There is No "Post":
How Trauma and Violence Affect the Lives of Young Males of Color

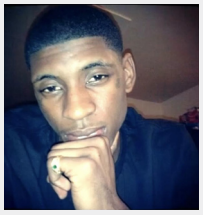
The goal of this brief is to help practitioners and policymakers – particularly those affiliated with organizations that interact with boys and young men of color (BMoC) such as clinics, schools, courts and nonprofit service providers – understand the widespread nature of trauma, how it tends to express itself in BMoC, and what they can do about it. Our hope is that this brief will lead practitioners and policymakers to understand how these boys and men needlessly suffer when there are solutions at hand, and to commit to addressing trauma in BMoC as a high priority within their organizations.

WHAT DO WE EVEN MEAN BY TRAUMA?

According to the National Center for Trauma-Informed Care, "Trauma occurs when an external threat overwhelms a person's coping resources." It's when something threatening happens to you and the resources you have around you and within you are not enough to cope with that threat. All kinds of experiences can be traumatic, which is to say threatening and overwhelming. Although the literature on trauma often focuses on experiences of violence, abuse and disaster, there are other experiences that can be traumatic and also common and repeated for BMoC, including poverty, racism/discrimination, and detention and incarceration. PTSD or post-traumatic stress disorder is how trauma is often discussed but, as we will explore, PTSD fails to fully or accurately represent the trauma experiences of boys and men of color.

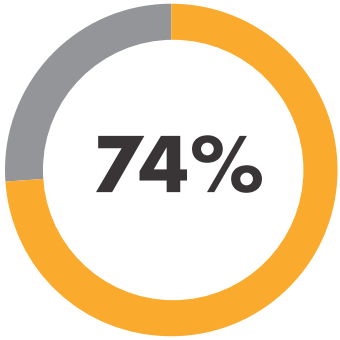
HOW COMMON IS TRAUMA AMONG BOYS AND YOUNG MEN OF COLOR?

Boys and men of color who have been victims of violence have high rates of PTSD and other traumatic symptoms. Boys and men of color disproportionately experience violence. According the Centers for Disease Control and Prevention, homicide is the leading cause of death for young African-American men, and the second leading cause for their Latino counterparts. Victims of crime often suffer symptoms of traumatic stress with up to 45% having PTSD[1] These rates may be even higher among young male victims of violence in inner-city neighborhoods. A study of young victims of violence in Philadelphia found that 74% had full-blown PTSD. Even those who did not have PTSD showed other troublesome symptoms of trauma. Research done in Baltimore found that losing peers to violence was a common experience for many black men.[2] PTSD fails to represent the trauma experiences of BMoC.



Dedicated to the memory of Maceo Bell, Jr. (1993-2014), whose tragic death cannot overshadow his vibrant life. His words and wisdom live on in this work.

Many boys and young men of color have experienced significant Adverse Childhood Experiences (ACEs). The original research on ACEs listed ten potentially traumatic experiences: 5 of those 10 are related to personal abuse and neglect, and 5 are related to caregivers, such as alcoholism, divorce or domestic violence. Even with this fairly restricted list of potential adverse experiences, the data was striking: adversity in childhood is connected to poor health outcomes in adulthood, from diabetes to lung disease to substance abuse.[3] Research on ACEs using an expanded list of stressors to include urban violence and discrimination found that males and African Americans had experienced more adversity than other genders or groups.[4] Studies conducted in Philadelphia with clients in Healing Hurt People, a hospital-based violence intervention program, found that 50% of injured victims had experienced four or more early childhood adversities before the age of 18.[5]



of a study of young victims of violence in Philadelphia had full-blown PTSD.

50% **of injured victims had experienced four or more early childhood adversities before the age of 18.**

Boys and young men of color who are victims of trauma often fail to get the help they need. Boys and young men of color lack access to primary care and behavioral health treatment. A report by the Kaiser Foundation found that almost half of non-elderly uninsured men are young adults between the ages of 19 and 35. About 25% of these young men are fathers.[6] Yet because they lack insurance, most of these men have no access to primary care. Even if they do, they are unlikely to find healthcare providers who understand the impact of trauma, and who are sensitive to the unique cultural and social needs of this population. In addition, since many of these young men only seek care in times of crisis, their experiences with health care providers often become re-traumatizing events. This is especially true if they are in need of medication for pain, or in need of mental health support. Due to the empathy gap for young men and especially for African-American and Latino males in our society, BMoC are dismissed as not really needing support and experience "victim-blaming" when they need help, with systems assuming they are somehow at fault for their experiences of trauma and violence, as will be discussed below. More generally, unfavorable experiences with systems like health care, school, social services and the police often bring about a deep mistrust in these boys and young men, leading them to avoid interaction with any systems that seek out personal information.[7]

