The Impact of Community Violence Exposure on The Health Behaviors and Health Service Utilization Among High-Risk Black Men

Paris Willis
paris.willis08@gmail.com

Follow this and additional works at: https://huskiecommons.lib.niu.edu/allgraduate-thesesdissertations

Part of the African American Studies Commons, and the Public Health Commons

Recommended Citation

This Dissertation/Thesis is brought to you for free and open access by the Graduate Research & Artistry at Huskie Commons. It has been accepted for inclusion in Graduate Research Theses & Dissertations by an authorized administrator of Huskie Commons. For more information, please contact jschumacher@niu.edu.
ABSTRACT

THE IMPACT OF COMMUNITY VIOLENCE EXPOSURE ON THE HEALTH BEHAVIORS AND HEALTH SERVICE UTILIZATION AMONG HIGH-RISK BLACK MEN

Paris Willis, PhD
College of Health and Human Sciences
Northern Illinois University, 2022
Melani Duffrin, Director

This qualitative study explored the lived experience of high-risk Black men exposed to community violence in hopes of understanding their health challenges and behaviors in highly violent communities. Eleven Black men considered high-risk participated in the study through individual semi-structured interviews addressing the research questions below:

1. How do high-risk Black men perceive community violence?
2. How do high-risk Black men maintain their health residing in high violent communities?
3. How do high-risk Black men in high violent communities utilize healthcare?
4. Do high-risk Black men exposed to community violence trust healthcare providers?

Community violence exposure is a complex multilayered topic with few studies qualitatively informing the understanding of how high-risk Black men’s health behaviors and health service utilization is impacted by exposure to violent crimes. This study serves as a starting point to begin to understand the challenges and health needs associated with this high-risk population.

Supplemental File: Integrative Review of Literature, pdf
THE IMPACT OF COMMUNITY VIOLENCE EXPOSURE ON THE HEALTH
BEHAVIORS AND HEALTH SERVICE UTILIZATION
AMONG HIGH-RISK BLACK MEN

BY

PARIS WILLIS
©2022 Paris Willis

A DISSERTATION SUBMITTED TO THE GRADUATE SCHOOL
IN PARTIAL FULFILLMENT OF THE REQUIREMENTS
FOR THE DEGREE
DOCTOR OF PHILOSOPHY

COLLEGE OF HEALTH AND HUMAN SCIENCES

Doctoral Director:
Dr. Melani Duffrin
ACKNOWLEDGEMENTS

To my dissertation committee: Thank you for believing in me and sticking with me throughout this journey. To my dissertation chair, Dr. Melani Duffrin, thank you for taking a chance on me and pushing me to unlock potential I did not realize I had. You have been one of the greatest mentors I have ever had, and I am grateful to have gone through this experience with such an amazing woman. To my dissertation committee members: Dr. Shondra Clay and Dr. Kathryn Mazurek, thank you for sharing your expertise, and knowledge and guiding me through my research. To my external committee member: Dr. Chris Duffrin, thank you for pushing me to critically think about qualitative research and giving your time to mentor me throughout this process. I am thankful for my committee’s commitment to this project and forever grateful for the knowledge gained.

Thank you to my husband, Rick for your support and for loving me through this mentally trying journey. Thank you for sticking by my side and keeping me grounded when I wanted to give up. To my baby’s, Zariah, Regan, and Ricky III everything I do is for you all, I love you. Zariah, thank you for being mommy’s cheerleader, strength, and understanding on the days when I had to juggle multiple responsibilities. Regan and Ricky III, to complete this journey with both of you growing inside me was demanding but both of your births pushed me to keep going even when things become tough. I love you all!
To the strongest woman, I have ever known, my mother Detrall. Thank you for showing me what a strong woman is and never allowing me to quit because of you I have always been motivated to succeed and make you proud. To my Granny, Brother, and Auntie thank you for always supporting me and babysitting my three angels. To my sisters from another mother, Kenyadda, thank you for always being there, volunteering your editing skills, providing words of encouragement, and consistently making sure I completed this journey, even during the hardest times.

Thank you to all the individuals that have contributed their talents, time, and resources to assist me through this journey, and thank you to all my family, friends, and colleagues for believing in me. “Anything is possible when you have the right people there to support you.”
DEDICATION

This dissertation is dedicated to my children, never allow anyone to stop you from achieving greatness. Remember, the only limitations we have are the ones we place on ourselves. You are black excellence, I love you.
# TABLE OF CONTENTS

| LIST OF TABLES | viii |
| LIST OF FIGURES | ix |
| LIST OF APPENDICES | x |
| DEFINITIONS AND ACRONYMS | xi |

## Chapter

1: INTRODUCTION ................................................................. 1

- Introduction ........................................................................ 1
- Statement of the Problem ..................................................... 5
- Integrative Review .............................................................. 6
- Solution ............................................................................ 7
- Theoretical Framework ......................................................... 8
- Rationale for Qualitative Methods ......................................... 17
- Purpose ............................................................................ 19
- Summary ......................................................................... 20

2: REVIEW OF LITERATURE ..................................................... 22

- The Design of Black Neighborhoods .................................. 24
- Black Males ..................................................................... 26
Barriers to Care .............................................................. 33
Healthcare Utilization ...................................................... 34
Medical Mistrust .............................................................. 36
Historical Context of CVE on African American Male Health Outcomes ........................................... 38
Summary ........................................................................... 42
3: METHODOLOGY .............................................................. 43
Research Design ................................................................. 44
Data Analysis .................................................................... 52
Summary ........................................................................... 55
4: RESULTS ........................................................................ 56
Introduction ........................................................................ 56
Participant Description ...................................................... 57
Story of Data and Results of the Analysis .......................................................... 59
Summary ........................................................................... 79
5: DISCUSSION, IMPLICATIONS, RECOMMENDATIONS FOR PRACTICE AND FUTURE RESEARCH .......................................................... 81
Summary ........................................................................... 81
Theoretical Implications ..................................................... 86
Interpretation of Results ...................................................... 87
Recommendations for Practice & Future Research .......................................................... 93
Limitations ........................................................................ 96
Conclusion .......................................................................... 97
## LIST OF TABLES

<table>
<thead>
<tr>
<th>Table</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1 Research Question and Measurement Questions Alignment Table</td>
<td>50</td>
</tr>
<tr>
<td>4.1 Study Demographics</td>
<td>58</td>
</tr>
</tbody>
</table>
# LIST OF FIGURES

<table>
<thead>
<tr>
<th>Figure</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1 Homicide Rates in Chicago</td>
<td>2</td>
</tr>
<tr>
<td>1.2 Public Health Critical Race Praxis (PHCRP) Model</td>
<td>12</td>
</tr>
<tr>
<td>1.3 Phenomenological Variant of Ecological Systems Theory (PVEST) Model</td>
<td>13</td>
</tr>
<tr>
<td>1.4 Study Logic Model</td>
<td>15</td>
</tr>
<tr>
<td>2.1 Chicago Poverty &amp; Violent Crime Map Comparison</td>
<td>39</td>
</tr>
<tr>
<td>2.2 Intersectional Disparities of a Black Man</td>
<td>41</td>
</tr>
</tbody>
</table>
# LIST OF APPENDICES

<table>
<thead>
<tr>
<th>Appendix</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. INTERVIEW GUIDE</td>
<td>117</td>
</tr>
<tr>
<td>B. DEMOGRAPHIC QUESTIONNAIRE</td>
<td>122</td>
</tr>
<tr>
<td>C. SEMI-STRUCTURED INTERVIEW</td>
<td>126</td>
</tr>
<tr>
<td>D. INFORMED CONSENT</td>
<td>128</td>
</tr>
<tr>
<td>E. BEHAVIORAL HEALTH RESOURCES</td>
<td>132</td>
</tr>
<tr>
<td>F. RECRUITMENT MESSAGING</td>
<td>136</td>
</tr>
</tbody>
</table>
DEFINITIONS AND ACRONYMS

Community Health Needs Assessment (CHNA): A community health needs assessment refers to a state, tribal, local, or territorial health assessment that identifies key health needs and issues through systematic, comprehensive data collection and analysis.

Community Violence Exposure (CVE): is defined as seeing someone shot with a gun, cut or stabbed with a knife, sexually victimized, mugged or robbed, threatened with a weapon or beaten up so severely that medical attention was required (Wright et al., 2016).

The Healthy Chicago Survey (HCS): Is an annual telephone survey that was launched in 2014 by the Chicago Department of Public Health (CDPH) to better understand the health of Chicagoans.

Health Outcomes: An outcome or result of a medical condition that directly affects the length or quality of a person's life.

Health Disparities: Are differences in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific population groups in the United States (NIH, 2002).

Integrative Review: A review method that summarizes past empirical or theoretical literature to provide a more comprehensive understanding of a particular phenomenon or healthcare problem.

Post-Traumatic Stress Disorder: Is a mental health condition that's triggered by a terrifying event — either experiencing it or witnessing it.

Socioeconomic Status (SES): Is the social standing or class of an individual or group. It is often measured as a combination of education, income and occupation.

Social Determinants of Health (SDoH): Are conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

Equity: An ethical value that may be operationally defined as striving to reduce systematic disparities in health between more and less advantaged social groups within and between countries.
Acronyms

AA: African American
CVE: Community Violence Exposure
SES: Socioeconomic Status
PVEST: Phenomenological Variant of Ecological Systems Theory
PHCRP: Public Health Critical Race Praxis
CHAPTER 1
INTRODUCTION

Community violence continues to be a major challenge facing the United States, including Chicago, Illinois. Chicago is one of the most racially and ethnically diverse cities in the country, made up of 77 diverse community areas that differ significantly in socioeconomics, race, and hardship (Hunt et al., 2019). Violence disproportionately ensues in the most disadvantaged neighborhoods (Fitzpatrick et al., 2019; Murphy et al., 2017). Chicago area census data was reviewed to identify that Blacks comprise more than 30% of the community areas in Chicago (U.S. Census Bureau, 2019). Although Chicago is a diverse city, it is segregated by communities of race and income (Scannell Bryan et al., 2021). Seen as the third-largest city in the United States, Chicago is one of the most violent cities with homicide rates exceeding those of similar-sized cities such as New York, Houston, Philadelphia, and Los Angeles; violence disproportionately impacts heavily African American populated disadvantaged communities like Englewood, Austin, East Garfield, and North Lawndale (see Figure 1.1) (University of Chicago Crime Lab, 2016; Yang, 2019). Chicago experienced 58% more homicides and 43% more non-fatal shootings between 2015 and 2016 increasing the prevalence of gun violence in Chicago’s violent crime history (University of Chicago Crime Lab, 2016). With extreme poverty, food insecurity (Illinois Commission on the Elimination of Poverty, 2018), a high rate of unemployment (U.S. Department of Labor & Bureau of Labor Statistics, 2020), failing public
schools (Dwyer, 2013), trauma center deserts (Patton et al., 2019), and at least 59 gangs with 625 factions and more than 100,000 gang members (Ramos, 2012; Isackson, 2012), violence in Chicago has become an epidemic and major public health conundrum.

Figure 1.1: Homicide Rates in Chicago.
Community Violence Exposure (CVE) has been shown to cause stressors correlated with poor physical health outcomes in youth including asthma, high blood pressure, post-traumatic stress disorder, and sleep deprivation (Wright et al., 2017; Overstreet & Braun, 2000). CVE is defined as seeing someone shot with a gun, cut or stabbed with a knife, sexually victimized, mugged or robbed, threatened with a weapon, or beaten up so severely that medical attention was required (Wright et al., 2016; Osofsky, 1995). CVE is a challenge in many high-poverty urban communities but particularly for Black men. In Chicago, most gun violence suspects and victims were Black men in their 20s and older (University of Chicago Crime labs, 2016). Many of the highly violent communities on the south and west side of Chicago are poverty-stricken neighborhoods with very few resources, joblessness, food insecurity, and a lack of housing (Illinois Commission on the Elimination of Poverty, 2018). Joblessness is the primary source of self-destructing behaviors in low-income communities including crime (Logan & Oakley, 2017). The perpetuating cycle of poverty in disadvantaged communities accompanies the cycle of violence to create detrimental outcomes in communities of color (Gilbert et al., 2016; Huang, King, McAtee, 2018).

CVE can have rippling effects on a victim’s family, friends, and surrounding community leading to compounding consequences (Tung et al., 2018). Studies have documented the negative long-term consequences of community violence without discovering a link between community violence and health (Barber et al., 2016; Janusek et al., 2017). Studies in Chicago have shown a correlation between violence exposure and low birth rates, substance abuse in gay men, post-traumatic stress, and low academic performance in adolescents (Hotton et al., 2019; Wright et al., 2013; Hong et al., 2019). Individuals that are exposed to violence earlier in life
pose an increased risk of lower educational and occupational attainment, post-traumatic stress disorder, and unhealthy behaviors like drug abuse, smoking, and alcoholism. (Reed et al., 2013). CVE (both witnessing and experiencing) has been linked to a variety of stress responses and reactions that may explain poor health outcomes of residents in disadvantaged communities (Huang, King, McAtee, 2018). Many Chicagoan adults with chronic conditions are at higher risk for violence, leading to inferior cognitive responses that affect daily activities, such as grocery shopping or visiting friends (Tung et al., 2018).

Between Blacks and Whites, racial disparities in health and mortality have persisted for years, yet these disparities are partly credited to neighborhood conditions (CDC, 2013; Ruel et al., 2010; Jee-Lyn García & Sharif, 2015; Logan & Oakley, 2017). Where a person resides is characterized by socioeconomic status (SES). Individuals of a high SES are not as concerned with neighborhood safety, in comparison to individuals of a lower socioeconomic status who are concerned with neighborhood safety and may not engage in healthy behaviors generating poorer health outcomes (Meyer, Castro-Schilo, & Aguilar-Gaxiola, 2014). Neighborhood-level factors, like the availability of healthy food, and individual-level factors, like lack of physical activity, contribute to health disparities and can be amplified by neighborhood conditions like CVE (Diez Roux & Mair, 2010). African Americans continue to experience health disparities in chronic conditions like diabetes and asthma (CDC, 2013). As violence continues to impact communities of color, there is a need to examine the health disparities associated with violence exposure in high-risk Black men to inform future interventions.
Statement of the Problem

CVE is more prevalent and spatially concentrated in disadvantaged Black neighborhoods, especially in Black men. Black men are nine times more likely than Black women to be hospitalized due to gun violence and to witness a homicide (Frazer et al., 2018). Being a witness or victim of a crime is more prominent among individuals who are gang-affiliated (Stuart et al., 2020). Incarceration is also common for poor minorities, particularly Black men without high school education and although mortality and morbidity are decreased for Black males in prison compared to the general population due to decreased risk for violence (Wildeman & Wang, 2017). Once returned to their communities, Black men once again face violence exposure. Violence exposure has been shown to produce poorer physical and mental health effects, particularly post-traumatic stress disorder (PTSD) (Raman et al., 2021; Tung et al., 2018). PTSD can trigger emotional and physiological distress potentially perpetuating future crime and violence (Raman et al., 2021). There is a need to explore the health of Black men who are considered at risk or high risk for violence exposure. This is defined as former or current gang members or returning citizens (individuals transitioning from incarceration back to the community) who have been victims or witnesses to community violence.

Black men’s health continues to stagger below any other group in the United States. For example, cancer incidence among African Americans differs as the median age of diagnosis for colon and rectum cancer is 66 years for Black men and 70 years for Black women (DeSantis et al., 2016). Biological, behavioral, and social issues have all been associated with increased morbidity and mortality in Black men. Nevertheless, one of the most prominent factors
contributing to high-risk Black men's unhealthy lifestyle is social and environmental conditions (Enyia et al., 2016). In the U.S., this is predominantly true as Black neighborhoods that are economically disadvantaged are often associated with greater poverty and higher crime rates.

**Integrative Review of Literature**

Prior to developing a study focusing on CVE on high-risk Black men, an integrative review was conducted and published to synthesize current empirical knowledge of CVE on the physical health outcomes of high-risk Black men (Appendix C). The Integrative review pulled 176 studies with Black men and health and used targeted keywords like CVE to analyze eight peer-reviewed studies published between 2009 and 2019 that analyzed the physical health of high-risk Black men exposed to community violence (Thomas et al., 2020). The integrative review confirmed the need to further explore CVE in high-risk Black men’s health outcomes as many health outcomes have not been explored to date and a majority of CVE studies are focused on youth mental and health outcomes (Thomas et al., 2020). The integrative review also put a spotlight on the need for more qualitative studies on CVE and high-risk Black men. Many of the studies reviewed were quantitative studies providing a limited lens on the problem of CVE. Studies have focused on stressors of African American men in the context of health practices, pregnancy, mainstream culture, technology, and so much more. As violence continues to increase in certain communities like Chicago, Illinois the need to explore health outcomes and stress-coping mechanisms of the men living in communities with rising crime rates is imperative.

Understanding that health and coping perceptions of high-risk African American men is important for developing interventions to improve their health outcomes (Goodwill et al.,
“Exposure to violence and traumatic event exposure presents many health challenges such as depression, anxiety, risky behaviors, and more” (Thomas et al., 2020). The studies reviewed in the integrative review covered primarily psychological trauma; CVE not only influences psychological functions but also physiological functions (Thomas et al., 2020). The integrative review demonstrated the need for more qualitative studies focused on physical health outcomes of high-risk Black men in order to fully understand the complexity of CVE. The integrative review supported this manuscript’s model and guided research questions to explore CVE on high-risk Black men’s health outcomes.

**Solution**

This manuscript will explore the lived experiences of high-risk Black men living in neighborhoods exposed to high levels of community violence, including how violence has influenced the way these men think about their health outcomes. Questions were constructed after a review of the current empirical literature on African Americans in violent communities, with the intent of gaining a deeper understanding of the lived experiences of these high-risk men. Semi-structured interviews were chosen to allow for the elaboration of participants’ CVE experiences and understandings instead of quantifying their experience based on conventional scales (Swierad et al., 2017). This study serves as a starting point to begin to understand the challenges and health needs associated with this high-risk population.

