

# Moving Toward Healing: Trauma and Violence and Boys and Young Men of Color



John Rich, MD, MPH  
Center for Nonviolence and Social Justice  
Drexel University



DREXEL UNIVERSITY  
School of  
Public Health



Robert Wood Johnson  
Foundation

## Introduction

Trauma and violence disproportionately affect the lives of boys and young men of color (BYMOC). Violence, when it claims the life of a young person, causes a devastating loss for individuals, families and communities, as well as a loss of potential for society overall. Young people with nonfatal violent injuries can suffer lifelong physical disabilities and pain which can limit their potential as learners, workers and citizens. Less often recognized are the psychological wounds left by violence which cause victims deep and daily distress, often in the form of post-traumatic stress or depression. The trauma of violence leaves scars on the individual and families, and the communities in which they live.

Other forms of trauma that affect BYMOC can also take a physiological and psychological toll. The impact of childhood adversity and unrelenting stress (also known as “toxic stress”) on future chronic disease and early death are well-documented. Beyond the specific personal and family adversities documented in public health and medical literature, BYMOC are more likely to suffer toxic stresses imposed by chronic poverty, racism, unconscious bias, brutality at the hands of the police, and other human-serving systems. Of great concern, is the lack of a healing response from the many systems—healthcare, mental health, public health, law enforcement, and social services—who are charged with protecting the lives and dignity of BYMOC. These systems often re-traumatize BYMOC who present to them in need of support and healing.

The purpose of this brief is to highlight the great burden that trauma, violence, adversity, and the social determinants of health impose on the health of boys and men of color. To protect BYMOC from the potential harm inflicted on them—and to mobilize the resilience and promise these young people hold—providers, leaders and policymakers must understand the physical, emotional and societal effects of trauma, violence, and adversity. They must also recognize the implicit and explicit racism and stigma faced by BYMOC. Only with this understanding can leaders effect the fundamental transformation to ensure that BYMOC heal, thrive, and realize their fullest potential.



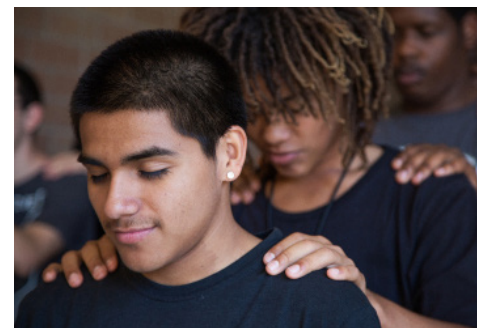
## Definition of the Problem – How Do We Understand Trauma, Violence and Adversity?

Most often when we talk about the disparate impact of violence on BYMOC, we are referring to interpersonal violence or violence perpetrated by one person on another. BYMOC are affected by this form of violence at a higher rate than any other group. Centers for Disease Control and Prevention (CDC) statistics show that homicide is the leading cause of death for African American males between the ages of 15 and 24 [1]. According to the CDC, even though overall homicide rates have fallen significantly in the past decade, 2,719 black males between the ages of 10 and 25 died as victims of homicide in 2014 compared with 546 white males. The death rate for black males in this age group (50.7/100,000) is more than 18 times higher than the rate for white males (2.75/100,000). Rates for Hispanic males (10/100,000) are more than three-and-one-half times the rate for white males. Between 1999 and 2014, more than 47,000 black males and more than 18,000 Hispanic males between the ages of 10 and 25 were victims of homicide [1]. Ninety-two percent of black male homicides and 83% of Hispanic male homicides in this age group were caused by firearms. While homicides for young men of any race or ethnicity are tragic, these statistics highlight the dramatic racial and ethnic disparity in homicide across the country.

Despite the tendency to focus on homicide as the prime indicator of violence, it is only the tip of the iceberg. The CDC has estimated that for every homicide there are 94 nonfatal violent injuries.[2] Available data also tell us that African Americans, and African American males in particular, are disproportionately affected by nonfatal assault. In 2013, black males between the ages of 10 and 25 suffered nearly three times the rate of nonfatal assaults as similarly aged white males. Hispanic males in this age range suffered nonfatal assault at one-and-one-half times the rate of white males.