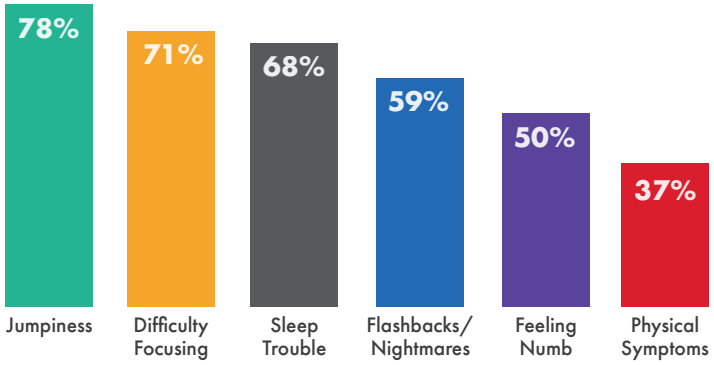
> "PTSD fails to fully or accurately represent the trauma experiences of boys and men of color."

Photo courtesy of Jason Mongue/Youth ALIVE!

WHAT DID YOUNG MEN OF COLOR TEACH US ABOUT THIS?

For this project, researchers from Youth ALIVE! conducted 4 focus groups with male survivors of gun violence recruited from our local hospital-based violence intervention program, Caught in the Crossfire. We then conducted 69 individual interviews with African-American and Latino men ages 18 to 30 recruited through a snowball sample from around Oakland, about whom we had no knowledge of their prior experiences of violence and trauma. We analyzed their words to understand their lived experience of trauma and their interactions with organizations that are intended to serve them. Screening for trauma symptoms revealed that most participants showed component symptoms of post-traumatic stress disorder (PTSD) using a modified version of the Primary Care PTSD Screening Tool [8], as shown in the chart below. The results show that psychological symptoms of trauma affect the majority of participants, whether they rise to the level of PTSD or not.

Symptoms of Trauma among Interview Population



> "The typical definitions associated with PTSD do not fit with the grinding, persistent and sustained trauma that these young people have experienced."

WHY PTSD DOES NOT QUITE FIT FOR YOUNG PEOPLE OF COLOR?

Such high levels of traumatic symptoms are consistent with other studies showing that young black men experience a disproportionate burden of loss from loved ones to homicide.[9] Recent studies have also shown that trauma symptoms in BMoC extend beyond those usually associated with PTSD to encompass high levels of depression, perceived stress and poor sleep quality.[5] When asked about their most recent traumatic experience, many BMoC find it difficult to identify a single significant experience to which they can link their experiences of trauma. This paradox of young people with significant symptoms of trauma which do not connect back to a large scale, life threatening traumatic incident has led a number of researchers and practitioners to observe that the **typical definitions associated with PTSD do not fit with the grinding, persistent and sustained trauma that these young people have experienced over** the course of their lives.

Because how systems talk about trauma doesn't fit BMoC:

- Providers who only consider PTSD in combat veterans or survivors of mass casualty attacks will overlook these symptoms in BMoC, considering them "unworthy" of the diagnosis of PTSD.
- Providers who consider BMoC to be solely responsible for creating the circumstances that led to their trauma will therefore not offer empathy or treatment, thus further traumatizing the young patient.
- BMoC themselves who lack an understanding of trauma and its consequences may simply internalize their own stress and conclude that violence is inevitable or is their "destiny."

Our focus groups supported these findings and provided context about the circumstances BMoC face. One young victim of violence spoke openly about the fact that trauma cannot be linked to a single direct injury but that it affects the community as a whole through indirect exposure:

"[Positive support] is for the community. It ain't just for people that's getting shot. 'Cause the people that ain't getting shot is goin' through the same stuff. Like I say, I got people that I know that walk around lookin' over they shoulders and they ain't never shot a gun or been fucked up with nobody ever in their life. That's just the way it is."

Another young man who had suffered a violent injury expressed the conclusion that he and his friends have come to because of the pervasive violence in their lives:

"One day we gotta die. So today's your day, shit, you gotta die. There's nothin' you can do about it. If it's your day, it's your day."

> "People assume BMoC are "unremorseful" or "hard," when they are, simply, traumatized."