CVE is a complex multilayered topic that impacts the lives of many individuals especially those that reside in low-income communities. Few studies have qualitatively informed the understanding of how high-risk Black men respond to CVE. This study aims to provide a
broader understanding of CVE on high-risk Black men's health outcomes in order to support future interventions to address the health of high-risk Black men exposed to community violence. An in-depth exploration of CVE of high-risk Black men’s health has the potential to identify challenges and intervention intersection points that are required to advance public health efforts addressing CVE in high-risk populations.

**Theoretical Framework**

The Public Health Critical Race Praxis (PHCRP) was the theoretical framework used as the lens of this qualitative inquiry. The PHCRP is a conceptual framework that advances the understanding of racial constructs and phenomena, critical analyses of knowledge production processes, and builds on community-based participatory approaches linking research, practice, and communities (Thomas et al. 2011). A supporting theoretical lens was also used to understand the lived experience of High-risk Black Men through the phenomenological approach, known as the Phenomenological Variant of Ecological Systems Theory (PVEST) (Spencer, 1995). Spencer (1995) proposed a dynamic combination of a traditional ecological systems model (Bronfenbrenner, 1979) with developmental processes and associated risk contributors that predict positive or negative life outcomes, including health. Although commonly used to explore youth of color's development experiences, this model offers a comprehensive supporting framework for the life-course theory of human development applicable across groups (Swanson et al., 2002).

**Public Health Critical Race Praxis.** The PHCRP is based on the critical race theory (CRT) and offers a guide for employing the CRT in racial health disparities research. The CRT
originates from law studies in response to continued structural inequity after the civil rights movement of the 1960s. The CRT reduces racial health disparities through five principles, 1) racism is systemic and embedded in society, 2) dominant societal viewpoints make racism invisible and shift attention away from racism as the root cause of inequities, 3) strides inequitable conditions for people of color in the United States are only allowable when they are in the interest of White America 4) racism thrives because whiteness is profitable to Americans in sociocultural, legal, and economic ways, 5) individuals of color have unique perspectives on marginalization and systemic oppression (Volpe et al., 2019).

The CRT takes into consideration the influence of white supremacy on the American mindset (Moore et al., 2018). This mindset suggests that the United States system is operating the way it was initially designed, and experiences of marginalized groups have been sustained through structural racism. The CRT also captures how racism is structurally embedded in U.S. institutions, such as community healthcare, through a process of assigning value, privilege, and opportunity based on physical characteristics (Gilbert et al., 2016). The CRT offers public health a new paradigm for investigating the root causes of health disparities (Ford & Airhihenbuw, 2010a) like community violence exposure. The PHCRP, along with the CRT, provides a framework that can be used to improve research on community violence exposure and address health inequities in high-risk populations. Healthcare access is underutilized by African American men. In order to address and implement interventions to improve access, public health professionals must understand how historical and structural margins have influenced the health behaviors and outcomes of high-risk African American men. Also, understanding how high-risk
African American men adapt and view violence in their community can inform research hypotheses about their health behaviors and attitudes.

The PHCRP builds on the CRT with four primary focuses: contemporary patterns of racial relations, knowledge production, conceptualization and measurement, and community-based action. Focus 1: In order to study the effect of community violence on high-risk African American men's health outcomes and access to healthcare, there is a need to understand how racism interacts in today's healthcare society. Focus 2: Shifts the focus on knowledge production and reinforces beliefs or phenomena of community violence exposure through existing knowledge of the subject. This focus reviews how existing literature has been informed by historical bias, conventional tools used, and findings that promote racial equity. Focus 3: Focuses on race-related constructs and the content-specific measurement of health equity in high-risk African American men exposed to community violence. Focus 4: Uses knowledge obtained to disrupt health inequities; this disruption can take place through interventions, practices, and even policies.

The PHCRP is the most appropriate framework for studying exposure to community violence on health outcomes because it offers a semi-structured process that combines theory, knowledge, science, and action to address health inequities. At the center of the PHCRP is race consciousness, also synonymous with racism; you cannot investigate health inequity without understanding racialization. Community segregation is a form of structural racism. Underserved African American communities are not coincidently marked by violence; these communities are the result of inequities experienced by African Americans post the civil rights era. In order to
investigate community violence, one must understand why community violence is a problem for African American communities and the historical and social foundations that created this problem. This is demonstrated in Figure 1.2 utilizing the Andersen access to care model, which has previously been used in studies to explore the socioecological framework and Critical Race Theory concepts. Many researchers on this topic subjectively discuss race through individualism, color blindness, and meritocracy, yet racism is integral in society for minorities every day. Race consciousness pulls away from the stigma that community violence is an individual or "black" problem. The topic of community violence has traditionally viewed health outcomes as a result of the neighborhood environment that participants reside in. "Black on black" crime as it is publicized focuses on blaming men for their victimization instead of viewing them as the victim in need of support (O'Connor, Weinstein, Stylianou, 2017). The PHCRP goes beyond just understanding and proposing solutions to health disparities and instead looks to eliminate health disparities for marginalized groups (Thomas et al. 2011).
Figure 1.2: Public Health Critical Race Praxis (PHCRP) Model.

**Phenomenological Variant of Ecological Systems Theory.** PVEST is the best supporting theoretical model in this study for PHCRP because it explains how prosing, enabling, and needs factors interact. PVEST examines human development through the interaction of identity, culture, and experience and accounts for the differences in experience, perception, and stress response (Swanson et al., 2003). This model considers a person's social environment and how risk contributors such as gender, race, poverty, and maturation level are factors predisposed to adverse outcomes (Smith & Patton, 2016). A huge stressor that high-risk Black men may be exposed to includes experiences of neighborhood or community violence, known as stress engagement (Spencer, 1995).
In social science research, there has been a struggle to capture the experiences of minorities in urban environments in empirical models. The PVEST framework allows researchers to model and understand studies of high-risk Black men that reflect their phenomenological experiences of community violence exposure. PVEST offers a framework that examines normal human development, through the interaction of identity, culture, and experience (Swanson et al., 2003). The PVEST consists of five basic components, (a) risk contributors, (b) stress engagement, (c) reactive coping strategies, (d) emergent identities, and (e) coping outcomes. For this study, the construct of emergent identities is excluded, as it views how individuals view themselves in the context of development (Swanson et al., 2003). Figure 1.3 outlines the aspects of the PVEST that were most relevant to this dissertation and can be applied to the phenomenon of CVE and its effect on the health of high-risk Black men.

Figure 1.3 Phenomenological Variant of Ecological Systems Theory (PVEST) Model.
The combination of predisposing risk factors and stress engagement creates how men respond, defined as reactive coping strategies (Smith & Patton, 2016). These coping strategies can either be adaptive or maladaptive and resolve stress-producing situations like community violence. Coping strategies dealing with stress are influenced by gender-appropriate coping strategies that the surrounding environment provides. For example, high-risk Black men may partake in alcohol, tobacco, and substance abuse, or engage in criminal activity as a coping strategy for the neighborhood violence surrounding them (Jackson & Knight, 2006; Gilbert et al., 2016). Although the listed coping strategies have adverse physical health effects, they may be commonly used to deal with the neighborhood stressors that many high-risk Black men face, including community violence. This model may explain why African Americans have higher morbidity and mortality rates in many diseases compared to White Americans.

Consistent with Spencer's PVEST, this study's model takes into consideration coping strategies, whether adaptive or maladaptive and hypothesized differences in levels of stress (exposure to violence) in which Black men are exposed (neighborhood setting) to predict their health outcomes. Increased exposure is predicted to have a more adverse outcome on the health outcomes of high-risk Black men. PVEST has been used to develop and answer quantitative research questions and used in qualitative exploration. PVEST informed the development of the semi-structured interview questions that sought to understand the risk factors and stress influence that CVE has on the health of high-risk Black men. PVEST was chosen as a supporting framework to guide the research design and data analysis in this dissertation manuscript because it provides conceptual management for understanding how exposure to community violence

There is a clear need to investigate how CVE influences the health outcomes of high-risk Black men in high-crime communities. This logic model (see Figure 1.4) for this dissertation provides the justification and methodology for the overall goal of the three manuscripts.

Figure 1.4: Study Logic Model.
**Inputs.** The knowledge that is known about high-risk Black men includes that they experience health disparities due to their socioeconomic status and health behaviors (Moore et al., 2016; Wiltshire et al., 2011). High-risk African Americans exposed to community violence are at risk for a range of negative health outcomes and are less likely to utilize healthcare services (Bharmal et al., 2012; Reed et al., 2013; Ravenell, Johnson, & Whitaker, 2006).

**Assumptions.** This study was developed based on several assumptions that CVE primarily impacts high-poverty urban communities. These communities are predominately Black and show that community violence influences the mental health of those exposed. Black men exposed to CVE are considered to be at higher risk for CVE if they have ever been a member of a gang or a returning citizen. Black males in the United States ranked the lowest in morbidity and mortality rates compared to other groups (Gilbert et al., 2016).

**External Factors.** The positive influences driving this study include the significance of CVE in the public health field and the significance of violence on the lives of high-risk Black men in underserved communities. Negative influences that impact this study include that healthcare has overlooked CVE as a contributing factor to a person’s adverse health outcomes.

**Outputs.** Outlined in the chapter overview, manuscript activities include an integrative review that synthesizes research on the impact of CVE on the health of high-risk Black men. Additional activities included semi-structured interviews that explore the phenomenon of community violence.
Outcomes. This study’s manuscripts hope to achieve short, intermediate, and long-term results of the conducted research. Short-term results include increased knowledge about CVE on the health outcomes of high-risk Black men and their access to healthcare services. This study also hopes to increase knowledge around the importance of neighborhood safety and the influence it has on high-risk Black men’s health outcomes.

Intermediate-term results hope to inspire action-driven outcomes that support future studies hoping to untangle the complex association between violence and health in high-risk Black men. Other actionable results include the development of interventions to address health outcomes in high-risk Black men and increased utilization of healthcare services by high-risk Black men exposed to community violence. Long-term results hope to improve conditions for Black men through increased tools to address CVE in healthcare and increased resources in the community. Future results expect to see a decrease in the morbidity and mortality rates for high-risk Black men.

Rationale for Qualitative Methods

This study utilized a qualitative methodology to explore the health of high-risk Black men exposed to community violence because community violence exposure is a complex research topic that requires the use of interpretive frameworks. Quantitative research tests theories through the examination of relationships between variables, while qualitative research seeks to explore human problems through individual or group understanding (Creswell, 2014). Robust research involves philosophical assumptions shaped by the nature of the research, the researcher’s background, and past research experiences (Creswell, 2014). I am seeking to
understand how high-risk individuals’ health is impacted when growing up and residing in a community plagued by violence. This subject requires a social constructivism framework with human engagement to truly investigate as community violence exposure involves historical and social context understanding which can be achieved through a subject’s shared view.

The qualitative method of phenomenology was chosen for this study, as phenomenology is the science of pure phenomena (Eagleton, 1983; Groenewald, 2004). A phenomenological approach was chosen over other qualitative methods because it best describes the lived experiences of an individual, including their perceptions of their world. Perceptions provide us with evidence of the world, not as it is assumed to be, but as lived (Groenewald, 2004; Creswell, 2014). This is a critical point as it supports the need to utilize a qualitative methodology to develop a thorough description of “what” and “how” high-risk Black men experience CVE in their everyday lived health experiences. This study hopes to explore the phenomena of community violence exposure and its contribution to the health inequities impacting high-risk Black men. Creswell states that phenomenology seeks to understand what participants have in common as they experience the phenomenon, this study is using this same approach to understand health behaviors, healthcare utilization, and healthcare trust of high-risk Black men exposed to community violence and their perception.
Purpose

The purpose of this research is to understand the complexity of CVE on the health outcomes of high-risk Black men residing in Chicago communities. Based on previous literature on CVE, high-risk Black men exposed to community violence are predisposed to deficient health outcomes. This indicates a strong relationship between CVE and high-risk Black men’s health outcomes.

Studies of violence exposure must attempt to understand the role of being a Black man as a risk factor for CVE. There is also a need to understand the risk factors associated with health outcomes for this group, including gang affiliation, incarceration, quality of care, quality of life, and healthy behaviors. Understanding the macro-level forces driving and sustaining inequities in low-socioeconomic communities will help address health inequities in high-risk Black men.

It is essential to understand if Black men considered high-risk have a higher probability of poor health outcomes as a result of community violence exposure or participation. This study will serve to increase knowledge and evidenced-based research surrounding the impact of CVE on high-risk Black men’s physical health outcomes. The study was designed to shed light on high-risk Black men’s health outcomes when exposed to community violence through the following research questions:

RQ1: How do high-risk Black men perceive community violence?

RQ2: How do high-risk Black men maintain their health residing in high violent communities?
RQ3: How do high-risk Black men in high violent communities utilize healthcare?

RQ4: Do high-risk Black men exposed to community violence trust healthcare providers?

Building on the limited existing research, I aim to gather a better understanding of how community violence impacts health and health disparities, particularly in high-risk Black male populations. The following research questions will inform future studies on the importance of high-risk Black men’s health needs in relation to their perception and exposure to community violence. Additionally, I believe understanding these factors will assist in gaining a better understanding of how important it is to bring awareness to the impacts of violence on health and seek ways to inform culturally sensitive community-based participatory programming and research. This study will lay the foundational work for future evidence-based and translational research in the high violent crime areas of Chicago.

Summary

Chapter 1 introduces the problem of high rates of violent crime in Black Chicago neighborhoods, with Black men significantly being the perpetrators and victims of this crime and having the poorest health outcomes and lowest life expectancy. Chapter 1 also reviews the Integrative Review of Literature conducted prior to this study (Thomas et al., 2021) to show that there is a gap in research in correlation to Black men and health outcomes apart from mental health. Chapter 1 proposes two theoretical frameworks to guide the research and provides a research logic model to explore the impact of CVE on health behaviors and health outcomes using qualitative methods to understand the lived experience of high-risk Black men.
The remaining chapters will detail more specific information about the research. Chapter 2 will present the literature of review and review research findings and explore how systematic racism influenced the structure of Chicago communities and outcomes of high-risk Black men. Chapter 3 will review the research methodology used to explore the lived experiences of high-risk Black men. Chapter 4 will present research findings, and Chapter 5 will summarize theoretical and practical implications with recommendations for practice, policy, and future research.
Chapter 2: REVIEW OF LITERATURE

Community violence has been associated with being a normal part of growing up for high-risk Black male populations, although violence exposure (whether direct or indirect) has rarely been shown to affect health outcomes in Black men (Bharmal et al., 2012; Reed et al., 2013). Violence exposure is correlated with numerous adverse mental and physical health outcomes, including depression, substance abuse, illness, and disease (Pahl, Brook & Lee, 2013; Cho & Kogan, 2016; Bowleg et al., 2014). CVE and its impact on health outcomes are based on the historical racialized experiences of Black men in the United States. Exposure to community violence leads to emotional distress and high levels of uncontrollable stress that impact the physical health of high-risk Black men. Men who witness violence are at greater odds for a range of negative health outcomes, like developing hypertension at higher rates compared to their unexposed female peers (Ford & Browning, 2014).

Although Chicago has seen a decline in crime since the early 2000s, there have been major rises in violent activities in 2016 and 2020 mainly involving homicide, armed robbery, gang violence, and aggravated battery (Chicago Police Department, 1996; 2017; 2020). Studies have shown that the highest CVE occurs in Black communities (54.4%) (Chen et al., 2016). In a 30-city homicide mortality study, Chicago and Baltimore showed higher than average mortality
disparities for Black communities (Schober et al., 2021). Even though Chicago has seen a large outmigration of Black populations leaving the city, particularly on the south and west side of the city (UIC Today, 2022), Black Chicagoans made up 80.38% of homicide victims in 2020 but only 29.2% of the population and Black men were 71.16% of those homicide victims (Chicago Police Department, 2020). The same trends are reflected as Black men were the most victimized in crimes involving robbery (31.74%) and aggravated assault and battery (32.83%) (Chicago Police Department, 2020). Violence rates in Chicago saw an alarming increase in 2020 aligning with the death of George Floyd in police custody that year, with the deadliest day since 1991, of 18 murders on May 31, 2020 (BBC, 2020).

Individuals who reside in these communities experience stress due to the fear caused by living in a community that exposes them to violence (Al'Uqdah et al., 2015). Adults in the United States are exposed to crime and violence at alarming rates and are victims of crime, however, Black adults are at a greater risk for violence victimization due to their disproportionate overrepresentation in neighborhoods marked by high rates of CVE (Centers for Disease Control and Prevention, 2009; Truman & Langton, 2014). Although violence impacts various geographic areas, CVE is highest in impoverished urban communities (Richters & Martinez, 1993).

CVE varies depending on the Chicago neighborhood; African American neighborhoods with a lack of resources and increased levels of gang activity such as Englewood, West Garfield Park, and Austin have homicide rates ten times greater than other Chicago communities (Chicago Police Department, 2014). Chicago is a city populated with 2.7 million people (U.S.
Census Bureau, 2021) with an estimated active gang member population of 100,000 (AbcNews, 2015), gangs were responsible for 61% of homicides in 2011 (Chicago Police Department, 2011). Although Chicago is smaller than New York City, it has consistently seen more murders than other major cities and in 2016 had more murders than New York City and Los Angeles combined (Gorner et al., 2016). Although Illinois has very strict gun laws, firearm homicides make up 89.90% of homicides in Chicago, an increase of over 35% from 2019 (Chicago Police Department, 2020). High-risk Black men residing in highly violent neighborhoods are exposed to elevated numbers of crimes, including gun violence. There is a disproportionate exposure of violence upon Black communities and specifically high-risk Black men as homicide is the leading cause of death of Black males aged 25 to 34 (CDC, 2011).

**The Design of Black Neighborhoods**

In order to properly correlate health disparities and high-risk Black men, a historical review of America and the systems and policies that support inequality and the formation of disadvantaged racially isolated communities. Inequality between races is due to racism, defined as an ideology that categorizes and ranks human groups, with some being inferior to others (Williams, 1998); from the 1700s and still today the most inferior group is African Americans (Williams, 1998). America’s inferiority beliefs regarding African Americans have been translated into policies that aid the social exclusion and reduced economic mobility for Black Americans (Gamble & Stone, 2006; Williams, 1998). This inferiority belief of Blacks is rooted in American history going back to the colonial period and slavery (Banaji et a, 2021). Between 1876 and 1900, 90% of African Americans lived in the South, 83% lived in poor rural areas and
were not perceived to be a threat to White supremacy until The Great Black Migration (1900 - 1970) when millions of African Americans left the South in search of better lives in industrialized cities throughout the nation (Banaji et al., 2021). During this period of time, African Americans moved into urban cities forming communities labeled as “Ghettos” creating the racial stratification known as segregation (Banaji et al., 2021; Massey, 2015).

