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Shook Ones: Understanding the Intersection of Nonfatal Violent Firearm Injury, Incarceration, and Traumatic Stress Among Young Black Men

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Abstract

Violent injury is a leading cause of death and disability among young Black men, with the highest rates occurring in low-income urban populations. Hospital-based violence intervention programs (HVIPs) offer a promising opportunity to address the biopsychosocial factors that adversely affect this population. However, there are major gaps between the needs of young Black male survivors of violent injury and the forms of care provided by HVIPs. Patient-centered outcomes research provides a useful mode of inquiry to develop strategies to decrease these differences. Care for survivors, including treatment for traumatic stress disorders, must be reconceptualized to center the lived experiences of young Black men. This paper qualitatively explores how these survivors of gun violence express symptoms of traumatic stress and the ways in which their narratives can inform the implementation of the biopsychosocial model in HVIPs. A phenomenological variant ecological systems theory framework was used to analyze participant narratives to aid in understanding their symptoms of traumatic stress and post-injury affective changes as both psychologically and socially important experiences. Such insight may inform changes to HVIP practice to address persistent health disparities related to violence.

Keywords

intentional injury, behavioral issues, male-on-male violence, risk factors, violence, men's health interventions

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Young Black men experience a disproportionate burden of violence-related death and disability, largely due to firearm injury. Homicide is the leading cause of death among Black males between ages 15 and 34 (Centers for Disease Control and Prevention National Center for Injury Prevention and Control, 2020). In 2018, nearly 14,000 individuals were killed in firearm-related homicides, which made up 74% of all criminal homicides in that year. Black males between ages 15 and 34 experience firearm homicide deaths at rates over 10 times higher than corresponding white males (Centers for Disease Control and Prevention National Center for Injury Prevention and Control, 2020). Approximately half of young Black men who survive a violent trauma are hospitalized for a similar penetrative injury within 5 years. Among this population, 20% will die from their wounds (Rich, 2009). In addition to homicide, over 100,000 individuals suffered nonfatal

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injuries from firearm-related violence (CDC, 2020). These survivors experience significant challenges to their physical, psychological, and social well-being that are exacerbated by significant barriers to treatment (Hanson et al., 2010; Kazlauskas, 2017; Motley & Banks, 2018; St Vil et al., 2018; Vella et al., 2019; Wong et al., 2007).

The causes of interpersonal violence between Black men living in socioeconomically deprived urban environments are complex and vary by context. Like other health disparities, violent injury is related to the interaction of structural, local, and individual factors including institutional racism, mass incarceration, poverty, neighborhood disadvantage, as well as social and individual trauma (DaViera & Roy, 2019; Johnson, 2019; Pager et al., 2009; Voisin, 2019; Wacquant, 2010). Interpersonal violence itself contributes to further traumatization, community disruption, and new forms of social interaction that produce additional violence (Duck, 2015; Motley & Banks, 2018; Rich & Grey, 2005; Voisin, 2019). These relationships are evidenced by the high rates of repeat violent victimization recognized in hospitalized trauma patients, with the average rate in the United States being approximately 35% and reaching up to 65% (Cooper et al., 2000; Richardson et al., 2016). Authors such as Anderson (1999), Rich and Grey (2005), and Duck (2015) have proposed conceptual models for how direct violent victimization can result in reinjury. Nuanced understanding of the mental health consequences of violent injury among young Black men can better inform health services to support survivors and reduce repeat violent injury.

Approaches to Researching Gun Violence

The combination of the biopsychosocial model of health and phenomenological variant ecological systems theory (PVEST) provides a useful framework to analyze how individual experiences with violence are related to social processes. Hargarten et al. (2018) characterize gun violence as a biopsychosocial disease; this approach acknowledges the complex relationships between biological, psychological, and socio-ecological processes. The authors emphasize the importance of considering pre-, peri-, and post-injury factors, which necessitate solutions across numerous levels of intervention. The biopsychosocial model requires that research is informed by a holistic set of data that reflects the lived experiences of survivors. This framework recognizes the ways in which direct victimization, perpetration, indirect exposure to violence, and institutionalized violence are linked as consequences and causes of trauma endured throughout the life course, socially, and intergenerationally (Brackney-Wheelock, 2017; Johnson, 2019; Motley & Banks, 2018; Voisin, 2019).

PVEST is a variant of Bronfenbrenner's (1979) ecological systems theory, which links individual meaning-making processes to multiple levels of context and group membership to understand identity development, responsive behaviors, and outcomes throughout the life course (Smith & Patton, 2016; Spencer, 1995, 2006, 2008; Velez & Spencer, 2018). This theoretical perspective provides an integrating framework for understanding an individual's development in the context of "power dynamics and interconnected systems [that] lead to differential outcomes within socially constructed categories like class, race, and gender" (Velez & Spencer, 2018). This approach is useful in considering how previous exposures to violence and homicide may alter the ways in which poor young Black men living in urban areas respond to and express traumatic stress. This study employs PVEST to analyze the psychosocial consequences of violent victimization for young Black men treated in a hospital-based violence intervention program (HVIP) in suburban Maryland to improve social service and mental health provision.

Effectiveness of HVIPs and the Need for Patient-Centered Outcomes Research

According to the Health Alliance for Violence Intervention, HVIPs are "multidisciplinary programs that identify patients at risk of repeat violent injury and link them with hospital- and community-based resources aimed at addressing underlying risk factors for violence" (The Health Alliance for Violence Intervention, 2020). These resources vary by HVIP but typically include bedside engagement in the hospital after admission for violent injury, outpatient psychological counseling, case management, mentoring, and connections to education, employment, and housing services (HAVI, 2020; Purtle et al., 2013).