A large body of research also tells us that violence is a chronic, recurrent problem. Victims of intentional violence are at greater risk of being victimized again, sometimes resulting in death. By some estimates, more than 40% of victims who have suffered a penetrating injury are shot or stabbed again within five years of initial injury. Of these victims, many of whom are young men of color, 20% are dead in five years [3-5]. The pathways that lead to repeat injury and death are often complex and involve traumatic stress, self-medication to ease the symptoms of

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trauma, perceived pressure to retaliate, and involvement in other high-risk activities—either related to involvement in illicit activities or related to traumatic stress itself [6]. Clearly trauma plays a powerful role in feeding the cycle of violence for all victims and, especially, for BYMOC, who disproportionately live in neighborhoods marked by poverty.

While many of these nonfatal assaults occur in the community, nonfatal injury at the hands of the police also disproportionately affects black and Hispanic males. Data show that black males suffer more than three times as many nonfatal injuries at the hands of the police than white males [7]. Data from the Centers for Disease Control and Prevention show that black males between the ages of 10 and 25 suffer more than five times as many police-related nonfatal assaults as white males of the same age. In this age group, Hispanic males suffer more than one-and-one-half times as many police-related assaults as white males [1]. While the full impact of police violence against BYMOC is still being assessed, police violence undermines trust in law enforcement and reinforces the widely held belief among

BYMOC that the police are not there to protect them [8]. The consequences of this mistrust are serious. Young people who do not trust the police, and who live in communities where the police are viewed as victimizers, are reluctant to cooperate with authorities for fear of being seen as “snitches.” In addition, traumatized young people who may feel constantly in danger, sometimes turn to weapons or membership in gangs and other groups as a means of self-protection [6].

## Understanding Trauma

Beyond physical violence, trauma has an enduring impact on physical and emotional health. Bessel van der Kolk, a noted trauma expert and author of *The Body Keeps the Score*, has defined trauma as follows: “When internal and external resources are insufficient to deal with an external threat [9, 10].” Trauma results from substantial negative experience(s) imposed directly on a person and relates to what happens around them in their families, communities, and the broader society. Since BYMOC are disproportionately poor and live in neighborhoods that lack economic resources, they will be exposed to higher levels of violence in the community. Poor BYMOC are more likely to report that they have lost friends and acquaintances to violence and that they have directly witnessed assaults or murders [11].

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A diagnosis of a trauma-related illness requires the traumatized person display a specific set of symptoms that fall within predefined categories. Post-traumatic stress disorder (PTSD), for example, requires that the traumatized person has experienced a serious, life-threatening event, and has symptoms that fall into the following categories: re-experiencing, avoidance, disturbance of cognition or mood, and hyperarousal [12]. For depression, a common result of trauma, the traumatized person must report specific symptoms such as sad mood, sleep disturbance, and lack of energy consistent with a formal diagnosis.

Research on young men and women who have been victims of urban violence reveals high rates of post-traumatic stress disorder among this group. A survey of clients in Healing Hurt People (HHP) a trauma-informed, hospital-based violence intervention program serving victims of violence in Philadelphia, Pennsylvania found that 75% of the clients had diagnosable PTSD and 50% reported more than four adverse childhood experiences before the age of 18 [13]. Clients in the study ranged between 16 and 35 years old and most (91.4%) were African-American or Hispanic males. Qualitative studies with young men of color in Boston, Massachusetts have found similar levels of PTSD and have described how symptoms such as hyperarousal, sleeplessness, nightmares, and flashbacks can interfere with the quality of life of these young men [14].