As African Americans settled into northern industrial cities, demand for politicians to do something about the Black invasion commenced. Small cities responded by enacting “sundown laws” that required all Blacks to leave town by sunset and larger cities put ordinances in place to confine Black residents to already disadvantaged neighborhoods to exclude them from all others (Banaji et al., 2021). The goal of separating Black Americans was to spatially isolate and marginalize them socially, economically, and politically (Massey, 2015). Even after the United States ended legal segregation in cities and African Americans settled into industrial cities or established Black neighborhoods, they were met with violent resistance known as the anti-Black race riots like the Great Chicago Race Riot of 1919 and the Tulsa Massacre of 1921 (Banaji et al., 2021). After these race riots took place and hundreds were killed and thousands were left homeless, the real estate industry moved to institutionalize racial discrimination in housing markets to control racial change in cities (Banaji et al., 2021; Massey, 2015).

Today’s disparities experienced in Black communities are attributed to neighborhood-based racial discrimination like redlining which denies credit to white residential areas (Steil et al., 2018). Race, residential location, race-specific income, and homicide rates are all correlated
with a lower life expectancy for African Americans (Land & Bird, 2015). Other racial
discrimination practices include higher costs related to closing, higher interest rates, and long-
term mortgages (Steil et al., 2018). Restricted to communities based on race and income, African
Americans also face environmental conditions that contribute to health disparities including
exposure to unhealthy advertisements, fewer pharmacies, and food deserts that have been
correlated with neighborhood violence (Walker et al., 2010; Hunt et al., 2015).

**Black Males**

Decades after the ratification of the 13th amendment, the health of Black men continues
to stagger below any other group in the United States, including Black women. Although African
Americans experience disparities due to their health behaviors like physical inactivity, unhealthy
eating, smoking, and alcohol consumption; they also experience health disparities due to
socioeconomic factors such as unequal access to care, medical mistrust, health beliefs, health
insurance, health literacy and residential segregation (Moore et al., 2016; Moore et al., 2013).
High-risk Black men have the poorest health outcomes and the largest barriers to health care
(Powell et al., 2019; Williams, 1998). The World Health Organization defines health outcomes
as changes in health status that result from the provision of health. Black men are the most
neglected population in the United States (Gamble, 1997; Alsan, & Wanamake, 2018). Black
men account for 6% of the population in the U.S. however, the average life expectancy rate for
Black men is 71.8 years almost seven years younger than the average total life expectancy rate in
the US at 78.7 years (Hill et al., 2015; Jones-Webb, Calvert, & Brady et al., 2018). Black men in
the United States experience health disparities in several major diseases compared to their white
counterparts (CDC, 2013). Black men have higher rates of diabetes, cardiovascular disease, obesity, and new AIDS cases than any other group (CDC, 2013; Jones, Crump & Llyod, 2012). Black men have higher rates of high blood pressure which could explain the differences in morbidity in stroke, coronary heart disease, chronic kidney disease, and heart failure across racial/ethnic groups (Chen et al., 2019). Black males also have the highest homicide death rate, almost ten times higher than the rate of their white counterparts (Noonan, Velasco-Mondragon, & Wagner, 2016).

Socioeconomic Status. Health disparities are not randomly distributed across society but instead systematically biased against individuals of a lower social status. An individual's socioeconomic status (SES) reflects the resources available to them, including exposure to everyday circumstantial forces that can be beneficial or harmful (Jee-Lyn García & Sharif, 2015; Steinberg, 2009). This is reflected in African Americans' health as their health is often governed by the implication of decisions concerning health care, food delivery systems, zoning laws, urban infrastructures, and medicalization (Metzl, 2013). Even when high-risk Black men may want to engage in healthy behaviors, they do not necessarily have equal opportunities to make health decisions based on their social status (Gilbert et al., 2016).

Socioeconomically disadvantaged high-risk Black men that reside in communities with high rates of violence not only face issues of safety but are also at risk for health disparities. High-risk Black men often experience negative trajectories in socioeconomic conditions, health insurance, access to health services, and resources to promote healthy behaviors, as well as lack of quality education, adequate housing, and employment, (Jee-Lyn García & Sharif, 2015;
Socioeconomic status is one of the strongest predictors of health disparities, as high-risk Black men’s quality of life is often influenced by stress (Enyia et al., 2016). Stress and socioeconomic status have been well documented to coincide, as high-risk Black men are more likely to have lower-wage jobs and high stress (Williams, 2003; Enyia et al., 2016).

**Stress.** Stress can be a critical contributor to poor health outcomes among high-risk Black men (Ellis et al., 2015; Seth et al., 2012). Residing in disadvantaged neighborhoods increases residents’ chance of additional stressors. Race, age, and sex have all been linked to the level of stressors that individuals encounter. For men, these stressors are amplified by experiences of violence, drug abuse, homelessness, or incarceration (Jackson, Karasz & Gold, 2011). The variety of challenges imposed creates stress that poses a threat to Black Men’s psychological and physiological health (Perkins, 2014). High-risk Black men exposed to community violence with high stress have a greater likelihood of developing poor health outcomes like an increased risk for inflammatory-based disease, particularly cardiovascular disease compared to Black women and non-Hispanic whites (CDC, 2019; Janusek et al., 2016).

Adverse health outcomes have been hypothesized to be a result of the stress experienced by African Americans through high unemployment rates, crime, and physical decay; African Americans also face limited opportunities for physical activity and purchasing healthy food as their communities are known to be resource-poor and experience food deserts (Mellman et al., 2015). Although Whites residing in high-poverty urban neighborhoods reported increased psychological distress, it is assumed that African Americans have developed more effective coping strategies for their hostile environments (Perkins, 2014). This is shown as high-risk Black
men with high levels of city stressors have been found to have higher rates of binge drinking and illicit substance use than other racial groups (Seth et al., 2012).

**Everyday Discrimination.** Along with city stressors, Black men frequently experience routine unfair treatment known as everyday discrimination (Taylor et al., 2018). Adverse life circumstances like lower educational attainment and poverty are determined by the mistreatment of African Americans due to institutional and interpersonal discrimination (Mouzon et al., 2019). Even without a criminal record, Black men are often treated with less respect as they encounter harassment from police, receive poor service, and are assumed to be dishonest and uneducated (Taylor et al., 2018). Racism-based discrimination has contributed to the community disadvantage Black families face as they are denied bank loans, redlined, are targets for predatory banking practices, and segregated into poverty-stricken violent communities (Taylor et al., 2018).

The highest risk of everyday discrimination is experienced in Black men with a history of incarceration as they also deal with legal forms of discrimination daily (Assari et al., 2018). Policies like “stop and frisk” and the “Three Strikes Law” increase Black men’s exposure to the criminal justice system and increase their likelihood of everyday discrimination (Hetey & Eberhardt, 2014; Jackson et al., 2010). There has been mistrust in the police traditionally in communities of color; approximately 50% of African American men will be arrested at least once before their 23rd birthday (Fielding-Miller et al., 2018). Police are seen as social control agents in communities, and Black men are seen as dangerous and criminal (Logan & Oakley, 2017; Moore et al., 2018). Underserved communities where these men reside commonly
experience hyper-policing and hyper-surveillance, where they experience unusual levels of police attention that does not advance the community or resident confidence in police forces (Blankenship et al., 2018). Institutional racism reinforces the centuries-old distrust of the police, which creates obstacles to authentic public safety in these communities (Santilli et al., 2017). These forms of racialized social control heighten Black men’s experience with everyday discrimination and have been correlated with poor mental health outcomes (Assari et al., 2018).

**Gang Affiliation.** Gangs began as a product of assimilation as migrants traveled from overseas, in Chicago as early as the 1900 gangs were primarily White with the Irish and Italians controlling segregation in Chicago neighborhoods (Hagedorn, 2006). Chicago’s Black gangs were not developed until the 1960s as black migration and unemployment increased, originally beginning as assemblies to push back on the housing segregation and contest the abuse of white gangs; with a membership close to 50,000 they engaged in illegal activities as well as civil rights activism (Hagedorn, 2006). Today, Chicago is not primarily run by one gang but at least 59 gangs with 625 factions with more than 100,000 gang members (Ramos, 2012; Isackson, 2012). Black teens, particularly in Chicago’s inner cities, may seek a sense of belonging among gangs due to strained family relationships or relocation (Voison, 2014). In underprivileged families where Adverse Childhood Experiences defined as various forms of physical and emotional abuse, neglect, and household dysfunction experienced in childhood are most likely to influence gang induction (Trinidad, 2021).
Incarceration. High-risk Black male populations not only have higher exposure to community violence and greater health disparities linked to socioeconomic status, discrimination and stress; they are also greatly impacted by mass incarceration as they overrepresent state and federal prisons populations (Brown, Bell & Patterson, 2016; Mahaffey, Stevens-Watkins, & Leukefeld, 2018; Williams, Wilson & Bergeson, 2020). Communities with higher rates of violence and concentrated disadvantage defined as the percentage of the population in poverty, unemployed, on welfare, and in single-parent households, are predictors of incarceration (Sampson & Loeffler, 2010). As Black male populations have the highest morbidity and mortality rates in general in the U.S., for formerly incarcerated populations the need for healthcare resources is even more evident as incarceration can worsen mental and physical health (Williams, Wilson & Bergeson, 2020).

Mass incarceration and the evaluated levels of stress experienced while in prison play a huge role in limiting the quality of life for high-risk Black men, as they encounter overcrowding, limited health access, inhumane conditions, and treatment (Williams, Wilson & Bergeson, 2020). Research has demonstrated a strong relationship between incarceration and health as it negatively impacts life expectancy (Blankenship et al., 2018; Williams, Wilson & Bergeson, 2020). Even upon release, the vulnerability continues as men are less likely to have a primary care provider, are released without required medications, often utilize the emergency room for care, and have higher preventable hospital admissions (Wilderman & Wang, 2017). High-risk Black men also face the risk of engaging in risky behaviors such as alcohol/substance abuse, as they often struggle with housing instability, unemployment, re-establishing social ties, poverty, limited access to treatment, and poor health and mental health outcomes (Wilderman & Wang,
2017; Taylor et al., 2018; Scanlon et al., 2018; Yu, 2018). With high-risk Black men being born after 2001 having a 1 in 3 chance of spending some time in jail or prison (Taylor et al., 2018), it is evident that race, disadvantage, and incarnation are linked to communities with high levels of violence which threatens the public health of these communities (Wilderman & Wang, 2017; Scanlon et al., 2018; Yu, 2018).

**Education & Employment.** Education inequities create a path toward negative economic and social consequences for Black men (Perkins, 2014). Violence is not one-sided; it is complex and a normality in low socioeconomic communities (Gaymen et al., 2017; Jee-Lyn García & Sharif, 2015; Steinberg, 2009; Metzel, 2013). Quality education is a predictor of socioeconomic status, with poorer education being correlated with lower income and SES (Tobler et al., 2011; Cagney & Lauderdale, 2002). Education shapes the way individuals view the world and can contribute to decision-making processes that alter an individual’s path in life (Metzl, 2013). Without quality education, many Black men become stuck in the structural chains of society (Metzl, 2013; Barber et al., 2016).

Black men’s health is historically negatively impacted by wealth, as many feel the pressure to be providers for their households yet are paid less and encounter higher rates of unemployment than their white counterparts (Gilbert et al., 2019). “Secure employment is the most basic means to acquire the necessary economic resources for full participation in today’s society. Work type and employment status are primary drivers of one’s identity and place within society, which influence social gradients and resulting physical, mental, and social well-being” (Mullany et al., 2021). Structural barriers deny many high-risk Black men access to success,
reproducing the cycle of poverty that causes them stress-related health issues (Gilbert et al., 2019). In order to reduce SES disparities in health, it will require policy initiatives that address SES components like income, education, and occupation (Adler & Newman, 2002).

Incarceration history also puts a strain on employment for high-risk Black men post-release (Brown, Bell & Patterson, 2016). With earning difficulties, these formerly incarcerated men must depend on family and friends for financial assistance; as many do not have the support needed, they experience alcohol and drug-related problems, health challenges including mental health, and end up reincarnated (Mahaffey, Stevens-Watkins, & Leukefeld, 2018). Although those that are able to find steady work are less likely to return to prison, they still face discrimination in wages making reentry into society challenging (Pager et al., 2009).

**Barriers to Care**

As healthcare commonly focuses on the treatment of disease rather than prevention, the health of Blacks still lags behind White Americans with higher incidence and mortality rates in many diagnoses as healthcare has not adjusted its model of care or removed barriers to care (Levine et al., 2001). Care is commonly segregated and of lower quality for African Americans, as they are less likely to receive appropriate cardiac procedures, state-of-the-art care, appropriate preventive services, and receive care from physicians who are less likely to be board-certified (Gamble & Stone, 2006). Although high-risk Black men experience health disparities due to poor access and engagement in preventative screenings, the health disparities experienced are complex (Jones, Crump & Lloyd, 2012).
White Americans associate crime with Blacks and, deem them to be untrustworthy, have low-level jobs like cashiers, janitors, and dishwashers, and assumed them to be incompetent leading to racially discriminatory behavior and treatment (Banaji et al., 2021). Racism has also been associated with low patient satisfaction and poor health outcomes in Black men (Moore et al., 2013). High-risk Black men perceived discrimination in their quality of care based on the type of health insurance coverage (Wiltshire et al., 2011). With higher copays, premiums, and limited access to quality facilities, Black men are more likely to have an unusual source of care like emergency room utilization (Hammond et al., 2011). With distrust of the medical profession and barriers to healthcare, Black men continue to experience health disparities like the delayed detection of chronic illnesses. Healthcare providers disconnected from their Black patients do not discuss environmental content like community violence exposure nor do they consider the effects of violence on African Americans’ health, missing opportunities to address challenges (Tung et al., 2018).

**Healthcare Utilization**

Even with the higher rates of death, high-risk Black men are less likely to utilize healthcare services, especially primary care and outpatient services (Ravenell, Johnson, & Whitaker, 2006). Black men are 75% less likely to have health insurance, and even those with insurance are 50% less likely to have contact with a primary care physician during the past year (Gilbert et al., 2016). Even Blacks with Medicare are more likely to have fewer visits to physicians for ambulatory care, fewer mammograms, and immunizations but are often hospitalized and have higher mortality rates (Gornick et al., 1996). High-risk Black men are less
likely to access healthcare services more than any other group, and this avoidance contributes to poorly managed chronic conditions like cardiovascular disease.

Black men have the highest age-adjusted death rates for homicide, heart disease, HIV/AIDS, cerebrovascular accidents, and cancer (Bharmal et al., 2012; Gilbert et al., 2016). Key factors found to influence health outcomes in African American men include socioeconomic status, racism, gender, physical environment, residential racial segregation, and geography (Ormelas et al., 2009). Health disparities in high-risk Black men can be attributed to the reduced utilization of healthcare services; these health disparities are increased for Black Chicagoans compared to other states (Keppel et al., 2010). Many studies have described a relationship between community violence and poor health outcomes, but there are very few studies establishing a clear link between the two (Barber et al., 2016; Gilbert et al., 2016). Part of the problem is that most studies are correlative, meaning these studies can only show that violence exposure and adverse health outcomes are related but cannot show how they are related or whether there is a causal relationship between the two. The relationship between community violence and high-risk Black men’s health outcomes is an overly complex one, and many factors are involved.
Medical Mistrust

Adverse experiences have led to mistrust in the healthcare system; African Americans have a level of mistrust that is rooted in their culture. African Americans have been traditionally exploited in the healthcare profession with evidence of racism, inferior care, and low patient satisfaction (Moore et al., 2013). It has been shown that high-risk Black men of a low SES do not trust doctors, with trust being associated with age, education, and income (Wiltshire et al., 2011). Black men without higher education and lower income are more likely not to trust the medical profession and observe racism throughout their healthcare experiences. Many minorities also do not feel welcome or respected within the healthcare system (Wynia et al., 2006). High-risk Black men’s lower utilization of healthcare is associated with their mistrust of medical systems, healthcare organizations, and professionals (Powell et al., 2019; Shelton et al., 2010; Hammond et al., 2010; Jaiswala, 2019).

“Medical mistrust is defined as the inclination to distrust medical systems and health care personnel that are believed to represent the dominant culture” (Valera et al., 2018). Medical mistrust in African American populations has often been attributed to unethical research like the Tuskegee Study of Untreated Syphilis, a 40-year government study (1932 to 1972) in which 399 Black men from Macon County, Alabama, were intentionally denied treatment for syphilis; the distrust is deeply rooted in centuries of racist mistreatment by physicians and researchers (Thompson et al., 2021; Powell et al., 2019; Alsan & Wanamaker, 2018; Jaiswala, 2019; Gamble, 2006). Emphasis has been placed on this single historical event and is commonly noted as the reason for African American medical skepticism but distrust dates to slavery times where
Black slaves buried or alive were used as subjects of dissection and medical experimentation that was cruel and a majority of the time fatal (Gamble, 2006).

Although mistrust is inclusive to all African Americans, it is greater in men compared to women (Powell et al., 2019; Jaiswala, 2019). Reduced trust in the healthcare system is correlated with lower healthcare utilization, lower willingness to seek medical care, lower medication non-adherence, and negative health-related attitudes that lead to increased morbidity and premature mortality for Black men (Shelton et al., 2010). African American populations are also more likely to experience perceived racism known as the perception that individuals are treated differently because of race, particularly in healthcare (Powell et al., 2019). Racism has been associated with low patient satisfaction and poor health outcomes in high-risk Black men (Moore et al., 2013). With higher copays, premiums, and limited access to quality facilities, Black men are more likely to have an unusual source of care like emergency room utilization (Hammond et al., 2011).