HVIPs are often theoretically framed by the Health Beliefs Model (HBM); this paradigm posits that people alter risky health behaviors as they better understand their decisions, the consequences of those decisions, and strategies for prevention (De Vos et al., 1996, Evans & Vega, 2018). For HVIPs, this idealized HBM intervention occurs during a "teachable moment" after an individual is hospitalized for acute violent injury. It is during these moments that a survivor is offered and provided social services that enable them to identify and modify factors that put them at risk for recurrent injury (Bonne & Dicker, 2020; Goldman, 2020; Johnson et al., 2007). However, HBM frameworks face important limitations. Many factors that correlate to recurrent violent injury among this population, such as history of criminal justice engagement, unstable housing, substance use, and participation

in informal economies, are related to complex individual, interpersonal, and social processes such as mass incarceration, redlining, and other processes of institutionalized racism (Johnson, 2019; Rich & Grey, 2005; Richardson et al., 2016; Voisin, 2019; Wacquant, 2010). Because recurrent violent injury is interrelated to processes of interpersonal and structural violence, interventions that address root causes of violence and injury offer advantages over behavior-based approaches (Juillard et al., 2016). Using a PVEST perspective allows analysis of how HVIPs frame health crises and provides an opportunity to examine the therapeutic approaches provided by these programs. This perspective emphasizes subjective experiences in numerous contexts, focuses on the life course, and holistically conceptualizes contributing factors to injury, thereby offering a means to develop new paradigms for care for HVIPs.

HVIPs have been reported to reduce both trauma and criminal justice recidivism (Cooper et al., 2006; Shibru et al., 2007); however, there is limited and mixed evidence to support their effectiveness (Affinati et al., 2016; Chong et al., 2015; Cooper et al., 2006; Dicker, 2016; Juillard et al., 2016; Purtle et al., 2013; Smith et al., 2013). Despite their increased risk for emergency department visits for violent injury and participation in HVIPs, there is dearth of qualitative literature on the effectiveness of HVIPs, specifically psychological care, from the perspectives of young Black male survivors of violence (Monuteaux et al., 2017).

HVIPs frequently incorporate cognitive behavioral therapy (CBT) into service models that guide care for survivors of violence while prioritizing varied psychosocial health outcomes (Karraker et al., 2011; Monopoli et al., 2018). However, HVIPs have no common therapeutic model or set of outcomes that have been consistently developed, measured, or validated using standardized tools (Monopoli et al., 2018). No comprehensive, evidence-based, and trauma-specific therapeutic model has been developed to ameliorate traumatic stress among violently injured young Black men (Monopoli et al., 2018). In the absence of the appropriate population-specific model, the HVIP in the study used the Men's Trauma Recovery Empowerment Model (M-TREM). M-TREM, which was developed as a trauma-specific intervention for incarcerated and substance-abusing populations, as well as other population-specific CBT interventions, effectively reduce post-traumatic stress (e.g., Bosch et al., 2020; Nancy Wolff et al., 2013; Roberts et al., 2015; Wolff et al., 2015). While violently injured young Black men often experience incarceration and substance abuse, the present lack of a comprehensive therapeutic model for this population presents a significant gap in evidence-based treatment and understanding of interpersonal violence (Richardson et al., 2016).

To provide meaningful services, HVIPs must center and emphasize the perspectives and priorities of young Black male participants as therapeutic models and programs emerge. Patient-centered outcomes research (PCOR) offers a viable means to access the unique perspectives of patients and their social networks; these data can change and improve the pursuit of clinical questions (Frank et al., 2014; Snyder et al., 2013). PCOR stresses the importance of research "informed by the perspectives, interests and values of patients" throughout the entirety of the research process (Snyder et al., 2013). Such research directly informs evidence-based practice to improve the quality of services provided to young Black men who survive violence.

Methods and Data

Design

A *Researcher 2 Practitioner Fellowship* funded by the Center for Victim Research and a *PCOR Seed Grant* from the University of Maryland, Baltimore Patients Program provided the necessary financial support for the HVIP Research Director and the HVIP violence intervention specialist (VIS) to serve as co-investigators on this project. These grants were designed to determine how survivors of violent injury defined healthy outcomes and how they envisioned strategies to empower them in healthcare decision-making processes. This research emphasized qualitatively exploring the intersection and impact of the health care and criminal justice systems in the lives of violently injured young Black men, with specific attention to the collateral consequences associated with both a felony record and violent injury. In accordance with a PCOR approach, this study explores the narratives of these men in order to understand how participants describe their mental health—psychological, affective, behavioral, and social—experiences related to violent injury with the explicit goal of identifying opportunities to inform the types of services provided.

Subjects were drawn from low-income young Black male survivors of violent nonfatal firearm injury who were ages 18–30 and participating in HVIP programming ($N = 11$). A focus group and individual in-depth semi-structured interviews were utilized to generate the data. The singular focus group, composed of six participants, was conducted to determine a range of survivors' experiences, level of shared experience, differing needs for services, and possible differences in psychological well-being after discharge. The findings from the focus group directly informed the research questions and instruments used during the ensuing in-depth qualitative interviewing phase of the project. Each survivor was interviewed one time, with interviews lasting approximately 60 min. The interviews

were also filmed and recorded as part of a digital storytelling project (Richardson & Bullock, 2019). Semistructured interviews were used to provide an understanding of the complexity of psychological and social experiences relating to injury. Survivors were asked open-ended questions regarding the day they were injured, their experiences at the HVIP, their psychological well-being, and their perspectives on what changes would best allow the program to meet their needs. Participants were paid $50 cash and received free Uber rides to and from the interview location. The choice to offer this mode of transportation was informed by best practices for trauma-informed research with young Black men who have survived violent injury (Richardson et al., 2020).

