoretical framework for understanding the phenomenon under investigation.

After reviewing the patterns, emerging themes and re-examining the data, the researcher presented exemplars of the participants thoughts and feelings that surround their experience with trauma using the selection of key findings and participant comments. The study's data was presented among diverse populations of key stakeholders that include but should not be limited to: (a) BAAM and their families (b) public service officials, (b) helping professionals, (c) social justice advocates, and (d) academic scholars and researchers.

Theoretical thematic analysis allowed the use of the researcher's pre-understandings when conducting the data analysis. This method of analysis is often employed in a situation in

which the research has some predetermined categories or themes (Percy et al., 2015). The 13 procedures that were used in this generic qualitative inquiry are listed below:

1. The researcher engaged in a process of data immersion, whereby he familiarized himself with participant data, including interviews, journals, field notes, records, and documents. He conducted a thorough examination of each piece of data, intuitively highlighting sentences, phrases, and paragraphs that were pertinent to the research question.
2. Relevant data was systematically highlighted, stored, and compared to pre-existing knowledge, theory, and the research question to ensure their alignment.
3. Extraneous data that did not correspond to the research question was segregated and transferred to an alternate file. This data was subsequently reviewed again to confirm its exclusion from the analysis.
4. Characteristic codes (ACE1, ACE2, ACE3, ACE4, etc.) were assigned to the pertinent highlighted data to facilitate its tracking and retrieval.
5. The researcher engaged in a process of data clustering to identify patterns and connections that were relevant to the research question.
6. Using a constant comparison method, the researcher systematically coded and clustered each piece of data. He compared and contrasted subsequent data with previously analyzed data to ensure consistency and accuracy of the analysis.
7. Data related to specific patterns was identified, extracted, and organized with the corresponding pattern. Direct quotes were taken from the data (interviews, field notes, documents, etc.) to explicate the pattern.

8. The researcher reviewed all of the identified patterns for the emergence of overarching themes. This involved combining and clustering patterns to identify themes that were supported by the data.
9. The patterns and themes evolved throughout the analysis process as the researcher compared and contrasted previously completed analyses with new data.
10. After analyzing all the data, the themes were arranged to correspond with supporting patterns. These patterns were used to explicate the identified themes.
11. The researcher documented a detailed analysis, providing a comprehensive description, scope, and substance of each theme.
12. The identified patterns were described and explicated using direct quotes from the data.
13. Finally, the data was synthesized to create a composite overview of the challenges faced by Black African American Men who have experienced trauma.

Instruments

This generic qualitative research used the researcher as the primary instrument for collecting descriptive data using a combination of qualitative methods (Percy et al., 2015; Polkinghorne, 2005). The collaboration between the researcher and the participants produced a collection of authentic data to mutually construct an answer to the research question (Crabtree & Miller, 1992; Mills et. al., 2006; Patton, 2002). The researcher used screening tools and questionnaires to identify the appropriate participants and to gather baseline information about the study sample. The participant screening tool collected demographic information including age, employment status, marital status, support network, and availability. The National Public Radio (NPR) online ACE questionnaire, a variation of the original ACEs study questions, was

used to determine the participants ACES score (NPR, 2015). According to the ACE study, the rougher your childhood, the higher your score is likely to be and the higher your risk for challenges such as health related problems later in life (Anda & Brown, 2007; Felitti et al., 1998; Gilbert et al. 2015; NPR, 2015).

Role of the Researcher

In this study the researcher served as a writer, interviewer, observer, and professional ally among the participants. This study was designed to use the researcher as an instrument to explore the topic through someone else's eyes (Dickson-Swift et al., 2009). The researcher's role and responsibilities included: the selection of study participants, conducting interviews, asking questions, recording responses, transcribing interviews, analyzing data, interpreting data, detailing data, and maintaining all data collected within the study. Overall, the credibility of the research study depends on the skill and competency of the researcher (Eisner, 1997).

A key component of this generic qualitative inquiry was reflexivity meaning that experience of the researcher influenced this study's outcome and could also unintentionally interfere with the interpretation of the research data (Kennedy, 2016; Liu, 2016). This study's design promoted a constant sense of self-criticism and scrutiny; however, it was not possible for the researcher to be completely free of bias due to the intersectional nature of the topic (Strauss & Corbin, 1998; Vire, 2006). As previously discussed, the researcher, a BAAM doctoral learner, became the primary instrument, collecting and analyzing the data used in this study. This reflexivity encouraged self-awareness, including awareness of how the researcher had participated in developing understandings about the topic (Fischer, 2009).

The purpose of providing the reader with information about the researcher's own life experiences is to help explain how the researcher may interact with and interpret the participants

narrative data. The researcher has personal experience with trauma with direct experience as well as professional knowledge as a certified rehabilitation counselor working with individuals who have experienced trauma in clinical settings (i.e. hospitals, community organization, integration, transition programs and facilities). The study design will utilize the researcher's pre-knowledge as an instrument during the exploration of the topic (Dickson-Swift et al., 2009). This researcher's lens focused upon the premise that reality is socially constructed between the researcher and participants; reality is what the participants perceive it to be (Creswell & Miller, 2000). The researcher's personal orientation does not refute the existence of objectivity in the world; instead, is more concerned with the truth made real in the minds, words, and actions of its members (Reiger, 2019).

The researcher's personal background as a BAAM who has experienced trauma intersects with the subject matter of the research. The researcher embarked on the challenging investigation of disparities affecting Black males while pursuing undergraduate studies at Wilberforce University (W.U.), under the guidance of Dr. Kenya Messer. Furthermore, the researcher has gained extensive hands-on experience working with adjudicated adolescents as a treatment specialist at the Montgomery County Center for Adolescent Services, as well as a volunteer in faith-based outdoor recreation programs catering to low-income youth, particularly young Black African American youth from inner-city areas (such as Chicago, Indianapolis, and Cincinnati) who have suffered or were at a high risk for Adverse Childhood Experiences (ACEs). Subsequently, after obtaining a master's degree, the researcher served BAAMs in Dayton, Ohio, through the Second Chance Program, a faith-based community initiative that provides transitional resources such as housing and vocational assistance to BAAM who have been released from prison.

Guiding Interview Questions

Semi-structured interviews were used to gather perspective information from participants about the topic. Interviewing is one of the most common methods of data collection within qualitative research (Hardy, 2019). The interview questions generated to answer the research question derived from a combination of reviewed literature, and instruments such as the ACE Family Health History and Health Appraisal Questionnaires (CDC, 2020) and the Life Events Checklist-5 (Weathers, 2013). The study's interview questions evolved with the assistance of prospective participants, professional peers, emerging trends and theoretical concepts apparent within the data. The open-ended questions that were be used to guide the interview sessions are as follows:

1. In your own words, please describe what the term trauma means to you?
2. From your perspective what are some of the challenges associated with ACES.
3. Help me understand what the quote "Black people are essentially born traumatized and have been for centuries" (Crawford, 2019 p.1) means to you.
4. From your perspective how would you describe the challenges for Black men who experienced trauma?
5. Please help me understand what physical health and wellbeing means to you?
6. How does trauma impact physical health and wellbeing of Black men?
7. Please help me understand what mental health and psychological wellbeing means to you?
8. In your opinion, how does trauma impact mental health and psychological wellbeing of Black men?

9. Help me understand why it may be difficult for BAAM who have experienced trauma to seek professional mental health treatment?
10. Please describe how has trauma limits opportunity for BAAM, in past and present years?
11. In your opinion how does trauma impact the world of work for BAAM?
12. In your opinion how has trauma impacted the black community?
13. Please describe any support(s) or resources that you are aware of that are being offered to BAAM that help to address trauma related challenges.

Ethical Considerations

The role of practitioner-researcher provided valuable insights into practice, but also introduced certain assumptions and biases that have ethical implications (Reid et al., 2018). The researcher obtained approval from the University of Arkansas Institutional Review Board (IRB) prior to conducting the study (refer to Appendix A). It is crucial to communicate to the Black African American Men/Males (BAAM) that they are not mere subjects of the research, but rather important contributors to a body of knowledge on BAAM trauma. Ethical considerations for this study include the measures taken by the researcher to ensure that the research was conducted safely, with the protection of the participants as the top priority.

Management and Storage of Data

All physical data was stored inside of a locked file cabinet to which only the researcher had access. Digital files were downloaded to a password protected computer and secured at the researcher's home. Backup copies of the collected data (i.e. informed consent, screenings, and written documents) were kept on a flash drive, which will also be secured in a locked file cabinet in the researcher's home. After seven years, the transcripts, written reports, digital data and

recordings contained on the computer and flash drive pertaining to this study will be deleted and physically destroyed by incineration.

Trustworthiness

It was important for this generic qualitative inquiry to demonstrate rigor, trustworthiness and credibility of the data. The notion of what constitutes a rigorous qualitative study has been the subject of hotly contested debates over the past two decades and is often intertwined with debates about what constitutes quality criteria (Caelli, Ray and Mill, 2003 p.7). This section will delineate the implications for the trustworthiness and credibility of the data as follows: (a) triangulation of data (b) prolonged engagement, (c) persistent engagement, (d) investigator triangulation, (e) peer debriefing, (f) member checks, and the (g) audit trail. The confidence of the data, its interpretation, and methods that the researcher employ ensured the quality of a study (Connelly, 2016).

Triangulation of Data

The generic qualitative approach utilized a combination of systematic methods that allowed the researcher to remain anchored to the data. The study triangulated data, using multiple data sources as a strategy to improve trustworthiness (Lincoln & Guba, 1985). These multiple data sources were comprised of a collection literature, documents, field notes, and interviews.

Prolonged Engagement

For this study, it was important for the researcher to stay in the field, immersed within relevant literature, documents and participants for an extended period when conducting the generic qualitative inquiry. Prolonged engagement allowed the researcher ample time to become familiar and build mutual trust and respect for topic (Al-Yateem, 2012). Extensive interactions

with BAAM who have experienced trauma was essential to enhancing the trustworthiness of the study data. This researcher's lived experience as a BAAM who has also been impacted by trauma proffered additional insight and credibility for understanding the topic and participant perspectives.

Persistent Engagement

Persistent engagement referred to staying in the field and collecting data long enough and persistently enough to not close the data collection process prematurely. One problem that many researchers have is thinking they know "what is going on" with a situation. This situation has sometimes been called "going native" (Lincoln & Guba, 1985, p. 7). Researcher(s) may be so close to the situation or group of people that they become comfortable with quick interpretation of events. Persistent engagement allowed the researcher to select relevant data through a logical process of elimination.