With distrust of the medical profession and barriers to healthcare, high-risk Black men continue to experience health disparities like the delayed detection of chronic illnesses. Prior studies have linked medical mistrust, healthcare utilization, and behavior in high-risk Black men to masculinity norms like extreme autonomy, fortitude, and healthcare avoidance (Hammond et al., 2010). If high-risk Black men trusted and utilized healthcare resources, they could prevent avoidable mortality with improved early detection and timely preventative health screenings. Mistrust is not exclusive to healthcare and is entangled with other components of a society that is
structurally inequitable, to create interventions that target medical mistrust, mistrust must be actively disassembled (Jaiswala, 2019).

**Historical Context of CVE on High-Risk Black Male Health Outcomes**

The health outcomes of high-risk Black men are not merely shaped by individual choices but by structural institutions that have shaped the health of African Americans for decades. The United States’ history of community disenfranchisement and marginalization has shaped the socioeconomic factors that impact many Black communities today. Through institutional racism, African American families of low socioeconomic status are more likely to reside in impoverished urban communities marked by strenuous poverty, residential instability, joblessness, violent crime, and educational shortages (Simning, Wijngaarden, & Conwell, 2012).

The critical race theory suggests that social and economic injustice are the root causes of unfortunate health outcomes among racial and ethnic minorities (Ford & Airhihenbuwa, 2010). High-risk Black men that reside in socioeconomically deprived residential settings are disproportionately exposed to community violence due to structural factors such as residential segregation by both race and class (Barber et al., 2016). Poverty and violent crime impact similar minority Chicago communities (see Figure 2.1) like Englewood, Austin, South Shore, West Garfield Park, and Riverdale (The Field Foundation of Illinois, 2020). Residential segregation is often a reflection of laws and economic policies that contribute to the unreasonable burden of illness and premature mortality that faces neighborhoods (Ansell, 2017). Racial discrimination is associated with negative physical and mental health outcomes in Black men (Reed et al., 2010). There is a need in health studies to realize that the lived experience of high-risk Black men
forces them to face social and economic constraints, subjecting them to health inequities. In order to address the higher mortality and morbidity rates in high-risk Black men, society must first address the social inequities that have led to poor health outcomes and the underutilization of healthcare services.

Figure 2.1 Chicago Poverty & Violent Crime Map Comparison.

African Americans have adverse health outcomes for numerous health conditions, especially high-risk Black men. High-risk Black men's health outcomes are often regarded as a result of their lifestyle choices, yet that is an inaccurate depiction as the health of high-risk Black males is far more complex (Metzl, 2013). Neighborhood concentrations of certain race/ethnic groups are associated with adverse health outcomes as a consequence of residential segregation, race/ethnic composition serves as a proxy for adverse social and physical contexts, including a
higher prevalence of stressors and more inadequate access to resources (Mair et al., 2010). Black people commonly have pre-existing disproportionately high rates of stress and chronic conditions due to the social determinants of health that affect underrepresented minorities (Archibald et al., 2018).

High-risk Black men are often forced to reside in undesirable neighborhood locations with high crime, frequently creating adverse health outcomes in this population (Treadwell et al., 2012). Adolescent studies have reported that high-risk Black males have higher rates of CVE, as becoming a victim, and experiencing the homicides of loved ones (Zimmerman & Messner, 2013; Smith, 2015).

Empirical evidence on the consequences of violence exposure focus on children and evidence on the consequences for adults is scarce (Huang, King, & McAtee, 2018). There are few studies that talk directly to high-risk Black males about their neighborhood and exposure to community violence. High-risk Black male homicide rates exceed those of any other group at 51.5 deaths per 100,000 compared to the rate of Hispanic males at 13.5 deaths per 100,000 and white males at 2.9 deaths per 100,000 (CDC, 2012). There is an abundance of data that supports evidence showing that neighborhoods affect health, as they are identified by social disorder (Santilli, 2017). Black men die seven years earlier than any other race and they are most likely to have undiagnosed or poorly managed chronic conditions (Gilbert et al., 2016).

High-risk Black men with adverse childhood experiences and have a lower socioeconomic upbringing are more likely to receive a lower quality education leading to low education attainment, unemployment, low-wage jobs, incarceration, and residential confinement.
to racially segregated poverty-stricken communities with high rates of community violence (Jackson et al., 2016). This cycle of disadvantage (demonstrated in Figure 2.2) leads to health disparities and poor health outcomes (Treadwell et al., 2012; Metzl, 2013; Barber et al., 2016). This is amplified for high-risk Black men reentering society or previously incarcerated (Wilderman & Wang, 2017; Taylor et al., 2018; Yu, 2018; Wilderman & Wang, 2017). This study explores the experiences of how previously incarcerated high-risk Black men perceive their health while residing in neighborhoods plagued with community violence.

Figure 2.2. Intersectional Disparities of a Black Man
Chapter 2 reviews the structure of Chicago and explains the segregation of the city based on race/ethnicity and income. This chapter reviews the distribution of violent crimes in neighborhood areas and discusses the perpetrators and victims of violent crimes. Chapter two also reviews the state of health of Black men and reviews data to show the health inequities experienced by this population. Chapter 2 does review previous literature surrounding barriers to care, healthcare utilization, medical mistrust, and the historical context of CVE on High-Risk Black Male health outcomes. Chapter 3 will provide a detailed description of the research methodology.
Chapter 3: METHODOLOGY

This study aimed to understand the complexity of Community violence exposure (CVE) on the health outcomes of high-risk Black men residing in highly violent communities through semi-structured interviews. A qualitative method was chosen to gain a deeper understanding of the phenomena of CVE (Constantinou et al., 2017). CVE is essential when considering high-risk Black male adult health outcomes. Prior to data collection, an integrative review of literature was conducted to synthesize the understanding of the impact of CVE on the health of high-risk Black men (Appendix C). Based on the findings of the integrative review, the following research questions were constructed to explore the impact of CVE on high-risk Black male populations:

RQ1: How do high-risk Black men perceive community violence?

RQ2: How do high-risk Black men maintain their health residing in high violent communities?

RQ3: How do high-risk Black men in high violent communities utilize healthcare?

RQ4: Do high-risk Black men exposed to community violence trust healthcare providers?
Research Design

Phenomenology developed by Edmund Husserl focuses on how a person experiences phenomena through how people perceive and talk about events and objects (Pietkiewicz & Smith, 2014; Groenewald, 2004). An Interpretative Phenomenological Analysis (IPA) was utilized to explore how the experiences of high-risk Black men living in neighborhoods plagued by community violence influence their health outcomes. IPA attempts to understand what it is like to stand in the shoes of the subject through interpretative activity through detailed questioning (Pietkiewicz & Smith, 2014). A phenomenological approach was chosen because it best describes the lived experiences of an individual, including their perceptions of their world. Perceptions provide us with evidence of the world, not as it is assumed to be, but as lived (Richards & Morse, 2013). This is a critical point as it supports the need to utilize a qualitative methodology to develop a thorough description of "what" and "how" men experience community violence in their everyday lived health experiences (Creswell, 2014). IPA with descriptive data collection methods was utilized to explore how the experiences of high-risk Black male adults living in neighborhoods plagued by community violence, and health outcomes are influenced. This approach was selected because it allows in-depth interviews to explore the unique lived experiences of high-risk Black males living in neighborhoods exposed to elevated levels of community violence, including how CVE has influenced their health outcomes. Phenomenology was elected to ensure a deep understanding of how high-risk Black men view their health while living in a low-income, high violent neighborhood. This study aimed to explore the lived experience of high-risk Black men exposed to community violence in hopes of understanding their health challenges and needs.
Qualitative studies reject formulating hypotheses prior to data collection, instead, an inductive approach is taken to generate rich details. The in-depth exploration led to the development of interview questions appropriate for CVE exploration in high-risk Black men. A phenomenological approach best describes lived experiences, including the individual’s perceptions of their world (Richards & Morse, 2013). In order to thoroughly understand the impact that CVE has on the health outcomes of this high-risk population, it is essential to understand how they perceive community violence and health.

Since this study involves a qualitative research design, statistical modeling and measures were not identified. Qualitative research involves collecting data in a natural setting to analyze data inductively and deductively to establish themes (Creswell, 2014). This study used an in-depth semi-structured interview format to examine high-risk Black men's lived experience in a highly violent neighborhood within Chicago, Illinois. This approach was selected because semi-structured interviews allow participants to elaborate on their own experiences and understandings instead of quantifying their experience based on conventional scales (Swierad et al., 2017). Qualitative research interviews attempt to understand the world from the subject’s point of view to unfold the meaning of people’s experiences (DeJonckheere & Vaughn, 2019). This study aimed to answer the following research questions: (1) How do high-risk Black males perceive community violence? (2) How do high-risk Black males utilize healthcare services and participate in healthy behaviors within their community? (3) How do high-risk Black men in high violent communities utilize healthcare? (4) Do high-risk Black men exposed to community violence trust healthcare providers?
**Sample Recruitment.** Qualitative research traditionally focuses on a small sample size; phenomenological studies should study between 3 to 10 subjects with the goal of collecting extensive details on a few individuals (Creswell, 2013; Dukes, 1984; Pietkiewicz & Smith, 2014; Groenewald, 2004). There is no rule regarding how many participants should be involved in the qualitative inquiry but generally, it depends on the depth of analysis, the richness of the individual cases; how the researcher wants to compare or contrast single cases; and the restrictions one is working under (Pietkiewicz & Smith, 2014). IPA should focus on the breadth of data collected in the study (Pietkiewicz & Smith, 2014), a smaller number of participants included in a study permit a more in-depth examination of respondent’s experience, while still providing an opportunity to compare perspectives between participants (M. Q. Patton, 2002). This study sought to obtain between 8-10 participants in an effort to explore in depth how a few individuals experience a phenomenon and then analyze the data to develop a proposed integrated description of the experience for others who may then share in the phenomenon.

The participants of this study were identified through the utilization of purposeful criterion sampling. Criterion sampling was chosen because it allowed researchers to find participants who have relevance to the problem. All participants studied had to experience the phenomenon of community violence exposure. Participants were recruited utilizing outreach through social media networks, community non-profits, word of mouth, and flyers. Social media has been shown to be effective in recruiting hard-to-reach or difficult participants (Topolovec-Vranic & Natarajan, 2016). Facebook and Twitter are accessed daily with over one billion users each (Khatri et al., 2015) and were harnessed to advertise research to high-risk Black men residing in Southshore, Roseland, East Garfield Park, West Pullman, Austin, Avalon Park,
Riverdale, Englewood, North Lawndale, and West Garfield Park. Recruitment in these neighborhoods was imperative as they are low-income neighborhoods with a lack of resources and high violence rates. Incentives for participants included a $50 gift card for study participation. The gift card provided at interview completion is a direct benefit of participating in the study.

**Inclusion and Exclusion Criteria.** The study's inclusion criteria included participants who identify as Black and male, between the ages of 35-49 and considered high risks for violence exposure. Participants were required to reside within Chicago's highest violent communities, including Southside, Roseland, East Garfield Park, West Pullman, Austin, Avalon Park, Riverdale, Englewood, North Lawndale, and West Garfield Park. Violent communities were identified by the Chicago Police Crime Index as communities that have high rates of murder, criminal sexual assault, robbery, aggravated battery, burglary, theft, and shooting incidence. The exclusion criteria included men who are not Black.

High-risk Black men between the ages of 35-49 were specifically chosen for this study because this population is not only vulnerable to CVE but also more likely to be diagnosed with a chronic condition and have experiences utilizing healthcare services. This age group was selected because it was the appropriate age group that would have experienced or been exposed to community violence and the most vulnerable to a chronic condition diagnosis. Black men between the ages of 35-49 are at the highest risk for obesity and have a high incidence rate of high blood pressure and diabetes diagnosis following men over the age of 50 (CDC, 2017). As Black people are being diagnosed with conditions at younger ages, it is important to understand
the risk factors that may be silent during these early years and lead to earlier death. With 1.5 million Black males between the ages of 25 to 54 years absent from life due to premature mortality or incarceration (Gilbert et al., 2016), it is appropriate to understand the lived experience of high-risk Black men within this age category.

Protection of Participants. While no study is entirely risk-free, the researcher did not anticipate participants enduring any detriment or distress. To ensure ethical practice, prior to interviews, participants received informed consent forms (Appendix D) to gain consent for:

- Participation in research
- The purpose of the research
- The procedures of the research
- The risk and benefits of the research
- The voluntary nature of research participation
- The subject’s (informant’s) right to stop the research at any time
- The procedures used to protect confidentiality

Participants were advised to contact the researcher if they had any questions about the consent form. Given the nature of the proposed study, there were potential risks for the participants to experience emotional and/or psychological distress during the qualitative interviews, given the context that the interviews asked participants to share their lived experiences, which could have become distressing. In the event that a participant required attention, a comprehensive list of counseling service referrals was available to all participants. The researcher gave participants a comprehensive list of recommendations for Federally
Qualified Health Centers and free clinics (Appendix E), that provide behavioral/mental health therapists to insured and uninsured populations at minimal to no cost. The researcher informed participants that if they experienced any emotional or psychological distress, they could obtain assistance with scheduling a session with a therapist to address any urgent needs or emotions that might be discovered while proceeding through the interview process. Any participant that needed to obtain counseling services was navigated to the case management department in the Federally Qualified Health Centers to help them obtain an appointment.

**Expert Review.** The researcher conducted an expert review to verify that interview questions accurately aligned with the research question and validated that those questions posed no risks to participants. Interview questions were forwarded via email to three professionals who grew up in these communities or were public health professionals that have worked closely with the target communities identified to review questions for inclusion in the study. Expert reviewers were chosen by recommendations from the advisory committee based on their experience and research with underserved urban communities.

**Measures.** The current study explored phenomena through semi-structured in-depth interviews. The survey instrument included demographic questions (Appendix A) and nine semi-structured questions (Appendix B). Interview questions were developed based on a comprehensive review of the current empirical literature on high-risk Black men's health outcomes exposed to community violence. A consultation with a subject matter expert in the field was requested to assess the cultural sensitivity of the questions. This study is intended to be culturally appropriate and reveal emerging themes in depth.
Table 3.1

Research Question and Measurement Questions Alignment Table

<table>
<thead>
<tr>
<th>Research Questions</th>
<th>Data Collection Instrument or Method</th>
<th>Item on survey instrument</th>
</tr>
</thead>
</table>
| RQ1: How do high-risk Black men perceive community violence?                       | Semi-structured Interviews (Phenomenology)    | 1. How would you describe your neighborhood and culture to someone who has never been there? Probe: Discuss how your neighborhood and culture have shape you?  
2. Do you see violence in your community? Probe: Describe what type of violence and whether it does or does not impact your daily activities? |
| RQ2: How do high-risk Black men maintain their health residing in high violent communities? | Semi-structured Interviews (Phenomenology)    | 3. How would you describe your health? Probe: Do you feel your best, why or why not? Is there anything about your health that you would want to change in the future?  
4. Describe how you maintain your health? Probe: Does your neighborhood environment impact the way you maintain your health, why or why not? |
6. When you see a healthcare provider, have they asked about your neighborhood setting? Probe: If so, what type of questions did they ask explain if they didn’t what would you want your healthcare provider to know? |
| RQ4: Do high-risk Black men exposed to CV trust healthcare providers?              | Semi-structured Interviews (Phenomenology)    | 7. Do you trust healthcare providers? If you do trust health care providers, please explain why. If you do not trust your healthcare providers, please explain why not. Probe: How do you deal with this? |

**Procedures.** Before beginning each interview, the researcher introduced themselves and explained the purpose of the study. Participants were given a physical description of the purpose of the study. After the introduction, permission to audio record the interview was requested. The researcher read the interview questions in sequence, incorporating the semi-structured interview format. The semi-structured format used predetermined probes to extract information on themes from participant responses. Predetermined probes included open-ended questions. Interview questions aimed to explore the lived experience of participants.

Semi-structured interviews lasted 30 to 45 minutes depending on the participant’s elaboration of stories and probes conducted to obtain a further explanation, with one round of
interviews. Interview questions proceeded from general to specific questions, with extensive probing for additional detail. Interview questions aimed to explore two major themes: 1) how high-risk Black men view their health when exposed to community violence and 2) how community violence exposure impacts the health of high-risk Black men. The semi-structured interview included a list of open-ended questions aimed at gathering information about each participant's experience in his community and his life experiences concerning the perceived impact of community violence on his physical health outcomes. The researcher asked follow-up questions to gain further understanding and clarity concerning the participants' answers. Participants were also encouraged to elaborate on and share as many details of their experience as possible.

Interviews were audiotaped, transcribed verbatim, and imported into the qualitative software NVivo Version 12. All of the participants were audio recorded during the interview to ensure that the researcher addressed the needs of the participants at the moment. Additionally, the recordings allowed the researcher to transcribe the interview responses verbatim. The researcher recorded all interviews on a handheld recorder. The recorder was stored in a locked cabinet accessible only by the researcher when it is not used for the study. Completed interview recordings were transferred from the handheld device to the researcher’s computer and placed in a password-protected digital folder. The researcher transcribed all the participants' interviews, and the transcriptions were stored in a password-protected digital folder.
A set of questions were posed to disclose the researcher’s experience with the phenomenon after concluding interviews:

1. *What dimensions, incidents, and people intimately connected to the experience stand out to you?*
2. *How did the experience affect you? What changes do you associate with the experience?*
3. *How did the experience affect significant others in your life?*
4. *What feelings were generated by the experience?*
5. *What thoughts stood out to you?*
6. *What bodily changes or states were you aware of at the time?*
7. *Have you shared all that is significant with reference to the experience?*

**Data Analysis**

A phenomenological approach is appropriate for exploring the meanings and perspectives of research participants (Creswell, 2014). This approach aims to understand the essence of how a participant is present to the world using a participant's description (Richards & Morse, 2013). Data was reviewed using an outsider’s perspective to develop higher-level theories and insights. This study utilized IPA to produce an in-depth examination of the phenomena of CVE. The initial stage of analysis involved a close reading of the transcripts a number of times and reviewing audio recordings multiple times to immerse in the data and recall the atmosphere in which the interview was conducted. After reviewing interview transcripts and recordings, note-taking took place regarding observations and reflections about the interview experience and
added significant information. Traditionally personal reflexivity and emotional responses were also to be noted but due to the COVID-19 pandemic, interviews were conducted with both the interviewer and interviewee wearing masks and sitting six feet apart. Notes from the audiotapes and transcribed texts were reviewed to find patterns and emerging themes. Audit trails were conducted throughout the study.