There are notable methodological considerations and challenges to conducting research with young Black men who have sustained a violent injury. Practically, these challenges included scheduling and coordinating the focus group and interviews between survivors and the research team. The intersectional relationships of race, gender, class, and violent injury contribute to compounding challenges. These factors are exacerbated by fatigue, traumatic stress, and sedation, which are common after violent injury (Liebschutz et al., 2010; St Vil et al., 2018). The VIS played a key role in the recruitment for and facilitation of individual interviews and the focus group. This approach was chosen because of the VIS's use of a relational model of engagement and his established trust and rapport with survivors (Wical et al., 2020). By sharing his personal history of surviving violent assault and experiencing traumatic stress, the VIS provided a shared language to discuss survivors' own physical and mental health. These commonalities with survivors were essential in fostering trust in the program; this was beneficial in achieving sustained participation in the research and program. The VIS has formal training in M-TREM, trauma informed care, motivational interviewing, certification from the CITI program for research with human subjects, and received extensive mentoring from the program director.

Participants and Setting

The inclusion criteria for the study were (1) survivor of a gunshot wound; (2) history of criminal justice involvement (incarceration, probation, or parole); (3) participation in the HVIP; and (4) at least 18 years old. Five of the 11 participants (45%) had experienced 2 or more hospitalizations for a violent injury. All of the survivors had been treated at the same level II trauma center in Maryland. Each member of the sample also participated in the programming offered by the HVIP. The hospital is located in a suburban region of Maryland, approximately 1 mile from the District of Columbia's northeastern border. Participants in the HVIP and the study were residents of Washington, DC or Maryland. Some participants resided in communities where they were chronically exposed to high levels of structural and interpersonal violence, and as a result, many experienced a continuum of trauma over the life course. The survivors who participated in HVIP programming were representative of the patient population that received care for violent injury; relevant sociodemographic information is summarized in Table 1 (from the hospital trauma registry). All participants in this study were low-income and lived in public or section 8 housing. Importantly, several survivors also experienced housing insecurity due to "bar notices," which legally barred them from the apartment complexes or housing projects where they had previously lived.

Table 1. Sociodemographic Information of Patients Treated for Violent Injury.

Sociodemographic Information from Trauma Registry (%)	
Gender	
Male	87.0
Female	13.0
Age	
0–12	0.1
13–18	7.2
19–30	44.3
31–50	36.1
51–65	9.5
>65	2.8
Race/ethnicity	
Black	75.0
White	6.4
Hispanic	12.4
Other/Unknown	6.2
Mechanism of injury	
Gunshot	31.6
Stab	30.6
Assault	37.8

The HVIP where the study took place was not formally evaluated for its effectiveness in reducing trauma and criminal justice recidivism. In the first 16 months of the HVIP, 116 participants received psychosocial services. Only one survivor returned to the hospital for a violent injury during this time period. This less than 1% violent trauma recidivism rate is in stark contrast to the pre-HVIP rate of 32%. Seventy percent (70%) of program participants ($N = 71$) were involved in the criminal justice system under community supervision (primarily probation). Only seven (6%) of these participants committed technical violations of their probation (i.e., testing positive on drug urinalysis, allowing ankle monitor to shut off). Two participants (2%) from the total population of program participants were arrested and convicted for new offenses. This is notably lower compared to a

longitudinal 9-year national study on criminal justice recidivism, which found a recidivism rate of 45% in men in the first year following release from detention (Alper et al., 2018).

Procedures

Institutional Review Board approval was obtained through the University of Maryland, College Park. Survivors gave written and informed consent for the focus group. The consent process was also completed for their interviews that were filmed and recorded as part of the digital storytelling project. The researchers utilized a "spirit of informed consent" approach (Fluehr-Lobban, 1994), as they repeatedly asked interviewees throughout the research process if they were comfortable with the dissemination of their narratives in the film. This was particularly important due to the sensitive nature of the questions asked during both the focus group and interviews. Survivors were given the option to have their interview removed from the project at any point. The duration of the interviews ranged from 45 to 60 min. The research director of the HVIP was the primary interviewer with cofacilitation of the focus group by the VIS. Both interviewers were Black men with high levels of trust and rapport with the survivors; they have extensive training in trauma informed care. Additionally, the research director has significant experience with researching violent injury and trauma among young Black men. The positionalities of the research director and VIS were vital in facilitating conversations regarding survivors' experiences of injury and mental health. The interviewers facilitated these conversations in an informal manner and displayed clear and nuanced understanding of the survivors' lives.

Data Collection

The duration of the study was approximately 15 months; this includes recruitment and facilitation of the focus group and interviews. There was a high level of retention, as only one survivor did not continue participation in the project. Upon obtaining consent, the semistructured interviews and focus group were conducted at the University of Maryland, College Park. The guide for the semistructured interview explored the lived experiences of violent victimization, individual and community-level criminal justice involvement, family reactions to injury, experiences of traumatic stress, and barriers to care. Responses had significant variation in depth and clarity depending on the survivors' level of comfort and ability to discuss each question. Individuals were not asked to share any specific details of current and open criminal justice cases. Sample questions for topics covered in the focus group and interviews are included in Table 2.

Analysis

Upon transcription, an iterative coding strategy was utilized to determine emerging codes and themes among participants. This emergent thematic analysis did not allow the use of a priori codes other than symptoms of traumatic stress disorders, as defined by the Diagnostic and Statistical Manual 5th edition (DSM-V). This approach was chosen to allow emergent themes regarding how survivors express their mental health and post-injury experiences to serve as the primary analytical categories. The codes relating to DSM-V diagnostic criteria were used to highlight the nuanced ways that survivors discussed their mental health as both psychologically and socially dependent experiences.

