

CHANGING PLACES



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HOW COMMUNITIES WILL IMPROVE
THE HEALTH OF BOYS OF COLOR

**Edited by Christopher Edley Jr.
and Jorge Ruiz de Velasco**

With a foreword by Robert Phillips



The Chief Justice Earl Warren Institute on Race, Ethnicity and Diversity at the University of California at Berkeley School of Law is a multidisciplinary, collaborative venture to produce research, research-based policy analysis, and curricular innovation on issues of racial and ethnic justice in California and the nation.

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Cover: The cover image was designed by Oakland, California-based printmaker and digital artist Favianna Rodriguez. Using high-contrast colors and vivid figures, her composites reflect literal and imaginative migration, global community, and interdependence. She has lectured widely on the use of art in civic engagement and the work of bridging community and museum, local and international. Rodriguez is coeditor of *Reproduce and Revolt!* with stencil artist and art critic Josh MacPhee (Soft Skull Press, 2008). An unprecedented contribution to the Creative Commons, this two-hundred-page book contains more than six hundred bold, high-quality black and white illustrations for royalty-free creative use. Rodriguez's artwork also appears in *The Design of Dissent* (Rockport Publishers, 2006), *Peace Signs: The Anti-War Movement Illustrated* (Edition Olms, 2004), and *The Triumph of Our Communities: Four Decades of Mexican Art* (Bilingual Review Press, 2005).


THIRTEEN**APPROACHING THE HEALTH AND
WELL-BEING OF BOYS AND MEN OF COLOR
THROUGH TRAUMA-INFORMED PRACTICE**

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ABSTRACT

This chapter deals with trauma-informed approaches to the health of boys and men of color. We begin with an overview of what we know about the health of this population, with a life course perspective understanding the health issues that affect boys, adolescents, and men. We pay particular attention to the social conditions of trauma and adversity and provide critical data about the incidence and prevalence of these conditions. The chapter then shifts to a focus on trauma theory, wherein we describe the evidence that there is a relationship between physical and psychological health and early childhood adversity and trauma. Foundational to this discussion is the Adverse Childhood Experiences study, which demonstrates the profound fact that early life adversity has an effect on future chronic disease.

Next we apply trauma theory to a number of systems that serve boys and men of color. In particular, we focus on the health and public health system and its response to interpersonal violence. This focus provides an example of the overlap of multiple systems that are critical to determining the health of traumatized men. We describe the literature suggesting that violence is a chronic recurrent problem, exacerbated by the hostile social context in which many young men of color live. We then outline the dearth of literature that depicts posttraumatic stress disorder in urban male populations. We illustrate these points by tracing a hypothetical young man through systems

Based on this description, we apply trauma-informed principles to the systems cited earlier. We describe existing efforts throughout the United States that serve as promising practices that incorporate trauma-informed principles into the care and development of boys and men of color. The chapter concludes by describing how a trauma-informed system would serve boys and men of color throughout their lives.

INTRODUCTION

Men of color are disproportionately affected by ill health and social inequality. Men of color are also disproportionately victims of violence. This results in higher rates of death by homicide than any other group of males as well as higher rates of nonfatal injury. Nonfatal injury itself carries with it the risk of reinjury and death. Less often recognized are the psychological wounds of violence, trauma, and adversity, which may lead to intrusive symptoms of posttraumatic stress and depression and may predispose them to substance use and further violence.

Recognition of the effects of violence and trauma among combat veterans and victims of sexual assault has provided insight into the damaging effects of trauma. However, these lessons are seldom applied to the experiences of men of color. Recent approaches to trauma-informed care show that by understanding how violence has affected the lives of men of color through racism, rejection, and poverty and applying emerging trauma-informed frameworks, we can more effectively serve the needs of this population. The alternative to the disconnected, traumatized, and traumatizing systems that young men and boys of color encounter is a trauma-informed health and human service delivery system. More specifically, trauma-informed efforts to decrease violent injury in health-care settings, and efforts to interrupt the cycle of violence in the community demonstrate the promise of trauma-informed approaches to the health of boys and men of color.

DATA AND BACKGROUND

Young African American males (ages fifteen through twenty-nine) have a death rate from all causes that is 1.5 times the rate for young white males (Kaiser 2006). Young African American males die from homicide at a rate that is nineteen times higher than white males between the ages of fifteen and twenty-four (CDC 2008). HIV death rates for African American men between the ages of twenty-five and forty-four are more than seven times

higher than the HIV death rate for white men. Despite these health disparities, more than a third of African American men between the ages of eighteen and twenty-nine lack health insurance (Kaiser 2006). With regard to social impact on health outcomes in 2005, the percentage of African American men between the ages of eighteen and twenty-nine who were in prison was nearly seven times that of their white male counterparts (Kaiser 2006). Also in that year, nearly 20 percent of African American men between the ages of sixteen and twenty-five were unemployed, compared with 8 percent of white men. In November 2009 the *Washington Post* reported: “Joblessness for 16-to-24 year old Black men reached Great Depression proportions—34.5 percent in October, more than three times the rate for the general U.S. population” (Haynes 2009).