The term “post-traumatic stress” implies that there is a “post” to the trauma where BYMOC return to a place of safety; however, there is little escape for these young men. To fully understand the impact of trauma on BYMOC, it is important to stress that negative impacts of violence, trauma, childhood adversity, and social determinants of health are additive; perhaps, even synergistic, and must be considered together. Human-serving institutions and systems must recognize the grinding weight of everyday violence and toxic stress on BYMOC. Many BYMOC are never free of the effects of trauma. They live in conditions characterized by neighborhood poverty, implicit and explicit racism, lack of resources, and exposure to violence in their family and communities. For BYMOC, the continuous background weight of these social determinants of health is often punctuated by interpersonal violence, the loss of a friend to violence, or police brutality whether as victims or witnesses to trauma.



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## How Do We Measure Trauma and its Impact?

Various instruments have been developed to measure trauma and adversity. The Adverse Childhood Experiences (ACEs) Study questionnaire and related scales are being used with increased frequency to measure childhood adversity in individuals and populations. In pediatric settings, information about parental adversity can help providers reinforce protective factors and resilience for children. For adults, knowing about childhood adversity and its effects can help providers to educate patients about how to decrease risk factors which can lead to chronic disease.

There are also many instruments to measure PTSD which can be used in clinical settings. Increasingly, primary care providers are utilizing brief PTSD screens to find out whether patients have symptoms that need referral to psychiatrists or psychologists. In the primary care setting, screenings may also be helpful for patients not needing referral to a psychiatrist but are in need of help managing symptoms related to trauma. In this way, PTSD screening instruments can be used as opportunities for providers to educate patients about how trauma may be affecting them and teach coping skills such as meditation, relaxation, and movement to manage symptoms.

A pilot is underway in Oakland California to test a brief screening and intervention strategy for young African American and Hispanic youth who have been victims of violence. Healthcare providers administer a culturally appropriate screening with the goal of assessing and managing symptoms of trauma, rather than to label participants with a specific diagnosis. Named START (Screening Tool for Awareness and Relief of Trauma) the intervention was developed based on focus groups with young victims of violence, most of them young men of color, served by Youth Alive!, a violence prevention and positive youth development organization.[15] Participants in the focus groups helped to refine the screening questions used and helped to identify a range of interventions that they would feel comfortable using in their homes and communities. Designed for use in healthcare and community settings, START allows a clinician or community health worker to screen for symptoms and then instruct the participant in sleep hygiene, meditation, grounding techniques, and other effective strategies in order to decrease stress.

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## Systems Perpetuating the Experience of Trauma

A key concept in trauma-informed practice is the understanding that institutions can often intentionally or unintentionally re-traumatize victims when they are supposed to be helping them. It is well-documented that people of color receive worse care within the healthcare system. Increasingly, researchers are documenting unconscious bias and institutional racism on the part of healthcare providers which leads to disparate healthcare services and outcomes for people of color. Providers of all sorts of services may hold the idea that young black males incite their own injury through provocation, illegal activity, or simply by being in a place they should not have been. For victims of violence, these biases can span throughout the injury experience from the emergency medical services personnel who arrive on the scene and the police who investigate the injury at the scene, to emergency department personnel and trauma surgeons who operate on them. This is clear evidence that within multiple systems, BYMOC are viewed as responsible for their victimization. When this perception is held by providers within all of the systems that serve injured young people of color, the experience of re-traumatization can be potent. Victim services providers, especially domestic violence providers, may also view BYMOC as perpetrators of violence rather than victims. Anecdotally, young people who sought victim services for help after an injury have had the staff call the police believing that they were there to victimize an intimate partner rather than to receive services themselves [16, 17].

Long known to exist, but only more recently documented for the broader public, are traumatizing experiences of violence at the hands of the police. Dramatic video of police killings of Michael Brown, Eric Garner, Freddie Gray, and Tamir Rice have sent the chilling message to BYMOC that their lives are valued less than the lives of their white counterparts. Beyond the brutal, excessive, and unjustified force used in these incidents, the disregard for the dignity of the bodies of these young people after their fatal injuries carries a message of dehumanization. Despite the growing condemnation of police violence, these incidents reinforce the perception that the police likely regard BYMOC as perpetrators first and; therefore, are more likely to do harm to them. While data and statistics have long supported this conclusion, the tangible visible evidence sends its own traumatizing message.