The next stage of analysis involved looking for connections between emerging themes, grouping them together according to similarities, and providing each cluster with a descriptive label. Themes were dropped at this stage if they did not fit well with the emerging structure. The final stage of analysis involved taking the themes identified and writing them up one by one. The researcher used a systematic classification process to text data into less content-related themes that share the same meaning. Essential quotations and assigned codes were identified in each text segment. Themes were discovered by reviewing quotes under each code and reaching a consensus with external reviewers before determining the final themes.

An inter-coder reliability measure was calculated by comparing the transcripts and validating the structure of themes alongside the interview data. Saturation is defined as no new properties, dimensions, interactions, or consequences seen in the data (Saldana, 2021; Strauss & Corbin, 1998). Saturation was achieved in this study when no new information was discovered and the themes that emerged from the dataset were repeated. Once shared beliefs among participants were repeated, saturation was achieved. The number of beliefs was measured in the first interview and continued through follow-up interviews until there are no new shared beliefs. Member checking was conducted with three Black men from the study to confirm the
researcher's interpretation of the data. Member checking was utilized to increase researcher confidence that key themes were identified in this study. The credibility of the data analysis was also achieved by conducting multiple discussions with coders until a consensus was achieved about each aspect of the data analysis.

This study achieved scientific rigor by addressing standards of credibility, transferability, dependability, conformability, and the study's clinical significance (Constantinou et al., 2017). Study credibility was attained by transcribing interviews by individual transcribers and conducting member checking with three participants from the study to review the accuracy of the information participants shared with the researchers. Transferability was achieved by including detailed descriptions of the studies methods including organizations that took part in the study, the number of participants that were interviewed, rich details of the data collection, and background information on high-risk Black men's health trends and the impact neighborhood violence has on the community members that reside there. Study dependability was achieved by an inter-coder reliability measure that was calculated by comparing the transcripts.

Interview data revealed themes for explaining how stress contributes to high-risk Black men's health and how social and demographic characteristics (e.g., sex, race, gender, age, socioeconomic status) jointly affect health outcomes for high-risk Black men in the Chicagoland area. Study confirmability was achieved by a phenomenological reduction conducted to bracket knowledge and reduce bias and preconception. “Bracketing is a means of demonstrating the validity of the data collection and analytic processes” (Ahern, 1999). This was accomplished through sessions where existing literature and personal understandings of experience were
discussed (Dory et al., 2017). Audit trails were also conducted to achieve confirmability. This study is clinically significant because understanding African Americans' lived experience in highly violent communities is essential for understanding and addressing high rates of stress-related chronic disease and premature mortality in high-risk Black men.

Summary

Chapter 3 reviewed the research questions and phenomenology methodology design including the sample recruitment, inclusion, and exclusion criteria, and reviewed the protection of participants. Chapter 3 also reviewed the study procedures and data analysis that was used to explore study results. Chapter 4 will elaborate on the findings from the analysis.
CHAPTER FOUR: RESULTS

Introduction

African American men have one of the lowest average life expectancy rates, in addition, they are socioeconomically disadvantaged and live in neighborhoods containing chronic sources of stress. This qualitative study used an Interpretative Phenomenological Analysis to discover the lived experience of high-risk Black men and their health outcomes as they relate to the increasing violence trends in low-income Chicagoland neighborhoods. This study aimed to answer the following research questions: (1) How do high-risk Black males perceive community violence? (2) How do high-risk Black males utilize healthcare services and participate in healthy behaviors within their community? (3) How do high-risk Black men in high violent communities utilize healthcare? (4) Do high-risk Black men exposed to community violence trust healthcare providers? Questions aimed to explore two major themes: 1) how high-risk Black men view their health when exposed to community violence and 2) how high-risk community violence exposure impacts the health of Black men.
Participant Description

This study aimed to understand the lived experience of Black men at high risk for CVE and the impact violence exposure plays on their health and health utilization. Black men who grew up in Chicago’s most violent communities were recruited as study participants. Seventeen men were recruited for the study, with eleven participants meeting the inclusion criteria. Black men considered high-risk due to gang affiliation, transitional housing state, and previous involvement with the justice system were interviewed in person. At the start of the interview, the researcher gathered broad preliminary demographic information for all participants. The researcher excluded any specific information that could be linked to participants and used pseudonyms to transcribe and analyze interviews. Participants were also asked to use pseudonyms when discussing experiences with other individuals. Participants provided information regarding sex, race, ethnicity, age, marital status, the neighborhood of residence, education, employment, annual and household income, upbringing, gang affiliation, justice system involvement, living situation, chronic condition diagnosis, emergency room and hospital utilization in the prior two years (see table 4.1).
Interviews were conducted with high-risk men who grew up in the inner city of Chicago in neighborhoods with higher rates of community violence, all participants identified as Black and male, with one participant disclosing his Hispanic culture. A majority of participants (91%) identified as single, gang affiliated, and disclosed previous experience with the justice system. Participants currently reside in Austin, Riverdale, and Englewood, Chicago, IL with some having upbringing in the Cabrini Green and Rockwell Garden public housing of the Chicago Housing Authority. Participants were between the ages of 35-49 and were either renting or in transitional
housing with a median income of $31,000 - $40,000. A majority (91%) of participants had also been diagnosed with a chronic condition including substance abuse, asthma, high blood pressure, high cholesterol, diabetes, cancer, PTSD, and depression.

**Story of Data and Results of the Analysis**

The first purpose of this study was to understand the lived experience of high-risk Black men residing in communities with high rates of violence and address research Q1: How do high-risk Black males perceive community violence?; Q2: How do high-risk Black males utilize healthcare services and participate in healthy behaviors within their community?; Q3: How do high-risk Black men in high violent communities utilize healthcare?, and Q4: Do high-risk Black men exposed to community violence trust healthcare providers? An analysis of interview data generated several themes that explain High-risk Black Men’s ability to prioritize health care. Themes of importance will be discussed below utilizing theoretical frameworks, the PHCRP with supporting components on the PVEST:

The external environment that these men grew up in interacts with population characteristics to determine how they prioritize their health and healthcare behaviors. This is explored through the first theme:

1. Childhood and previous experiences influenced their trajectory of lives and adverse outcomes.

Through the PHCRP, individuals of color have unique perspectives in marginalized situations which is shown through proposing factors, this is explored in theme 2:
2. CVE exposure has an impact whether direct or indirect on actions, thoughts, and movements.

Through the lived experience of High-risk Black Men, there were several enabling factors that influence the way they prioritize health and participate in behaviors related to health, which are explored through the four-themes listed below:

3. Redemption and the need to advocate for gang-affiliated youth or sons,
4. A healthy state is subjective and health maintenance practices stem from childhood experiences,
5. Men are aware of their health status, but environmental safety concerns influence their ability to stay healthy,
6. Community resources impact the ability to maintain a healthy state.

Need factors or the way that High-risk Black Men perceived health care impacts the way they prioritize their health and explores the lens of racism embedded in systems through the three themes below:

7. Healthcare utilization is linked to community connections and based on former experiences,
8. Provider inquiry about CVE may produce unbiased perceptions and impact care,
9. Trust is not restricted to healthcare but is based on beliefs and experiences.

All themes discovered will be explored in the next session.
Theme 1: Childhood and previous experiences influenced their trajectory of lives and adverse outcomes

Violence exposure is a primary problem for participants in the study, impacting their lives from early stages in their life. Environmental influence not only shaped experiences but forecasted life outcomes for these men. 64% of participants expressed that they did not feel safe in their environment with 37% identifying their safety concerns began as children. Years ago, Chicago’s predominantly Black communities had a family focus with an emphasis on community. When asked to describe their neighborhood to a stranger, many participants talked about growing up witnessing and being aware of violence, but violence not being as bad as today. As youth, the neighborhood was perceived as good although gangs and violence were not out of sight. Participant A reflected:

“Actually, I grew up in Lawndale community, I do not know if you're familiar with that. It was a good neighborhood, but it still had its issues being that it was Black, you know a Black neighborhood or any Black neighborhood, but I would say it was overall good. I went to a good school, but we still had incidents taking place. There was still gangs around. You got to join them.” (A)

I would describe it... Now? I would describe it as very vicious. Then... I would describe it as the best neighborhood ever. (K)

We have a good neighbor here. We kind of have these moments, the wrong crowd decides they want to hang out. That's neither here nor there. (D)

The violence experienced in years passed was primarily seen as mild and under control compared to current-day community conditions. Although some men experienced optimistic upbringings, violence was never out of sight. Every participant did identify childhood
experiences involving gangbanging, domestic violence, prostitution, muggings, gun fights, rodent and bug invested living conditions.; participant reflections are below:

“I remember, of course I didn't notice this at first, but as time went on. Of course, you are fighting and then later on the guns came and then the guns actually were used. You know? So, it kept going worse and worse.” (F)

“People crossing each other, family crossing each other, people lying on each other, people setting people up, people pretty much out there shooting each other.” (K)

“Seeing people being shot or stabbed or whatever the case may be. You have to ditch school because today might be the day that you get into it with the persons or whatever it is there, different games there was in the schoolyard or whatever. And then experiencing myself being shot at or stabbed. So, it was basically a lot. It was a lot going on in the neighborhood.” (J)

“I mean the drug selling on the street and people getting beat up from time to time.” (E)

“I haven't witnessed violence firsthand in a long time but as a kid, I've seen violence when I was a child. I've seen violence in the household, I've seen violence in the streets, and other neighborhoods throughout Chicago, like Cabrini-Green and things like that, I have family that grew up there, I've seen somebody get shot in front of me. I've seen people get shot plenty of times before so, I've had guns put to me before so.” (F)

“Gang fights, people waiting for other people at the bus stop.” (G)

“Well, started when I was young. I got stabbed in my eye. I'm blind, been in a coma three times. Carjacked, robbed, blah, blah, blah. I got shot in my leg once.” (I)

“No, it was riddled with gun violence, mugging, violence, anything that can pop your name. I have seen rapes and women getting beaten.” (H)

Although neighborhoods were described as tight-knit and perceived as safe, men became gang affiliated to become a part of another family, one that protected them in the streets. One man (K) stated that “you create a family” in those communities. The families’ created have led to
what one man (B) stated as a “false sense of purpose.” This sense of purpose led many of these men down destructive paths that turned them into the victims and perpetrators of violent acts, reflected below:

“I became a product of my environment.” (B)

“I was a really bad guy.” (C)

“For myself, I've been shot five times and almost gone.” (G)

“Getting into fights, stealing, gang banging, just disrespecting my mother and doing things that a young kid shouldn't.” (H)

“I started gang banging at an early age. And it's like, I liked the streets more than just sitting in the house. And I was influenced at an early age with gang banging, drugs, and things of that nature.” (I)

“As a youngster we were given false sense of purpose. And we thought the streets was our purpose.” (K)

Theme 1 explores the external environment participants were raised in and begins to explain coping mechanisms participants use to survive in communities with high violence. This theme showcases how participants have been surrounded by violence their entire lives and begins to highlight the systemic oppression of this population.

**Theme 2: CVE exposure has an impact whether direct or indirect on actions, thoughts, and movements**

Concerns about safety were reflected during interviews as men mentioned their fears and concerns about moving throughout their neighborhood. Feelings about the community included, “Dangerous”, “Lack of remorse”, and “Not Safe”. Men reflected the need to move or carry themselves differently to be safe in their community or remain “sheltered” from the violence
occurring in their neighborhoods. The same communities referred to as once good had negative
expressions associated with them including “Vicious”, “Bleak”, “Not Good”, “Gang Infested”,
“Worst”, “Unsettling”, and “Traumatic”. As many of these men grew up to become “a product of
their environment”, the violence surrounding them heightened. All of the men in the study have
been a witness and exposed to multiple forms of violence including fights, drug dealing,
prostitution, gang activity, muggings, rape, gun activity, and more. As participants reflected on
CVE and discussed survival, as fear and apprehension overshadow their ability to exist, reflected
below:

“I just bought a car and half the time be scared to stop at a stop light because they
do a lot of shooting now on expressways.” (I)

“You have to be aware of what's going on. Anything could happen. Especially
with my situation.” (G)

“People don't come outside no more because they don't know what's going to
happen.” (D)

“I'm shaking, I'm scared because it was so much shooting.” (C)

“I like to move around, but I can't move like I'd like to.” (B)

“Well, I could say yes and no, because don't no one knows me in this
neighborhood like that. But then you could be mistaken as a different person from
someone else if you're wearing a hoodie or whatever. The stigma again... And
sometimes people get shot by accident.” (J)

“No, I don't feel safe. The only place you feel safe would be up north and south
suburbs. Not even that really anymore, but yeah, I don't feel safe, I've just got to
be aware of it.” (G)

“I literally not too long ago just seeing a person in the middle of the street, just
run up and just snatch somebody out the car at gunpoint and shoot. I don't know
what the case may have been, but it's different from when I went in 25 years ago.”
(H)
Although CVE in the communities the men currently reside in is unavoidable, some men reflected feeling safe in their community and said that they had no concerns about safety and spoke about their spiritual beliefs to protect them through unsafe situations, violence not being targeted to them or having legal protection that keeps them protected in their community.

“The only reason I feel a little safe is because I'm a believer in God of everybody.” (A)

“Yes. I feel safe, but I feel safe because I know a lot that goes on, may not apply to me, but it concerns me. By not being involved, being retired, and all that. All of us could not be involved, but we're there to discern, because anybody be hurting you. Because you still have love for the community. And actually, it's not a community no more.” (K)

“I mean, for one, I got God on my side. I can't live in the fear. I just got to be careful of my surroundings and don't put myself in predicaments where I could be injured.” (D)

“I do, because I make sure that I'm safe. You know what I'm saying? I am a legal carrier.” (F)

Theme 2 highlights proposing factors surrounding violence exposure and the inequitable conditions participants have been surrounded by. Themes 1 and 2 discovered how participants grew up in a violent community setting and the impact that played on their life trajectory of being gang-affiliated, experiencing run-ins with the justice system, and being the perpetrators and victims of violent acts. Themes also found that today’s violence is seen as more common and brutal, causing men to move cautiously or remain sheltered from harm.
Theme 3: Redemption and the need to advocate for gang-affiliated youth or sons.

As many of these men have survived community conditions and are returning citizens their tolerance for violence has decreased. Men included in the study are looking for solutions to help stop today’s violent youth as they consider today’s violence to be worse than the violence they experienced as a youth. The men reflected on today’s youth not having guidance and missing fathers including themselves as some participants are fathers and felt they contributed to their community’s destruction by not being able to show their own sons a different path instead of following their fathers’ footprints. This was reflected by participant (K) in detail:

“And my sons and other people's son, they're shooting each other, these youngsters, but it is to a high degree, is our fault. Because I was separated from my sons and somebody else was separated from their son due to imprisonment. Our kids don't know that we are good friends, He wouldn't want to shoot him. But they don't know that their fathers are good friends. After the fact, somebody ends up dead or in jail.

They're visual, we got to show them. But it's always that one person, somebody will listen to, to a high degree. But if they in prison, they can’t reach out to them. They need to be up close in person, because over the phone, after five minutes on the phone. Ain't nothing like being up close and personal. You engage better. So, if I could just have buses to go see people, whether it be in a Fed joint or a state joint whether they're in another city or another state, they need to see that youngster or the young lady who thinks they’ll succeed.”

Participants also reflected on their maturity and the current way that they see violence. Participants were remorseful for previous engagement in violence or gang activity and spoke about their growth as individuals using terms like “mindful”, “changed”, “wise” and “mature”. Participant reflections are listed below:
“Well, I can't say it's all that made me today, but it helped me to realize that it's more to life than just the way I grew up. So far... I mean, with that being said, it shaped me to be more mindful of what's going on today. I can deal with certain situations now that I did back then.” (J)

“Well, it woke me up to the realization that it takes a community of people to support one another to help guide you through life. And I didn't have that. I’ve never even seen that. I'm sorry. And that was the problem that there was no help.” (C)

“I seen a lot of things change from when I was growing up. I want to say right around I made my change for the good, around 2013. That's when I really got fed up with seeing all these young men out here getting killed and going down the wrong path. I just want to see whatever who it is, try to steer them and take them another direction.” (D)

“Just as you mature as a man you grow up; you start to realize what your purpose is and you understand where you want to take your life. I think growing up, I didn't have... I didn't know about money. I didn't know about saving.” (F)

**Theme 4: A healthy state is subjective and health maintenance practices stem from childhood experiences**

In order to connect CVE, Black men, and health outcomes, it was imperative to understand how CVE impacts the health of Black men and ultimately how high-risk Black men interpret their own health. The next theme discovered through this study was that health is subjective and that participants are aware of their health failures and areas of improvement. The question around health maintenance, “How would you describe your health?” and “Describe how you maintain your health?” was asked of participants with additional probes to understand their response. Half of the participants considered themselves healthy or moving towards a holistic state as many reflected on their physical fitness routines, dietary changes, and overall holistic approaches to health. Participants also reflected on their upbringing with some stating they were “raised unhealthy”. Participants’ reflections are below:
“I've developed real bad asthma to a certain degree. I had asthma growing up, but it got worse by using drugs. I've got high blood pressure; I think it runs in my family. But I try to work out, exercise, eat right, the best way I can. And overall, I'm okay, I think.” (J)

Because anytime a person gets diagnosed with high blood pressure, you can't say your health is extremely good. (H)

“I don't use no diets. I don't do no supplements or none of that. I just, I work out. Oh, and then due to the fact I don't have a vehicle, I do a lot of walking. Another form of exercise.” (H)

“I had been incarcerated for three years, so when I came out, I gained 15 pounds. I was just eating like crazy, but I've calmed down a lot. I try to eat more healthier at least four or five times over the week. Just more vegetables and stuff like that.” (G)

“I couldn't even wear shoes like this or pants like this, my leg was all the way out here, I thought my leg was going to have to get cut off. And I said I'm done. I had reached out to a young lady at Hyde Park, I called her my sensei. And she basically gave me a three-day fast or three-day cleanse. And I stopped eating meat. I haven't eaten chicken, pork, beef, no dairy, none of that.