The homicide rate for Latino males ages fifteen to twenty-four is six times higher than the rate for similarly aged white males. Latino males have almost three times the AIDS rate as white males and are 2.5 times as likely to die from HIV/AIDS as white males (Heron 2010). Despite these health problems, 56 percent of Latino males ages eighteen to twenty-nine lack health insurance, more than any racial or ethnic group in this age range (Kaiser 2006). In examining the social impact on health for Latino males, only 61 percent have a high school diploma, which is the lowest high school graduation percentage of any racial or ethnic group. The percentage of young Latino men ages eighteen to twenty-nine who are in prison is more than twice the percentage of white men in the same age group (Kaiser 2006).

These data show that African American men and Latino men have poorer health status and social position. Violence in particular disproportionately affects men and boys of color. According to national statistics on violence among ten- to twenty-four-year-old males, homicide is the leading cause of death for African Americans, and the second-leading cause of death for Latinos. Young African American men have a firearm-related death rate 10.1 times that of young white men; young Latino men have a rate that is 3.3 times greater (CDC 2008). Nonfatal violence disproportionately affects men and boys of color as well. In 2008 more than 518,000 males ages ten to twenty-four were treated in emergency departments for nonfatal violent injuries (*ibid.*). Although these statistics represent all young males between ten and twenty-four, 25 percent of those violently injured were African American, despite making up only 16 percent of the population in this age group. Forty-four percent of patients with a penetrating injury suffer another penetrating injury within the following five years, and 20 percent are dead (Sims et al. 1989).

Research shows that boys and men of color are two times more likely than white boys and men to have witnessed domestic violence and to have been exposed to other forms of violence. African American children and youth are nearly three times as likely to witness a shooting, bombing, or riot. Similarly, Latino children and youth in the state are just over two times more likely to witness a shooting, bombing, or riot than white children and youth. The odds that an African American child or youth will have someone close to him murdered is 7.8 times higher than for a white child or youth; a Latino child's odds are 7.4 times higher than for a white child or youth (Finkelhor et al. 2005).

A child's exposure to violence can have dire consequences for his development. Children exposed to violence are more likely to have behavior problems (Peled, Jaffe, and Edleson 1995). Children who witness violence are at increased risk for becoming victims themselves, suffering from post-traumatic stress disorder, abusing alcohol or drugs, running away from home, or engaging in criminal activity (McAlister-Groves 2002). Studies have found that males are more likely than females to be victims and witnesses of violent acts (Fitzpatrick and Boldizar 1993; Schwab-Stone et al. 1995; Singer et al. 1995; Selner-O'Hagan et al. 1998). Prevalence studies comparing adolescents who differed in ethnicity or social class found that exposure to violence was greater among ethnic minorities. Several studies have reported higher rates of exposure among African Americans or African American and Latino/Latina students combined than among white youth (Fitzpatrick and Boldizar 1993; Schwab-Stone et al. 1995; Singer et al. 1995; Selner-O'Hagan et al. 1998). Medical and public health literature supports the finding that trauma contributes to poor physical and psychological health. This literature provides insight into the mechanisms through which trauma does harm.

DEFINING TRAUMA

We refer to psychological trauma as experiences that are emotionally painful and distressing and that overwhelm an individual's capacity to cope. Although there has been some debate about how to define a traumatic event, most definitions agree that when internal and external resources are inadequate to cope with external threat, the experience is one of trauma. The powerlessness that a person experiences is a primary trait of traumatization (Van der Kolk 2005). Trauma has sometimes been defined to mean circumstances that are outside normal human experience. This definition does not hold true with the boys and young men of color who are the focus

of this project, however. For this group and for others, trauma can occur often and become part of the common human experience. Besides violence, assault, and other traumatic events, we assert that subtler and more insidious forms of trauma—such as discrimination, racism, oppression, and poverty, which are often experienced by African American and Latino males—are pervasive. When experienced chronically, these events have a cumulative impact that can be life-altering. Such traumas are directly related to chronic fear and anxiety, with serious long-term effects on health and other life outcomes for males of color.

We do not yet fully understand the multiple ways in which repetitive and multigenerational exposure to violence, oppression, neglect, discrimination, criminalization, and poverty can affect individuals and entire communities. This work focuses on boys and young men of color who have experienced and are still experiencing such forms of structural and systemic violence. The term (or trauma-related term) “adversity” helps to clarify what people of color experience in the United States. It includes not just experiences outside usual human experience, but those that have become all too common a part of everyday existence.

Trauma Theory

“Trauma theory” is a relatively recent concept that emerged in the health-care environment during the 1970s, mostly in connection with studies of Vietnam veterans and other survivor groups (including Holocaust survivors, abused women and children, disaster survivors, refugees, and victims of sexual assault). In 1980 the now common syndrome known as post-traumatic stress disorder was added as a new category in the American Psychiatric Association’s official manual of mental disorders. Trauma theory represents a fundamental shift in thinking from the supposition that those who have experienced psychological trauma are either “sick” or deficient in moral character to the notion that they are “injured” and in need of healing. To make this shift regarding boys and men of color, it is critical to understand the effects of trauma on the brain and the body over the course of a lifetime.