Investigator Triangulation

With this qualitative research, investigator triangulation cross-checked the data generated from the interviews. Studies that use two or more interviewers have potential to decrease bias that may occur from a single person collecting all the data (Patton, 2002). This type of triangulation seeks to strengthen the confirmation of findings and different perspectives, adding breadth and depth to the phenomenon of interest (Denzin, 1970). For this reason, the researcher reviewed the data with another trained researcher, a BAAM licensed professional counselor, to provide additional insight and perspective conclusions (Carter et al., 2014). During the ZOOM meetings the principal investigator (researcher) conducted interviews and the secondary researcher cross-checked participant data after the interview was completed. After the initial interview was completed, the secondary observer may suggest follow-up interviews to fill

informational gaps and/or to provide additional clarity about the topic if either investigator deems it necessary.

Peer Debriefing

Peer debriefing was a reflective process that occurred when the researcher shared the research findings with peers and requested their support and opinions, particularly regarding the interpretation of unidentifiable data. This process helped the researcher ensure that the conclusions and analysis of the data were coherent to other researchers and that data were collected consistently and systematically. During peer debriefing, it was essential for peers to comprehend how the interview process might elicit emotions from the researcher, who is a Black African American Man with personal trauma experiences. To maintain confidentiality, the peer debriefing sessions utilized pseudonyms for the participants when necessary and included unidentifiable transcript data.

In this study, the researcher used peer debriefing as a reflective process to maintain support and insight about the potential impact of the research on their emotions (Hubbard et al., 2001). When investigating emotionally charged issues such as trauma and abuse, "the researcher's own emotional response to a participant's experiences can be used to interpret data and may be a necessary part of the reflective process" (Hubbard et al., 2001, p. 131). Lincoln and Guba (1985) explained how debriefing can be useful for the researcher:

> The debriefer was a non-involved professional peer with whom the inquirer could have a no-holds-barred conversation at periodic intervals. The purposes of the debriefing were multiple: to ask the difficult questions that the inquirer might otherwise avoid (to keep the inquirer honest), to explore methodological next steps with someone who has no axe to grind, and to provide a sympathetic listening point for personal catharsis" (p. 283).

Member Checks

The fundamental purpose of member checking was to establish truth (Bell, 2014; Cho & Trent, 2006) and allow each participant an opportunity to match and validate their experiences (Bell, 2014; Koelsch, 2013). Recording allowed the "researcher to replay the recordings several times to scrutinize details and correct possible misconceptions" (Buchwald et al., 2009, p. 16). Each participant received a transcription of their interview via email to review it for accuracy.

Emotionally charged topics such as trauma can potentially elicit disturbing thoughts and feelings during and/or after the interview. Member checks can be used to help the participant debrief and talk through complex emotions and feelings that had been discussed (Hubbard et al., 2001). Researchers should maintain contact with study participants after the interview process and through member checks to help participants manage any unsettling emotions that were brought up while participants shared their experiences (Dickson-Swift et al., 2009).

It is also important to note that the researcher informed participants of the member checking process prior to study's data analysis. Member checks provide and additional level of credibility regarding the accuracy of emerging themes (Bellini & Rumrill, 2009 pg. 203). This process improves the dependability of the study data. Thomas (2017) regards member checks as useful validation technique to ensure that participants agree that findings constructed by the researchers adequately represent the reality that participants will report.

Audit Trail

The audit trail provided for an organized examination of the research. It illustrated a record of the detailed step-by-step process including some of the decisions that led to the findings. In addition to establishing rigor of the study, it aimed to increase validity, credibility, and help an independent/peer auditor to track textual evidence of data back to the interpretations

and vice versa. When conducting a qualitative study, “developing and maintaining an audit trail may be the single most important trustworthiness technique available” (Lincoln & Guba, 1985, p. 283).

The audit trail in this study was composed of six distinct categories: (a) raw data, (b) data reduction and analysis products, (c) data reconstruction and synthesis products, (d) process notes, (e) materials pertaining to intentions and dispositions, and (f) information about instrument development (Carcary, 2020; Halpern, 1983;). Within these categories, the use of various tools such as interviews, transcriptions, observation notes, documents, the researcher's journal, and other field notes were incorporated.

The first category, raw data, pertains to the original data collected during the study, including audio recordings and written notes. The second category, data reduction and analysis products, includes the coding and analysis of the raw data. The third category, data reconstruction and synthesis products, involves the integration of the coded data into themes or patterns. The fourth category, process notes, consists of detailed documentation of the research process, including decisions made during data collection and analysis. The fifth category, materials relating to intentions and dispositions, includes documentation of the researcher's intentions and assumptions during the study. Finally, the sixth category, instrument development information, encompasses the development and refinement of research instruments used in the study.

Summary of the Methodology

Chapter three presented the research design and methods that will be used to answer the research question, “What are the challenges for Black American men who have experienced trauma?”. The chapter included a description of the generic qualitative approach along with

information about the study population and sampling methods. Details about the study's procedures for data collection and analyses were provided. Then the ethical considerations and methods for ensuring trustworthiness were discussed; and finally, the chapter summary. Next, chapter four will present the findings from the study.

CHAPTER 4:

PRESENTATION OF THE DATA

Chapter four provides an in-depth analysis of the challenges faced by Black African American Men (BAAM) who have experienced trauma. A generic qualitative inquiry approach outlines the methodology used to collect, organize and analyze the study data. This chapter contains four sections, including a brief overview of the research process, details of the study sample, a presentation of the data and its analysis, and a summary of the findings. Presentation of the study data offered valuable insights into the unique challenges and experiences of BAAM who have undergone trauma and provided a deeper understanding of their struggles which can inform future research in the field.

Research Description

A generic qualitative inquiry was conducted by the researcher to explore the challenges faced by Black African American Men (BAAM) who have undergone trauma. The study employed qualitative methods such as interviews, field notes, records, and documents, along with systematic procedures for recruitment, data collection, and analysis. (Braun & Clarke, 2006;2012; 2021; Percy et al., 2015). The participant's subjective opinions, attitudes, beliefs, and reflections about the research topic were investigated to gain a fair and effective understanding of the issue. (Crabtree & Miller, 1992; Koch et al., 2014; Mills et. al., 2006; 2016; Patton, 2002).

The analysis and interpretation of data is influenced by a researcher's biases, assumptions, and presuppositions (Caelli et al., 2003; Creswell, 2013). In the present study, the researcher's personal experience with trauma provided an insider perspective, which helped build rapport with participants (Koch et al., 2014; Hardy, 2019). Although this personal experience

may have influenced the analysis, it also played a crucial role in shaping the study. By collaborating with the participants, an authentic collection of data was created that mutually constructed and answered the research question (Crabtree & Miller, 1992; Mills et. al., 2006; Patton, 2002); what are the challenges for Black African American Men (BAAM) who have experienced trauma? According to Lincoln and Guba's (1985) findings, this partnership played a critical role in generating naturalistic outcomes that were dependable and trustworthy.

Description of the Sample

In this study, a purposive sampling approach was employed to identify and select a cohort of five Black African American Males (BAAM) for the purpose of conducting semi-structured interviews. The recruitment process involved a variety of methods, including the distribution of informational flyers (see Appendix H), word-of-mouth referrals, and the placement of advertisements at local community venues such as barbershops, churches, recreation centers, and events. To determine eligibility for inclusion in the study, predetermined criteria was established, including the use of a participant screening instrument (see Appendix A) and the Adverse Childhood Experiences (ACE) questionnaire (see Appendix F).

The study employed a participant screening instrument to gather demographic and Adverse Childhood Experiences (ACE) data. The participants who enrolled in the study, belonging to the BAAM cohort, had an age range of 29 to 53 years and ACE scores ranging from 4 to 9. All five participants reported being employed, four were married and one was divorced. Semi-structured interviews were conducted to gather experiential information related to the research topic. The researcher leveraged their professional background as a certified rehabilitation counselor, current status as a doctoral candidate, and prior experience in

conducting semi-structured interviews as a director at a behavioral health hospital, to inform the research methodology.

The study aimed to examine the experiences of BAAM who have experienced childhood trauma. A purposive sampling strategy was utilized to recruit a cohort of five participants, who provided informed consent and completed various study measures, including recruitment forms, participant screeners, and Adverse Childhood Experiences (ACE) questionnaires. Following the completion of these measures, five participants were selected to complete semi-structured interviews remotely via the ZOOM. The following narratives provide a brief description of the interviewed participants.

Participant 1 (P1), a 33-year-old BAAM who scored 9 out of 10 on the ACE questionnaire. P1 reported being married and employed on the participant screener, as well as having a positive support system and prior experience with professional counseling services. During the interview, P1 expressed how difficult it is for BAAM to acknowledge traumatic experiences. During the semi-structured interview, the participant articulated the challenge of recognizing traumatic experiences as a Black African American male. He stated that the belief in persevering and the perception that trauma is not a valid topic of discussion are significant factors that inhibit acknowledgment of trauma, “The sense that you just got to put your head down and keep being you know, perseverance is the thing that kills us and also thinking like, you know, nobody wants to hear it (trauma) is a big thing.”

Participant 2 (P2), a 53-year-old BAAM who scored 5 out of 10 on the ACE questionnaire. P2 reported being divorced and employed on the screener and revealed having a positive support system and prior experience with professional counseling services. During the interview, P2 discussed the challenges of communication and silence for BAAM who have

experienced trauma, stating that individuals should not be afraid to speak up when others are being hurt, “Everything doesn't need to stay in house. We can't pick what we want to talk about, you know, in the household, you don't get to pick the no snitch rule, that doesn't, that doesn't apply when people are being hurt”.

Participant 3 (P3), a 29-year-old Black African American Male, scored 4 out of 10 on the ACE questionnaire and reported being married and employed. He indicated having a positive support system and prior experience with professional counseling services. In the interview, P3 emphasized the issue of ignorance and desensitization for BAAM who have undergone trauma, citing a lack of education or comprehension as the reason for individuals not recognizing the impact of traumatic experiences. As he put it, “I didn't hear the word trauma until like close to maybe my junior year of college. All my life, I grew up like in the in the hood, you know, not knowing that I was going through these things”.

Participant 4 (P4), a 41-year-old BAAM who scored 4 out of 10 on the ACE questionnaire. P4 reported being married and employed on the participant screener and revealed access to a positive support system and prior experience with professional counseling services. During the interview, Participant 4 discussed the challenges posed by cultural and psychosocial factors such as structural racism, discrimination, education, opportunity, and resources. P4 expressed that these factors can make it difficult for individuals who have experienced trauma to cope and recover. As P4 stated, "We are brought into a society that is designed for and constructed by those who have oppressed us." This perspective underscores the necessity of devoting more attention to and gaining a better understanding of the systemic factors that contribute to trauma in Black African American communities.