Dedoose qualitative software was used for data analysis. A codebook was developed based on recurring themes throughout the transcribed interviews. The research team discussed each code and reached consensus on how codes should be applied. Codes that were not unanimously agreed upon were not used. Formal definitions and representative cases were determined prior to the final coding process; this allowed the codebook to be iteratively modified to reflect changing conceptualizations of themes and relationships between codes. Generated codes included traumatic stress experiences, masculinity, criminal justice involvement, structural barriers to services, importance of fatherhood, substance use, and participation in the HVIP. Data saturation was reached after the eighth interview; the additional interviews were analyzed to ensure no new information could be garnered. The results from the data analysis were shared with all participants who were able to be contacted; this was done in order to ensure that the findings reflected their experiences.

Results

Participant experiences of traumatic stress symptoms included hypervigilance, avoidance, sleep disturbance, irritability, isolation and distrust, spirituality, and violent injury serving as a "wakeup call" for a change in the survivor's life. Several themes are consistent with the literature descriptions of traumatic stress among this population (Liebschutz et al., 2010; Rich & Grey, 2005; Smith & Patton, 2016). Patients described these experiences as influencing their psychological recovery from trauma, ability to maintain social relationships, and HVIP engagement.

Hypervigilance

Survivors emphasized how getting shot affected their sense of safety in differing social contexts. They explained

Table 2. Sample Questions from Focus Group and Individual Interview Guides.

Focus Group	
Topic	Sample question
Social Context of Violence	Is there a code of the street, and if so, what are the codes?
Gun Violence Reduction	What do you think could be done to decrease the rates of gun violence in the area?
Physical Consequences	Since you have been injured how has your life changed physically?
Changes to Mental Health	Have you experienced changes to your mental health after injury?
Coping	What do you do to cope with these feelings?
Experience at HVIP	What was it like when you were first in the hospital and contacted by the program?
HVIP Services	How could services be changed to better meet your needs?
Qualitative Interviews	
Topic	Sample question
Lived Experiences of Violent Injury	What was going through your mind once you were hit (shot)?
Criminal Justice Involvement	Have you ever experienced any difficulty in finding a job due to a criminal record?
Family Reactions to Injury	How did your family react to you being injured?
Barriers to Care	What has been the biggest difficulty in receiving the services you needed?
Experiences of Traumatic Stress	Have you experienced any nightmares, flashbacks, or changes in mood?

that these experiences of hypervigilance were profoundly impacted by their return to the same neighborhoods and social contexts in which they were injured. Biggs, a 17-year-old who was shot 8 times, noted his comfort level in his neighborhood before and after his injury,

> Before I was grooving but now it just be like, everything, walk pass me, anything, you looking, anything, everything. Before I got shot I just be jolly, I wasn't thinking nothing but now it is just being on everything. Cars, everything, people, everything. They got they hands in they jacket, I be looking at all that.

Survivors highlighted how hypervigilance may reduce a patient's ability to receive services. Lo, a 23-year-old survivor, explained,

> I am sitting in the lobby, at first I was comfortable, I was sitting in the lobby just talking to my girl, I get to looking around and I just, I started judging myself, I am like you are too comfortable now. You feel me, so, I didn't even wait for the nurse to come call my name, we just went right back out. That is how bad it got me, you feel me. I was just thinking like anybody could do anything right now.

This sentiment was echoed by Slim, he noted a preference for care received off-site from the hospital.

> It'll be much better if the program (HVIP) were up here (on university campus) cuz then you don't have nothing to worry about, you can go somewhere, you ain't gotta worry about looking over your shoulder, looking around every five minutes, really gotta watch everybody around you and stuff like that when you go to [the hospital]. It'll be better if you could just go to campus, the hospital is not safe.

Some survivors clarified that they had experienced hypervigilance before being injured. The prevalence of traumatic stress symptoms prior to injury was frequently associated with chronic exposure to violence during childhood and adolescence—including witnessing the deaths of close family members. Lo, who as an adolescent, witnessed his cousin die from a gunshot wound, and noted that he experienced symptoms of hyperarousal from this incident. Lo explained,

> We was kind of more, just like stuck. Because I was like 14 years old so, when he got hit, uh, we heard the gunshots, came up stairs, ran upstairs, we was in the basement, ran upstairs, and we just seen him, right there. And he was like gasping, gasping, gasping, and then he just went stiff, like he just went. Like it was like a cold feeling in the room, he just went stiff. All of us, we too young, you know what I am saying, we ain't even call the police we just called his mom. His mom, she drove all the way there, you feeling me, called the police and then they pronounced him dead right there.

Lo noted that the untreated trauma from this event was compounded by his recent injury,

> If I couldn't see the whole room, I wouldn't be able to sit there and be comfortable, you feel me like, like every time somebody walk in there, I would be in McDonalds, somebody would walk in, and I am always thinking like, do I know you, why are you looking at me so long. . .But then afterward my injury, it just got bad.

Avoidance of External Reminders

Survivors noted avoiding external reminders and triggers to prevent re-experiencing unwanted traumatic memories. For some, avoidance also served as a protective strategy against repeat victimization. They stated that the primary way in which they sought to reduce the severity of their symptoms required a change in their previous routines and peer groups. Even after receiving services from the HVIP, a focus group participant remarked that he still would not leave his home,

> I'm still doing the same thing I do when I be leaving here. And that is really nothing, I'm in the house. Doing nothing, for real.