Brain Development in Children

The human brain develops from the bottom up—or more precisely from the simplest functions to the most complex. The brain stem houses the most basic functions needed for survival (heart rate, body temperature, and blood

pressure). From there the midbrain develops, controlling the functions of sleep, appetite, digestion, and arousal. Next to develop is the limbic brain, the seat of emotions and memory. The last portion to develop is the cortex, which houses the highest functions of the brain—abstract thinking, reasoning, and other complex thought processes needed for problem solving, judgment, impulse control, and emotional regulation. It is important to note that the lower, more primitive parts of the brain are less plastic (that is, they are less able to rewire and change). Plasticity increases with higher brain functions, with the cortex being the most adaptive to change and rewiring.

The spinal cord and brain stem of a newborn child are almost fully developed, ready to help the newborn achieve its only biologically determined goal: survival. Otherwise, the brain of the newborn from the midbrain through the cortex is primitive and highly underdeveloped. The brain is designed for continued growth of these higher functions through touch, movement, and interaction—experiences that all serve to wire the brain for growth and more advanced functioning. The quality of this brain development is directly linked to the quality of these early childhood experiences. The window from birth to age three is critical to forming the basic mental processes that children rely on throughout their lives. We now have a wide body of research indicating that the brains of children who are exposed to chronic trauma and stress are wired differently from those of children whose experiences have been more secure. Two key developmental processes are adversely affected by exposure to trauma: neurodevelopment (the physical and biological growth of the brain) and psychosocial development (personality development, capacity for relationships, development of moral values and social conduct).

When experiencing stress or threat, the brain's fight-or-flight response is activated through increased production of the hormone cortisol. Although cortisol production can be protective in emergencies, its level is toxic in situations of chronic stress and can damage or kill neurons in critical regions of the brain. Especially damaging is the experience of stressors that occur in an unpredictable fashion (for example, when an individual is confronted with community violence or domestic violence). In extreme cases chronic exposure to trauma causes a state of hyperarousal or dissociation. Hyperarousal is characterized by an elevated heart rate, slightly elevated body temperature, and constant anxiety. Dissociation involves an internalized response in which the child shuts down, detaches, or "freezes" as a maladaptive way of managing overwhelming emotions or situations. The younger the child is, the more likely he or she will respond with dissocia-

tion. Children are more susceptible to posttraumatic stress because in most situations they are helpless and incapable of either fight or flight. Through the repeated experience of overwhelming stress, children may abandon the notion that they can affect the course of their lives in a positive way. The result is a state of learned helplessness. When trauma or neglect happens early in life and is left untreated, the injuries sustained reverberate at all ensuing developmental stages.

Effects of Trauma into Adulthood

The relationship between traumatic childhood experiences and physical and emotional health outcomes in adult life is at the core of the landmark Adverse Childhood Experiences Study (hereafter known as “the ACE study”), a collaborative effort of the Centers for Disease Control and Prevention and the Kaiser Health Plan’s Department of Preventative Medicine in San Diego, California. The results of the study were first published in 1998. The ACE study involved the participation of more than seventeen thousand middle-aged (the average age was fifty-seven), middle-class Americans who agreed to help researchers examine the following nine categories of childhood abuse and household dysfunction:

- Recurrent physical abuse
- Recurrent emotional abuse
- Contact sexual abuse
- An alcohol or drug abuser in the household
- An incarcerated household member
- A household member who is chronically depressed, mentally ill, institutionalized, or suicidal
- The mother is treated violently
- One or no parents are in the household
- Emotional or physical neglect

Each participant received an ACE score between zero and nine, reflecting the number of the above experiences he or she can claim (for example, a score of three indicates that a participant experienced three of the above ACEs). Nearly two-thirds of ACE study participants reported at least one ACE, and more than one in five reported three or more. The higher the ACE score, the greater the likelihood of chronic disease in adulthood.

The study claims two major findings. The first is that ACEs are much more common than anticipated or recognized, even in the middle-class population that participated in the study, all of whom received health care via a large HMO. It is reasonable to presume that the prevalence of ACEs is significantly higher among young African American and Latino males, many of whom live with chronic stress and do not have a regular source of health care. The study's second major finding is that ACEs have a powerful correlation to health outcomes later in life. As the ACE score increases, so does the risk of an array of social and health problems, including social, emotional, and cognitive impairment; the adoption of health-risk behaviors; disease, disability, and social problems; and early death. ACEs have a strong influence on rates of teen pregnancy, likelihood of smoking or substance abuse, risky sexual behavior, the risk of revictimization, performance in the work force, and the stability of relationships. The higher the ACE score, the greater the risk of heart disease, lung disease, liver disease, suicide, HIV and sexually transmitted diseases, and other leading causes of death (Felitti et al. 1998).