Participant 5 (P5), a 39-year-old BAAM who scored 5 out of 10 on the ACE questionnaire. P5 reported being married and employed on the participant screener and revealed access to a positive support system and prior experience with professional counseling services. Participant 5 discussed the difficulties faced by individuals who have undergone trauma in receiving sufficient support due to the scarcity of culturally congruent resources during the interview. P5 suggested that the lack of resources contributes to the prevalence of trauma-related problems in certain communities. As P5 stated, "I believe that is partly because we don't have the resources associated with the trauma. The lack of resources creates what you see in places like Little Rock or Chicago." This viewpoint emphasizes the importance of culturally appropriate resources to assist in addressing the trauma-related issues faced by Black African American communities.

Research Methodology Applied to the Data Analysis

A generic qualitative inquiry was conducted to investigate the challenges faced by BAAM who have experienced trauma. The inquiry employed a combination of qualitative methods, such as document analysis, field notes, and semi-structured interviews, to gather descriptive information from the participants. The data was analyzed using a constant comparison method, which allowed for the identification and examination of patterns and themes.

The present study was guided by Sotero's (2006) conceptual model of historical trauma, which was adapted as a framework for the research. The study's data was subjected to theoretical thematic analysis, which is a common analytical approach in research studies. The analysis process was guided by Percy et al.'s (2015) model of theoretical thematic analysis with constant comparison, which is particularly relevant when the researcher has pre-existing knowledge about

the research topic. Overall, this approach enabled the investigation of the research questions in a rigorous and systematic manner.

This methodological approach allowed for in-depth data analysis, which involved a detailed comparison, contrast, and examination of the data obtained from the study participants. The researcher utilized an iterative process to constantly shift between the newly acquired data and the previously analyzed data to identify novel themes and patterns (Glaser, & Strauss, 2017; Maxwell & Chmiel, 2014). Subsequently, the data patterns were organized into appropriate themes to address the underlying research question. This analysis included thirteen steps from Percy et al.'s (2015), which are described below.

1. The researcher engaged in a process of data immersion, whereby he familiarized himself with participant data, including interviews, journals, field notes, records, and documents. He conducted a thorough examination of each piece of data, intuitively highlighting sentences, phrases, and paragraphs that were pertinent to the research question.
2. Relevant data was systematically highlighted, stored, and compared to pre-existing knowledge, theory, and the research question to ensure their alignment.
3. Extraneous data that did not correspond to the research question was segregated and transferred to an alternate file. This data was subsequently reviewed again to confirm its exclusion from the analysis.
4. Characteristic codes (ACE1, ACE2, ACE3, ACE4, etc.) were assigned to the pertinent highlighted data to facilitate its tracking and retrieval.
5. The researcher engaged in a process of data clustering to identify patterns and connections that were relevant to the research question.

6. Using a constant comparison method, the researcher systematically coded and clustered each piece of data. He compared and contrasted subsequent data with previously analyzed data to ensure consistency and accuracy of the analysis.
7. Data related to specific patterns was identified, extracted, and organized with the corresponding pattern. Direct quotes were taken from the data (interviews, field notes, documents, etc.) to explicate the pattern.
8. The researcher reviewed all of the identified patterns for the emergence of overarching themes. This involved combining and clustering patterns to identify themes that were supported by the data.
9. The patterns and themes evolved throughout the analysis process as the researcher compared and contrasted previously completed analyses with new data.
10. After analyzing all the data, the themes were arranged to correspond with supporting patterns. These patterns were used to explicate the identified themes.
11. The researcher documented a detailed analysis, providing a comprehensive description, scope, and substance of each theme.
12. The identified patterns were described and explicated using direct quotes from the data.
13. Finally, the data was synthesized to create a composite overview of the challenges faced by Black African American Men who have experienced trauma.

Final Stage of Analysis

The study adhered to the research protocols outlined in Chapter 3. Member checks were executed without issue, whereby participants were furnished with transcripts and solicited for feedback before commencing data analysis. Subsequently, all five participants were contacted

and three of them elected to engage in a review of their transcribed data. The data was scrutinized, validated, and confirmed for precision. No supplementary input was received from the participants, nor was any further data procured. Following the completion of data analysis, a synopsis of the emerging themes was generated.

Presentation of Data and Results of the Analysis

This section will present the data and results of the analysis, which includes the adapted conceptual model of historical trauma theory depicted in Figure 3. The researcher used pre-existing knowledge to develop this conceptual model, which was then analyzed using various techniques. The model's codes and patterns evolved organically during the data analysis process, and seven emergent themes were identified using quotes from semi-structured interviews. These themes are as follows: adverse childhood experiences; mental health and wellbeing; behavioral stress and coping; victimization and desensitization; post-traumatic stress, anxiety and depression; help-seeking; and historical trauma.

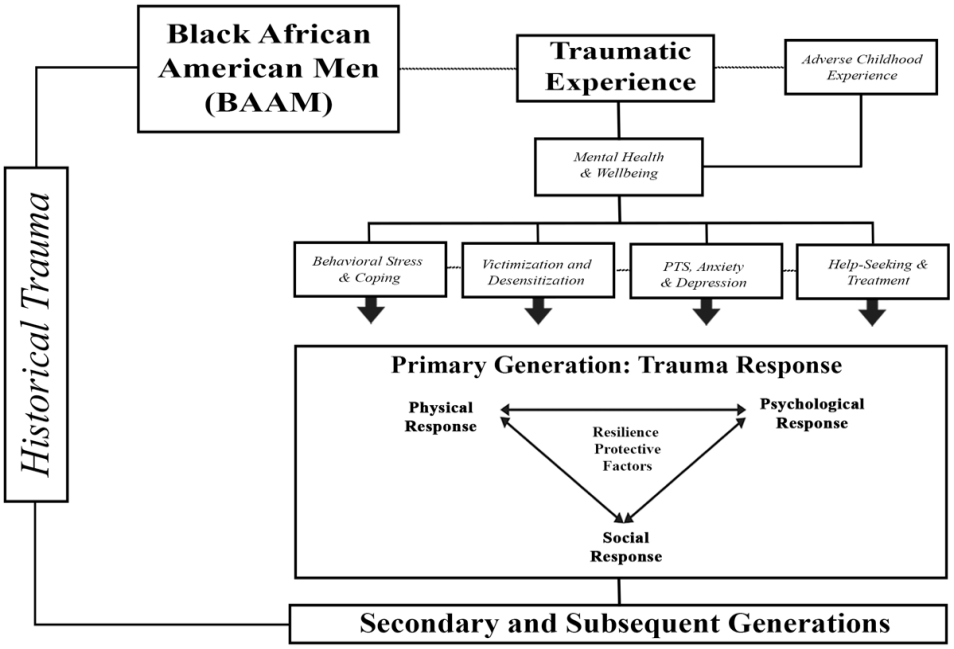

Figure 3.1. Adapted model of historical trauma. Note. Adapted from "A Conceptual Model of Historical Trauma: Implications for Public Health Practice and Research" by M. Sotero, *Journal of Health Disparities Research and Practice, 1*(1), p. 98. Copyright 2006 by Center for Health Disparities Research School of Public Health

The transcript data obtained from the participants underwent rigorous thematic analysis. The resulting matrix, presented in Table 2, effectively showcases the emergence of distinct themes and patterns observed across participants (P) 1-5 of the BAAM program. Each theme was thoroughly characterized by descriptors of the identified patterns, enabling a comprehensive understanding of the data. This analytical approach facilitated a scientific and methodical exploration of the research topic.

Table 2.1. *Matrix of Themes and Corresponding Patterns Across Participants*

Themes and Patterns	P1	P2	P3	P4	P5
Adverse Childhood Experience (ACE):					
Abuse	*X*	*X*	*X*	*X*	*X*
Neglect	*X*	*X*	*X*	*X*	*X*
Household Dysfunction	*X*	*X*	*X*	*X*	*X*
Mental Health & Wellbeing:					
Acknowledged Importance	*X*	*X*	*X*	*X*	*X*
Resistance	*X*	*X*	*X*	*X*	
Resilience	*X*	*X*	*X*	*X*	*X*
Coping & Utilization	*X*	*X*	*X*	*X*	*X*
Behavioral Stress & Coping:					
Internalized	*X*	*X*	*X*	*X*	*X*
Externalized	*X*	*X*	*X*	*X*	*X*
Victimization & Desensitization:					
Environmental	*X*	*X*	*X*	*X*	*X*
Emotional	*X*	*X*	*X*	*X*	*X*
Relational	*X*	*X*	*X*	*X*	*X*
Post-Traumatic Stress, Anxiety & Depression:					
Stress	*X*	*X*	*X*	*X*	*X*
Anxiety	*X*	*X*	*X*	*X*	*X*
Depression	*X*	*X*	*X*	*X*	*X*

Table 3.1. *Matrix of Themes and Corresponding Patterns Across Participants*

Themes and Patterns	P1	P2	P3	P4	P5
Help-Seeking & Treatment					
Cultural Congruence	*X*	*X*	*X*	*X*	*X*
Familial Support	*X*	*X*	*X*	*X*	
Self-Empowerment	*X*	*X*	*X*	*X*	*X*
Professional Support	*X*	*X*	*X*	*X*	*X*
Mental Health & Wellbeing:					
Impact of Slavery		*X*	*X*	*X*	*X*
Intergenerational Impact	*X*	*X*	*X*	*X*	*X*
Impact of Race and Society	*X*	*X*	*X*	*X*	*X*

Note. Participant semi-structured interview transcripts.

The current research employed a qualitative method to develop themes through coding and theme development, which were informed by pre-existing theoretical knowledge. The semi-structured interviews were analyzed to reveal patterns in the data. The researcher was persistently engaged with the constant comparison of study data, and as a result, seven themes were conceptualized to address the research question (Braun & Clarke, 2021).

ACES

One of the themes that emerged from the data was Adverse Childhood Experiences (ACEs), which includes traumatic events experienced before the age of 18, such as physical abuse, substance abuse, exposure to abuse in the household, and physical and emotional neglect. Previous research suggested that ACEs can have a significant impact on the regulation of

biological and neurological systems across the lifespan (Felitti et al., 1998). In the present study, each participant reported experiencing four or more ACEs, and they described the associated challenges during the interviews.

The data revealed that exposure to abuse or household dysfunction during childhood was associated with various risk factors for leading causes of death in adults (Almuneef et al., 2016; Berens et al., 2017). For instance, P5 reported witnessing violence in their household and community, stating, "My mama, my daddy, my whole family fighting each other. The shootings, none of it's healthy and you see it on a day-to-day basis." Similarly, P4 recalled experiencing trauma due to the absence of a father and the normalcy of violence in their community, saying, "In some communities, getting killed is a big deal. You know, a teenager or a young adult male getting killed is a big deal, that's traumatizing."

