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Shape-Up: Efficacy of a Culturally Responsive Barbershop-Based Violence Reduction Intervention RCT for Young Black Men

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Developing culturally responsive interventions to improve the health of Black males is a growing field. This study assessed the impact of a culturally responsive barbershop-based violence retaliation risk reduction intervention (Shape-Up) for emerging adult African American men. Using RECAST (Racial Encounter Coping Appraisal and Socialization Theory), this intervention included racial literacy protective and risk factors in its curriculum conceptualization, measurement, and delivery. Participants included 618 heterosexual cis-gender-identified African American men aged from 18 to 24 years old and used randomized control trial (RCT) methodology. Compared to a control group targeting sexual risk reduction, the retaliation reduction intervention successfully reduced violence behavior up to 3 months postintervention, through mediated mechanisms of reducing hypermasculinity beliefs and increasing Black manhood vulnerability beliefs. This study supports research on how culturally responsive theory-based interventions can increase the likelihood of positive health outcomes in communities of color. Developers of men's health interventions should consider the importance of both countering negative masculine identity stereotypes and promoting healthy gender-racialized narratives before expecting to improve Black young adult males' receptivity to psychological and behavior health change education and coping strategies.

Public Significance Statement

What if the most successful health interventions to reach African American young men were provided where they felt the most talkative, attractive, and culturally safe? Barbershops are spaces men share and listen to each other's stories of life accomplishments and struggles. The Shape-Up Project intervention was found to reduce the frequency of violent incidents by using barbers in Black neighborhoods as counselors for 618 African American heterosexual cis-gender men. We found that barbers are excellent teachers of healthy in-the-moment stress management and decision-making skills to men with cultural style and passion, all while cutting their hair.

Keywords: culturally-responsive intervention, racial literacy, randomized controlled trial, risk reduction, Black men

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The findings and conclusions in this report are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention.

The authors would like to give a special thanks to the intellectual and recruitment contributions of Dr Shawn L. White who passed away during the completion of the Shape-Up Building Better Brothers Barbershop Project. His tireless efforts to walk into barbershops across very different neighborhoods, engage the owners, barbers, and patrons, and build strong relationships to successfully complete this project were remarkable. His heart and soul are embedded within the design of the intervention, both in the culturally responsive construction of curriculum content and it is delivery by the barbers and cannot be ignored. We who are left to write up this work are indebted to his sacrifice, his undying passion, and his creative commitment to improving the lives and health of Black young adult men.

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The decade of emerging adulthood is one of the most challenging in the lifespan for Black Men and a critical time for healthy decision-making (Cooper & Smith, 2011; Curtis et al., 2020). The public narratives regarding Black young adult men have depicted them as incorrigible, hard-to-reach, or uniquely violent (Brown, 2011) and as a result, their cultural, racial, gender, and neighborhood risks and protections remain ignored (Stevenson, 2017). Culturally responsive health interventions have the potential to change the initiation of healthy and restraint of unhealthy behaviors among Black emerging male adults while combatting the negative psychological effects of stereotypes. Unfortunately, research on interventions that integrate the cultural experiences of people of color to therapeutically ameliorate the daily racial trauma of people of color and particularly Black men, is scarce (U.S. Department of Health and Human Services, 2001; Zane et al., 2016).

A central barrier in identifying, developing, and validating culturally responsive interventions is the myth that emotional illness is universal and thus universal interventions are adequate (Benish et al., 2011; Frank & Frank, 1993, 1998). While evidenced-based treatments (EBT) hold promise for producing behavior change and therapeutic results in general (Kitson et al., 1998), rarely have EBTs targeted people of color and Black males (Kataoka et al., 2010; Lau, 2006). EBTs are challenged by low participation rates of ethnic minorities and community mental health providers (Kataoka et al., 2002; Weisz et al., 2005), low transfer of lab-based experiments to community-based clinical and practice contexts (Baumann et al., 2015), and low sensitivity to the depth of cultural experiences of ethnic minority populations (Bernal & Domenech Rodríguez, 2012; Bernal et al., 2009). In contrast, interventions that target racial/ethnic groups are four times more effective than those that target mixed racial/ethnic samples while those that are conducted in the native language of the participants are twice as effective as English-only interventions (Griner & Smith, 2006).

Current research on evidenced-based approaches to violence for Black men have called for more specificity in addressing the unique experiences Black men face (Hawkins, 2017). Neglecting the role of cultural and racism factors within the theoretical, behavioral, and contextual problem-solving strategies can lead to less effective behavioral change outcomes (Waller, 2016). Without a clear articulation of race-specific risk and protective factors unique to Black males, interventions will not address their daily life traumas (Jones & Neblett, 2016).

The Racial Context of Exposure to Violence for Black Young Adult Men

While homicide remains the leading cause of death for Black males aged 10–24 (Carter et al., 2015), many more are injured and endure significant life-long negative emotional and physical health consequences including grief, anger, physical immobility, mental illness, stigmatization, and struggles of retaliation (Hawkins, 2017; World Health Organization, 2016). This is substantial as many nonfatal incidents nationally, go unreported. Moreover, exposure to violence (ETV) for African American young men is higher than for any other racial and gender group in the U.S. (Thomas & Hope, 2016; Zimmerman & Messner, 2013).

African American men are often identified as perpetrators of aggression without any attention paid to the trauma or discrimination histories of these men or their unique cultural and neighborhood risks and protections (Brown, 2011; Demby, 2016; Desmond et al., 2016; Stevenson, 2017). Being at risk as a victim or perpetrator of violence represents two sides of the same coin and is related to the exposure to concentrated impoverished or dangerous neighborhoods, unreliable social economies, and relationships that utilize violence as a daily stress management approach (Mani et al., 2013; Mitchell et al., 2014; Oliver, 1989; Sampson & Groves, 1989). Blacks and American-born Hispanics compared to Whites show greater and cumulative exposure to multiple stressor categories (financial, employment, relationship, acute life events, early life, community, and job and life discrimination), which is linked to greater health risks (Sternthal et al., 2011; Utsey et al., 2008; Williams et al., 2019; Zimmerman & Messner, 2013). Curtis et al. (2020) found that greater childhood trauma and income instability predicted emerging adult Black men's greater endorsement of reputation-based over a more prosocial respect-based masculinity.

These interrelated dynamics of concentrated neighborhood risk and personal stress and coping challenges must be considered when developing violence interventions for Black emerging adult men, whether they are victims, bystanders, perpetrators or some combination (Mani et al., 2013; Mitchell et al., 2014; Oliver, 1989; Sampson & Groves, 1989). This paper evaluates the effect of an intervention that considers cultural strengths, racial socialization, and gender vulnerability on how frequently Black young adult males engage in and restrain from physical and verbal violence in their partner, friend, and stranger relationships.