TRAUMA AS A SOCIAL DETERMINANT OF HEALTH

The researchers Clare Xanthos, Henrie Treadwell, and their colleagues (2010) have detailed data showing that men of color are disproportionately affected by adverse social factors, including poverty, lack of education, lack of social support, and lack of access to social capital when compared with other racial, ethnic, and gender groups in the United States. They are also disproportionately affected by other environmental issues, including living in unsafe neighborhoods with unstable economic and physical infrastructure. Attempts to address the health of boys and men of color must consider the impact that these social determinants have on health. From a trauma-informed perspective constant exposure to such negative factors in daily life constitutes a form of trauma. The epidemiologist Michael Marmot (2004), who has written extensively about the social determinants of health, argues that while material deprivation due to poverty may in itself predispose one to disease (for example, through lack of access to healthy foods or exposure to toxic environmental elements), a major way that poverty exerts its effect is through chronic stress.

Marmot and others have studied the effect not only of poverty but also of social position and inequality. His work suggests that African Americans, because of their position at the margins of U.S. society, suffer the most damaging effects. African Americans are lower on the social hierarchy

than any other group. This in turn limits their ability to develop a sense of empowerment and control over their lives. Constant bombardment with racism, discrimination, and lack of opportunity furthers this disempowerment. Marmot and others have argued that it is this adverse social position that creates conditions of chronic stress in the body. Chronic stress is characterized by ongoing activation of the fight-or-flight system that is normally activated only under acute self-protective stress. Over time this hyperactivation can lead to a range of chronic physical disease and behavioral maladaptations. Marmot's work has shown that even among employed workers, occupying a lower position in the social hierarchy is related to higher rates of death from cardiovascular disease (Marmot 2004).

Marmot's work also showed that social engagement—the ability to participate as a full member of society and the attendant self-esteem—is critical to positive health outcomes. This has particular relevance for the health of boys and men of color. As noted earlier, young African American men have remarkably high rates of unemployment and incarceration and low rates of college enrollment, even lower than those for African American women. As we consider the effects of stress on these men, we conclude that simply addressing poverty and education, for example, in the short run is not enough. Ultimately, through trauma-informed approaches, we can address the adverse effects of chronic stress that come from the social position of this population. Providers of care to this population should be versed in trauma-informed care to help address the issues faced by men and boys of color. These issues would normally go ignored when the young man puts on the mask of masculinity to avoid intimate details of his history of adversity. Uncovering this hidden trauma and focusing on healing is what is needed. Critical to any intervention that addresses the health of men of color is the improvement of systems that serve them and with which they interact. If denied opportunity by those systems, members of this population will face further health problems.

Understanding Masculinity in the Context of Improving Health Outcomes

In attempting to understand the health of men of color, it is important to examine masculinity, both in its biological and social contexts. Levels of the hormone testosterone increase after puberty to amounts that are twenty times higher than in the prepubescent male. The presence of testosterone is related to aggressiveness and violence, although the social context

in which men live can largely either mitigate or exacerbate these biological effects (Zitzmann and Nieschlag 2001). The presence of testosterone predisposes adult males to a number of diseases, including cardiovascular disease, stroke, and some forms of cancer (like prostate cancer) that are sensitive to the presence of this hormone.

Perhaps more significant than the biological effects of maleness is the meaning of masculinity in American society. Masculinity is often associated with such qualities as aggressiveness, strength, independence, emotional distance, self-control, and hypersexuality. Many boys are socialized to understand the meaning of manhood both implicitly and explicitly based on images of masculinity in the media and in their day-to-day lives. In neighborhoods where parents feel that their children are likely to be assaulted or bullied, parents may teach their children that fighting back is part of “being a man,” rather than walking away or negotiating, which may be perceived as weak.

Studies have shown that men who hold traditional notions of what it means to “be a man,” such as the ones just described, are more likely to engage in high-risk behavior (Courtenay, McCreary, and Merighi 2002). These studies also find that African American men are more likely to hold these traditional ideas of masculinity. This tendency toward high-risk behavior accounts in part for the higher rates of accident-related illness among men. Men of color who see themselves as powerless may be more likely to try to assert their manhood through risky behaviors (Courtenay 2000; Courtenay and Keeling 2000). The psychologist Will Courtenay and others have argued that risk-taking behavior provides a way for marginalized males to prove themselves as men because they lack more productive ways to show power.

The powerful messages about what it means to be a man constrain the ways in which men talk about their trauma. Early in life, most boys are taught to be emotionally unexpressive, self-reliant, and to behave in stereotypically “masculine” ways. When they then face trauma in such forms as childhood physical abuse, childhood sexual abuse, witnessing violence against their mothers, seeing violence in their communities, or being victims of community violence, they may feel ashamed to display their pain or to seek comfort (Mejia 2005). The powerful overt and subliminal messages of masculinity make it difficult for men to acknowledge trauma and seek help. Many men perceive that they will be viewed as weak or “unmanly” if they acknowledge their physical and emotional pain. Unable to express their pain in a healthy way, men may self-medicate with alcohol or other drugs.

Other men externalize their pain by committing acts of violence in their communities or against their intimate partners. Thus the trauma experienced by boys and young men of color is often intertwined with coming to terms with their own masculinity and notions of masculinity in general.