Other survivors agreed with this protective strategy, and another focus group participant explained,

> Like just stay out of the neighborhood, stay lowkey, and just don't go in drama no more and stay out of bad neighborhoods that will happen again and all that.

Survivors' feelings about their neighborhoods and the social context in which they were injured are complex, as some survivors felt most comfortable in their neighborhood despite wanting to avoid external reminders associated with being shot. Slim, a 29-year-old who was shot in the chest and had been recently stabbed 12 times in the head, face, ribs, and back, stated,

> I am right back where I got shot. I am around the same people, like you think, like I said, my neighborhood is one of the neighborhoods where everybody grew up with each other so, I am going around where I am comfortable around.

The external reminders of being violently injured were not limited to survivors' neighborhoods, as they also reported hesitancy to return to the hospital for mental health counseling. Sonny, a 27-year-old survivor of three gunshot wounds, described that he was only able to visit his brother once during his brother's hospitalization for a gunshot wound. His brother was shot 2 weeks after Sonny was shot and treated in the same hospital. Sonny explained being retraumatized visiting the hospital,

> I visited one time in that hospital man, one time. Just because I couldn't, it just hurt bruh, it was just like man, his injuries was a little more severe than mine. . .Man, he was shot 5 times, twice in the face, once in the trachea, you know what I am saying, two in the chest, one in his lung can't come out. . .I thought my brother was going to have a hole in his throat. . .we are really losing now, this is, this is a loss.

Sleep Disturbance

Survivors reported serious changes in their ability to fall asleep and their quality of sleep. T.O. explained,

> Yeah, I have trouble sleeping, sweating, sweats, and when I do sleep, I sweat in my sleep, nightmares.

Sonny had similar experiences with cold sweats and noted the lack of information he was given on possible symptoms he might experience,

> I ain't even know that it would react that fast but that is what I was experiencing immediately, day one out of the hospital.

The psychological discomfort that arises from an inability to sleep coupled with the lack of consistent access to therapy contributed to polysubstance abuse, as survivors attempted to regulate their changing emotional states and sleeplessness. Sonny highlighted the inseparability of these factors,

> I try to like do what we talk about in the group (counseling) is, you know coping methods and I am working on adjusting my negative coping methods into more positive coping methods. . .I might be up two days straight, I won't sleep at night. . .it's not that I am scared to go to sleep but it is just like, I am so anxious, I am so turned up, I need something to calm down, let me go hit this J (marijuana). . .let me go drink this Seagrams (liquor). . .let me go hit this boot (intravenous injection). . .hit the molly. Those coping methods right there, I am trying to figure out a way to flip that.

Survivors also emphasized how the rapid discharge from the hospital and return to the neighborhood of their injury impacted their ability to sleep. Many survivors returned to their neighborhoods within 24–48 hr after being treated for a gunshot wound. Tip stated,

> Going straight back out there, like ain't nothing happened, man it was heavy, man. It was heavy. That is why all my thoughts was war time. I couldn't sleep, none of that.

Increased Irritability

Multiple survivors described profound changes to their mood and behavior, with feelings of increased anger being the most common and harmful to their well-being. Smokey explained, "Like my anger was worse, like everything was more on a different level. But the anger was at its most high." Tip reiterated this sentiment, "My attitude, definitely. Um, my eating habits, my breathing, my anxiety. Mainly anger though." These changes were contrasted with the pre-injury ability to control their mood, Slim

clarified, "A lot of frustration, attitude. Like, different stuff, like, before I got shot you couldn't really get to me about nothing for real. But, now like a lot of stuff get to me. Like everything. I've been more irritable."

Survivors also noted how increased irritability and loss of emotional regulation caused issues for their caregivers who were not accustomed or familiar with these symptoms. Lo elucidated these experiences by describing how his parents' movements inadvertently reminded him of the person who shot him, "If I was sleeping and somebody came in the room without knocking, like I would just spaz out on them, I got mad at them. . .like it is the same instance from that night I got shot, somebody crept around and hit (shot) me. . .if they (parents) was bringing me food or they (parents) was coming in there to turn a light off or something and I just woke up and they was in there, like I don't know, like I was spazzing out."

Smokey noted his initial desire to retaliate against his victimizer, which was exacerbated by his increased irritability. Smokey explained, "And the things [the VIS] was telling me was, straight, you know control my anger and stuff, and the thing I had after I got shot was just anger, I couldn't trust nobody, and I was just seeking murder, like I wanted revenge real bad." However, because of his trust and relationship with the VIS, Smokey utilized coping skills and therapy to decrease his feelings of anger.

Affective Experiences After Injury

While survivors did report symptoms that are clearly defined by the DSM-V, they also expressed experiences relating to their injuries that are not delineated in formal definitions.

Isolation and Distrust

Survivors described self-imposed forms of social isolation as necessary coping mechanisms to combat their irritability, loss of emotional regulation, and decreased behavioral inhibition. Survivors perceived social withdrawal as a mechanism of reducing harm to their family members. Cain explained,

> When I am in like a depressed type of stage and I don't, I don't want to talk to anybody. Not even my family, so it's like, I am going to just shut everybody out. At a certain point in time, until I get myself together. And I know that is not always right to try and just do things on your own because that is, that is not how it always works. So, basically, I tried to just stay away for a while, try to work on myself and my anger.

Isolation was a particularly salient experience in cases where survivors did not have friends or family members who were able to care for them. Slim highlighted how the dearth of viable social support restricted his ability to share his experiences of traumatic stress, "Because I am from where you don't talk about shit. Everything is omerta (code of silence), keep it quiet, stay to yourself with it. You hold it in. You know what I am saying, I never had no father. I don't know about talking to another man about me."