Using RECAST Theory to Develop a Culturally Responsive Barbershop-Based Intervention

A different conceptualization of Black male violence incorporates sociocultural (gendered and racial), developmental and identity processes to best explain their coping behaviors during stressful social interactions. This framing not only appreciates the unique health experiences of Black men, but also factors that influence their behavioral decision-making (Broomes & Perry, 2016). Theory-based interventions that consider culturally relevant racial/ethnic risk and protective factors have proven effective in reducing interpersonal violence toward peers and partners (Enriquez et al., 2012; Kaslow et al., 2010). Key elements of these approaches that have led to reductions in violence and drug use for Black young adult males include the appreciation of kinship and cultural supports and use of cultural content in the curriculum (Liddle et al., 2006; Richardson et al., 2013). Still, the ways Black men use culture to overcome stressful encounters must be evident in the intervention curriculum, delivery, helpers, and location. As the least likely racial/gender group to seek formal health information and care (Parker et al., 2017), Black male adults are most likely to build long-lasting trust in evidenced-based health interventions if they are conducted in natural, safe, and familiar environments by people they already trust.

Racial Encounter Appraisal and Socialization Theory (RECAST; Stevenson, 2014) argues that racial socialization and literacy can prepare individuals to manage the trauma of racial and nonracial decision-making and coping behaviors that occur from constant exposure to racial/gender discrimination stress (Anderson & Stevenson, 2019). A key aspect is the incorporation of sociocultural (gendered and racial), developmental, identity and socialization processes in interventions (Broomes & Perry, 2016) to build racial trust and self-efficacy. Moreover, it is expected that racial socialization and

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literacy skills can positively influence one's appraisal and resolution of the stressfulness and coping demands of discriminatory racial and gender encounters (Anderson et al., 2019). Subsequently, RECAST theory interventions are expected to include racial/gender-specific stress management mediators that promote behavioral outcomes (Figure 1; Stevenson, 2003).

Barbershops as Safe and Brave Spaces for Black Men

Black barbershops are historically supportive of racial and gendered political debates that can stimulate greater Black male self-disclosure of personal adaptive and maladaptive health decisions (Baker et al., 2012, 2018; Brawner et al., 2013). Ravenell et al. (2008), identified both internal ("intrinsic") and system barriers ("extrinsic") that interfere with Black men's use of healthcare. Racial mistrust of medical care, lack of health awareness, and cultural relevance of services were key factors. The role of barbershops in preserving the life and health of African American communities has been significant (Bristol & Bristol, 2009; Franklin, 1985; Frencher et al., 2016; Luque et al., 2015; Marberry, 2005; Mills, 2013; Victor et al., 2011). As stable sites of resistance to political oppression, barbershops are trustworthy contexts to establish health interventions to improve Black men's understanding and knowledge of hypertension, prostate cancer, sexual risk, obesity and unhealthy diets, and violence reduction (Hart et al., 2008; Hood et al., 2012; Mills, 2005; Moore et al., 2016; Releford et al., 2010; Victor et al., 2009, 2011).

Unfortunately, there remains little systematic study of these venues. Luque et al. (2014) reviewed 901 studies that targeted barbershops as feasible for Black male health interventions and found only 35 applied a consistent integration of theory and approach, methodological rigor, and effectiveness determination. The largest randomized controlled trial on barbershop health promotion is the hypertension intervention study in New York city (Victor et al., 2011). The intervention was significant in using the barbershops and barbers as health educators to both assess and improve blood pressure control over the course of several months for African American men compared to the control group. Extending this work of barbers as health educators from health screenings regarding blood pressure control to risk reduction behaviors is a natural next step. This study examines the efficacy and mediation of a culturally-tailored two-session, barbershop-based risk reduction intervention designed for heterosexually-identified Black men between the ages of 18–24 to reduce physical violence. RECAST theory drove the development of the violence retaliation intervention curriculum and implementation of the Shape-Up program.

The Shape-Up Barbers Building Better Brothers Project

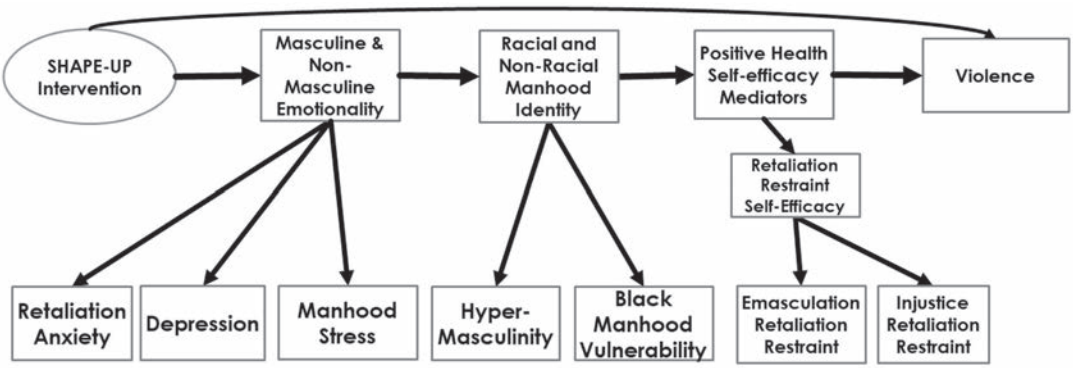
Shape-Up: Barbers Building Better Brothers involves comparing two risk reduction intervention conditions (human immunodeficiency virus; HIV/sexually transmitted diseases; STD and Violence Retaliation) within an attention-control design. Both are two sessions within 3 weeks, one-on-one, age appropriate, culturally-tailored, gender-specific coping skills curriculum for African American young men ages 18–24 and both are delivered by barbers in barbershop settings (Baker et al., 2018). The rationale for this study was to reduce risky behaviors among young adult Black men. HIV/Acquired Immunodeficiency Syndrome; AIDS and violence retaliation risks are both relationship challenges for some Black men, but they each are experienced differently. By choosing two high-risk behaviors that involve stress management during face-to-face (FTF) decision-making and conflict-resolution, we could test if different interventions specific to each risk were of equal or greater potency in regulating the stress of those relationship behaviors.