Ideas about masculinity have an effect on how and when males access health care throughout their boyhood, adolescence, and adulthood. Social notions of masculinity often portray getting health care as weak and unmanly. For example, men may avoid seeking help from behavioral health services, as they often believe that any acknowledgment of depression or anxiety is a sign of weakness. They may also lack unemployment and health insurance. When they do find their way into medical settings, men often encounter providers who are unsympathetic or unfamiliar with the issues they face. More fundamentally, young adult black and Latino men may lack basic health insurance coverage. Until the recent passage of health-care reform in the United States, even young men covered under their parents' health insurance lost their coverage when they reached the age of nineteen. Fortunately, under the new health-care bill, this coverage is extended through the age of twenty-six.

The Problem of Violence as Related to Health

As providers of medical and emergency care to young people in the inner city, we are able to describe the process of care for young victims of violence as well as the social and psychological factors that can lead to recurrent violence. Figure 13.1 represents the way in which many young people, particularly young men, interact with various systems. A young man is shot, stabbed, or assaulted. If his injuries are thought to be severe enough, he is brought to the emergency department. Depending on the extent of the injury, he might be discharged back into the hostile environment from which he came, or he might be admitted to the trauma in-patient service. In any of these scenarios the young man is eventually discharged. Few facilities are currently equipped to deal with the social and emotional aftereffects of the young man's injuries and medical treatment. He is not prepared for—nor may he be aware of—symptoms of acute or posttraumatic stress. Contributing to the trauma may be multiple adverse childhood experiences that heighten his anxiety, paranoia, and disdain. He gets a weapon and he smokes marijuana to alleviate some of his fears. In his traumatized and intoxicated state, he encounters the person or people who harmed him. He retaliates. He is then headed for reinjury, jail, or death. The cycle is not

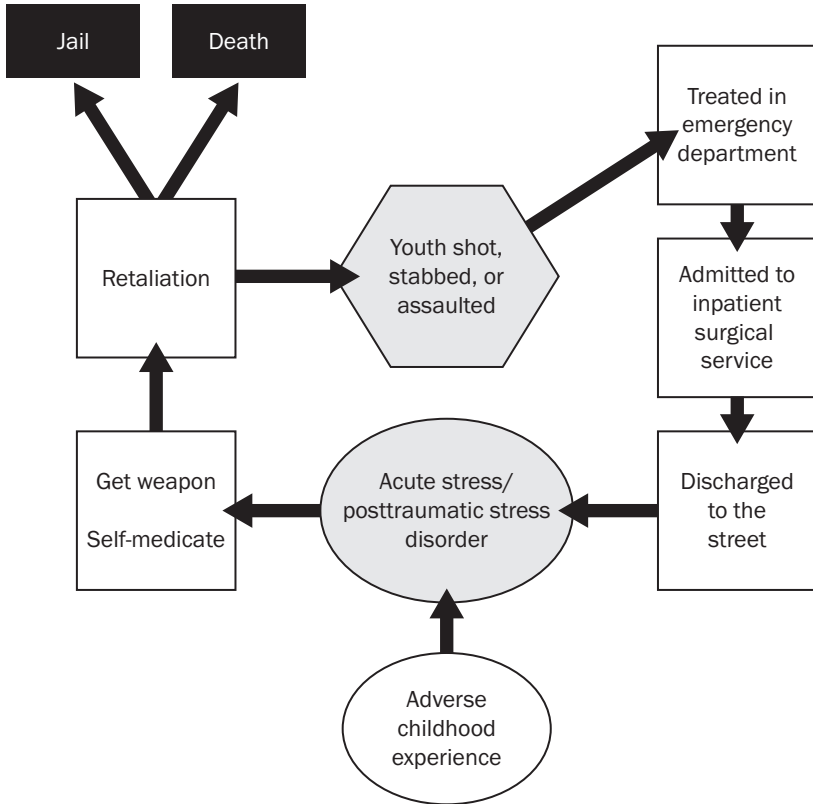


Figure 13.1. Cycle of Recurrent Violence. *Source:* Author's rendering.

uncommon for boys and young men of color who suffer violence injury. Unfortunately, all too frequently there is no intervention to identify and intervene with these young men and boys. Most often, the young men are left to deal with the impact of the violent incident on their own.

The patient's experience of moving through this system of care is deeply influenced by his trauma experiences earlier in his life. Yet this critical history is routinely unavailable to health-care providers, either because they fail to ask or because the patient lacks sufficient trust in his health-care providers to disclose his history. Most commonly, the competing demands and incentives of care fail to leave space for this critical communication to take place. Consider the case of Eddie (see the sidebar), a patient who is a victim of urban violence.