This conclusion that violence is inevitable and that there is no future is consistent with how trauma often creates a foreshortened sense of the future among survivors. However, when young people lack an understanding about trauma *and* they are blamed and stigmatized by providers because of their race and gender, their trauma can turn into hopelessness and resignation. The experience of one kind of trauma is then compounded and multiplied by the trauma of racist and discriminatory experiences. When providers detect this resignation and hopelessness from BMoC without an understanding of the young person or his context, they further traumatize the person by assuming that these emotions represent a lack of willingness to change or heal.[10] People assume BMoC are "unremorseful" or "hard," when they are, simply, traumatized.

Photo courtesy of Jason Mongue/Youth ALIVE!

HOW DO YOUNG MEN OF COLOR TALK ABOUT THEIR TRAUMA?

Similarly, BMoC talk about their symptoms of trauma in ways that make sense for them, but which may be further misjudged by the providers and institutions that interact with them.

Participants in our focus groups seldom identify with the term "trauma" but rather, speak to their stress using terms like:

- Confusion
- Stressin'
- Stressed out
- Depressed
- Trippin'
- Angry
- Psychological warfare
- Feeling trapped

> "Unfavorable experiences with systems like health care, school, social services and the police often bring about a deep mistrust."

Providers who are pressed for time in a medical encounter or whose implicit biases against BMoC prevent them from listening with empathy, may fail to understand that these complaints are synonyms for trauma and stress.

Participants in the focus groups also tended to speak about their traumatic stress in physical terms, noting how stress can affect physical appearance ("grey hairs") and shorten one's life ("killing yourself slowly").

As one survivor of violence put it:

"You're killing yourself slowly. Like, because I found out that stress actually does kill you. So if you keep stressing off of certain things it can kill you in the long run. That's what I believe."

Another young survivor in the same group offered:

"We're too young to be stressing and I'm learning not to stress a lot. So, I've been avoiding that, you know? It's not good to stress because then I'm gonna put more gray hairs than I already have."

HOW DO SYSTEMS MISINTERPRET THE COPING METHODS THAT BMOC USE TO ADDRESS THEIR TRAUMA?

Often, providers hearing about physical symptoms from BMoC interpret these young people as drug seeking and dismiss their complaints. This negative assessment by care providers is often exacerbated by the fact that some young people who are faced with the intrusive and distressing symptoms of nightmares, flashbacks and insomnia turn to cannabis or alcohol to help them sleep.

An example of such self-treatment was reiterated several times in our focus groups. One young survivor of violence explained:

"If I get sick, I just smoke weed, smoke a couple blunts. I be good."

Another young survivor concurred, adding:

"All that goin' to the hospital for $10.00. That's gonna waste your time. You can smoke this blunt in 5 minutes and be cool in 10. And go to sleep in 20."

A full 68% of the young people in our interviews experienced sleep dysfunction. If you are not trauma-informed, you may view the use of marijuana in this case as some kind of moral failure or, at best, as a social ill. A trauma-informed perspective understands the logic of self-medication for a person who is having trouble sleeping and does not have the time or money or hope to waste on seeking formal medical care to address his need for relief when another solution is at hand.

NEW WAYS OF THINKING ABOUT TRAUMA IN BMoC IN THE SOCIAL CONTEXT

Increasingly, researchers and practitioners who are hearing the poignant voices of BMoC are formulating new ways of thinking about trauma in the social context in which these young people live. PTSD was a diagnosis developed for soldiers who came home from the battlefield, not home to it. Consequently, for many BMoC there is no "post" to the traumatic experience when they live with it daily, returning to the place where it happened or is still happening. We are increasingly considering how the standard idea of PTSD fails to represent the trauma experiences of BMoC and other marginalized groups. PTSD fails to take into account the accumulation of stress brought on by poverty, racism/discrimination and victimization at the hands of those who are supposed to be in the position to help, specifically police, schools, health care and social services.

A brief list of emerging alternative formulations of the overwhelming stress include:

- Continuous traumatic stress – Kaminer and collegues in South Africa[11]
- Post Traumatic Slave Syndrome –DeGruy[12]
- Synergistic Trauma – Pinderhughes[13]
- Persistent Traumatic Stress Environment – Ginwright[14]
- Sustained Traumatic Stress Reaction – A term that we use at The Center for Nonviolence and Social Justice

Photo courtesy of Jason Mongue/Youth ALIVE!

> "For many BMoC there is no "post" to the traumatic experience when they live with it daily, returning to the place where it happened or is still happening."

While an in-depth discussion of each of these emerging concepts is beyond the scope of this brief, they demonstrate that there is an increasing recognition that the traditional designations of trauma, embodied in notions like complex trauma or PTSD, fail to represent BMoC and must yield to more effective, human and socially just concepts.