Embracing the cultural support and trust of the barbershop context was essential in gathering baseline racial and gender identity and stress data to develop preintervention conceptualizations of Black men's health decision-making (Baker et al., 2018). Three differences between the conditions include theory foundation, curriculum focus, and behavioral outcome targets. The sexual risk reduction intervention curriculum was based on the Theory of Planned Behavior (TPB; see Figure 1; Ajzen, 1985, 1991, 2002; Madden et al., 1992) targeting sexual risk reduction while the violence retaliation intervention curriculum was based on RECAST Theory (see Figure 2) and integrated racial literacy training that taught racial coping skills for face-to-face encounters (Anderson & Stevenson, 2019; Stevenson, 2014).

Both the Violence Retaliation Reduction (*intervention arm)* and the HIV Risk Reduction (control arm) interventions involved four, 30-min modules implemented over two sessions, with the second conducted 2 weeks later, delivered by specially trained barbers in barbershops using iPads. Both interventions had a similar format, but different psychoeducational content. In the violence intervention

Figure 1

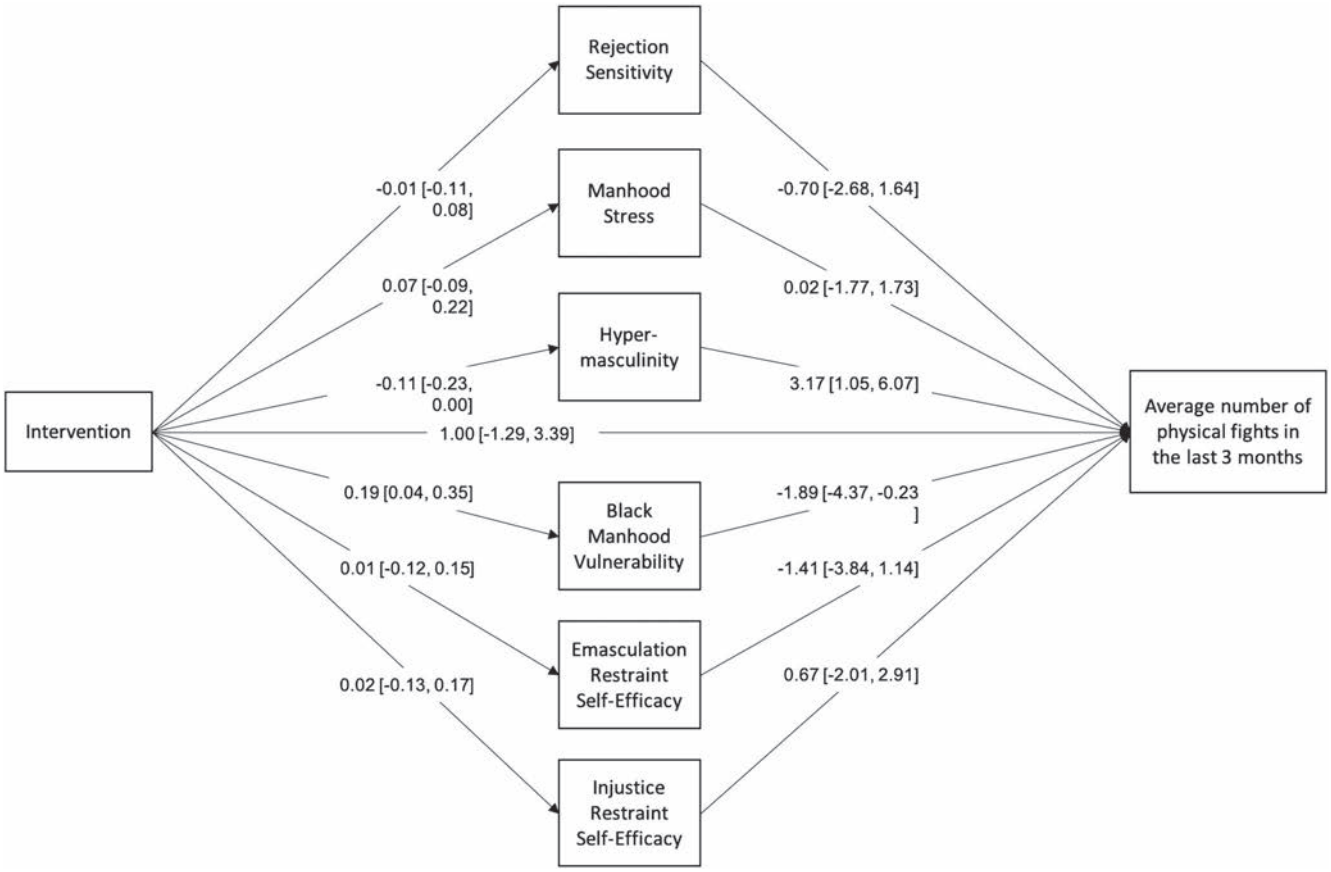
Racial and Manhood Identity Intervention Model of Black Male Retaliation Restraint and Violence Using RECAST Theory



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Figure 2

Serial Mediation Model of the Effects of the Barbershop-Based Intervention on Theoretical Constructs and the Self-Reported Number of Physical Fights in the Past 3 Months



Note. The mediators were measured at the immediate postintervention assessment. The behavioral outcome was measured at the 3-, 6-, 12-month postintervention assessments. Paths include unstandardized coefficients and 95% CI estimated from the structural equation model based on the bootstrapping method with 5,000 replicates. The model adjusted for correlation within a barbershop. For α paths, the effects were adjusted for intervention and the baseline outcome. For β path, the effects were adjusted for intervention, the baseline outcome, and time. Covariances between all pairs of mediators were included and estimated in the model, but the paths are not shown here for simplicity.

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condition barbers were taught skills in de-escalation, emotional regulation, self-awareness (verbal and nonverbal expressions), and humanity engagement (providing protection, affection, and accountability to patrons) during stressful FTF encounters Stephan and Stephan (1985) who in turn taught the participants (Stevenson, 2014). They were highly structured, enjoyable, engaging, and implemented by specially trained barbers, who served as facilitators. Both involved culturally responsive video clips, interactive activities, experiential exercises, role-play activities. Each iPad interactive video session was intended to evoke feelings, thoughts, attitudes, beliefs, and stereotypes about risky behavior and prevention skills related to HIV/Sexually Transmitted Infections; STI or violence issues that combined intervention-related content and depicted African American young men.

Both interventions involved a one-on-one discussion with the barber in his chair while getting a haircut, where he enhanced learning through practice, role-playing, modeling, and reinforcement of behavioral change. Each intervention recommended use and maintenance of specific behavioral strategies like resisting and anticipating triggers for unsafe behavior in high-risk situations and interpreting relationship dynamics that can enable long-term behavior change. When asked to describe "being a man," participants felt "a man" provided protection and support to his community, family members, sexual partners, and themselves. As a result, we incorporated a "BE-A-MAN" approach as the primary intervention theme, defined as follows: BE—breathe and exhale, A—analyze your body, M—manage your emotions, A—analyze the danger, N—negotiate the danger. Each violence restraint session incorporated the theme of "Be a Man" (Breathe–Exhale–Analyze–Manage–Analyze–Negotiate) which taught skills in emotional regulation and stress management and encouraged each participant to protect themselves, their families, sexual partners, and communities.