THE CASE OF EDDIE: VICTIM OF URBAN VIOLENCE

Eddie, a twenty-year-old man of color, arrives at the emergency department with ten gunshot wounds to the back, leg, chest, and arm. The doctors and nurses stabilize him in the emergency room and quickly transport him to the operating room. After surgery he is admitted to the surgical intensive-care unit. Eddie is in critical condition at first but improves after a few days and is transferred to a room on the regular surgical ward. A social worker talks with him and learns more about the night Eddie was shot: On that evening Eddie had gone to a birthday party for a friend. He met a young woman and began to dance with her. He did not realize that the woman had a boyfriend who was also at the party. The boyfriend confronted Eddie and they argued. After a brief scuffle, Eddie walked away, thinking that the argument was over. He went outside and was shot from behind ten times by the girl's boyfriend.

The social worker learns that two years earlier, Eddie had been treated in the emergency department for a stab wound. His wound had been cleaned and stitched up, but Eddie had not been admitted to the hospital because the knife did not penetrate any vital organs or joints. Instead, Eddie returned to the same neighborhood where he was stabbed. At that time no one asked him about whether he was safe, whether he felt fear or anger, or whether he planned to retaliate against the person who had stabbed him. Eddie had to manage on his own. During this time he did not feel safe. He had trouble sleeping and had nightmares about getting stabbed again. Because of these sleeping problems, Eddie started to smoke marijuana. He did this every night and found that it helped him sleep. Occasionally, thinking that more marijuana would help him sleep even better, Eddie smoked too much, which made him paranoid and anxious. His use of marijuana caused other problems as well. Eddie was stopped by police in his neighborhood and was arrested and jailed for possession of marijuana.

Now in the hospital with multiple gunshot wounds, Eddie tells the social worker that he is currently on probation. He also reveals that he has a four-year-old son, but that he and his child's mother do not get along. What the social worker does *not* learn is that as a child, Eddie was neglected by his own parents. When Eddie was two years old, his father went to jail for a gang-related crime, but before that arrest he abused Eddie's mother. Eddie witnessed each episode of violence against his mother. His mother suffered from depression and prescription drug abuse, which precipitated Eddie's removal from the

(continued)

THE CASE OF EDDIE *(continued)*

home. After six years in several foster homes, Eddie was ultimately returned to his mother. Just a year ago, he witnessed the fatal shooting of a cousin.

Eddie's symptoms of posttraumatic stress disorder were never addressed when he was in foster care, in jail, or while on probation. During foster care he never had a chance to talk about the trauma of being separated from his parents or witnessing domestic violence. He had not received any counseling or mentorship while he was in jail, nor had he received referrals to any mental-health services after his release. Like most young men his age, Eddie has internalized strong notions about masculinity and what it means to "be a man." These ideas have influenced how he seeks (or does not seek) health care, how he raises his son, how he behaves when he is placed in danger, and how he reacts when he feels his masculinity is threatened in some way.

Since getting shot, Eddie has been going from system to system—getting health care, trying to get back into school, looking for a job—but none of these systems has helped him heal from his trauma. Each time Eddie has tried to get help, he tells his story all over again. Each time he feels a resurgence of stress and anxiety.

Trauma as the Problem

In Eddie's case he has been the recipient of multiple human services throughout his life, including the health care, child welfare and foster care, and juvenile justice systems. No clear picture of him emerges from the records of his interactions with these systems, however. It is not until the critical moment of injury—when he meets a hospital social worker to talk about his bill for medical services—that the picture of a traumatized young man emerges.

We know many young men like Eddie who have experienced trauma and adversity throughout their lives. Yet as they move through the array of systems assigned to help them, their histories of trauma are seldom explored. Even worse, these systems—schools, juvenile justice, courts, health care, mental health—often take a punitive rather than healing approach to these young men, interpreting their symptoms as a sign that they are delinquents or sociopaths rather than as signs of physical and emotional traumatic injury. The systems designed to help these young men thus traumatize them further. The alternative to the disconnected, traumatized,

and traumatizing systems that Eddie has encountered throughout his life is a trauma-informed health and human service delivery system.

Eddie would have benefitted in significant ways from a trauma-informed approach. Such a system would have called for intervention early in his mother's life. The child-protection system would have recognized that substance abuse, victimization, and depression are likely effects of early childhood trauma. A trauma-informed system would have recognized that when Eddie witnessed violence against his mother and ultimately lost his father to prison, Eddie's risk for trauma-related problems and posttraumatic stress would have increased. A trauma-informed system would have addressed the needs of the family as a unit and would have sought to provide healing to each member of this traumatized family to reunify them. For Eddie this would have meant placement in a stable foster home, where all members of the home would have received training to understand the early adversity in Eddie's life. The foster family and child protection staff would have had skills to address Eddie's trauma through therapy, arts, exercise, and other healing modalities. A trauma-informed school system would have worked closely with the foster-care and health-care systems to learn about the early trauma in Eddie's life and to provide trauma-informed learning support, healing after-school activities, safety, and a vision for the future.

A trauma-informed health system would have recognize that early adversity has the potential to promote risky behaviors and chronic disease. Eddie would have been connected to early pediatric care, where screening for trauma, substance abuse, and other risks would have taken place. A trauma-informed pediatric health-care system would have provided strong anticipatory guidance and counseling to Eddie's parents and foster parents about the potential impact of early trauma on their son. Such primary care would also have included education about the danger of keeping firearms in the home and would have supported the child's academic development by coordinating with the school system.