Trust and distrust also powerfully influenced their experiences of traumatic stress. Slim further explained how the loss of his close friends to incarceration and being victimized by close friend who stabbed him multiple times influenced his lack of trust of peers,

> I don't trust nobody. I don't really, like my, there is no way I can trust you, there is no way I can trust you. . .I can fuck with you, but can't trust you. . .I ain't going to hold nothing back as a friend, you can be my friend or whatever, you know what I am saying, we can be cool, but I ain't about to trust you though.

Smokey was also shot by a close friend and expressed a similar experience,

> There is no way to trust them once your loyalty is broken, it's hard to trust somebody ever. . .you put your trust in at one point in time, yeah that was my friend. But he snaked (betrayed) me out over something, so it's like, how can you trust anybody?

The development of a trusting relationship between patient and practitioner is essential for HVIPs to successfully address the traumatic stress and mental health challenges of young Black male survivors of violence. Social isolation and distrust may be initial barriers, as Tip described, "Trust nobody. Nobody. Even with y'all (HVIP staff), when y'all called me, I was like trust nobody." Despite increased distrust of institutions and individuals after their injury, participants had a high level of trust in the VIS because he had a shared lived experience with survivors. Wall stated, "I only trust Chris (VIS) because he's just like me, he been through the same things I been through, if he can do it then I can do it ."

Although Slim experienced intense feelings of distrust, he explained that he was willing to work with the HVIP to improve his life for his daughter. He stated,

> I been thinking about my daughter man. . . I would be fucking her up, you know what I am saying (by not addressing trauma), like I don't got it all for her, as far as me. Not financially, not nothing like that, just as far as my emotions, my mental, for her. If they say that this can help me on them type of times, then I am all in, you know what I am saying.

Spirituality

Survivors highlighted the multiple ways in which spirituality shaped their experiences of traumatic stress. Spirituality frequently served as a coping strategy, with one survivor noting that he attempted to "pray off" any intrusive thoughts. Cain explained,

> I am just going to stay prayed up. And that is the most I can do, just stay prayed up. And just like I said, just rebuke all the bad thoughts that is coming into my mind, that comes, rebuke them. Just start to think positive and that is what I have been doing.

Several study participants reported that negative thoughts included retaliating against the person who had victimized them. For individuals with a limited support system, praying served as an important mechanism to stop thoughts of retaliation, decreasing the likelihood of further harm to themselves and others. Sonny stated,

> Honestly, I wanted to hit back (retaliate). That is what was going through my mind, impulsive, just reaction. I already knew what was going on in my situation, already knew what it was in for, what I was doing was, it was just, that was the only reaction to it.

However, he did not retaliate, he received spiritual support from his family in the hospital that allowed a reframing of his survival as a spiritual blessing. He explained,

> My grandma, she was coming through and was disclosing, just you know like, blessings. 'You just don't know, you just don't know,' like that is what she was telling me. She was like, 'you just don't understand, you know what I mean, like how amazing [God's] hand is and how he is over you right now,' you know what I am saying. And here you are, you know you made a mistake and that was the most comforting thing I could ever hear, to acknowledge right there, from my grandmother.

Spirituality enhanced survivors' efforts to change their lives through participation in the HVIP—specifically their relationships with the program staff such as the VIS. Smokey described his experience, "I feel like God put that somebody in my life that I needed to realize, to listen to, something I never had. So, that's how I took it, how I look it. I ain't never had nobody trying to keep me on the positive route." He further noted that he was particularly receptive to trying to change his life because of his injury, "Any time something real, real, like a situation like you getting shot, stabbed. . . you make it through it, that's God trying to tell you something. He trying to tell you to slow down, he trying to tell you, you blessed."

A Wake-Up Call

Survivors reported that their violent injury and resulting traumatic stress disorders were defining moments in their lives. Despite feeling angry and desiring to retaliate with violence, Cain highlighted that seeking revenge would not benefit him,

> I was thinking like, I am going to kill him. I am going to kill him. . .it was just like, dang, like, maybe, like, you should, like, take this as a lesson learned. . .like, a wake up call. Yeah, a wake-up call. . .The path I was going down, like I wasn't, I am not an innocent person. I wasn't just, oh, I am innocent, I was doing everything right. I wasn't like that, so it's just like damn. Like, you just gotta wake up. You know, just take life more serious.

Not all survivors explicitly indicated that they viewed their injuries as a "wake up call"; however, participants often stated that they had been given a second chance to make changes in their lives. All survivors who had children emphasized that maintaining their safety and providing a better life for them was a primary reason for changing their lifestyle. Smokey explained,

> Yeah I have a daughter, but I was chasing the streets cuz I am thinking, man this street money going to take care of her, but for how long? That is the question I never answered. So, once I finally answered that question, it was too late. . .So it's like, instead of going through that revolving door and keep going back in circles every day or whatever, whatever. Slow down. Be a father first. . .[My daughter] changed that. Before my injury I wasn't worried about nothing. I was a loose screw. Like, I wasn't even thinking. Like, a situation, altercation could happen and the first thing I want to do is react how I know. But now, once I had her and met my baby momma, it's like everything I started thinking more. So, once I started thinking more, it was like, you doing something you never did, you thinking. Shouldn't that tell you something? So, I started paying attention to what was more in my gut then what was really on the mind.

After experiencing a "wake up call," Slim clarified that an essential part of providing a better life for his daughter included addressing his traumatic stress symptoms,

> Because I ain't talk to nobody after I got shot. . .[my grandmother] is like, I don't act the same since the situation. . .I was down (depressed). I had to learn how to walk again, couldn't pick my daughter up, can't pick my daughter up, in my arms, I can't hold her. My daughter notices it too. She want me to pick her up. I leave out the house, when I leave out now, if I go out, she don't want me leaving. I get a call like two seconds after I go out the door, I had to tell her I am coming back, I just told her I was coming back before I went out the door but she is crying. That shit fucks me up.