Each condition-specific participant received a backpack with small booklet containing background information and skill building tools they learned in the sessions including a resource guide to assist in linking the men with the proper resources to meet their specific needs, and a DVD copy of the iPad intervention video. The violence

retaliation reduction group was developed as a comparison group to the HIV/AIDS sexual risk reduction intervention group to determine in a randomized controlled trial which of the two would have a greater effect on prosocial and behavioral (violence behaviors and restraint beliefs) health outcomes. A detailed description of the violence retaliation intervention development and implementation is found in Baker et al. (2018).

Two research questions were investigated:

1. Does a culturally-responsive, racial literacy-infused barbershop violence restraint intervention lead to greater reduction of violence behaviors compared to an HIV/AIDS risk intervention among heterosexually-identified Black emerging adult men?

2. Do heterosexual Black emerging adult males' understanding of racial and gendered identity factors influence how the intervention reduces violence behaviors or increases restraint self-efficacy?

Method

Random Assignment of Barbershops

The design of the study is a cluster-randomized attention-control trial where both conditions received the same amount of time and intervention trial. Barbershops (the clusters) serving primarily African American men in zip codes of Philadelphia, PA with the highest rates of HIV/AIDS were eligible to participate if they were (a) located in a selected zip code, (b) served at least 50 men in the target population in the past 6 months, (c) had at least two barbers, (d) had at least two barber chairs, (e) were willing to be randomized, and (f) agreed to implement interventions with 24 men and to cooperate with data collection.

We matched the barbershops in pairs similar on zip code, the number of barbers, and number of barber chairs. We used computer-generated random number sequences to randomize one barbershop to the HIV/STI risk reduction intervention and the other to the attention-matched control intervention using concealment of allocation techniques designed to minimize bias in assignment. A coinvestigator conducted the computer-generated random assignments and the project director implemented the assignments. We enrolled barbershops during the 30-month period beginning in November 2011, with all data collection completed by September 2015. Of the 53 barbershops that were trained and randomized, five (2 in the HIV risk reduction arm and 3 in the violence-prevention arm) did not recruit participants or implement their randomized intervention after numerous attempts to get them to do so. Thus, 48 barbershops participated in the trial (24 in the HIV risk reduction arm and 24 in the violence-prevention arm). As compensation for their space, the barbershop owners received $250, $100 for each of the two intervention session days and $50 for each of the three follow-up session days and the owners paid the barbers.

Participants

Men were eligible to participate if they self-identified as African American or Black, were 18–24 years of age, resided in Philadelphia and planned to reside in Philadelphia for the next 18 months, and reported having sexual intercourse with a woman at least once in the past 12-months. The National Institutes of Health (NIH) funding behind the project targeted heterosexually-identified Black males at risk for HIV/AIDS. Barbers employed at the barbershops recruited the men using a common, standardized scripted recruitment procedure, irrespective of the intervention condition. Barbers told the potential participants that they might receive an HIV/STI prevention intervention or a violence-prevention intervention.

When participants arrived at their initial intervention session, they were informed of their assigned intervention. Participants signed consent forms. They received a free hair cut at each of the two intervention sessions, $30 and a free haircut for participating in each of the 3- and 6-month follow-up sessions, and $40 and a free haircut for the 12-month follow-up session. Thus, they received a total of $100 and five free haircuts for full participation in the trial.

Barber Facilitators

The minimum qualifications for barber facilitators were employment at a participating barbershop, a high school diploma or equivalent, ability to read and write English, comfort with teaching others about sensitive health topics (e.g., sexual behavior, retaliation violence), ability to follow written and oral instructions, amenability to being evaluated, interpersonal flexibility, and willingness to implement either intervention. The facilitators received a 1-day 6-hr training in their assigned intervention with manualized training materials. The training covered overview of the study, the culture of the barber and barbershop in the African American community and how to use it as a facilitator, the specific background content of their intervention; and practice implementing their assigned intervention with feedback from trainers and other barbers. The training emphasized the importance of fidelity of implementation and confidentiality through rehearsal or review of previous trainings and checking of facilitator completion of intervention steps. Facilitators were certified upon successful completion of the training.

Data Collection and Measures

Participants completed confidential questionnaires via Audio Computer-Assisted Self-Interview (ACASI) before the intervention, immediately after the intervention, and 3, 6, and 12 months after the intervention. The reliability and validity of the measures had been established in previous research and included the Cutting down, Annoyance by criticism, Guilty feeling, and Eye-openers (CAGE; Ewing, 1984) and Texas Christian University Drug Screen (TCUDS; Knight et al., 2002) tests for testing drug use and alcoholism. To increase the validity of self-reports we used strategies employed in previous intervention trials that found that self-reported sexual and aggressive behavior and changes in sexual and aggressive behavior were unrelated to a standard measure of social desirability response bias (Botvin et al., 1995; Goldberg Lillehoj et al., 2004; Jemmott et al., 2007, 2008). For example, to reduce problems in memory, we asked respondents to recall sexual and aggressive behaviors over a relatively brief time period (i.e., 3 months), which would facilitate their ability to recall. To further increase accuracy of recall, we gave participants a calendar, with the dates clearly marked, which made salient to respondents the dates that are included when we ask them to recall their behavior "in the past 3 months (90 days)."

To reduce the likelihood that the participants would minimize or exaggerate reports of their sexual experiences, the importance of

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responding honestly was emphasized. They were informed that their responses will be used to create programs for African American men like themselves, and that we could do so only if they answered the questions honestly. Participants were assured that their responses would be kept confidential and that code numbers rather than names would be used on the questionnaires. Participants signed an "agreement" pledging to answer the questions as honestly as possible, a procedure that has been shown to yield more valid responses on sensitive issues.

The following scales were developed specifically for this study of emerging Black adult men and subjected to factor analytic procedures. Initial pilot testing with a group of 100 Black men fitting the criteria of this study was conducted on all Shape-Up measures. Once item descriptive analyses of skewness, kurtosis, range, and relevance to the constructs were conducted, the following rules were applied to each scale: Cattell's scree test (Cattell, 1966); each factor needed to retain at least five items with loadings equal to or greater than .37 as it is robust enough of a cutoff to isolate items that have low correlations to the total subscale; items must have loaded exclusively on one factor; yield adequate internal consistency for the items; and make intuitive sense based on the theoretical foundations of RECAST theory. For some factors, there may have been fewer than five items, but if the internal consistency was adequate, there was minimum correlation between subscale factors, and it made conceptual sense, those factors were retained.