I feel my best because I started in 2018, June of 2018 and before that I was just not happy. I was a lot bigger than I am now, probably couldn't even fit in this chair. I realized that I had to change my eating habits. I started getting in tune with people like Dr. Sebi, Dr. Africa. And they enlightened me. Lisa Left Eye Lopes was probably the main person. I was watching her Honduras videos before she died on YouTube kind of inspired me, Michael Jackson talking about it and then just realizing that I had to change my eating. Changing my eating allows me to change how I live and carry myself altogether because health is wealth. You know what I'm saying? So, yeah. That's pretty much it.” (F)

“I don't drink. I don't put anything in my system that's really bad. I do eat sugar. So, I don't smoke cigarettes. I don't do anything of that nature. So those are pluses. Even if you just did it a little bit, it would catch up with you sooner or later” (C)

“Yeah. I feel my best, but even though my numbers weren't good yesterday, they say it's a silent killer, so I'm feeling good. But they said, “You could drop.” You know the numbers might indicate that you're not doing so well, but you don't feel like, man, I feel bad. So, I'm glad I got the wisdom to know that, hey, I need to do
better no matter how I feel and I'm going to stop eating this stuff and think I'm feeling good.” (A)

Through reflections participants did link a majority of their health behaviors to their upbringings as children and were aware of the dangers in certain foods and drinks, reflecting on subjects such as lead in their water pipes, food chemicals, and the amount of sodium and sugar in foods. Many participants spoke about trying to be healthy but not following through due to loss of hope, physical pains, and addictions to certain foods. There was also the theme of blame on the food industries and the government for not caring about Black people or people in general which is why it is hard to maintain health. Participant reflections are below:

“Most things they tell you not to eat. I'm a diabetic, I love sweets. I eat out a lot, in restaurants. I tried my best to do healthy things, but sometimes we just ... We was kind of raised unhealthy. In our community we grew up on potato chips and pops and sodas and hamburgers and pizza, that's what we like.” (A)

“But I used to exercise a lot, that played a big part in, do a lot of walking, try to jog a little bit. But being up in age, my knees aren't the same.” (K)

“I'm really not maintaining it really. I'm not eating good. Not doing the exercises that I should. But as far as my personal hygiene and upkeep, that's tip top. That's a plus.” (D)

“I want to work out and be more active, but I just don't feel like it because my stomach and I got a lot of aches and pains and stuff from all the surgeries. No, I don't feel the best I can feel.” (G)

“I've been neglecting my health because I done got to a point that I just want to give up. I stopped drinking water. I drink a little coffee here. We're not allowed to drink or do drugs. So, it's like I can't medicate my feelings and stuff. So, I've been taking more pain pills than I should. I think I'm messing up my stomach with the shit. But it's more than I could bear. And I don't know where to go.” (I)

Although this study was not focused on the COVID-19 pandemic, study interviews did take place between December 2020 – May 2021, which prompted many participants to also
reflect on COVID-19 and the COVID-19 vaccine as they reflected on their state of health.

Participants' health routines were altered due to COVID-19 with many taking precautions to keep loved ones safe or just following social distancing guidelines. Many participants also felt skeptical about COVID-19 and some regretted getting the vaccine and reflected on complications:

“I caught COVID three times. The first time almost died. Then I got well, then caught COVID three months later. And then three more times only three months after that. Then I went and got the first shot before I got released in March. Then they said I had to wait 28 days to get the second shot. Now I regret taking it because it's like, since I had the shot, I've been having complications.” (I)

Participant A recalled a conversation he had with his daughter and her husband: “Man, I've been tested. We've kind of got into an argument then” (referring to daughter). “It's like, if they come up with a vaccine, I said, "Yeah, I'm going to get it. I ain't got nothing to lose. I mean, everybody will get it.”

Daughter: “It's like, man, that's so bad Dad. Man, you old school, that's naive.”

Her husband: “We both had coronavirus and I cured it.”

Participant A: “I was like, oh lord. So, I see why we're arguing now. I said, ”You guys need to. I got it, man. I need y'all to. I need to ask you y'all do y'all got a mask.”

Daughter: “This is your house, but I'm straight. At least I know what I got.”

Participant A: “You come and you cured that. How do you know you cured it? You ain't even tested, man. So, you cured ... Now you’re a doctor. She's looking all funny. I'm like, what devils, man.” (A)

“COVID is real. People are dying daily from it, lost a lot of lives, it's serious. The vaccination is real for those who take it.” (B)
Theme 5: Men are aware of their health status, but environmental safety concerns influence their ability to stay healthy.

Study participants were able to acknowledge their health concerns and areas of improvement, a majority of participants felt that they could be healthier through exercise but continuously brought up the concern of environmental safety. Participants spoke about their neighborhood safety concerns and stressed the importance of vigilance in their community which led many to limit outside exercise options such as walking around the block. Participants were limited to the daily physical activity they were able to receive unless they did exercises in their homes or counted work duties as physical activity. Participant reflections are below:

“It makes me not want to go outside at nighttime or be cautious of what I'm doing when I'm out. I don't listen to music. Most people have headphones near here. I don't take headphones with me. I be very vigilant when I'm out and about, because if anything happened at any time, there's been a lot of shootings around here, in this area, mostly at this gas station out here. So, you've got to be careful where you go in those gas stations. So, I don't even go there.” (J)

“Well, I like to move around, but I can't move like I'd like to. Just being cautious of how I tread. I usually liked to be out, but now I'm a sheltered being.” (B)

“People don't come outside no more because they don't know what's going to happen. The other day, a bullet came through my window, and I was like, no kids be up in there playing a game. And it so happened, they just left about an hour before.” (D)

“Yeah, because you can't go, say you want to jog around this block, we can't go down there because you afraid of what might happen because it has a lot of shootings and that's what's going on now. Certain people can't go to certain blocks, or they feel they'll get shot at or retaliated against and that's what's going on. This is all retaliations, back and forth. You do this, I'm going to get you and do that back and just, back and forth. And it just needs to just stop.” (D)
Consistently throughout participant interviews, concerns of safety were common with all participants aware of the danger in their neighborhood or “just down the street”. Not only did safety concern impact their ability to be physically active daily but it also impacted their daily activities such as sitting on the porch or having conversations with neighbors on the street.

**Theme 6: Community resources impact the ability to maintain a healthy state**

Participants’ concern for safety was half of their battle to remain healthy, the second barrier keeping participants from engaging in healthy behavior dealt with community resources and availability. Participants reflected on the lack of healthy food options like grocery stores and healthy restaurant availability, as well as the lack of gyms. Intertwined in all responses was still the common theme of safety concerns and violence. Participant K reflected saying, “Of course, because if we have a gym in the neighborhood kids can't even play in the front yard, let alone go to a gym. Kids can't have a basketball tournament without somebody getting into it. So, it's like this.” Participants also noted the concern of safety for businesses in the community and expressed beliefs of businesses being afraid to operate in their community as a key component of health-related resource gaps.

“Then in the neighborhood, every corner, ain't nothing healthy. You got bars, liquor stores, everything processed, nothing fresh around here. You know what I'm saying? To have a bowl of fresh fruit, ask somebody the last time they had it, or a nice salad. Okay. They can tell you about Harold's Chicken, and McDonalds, Burger King, all of that, which is cool.” (K)

“Maybe if there was a healthier choice around here to eat later in the evening. A lot of places close because they're scared to get robbed, safety issues and stuff.” (G)
Themes 3-6 showcased enabling factors that influenced surrounding gang affiliation, health behaviors, community resources, and safety concerns. These themes also showed how participants viewed their own health status and how environmental factors influence health behaviors and resources. Aligned with the PHCRP, these themes bring attention to structural inequities experienced in these communities and brings attention to racism as a root cause. Racism is shown in these themes as communities of high violence lack community resources like grocery stores, gyms, and healthy restaurants. This is highlighted by participants as a result of the violence levels in these communities. Leaving marginalized communities without resources is the result of systems that have been in place for decades and to continue to leave these communities without equitable resources leaving them vulnerable to poor health outcomes and systemic oppression. With all participants reflecting on their health needs and varying levels of health, the commonality between these themes shows the need for safety to engage in health behaviors and health resources to be maintained in community settings.

**Theme 7: Healthcare utilization is linked to community connections and based on former experiences**

Black men’s experience with the healthcare system is the next connecting piece to understanding the impact of CVE on Black Men’s health outcomes. Participants were asked where they seek care with additional probes to understand reflections. A majority of participants were connected to their current healthcare through transitional housing. The transitional housing campus had a clinic with a doctor and medical students that provided care to residents, a common reflection among these participants was their level of trust in the doctor in charge of the
clinic. Trust in this medical provider was based on previous experiences and the detailed care and concern they showed to participants. Many of the participants made it clear that they would not be utilizing healthcare without the clinic staff whom they are very fond of and have created a line of trust and safety for men to access care without barriers. Those who had a regular place of care reflected on positive experiences:

“I went to Rush hospital. I embraced everything, the atmosphere. Everybody genuinely cared about you. They were considerate.” (K)

“I didn't have any problems so I feel if I can be comfortable with somebody, then I'll go back if I need to.” (F)

“They do research to see... they tried to tap into it. They don't want to just... if you're going through some pain, they don't want to ease the pain. They will try to radar target what causes the pain. And they go beyond the job. I don't really know the full job duties with the titles, but you know when somebody genuinely cares about you. Because it's like, they don't want to let you leave until you figure out, you're okay. They want to know you're okay. They need to know you got the right medication. They do the research on the medication. They want to check the side effects.” (K)

“She introduced me to him, and I went to see him, and we hit it off and I thought he was the best fit for me at that time.” (J)

“I think I do need to get me a primary doctor though.” (D)

Participants who did not utilize healthcare or did not have a primary care provider reflected on mistrust and experiences of judgment when trying to access care or opted for holistic approaches in the belief that the healthcare system is flawed. Experiences perceived as judgmental or culturally insensitive also push men away from routine care practices and instead utilize emergency care services like the county emergency room, urgent care, and the minute clinic. Reflections of participants are below:
“I had a European male doctor tell me, because I told him, I said, "Now, I'm pre-diabetic," because I was on pills and he was like, "Oh, no. There's no such thing as that." He said, "If you're diabetic, you're diabetic." (C)

I realized they didn't shut all the places down to help people mentally and all that shit. And they lock them up. And then they put them right back out there worse than they was off of all kinds of meds and shit (I)

“The whole thing is traumatizing. It just adds to my trauma already. And it wasn't necessarily the providers. It was more the officers that were from the jail were making things harder for me too. The providers were just scared. I've just had my whole abdomen cut open and then they got both of my legs shackled to the bed and one of my arms. I have to use the bathroom. I have to do all this. All my ab muscles cut open. It was just too much, I don't know.” (G)

“I think they are doing a lot of experimenting and shit. Then they asked you come back and do a follow-up. Then you'll say, "You having any complications?" I'll be like, "Yeah." And all this shit. I was on medication and that shit had me so big and it was hurting me. I'm like, "Take me off this shit." And they always saying, "You okay." But how do I know you're not lying to me just to get my little medical card? Y'all done charged all this God damn money just to listen to my heart. Y'all still ain't told me shit. So, I'm not going to keep going through that sitting there. I sat there 13 hours for them to tell me I'm okay. (I)

Theme 8: Provider inquiry about CVE may produce unbiased perceptions and impact care

A potential solution for healthcare to address the effects of CVE on health outcomes has involved providers inquiring about violence exposure and a person’s environment. Participants were asked, *When you see a healthcare provider, have they asked about your neighborhood setting?* Participants were asked probing questions to understand reflections. All participants agreed that it would not be a good idea to have a provider inquire about their environment and violence exposure, as this could be seen as “offensive”, “invasive”, and “unnecessary” and have the potential to lead to additional prejudice in healthcare delivery. Participant reflections are below:
“It's not like I thought they would be able to help, but they'll do something with it. So, I didn't entertain the thought.” (K)

“That's too much information.” (D)

“I don't think they care.” (E)

“I would take that question to be offensive, personally.” (F)

“I'm not really sure if that's a good idea, because I don't want someone judging me about my neighborhood or what I have to go through. I think that that might influence my care or scare them away or something like that. I already have to tell them, "Oh, I got shot." And all this other stuff, "I've been to prison." And that's already a mountain right there.” (G)

“They don't care about your neighborhood.” (H)

**Theme 9: Trust is not restricted to healthcare but is based on beliefs and experiences**

Participants reflected on their levels of trust in providers and the healthcare system. A recurring theme throughout interviews for both sides of trust was that trust was not based on healthcare but based on beliefs, for those who did not trust healthcare providers, did not trust anyone. For those who did trust healthcare providers, they had trust in God ultimately. Those who did have trust in healthcare reflected on their faith beliefs as the foundation of how to interact and have confidence in healthcare providers:

“Because they're very cordial. You got some nice healthcare, putting themselves in jeopardy, but helping you because of the epidemic and everything that's going on. So, I trust and believe them.” (J)

“And they go beyond the job. I don't really know the full job duties with the titles, but you know when somebody genuinely care about you.” (K)

“Well, because basically, I trust God and I was like, "Well, he ain't going to lead me wrong." So I figured, he leads me in the right direction. It's basically like they're authority figures and that's what they tell you in the bible, to obey authority figures.” (E)
"If you don't got no type of healthcare, what's that doing for you?" (A)

Men who trusted healthcare providers to a certain extent or not all had reservations based on previous experiences of mistrust and an overall mistrust for people in general. Many may assume that healthcare trust is isolated based on history, but medical mistrust is associated with mistrust of people in general and is rooted in fear. Participants reflected on this as they showed concern for experiences that hurt or killed others, were fearful to take medication or vaccines that they are unknowledgeable about and hesitant to trust providers who did not answer their questions or gave conflicting information. Participants also reflected on healthcare being a business and providers solely being focused on money without authenticity or care for the person. These participants have experienced many traumatic events and have used being guarded as a means of protection. Participant reflections are below:

"If you practice medicine, that means there's always room for improvement." (G)

"I know that the plot of the world today is to destroy the Asiatic man. I know this. I know that I've watched people go to the clinic for dental and they have lost certain things after that. I met one guy who went to get his teeth cleaned and they ended up taking all his teeth out his mouth and he died a month later." (C)

"It's really odd to me. I don't know, but I do have a certain trust issue when it comes to doctors and everything because we don't know what they giving us, we not really educated in that field. So, they could be doing anything to us." (D)

"Doctors, they need you to come back, right? And that's the goal. If they can cure what you have, then you never have to come back, right? So a lot of times we take medicines that cure one thing but then have us to come back for another thing so their goal is for you to come back, they need a customer." (F)

"I don't trust them fully because I've seen them tell people that everything is going to be okay or they ain't going to live and stuff like that. And it's complete opposite." (H)
Themes 7-9 highlighted the need factors of participants regarding healthcare and begins to explain why they choose or choose not to interact with the healthcare system. Along with the PHCRP, these themes have significance and show that community violence is not just an individual problem but a problem that needs everyone. As participants had mixed responses based on their utilization of healthcare with a majority of the participants seeking care through their housing system and others accessing care only for emergency needs. A majority of participants questioned the authenticity of healthcare providers and stated a lack of trust in the system as it is ultimately a business. Themes 7-9, also show components of the PVEST as copying mechanisms related to healthcare are explored, as participants are adaptive or maladaptive. Participants with religious belief, have become adaptive and prioritize healthcare, whereas participants with greater distrust in systems were maladaptive to healthcare prioritization. A unanimous response among all participants surrounded providers inquiring about participants' neighborhood setting and violence exposure, all participants thought this was too personal and that providers ultimately do not care and will judge them based on their lived experience. This also illustrates how participants are aware of racial inequities and do not want to contribute to the oppression experienced by volunteering additional details on their environment and living conditions.
Summary

In this chapter, results from the qualitative analysis, identified nine themes to answer research questions and was elaborated on for additional detail. The researcher provided detail on the results of the semi-structured interviews. Theme analysis was broken up to further explore theme similarities and explore connections through a theoretical lens. All semi-structured interviews provided insight into high-risk Black men’s experiences with CVE and health utilization and the impact CVE plays on their health behaviors.

The results of the analysis in this chapter imply that CVE has a significant impact on the lives and health of high-risk Black men. Particularly for this study, the men interviewed were considered high-risk as they have been gang-affiliated, had experiences with the justice system, and have been the perpetrators or victims of violent activity in their community. Results of the analysis suggest that these men have heightened concerns about safety in their neighborhoods and have been aware of violence since childhood, becoming gang affiliated at an early age to become a part of a family. Participants also expressed their concern for their neighborhoods today as violence was considered much more rampant than the violence they experienced as children. Taking into the safety concerns, many participants did not feel safe to participating in physical activity in their neighborhood as acts of violence have no target and can be the result of being at the wrong place at the wrong time.

Analysis results also suggest that communities with high violence lack the proper resources like grocery stores and gyms to equip these men with the proper tools to become healthy. High-risk Black men seek care based on their beliefs and care access proximity, if they
have beliefs rooted in faith, they are more likely to seek care with the beliefs that God has them covered and if they have care embedded in their housing system or within close vicinity, they will also utilize that healthcare access. The key result of this analysis is that healthcare trust levels vary but that these high-risk Black men do not want to explain their neighborhood conditions or lived experiences to healthcare providers for fear of judgment and neglect that could ultimately impact their care delivery. This thematic analysis makes it clear that high-risk Black men are exposed to high rates of community violence, and this impacts their ability to engage in healthy behaviors and prioritize healthcare.

In chapter 5, the last chapter of this dissertation, the findings of this research study will be discussed and summarized. Chapter 5 will also assess the analysis findings with the theoretical framework and discuss the limitations of the research. Chapter 5 will conclude with recommendations for practice, policy, and future research.
CHAPTER 5: DISCUSSION, IMPLICATIONS, RECOMMENDATIONS FOR PRACTICE AND FUTURE RESEARCH

Summary

The current state of some of Chicago’s inner-city neighborhoods with high crime rates has been compared to war-related trauma, with so many people being affected, especially Black men. Black men face numerous challenges including those that stem from social attitudes and perceptions about Black men, especially as these perceptions impact education, poverty, employment, and health-related problems. Challenges are amplified for Black men considered high risk, who are gang affiliated, have previous involvement with the justice system, and reside in high-violence communities. High-risk Black men residing in high-crime environments like Chicago are at risk for poorer outcomes for numerous chronic health conditions.