When Eddie had been arrested for possession of marijuana, a trauma-informed justice system would have screened for trauma and considered the possibility that Eddie's substance abuse was related to his past trauma. The most effective step would then have been to divert Eddie from incarceration and toward effective treatment for both his substance use and his past trauma. Trauma-informed rites of passage and mentoring programs that focus on ways to build a safe identity as a man would have been prioritized above imprisonment. A trauma-informed human services delivery system would have recognized that Eddie's past trauma places his own child at

risk as well. Such a system would have intervened actively with parenting services designed specifically for fathers like Eddie and would have considered the challenges that fathers face, along with the often marginalized role they have as parents because they are viewed only as “breadwinner” or “disciplinarian.” Trauma-informed parenting would have helped Eddie see how his early childhood adversity has shaped him and would have helped him avoid the same problems for his son.

Within each of these intersecting systems, staff would understand how their work is connected to the work of other agencies and community-based organizations. They would seek to create a culture of safety that would allow them to engage their traumatized clients and to work in full partnership with their colleagues. Incorporating trauma survivors as peer navigators would help to build meaningful connections with clients. Most important, as Eddie moves among the systems designed to help him and his family, he would be regarded as an individual with a unique history. He would not fear that his past trauma would be revisited each time he reaches out for help. Such a system would not remove Eddie’s own responsibility to make life choices that would expand rather than constrain his freedom. Rather, it would allow him to move from victim to full participant through a process of healing.

VIOLENCE PREVENTION AS HEALTH PROMOTION

The various points of entry into the health-care system for boys and young men of color must be made sensitive to the impact that trauma has had on their lives when appropriate. Unfortunately, many boys and men of color use the emergency department as a source of primary care and are seen there because of nonfatal intentional injuries. Public health practitioners might argue that intervening in the emergency department is a form of tertiary care; however, in addressing trauma, these boys and men of color who are affected by adversity and violence would benefit from assessment and direction for healing past as well as current emotional wounds.

The various points of entry at which boys and young men enter the health-care system present opportunities to address the multiple levels of trauma that affect their daily lives. Trauma-informed practice in emergency departments, primary-care settings, and the justice system could help young men and boys of color choose healing over the more common path of retaliative violence, reinjury, jail, or death. A study by Dr. Joel Fein and colleagues found that “emergency department clinicians recognize the

need for evaluation of youth at risk for violence. They are able to identify violently injured youth, but less often perform risk assessment to guide patients to appropriate follow-up resources” (Fein et al. 2000: 495). Hence clinicians are able to identify violently injured youth but rarely able to delve into uncovering trauma. Emergency providers are especially taxed given the swell of emergency departments with patients and the need to provide speedy care.

At the University of Maryland Shock Trauma Medical Center, Dr. Carnell Cooper, trauma surgeon and director of the Violence Intervention Program, has showed that patients enrolled in their violence-intervention program were three times less likely to be arrested for a violent crime, two times less likely to be convicted of any crime and four times less likely to be convicted for a violent crime (Cooper, Eslinger and Stolley 2006). The violence-intervention program, although based in a health-care setting, has had an impact on the reduction of involvement with the criminal justice and juvenile justice systems (ibid.). A study conducted at two urban emergency departments found that “acute stress symptoms assessed in the emergency department in the immediate aftermath of traumatic injury are useful indicators of risk for later posttraumatic stress” (Fein et al. 2002: 836). This applies not only to acute-care settings but to primary-care settings as well.

Based on this evidence, we suggest that a trauma-informed approach to violence prevention that addresses the needs of African American and Latino boys and young men should consider the following:

- Offering trauma-informed training for professional development of judges, law-enforcement personnel, health-care providers, teachers, social-service providers, and other providers who encounter youth who are at risk of involvement in violence.
- Infusing trauma-informed training into the basic education of law, medicine, education, law enforcement, and social services.
- Interrupting the cycle of violence by providing services for victims of violence who are especially vulnerable to recurrent violence and retaliation. Emergency department and hospital-based interventions have the potential to accomplish this.
- Training peer health navigators and mentors in trauma-informed methods and employing them to help youth who are at risk for violence to heal and to navigate difficult systems and reconnect to school and work.

- Incorporating a deep understanding of masculinity and the meaning of respect into violence-prevention efforts at all levels.
- Enhancing violence-prevention curricula with trauma-informed knowledge and principles.
- Creating effective trauma-informed violence-prevention and male-development approaches—especially group-based strategies such as healing circles and trauma-recovery groups—that are acceptable and accessible to men and boys.