Gendered-Racial Attitude Scales. *The Black male vulnerability awareness scale* is a three-item measure which was originally seven items but after item analyses and reliability analysis, and after one and two-factor models were tested. It was determined that one-factor model was best and three items adequately represented the concept. In the pilot study, Black Male Vulnerability Scale Awareness (BMVA) alpha reliability was (.65). The items target how much Black men agree with ideas that reflect an awareness of how Black men experience risks of violence, discrimination, and financial hardship at greater levels than their peers. An example of an item includes, "Black young men are at more risk of injury or death by violence than any other racial or gender group." The internal consistency of this measure was found to be less than moderate ($\alpha = .62$). The seven-item *Manhood Stress Scale* asks respondents how stressful it is to manage the pressures of manhood expectations of keeping partners happy, proving toughness to women and men, or fielding questions of one's manhood. An example of an item includes, "It is stressful to prove to women that I am tough and strong." After testing a two-factor model, the one-factor made most sense and the internal consistency of this measure in the pilot and in this larger randomized control trial (RCT) study was found to be at the moderate level ($\alpha = .80$). *The hypermasculinity scale* includes a set of six items that ask respondents to endorse attitudes that justify men using physical violence toward women partners or male strangers who publicly disrespect them to protect one's manhood. An example of an item is "A real man has to sometimes physically fight his women sexual partners to protect his manhood." The internal consistency of this measure in the pilot study was ($\alpha = .65$) and in this study was moderate ($\alpha = .61$).

Retaliation Restraint Self-Efficacy. The Retaliation Restraint Self-Efficacy (RRSE) scale asks participants to rate on a 4-point scale from how very easy to very hard it would be to restrain themselves from retaliating after experiencing different encounters of injustice or emasculation. Following testing one-, two-, and three-factor models based on the scree test, the one-factor model was accepted. The 14-item scale includes situations of defending oneself, calmly using words, holding in anger, and limiting physically fighting. Situations include when police are harassing, female partner humiliating in public, and male or female questioning manhood. High scores represent significant restraint of retaliation and the RRSE yielded a moderate reliability score of .85 in the pilot study and in the present study.

Rejection Sensitivity. The Rejection Sensitivity Questionnaire (RSQ) is a self-report measure modified for adults based on the Children's Rejection Sensitivity Questionnaire (CRSQ) developed by Downey et al. (1998). Part One of the RSQ measures the extent men anxiously or angrily expect rejection before and react to rejection after an ambiguously intentioned rejection situation. The anxiety and anger responses range from 1, *not nervous* or *not mad*, to 6, *very, very nervous* or *very, very mad*. High scores represent the anxious or angry expectation or anticipation of rejection and low scores indicate the expectation or anticipation of acceptance. Part Two of the RSQ includes vignettes of relationships with female partners, strangers and friends in which they are rejecting the respondent during arguments (partner disagreements), social interaction (like fights during basketball play). The anxiety and anger items were combined to make one rejection sensitivity scale and score as there were no differences of the different anxiety and anger rejection anticipation. The content of the rejection in the vignettes usually included rejections of injustice or unfair treatment or emasculation of the challenging or humiliation of one's manhood. The RSQ yielded an alpha reliability coefficient in this study of .87.

Violence Behavior in Relationships. Several outcome behavior questions regarding the frequency of physical and violence behaviors over the last 3, 6, and 12 months were posed to the respondents for different relationships of friends, strangers, and female partners. Some items focused on how many events of violence and others asked how frequently according to times per week or year ranging from "0 times a year" to "3 times a week" along a seven-choice response scale.

Statistical Analysis

We used descriptive statistics to summarize the participants at baseline on sociodemographic variables and Chi-square tests and logistic regression to analyze attrition. We tested the efficacy of the Retaliation violence reduction intervention over the 3-, 6-, and 12-month follow-ups by using logistic, linear, multinomial, or Poisson generalized estimating equations (GEE) regression models, depending on the nature of the outcome (binary, continuous, ordinal, or count, respectively), accounting for clustering of participants within barbershops. The models were fit and contrast statements specified to obtain estimated odds ratios and their corresponding 95% confidence intervals (CI). Robust standard errors were used and an independent working correlation matrix was specified. The models included time-independent covariates, baseline measure of the criterion, intervention condition, and time (3 categories representing 3-, 6- and 12-month follow-up). Models assessing whether the efficacy of the intervention differed among the three follow-ups included the baseline measure of the criterion, intervention condition, time, and the Intervention-condition × Time interaction in addition to adjusting for other significant covariates of manhood vulnerability, hypermasculinity, rejections sensitivity, and manhood stress. The analyses were performed using an intent-to-treat mode with participants analyzed based on their

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intervention assignment, regardless of the number of intervention or data-collection sessions they attended.

Mediation was assessed using a product-of-coefficients approach (MacKinnon et al., 2002). In this method, the effect of the intervention on a potential mediator at the immediate postintervention assessment is denoted as α path, and the effect of the mediator on an outcome is denoted as β path. The indirect effect of the intervention, thus, is quantified as αβ, the product of α and β. An αβ product that significantly differs from 0 indicates mediation. The effect of the intervention on an outcome was evaluated separately for each potential mediator. Each α path was estimated using a GEE linear regression model on the mediator at the immediate postintervention assessment, controlling for baseline of the mediator and baseline of the outcome. For outcome variables indicating frequency of behaviors for the past 3 months, each β path was estimated using a GEE Poisson regression model, controlling for time, intervention, baseline of the mediator, and baseline of the outcome. For the α and β paths, we report estimated mean differences and 95% CI. For the mediated effects, we report estimated αβ products and asymmetric confidence interval (ACI) based on bootstrap quantile method (MacKinnon et al., 2004) with 1,000 replicates, because of nonnormal distribution of an αβ product. We used the $p < .05$ two-tailed significance criterion. The analyses were conducted using SAS Version 3.6.

We tested multiple mediation using structural equation modeling (SEM). Model fit was assessed based on root mean square of approximation (RMSEA), comparative fit index (CFI), and standardized root mean square residual (SRMR) using Maximum likelihood (ML) estimator. RMSEA < 0.06, CFI ≥ 0.95, and SRMR < 0.08 are used as criteria indicating a good fit (Hu & Bentler, 1999). Due to nonnormal distribution, the mediated effects were estimated using boostrap quantile method with 2,000 replicates. The analyses were conducted using M-Plus Version 7 (Muthén & Muthén, 2012).