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## Through the Eyes of a Young Victim

Few people can fully understand the trauma of a violent injury for a young person. It is easy to imagine that the most traumatic moment is the injury itself, yet the process that follows the injury—including the medical care—are often also traumatizing. What follows is a brief, typical account of a young person shot during a robbery.

*Andre, a 19 year-old African-American man, was walking home from work in an area of the city where violence often occurs. As he neared his home, another young man on a bicycle tried to rob him of his necklace. Andre fought back, trying to push the assailant off his bicycle and run; however, the assailant fired several shots which hit Andre in the abdomen and the leg. The assailant stole Andre's necklace and rode away.*



*As Andre lay bleeding in street, several neighbors came to his aid. When the police arrived, they prevented anyone from touching Andre while they awaited the arrival of emergency medical services and more police. Andre could see that he was bleeding and asked for help, but the officers continued to prevent anyone from assisting him. Andre reports that a police officer stood over him and said "Don't do nothing stupid like die." The officer insisted that Andre knew who shot him and demanded that he provide law enforcement with the name of that individual. Andre insisted that he didn't know the young man who robbed him.*

*The ambulance arrived and quickly ushered Andre to the hospital. Throughout the ride, Andre felt pain each time the ambulance hit a bump or turned a corner. At the hospital, Andre was whisked into the trauma bay where the trauma team descended on him in an attempt to save his life. He remembers that at some point, without explaining what he was doing, a doctor put a mask over his face. Andre recalls, "I thought he was trying to smother me." Andre was taken into surgery where they were able to repair the damage to his internal organs. He remembers awakening with tubes coming out of his mouth, nose, wound. Although Andre was in extreme pain, he had difficulty obtaining pain medications. Thinking back on that time, Andre concludes "I'm never going back to the hospital."*

***"Don't do nothing  
stupid like die."***

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*After surgery, Andre was discharged to the home he shared with his grandmother. Because he did not have insurance, Andre received no rehabilitation or home nursing services for his extensive injuries. His follow-up appointments were to occur in a trauma clinic.*

*Andre's grandmother, completely overwhelmed by his assault having lost another grandson to gun violence three years before, attempted to advocate for compensation from the state victim assistance fund. Those efforts were thwarted when she was refused a copy of his police report which would have been necessary in order to access victim services. Andre's grandmother also sought temporary disability for her grandchild but this attempt was blocked by the attending physician who estimated that Andre would recover "quickly enough" to return to work.*

*In addition to physical pain, Andre suffered severe nightmares, sleeplessness, flashbacks, and extreme nervousness. He did not feel safe enough to leave the house and missed his few medical follow-up appointments. Andre began to smoke marijuana and drink beer in order to cope with the flashbacks enough to rest. He also considered obtaining a firearm for protection.*

*Once the police arrested an assailant, Andre willingly and positively identified the person that shot him. Not surprisingly, Andre's cooperation with the police was another source of unease. Andre feared that he would be labeled a "snitch" because the police made multiple visits to his home. Still, Andre agreed to testify at trial and his assailant was sentenced to prison. Unfortunately, the knowledge that the person that harmed him had been brought to justice did not help to make Andre feel safer.*

This narrative illustrates the multiple levels on which the experience of violence can be disruptive and traumatizing. For the victim, the trauma begins prior to reaching the hospital and extends well into the months and years that follow. Unlike Andre, 80% of young victims of violence who are seen in the hospital are discharged home the same day with the majority of medical resources mobilized only for those with life-threatening injuries [1]. For these young people, assistance with the psychological damage brought on by violence rarely exists.