Discussion

This study advances previous efforts to place the experiences of young Black men who survive violence into context (Fader, 2013; Rich & Grey, 2005; Smith & Patton, 2016). Thematic analysis of participant interviews and the focus group identified psychological and behavioral impacts of injury—including hypervigilance, avoidance, sleep disturbance, and irritability—consistent with the literature on traumatic stress disorders (Boccellari et al., 2007; Corbin et al., 2013; Greenspan & Kellermann, 2002; Rich & Grey, 2005; Smith & Patton, 2016). These align closely with the DSM-V diagnostic criteria B-E of avoidance, intrusion symptoms, negative alterations in cognition and mood, and alterations in arousal and reactivity for post- and acute stress disorders (American Psychological Association, 2013; Smith & Patton, 2016). Participants also describe experiencing isolation, spirituality, and a "wake-up call," which are consistent with existing literature (Liebschutz et al., 2010; Rich & Grey, 2005; Smith & Patton, 2016). These phenomena—symptoms of traumatic stress, altered relationships to others, and new forms of meaning making (e.g., spirituality) — demonstrate the relationships between psychological and social impacts of violence.

Psychosocial Well-being and Reinjury Risk

Participant experience of violence suggested important interactions between psychological and social impacts of violence occurring in domains of the self, intimate relationships, and place. Analyzing narratives through the lens of PVEST provides an integrating framework for how the lived experience of violent injury becomes incorporated into a survivor's identity, thoughts, feelings, relationships, and ways of existing in the world (Smith & Patton, 2016; Spencer, 2008). In relation to the self, outcomes of violent injury, particularly feelings of anger, intrusive thoughts, and sleep disturbance, disrupted participants' sense of control over themselves and their safety. Similar to observations by Smith and Patton (2016), several participants in this study noted substance use as a coping mechanism for managing intrusion symptoms. Previous literature has described the expectation of early mortality among Black male survivors of violence (Liebschutz et al., 2010). Participants in this study noted feelings of spirituality and purpose following their injury.

Survivors also held complex and sometimes contradictory relationships to intimate people and places. Feelings of anger motivated several participants to distance themselves from intimate family members and caregivers, including parents, spouses, children, and siblings, to protect their loved ones. While this strategy may be considered protective it also limits social support during recovery. Several participants noted a "wake-up call" that motivated them to build stronger relationships with their children and spouses. For other intimate relationships, such as peers, participants describe both feelings of comfort and distrust. Although some participants sought distance between themselves and intimate relationships as well as places and spaces to avoid reinjury, many found themselves trapped in the social context that led to their injury. Participants tended to return to the same neighborhoods and social contexts in which they were injured because they have deeply rooted social ties and lack of housing options to move away. While interacting with these same people and places, distrust of others, fear of reinjury, and a disrupted sense of safety led to both physical isolation and feelings of isolation. Such isolation and self-reliance may limit recovery post-injury as well as increase risk for violent reinjury and potential violent early mortality by motivating behaviors such as carrying a firearm, threatening to use or using a weapon, responding to disrespect with aggression or violence, and substance abuse (Cooper et al., 2006; Rich & Grey, 2005; Richardson et al., 2013, 2016; Teplin et al., 2005).

Implications for HVIPs

These experiences of injury have important implications for HVIP practice including therapeutic interventions, program structure, and program evaluation. The HVIP in this study used PCOR to continuously engage in qualitative research in order to understand the nuanced and complex issues that young Black male survivors of violent injury experience. This research informed the implementation of new services (i.e., the use of Uber Health) and allowed the program to adjust how care was provided to better suit the needs of survivors. A movement toward shared-decision-making approaches offers a viable means to effectively empower survivors in achieving their desired health outcomes.

Participants identified several interventions as therapeutic including group therapy facilitated by a psychotherapist and co-facilitated by the VIS. Group counseling provided a framework for discussing shared experiences of violence and identifying coping methods. However, this treatment failed to provide effective tools for managing substance abuse associated with intrusion symptoms. Although not a clinical therapist, participants noted that their relationship with the VIS was therapeutic and central to their recovery (Wical et al., 2020). In many cases, the VIS was the only person that survivors would trust and build a strong relationship with; this bond helped address feelings of isolation and distrust that may contribute to reinjury. This relationship also improved help-seeking behaviors for young men experiencing trauma. Participants also noted the importance of caregivers in

their recovery, and as a result the HVIP developed caregiver support groups that helped caregivers understand and develop coping strategies for primary and secondary trauma.

The psychotherapist and VIS noted that M-TREM was not sensitive to the needs of the survivors, including flexibility in programming. Participants noted jarring symptoms of traumatic stress, without coping skills to manage them, immediately upon return to their neighborhoods following hospital discharge. This suggests a gap in programming that may leave participants particularly vulnerable. Previous studies on this CBT model were conducted on incarcerated populations where attendance and attrition problems were not significant barriers to successful completion of the entire therapeutic course due to mandatory conditions for release or institutional practices. In contrast, the usage of services from HVIPs is voluntary. Retention in the 18-week M-TREM course among HVIP participants poses a significant challenge, as one missed session required the survivor to wait until the next cycle of M-TREM to begin again. Although participants expressed that the M-TREM model was helpful in developing coping mechanisms to deal with traumatic stress, the HVIP was unable to evaluate its effectiveness due to high rates of missed attendance. A modification of the M-TREM model is necessary in which there are multiple days a week that offer the same module. Additionally, a telehealth model should be implemented in order to allow sustained participation during the COVID-19 pandemic. This approach also addresses survivors' concerns for their safety in receiving services at the hospital, as it would allow survivors to receive care without having to leave their home.