Results

Characteristics of the Sample

Table 1 reflects the basic demographic characteristics, violence and sexuality behaviors, and participation rates of the barbershops, the barbers, and the patrons from the intervention and control conditions. There were 618 young adult African American men:

Table 1

Baseline Sociodemographic Characteristics of Participating Barbershops and African American Men by Intervention Condition, Philadelphia, PA, 2011–2014

Characteristic	Total no. (%) or *M* (*SD*)	Violence intervention no. (%) or *M* (*SD*)	HIV/STI intervention no. (%) or *M* (*SD*)
Barbershop			
No.	48	24	24
M (*SD*) no. of barbers	4.70 (2.31)	5.08 (3.28)	4.79 (2.08)
M (*SD*) no. of chairs	5.84 (2.37)	6.29 (2.93)	5.92 (2.00)
M (*SD*) no. of haircuts per week	190.55 (208.97)	172.33 (141.22)	190.13 (164.79)
M (*SD*) no. of years open	10.69 (9.88)	10.96 (10.86)	9.13 (6.62)
Participant			
No.	618	299/618 (48.38%)	319/618 (51.62%)
M (*SD*) age (years)	20.76 (2.02)	20.66 (1.98)	20.86 (2.08)
No. (%) employed full time	99/237 (41.77%)	49/114 (42.98%)	50/123 (40.65%)
No. (%) education			
No formal schooling	25/618 (4.05%)	8/299 (2.68%)	17/319 (5.33%)
Less than high school diploma	167/618 (27.02%)	72/299 (24.08%)	95/319 (29.78%)
A high school diploma (or GED)	297/618 (48.06%)	147/299 (49.16%)	150/319 (47.02%)
Some college or 2 year degree	117/618 (18.93%)	65/299 (21.74%)	52/319 (16.30%)
4 year college	8/618 (1.29%)	6/299 (2.01%)	2/319 (0.63%)
Postgraduate work	4/618 (0.65%)	1/299 (0.33%)	3/319 (0.94%)
No. (%) monthly income			
Less than $400	337/618 (54.53%)	172/299 (57.53%)	165/319 (51.72%)
$400–$850	155/618 (25.08%)	66/299 (22.07%)	89/319 (27.90%)
$851 or more	126/618 (20.39%)	61/299 (20.4%)	65/319 (20.38%)
Marital status (never married)	601/618 (97.25%)	293/299 (97.99%)	308/319 (96.55%)
No. (%) sexual preference			
Women only	611/618 (98.87%)	294/299 (98.33%)	317/319 (99.37)
Same gender sex	7/618 (0.65%)	5/299 (1%)	2/319 (0.31)
No. (%) ever tested for STI	117/614 (19.05%)	51/296 (17.23%)	66/318 (20.75%)
No. (%) ever told had HIV	4/618 (0.65%)	0/299 (0%)	4/319 (1.25%)
No. (%) alcohol dependent[a]	91/618 (14.72%)	41/299 (13.71%)	50/319 (15.67%)
No. (%) drug dependent[b]	62/618 (10.03%)	28/299 (9.36%)	34/319 (10.66%)
No. (%) ever in jail or prison	172/618 (27.83%)	81/299 (27.09%)	91/319 (28.53%)
M (*SD*) days in jail or prison	330.63 (602.46)	244.44 (391.8)	410.54 (736.97)
Barbershop			
Regular barbershop	383/618 (61.97%)	179/299 (59.87%)	204/319 (63.95%)
Have a regular barber	514/618 (83.17%)	246/299 (82.27%)	268/319 (84.01%)
Barber trust of health info	514/618 (83.17%)	214/246 (86.99%)	238/268 (88.81%)

Note. No. = Number; GED = General Education Development Test.

[a] Based on a score of 2 or greater on the CAGE (cutting down, annoyance by criticism, guilty feeling, and eye-openers) questionnaire. [b] Based on a score of 3 or greater on the TCUDS (Texas Christian University drug screen) questionnaire.

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299 in the violence retaliation reduction intervention and 319 in the HIV/STI risk reduction control condition. Participants' age ranged from 18 to 24 years ($M = 20.76$; $SD = 2.02$). Out of the 618 participants 38% were employed, and 48% had completed high school while nearly 80% of the participants had an monthly income of less than $851. Only 19% were ever tested for an STD, and of those only four participants (0.65%) had been told they had HIV.

A small number of participants, 15% were alcohol dependent based on the CAGE scale (Shields & Caruso, 2004), and 10% were drug dependent based on the Texas Christian University Drug Screen (Institute of Behavioral Research, 2007). About 28% had a history of incarceration in prison and the mean number of days in jail or prison was 330. A large minority reported substance use in the past 90 days, including marijuana (46%) and other illegal drugs (8%).

About 81% said they had intercourse with a main or casual partner in the past 90 days. About 99% self-identified as having sex with only women, 0.40% self-identified as having sex with only men, and 0.60% self-identified as having sex with both men and women. Most of the participants were never married (97%). About 62% had a regular barbershop, and 83% had a regular barber, and 83% reported that their barbers were a trustworthy source of health information.

Intervention Attendance and Follow-Up Retention

High percentages of participants completed the postintervention assessments: All participants (618) attended intervention session 1 and 572 or 93% completed the immediate postintervention test; 481 or 78% completed the 3 months postintervention follow-up; 457 or 74% completed the 6 months postintervention follow-up; 448 or 72% completed the 12 months postintervention follow-up. Of the original 618, 538 or 87% attended at least one of the four follow-ups. The retaliation violence reduction intervention (86%) and control (88%) conditions did not differ significantly in the percentage attending at least one follow-up using the "$N - 1$" chi-squared test (Campbell, 2007; Richardson, 2011).

Baseline measures of outcomes did not predict attending at least one follow-up. In addition, none of the baseline sociodemographic characteristics such as age, education, employment status, incarceration, and marital status predicted returning for at least one follow-up. Participants' evaluative ratings of the interventions were positive. The mean rating of how much they liked the program was 4.1 on a 5-point scale and how much they learned from the program was also 4.1 on a 5-point scale. When asked if they would recommend the program to other young men, the average rating was 4.6, demonstrating a high degree of satisfaction with the program.

Barbershop Retaliation Violence Reduction Intervention Effects on Violence Behaviors

Table 2 presents the descriptive statistics for violence behavior outcomes by intervention condition and assessment period. Table 3 presents estimated intervention effects unadjusted and adjusted for baseline measure of the criterion and other significant covariates. There were no significant intervention effects.