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## Adverse Childhood Experiences

Over the past 30 years, a growing body of literature and research has uncovered the damaging impact of adversity in childhood. The initial insights for this construct emerged from the Adverse Childhood Experiences (ACE) Study conducted in the mid-90s in the Kaiser Health System by Anda and Felitti [18]. The researchers found that ten adversities in childhood—physical abuse, physical neglect, emotional abuse, emotional neglect, sexual abuse, household member with substance abuse, seeing one’s mother treated violently, household member with mental illness, incarcerated family members, and parental discord—were excellent predictors of the development of specific chronic conditions in adulthood which include heart disease, lung disease, diabetes, obesity, cancer, depression, suicide attempts, and substance abuse. These adversities also correlate with the practice of certain unhealthy behaviors including smoking, large number of sexual partners, and intimate partner violence as a perpetrator or victim. The findings of this important research have laid the foundation for subsequent studies designed to understand the detrimental effects of early trauma, and the mechanisms through which these effects may occur.

In June, 2015, Cronholm et al surveyed a sample the population in the Philadelphia using an expanded version of the ACE questionnaire [19]. This time, 44% of respondents were African American versus only 4.8% of the respondents in the original ACE study population. Cronholm’s version incorporated items relating to witnessing bullying and/or violence, experiencing discrimination, lack of community cohesion, and growing up in foster care. The researchers found that African-Americans, Hispanics, and Asian Pacific Islanders had a higher risk of adversity than their white counterparts. This study confirmed the suspicion that structural violence in the form of racism and community trauma such as witnessing violence and feeling unsafe are factors that disproportionately cause trauma for people of color and those who are economically disadvantaged. Other studies have supported the finding that community violence and poverty pose a particular form of adversity and toxic stress for youth [20].

Another important contribution to understanding childhood adversity was made by Finkelhor and colleagues who looked within their population of nearly 5000 children and augmented the ACE questionnaire with items they had collected on peer victimization, peer isolation, parental conflict, having had property/belongings stolen, exposure to community violence, socioeconomic status, and school performance [20]. They found that while peer victimization, peer isolation and exposure to community violence were related to *increases in distress* among children in the study, low



socioeconomic status was related to poor physical health status. This vital finding suggests that different types of stresses in children elicit different types of effects.

## Trauma and Violence Touch the Lives of Boys of Color from Early Childhood to Young Adulthood

A significant amount of biological research aimed at understanding the mechanisms involved in the physiological changes in the brain has paralleled these versions of the ACES Study. Some of this research has identified changes in the structures of the brain that govern emotion (amygdala), learning and memory (hippocampus), and decision-making (prefrontal cortex). Overall, the effect of trauma and stress depend, in part, on age and stage of development in children.

### Infants and Young Children

Exposure to violence and trauma can cause different effects depending on the person's age. Young children and infants may be victims of physical abuse or neglect. They may also witness violence directed against their mothers or siblings. As children age and make their way into the world, they may see violence in schools and in their communities. In communities with high levels of violence, children may view violence as normal and seem unfazed by it. However, witnessing violence can cause psychological and physical effects that last into adulthood. The same is true for immigrant or refugee children who have departed war zones or fled abuse in search of safety.

A great deal of attention has been paid to the correlation between trauma and early brain development, specifically the ways in which the infant brain begins to connect neurons. It appears that the developing brain supports connections between neurons based on how much the pathway or connection is used. If the developing brain encounters danger, threat or neglect, survival pathways in the brain become connected at the expense of other pathways (such as those supporting learning and artistic creativity). These changes appear to be driven by stress hormones like cortisol and adrenaline, which are activated under extreme stress [21]. While this pathway is critical to survival when it functions in the body's normal fight of flight mechanism, toxic stress can be damaging to brain development. Toxic stress can also harm how cardiovascular and endocrine systems function, leading to higher rates of adult heart disease and diabetes[22].



## Adolescents and Young Adults

Research now tells us that the adolescent brain is far from complete in its development and maturation [23]. In fact, a critical period of brain development begins in adolescence and continues well into the mid-twenties. The key focus of continued development is the prefrontal cortex, a high-functioning region of the brain that is necessary for decision-making, reining in emotions, and resolving conflicts. While this portion of the brain is approaching full development, other portions of the brain such as the amygdala (a region driven by emotions), may be dominant in particularly stressful situations. These changes in the brain are occurring simultaneously with other important adolescent milestones. Adolescents are experiencing rapid physical growth and maturation in puberty. They are also developing social skills in a mainly peer-driven environment. Finally, the adolescent period of growth is characterized by normal risk-taking behavior which is essential for the young person to develop a sense of autonomy and self-efficacy. The perils of the adolescent risk-taking phase are reflected in their leading causes of death which include experimentation with drugs, tobacco and alcohol, tendencies to underestimate the risks associated with driving under the influence, and higher rates of accidents. Particularly for poor youth, male youth, and youth of color, high rates of violent injury and homicide accompany this risk-taking phase.