Based on our work, we offer a set of recommendations for organizations looking to advance their ability to address trauma in BMoC.

THREE THINGS YOU CAN DO

1. Improve your organization's ability to be trauma-informed, holding in mind the needs of BMoC.

A critical first step for any organization intending to serve BMoC or other populations under stress is to become trauma-informed. By definition, trauma-informed organizations transform themselves by taking into account the stress, trauma and adversity that individuals and communities experience, including the stress that comes from historical oppression and constant devaluation. A trauma-informed organization is one in which providers ask "What happened to this person?" rather than "What's wrong with this person?

Photo courtesy of Jason Mongue/Youth ALIVE!

Organizations seeking to become trauma-informed can proceed by:

Training your entire organization in trauma-informed practices. Resources for such training can be found through:

- The Substance Abuse and Mental Health Services Administration (SAMHSA) at https://www.samhsa.gov/nctic/trauma-interventions
- The National Child Traumatic Stress Network (NCTSN) at http://www.nctsn.org/resources/topics/creating-trauma-informed-systems
- The National Network of Hospital-Based Violence Intervention Programs (NNHVIP) at http://nnhvip.org/trauma-informed-care

Initiating a trauma-informed organizational assessment like: http://traumaticstressinstitute.org/wp-content/uploads/2010/06/Trauma-Informed-Care-Org-Self-Assessment-Final.pdf. Such an assessment will help organizations identify strengths and weaknesses in their ability to provide trauma-informed care.

> "A trauma-informed organization is one in which providers ask 'What happened to this person?' rather than 'What's wrong with this person?'"

2. Address implicit bias and improve cultural responsiveness to BMoC.

In addition to creating a trauma-informed environment, organizations should actively assess implicit and explicit biases that play out in the care of BMoC. Organizations that are vigilant in creating equity in the care of all clients/patients will acknowledge that inequities usually exist and are only uncovered if we actively look for them. In this regard, organizations would be well served to:

Assess how they are serving BMoC

BMoC should be actively engaged to provide feedback about the processes and outcomes of their care, especially their treatment by direct service providers. Such feedback should be collected in an open-ended and non-threatening way, so that clients feel safe to share concerns without fear of losing access to services. Where possible, staff of color, especially peers, should conduct the interviews and participate in the analysis of the findings.

Review current protocols

Organizational leaders should review current protocols for race and gender bias to understand if certain clients, especially BMoC, receive differential care. Organizations should ask themselves and staff questions about how trauma might be misjudged when dealing with BMoC such as:

- Does our staff tolerate different behaviors for people experiencing certain types of trauma and not for others?
- Does our staff consider certain reactions to trauma (self-treating symptoms by smoking marijuana, carrying a weapon to feel safe, impulsivity and reactivity to conflict) unworthy of empathy and support? Does our behavior imply that we believe that?
- Is our organization's staff diverse, including males of color as providers, peers, and counselors?

Assess implicit bias and train staff to understand how to mitigate these effects

Growing understanding of the impact of unconscious/implicit bias tells us that we are often unaware of our deeply held biases. These unconscious biases can then affect the care we deliver to clients or patients.

Organizations that are seeking to further health equity can address these biases by:

- Using the Implicit Association Test, an online tool developed by researchers at Harvard University (https://implicit.harvard.edu/implicit/takeatest.html) to test for unconscious biases. The test allows individuals to learn if they hold a preference for a particular racial group, gender, religion, sexual orientation, body type or country of origin.
- Training and educating all staff about unconscious biases to raise their awareness of potential barriers to effective care for BMoC.

> "Does our staff tolerate different behaviors for people experiencing certain types of trauma and not for others?"

3. Connect BMoC to needed services

Organizations that want to improve care for BMoC should develop strong partnerships with like-minded providers who embrace trauma-informed care and socially just and equitable services.

Organizations should work to link BMoC who have suffered violence or trauma, not only to medical services but also to trauma-informed and culturally responsive behavioral health care. This includes using culturally responsive, trauma-informed program models, such as hospital-based violence intervention programs, community-based health centers that employ community health workers and arts/movement-based/faith-based programs that create culturally safe healing spaces for BMoC.

Photo courtesy of Jason Mongue/Youth ALIVE!

ABOUT THE *HEALING IN COLOR* ACTION BRIEF SERIES:

This is the first in a series of action briefs commissioned and funded by The California Endowment in partnership with Youth ALIVE! and the Center for Nonviolence and Social Justice at Drexel University entitled Developing Health Care Standards of Practice for Boys and Men of Color (BMoC) Exposed to Violence. Under this initiative, researchers from Youth ALIVE! and UCSF conducted 4 focus groups with male survivors of gunshot wounds and 69 individual interviews with young men of color from the local area, and analyzed their words to understand their lived experience of trauma and their interactions with health care, education, criminal justice and human services organizations.