A number of models have been identified that embody elements of trauma-informed practice as it relates to boys and men of color. These include the following programs:

Caught in the Crossfire (Oakland, California). The Caught in the Crossfire hospital-based peer intervention program hires young adults who have overcome violence in their own lives to work with youths who are recovering from violent injuries. These highly trained intervention specialists offer long-term case management, links to community services, mentorship through home visits, and follow-up assistance to violently injured youths. The program's mission is to promote positive alternatives to violence and to reduce retaliation, reinjury, and arrest.¹

The Wraparound Project (San Francisco General Hospital, San Francisco). The San Francisco Wraparound Project's mission is to prevent violent injury and break the cycle of violence in the most vulnerable communities by addressing root causes and risk factors with culturally competent case management and vital community resources. Although physical rehabilitation is provided to victims in the aftermath of injury, services to reduce or eliminate risk factors associated with violent injury are not traditionally offered upon hospital discharge. The Wraparound Project addresses this gap by serving as a vital point of entry. The program provides mentorship and links clients to essential risk-reduction resources. The goal is to reduce injury recidivism and criminal recidivism among San Francisco's most vulnerable citizens.²

National Latino Fatherhood and Family Institute (NLFFI) (Hombre Noble/Joven Noble, Los Angeles). The NLFFI offers a nationally recognized mentoring program focused on nurturing young fathers as they learn about the growth and development of their children and their responsibilities as fathers.³ The institute also offers El Joven Noble, a program for young Latino men that seeks to instill positive values, behaviors, and acceptance of personal responsibility through educational and mentoring

activities. This work outlines many of the underlying traditions of Latino culture and blends them with strategies that have been found to encourage and support Latino men as they work to heal their personal pain and to strengthen and maintain their families. This work is deeply grounded in providing services in the context of the family (*la familia*) and endorses for men the notion of *un hombre noble* (a noble man who keeps his word). The National Latino Fatherhood and Family Institute is a project of the National Compadres Network in collaboration with Bienvenidos, Inc. and Behavioral Assessment, Inc.

Barrios Unidos (Santa Cruz, California). Barrios Unidos is rooted in the Chicano experience.⁴ A central premise of the Barrios Unidos theory of change is the understanding that the identities of Latino and other socio-economically disadvantaged youths are shaped by political and economic forces with little regard for the best interests of this population. The focus of Barrios Unidos programs is to restore a sense of belonging to young people, their families, and communities. The organization is focused on three things: (1) running the Cesar E. Chavez School for Social Change (a charter school that seeks to empower youth to become positive role models of social change); (2) doing community outreach; and (3) encouraging community economic development. Barrios Unidos has developed alongside the work of Jerry Tello, an internationally recognized expert in the areas of family strengthening, community mobilization, and culturally based violence prevention and intervention issues. Tello has extensive experience in the treatment of victims and perpetrators of abuse and in addictive behaviors, with a specialization in working with multiethnic populations, to promote the healing properties of tradition in cultures. Barrios Unidos serves as one of the key community-action projects of the California Wellness Foundation's Public Health Initiative to Prevent Youth Violence.

Healing Hurt People (Drexel University, Center for Nonviolence and Social Justice, Philadelphia). Healing Hurt People (HHP) is the cornerstone programmatic component of the Center for Nonviolence and Social Justice.⁵ HHP is a community-focused, hospital-based program designed to reduce recidivism among youth ages twelve to thirty. The program is affiliated with the emergency department at Hahnemann University Hospital and the Drexel University College of Medicine. HHP staff work with youth in the emergency department in an effort to reduce patients' immediate and future need for retaliation and continued connection to violence and crime. When a patient is seen in the emergency department for intentional injury, the hospital staff contacts HHP after wounds are treated and the patient is cleared medically. The program's injury prevention coor-

dinator and community intervention specialist then assess and work with the patient to determine whether he or she would benefit from receiving assistance in bridging services, such as receiving psycho-social therapy or other posthospital care. Next, staff members make sure that the patient has a safe place to go upon discharge and they contact a referral service for him or her. Follow-up occurs through phone calls and scheduled home visits after discharge to confirm that the client has successfully connected to the referred support service. Scheduled home visits by the community intervention specialist or the injury prevention coordinator continue on a periodic basis to assure progress. In some instances HHP staff serves as the patient's navigator to various support services. Weekly reviews are conducted by the interdisciplinary team to ensure the program's effective functioning and to track management of difficult cases.

The stories and examples presented in this chapter suggest that although it will be fruitful to implement trauma-informed practices in health-care settings, a broader, system-level approach is ultimately the best strategy to improve health and decrease violence over the lifespan of boys and men of color. Their lives are touched by multiple systems: health care, juvenile justice, child welfare, and education. By implementing trauma-informed organizational approaches to transform these systems away from a punitive approach toward one that acknowledges and attends to the physical and psychological effects of violence, we will have a much better chance to improve the health and the social position of this critically underserved population.

NOTES

1. Learn more about the Caught in the Crossfire project at <http://www.youthalive.org/cinc/>.
2. The Wraparound Project is at <http://violenceprevention.surgery.ucsf.edu/>.
3. Learn more about the National Latino Fatherhood and Family Institute at <http://www.nlffi.org/>.
4. See <http://www.barriosunidos.net/> for more information on the Barrios Unidos program.
5. Healing Hurt People, based at Drexel University's Center for Nonviolence and Social Justice, can be found at <http://www.healinghurtpeople.org>.

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