While a full discussion of the biological effects of stress at various periods in life is beyond the scope of this brief, trauma, adversity and toxic stress all take a toll on the brain and the body in ways which are only now being fully understood. In the same way that trauma and adversity take their toll on the body in terms of adult chronic disease, they also affect how we learn, what risk behaviors we engage in, and how we react to stress in the future.

## Social Determinants of Health

At the societal level, it is widely understood that social determinants of health, particularly poverty, social isolation, environmental threats, lack of education, racism, and discrimination are powerful stressors that affect the way people function in the world and can have a negative effect on their health. The impact of poverty goes beyond the results of simply not having enough money to get the things that you need. The toxic environments in which poor people live may be more important drivers of disease than personal behaviors such as poor diet, excessive use of alcohol and drugs, or poor adherence with medical therapies. Poverty, along with other forms of deprivation, can create a “biology of disadvantage,” where the body’s

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stress response is highly active, resulting in higher rates of chronic disease and early death [24, 25]. Other research has shown changes at the cellular level that indicate premature aging as a result of stress, including stress related to discrimination in African American men [26-28].

An important caveat must be offered here. While the scientific community has generally moved away from the notion of a biology of race, there are still lingering misconceptions that race is a genetic, rather than social construct, and that genes are more powerful than environment in determining overall health. In this context, scientific findings relating to biological differences which align with disadvantage or poverty can be misinterpreted. Because people of color are subject to racism and discrimination, they are disproportionately likely to be impoverished. If stresses like trauma or poverty change how the body turns on or off certain genes, then some might misinterpret this as meaning that people of color or poor people are irreparably damaged or defective. For BYMOC, who already face poverty, racism, discrimination stigma, and dehumanization, attributing these challenges to their fundamental biology will only serve to compound their trauma. Unchecked, these assumptions of determinism might fuel hopelessness about the future prospects and possibilities of BYMOC. For this reason, it is important to understand the complex relationship between the physical and social environment as critical factors in the health of people of color, the impoverished, and those on the lowest rungs of the social ladder, including BYMOC.

***Unchecked, these assumptions of determinism might fuel hopelessness about the future prospects of possibilities of BYMOC.***

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## Examples of Promising Strategies

### Healthcare based examples:

- The National Network of Hospital-based Violence Intervention Programs (NNHVIP) is a coalition that focuses on meeting the needs of victims of violence in the healthcare system across the country. Built on the original hospital-based intervention program, Caught in the Crossfire, these programs endeavor to decrease recurrent violent injury, involvement with the criminal justice system, and the physical and mental health consequences of trauma. NNHVIP also seeks to transform the culture in hospitals such that practitioners understand the importance of addressing trauma and humanize the treatment of young victims of violence.

- Healing Hurt People (HHP) is a hospital-based violence intervention program in Philadelphia, Pennsylvania that provides comprehensive case management and trauma-informed therapies for young victims of violence. HHP is being replicated at all level I trauma centers across the city with funding from the Philadelphia Department of Behavioral Health and Intellectual Disability Services. The program is built on a foundation of trauma-informed practice and incorporates emerging science on trauma into its training, program activities, and evaluation. HHP has previously been successfully replicated in Chicago, Illinois and Portland, Oregon.
- In the Bayview/Hunters Point neighborhood of San Francisco, California, Dr. Nadine Burke Harris applied the extensive research about adverse childhood experiences to a broad effort to alleviate the chronic mental health and physical consequences of trauma in children. Using cutting-edge science, she built an innovative Center for Youth Wellness that advocates for clinical services, research, prevention, and policy change to “revolutionize pediatric medicine and transform the way society responds to kids exposed to significant adverse childhood experiences and toxic stress.”