Table 2
Self-Reported Violence Behavior by Intervention Condition and Assessment Period, African American Men, Philadelphia, PA 2011–2014

Self-reported violence behaviors	Baseline		3-Month		6-Month		12-Month	
	HIV/STI	Violence	HIV/STI	Violence	HIV/STI	Violence	HIV/STI	Violence
M (*SD*) number physical fights in the past 3 months	3.78 (21.04)	3.32 (36.32)	1.68 (8.42)	1.98 (7.39)	4.42 (22.95)	4.07 (25.73)	5.06 (27.35)	3.79 (14.83)
M (*SD*) number verbal fights in the past 3 months	8.46 (33.48)	9.41 (64.58)	4.04 (11.52)	4.08 (10.93)	4.99 (14.55)	5.78 (17.57)	4.00 (10.16)	4.28 (12.70)
M (*SD*) number of physical fights in the past 12 months	13.91 (93.32)	16.53 (133.70)	9.32 (29.22)	6.13 (19.08)	9.18 (28.42)	6.83 (19.65)	10.27 (34.88)	10.68 (40.48)
M (*SD*) number of verbal fights in the past 12 months	1.05 (1.17)	1.01 (1.08)	0.76 (0.96)	0.74 (0.89)	0.71 (0.97)	0.65 (0.89)	0.59 (0.89)	0.64 (0.96)

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Table 3
*GEE Empirical Significance Tests, Odds Ratios (*OR*), and 95% Confidence Intervals (CI) for the Overall Intervention Effect Unadjusted and Adjusted for Baseline Prevalence and Significant Covariates, African American Men, Philadelphia, PA 2011–2014*

Outcome	Unadjusted		Adjusted for baseline	
	OR [95% CI]	*p* value	*OR* [95%CI]	*p* value
Frequency of physical fights in past 3 months	0.43 [0.004, 51.22]	.7299	0.85 [0.009, 79.48]	.9434
Frequency of verbal fights in past 3 months	2.07 [0.06, 71.73]	.6871	3.97 [0.11, 148.9]	.4555
Frequency of physical fights in past 12 months	0.67 [0.28, 1.60]	.3668	0.65 [0.27, 1.57]	.3428
Frequency of verbal fights in past 12 months	1.15 [0.70, 1.88]	.5824	1.21 [0.75, 1.95]	.4401

Note. The intervention effect is averaged over the 3-month, 6-month, and 12-month postintervention assessments. All adjusted analyses adjust for baseline of the criterion. GEE = generalized estimating equations.

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Mediation Analysis of Intervention Effect on Number of Physical Fights in Past 3 Months

For the average number of physical fights in the past 3 months, among the six β paths to the outcome from potential mediators that the intervention targeted, one from Black manhood vulnerability awareness was significant (Table 4). Black manhood vulnerability awareness also produced a significant αβ product. It indicates that the intervention significantly decreased average numbers of physical fights in the past 3 months through the mediator.

We tested a multiple mediation model using structural equation modeling. The model includes paths from the intervention to theoretical constructs (rejection sensitivity, manhood stress, hypermasculinity, Black manhood vulnerability awareness, emasculation retaliation restraint, and injustice retaliation restraint), paths from the theoretical constructs to the outcome variable (the number of physical fights in the past 3 months), and a direct path from the intervention to the outcome. Each theoretical construct covaried with all other theoretical constructs. The model fit was good: RMSEA = 0.03, 90% CI [0.03, 0.04]; CFI = 0.942; SRMR = 0.05. Regarding model estimates, the intervention had a significant effect on Black manhood vulnerability awareness. The effects of hypermasculinity and Black manhood vulnerability awareness on the reduction of physical fights were also significant (Figure 2). To be specific, the product of the two coefficients on the path from the intervention to the outcome through Black manhood vulnerability awareness was significant, −0.35, 95% ACI [−1.19, −0.02]. The product of the two coefficients on the path from the intervention to the outcome through hypermasculinity was also significant, −0.35, 95% ACI [−1.11, −0.05].

Discussion

As the first study this large to investigate the intervention reduction of violence retaliation and sexual health risk of African American heterosexually-identified men using barbershops as a health education context, several implications for future research are identified. In this study, hypotheses generated from the two research questions posed regarding this RCT were partially supported. Hypothesis one proposed that the Shape-UP barbershop intervention would demonstrate a significant decrease in the frequency physical fights across 3-month, 6-month, and 12-month postintervention assessments for African American young adult men in relationships with friends, partners, and strangers, compared to the HIV/Aids sexual risk reduction intervention. No significant result was found to support this hypothesis. That both interventions were found to decrease violence behaviors suggests that negotiating sexual risk partner relationships is not dissimilar to negotiating angry or potentially violent encounters that may require emotional and behavioral restraint.

The second research hypothesis proposed that the intervention would result in a reduction of the frequency of physical fighting across all relationships but through the mediating influence of gendered-racial socialization. This mediation hypothesis was

Table 4
Mediation Table

Mediation table	α path		β path		Indirect effect α–β product [95% CI]
	Mean difference [95% CI]	*p* value	Mean difference [95% CI]	*p* value	
Average number of physical fights in the past 3 months					
Rejection sensitivity	−0.01 [−0.10, 0.08]	.870	0.45 [−0.06, 0.96]	.084	0.00 [−0.05, 0.05]
Manhood stress	0.07 [−0.08, 0.21]	.363	0.15 [−0.43, 0.73]	.601	0.01 [−0.05, 0.10]
Hyper masculinity	−0.11 [−0.22, 0.01]	.068	0.28 [−0.17, 0.73	.220	−0.03 [−0.13, 0.04]
Black manhood vulnerability awareness	0.19 [0.03, 0.34]	.018	−0.61 [−0.97, −0.26]	<.001	−0.12 [−0.26, −0.02]
Emasculation retaliation restraint	−0.01 [−0.14, 0.11]	.857	−0.51 [−1.12, 0.10]	.101	0.00 [−0.07, 0.09]
Injustice retaliation restraint	0.02 [−0.14, 0.17]	.832	−0.55 [−1.13, 0.03]	.060	−0.01 [−0.13, 0.09]

Note. Mediators were measured at the immediate postintervention assessment. Each α path indicates the effect of the intervention on the mediator and was adjusted for the baseline outcome, the baseline mediator, and correlation within a barbershop. Each β path indicates the effect of the mediator to the outcome measured at the 3-, 6-, and 12-month postintervention assessments and was adjusted for intervention, the baseline outcome, the baseline mediator, and correlation within a barbershop. CI = confidence interval; ACI = asymmetric confidence interval, is based on bootstrap quantile method with 5,000 replicates.

partially supported. While the collection of Black male identity factors did not prove to explain the impact of the Shape-Up intervention, one factor, Black male vulnerability found to be significantly influential in reducing the number of physical fights in all relationship types at the 3 months postintervention assessment.