Black men may be more frequently exposed to certain stressors because of their social and economic circumstances. Most of the violent crime committed in the city of Chicago takes place in neighborhoods with individuals of a lower socioeconomic status. The demographic makeup of these communities is predominantly inhabited by African Americans and minorities, congruently men in these communities are more likely to be the offender or target of a violent
crime. Additional stressors related to High-risk Black men’s health outcomes residing in high-violence neighborhoods could also require more than the recommended treatment guidelines that may not consider socioeconomic reality and the conditions of living in violent communities.

The health and well-being of high-risk Black men living in violent communities is an understudied yet essential public health concern. Studies have focused on the stressors of African American men in the context of health practices, pregnancy, mainstream culture, technology, and so much more (Thomas et al., 2020). However, there are few studies focused on high-risk Black men’s perceptions of healthy living when exposed to CVE. Constantly, it has been revealed that individuals of a lower socioeconomic status encounter more health challenges and poorer outcomes than those of a higher socioeconomic status. Yet, as violence is on the rise in communities of lower socioeconomic status, there is an imperative need to explore the health outcomes of men living in these communities. The experiences of high-risk Black men cannot be generalized to all Black men exposed to community violence. This study aimed to address the following research questions to understand the lived experience of high-risk Black men:

RQ1: How do high-risk Black men perceive community violence?

RQ2: How do high-risk Black men maintain their health residing in high violent communities?

RQ3: How do high-risk Black men in high violent communities utilize healthcare?

RQ4: Do high-risk Black men exposed to community violence trust healthcare providers?
Need and Significance of Study. Although the life expectancy of Black Chicagoans has dropped below 70 years for the first time in decades due to COVID-19 (Bauer, 2022), Black men’s life expectancy in Chicago has lagged behind since 1990. With a life expectancy of 68.8 years compared to the 76.5 years of White non-Hispanic males and the leading cause of death being homicide between the ages of (18-44), there is a critical necessity to address the needs of this population (Meredith & DeGooyer, 2020). Through an integrative review conducted prior to this study, it was found that literature surrounding the topic of Black men’s exposed to community violence and health outcomes was limited, as many studies focused primarily on women and youth (Thomas et al., 2021). With the poorest health outcomes and lowest life expectancy Black men’s health needs require prioritization as they not only face health inequities but also reside in communities with high rates of violence which leads to additional stressors that impact health outcomes.

With limited research surrounding the topic of CVE and health outcomes in Black men, this study was able to add to the literature through qualitative inquiry. A majority of CVE-focused studies used quantitative methods to analyze violence exposure, and there is a need to understand the lived experiences of Black men. This study used a qualitative methodology to understand the experience of a hard-to-reach population in order to understand first how they view violence in their communities and secondly how community violence impacts health behaviors and their ability to access healthcare.

Literature Review. With the poorest health outcomes and the largest barriers to health care, Black men are the most neglected population in the United States. Black men that reside in
socioeconomically deprived residential settings are disproportionately exposed to community violence due to structural factors such as residential segregation by both race and class (Barber et al., 2016). Socioeconomically disadvantaged Black men that reside in communities with high rates of violence not only face issues of safety but are also at risk for health disparities. Key factors found to influence health outcomes in Black men include socioeconomic status, racism, gender, physical environment, residential racial segregation, and geography (Ormelas et al., 2009). Even with the higher rates of death, Black men are less likely to utilize healthcare services (Ravenell, Johnson, & Whitaker, 2006). With high levels of mistrust and years of racist structures contributing to the outcomes of this population, it is essential to understand how health behaviors and healthcare utilization are influenced by environmental circumstances such as community violence exposure.

**Methodology.** A qualitative phenomenological research study was conducted to explore how the experiences of Black males living in neighborhoods afflicted by community violence influence their health outcomes and behaviors. Qualitative inquiry was selected because it provides a non-threatening environment for participants (Creswell, 2013). Interviewing high-risk populations requires approaches that allow participants to elaborate on their own experiences and understandings instead of quantifying their experience (Swierad et al., 2017). Through semi-structured interviews, 11 high-risk Black men were interviewed regarding their experience with community violence, health behaviors, healthcare utilization and trust.

Utilizing an Interpretative Phenomenological Analysis, transcripts and audiotape were reviewed numerous times to understand the data and recall the interview atmosphere. With each
interview using pseudonyms to protect participants, connections with emerging themes were discovered and clustered with similarities, using descriptive labels. Reliability was established by comparing transcripts and validating the structure of themes alongside interview data. Saturation was determined when themes from the dataset were repeated. Credibility was obtained by transcribing interviews by individual transcribers and conducting member checking. Transferability was obtained through a detailed description of the study design, as shown in Chapter 4. Dependability was achieved by inter-coder reliability and confirmability was achieved by a phenomenological reduction, to bracket knowledge and reduce bias and preconceptions.

**Findings.** Nine themes emerged from the researcher’s analysis of the eleven participants through semi-structured interviews. Participants identified with the nine identified themes. Themes included:

1. Childhood and previous experiences influenced their trajectory of lives and adverse outcomes,
2. CVE exposure has an impact whether direct or indirect on actions, thoughts, and movements,
3. Redemption and the need to advocate for gang-affiliated youth or sons.
4. A healthy state is subjective and health maintenance practices stem from childhood experiences,
5. Men are aware of their health status, but environmental safety concerns influence their ability to stay healthy,
6. Community resources impact the ability to maintain a healthy state.
7. Healthcare utilization is linked to community connections and based on former experiences,

8. Provider inquiry about CVE may produce unbiased perceptions and impact care,

9. Trust is not restricted to healthcare but is based on beliefs and experiences

**Theoretical Implications**

This study aligns with the theoretical model suggested in Chapter 1, the Public Health Critical Race Praxis (PHCR). As PHCRP uses race consciousness as a backbone (Ford & Airhihenbuwa, 2010a), keeping in mind institutional systems that place participants in traumatic situations including their environment influenced by residential segregation, high rates of violence experienced in their communities as youth interacting with proposing factors like their violence exposure, enabling factors such as gang affiliation and need factors such as perceived risk product adverse health outcome for high-risk Black men as they deal with systems that have been in place for decades. There is a need to address the environment, proposing and enabling factors in order to see improved health outcomes. This includes allowing opportunities for employment and education, providing resources, and addressing the root causes of community violence produced by systematic oppression.

The supporting model the Phenomenological Variant of Ecological Systems Theory (PVEST) examines human development through the interaction of identity, culture, and experience and accounts for the differences in experience, perception, and stress response (Swanson et al., 2003). This model takes into consideration predisposing factors like race, sex, etc., and how these factors engage with stress to produce a flight or fight type of response.
manipulating health outcomes. This is demonstrated in the results of this study as participants who have a lack of trust in government systems and experience or overheard about poor experiences with healthcare do not prioritize healthcare, unlike participants who had religious beliefs and positive healthcare experiences who seemed more likely to prioritize healthcare. Public Health must address health coping mechanisms to support high-risk Black men to achieve improved health outcomes.

**Interpretation of Results**

The purpose of this study was to explore how violence exposure influences the health outcomes and behaviors of Black men living in the most violent neighborhoods of Chicago, Illinois. This study aimed to explore the lived experiences of African American men in high-violence neighborhoods by answering the following research questions, How do high-risk Black men perceive community violence; How do high-risk Black men maintain their health residing in high-violent communities; How do high-risk Black men in high violent communities utilize healthcare; Do high-risk Black men exposed to community violence trust healthcare providers? Nine themes were discovered from the analysis and will be interpreted below.

**Theme 1: Childhood and previous experiences influenced their trajectory of lives and adverse outcomes**

All study participants reflected on their childhood upbringing and the adverse experiences they witnessed as children that either made them aware of violence at a young age or become gang affiliated to protect themselves from the violence. This is confirmed in the
literature surrounding the topic of adverse childhood outcomes and Black men with a criminal history, as Black men with criminal histories have high rates of attachment stemming from their childhood experiences (Donadia et al., 2022). A commonality among participant responses about violence compared violence of previous years to be considered mild compared to the violence experienced in neighborhoods today. As neighborhoods were reflected as “tight-knit”, participants became gang affiliated to “create a family”, participant K reflected. This explains how growing up in neighborhoods with community violence can be perceived as safe as community members become desensitized to the violence they experience, and young men are compelled to become a part of a street family for their own protection and safety.

**Theme 2: CVE exposure has an impact whether direct or indirect on actions, thoughts, and movements**

With all participants being a witness to a violent crime, all reflected on the need to move differently throughout their neighborhood as it was considered dangerous. They spoke about not feeling safe enough to walk in their neighborhood and being aware of their surroundings as violence is common and has no direct target at times. Participants' thoughts, actions, and movements were all modified to adjust to the violence in their neighborhood setting. Participants had minimal physical activity, were restricted to eating fast food, and were even terrified to drive a vehicle in their neighborhood. Some participants who did have religious beliefs felt protected by their God and had limited fear because they believed in a higher power. The conscious decision to be cautious must add to the stress and trauma these men have previously been exposed to, particularly those with religious affiliations. Men without strong religious beliefs
have increased difficulties compared to Black men with strong religious beliefs (Motley et al., 2017). For example participant C (without strong beliefs) reflected on neighborhood safety and stated, “I'm shaking, I'm scared because it was so much shooting”, compared to participant A(with strong religious beliefs) stating “The only reason I feel a little safe is because I'm a believer in God.”

**Theme 3: Redemption and the need to advocate for gang-affiliated youth or sons**

Participants spoke of today’s violence and youth as having no structure or guidance to support them leading them to create chaos for those in their neighborhood. Participants also spoke of their own remorse for engaging in violent activities and the lack of support or help they had which led them to become gang affiliated. Participant C reflected, “Well, it woke me up to the realization that it takes a community of people to support one another to help guide you through life. And I didn't have that. I've never even seen that. I'm sorry. And that was the problem that there was no help.” This was eye-opening for participants as they not only reflected on their engagement with their community as a youth but also many expressed the need and desire to help support youth today so that violence can cease in their communities.

**Theme 4: A healthy state is subjective and health maintenance practices stem from childhood experiences**

A common reflection among participants was what they considered healthy. Many spoke about hygiene, physical activity, and diet as markers of their health. With varying markers of health, some participants considered themselves healthy if they had good hygiene or went to
work every day (which was considered physical activity), while others may consider themselves unhealthy if they ate pork. Health is subjective among participants, and they had no real way to determine or identify a healthy state. This could also be subjective as participants spoke extensively about their upbringing and how their childhood experiences impacted the way they maintained their health today. Participant A reflected, “We were kind of raised unhealthy. In our community we grew up on potato chips and pops and sodas and hamburgers and pizza, that's what we like.” Through participant reflections the greatest way to improve health is through diet and physical activity.

**Theme 5: Men are aware of their health status, but environmental safety concerns influence their ability to stay healthy**

Participant D reflected, “say you want to jog around this block, we can't go down there because you’re afraid of what might happen.” Statements of this nature were mutual among participants as all had safety concerns when it came to the ability to stay healthy. Especially as diet and physical activity are the ways that participants stay healthy, they reflected their limitations particularly in the case of physical activity being debilitated due to safety concerns surrounding community violence. There has been a correlation between urban spaces, violence, and health outcomes (Kondo et al., 2018), demonstrating the disparity in health outcomes among participants as they limit their physical activity for basic safety.
Theme 6: Community resources impact the ability to maintain a healthy state

Another line of reasoning supporting the theme to not be able to maintain health was the lack of community resources. Participants spoke about not being able to get physical activity outside due to violence and were also not able to achieve or begin fitness routines due to the absence of gymnasiuims or fitness centers. For those who did participate in exercise, they did so in the comfort of their homes. Safety was not only a concern for participants but for businesses. They reflected on their need for healthy food options or grocery stores but residing in communities that cannot retain these businesses as the violence becomes too overwhelming for them to remain in their communities. With a lack of fitness centers and limited food options, these men do not have the proper resources to maintain their health through their preferred health behaviors of physical activity and diet.

Theme 7: Healthcare utilization is linked to community connections and based on former experiences

Half of the participants were connected to healthcare through their transitional housing system and had a relationship with the provider overseeing the clinic and spoke highly of this provider. There was one participant that did not use the housing provider but also had previous adverse experiences with the healthcare system that left him questioning healthcare. Other participants outside of the transitional home were on the opposing side and preferred to use healthcare only in emergency situations and sought out care through emergency rooms and minute clinics. Those who did have a regular care provider and sought emergency care also reflected on traumatic experiences with the healthcare system, where they experienced judgment,
coldness, and negligence. Participant I reflected, “I think they are doing a lot of experimenting”, alluding to this as a major reason he did not have a routine care provider. Cultural competency has been widely accepted as important in healthcare, but there is a gap in how this is applied in healthcare practice (Henderson et al., 2018).

Theme 8: Provider inquiry about CVE may produce unbiased perceptions and impact care

This study also aimed to probe at possible solutions to help providers understand more about clients’ residential situations in an effort to understand trauma and health behaviors. This was discouraged by all participants as they felt that healthcare providers gaining additional insight into their neighborhood setting and lives would be unnecessary or cause providers to be even more judgmental. “I'm not really sure if that's a good idea, because I don't want someone judging me about my neighborhood or what I have to go through” (Participant G). Participants also reflected on having to explain history of incarnation or gun wounds and felt judged by having these conversations, so they frowned upon having a discussion about the violence they experienced in their community with providers.

Theme 9: Trust is not restricted to healthcare but based on beliefs and experiences

Participants did have split views on their trust in healthcare providers, those who had strong religious beliefs were more inclined to trust healthcare providers because of their trust in religion. This was also common for the participants who utilized care through transitional housing systems, as they felt they could trust the provider. The other half of the participants had a great distrust for healthcare providers, this was due to others’ experiences, stories of death after
provider encounters, and ultimately a skepticism for anyone not just providers. Participant D reflected, “I do have a certain trust issue when it comes to doctors and everything because we don't know what they giving us, we are not really educated in that field.” Lack of trust stemmed from a lack of knowledge or healthcare interactions. There were some reflections that noted that government wants to annihilate the Black Man, which is not just a cynicism of health care but of all government systems, which includes healthcare.

**Recommendations for Practice, and Future Research**

**Practice.** This study adds to the literature supporting the need for healthcare to prioritize marginalized communities, specifically through community education and access, as well as provider training on cultural competency. Future healthcare practice should focus on education as a tool to target high-risk Black men, so that they may better understand health outcomes and behaviors to support a healthy lifestyle. This is also necessary as Black men have identified not having the proper knowledge to question or understand what providers are suggesting. With the proper education, this population will be more inclined to question healthcare providers and even take more of a charge when it comes to their health outcomes. The second suggestion for practice would be access, with this study we saw that increased healthcare engagement took place in transitional housing, suggesting that access and proximity is essential to healthcare utilization. Healthcare providers located in close proximity to neighborhoods with high violence must make a strategic effort to bring their services to the community and offer them at a discounted, if not free price. There are organizations dedicated to this type of work and would like to support healthcare providers by providing additional access. Healthcare must partner with
community-based organizations to address these issues as community-based organizations have built trust with community members and correspond in a community-centered voice.

A variety of factors impact health equity including age, cultural and linguistic barriers, disability, education, genetic and biological factors, geographic location, income, sexual identity, and sexual orientation (Abrishami, 2018). Factors that are not traditionally included when discussing cultural competency include criminal background and gang affiliation. As healthcare, along with the rest of society makes leaps to become more diverse, equitable, and inclusive there is a need to expand on cultural competency to include ostracized populations to provide training to healthcare providers on how to interact with these populations and do so in an open and inclusive manner without judgment. Another consideration surrounding cultural competency is the implementation into practice, with current strategies only focused on training and not implementation or practice (Henderson et al., 2018). Healthcare providers need to not only understand cultural competency for the diverse set of patients they encounter but also be able to turn those trainings into actual practice with patients with diverse and complex backgrounds. This will be particularly important for high-risk Black males, as they are heavily guarded and have limited trust in government structures. This will include being intentional to understand patient needs while also being respectful of their privacy and nonjudgmental of experiences that they are willing to share. An open line of communication unbiased with respect is essential to build patient trust.
Future Research. Future research needs to focus on women, and children but also on Black men (Thomas et al., 2021). This is even more necessary for Black men who have been previously incarnated, or gang affiliated. Research should focus on Adverse Childhood Experiences (ACEs) and conventional scales but should also increase research surrounding qualitative inquiry. As experiences surrounding CVE are complex, it is critical to understand and investigate community voices and perspectives. This provides detail to quantitative scales and gives additional insight into the specific needs of communities.