## Place-based initiatives

- The mission of the National Compadres Network (NCN) (<http://www.nationalcompadresnetwork.com/index.html>) is “to strengthen, rebalance, and/or redevelop the traditional ‘Compadre’ extended family system” through programs to “encourage and support the positive involvement of Latino males as fathers, sons, grandfathers, brothers, compadres, partners, and mentors in their families and community.” A key component of the NCN is to reinforce positive male values through culturally-based healing informed programs.
- The California Endowment has led an ambitious, place-based initiative called Building Healthy Communities which seeks comprehensive and collaborative transformation in 14 California communities (<http://www.calendow.org/places/>). A foundational component of Building Healthy Communities is appreciation of the impact of trauma, particularly on boys and men of color, and integrating trauma awareness throughout all aspects of the initiative. In fact, many of the communities have focused



specifically on addressing stress and trauma by building systems that restore and heal.

- In Walla Walla, Washington, Children’s Resilience Initiative (CRI) is an innovative effort is ongoing to address childhood adversity throughout the community. Washington was one of the first states to collect data about childhood adversity in their annual Behavioral Risk Factor Surveillance Survey (BRFSS), (the nation’s premier system of health-related telephone surveys that collect state data about U.S. residents regarding their health-related risk behaviors, chronic health conditions, and use of preventive services, funded by the Centers for Disease Control and Prevention.) The community used the data about adversity to create a community-wide effort to address trauma and its consequences, and to measure the impact of their programmatic efforts. These efforts, along with those of Dr. Nadine Burke Harris (previously mentioned) have recently been the subject of the documentary film Resilience which was previewed at the Sundance Film Festival in 2016.

## Recommendations

***Create a new narrative about the strengths and vulnerabilities of BYMOC consistent with RWJFs focus on creating a Culture of Health.***

Because the frontiers of trauma research continue to push forward, we need a new national dialogue centered first on the strengths and potential of BYMOC, and then on the damaging impacts of stress, trauma and socioeconomic disadvantage on health. Any narrative that focuses only on potential challenges but ignores strengths will only serve to further stigmatize BYMOC. To address the disproportionate impact of trauma and violence on BYMOC, policymakers and philanthropy should:

***Any narrative that focuses only on potential challenges but ignores strengths will only serve to further stigmatize BYMOC.***

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- **facilitate a national conversation** by engaging a broad panel of experts across disciplines (psychology, biology, political science, history, critical race theory, African American studies, critical feminist theory, public health, and medicine) to examine the broad social, physical and psychological implications of violence, trauma, and adversity with respect to residents of low-income communities, people of color, and BYMOC in particular.

- **support broad efforts to translate the science of trauma and adversity**, together with the historical reality of discrimination and racism, into forms where it can be better understood by the care providers, policy makers as well as the general public.
- **support a broader understanding of trauma and violence**—and the added impact of racism—which would help leaders formulate public policy that meets the needs of BYMOC while focusing on strength and resilience.

**Humanize the systems that serve BYMOC by supporting and expanding efforts to create trauma-informed, socially-just institutions.**

To address the failure of human-serving institutions (healthcare, mental health, public health, law enforcement, and social services) to meet the needs of traumatized BYMOC, direct service providers and organizational leaders must propagate effective methods for organizations to assess the extent to which their processes and practices are trauma-informed and socially-just. Once evaluated, direct care providers should:

- **adopt and incorporate trauma-informed practices** and social-justice principles to remediate institutional racism and unconscious bias.
- **support specific training and professional development programs for providers across all sectors**, but especially in medical settings, to address their unconscious bias and disparate treatment of BYMOC. This must include education and monitoring to ensure that BYMOC who are victims of violence receive adequate treatment for pain, immediate intervention to prevent PTSD and other trauma related symptoms, rehabilitative services, and connection to primary care.
- **require that funded intuitions demonstrate competency** as a condition of continued financial support.