The young Black male survivors of violence reported harboring trepidations about receiving clinical counseling at the hospital due to issues concerning their personal safety and retraumatization. HVIPs must take these perspectives seriously in order for high levels of care to be provided. One innovative approach to improving the health outcomes and empowerment of survivors would be shifting the model from hospital-based to hospital-linked. In this model, recruitment of participants can be facilitated at bedside while the direct delivery of psychosocial services is provided off-site. The participants in the study routinely expressed that they preferred the program to be facilitated on the university campus where the interviews and focus group were conducted.

The survivors explained that they felt as though the campus was a safe space that reduced their level of hypervigilance, the need to carry a firearm, and encouraged them to attend college. The potential of a hospital-linked model on a university campus offered a wealth of psychological support resources. The university's Department of Psychology and the Department of Counseling offered to provide participants with additional mental health counseling resources. In addition, the University's Black Cultural Center facilitated a Black Male Initiative program (BMI) that provided academic, social and emotional, and mentoring services for Black male undergraduate students and young Black men living in the metropolitan area. Additionally, BMI offered a Prison to College Program, which provided academic, social, and mentoring for incarcerated boys and young men involved in the criminal justice system.

Strengths and Limitations

A major strength of this research is the central focus on the perspectives of young Black men who were treated for being shot and were involved in the criminal justice system. This study is the only qualitative inquiry conducted with specific recruitment of this population. Their narratives provide an intimate look into their subjective health experiences—both in ways that were and were not similar to those described in the DSM-V. These young men illuminated nuanced narratives of their coping strategies, meaning-making processes, and personal health-related goals.

Although this study has a small sample size ($N = 11$), data saturation was achieved in the individual interviews. A limitation of this study relates to only having one focus group with survivors of violent injury; the findings may not be representative of other groups. The demographic composition of the sample decreases the ability to make meaningful comparisons across racial and ethnic groups (Sileo & Kershaw, 2020). There are important regional considerations, as the rates of violent crime in Washington DC are higher than the national average. This reduces the generalizability of the findings, as exposure to violence prior to injury may differ significantly between urban areas. Additionally, the ways in which individuals respond to and discuss their trauma are subject to change over time, as the social contexts of HVIPs, neighborhoods, and cities are dynamic.

Future Directions

HVIPs are well positioned to conduct research on the needs of their participants and translate collected data into meaningful services and health education messaging. The use of a Researcher–Practitioner approach to collect data was successful in increasing the rates of recruitment and retention of study participants in this study, as it reduced the distrust and stigma of researchers and the health-care system. Using this approach, future research should examine male-specific depressive symptoms in this population (Johnson, 2019). Lindsey, Joe, and Nebbitt (2010) noted the centrality of family support

and frequent distrust of professionals as essential features in improving the ability to identify mental illness in African American adolescent boys. Further research is needed to assess how the inclusion of family enhances the provision of care through the HVIP model. This is only study to use a PCOR approach with young Black male survivors of nonfatal firearm violence. Future studies on firearm violence among this population particularly among participants in HVIPs should be conducted using a PCOR approach.

Unlike previous research on interpersonal violence in this population, which noted that victims and perpetrators are more likely to have loose social bonds with each other, survivors in the HVIP frequently reported being shot by a close friend. The dissolution of these close friendships caused serious psychological damage to the survivors; this group of men expressed higher levels of distrust in HVIP staff and their social networks. More contextual data are needed to understand this nuanced pattern of injury and trauma, as little is known about the experiences of young men who have been violently injured in these intimate same-gender relationships.

To date, there is no evidence-based research showing the effectiveness of CBT models used in HVIPs. Large-scale studies must be conducted on the effectiveness of any therapeutic model used to address traumatic stress in young Black male survivors of violent injury. This will require large-scale randomized control trials on the effectiveness of CBT in the reduction of trauma symptoms and the success of HVIPs in reducing trauma and criminal recidivism. These forms of research must utilize the growing number of HVIPs in the United States, several of which are situated in the same geographical region.

Conclusion

Simply meeting participants where they are is an insufficient approach in increasing health equity. HVIPs that provide direct services for young Black male survivors of violent injury must engage in programming that understands the intersection of race, gender, age, class, and trauma. Approaches, including PCOR, that recognize survivors' assets, engage them as partners in determining goals, and seek to improve emotional expression and communication are necessary. This must include an understanding of the ways young Black men describe their mental health symptoms similar to the DSM-V criteria as well as their use of culturally rich jargon. The findings presented in this study revealed alternative expressions of traumatic stress used by survivors that may be overlooked by the mental health researchers and practitioners who study and provide services.

The effective delivery of culturally appropriate psychosocial services for this population must first come from understanding how violently injured young Black men understand, process, and make meaning from their experiences. HVIPs must provide a space and opportunity to empower the voices of survivors, including the determination of what factors contributed to their injury. The young Black men in this study routinely emphasized the importance of considering both interpersonal violence (firearm violence) and structural violence (incarceration) in understanding their mental health. As researchers and practitioners, in the words of author and social justice champion Bryan Stevenson, "we must get 'proximate' to suffering and understand the nuanced experiences of those who suffer from and experience inequality, if we are willing to get closer to people who are suffering, we will find the power to change the world." This methodological approach and moral imperative allow the psychological and social dimensions of survivors' experiences to inform how care is provided through HVIPs, providing a viable means to improve health equity.

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