The development of themes in this study involved persistent engagement from the researcher, who grappled with the data to create a comprehensive understanding of the participants' experiences. The themes highlighted the profound impact of ACEs on individuals and the potential long-term consequences of exposure to abuse and household dysfunction during childhood.

Mental Health & Wellbeing

According to the data collected from semi-structured interviews, the theme of mental health and wellbeing among BAAM emerged. The conceptualization of this theme was influenced by the researcher's pre-existing knowledge and the collection of information from the interviews. The data analysis extracted meaning from participants' statements about their health and wellness.

The interview data analyzed the participants' perspectives on mental health and trauma among BAAM. P4's statement, "I think trauma is really at the forefront now, but it's always been there and we go through it a lot as black men," and P3's statement, "if we remain aware of our settings and our trauma, and what triggers us, then, then we could do so much better, like right now," highlighted the prominence of trauma in the lives of BAAM.

The study also analyzed a breadth of information about trauma and mental health among BAAM. P1's statement, "The kind of community that I grew up in people are trying to make it day to day. So they're not thinking about five ten years down the line right now," and P2's statement, "we never wanted to use the word trauma in the communities. No, never, one that we don't want to use that and that's what I found," revealed the priority of survival over mental health in BAAM communities.

In addition to mental health and trauma, the theme also analyzed data about BAAM's subjective wellbeing. P1's statement, "I think health and well-being man is this you know the sense of feeling whole and all those places," and P5's statement, "I think a life well-lived, I always say brings hope and I think if you live in in your purpose, you live in, you know, through a positive lens in life and have an extremely absorbent amount of faith," emphasized the importance of self-care and emotional wellbeing.

The data analysis revealed that the availability of resources for treatment among the BAAM were sparse. P1's statement, "there's a lot of trauma and there's not enough resources for everybody to get help," and P2's statement, "You gotta’ go upstream and reteach black families. How to navigate in their own household, that's healthy, you know," highlighted the scarcity of culturally congruent resources for BAAM to address their trauma-related challenges.

Behavioral Stress & Coping

This study aimed to analyze the behavioral response of participants to stressors related to trauma. The data collection involved documents, field notes, and semi-structured interviews with key participants. Participants shared their experiences and thoughts about their reactions to stress, including both internalized and externalized behaviors. The analysis of participants' responses revealed various coping and stress management strategies, including mindfulness and physical activities such as working out and sports. However, some participants also discussed maladaptive behaviors, including binge eating, consuming unhealthy foods, alcohol, and smoking.

One participant noted that some cultural norms around food may not be the healthiest. They commented, "like eating healthy, you know, black cuisine is delicious but a lot of times it's not very healthy." Another participant recognized the danger of smoking, stating, "I smoke all the fucking time because of the stress…I do medicate, but I need to do it wiser because I know that smoking in reality you can kill yourself and then you won't be there for your kids or they kids."

The emotional aspects of participants' responses to stress were also analyzed. All participants reported difficulty expressing their feelings due to stigma, ego, and pride as barriers to communication. One participant stated, "You have to be appropriate in your actions and we don't learn that a lot of times as men, you know, we're still trying to find ourselves, and we don't want to be perceived as weak, it's part of the ego." They also mentioned that violence was a learned response from their family. Another participant disclosed that they had sought help for anger management, recognizing the need to unlearn unhealthy responses. Overall, participants noted that the fear of being perceived as an "angry black man" hindered their ability to express emotions and communicate effectively.

Victimization and Desensitization

The present study explored the impact of Adverse Childhood Experiences (ACEs) on BAAM participants' victimization and desensitization. ACEs, which include household dysfunction, abuse, and violence, were found to increase the likelihood of revictimization and other adversities during adulthood. To better understand the participants' experiences, the researchers conducted interviews from an environmental and relational perspective.

The findings from the interviews highlight the challenges that BAAM participants faced in trusting others after experiencing victimization. Three of the participants reported difficulties in establishing trusting relationships due to past traumatic experiences. One participant described a close friend's predatory behavior, which made it hard to trust others. Another participant discussed how their lack of trust impacted their relationships and emotional connections, noting that their family had suffered as a result.

The participants also shared their experiences of desensitization to violence and trauma in their communities. All of the participants reported growing up in low-income areas characterized by drugs, crime, and violence. They recalled a sense of numbness and normalization of these experiences, with Participant 3 describing it as "just chalking it up to the game of life." Participant 4 described the trauma of hearing about gun violence and death in their community, highlighting that in some areas, it was so common that it did not elicit the same response as in other communities.

Overall, this study sheds light on the traumatic experiences of BAAM participants and the impact of ACEs on their victimization and desensitization. The findings suggest that addressing the trauma resulting from ACEs is crucial to preventing revictimization and promoting healing in this population.

Post-Traumatic Stress, Anxiety and Depression

The analysis of data on post-traumatic stress, anxiety, and depression among a significant intersection of pre-knowledge, terms, and key features associated with the theme. The participants' quotes were crucial in shedding light on the patterns related to the theme.

The research identified post-traumatic stress as a significant issue, with participants reporting flashbacks and long-term problems. P5's description of trauma as a "volatile experience" that reverberated through his body and mind is a reflection of the severe impact of trauma on BAAM. Such experiences can lead to difficulty in thinking and navigating through everyday life.

Social anxiety and fitting in emerged as a critical aspect of the participants' experiences. Participants expressed that being Black in a society that was not designed to benefit them was a significant challenge. P5 and P2's descriptions of constantly adjusting and evaluating how they should act highlight the emotional toll of constantly being on guard in public spaces.

The data also revealed that the participants were at risk of depression due to adverse childhood experiences and various other race-related factors. Although none of the participants explicitly stated that they had ever been depressed, the researcher identified terms like abuse, sadness, loneliness, and grief, which are associated with depression. Participants recounted experiences of feeling abandoned and disconnected from their loved ones, highlighting the emotional distress they go through.

The study further revealed that trauma-related depression can make individuals feel stuck and stagnant. Trauma can put a block on people and prevent them from moving forward. The participants emphasized the importance of having faith and believing in oneself. However, they

highlighted that the conditioning of Black men to focus only on providing for their families and making money often makes them lose faith in themselves.

In conclusion, the research provides valuable insights into the experiences and perspectives of Black African American Men (BAAM) regarding post-traumatic stress, anxiety, and depression. The study highlights the need for greater awareness of the mental health challenges faced by BAAM and the importance of providing access to culturally responsive mental health care.

Help Seeking & Treatment

The theme of help seeking among Black African American Men (BAAM) highlights the challenges and experiences that these individuals encounter when seeking help for trauma-related problems. The researcher analyzed data from semi-structured interviews to gain insights into the strategies, resources, and barriers that BAAM face when seeking help.

The findings suggest that one of the biggest barriers for BAAM is difficulty in verbalizing and communicating their need for help. They often feel shame and struggle to identify what is wrong or what help is available. Additionally, there is a cultural stigma around acknowledging and discussing trauma, as it is perceived as a sign of weakness. This is reinforced by values such as "no snitching" and "no telling" within the black community.

However, the data also suggests that BAAM do seek help and have used both professional and non-professional resources. Participants reported seeking help from family, friends, mentors, and counselors. They acknowledged the benefits of talking about their traumatic experiences and receiving support. Some participants had prior experience with professional counseling and reported positive outcomes from therapy.

Overall, the data highlights the complex and multifaceted nature of help seeking among BAAM. While there are significant barriers to accessing help, such as shame, stigma, and cultural values, BAAM do seek help and have found support in a variety of resources. The findings suggest that more awareness and understanding is needed to better support BAAM in accessing the help they need.

Historical Trauma

The theme of historical trauma among BAAM is a complex issue that spans across generations. The impact of slavery is still felt by the BAAM community today, with many participants stating that everything about Black America is rooted in slavery. The trauma from slavery has been passed down through generations, resulting in scars that individuals are born with. The intergenerational impact of historical trauma is further exacerbated by social inequities, racial disparities, and the acquisition and distribution of resources.

Racism and discrimination are also traumatic experiences for BAAM, with many participants describing the constant fear and anxiety of being discriminated against based on their skin color. The scarcity complex, as described by P2, is another form of trauma that stems from the historical trauma of slavery. The constant fear of not being enough, not getting a job or an apartment due to skin color is a constant burden that affects the mental health and wellbeing of BAAM.

Furthermore, the impact of race and society is seen in the structural racism and conspiracy that the BAAM community faces. P3 described how the United States has done its job in separating Black men, with policies such as the crack pandemic and war on drugs resulting in the imprisonment and separation of Black men from their families and communities. P5 pointed out the lack of representation and participation of BAAM in the future, with land

acquisition through eminent domain and city officials further perpetuating the historical trauma of dispossession and oppression.

Overall, historical trauma had a significant impact on the mental health and wellbeing of BAAM, with trauma being passed down from generation to generation. The intersection of historical trauma, racism, and societal injustices further exacerbate the trauma experienced by BAAM. Recognizing and addressing historical trauma is crucial in promoting healing and improving the overall mental health and wellbeing of BAAM.

Summary of the Presentation of the Data

Chapter four was dedicated to presenting the results of the data analysis conducted in response to the research question: "What are the challenges for Black African American Men who have experienced trauma?" The generic qualitative inquiry methodology was described and a thorough description of the sample was provided. Procedures regarding theoretical thematic analyses were elaborated on, and the themes that emerged from the participant responses were presented as study results. The study's seven themes were identified and organized accordingly: (1) adverse childhood experiences, (2) victimization and desensitization, (3) behavioral stress and coping, (4) help-seeking and treatment, (5) post-traumatic stress, anxiety, and depression, (6) historical trauma, and (7) mental health and wellbeing. Chapter five will subsequently highlight the further findings of this study.

CHAPTER 5:

DISCUSSION

This dissertation presents an investigation into the challenges faced by Black African American Men (BAAM) who have experienced trauma. The first two chapters of this dissertation provide an in-depth background of the study, including a contextualization of the topic and a review of relevant literature. Subsequent chapters present the research methodology and findings through the use of a generic qualitative inquiry. The objective of Chapter 5 is to elucidate the practical applications and implications of the study's findings by comparing the research outcomes with existing theoretical frameworks and assessing their relevance to counseling professionals and other stakeholders.

Chapter 5 provides a comprehensive summary of the research findings and a discussion of the challenges experienced by impacted BAAM. The results of the study are analyzed thematically and presented in the context of the conceptual theoretical frameworks. The chapter also examines the broader implications of the research for the field of counseling and provides recommendations for future studies. Recognizing and addressing potential limitations and sources of bias in a study is fundamental to ensuring rigor and reliability of future research. Overall, the chapter seeks to advance the understanding of the challenges faced by BAAM who have undergone trauma and enhance the ability of professionals and stakeholders to provide effective support and interventions.