Research should also aim to be more inclusive and use community experts to conduct studies, as this study was conducted the researcher often received comments about different researchers of other races coming into these community settings, using the members as guinea pigs, without ever providing feedback or resources to them. It is pertinent that in community-based research surrounding marginalized communities that we do not continue to increase mistrust for healthcare and research. Researchers should use community-aimed exploration as an opportunity to increase community knowledge and provide opportunities for community members to become research assistants, especially in qualitative inquiry. Researchers should also find ways to give back to marginalized communities without solely taking. This could include generating a community report once research data is collected, assisting with community resources identified through needs assessments, or simply volunteering within the community to show a commitment to the people you are wishing to conduct research around.
Limitations

Although this study adds to the literature surrounding CVE and high-risk Black men and delivers results to improve health behaviors, it did have some limitations. The first limitation was the number of participants, although 11 is an appropriate number for phenomenology this study is not generalizable to all Black men. Future studies should review violence exposure among various races and ethnicities, as well as explore violence exposure for men still residing in highly violent communities compared to those who have moved out. The second limitation is the self-reporting of information, participants could have chosen to withhold data to make themselves look or be perceived a certain way. Participants were informed to use pseudonyms for information or stories they wanted to share involving others, this could have been a barrier to interviewing previously incarcerated populations and potential concerns of oversharing and saying something that could implicate them, which could have made them hold back on responses. The third limitation was marginalized population recruitment. Because this study involves a very specific high-risk population, many men signed up but were difficult to get in touch with due to phone number changes, current street careers, and a general skepticism of strangers. This impacted the number of people who actually participated in the study as we had 17 men sign up but lost six due to the factors noted above. The fourth limitation of this study involved COVID-19, this study was developed prior to COVID-19 and was not designed to assess COVID-19 barriers but because questions were semi-structured and open, COVID-19 was brought into the conversation sinuously, as discussions of health took place. COVID-19 was also noted as a barrier to going outside with respondents merging COVID-19 social distancing guidelines and their individual standards for community safety in relation to going outside.
Conclusion

Community violence exposure, high-risk Black men, and health behaviors is a complex public health topic that needs further exploration. This study aimed to explore how violence exposure influences the health outcomes and behaviors of High-risk Black men living in the most violent neighborhoods of Chicago, Illinois. Through a phenomenology analysis, nine themes were discovered. Although this study did explore how high-risk Black men viewed violence in their neighborhood, it ultimately gave insight into areas of improvement that healthcare must deliver on in order to prevent adverse health outcomes and life shortages for high-risk Black men residing in highly violent communities. Healthcare must first target high violent communities and provide education on healthy behaviors to achieve optimal outcomes and ensure that health is measurable, whether it be through chronic disease management, healthy weight, and healthy behaviors. Not only does health need to be understood and measurable but also achievable. Public Health must support marginalized populations, particularly those with a lack of resources and provide alternatives for exercise and nutrition. Advocacy also plays a significant role in the fight for resources, as many resources have been provided to communities like grocery stores, but they are not constant and do not stay in these communities for long as violence erupts and increases.

The greatest and most important takeaway from this study would be the need for cultural competency-specific training for providers and methods on how to apply that to practice. This is indicated by a majority of participants feeling uneasy about provider knowledge about their community and displaying a lack of trust. Cultural competency training particularly for providers
in urban minority settings should have tailored specific training to address the needs of special populations within already marginalized communities like formerly incarcerated gang-affiliated Black men. Providers not only participate in training but be given the tools needed to apply pieces of training to their practice so that when they encounter a high-risk Black Male, they know how to deliver care in an unbiased, nonjudgmental manner.

Black men already have the lowest life expectancy and are frequently the victims of violent crime. When you add additional life experiences like incarceration or gang affiliation, Black men have an even bigger target on their backs as they face trauma, judgment, and uncertainty on a daily basis. With so many adverse experiences these men should be able to engage in healthy behaviors for health maintenance and as an outlet for stress. In order to combat health disparities, Public Health needs to invest in these issues and specifically advocate for communities that face greater resource challenges in life and are often overlooked in research.
REFERENCES


Ruel, E., Oakley, D., Wilson, G. E., & Maddox, R. (2010). Is public housing the cause of poor health or a safety net for the unhealthy poor?. *Journal of urban health : bulletin of the*


University of Chicago Crime Lab. (2016). *Gun Violence in Chicago.* Retrieved from https://urbanlabs.uchicago.edu/attachments/c5b0b0b86b6b6a9309ed88a9f5bbe5bd892d4077/store/82f93d3e7c7cc4c5a29abca0d8bf5892b3a35c0c3253d1d24b3b9d1fa7b8/UChicagoCrimeLab%2BGun%2BViolence%2Bin%2BChicago%2B2016.pdf


APPENDIX A: INTERVIEW GUIDE
Interview Protocol: Where I come from: Why CVE affects the health of African American men

Time of Interview:
Date:
Place:
Interviewer:
Interviewee:

(Briefly describe project) This interview explores African American men's experiences and how they perceive their health while living with exposure to community violence. Community violence exposure is defined as seeing someone shot with a gun, cut or stabbed with a knife, sexually victimized, mugged or robbed, threatened with a weapon or beaten up so severely that medical attention was required.

Chicago is one of the most racially and ethnically diverse cities and yet one of the most violent cities with homicide rates exceeding similarly sized cities such as New York, Houston, Philadelphia, and Los Angeles. Violence disproportionately impacts African American communities. With African American men having the most inferior health outcomes compared to other racial groups, it is important to understand African American men's health behaviors and how they perceive violence is essential for developing interventions to improve their health outcomes.

This research aims to understand and explore how community violence exposure impacts the health of African American men.

INTERVIEW QUESTIONS:

Let us get started. I’m going to start off with a simple question just to get our conversation going. Then, I’ll ask you a few more questions.

Remember, I’m interested in hearing about what you’ve experienced, so please give me a lot of personal examples and experiences. When you provide experiences, please do not refer to people by their real names. You can make up a fictitious name for that person or refer to them by their relationship to you. Remember, this is all about your personal experience. No information is too simple or too complicated.

Do you have any questions?

Alright. Let us start our discussion. Let’s talk more specifically about your experiences with community violence. Please try to give details and explain to the best of your ability about your experience within (community name): the more information you can provide, the better. I may also ask some probing questions in between your responses to understand your experience more.
A. Community Violence:

1. How would you describe your neighborhood and culture to someone who has never been there? Probe: Discuss how your neighborhood and culture have shaped you?

2. Do you see violence in your community? Probe: Describe what type of violence and whether it does or does not impact your daily activities? Do you generally feel safe in your neighborhood? Why or why not?

<table>
<thead>
<tr>
<th>OPTIONAL PROBES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Can you explain this more?</td>
</tr>
<tr>
<td>Can you give an example?</td>
</tr>
<tr>
<td>Can you think of anything else?</td>
</tr>
<tr>
<td>How does this make you feel?</td>
</tr>
<tr>
<td>How were you impacted?</td>
</tr>
</tbody>
</table>

[Optional Transition: Thank you. You’ve given me a lot of useful information.]
[Optional Transition: Ok, so we just talked about your personal experience with community violence. Now let’s talk about your health. Please provide details about your health status and practices.]

B. Health Maintenance:

3. How would you describe your health? Probe: Do you feel your best, why or why not? Is there anything about your health that you would want to change in the future?

4. Describe how you maintain your health? Probe: Does your neighborhood environment impact the way you maintain your health, why or why not?

<table>
<thead>
<tr>
<th>5. OPTIONAL PROBES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Can you explain this more?</td>
</tr>
<tr>
<td>Can you give an example?</td>
</tr>
<tr>
<td>Can you think of anything else?</td>
</tr>
<tr>
<td>How does this make you feel?</td>
</tr>
<tr>
<td>How were you impacted?</td>
</tr>
</tbody>
</table>
[Optional Transition: Thank you. You have given me a lot of useful information.]

[Optional Transition: Ok, so we just talked about your health. Now let’s talk about how you access healthcare providers. Please provide details about your experience seeking care.]

C. Healthcare Utilization:

6. Where do you seek care? Probe: Explain how you choose a healthcare provider when seeking preventative care?

7. When you see a healthcare provider, have they asked about your neighborhood setting?
   Probe: If so, what type of questions did they ask, please explain? If they did not what would you want your healthcare provider to know?

D. Healthcare Trust:

8. Do you trust healthcare providers? If you do trust health care providers, please explain why. If you do not trust your healthcare providers, please explain why not? Probe: How do you deal with this?

OPTIONAL PROBES

Can you explain this more?
Can you give an example?
Can you think of anything else?
How does this make you feel?
How were you impacted?
How were you impacted?

[Optional Transition: Thank you. You have given me a lot of useful information.]
[Optional Transition: Thank you. Were there any aspects you excluded?]

CLOSING:

Thank you for sharing with me today! We appreciate your help. I hope you have a great rest of the day!
APPENDIX B: DEMOGRAPHIC QUESTIONNAIRE
1. Are you male? ☐
2. Are you African American? ☐
3. What is your ethnicity?
   a. Hispanic
   b. Non-Hispanic
4. What is your age?
   a. 35-39
   b. 40-44
   c. 45 – 49
5. What is your marital status?
   a. Single
   b. Married
   c. Divorced
   d. Widowed
   e. Prefer not to respond
6. What neighborhood do you live in and how long have you lived in your neighborhood?

7. What is the highest level of education you have achieved?
   a. Never attended school
   b. Grades 1-8
   c. Grades 9-11 (some high school)
   d. Grade 12 or GED
   e. Some college or technical school
   f. College graduate
   g. Other (Please Specify)
   h. Prefer not to respond
8. Are you employed?
   a. Yes
   b. No
   c. Prefer not to respond
9. If so, how many hours per week do you work
   a. Less than 10
   b. 10 - 29
   c. 30 - 40
   d. 41 – 60
   e. More than 60
   f. Prefer not to respond
10. If employed, do you get benefits from your job?
    a. Yes
    b. No
11. What is your annual income?
   a. Less than $10,000
   b. $11,000 – $20,000
   c. $21,000 – $30,000
   d. $31,000 – $40,000
   e. $41,000 – $50,000
   f. $51,000 – $60,000
   g. $61,000 – $70,000
   h. $71,000 – $80,000
   i. $81,000 – $90,000
   j. $91,000 – $99,000
   k. More than $100,000
   l. Prefer not to respond

12. What is your household size?
   a. 1
   b. 2
   c. 3
   d. 4
   e. 5+
   f. Prefer not to respond

13. What type of household where you raised in?
   a. Two Parent Household
   b. Single Parent Household
   c. Foster Home
   d. Other
   e. Prefer not to respond

14. How you ever been involved in a gang?
   a. Yes
   b. No
   c. Prefer not to respond

15. Have you ever been incarcerated?
   a. Yes
   b. No
   c. Prefer not to respond

16. What us your annual household income?
   a. Under $20,000
   b. $20,000 – $40,000
   c. $40,000 – $60,000
   d. Over $60,000
   e. Prefer not to respond

17. Which best describes your living situation?
   a. Rent or own apartment or home
   b. Temporary/ transitional housing
c. Living with family/friends

d. Homeless

e. Prefer not to respond

18. Do you have you ever been diagnosed with any of the following: Obesity, High Blood Pressure, High Cholesterol, Diabetes, COPD, Cancer, Heart Failure, Drug/Substance Abuse, Alcohol Abuse, Asthma, Hepatitis, HIV/AIDS, Depression, Stroke or anything else?

19. Have you been to the Emergency Room in the last two years?
   a. Yes
   b. No
   c. Prefer not to respond

20. Have you ever been hospitalized in the last two years?
   a. Yes
   b. No
   c. Prefer not to respond
APPENDIX C: SEMI-STRUCTURE INTERVIEW QUESTIONS
RQ1: How do high-risk Black men perceive community violence?

1. How would you describe your neighborhood and culture to someone who has never been there? Probe: Discuss how your neighborhood and culture have shaped you?
2. Do you see violence in your community? Probe: Describe what type of violence and whether it does or does not impact your daily activities? Do you generally feel safe in your neighborhood? Why or why not?

RQ2: How do high-risk Black men maintain their health residing in high violent communities?

3. How would you describe your health? Probe: Do you feel your best, why or why not? Is there anything about your health that you would want to change in the future?
4. Describe how you maintain your health? Probe: Does your neighborhood environment impact the way you maintain your health, why or why not?

RQ3: How do high-risk Black men in high violent communities utilize healthcare?

5. Where do you seek care? Probe: Explain how you choose a healthcare provider when seeking preventative care?
6. When you see a healthcare provider, have they asked about your neighborhood setting? Probe: If so, what type of questions did they ask, please explain? If they did not what would you want your healthcare provider to know?

RQ4: Do high-risk Black men exposed to CV trust healthcare providers?

7. Do you trust healthcare providers? If you do trust health care providers, please explain why. If you do not trust your healthcare providers, please explain why not? Probe: How do you deal with this?
APPENDIX D: INFORMED CONSENT
Northern Illinois University

Consent to Participate in a Research Study

**Where I come from: Why CVE affects the health outcomes of African American men**

**Study Title:** Where I come from: Why CVE affects the health outcomes of African American men

**Investigators**

| Name: | Paris Thomas | Dept: | Health & Human Sciences | Phone: | XXX-XXX-XXXX |

**Key Information**

- This is a voluntary research study on how community violence exposure (CVE) impacts African American men's health and health behaviors in Chicago, Illinois.

- Community violence exposure (CVE) is defined as seeing someone shot with a gun, cut or stabbed with a knife, sexually victimized, mugged or robbed, threatened with a weapon or beaten up so severely that medical attention was required.

- This hour's study involves semi-structured in-depth interviews through video conferencing.

- The benefits include increasing knowledge in public health regarding the impact of community violence exposure on African American men's health; the risks include emotional and psychological distress on past experiences around community violence.

**Description of the Study**

The purpose of the study is to explore how violence exposure influences the health outcomes of African American men living in the low-income neighborhoods of Chicago, Illinois. If you agree to be in this study, you will be asked to do the following things:

Interviewed for an hour to an hour and a half on nine semi-structured questions aimed at gathering information about your experience in your community and your life experiences concerning the perceived impact of community violence on your health outcomes. Answer follow-up questions and share as many details of the experience as possible.

**Risks and Benefits**

While this study does not anticipate participants enduring any detriment or distress, the study has the following risks. First, given the nature of the proposed research, there are potential risks for the participants to experience emotional and/or psychological distress during the interview, given the context of interview questions, which may become distressing.

The benefits of participation are adding undiscovered knowledge in the field of public health regarding the impact of community violence exposure on African American men’s health and the potential increase of intervention effectiveness in high violent communities.
Confidentiality
• This study is confidential. Personal or identifying information provided by participants will only be seen by the researcher and identities will not be revealed to anyone outside of the study.
• The records of this study will be kept strictly confidential. Research records will be held in a locked file. All electronic information will be coded and secured using a password-protected file. Interviews will be audiotaped to help the researcher accurately capture your insights in your own words. The tapes will only be heard by the researcher for this study and destroyed after the report is published. If you feel uncomfortable with the recorder, you may ask that it be turned off at any time. We will not include any information in any report we may publish that would make it possible to identify you.

Compensation
You will receive the following compensation for your time: A $50 gift card that will be mailed to participants upon completing the interview.

Your Rights
The decision to participate in this study is entirely up to you. You may refuse to take part in the study at any time. Your decision will not result in any loss of benefits to which you are otherwise entitled. You have the right to skip any question or research activity, as well as to withdraw entirely from participation at any point during the process.

You have the right to ask questions about this research study and to have those questions answered before, during, or after the research. If you have any further questions about the study, at any time, feel free to contact the researcher, Paris Thomas, at Z1572040@students.niu.edu or by telephone at XXX-XXX-XXXX or Melani Duffrin at mduffrin@niu.edu. If you have any questions about your rights as a research participant that has not been answered by the investigators or if you have any problems or concerns that occur as a result of your participation, you may contact the Office of Research Compliance, Integrity, and Safety at (815)753-8588.

Future Use of the Research Data
After removing all identifying information from your data, the information could be used for future research studies or distributed to another investigator for future research studies without additional informed consent from you [or your legally authorized representative, if applicable].

Your signature below indicates that you have decided to volunteer as a research participant for this study and that you have read and understood the information provided above. You will be given a signed and dated copy of this form to keep, along with any other printed materials deemed necessary by the study investigators.
I give my consent to be audio recorded during the interview regarding my experience with community violence exposure on my health outcomes.

Participant’s Signature ___________________________ Date __________
APPENDIX E: BEHAVIORAL HEALTH RESOURCES
Behavioral Health Resources
Federally Qualified Health Centers

Federally Qualified Health Centers are community-based health care providers that provide care at a low cost on a sliding fee scale. Federally Qualified Health Centers offer a wide range of behavioral health services and programs to help individuals.

▪ **Southshore**
  - UIC - Mile Square Health Center - South Shore
    7131 S. Jeffrey Blvd 60649
    (312) 996-2000
- **Roseland**
  - Aunt Martha's Roseland Community Health Center
    200 E. 115th St 60628
    (877) 692-8686
  - Chicago Family Health Center - Roseland
    120 W. 111th St 60628
    (773) 995-3416
- **East Garfield Park**
  - ACCESS Madison Family Health Center
    3800 W. Madison Ave. 60624
- **West Pullman**
  - Chicago Family Health Center- Pullman
    570 E. 115th St 60628
    (773) 785-6800
- **Austin**
  - Circle Family Health Care Network - Parkside
    115 N. Parkside 60644
    (773) 921-9669
  - Circle Family Healthcare Network - Division
    4909 W. Division 60651
    (773) 921-8100
- PCC Austin Family Health Center
  5425 W. Lake 60644
  (773) 378-3347

- **Avalon Park**
  - UIC - Mile Square Health Center - South Shore
    7131 S. Jeffrey Blvd 60649

- **Riverdale**
  - TCA Health, Inc
    1029 E.130th Street 60826
    (773) 995-6300

- **Englewood**
  - Beloved Community Family Wellness Center
    6821 S. Halsted 60621
    (773) 651-3828
  - UIC - Mile Square - Englewood
    641 W. 63rd Street 60621
    (312) 996-2000

- **North Lawndale**
  - ACCESS Sinai
    2653 W. Ogden 60608
    (866) 882-2237
  - ACCESS Westside Family Health Center
    3752 W. 16th Street 60623
    (866) 882-2237
  - Lawndale Christian Health Center - Homan Square
    3517 W. Arthington 60624
    (773) 843-3002
  - Lawndale Christian Health Center - Ogden
    3860 W. Ogden 60623
    (773) 843-2718
- West Garfield Park
  - ACCESS Madison Family Health Center
    3800 W. Madison Ave. 60624
    (866) 882-2237
APPENDIX F: RECRUITMENT MESSAGING
Social Media Post:

Research study looking for **African American men** between the **ages 35-49** to participate in an hour study exploring how violence exposure impacts health outcomes and behaviors.

Must reside within one of these Chicago neighborhoods:
- Southshore
- Roseland
- East Garfield Park
- West Pullman
- Austin
- Avalon Park
- Riverdale
- Englewood
- North Lawndale
- West Garfield Park

$50 Gift Cards will be provided upon study completion.

**To learn more, contact the principal investigator of the study, inbox, or email Paris Thomas, at Z1572040@students.niu.edu.**