Specifically related to law enforcement, local police and law enforcement leaders should:

- **build on effective models of specially-designed training programs for law enforcement agencies** with the goal of creating an understanding of trauma and its impact on communities, BYMOC, and law enforcement personnel. Modules on social justice, unconscious bias, and anti-racism would be embedded in the training.



- **create a new culture of community policing** based on emerging knowledge of trauma, violence, adversity, and unconscious bias to transform police interactions with BYMOC so that law enforcement officers are regarded as advocates for public safety rather than threats to the well-being of BYMOC.
- **create specific interventions to address the trauma that police officers experience** and which often fuels violence against BYMOC.

### Address the problem of firearm violence

Firearms cause a devastating amount of injury and death among BYMOC. While this is widely acknowledged, little progress has been made in understanding how to decrease the impact of guns in impoverished communities of color. Furthermore, the fierce political debate about the roles and rights related to firearms hinders innovative approaches to decreasing gun violence. In 2013, President Obama issued an executive order lifting a decades long ban on federal research to study firearm violence. That same year, the Institute of Medicine issued a landmark report called *Priorities for Research to Reduce the Threat of Firearm-Related Violence* [29] detailing critical areas of investigation about the impact of guns on health. Despite these events, little funding has been allocated to the CDC and other federal agencies to study firearm injury. Policy makers, public health leaders and advocacy groups must advocate for research that creates sound evidence for ways to decrease the prevalence of guns in inner city communities, while also better understanding why people turn to the use of guns in circumstances of conflict and threat.



### Meet BYMOC where they are and support access to specialized services.

Systems should seek to offer healing services to victims of trauma of all ages, especially BYMOC, in the settings they are most likely to frequent. Locations for service provision could include: child care, medical, educational, employment and employment training, juvenile justice, and youth development settings. Direct service providers should support and build on effective trauma therapies for BYMOC to include nontraditional approaches such as arts, music, mindfulness, dance and movement based approaches, group therapy, and a range of resilience-building therapeutic interventions. To ensure adequate access to the therapies designed for them, health insurance leaders should, under the Affordable Care Act's Medicaid expansion, fund effective strategies such as peer community health workers, patient navigators, and community-based supports to help BYMOC move through systems effectively and augment health and trauma-informed services.

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## Create specific portals of entry into healthcare services to meet the needs of BYMOC.

As discussed earlier, boys and young men of color often face barriers to adequate health care due to bias and stigma presented in the systems and institutions that serve them. Systems that serve BYMOC should expand and build on hospital-based and community-based interventions for victims of trauma which focus on healing the psychological wounds of violence, thus, preventing re-injury. Based on the success young men's clinics in New York, Chicago and Boston have had in engaging BYMOC in effective and comprehensive care for trauma and its consequences, policymakers and providers should invest in innovative primary care medical home models which co-locate and integrate physical, behavioral and social health services specifically designed for BYMOC. Services would be delivered by a diverse team of trauma-informed providers who are empathic to the needs of BYMOC. Wherever services are delivered, key members of these service teams should be males of color as physicians, nurses, social workers, psychologists and therapists. In addition, BYMOC with the lived experience of violence who have successfully healed from their trauma should be equipped with the skills to serve and succeed as peer providers. Finally, policymakers and direct care providers must engage communities as partners, so that approaches to healing are deeply rooted in the neighborhoods that have great need and untapped capacity. At all levels, we must invest in making communities safer and ensuring that all systems collaborate to reduce the impact of violence and trauma on BYMOC.

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## Conduct an inventory of effective approaches to healing for BYMOC

While several examples of direct service, place-based and clinical approaches to healing for BYMOC are presented here, the broad range of potentially effective programs is not well documented. Philanthropic organizations should partner with public health leaders to survey the broad landscape of healing and prevention approaches that may ameliorate the effects of violence and trauma, specifically among BYMOC. Furthermore, such an inventory should specifically call out programs that are based on ineffective or outdated conceptual models (such as scared straight approaches) while elevating innovative approaches that have the potential for scalability, sustainability and broad adoption.

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