Summary of the Results

The present study employed a generic qualitative inquiry methodology to elucidate a pathway for addressing the research question of identifying challenges experienced by Black African American Men (BAAM) who have undergone trauma. According to the results, BAAM

face a distinctive array of challenges that have not been thoroughly investigated in previous studies. This research identified the challenges faced by BAAM who have experienced trauma, using their voices and perspectives. The theoretical thematic analysis of the study data revealed discernable patterns, with seven overarching themes identified. These themes are as follows: (1) adverse childhood experiences, (2) victimization and desensitization, (3) behavioral stress and coping, (4) help-seeking and treatment, (5) post-traumatic stress, anxiety, and depression, (6) historical trauma, and (7) mental health and wellbeing. In addition, the inquiry revealed a variety of adverse outcomes linked to the study themes, such as the deleterious impact of stigmatization and shame, the impact of cultural and societal aspects, the insufficient reliance on mental health experts, and the restricted accessibility of social support.

BAAM navigate unique and complex circumstances. Despite several advancements in social and civic contexts, the challenges related to trauma continue to remain unresolved and under-addressed, perpetuating the cycle of life-threatening dilemmas. The study's methodology used a combination of data (i.e. interviews, observations, field notes, and focus groups) to explore the perspectives, beliefs, and experiences of BAAM who navigate challenges associated with trauma.

BAAM experience trauma in various ways, including exposure to traumatic events before birth and conception due to epigenetic factors and historical trauma. Extant research describes the negative impact of trauma as intergenerational, meaning that individuals who were not present during the traumatic events may still exhibit symptoms of trauma (Mohatt et al., 2014; Yehuda & Lehrner, 2018). Degruy's (2005) publishing revealed that Black/African American people have been exposed to trauma through the transmission of trauma from generation to generation.

BAAM contend with the effects of historical trauma and commonly report experiencing discrimination and other race-related issues. Like other minority groups, BAAM, experience both racial disparities and inequalities in various aspects of life (i.e. education, healthcare, employment, and criminal justice). However, BAAM's disparities and inequalities can be attributed to structural and systemic factors such as discrimination, prejudice, and historical and institutional racism (Reeves, Nzau & Smith, 2020).

Historically traumatic experiences have been associated with diverse negative psychological consequences, including survivor guilt, exposure to stressful life events, intergenerational grief and bereavement, post-traumatic slave syndrome, and cultural trauma, among BAAM (Alegría et al., 2008; Ault-Brutus, 2012; Cook et al., 2007; Rich et al., 2020; U.S. Office of Minority Health, 2019). Overall, the research suggests the legacy of trauma has a profound impact on the posterity of BAAM and the negative consequences of trauma-related challenges are detrimental to their health and well-being.

The U.S. Department of Health and Human Services Office of Minority Health (2019) revealed that over half of the U.S. population experiences trauma from adverse childhood experiences (ACEs). Prior research has shown that racial minorities have a higher risk of experiencing trauma through ACEs (Zhang & Monnat, 2022). The BAAM key-informants suffer from four or more ACEs; having four or more ACEs significantly increases the risk for the leading causes of death among adults, including heart disease, stroke, cancer, COPD, diabetes, Alzheimer's, and suicide (Brown et al., 2009; Felitti et al., 1998;). Higher exposure to ACEs has also been associated with anxiety, anger, depression, and a higher likelihood of engaging in maladaptive coping strategies that included but were not limited to, smoking, alcohol

consumption, and/or drug use (Brooks & Moore, 2016; Ellis et al., 2015; Hyman, & Sinha, 2009).

Trauma can lead to physical, psychological and social consequences. Prior literature indicated that negative cognitive outcomes, such as depression, memory impairment, and reduced concentration, are associated with traumatic experiences (Hudson et al., 2018; Lindsey et al., 2018; Singletary, 2020). Furthermore, these experiences may result in decreased motivation, heightened irritability, disinhibition, aggression, hopelessness, and worthlessness (Blevins et al., 2015; Motley & Banks, 2018). In addition to these internalized outcomes, traumatic experiences also lead to social complications, such as difficulties with employment, education, and relationships. Maladaptive stress responses and externalized problematic behaviors, such as aggression and violence, have also been linked to traumatic events (Hunt et al., 2017; Singletary 2020; 2022). Overall, the research findings underscore the need for culturally sensitive interventions that cater to the unique experiences and requirements of BAAM, and highlight the potential implications of ignoring such concerns.

Discussion of the Results

The research methodology utilized a theoretical thematic analysis, which is a well-established approach for analyzing qualitative data (Braun & Clark, 2006; Percy et. Al., 2015). This method is particularly effective in identifying and exploring patterns and themes, as it allowed the researcher to integrate pre-existing knowledge and theoretical concepts to guide the data analysis. Utilizing this methodology, the researcher was able to identify seven emergent themes, previously mentioned, that facilitate nuanced comprehension of the challenges faced by Black African American males who have experienced traumatic events. These themes highlight the various psychological and emotional struggles experienced by this population, as well as the

impact of societal and cultural factors on their ability to cope with trauma. Overall, these themes illuminate the obstacles that these individuals must overcome.

The analysis of data patterns has revealed that males of Black African American descent are prone to early-life trauma due to Adverse Childhood Experiences (ACEs), a circumstance that may induce adverse effects throughout the entire lifespan (Felitti et al., 1998). The dissertation findings indicate that Black African American males are susceptible to early-life trauma due to ACEs, which can have negative repercussions throughout their lifetime. All five study participants reported experiencing four or more ACEs, with one individual describing the impact as reverberating "through your body, your psyche, and your whole life." Prior to participating in the study, four of the five participants were not aware of the term "ACEs" and how it relates to trauma and future generations.

Childhood adversities were prevalent among the participants, who also shared comparable survival strategies and discussed how they navigated and endured adversity in their households and communities. The participants experienced childhood trauma from abuse, household dysfunction, and neglect. Previous data suggest that exposure to abuse or household dysfunction during childhood is associated with various risk factors for leading causes of death in adults (Almuneef et al., 2016; Berens et al., 2017).

Interestingly, one of the participants reported growing up without a father as "the biggest trauma" they had encountered since they had to rely on their surroundings to teach them certain life lessons. The participants described how early childhood adversities influenced their logic, reasoning, and responses to situations later in life (Harris, 2018). For example, another participant reported that he had to handle issues on his own since childhood and that he learned to be or “act tough” in the face of adversity. Furthermore, additional research from Bernard et al.

(2020) advocates for the creation of a Culturally-Informed Adverse Childhood Experiences (C-ACE) framework to better understand the impact of racism on mental health outcomes among Black youth.

The present study's thematic analysis revealed an emergent theme related to the behavioral stress response demonstrated by BAAM following exposure to traumatic events (Hatcher et al., 2009; Myers, 2009; Wade & Rochlen, 2013). The commonly reported responses included shock, denial, anger, guilt, and shame, which were found to be expressed both internally and externally (Sellers & Shelton, 2003). BAAM may use alcohol as a coping mechanism or experience social anxieties as a response to the stress experienced. However, the study found that adaptive coping strategies, such as physical activities like workouts, jogging, and basketball, can promote positive health-conscious behaviors, while maladaptive strategies like smoking, drinking, and overeating can increase the risk of diseases and mortality (Caldwell et al., 2013; Fuller-Thomas et al., 2013). The study also found that stress related to trauma can affect the interaction between internal and external behaviors, and BAAM use a combination of adaptive and maladaptive strategies to cope with such stress.

Previous research has suggested that different ideologies about the significance and meaning of race can mediate the psychological response to perceived racial discrimination among African Americans (Sellers & Shelton, 2003). Identifying how race/ethnicity influences the causal pathways that link child maltreatment to adverse child behavior or juvenile delinquency can help to identify characteristics of youth that are most at risk (Hatcher et al., 2009). African American youth’s internalizing symptoms and externalizing behaviors were consistent and significantly higher than their Caucasian counterparts, which can help service providers to develop culturally specific theoretical explanations that can be used to design or

modify assessment and intervention strategies. Additionally, exposure to racism and discrimination can be contributory factors to diseases among African Americans (Myers, 2009). Furthermore, racism and discrimination were identified as significant common risk factors that negatively affected the physical health and well-being of many African American men (Wade & Tochlen, 2013).

Maternal nutrition, physiology, and psychological state can lead to divergent developmental pathways of offspring, altering epigenetic processes such as DNA methylation (Champagne, 2010). The study broadened research perspectives about the inheritance of risk and resilience in response to social interactions. Moreover, barriers to mental health service use, such as stigma and poor access to care, were found to be quite prevalent within the African American community (Ward et al., 2013). The study emphasized the need for addressing these barriers to improve mental health outcomes among African Americans.

The present investigation conducted unearthed noteworthy insights regarding the mental health and well-being of BAAM. The findings reveal that BAAM have been impacted by traumatic experiences, which can led to compromised subjective health and well-being. While the participants recognize the significance of self-care and emotional well-being for enhancing their mental health, their communities prioritize survival over mental health. Nevertheless, the study highlights the difficulty of articulating the exact nature of the mental health challenges faced by BAAM, and the communication barriers that exist concerning mental health. According to available empirical evidence, individuals who possess limited health literacy skills are at a greater risk of non-adherence to their healthcare protocols owing to multiple factors including demographic characteristics, awareness, knowledge, attitudes, beliefs, medication side effects, and depression (Ivanov and Ingram, 2013).

The lack of culturally congruent resources to address mental health issues is a pressing concern for BAAM, as identified by the study's participants. Interventions should consider their cultural, social, and historical context (Wells et al., 2001; Maulik et al., 2011; Snowden, 2012). Watkins et al. (2010) meta-study on the mental health and well-being of Black males revealed that they have a lower life expectancy. Moreover, lower treatment rates for African American populations have contributed to the high rate of mental-illness-related disability in this population (Snowden, 2012).

The present study has identified victimization desensitization as a salient challenge for Black African American males. This phenomenon assumes greater significance in low-income and high-risk neighborhoods, where the incidence of both direct and indirect traumatic events is pronounced. The participants have attested to the observation or personal experience of acts of violence, mistreatment, and police misconduct resulting in the death of unarmed individuals from the Black community. This finding corroborates the existing literature on the excessive vulnerability of the BAAM demographic to trauma (Coates, 2015; Hawkins, 2022; Smith-Lee, & Robinson, 2019).