Regarding these young men as experts in their own lives and their communities, we have summarized their wisdom and insights, and proposed approaches that will help systems that touch the lives of these young men to deliver more human and more effective care and intervention for trauma and its manifestations.

The first action brief, "There is No 'Post': How Trauma and Violence Affect the Lives of Young Males of Color," addresses the sustained and persistent nature of the trauma that BMoC face. The second action brief, "'Ain't nobody gonna come back because you didn't do nothin' while I was there': Making your Organization Responsive to BMoC," addresses how BMoC who have experienced violence and trauma perceive their treatment and care from organizations and institutions, and what they would like to see. The third action brief "Screening & Tool for Awareness & Relief of Trauma (START): A practical application of Trauma-Informed Care," describes an intervention tool developed through this initiative to not only screen for but to address the often hidden trauma that BMoC face. It is our hope that taken together, these three action briefs will provide a roadmap for BMoC-serving individuals and organizations to understand and intervene effectively to heal the wounds trauma.

Thank you for reading!

For more information: youthalive.org | drexel.edu/cnvsj | START2Heal.org

Authors: John Rich, MD, MPH, Anne Marks, MPP, Ted Corbin, MD, MPP and Linnea Ashley, MPH

January 2018

1. Sered, D. "Young Men of Color and the Other Side of Harm: Addressing Disparities in our Responses to Violence." *Vera.* Vera Institute of Justice, December 2014. Web.
2. Smith, J.R., and Patton, D.U. "Posttraumatic Stress Symptoms in Context: Examining Trauma Responses to Violent Exposures and Homicide Death Among Black Males in Urban Neighborhoods." *American Journal of Orthopsychiatry* 2016; 86(2):212.
3. Felitti, V. J., Anda, R.F., Nordenberg, D., et al. "Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults. The Adverse Childhood Experiences (ACE) Study." *American Journal of Preventive Medicine* 1998; 14(4):245-258.
4. Cronholm, P.F., Forke, C.M., Wade, R., et al. "Adverse Childhood Experiences: Expanding the Concept of Adversity." *American Journal of Preventive Medicine* 2015; 49(3):354-361.
5. Corbin, T.J., Purtle, J., Rich, J.A., et al. "The Prevalence of Trauma and Childhood Adversity in an Urban, Hospital-based Violence Intervention Program." *Journal of Health Care for the Poor and Underserved* 2013; 24(3):1021-1030.
6. Hinton, E., and Artiga, S. "Characteristics of Remaining Uninsured Men and Potential Strategies to Reach and Enroll them in Health Coverage." *The Kaiser Commission on Medicaid and the Uninsured.* The Henry J. Kaiser Family Foundation, 14 April 2016. Web.
7. Brayne, S. "Surveillance and System Avoidance Criminal Justice Contact and Institutional Attachment." *American Sociological Review* 2014; 79(3): 367-391.
8. Prins, A., Kimerling, R., Cameron, R., et al. "Primary Care PTSD Screen (PC-PTSD): Psychometric Properties, Operational Characteristics, and Clinical Implications." Annual Meeting, International Society for Traumatic Stress Studies, 1999, Miami, FL.
9. Smith, J.R. "Unequal Burdens of Loss: Examining the Frequency and Timing of Homicide Deaths Experienced by Young Black Men Across the Life Course." *American Journal of Public Health* 2015; 105(S3):S483-S490.
10. Rich, J.A. *Wrong Place, Wrong Time: Trauma and Violence in the Lives of Young Black Men.* Baltimore: JHU Press. 2009. Print.
11. Eagle, G., and Kaminer, D. "Continuous Traumatic Stress: Expanding the Lexicon of Traumatic Stress." *Peace and Conflict: Journal of Peace Psychology* 2013; 19(2):85.
12. DeGruy, J. *Post Traumatic Slave Syndrome: America's Legacy of Enduring Injury and Healing.* New York City: HarperCollins. 2017. Print.
13. National Academies of Sciences E, Medicine. *Community Violence as a Population Health Issue: Proceedings of a Workshop.* Washington, D.C.: National Academies Press. 2017. Print.
14. Ginwright, S. *Hope and Healing in Urban Education: How Urban Activists and Teachers are Reclaiming Matters of the Heart.* United Kingdom: Routledge. 2015. Print.