The results of the mediation analyses are quite informative in terms of suggesting improvements to the intervention in the future. One clear result was that the violence intervention was effective in increasing Black male vulnerability awareness and this reduced the number of physical fights in the 3 months after the intervention was delivered. When the intervention changed potential mediators, but the mediators were not related to outcomes, the intervention likely contains superfluous elements (i.e., those that changed the mediator). When the intervention failed to change a mediator that was related to an outcome, the intervention needs to be enhanced in addressing that mediator.

The limitations of this study include not reducing violence behaviors beyond 3 months postintervention. Unfortunately, participants were exposed to only two sessions with the barbers. Perhaps more frequent sessions could demonstrate greater gains at 6 and 12 months postintervention. A second limitation is the focus on heterosexually-identified Black men and the results might not generalize to Men who self-identify as gay or transgendered or who have sex with other men. Another limitation can be found in the violence retaliation reduction curriculum which focused more of its content on reducing physical violence and less on verbal violence between partner, friend, or stranger relationships. Two methodological limitations include not having a clear no-intervention control group to compare with the Shape-Up violence retaliation condition and weak internal consistency of two measures (BMVA and Hypermasculinity). Future research should assign equal dosage to both gender-specific coping mediators, physical and verbal fighting reduction skills. Finally, it is a limitation that the health behaviors in this study were more comorbid in relational decision-making than expected and resulted in both interventions showing reduction in fighting behaviors.

Research Implications

This study lends support to RECAST theory in that the Black men were responsive to psychoeducational curriculum content that illuminated their understanding of racial and gender oppression. This form of racial of gender socialization is key to the theory's assertion that as one's skills regarding managing oppression increases, so does one's confidence to engage those oppressions in a healthy manner. The implications for interventions for Black men in this work is that designers and researchers might need to be both cautious and bold in how specific racial and gender identity behavioral appraisal and intentions skills can contribute to effectively managing stressful daily social interactions unique to their life experiences. More work is necessary to isolate how these cultural aspects of decision-making are healthful. A benefit of using RECAST theory is that if one can change the stressfulness appraisal of violent, racial, and/or disrespectful encounters, one can potentially change unhealthy decision-making and behaviors. Perhaps, increasing Black men's awareness of their greater disproportionate ETV, racial discrimination, and financial hardship can promote violence restraint because navigating the stress from racial and masculinity politics is the greater threat. RECAST theory suggests that if interventions can persuade Black young adult men to deconstruct the dehumanizing racialized themes behind distorted masculinity narratives and see their influence on daily partner interactions, then they may recognize they have choices to reconstruct healthier masculine frames that lead to healthier relationship decisions.

This work extends the field of research on emerging adult development on Black masculine and racial identities. Curtis et al. (2020) assert that growing up with childhood adversity and income instability can push men to adopt negative stereotypical masculinity identities. Respect-based masculinities define Black men as hard-working and faithful while reputation-based masculinites define them as hypermasculine and promiscuous. The idea that Black men's racial identity conceptualization of their world or other people can significantly affect their health outcomes is not new. Chae et al. (2014) found that "Black men who had both experienced racial discrimination and harbored an anti-Black bias themselves—whether they knew they held one or not—aged quicker than other Black men. (p. 108)." The rationale is that by viewing other Black people as inferior to gain social or psychological status superiority, one's physical health and longevity is compromised because it is impossible to opt out of one's racial group or the inferiority stigma burden associated with it. Several studies link Black men's internalization of racism to health and relational problems (Taylor, 1990) and violence (Terrell & Taylor, 1980). Stock et al. (2018) found that using racial self-affirmation to address racial exclusion was beneficial in reducing substance-use vulnerability among emerging Black adults. It only follows that the counter-socialization of negative racialized narratives about Black men could lead to different interpersonal decision-making options. This study adds to the growing field of culturally responsive interventions where RECAST theory assumes that the adoption of negative respect-based masculinities can be disrupted and reconstructed (Anderson & Stevenson, 2019; SAMHSA, 2021; Stevenson, 2003).

Practical Implications

Black barbers are some of the most persuasive counselors on diverse life matters and when trained, can become competent health educators who use their cultural styles to teach a gendered-racial literacy and retaliation violence reduction skills curriculum to other men with fidelity (Botvin et al., 1995). Black men have been targeted as a hard-to-reach population by public and social service institutions without an appreciation of the contexts these men deem trustworthy (Armstrong et al., 2014). Not only can barbershops become satellites of health education, they represent culturally responsive environments that force scientists to reimagine their theories of participant recruitment, retention, and influence. The high rates of Shape-Up participant retention in 3-month, 6-month, and 12-month postintervention assessment are a testament to the reliable communication networks of Black barbershops.

This study also demonstrates the political and community credibility of barbershop owners, their shops, the climate within those shops, and their barbers to successfully accomplish neighborhood-based psychoeducational health intervention initiatives (Victor et al., 2009, 2011). The potential for scaling up these initiatives from local 3–5 block radius neighborhoods where barbers are most likely to have their greatest impact to larger neighborhood blocks is strong, but caution is recommended to not stretch barbers beyond their most powerful zones of influence.

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The Shape-Up intervention was successful in not only reducing hypermasculinity beliefs but also increasing Black manhood vulnerability beliefs, a process of countering negative male stereotypes with positive racial identities. While the intervention was not successful in changing retaliation restraint behaviors and attitudes that were approaching but not reaching significance, future research must modify the intervention to increase the self-efficacy of positive emotion-regulation mediators.

In essence, this present study focuses on the racial affirmation-, correction-, and protection-specific aspects within the intervention curriculum content and supportive barber interactions (Stevenson, 2003). The barbershop constitutes a place of safety to disclose personal information and the atmosphere that supports this safety cannot be dismissed or underappreciated. Future research might consider studying qualitatively how cultural coping strategies of persuasion and bonding of Black barbers enhance the openness of Black men to receive and apply health knowledge in their daily relationships and encounters with partners, peers, and strangers. In-depth analyses or case studies of successful barbers' counseling interactions can be illustrative and allow for more integration of measurable coping strategies in future health intervention studies. As the first study of its kind to integrate a barbershop intervention to target racialized manhood in the reduction of risky health behaviors. Through increased dosage and replication, the Shape-Up project holds promise as a culturally responsive approach when engaging and sustaining the health improvement of emerging African American adult men.

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