Repeated exposure to trauma can have detrimental effects on BAAM, including emotional numbing, decreased sensitivity, and a lack of empathy towards their own or others' suffering. These effects can further lead to negative coping mechanisms such as substance abuse, aggression, and violence. The desensitization resulting from repeated exposure to trauma makes it difficult for BAAM to form trusting relationships, compounding the detrimental effects of trauma on their mental health and overall well-being (Hawkins, 2022). Therefore, it is essential to identify and address the trauma experienced by BAAM, particularly those living in low-income and at-risk communities, to prevent long-term negative consequences.

In the current study, Black African American Men (BAAM) detailed their experiences with depression and anxiety, often linking these conditions to traumatic events in their homes, communities, and society. As previously noted in the literature, the effects of trauma may not be immediately discernible and can have long-lasting impacts on mental health.

Prior research on PTSD and anxiety in Black/African American communities identified various risk factors, such as exposure to violence, race-related stress, lack of support, and decreased use of mental health services. Family dysfunction, childhood abuse, and previous trauma are also associated with a higher likelihood of PTSD. Additional literature about PTSD and anxiety among African Americans in urban at-risk communities found various risk factors were associated with these conditions. For example, Alim et al. (2006) identified exposure to violence, race-related stress, lack of support, and decreased use of mental health services as risk factors for PTSD. Cougle et al. (2009) suggested that childhood abuse and previous trauma increase the risk of PTSD, while psychological resilience can buffer the effects of traumatic events. Smith and Patton (2016) found that young Black men exposed to community violence exhibited symptoms of PTSD and suggested that avoidant symptoms and hypervigilance may be adaptive coping strategies.

This research adds to the body of literature on help-seeking by emphasizing the importance of cultural congruence and individual factors in shaping BAAM decisions about seeking mental health services. The data showed that participants found it challenging to open up to professionals who did not share their cultural background. This finding is consistent with the extant literature from Ward (2005) on the importance of client-therapist match in shaping the counseling experience for BAAM clients. The present study also revealed that participants were hindered by a persistent lack of awareness of available trauma-related resource, similar to the

research by Davis et al. (2008) about the treatment barriers faced by low-income Black/African Americans with undiagnosed PTSD.

The present study further identified several avoidance factors that hindered help-seeking behaviors, such as social stigma, fear of clinical treatment, and self-esteem. This finding is consistent with the research by Vogel et al. (2007) on the avoidance factors that inhibit individuals from seeking professional help, particularly among minority populations. The present study also highlighted the positive impact of resilience, help-seeking, and treatment, with one participant expressing their satisfaction with their counseling experience. This study's findings were consistent with the existing literature on the importance of cultural congruence, individual factors, and avoidance factors in shaping individuals' decisions to seek mental health services.

The results of this generic qualitative inquiry indicate that the effects of historical trauma can endure over time, resulting in persistent repercussions on both mental and physical health outcomes. The group referred to as BAAM, being subject to historical trauma, have a heightened susceptibility to depression, anxiety, post-traumatic stress disorder, and other related mental health disorders, as suggested by Crawford (2019). Moreover, the intergenerational transmission of trauma encoded in DNA can also lead to an increased risk of adverse health outcomes, such as heart disease, cancer, and other chronic illnesses (Conching & Thayer, 2019; Petruccelli, Davis & Berman, 2019).

BAAM's experiences of racial stressors, including macroaggressions, microaggressions, and discrimination, also contribute to negative health outcomes. Exposure to racism and discrimination has been linked to adverse health outcomes, such as hypertension, cardiovascular disease, and premature death (Williams & Mohammed, 2013). Additional fears of experiencing

police brutality, which has claimed the lives of a disproportionate number of unarmed Black men, can also lead to significant psychological distress (Bor et al., 2018).

Historical trauma is a complex and collective trauma experienced by Black/African American populations due to their exposure to the long-term mass trauma of colonialism, slavery, wars, and genocide. BAAM's experiences of racial stressors across their lifespan can lead to negative health outcomes, including adverse childhood experiences, depression, desensitization, and death, several generations after the original trauma occurred. Therefore, addressing the impact of historical trauma is crucial for reducing health disparities and promoting health equity among Black/African American communities.

Conclusions

In summary, this research provides a comprehensive analysis of the challenges that Black African American Men face after experiencing trauma. The study utilizes a theoretical thematic analysis and identifies seven emergent themes that highlight the psychological and emotional struggles experienced by this population. It also emphasizes the impact of societal and cultural factors on their ability to cope with trauma. Adverse Childhood Experiences appear to be a significant contributor to the vulnerability of Black/African American Men to early-life trauma, which can have negative repercussions throughout their lifetime. The study highlights the need for culturally congruent resources to address mental health issues, particularly in low-income and at-risk neighborhoods where the incidence of traumatic events is high. It also underscores the importance of recognizing and addressing victimization desensitization experienced by this population, especially in the context of repeated exposure to trauma. Overall, the study highlights the importance of developing tailored interventions to promote positive health behaviors and improve mental health outcomes among Black/African American Men.

Comparison of Findings With Theoretical Framework and Previous Literature

The deleterious effects of historical trauma are evidenced in the health outcomes of ethnic and racial minority populations, particularly Black/African American Men, who exhibit heightened mortality rates and diminished life expectancy. There is a substantial body of research indicating that BAAM have a decreased life expectancy and increased mortality rates when compared to other ethnic, racial, and gender cohorts (CDC, 2016; Bond & Herman, 2016; Motley & Banks, 2018; Treadwell et al., 2012; U.S. Census Bureau, 2018; Watkins et al., 2010).

This study presents a modified conceptual framework of Historical Trauma Theory (HTT) that shares similarities and differences with Sotero's (2006) original work. Both models acknowledge the shared experiences of traumatic events that affect subsequent generations and contribute to negative health outcomes. However, the current study's framework is specific to the experiences of Black/African American males (BAAM), while Sotero's framework has a more comprehensive scope. The preliminary conceptual model of HTT comprises eight subcategories generated from the researchers' pre-existing knowledge about the subject.

Both frameworks highlight the significance of identifying the causes of trauma-related symptoms and designing effective interventions. The current study's theoretical thematic analysis reveals seven emergent themes that provide a nuanced comprehension of the challenges faced by BAAM who have experienced traumatic events. The themes emphasize the psychological and emotional struggles experienced by this population, as well as the influence of societal and cultural factors on their ability to cope with trauma.

One of the significant differences between the two frameworks is the focus on Black/African American males in the current study's modified HTT model. This particular emphasis provides a more detailed understanding of the challenges faced by this population in

coping with traumatic events. Furthermore, the adapted model demonstrates the impact of historical trauma on future generations through physiological, environmental, and social pathways, which contributes to an intergenerational cycle of trauma responses.

Overall, both frameworks are valuable in understanding the impact of historical trauma on the health and well-being of individuals from historically disadvantaged communities. The current study's modified HTT model provides a more comprehensive and specific perspective on the experiences of Black/African American males and offers guidance for reducing health disparities in this population. By utilizing these frameworks, further research can be conducted to investigate the intergenerational transmission of trauma-related symptoms and experiences and increase social awareness of different forms of trauma-related challenges.

Interpretation of the Findings

The current study employed a generic qualitative inquiry to explore the trauma-related challenges faced by Black African American Men (BAAM) with a history of Adverse Childhood Experiences (ACEs). The investigation encompassed multiple dimensions, including mental health and wellbeing, coping strategies for behavioral stress, experiences of victimization and desensitization, post-traumatic stress, anxiety, depression, help-seeking behaviors, treatment encounters, and the influence of historical trauma. Thematic analysis of the data revealed a significant and profound impact of ACEs on the mental health and overall wellbeing of BAAM, with participants articulating a diverse range of psychosocial challenges stemming from their traumatic experiences.

The study findings identified several barriers that hindered help-seeking behaviors among BAAM, including feelings of shame, mental health stigma, and adherence to cultural norms and values. Moreover, the research shed light on the intergenerational transmission of trauma,

highlighting the enduring impact of historical trauma on the mental health and coping mechanisms of BAAM. The outcomes of the research offer insights into the intricate interplay of cultural values and experiences within the BAAM community, emphasizing the pressing need for enhanced advocacy, treatment, and support services. Additionally, the results underscore the importance of recognizing and addressing the lasting consequences of historical trauma on the mental health and overall well-being of BAAM individuals. Given these compelling findings, mental health professionals and service providers are urged to embody civic tenderness, displaying genuine concern and empathy towards vulnerable individuals and marginalized groups in our society (Clardy, 2017).

Limitations

While the present study sheds light on the challenges faced by BAAM who have experienced trauma, there are several limitations that must be taken into account when interpreting the results. First, the sample size of only five participants is not sufficient to generalize the findings to the broader BAAM population. Additionally, all five participants had experienced four or more Adverse Childhood Experiences (ACEs), which is valid, but not generalizable to the wider population. The study's convenience sampling approach may have also introduced selection bias. Furthermore, the use of a single data collection method (semi-structured interviews) may not have captured the full complexity of the participants' experiences. Finally, the reliance on self-reported data may be subject to social desirability and recall biases.

Despite these limitations, the study's findings are valuable and provide insights into the challenges faced by BAAM who have undergone trauma. The use of Historical Trauma Theory as a framework adds to the current understanding of trauma and lays the foundation for future research. The results can also guide the development of culturally appropriate resources and

support to address mental health challenges among BAAM. The study's emphasis on the intergenerational transmission of historical trauma emphasizes the need to address the root causes of trauma and promote community healing. Further research with larger and more diverse samples is necessary to confirm and expand upon these findings.

Implications for Practice

The necessity for increasing the representation of Black African American Men (BAAM) within mental health professions has become an integral consideration as the field advances. This imperative is born out of multifaceted factors, including a conspicuous lack of BAAM representation in vital mental health roles, such as psychiatrists, psychologists, and counselors. The absence has led to an underutilization of the unique cultural insights and understanding inherent to the BAAM. To counter this, there must be dedicated programs and funding focused on promoting the education, hiring, and retention of professionals who are attuned to the cultural intricacies of this community.

Targeted initiatives can deepen the understanding of the specific needs and challenges the BAAM community faces, thereby fostering more culturally appropriate care. Targeted Recruitment Strategies may include but not be limited to:

1. Develop targeted recruitment efforts aimed at attracting BAAM to the mental health and helping professions. These efforts must include partnerships with BAAM-focused organizations, outreach programs in BAAM communities, and targeted advertising in platforms frequented by BAAM individuals.
2. Implement culturally sensitive messaging and communication during recruitment must resonate with potential BAAM candidates and highlight the value of their unique perspectives and experiences in the field.

3. Collaboration between academic institutions and professional organizations must create pipelines and pathways that encourage BAAM students and professionals to pursue careers in mental health and helping professions.

This leads to an overarching need within the counseling profession to nurture a workforce that reflects racial and ethnic diversity, with a particular emphasis on the perspectives and experiences of BAAM. The inclusion of culturally competent professionals who have a profound sensitivity to cultural experiences enables a more nuanced and empathetic approach to mental health care. Such an approach is essential to bridge existing communication and trust gaps within conventional therapeutic settings, forging deeper connections with the BAAM community. Cultivation of an inclusive workplace should include:

1. Create and enforce policies that promote diversity, equity, and inclusion within mental health and helping organizations. This may include establishing diversity committees, conducting cultural competency training for staff, and regularly evaluating and improving the inclusivity of organizational practices.
2. Foster a supportive work environment that is welcoming for BAAM professionals by providing mentorship programs, networking opportunities, and spaces for open dialogue and expression of their experiences and concerns.
3. Recognize and celebrate contributions from BAAM professionals within the workplace, acknowledging their unique perspectives and expertise in addressing mental health challenges within their communities.

Enhancing inclusivity within mental health professions demands a multifaceted strategy. This includes the creation of career pathways spanning educational stages from high schools to

community colleges, four-year institutions, and the workforce system. These pathways are geared towards inspiring BAAM to enter mental health and medical professions, thereby broadening representation and augmenting cultural responsiveness within these essential fields. Such entities must be intentional about infusing diversity, equity, and inclusion (DEI) delivered through programming, professional development, and ongoing training both in person and digital platforms. The information contained hereafter outlines tailored career pathways for recruitment and advancement for BAAM entering into mental health profession:

Early Education and High School Preparation:

1. Culturally Relevant Curriculum: Integrate culturally sensitive and inclusive content into the early education curriculum, ensuring that BAAM students see themselves reflected in the materials and feel motivated to pursue helping professions.
2. Mentoring and Role Models: Establish mentoring programs that connect BAAM students with successful professionals in helping professions, providing guidance, encouragement, and exposure to potential career paths.
3. Scholarships and Financial Support: Offer targeted scholarships and financial aid programs to BAAM students interested in pursuing degrees in mental health, counseling, psychology, or related fields.

Undergraduate and Graduate Education:

1. Culturally Attuned Programs: Develop undergraduate and graduate programs that incorporate culturally relevant coursework and clinical experiences, fostering a deeper understanding of BAAM experiences and needs in the helping professions.

2. Internship and Clinical Placements: Create partnerships with community organizations serving BAAM populations, practicum, externships and internship, and clinical placements that expose students to diverse clientele and diverse approaches to care.
3. Mentorship and Professional Development: Provide ongoing mentorship and professional development opportunities for BAAM students, helping them navigate the challenges of their educational journey and prepare for successful careers.

Workforce Integration and Retention:

1. Supportive Work Environment: Foster a supportive and inclusive work environment within mental health organizations, where BAAM professionals feel valued, respected, and empowered to contribute their unique perspectives.
2. Career Advancement Opportunities: Create clear pathways for career advancement, including leadership positions, to encourage BAAM professionals to remain in helping professions and continue making a positive impact.
3. Continued Education and Training: Offer ongoing education and training opportunities that focus on cultural competence and staying attuned to the needs of the BAAM community, ensuring that professionals remain effective and relevant in their practice.

Retention and Career Advancement:

1. Develop retention strategies that address the specific needs and challenges faced by BAAM professionals, such as offering professional development opportunities, work-life balance initiatives, and competitive compensation packages.

2. Provide ongoing training and support for BAAM professionals to enhance their skills and knowledge, ensuring continuous growth and career advancement within the mental health and helping professions.
3. Create career advancement pathways that promote and recognize the achievements of BAAM professionals, such as leadership positions, opportunities to lead culturally tailored programs, and involvement in decision-making processes.

This comprehensive outline emphasizes three crucial subcategories aimed at promoting the recruitment and retention of BAAM in the mental health and helping professions. By implementing targeted recruitment strategies, fostering an inclusive workplace, and providing opportunities for career advancement, these professions can enhance diversity, equity, and representation of BAAM professionals, leading to improved services and outcomes for BAAM communities. Additionally, prioritizing intentional DEI programming in counselor education programs ensures an enriched and culturally attuned mental health landscape, actively celebrating and integrating the unique cultural dynamics of the BAAM community, thus contributing to a more effective and empathetic mental health paradigm aligned with the community's distinctive needs, strengths, and values.

Recommendations for Future Research

This study's design emphasized the importance of culturally relevant research strategy. The generic qualitative inquiry shed light on the complex challenges faced by a group of BAAM from Arkansas, who had experienced trauma. The research approach was open-minded, flexible and well-suited for exploring culturally distinctive research questions. Generic qualitative inquiry can assist future investigations about culturally unique challenges among marginalized

populations including BAAM. Subsequent investigations must consider and prioritize the cultural components of their research. Investigators who choose to embrace this type of approach can contribute diverse, inclusive and equitable results among their respective body of knowledge, leading to more effective interventions and supports that are culturally grounded.

The generic qualitative inquiry adopted cohesive data collection and analysis techniques while encouraging researcher reflexivity. This approach also operationalized the benefits found within culturally congruent relationships between researchers and participants, as demonstrated in this study. A collection of cohesive factors enhanced the methodology's strength and enriched the depth of the study's findings.

To advance our understanding of the challenges faced by BAAM individuals dealing with trauma, future research could benefit from enhancing the diversity and depth of sampling and data collection. Adopting a mixed-methods research design that combines generic qualitative inquiry with cohesive quantitative methods can augment the robustness and applicability of research findings regarding trauma-related challenges within the BAAM community. Incorporating other culturally relevant tools, such as Bernard et al.'s (2020) Culturally-Informed Adverse Childhood Experiences (C-ACE) framework, may also strengthen insights about unique mental health challenges experienced within the BAAM community.

Generic qualitative inquiry is a valuable methodological approach for researchers who endeavor to explore the lives of BAAM and other marginalized, culturally unique populations. By employing this approach, future researchers can contribute to a more inclusive, culturally sensitive, and equitable body of knowledge, ultimately leading to more effective interventions and support for these communities. To reiterate, generic qualitative inquiry should be used with marginalized culturally unique populations for several compelling reasons:

1. Inclusivity and Cultural Sensitivity: Generic qualitative inquiry allows researchers to embrace an inclusive approach that values the unique perspectives and experiences of marginalized populations. By adopting this method, researchers can ensure that the voices of these populations are heard and that their cultural nuances are respected and understood.
2. Flexibility and Adaptability: Generic qualitative inquiry offers flexibility in data collection and analysis methods, making it well-suited for exploring complex and culturally diverse research questions. Researchers can adapt their approach to accommodate the specific needs and cultural contexts of the marginalized population under study.
3. In-depth Exploration of Lived Experiences: This qualitative approach enables researchers to delve deeply into the lived experiences of marginalized individuals, providing rich and nuanced insights that quantitative methods might not capture. By understanding the unique challenges and strengths of culturally unique populations, researchers can develop more informed and targeted interventions.
4. Addressing Gaps in Knowledge: Research on marginalized culturally unique populations is often limited. Generic qualitative inquiry can help fill these gaps by offering a more comprehensive understanding of their experiences, challenges, and needs. This, in turn, contributes to more inclusive and culturally relevant policies and services.
5. Empowerment and Advocacy: Engaging marginalized culturally unique populations in research through generic qualitative inquiry can empower them to share their stories and advocate for their rights and needs. The process of being

heard and understood can be validating and promote self-advocacy within these communities.

6. Social Justice and Equity: Research using generic qualitative inquiry with marginalized culturally unique populations aligns with principles of social justice and equity. By centering the experiences of marginalized individuals, researchers can work towards addressing disparities and promoting equality in health, education, and social services.

Finally, to further understanding about the challenges faced by BAAM with trauma, future research should consider enhancing the topics diversity, depth of sampling and data collection. This could be accomplished by adopting of a mixed-methods approach to that integrates generic qualitative inquiry with quantitative methods to enhance the robustness and applicability of research findings about the challenges befalling BAAM and their communities.

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Appendices

Appendix A: IRB Approval

UNIVERSITY OF ARKANSAS

To:	Randall L. Shakir
From:	Douglas J Adams, Chair IRB Expedited Review
Date:	06/08/2022
Action:	**Expedited Approval**
Action Date:	06/08/2022
Protocol #:	2112378579
Study Title:	A Generic Qualitative Inquiry of the Challenges for Black African American Males who have Experienced Trauma
Expiration Date:	03/01/2023
Last Approval Date:	

The above-referenced protocol has been approved following expedited review by the IRB Committee that oversees research with human subjects.

If the research involves collaboration with another institution then the research cannot commence until the Committee receives written notification of approval from the collaborating institution's IRB.

It is the Principal Investigator's responsibility to obtain review and continued approval before the expiration date.

Protocols are approved for a maximum period of one year. You may not continue any research activity beyond the expiration date without Committee approval. Please submit continuation requests early enough to allow sufficient time for review. Failure to receive approval for continuation before the expiration date will result in the automatic suspension of the approval of this protocol. Information collected following suspension is unapproved research and cannot be reported or published as research data. If you do not wish continued approval, please notify the Committee of the study closure.

Adverse Events: Any serious or unexpected adverse event must be reported to the IRB Committee within 48 hours. All other adverse events should be reported within 10 working days.

Amendments: If you wish to change any aspect of this study, such as the procedures, the consent forms, study personnel, or number of participants, please submit an amendment to the IRB. All changes must be approved by the IRB Committee before they can be initiated.

You must maintain a research file for at least 3 years after completion of the study. This file should include all correspondence with the IRB Committee, original signed consent forms, and study data.

cc: Brent T Williams, Key Personnel

Appendix B: Informed Consent for Screening

Appendix B. Phase I: Informed Consent for Screening
A Generic Qualitative Inquiry of the Challenges for Black African American Males who have Experienced Trauma

Researcher:
Randall L.M. Shakir, Doctoral Candidate
Brent T. Williams, Ph.D., CRC, Faculty Advisor
Department of Rehabilitation Education
University of Arkansas
Fayetteville, Arkansas 72701
479-575-8696

Compliance Contact:
Ro Windwalker, CIP
Research Integrity & Compliance
University of Arkansas
105 MLKG Building
Fayetteville, Arkansas 72701
479-575-2208

The Department of Rehabilitation, Human Resources, & Communication Disorders at the University of Arkansas support the practice of protection for human subjects participating in research. The information hereafter serves to help clarify your decision to participate in the research study. Your participation is voluntary, and you are free to withdraw from the study at any time. The full research study is split into two phases. Phase I will involve the Participant Screener and Adverse Childhood Experience (ACE) Questionnaire. Phase I will take approximately 25 minutes to complete. Please note that your participation in Phase I does not commit or guarantee further involvement in the full study or Phase II interview.

I humbly invite you to participate in Phase I of research that seeks to learn more about the challenges of Black African American men (BAAM) who have experienced trauma. Participating in this research may enhance your understanding of public health challenges related to trauma. Eligibility for inclusion in the full study has been predetermined using specific criteria developed by the researcher. If selected for the interview, you will receive additional communication via email and phone with details about consent and Phase II of the study.

To protect your privacy, create a pseudonym (fictitious name). The researcher will use your chosen pseudonym on all documents and reports. If you provide identifying information, your identity will not be disclosed within reports where the study may be published. All information collected during Phase I will be kept confidential to the extent allowed by law and University policy. Phase I participants who do not meet the criteria for Phase II of the study, or if having met the criteria and after being contacted for the interview, choose not to consent to participate; their screening data will be destroyed. After seven years, all participant data from this study will be destroyed.

Your participation is strictly voluntary. At the study's conclusion, a summary report will be available upon request by contacting Randall L.M. Shakir by phone at (417) 522-8203 or email Rlshakir@uark.edu.

Appendix B: Informed Consent for Screening (Cont.)

Participation in Phase I will involve:

1. Read the Participant Screening Instructions email.
2. Review and sign the Phase I: Informed Consent for Screening.
3. Complete the Participant Screener. (Approx. 10 minutes)
4. Complete the ACE Questionnaire. (Approx. 10 minutes)

If you have any questions or concerns about your rights as a research participant, contact the University of Arkansas Research Integrity & Compliance Department at 479-575-2208. The information provided hereafter is solely for your convenience. The University of Arkansas provides no endorsement or guarantee of the services provided by these facilities.

If you are currently safe and in need of mental health assistance:

Springwoods Behavioral Health:
Phone: 479-973-6000
Address: 1955 Truckers Dr.
Fayetteville, AR 72704

The National Suicide Prevention Lifeline:
Phone: 1-800-273-8255

If you need immediate medical assistance or feel unsafe:

Local Emergency Services:
Phone: 911

Research Participant:

First Name: _____ Last Name: _____

Signature: _____ Date: _____

Appendix C: Voluntary Participation Request

Greetings,
My name is Randall L.M. Shakir, M.S., CRC. Thank you for expressing interest in my dissertation research about the challenges for Black African American males (BAAM) who have experienced trauma.

Please enter your email address below to receive the Participant Screening Instructions. This email will provide additional information about the research, informed consent, confidentiality, and links to access the participant screening material.

If you have questions or concerns about the participation instructions, don't hesitate to contact Randall L.M. Shakir, M.S., CRC via email: rlshakir@uark.edu or 417-522-8203. If you have any questions or concerns about your rights as a research participant, you can contact the University of Arkansas Research Integrity & Compliance Department at 479-575-220.

UNIVERSITY OF ARKANSAS

1. **Email:**
   (please enter your email address below)

2. **Subject:**

   ☐ Request: Participant Screening Instructions

3. **We treasure human interaction** (Google reCAPTCHA)

   ☐ I am not a robot

Appendix D: Participant Screener

PARTICIPANT SCREENER

I appreciate your interest in the Challenges for Black African American Males who have Experienced Trauma. This participant screener will take about 10 minutes to complete. Please begin by selecting a pseudonym (fictitious name) to protect your privacy. The researcher Randall L.M. Shakir, *M.S., CRC* will use this pseudonym on all of your documents and reports.

For questions about the screener, contact Randall L.M. Shakir at ###-###-#### or email: rlshakir@uark.edu. If you have questions or concerns about your rights as a research participant, contact the University of Arkansas Research Integrity & Compliance Department at 479-575-2208

Please answer each of the questions below:

4. **Informed Consent**

I have reviewed and signed the informed consent letter. ☐ **YES** ☐ **NO**

5. **Demographic information**

Fictitious name: (First)_____ (Last)___ **Age**: _____
Phone: _____ **Email**: _____

Marital Status (check one): ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Employment Status (check one): ☐ Employed ☐ Unemployed

Where do you live in Arkansas: (City)___ (County)___ (Zip)

6. **Participation Checklist**

☐ I certify that I am 18 years of age or older.

☐ I identify as Black African American Male (BAAM).

☐ I have experienced a traumatic event(s) in my lifetime.

☐ I am not actively experiencing PTSD or depressive symptoms.

☐ I have access to my own self-identified support system(s) at this time.

☐ I am willing to complete an Adverse Childhood Experience's (ACE) questionnaire.

☐ I am willing to participate in a filmed interview about Black African American Male trauma.

Appendix E: Adverse Childhood Experience (ACE) Questionnaire

ADVERSE CHILDHOOD EXPERIENCE (ACE) QUESTIONNAIRE

Estimated Completion Time: **10 minutes**

If you have questions about the ACE Questionnaire, contact: Randall L.M. Shakir, M.S., CRC phone: ###-###-#### or email: rlshakir@uark.edu. If you have questions or concerns about your rights as a research participant, contact the University of Arkansas Research Integrity & Compliance Department at 479-575-2208.

I have **reviewed and signed** the Phase I: Informed Consent for Screening.

☐ Yes ☐ No

Please enter your Fictitious Name: (First)_____ (Last)_____

Please enter your Email Address: _____

Please select one answer for each of the remaining questions:

1. Before your 18th birthday, did a parent or other adult in the household often or very often…swear at you, insult you, put you down, or humiliate you? or act in a way that made you afraid that you might be physically hurt?

   ☐ Yes ☐ No

2. Before your 18th birthday, did a parent or other adult in the household often or very often…push, grab, slap, or throw something at you? or ever hit you so hard that you had marks or were injured?

   ☐ Yes ☐ No

3. Before your 18th birthday, did an adult or person at least five years older than you ever…touch or fondle you or have you touch their body in a sexual way? or attempt or actually have oral, anal, or vaginal intercourse with you?

   ☐ Yes ☐ No

4. Before your eighteenth birthday, did you often or very often feel that…no one in your family loved you or thought you were important or special? Or your family didn't look out for each other, feel close to each other, or support each other?

   ☐ Yes ☐ No

x

Appendix E: Adverse Childhood Experience (ACE) Questionnaire (Cont.)

5. Before your 18th birthday, did you often or very often feel that…you didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? or your parents were too drunk or high to take care of you or take you to the doctor if you needed it?

   ☐ Yes ☐ No

6. Before your 18th birthday, was a biological parent ever lost to you through divorce, abandonment, or other reason?

   ☐ Yes ☐ No

7. Before your 18th birthday, was your mother or stepmother: often or very often pushed, grabbed, slapped, or had something thrown at her? or sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? or ever repeatedly hit over at least a few minutes or threatened with a gun or knife?

   ☐ Yes ☐ No

8. Before your 18th birthday, did you live with anyone who was a problem drinker or alcoholic, or who used street drugs?

   ☐ Yes ☐ No

9. Before your 18th birthday, was a household member depressed or mentally ill, or did a household member attempt suicide?

   ☐ Yes ☐ No

10. Before your 18th birthday, did a household member go to prison?

Appendix F: Guiding Interview Questions

Guiding Interview Questions

1. In your own words, please describe what the term trauma means to you?
2. From your perspective what are some of the challenges associated with ACES.
3. Help me understand what the quote "Black people are essentially born traumatized and have been for centuries" (Crawford, 2019 p.1) means to you.
4. From your perspective how would you describe the challenges for Black men who experienced trauma?
5. Please help me understand what physical health and wellbeing means to you?
6. How does trauma impact physical health and wellbeing of Black men?
7. Please help me understand what mental health and psychological wellbeing means to you?
8. In your opinion, how does trauma impact mental health and psychological wellbeing of Black men?
9. Help me understand why it may be difficult for BAAM who have experienced trauma to seek professional mental health treatment?
10. Please describe how has trauma limits opportunity for BAAM, in past and present years?
11. In your opinion how does trauma impact the world of work for BAAM?
12. In your opinion how has trauma impacted the black community?
13. Please describe any support(s) or resources that you are aware of that are being offered to BAAM that help to address trauma related challenges.

Appendix G: Resource Packet

Links and PDF Files

1. Omega Psi Phi's "Brother You're On My Mind Factsheet"
    a. Depression and Stress in Younger African American Men [3 page PDF]
    b. Depression and Stress in Older African American Men [2 page PDF]
    c. Fact Sheet on Being Supportive to a *Brother with Depression [2 Page PDF]
2. Black Male Counselors and Clinicians Near You
    a. Washington County
    b. Benton County
3. 99 Coping Strategies [1 page PDF]
4. Springwoods Behavioral Health
    a. Inpatient Brochure [PDF]
    b. Outpatient Brochure [PDF]

IMMEDIATE HELP
If you are experiencing serious emotional distress and cannot wait for an appointment, reach out to these groups for immediate assistance:

- ❑ Emergency Medical Services: 911
    - If the situation is potentially life-threatening, get immediate emergency assistance by calling 911 at any time, day or night.
- ❑ National Suicide Prevention Lifeline: 1-800-273-TALK (1-800-273-8255) or live online chat at www.suicidepreventionlifeline.org.
    - If you or someone you know is suicidal or in emotional distress, contact the National Suicide Prevention Lifeline. Trained crisis workers are available 24 hours a day, 7 days a week. Your confidential and toll-free call goes to the nearest crisis center in the Lifeline national network. These centers provide crisis counseling and mental health referrals.
- ❑ Substance Abuse Mental Health Services Administration (SAMHSA) Treatment Referral Helpline: 1-877-SAMHSA7 (1-877-726-4727)
    - Get general information on mental health and find treatment services in your area. Live operators are available Monday through Friday, from 8 a.m. to 8 p.m. ET.
- ❑ National Alliance on Mental Illness (NAMI) Help Line: 1-800-950-NAMI (1-800-950-6264) or info@nami.org
    - Staff and volunteers can answer your questions about symptoms of mental illness and how to access local support groups and services for yourself or family members. Operators are available Monday through Friday, 10 a.m. to 6 p.m. ET.

Appendix H: Informational Flyer

BLACK AFRICAN AMERICAN MALE TRAUMA

Research conducted by : Randall L.M. Shakir, *M.S. CRC* UNIVERSITY OF ARKANSAS

WHEN
Summer – Fall 2022

WHERE
Online via ZOOM

PARTICIPANT CRITERIA:

- Must be over 18 years old
- Identify as Black African American Male
- Reside in Arkansas
- Not actively experiencing PTSD or Depression
- Experienced a traumatic event in their lifetime
- Give written consent to participate
- Agree to participate in a recorded 1-2 hour interview.

FOR ADDITIONAL DETAILS ABOUT THIS RESEARCH CONTACT:
Rlshakir@uark.edu

-OR-

SCAN ME