Posttraumatic Stress Symptoms in Context: Examining Trauma Responses to Violent Exposures and Homicide Death Among Black Males in Urban Neighborhoods

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Concentrated disadvantage in urban communities places young Black men at disproportionate risk for exposure to violence and trauma. Homicide, a health disparity, positions Black males vulnerable to premature violent death and traumatic loss, particularly when peers are murdered. Posttraumatic stress disorder (PTSD) has been demonstrated as a health consequence for middle-income and White homicide survivors; however, understandings of traumatic stress among young Black men situated in contexts of chronic violence exposure remains limited. Guided by phenomenological variant of ecological systems theory (PVEST), the current study used in-depth qualitative interviews (average length: 90 min) to examine the presence and expression of traumatic stress symptoms among 37 young Black men (18–24) in Baltimore who experienced the homicide death of a loved one. Participants were recruited over 18 months through fieldwork at a large organization that serves Baltimore youth and young adults. Confidential participant interviews were audio recorded, transcribed verbatim, coded, and analyzed in ATLAS.ti. Pseudonyms were assigned to all participants. More than 70% of participants reported experiencing 2 or more *Diagnostic and Statistical Manual of Mental Disorders*, fifth edition (*DSM–V*)–defined posttraumatic stress symptoms. Hypervigilance was most frequently experienced and expressed as being *on point*. Findings identify the prevalence of traumatic stress symptoms among young Black men in urban contexts; identify contextually specific expressions of traumatic stress; and, present implications for the mental health and clinical treatment of Black males living in environments where no "post" exists.

The tragic deaths of Tamir Rice (age 12, Cleveland, OH), Michael Brown (age 18, Ferguson, MO), Freddy Gray (age 25, Baltimore, MD), and other publicized cases of Black males who died following encounters with local police in 2014–2015 illustrate an enduring American reality: Black youth growing up in low-income, urban areas experience many contextually specific risk factors that make them susceptible to trauma and loss across the life course (Alegría et al., 2013; Garbarino, 1995, 1999; Johnson, 2010; Rich, 2009). Violence is one of the predominant traumatic events affecting the lives of Black youth and their communities (Centers for Disease Control and Prevention [CDC], 2011, 2012; Jenkins, Wang, & Turner, 2009; Rich & Grey, 2005; Smith, 2015). Research on urban youths' experience of violence exposure often compares it to that of youth growing up in war zones abroad (Bell & Jenkins, 1991; Garbarino, 1995, 1999).

The social determinants of violence—among them residential segregation, racism and discrimination, educational disparities, high unemployment rates, poverty, and overcrowding—increase the propensity for crime and violence in America's inner cities (Eitle, D'Alessio, & Stolzenberg, 2006; LaVeist, 2005; Stewart & Simons, 2010). Youth growing up in low-income neighborhoods report a greater likelihood of witnessing stabbings and shootings in their communities than youth growing up in communities of higher socioeconomic standing (Buka, Stichick, Birdthistle, & Earls, 2001; Paxton, Robinson, Shah, & Schoeny, 2004). Consequently, economically disadvantaged youth growing up in urban contexts are at a greater risk for traumatic exposure, violent injury, and premature death than middle-class youth growing up in suburban areas (Buka et al., 2001; Rich, Corbin, Bloom, Evans, & Wilson, 2009; Smith, 2015; Way, 1998).

Homicide is the leading cause of death for Black youth aged 10 to 24 in the United States. Among this population the homicide

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rate is 51.5 deaths per 100,000 (CDC, 2012). This rate exceeds the combined homicide rates of Hispanic/Latino males (13.5 per 100,000) and White males (2.9 per 100,000) of the same age range (CDC, 2012). This is a health disparity that disproportionately affects young Black men into adulthood, with homicide remaining the leading cause of death for Black males aged 25 to 34 (CDC, 2011). Indeed, more young Black men are killed annually than young men of any other racial-ethnic group in the United States.

Traumatic Loss and Homicide Survivorship

In addition to the trauma produced by violent exposure, homicide also creates experiences of loss (Smith, 2014, 2015). This disparity places Black males at disproportionate risk for experiencing traumatic loss of peers and becoming homicide survivors. While there are no official counts of homicide survivors, researchers estimate 7 to 10 close family members survive homicide victims—not including friends, classmates, and communities (Redmond, 1989). The likelihood that Black youth will have someone close murdered is 7.8 times that of Whites (Finkelhor, Ormrod, Turner, & Hamby, 2005), and this risk is highest for young, Black males. A recent study (Smith, 2015) examining the frequency and developmental timing of homicide death for young Black men aged 18 to 24 in Baltimore revealed that participants experienced an average of three homicide deaths of loved ones—chiefly male peers—across the life course. These experiences began in early childhood, increased during the school-aged and adolescent years, and continued into emerging adulthood, creating an enduring threat to health and well-being across developmental stages.

Despite these realities, less is known about the health and well-being of the surviving friends and family members of homicide victims (Hertz, Prothrow-Stith, & Chery, 2005; Miller, 2009a, 2009b; Sharpe, Joe, & Taylor, 2012–2013; Smith, 2014; Zinzow, Rheingold, Hawkins, Saunders, & Kilpatrick, 2009). The limited research conducted on the impact of homicide survivorship has primarily examined the experience of murder victims' family members (Amick-McMullan, Kilpatrick, & Resnick, 1991; Miller, 2009a, 2009b; Sharpe, 2008), primarily among White and middle-income populations. Previous research suggests that family members experience unique factors surrounding the homicide death of their loved ones that can complicate their grieving process. Specifically, the unanticipated, violent nature of homicide creates situations of traumatic loss, and surviving family members may experience both grief *and* trauma responses (Miller, 2009a; Rheingold et al., 2004).

Symptoms of posttraumatic stress—such as intrusive images of their loved one's death, nightmares, and anxiety—have also been evidenced in surviving family members, with many meeting the criteria for Posttraumatic Stress Disorder (PTSD; Amick-McMullan et al., 1991). Research indicates that PTSD can develop even among surviving family members who did not directly witness the death of their loved one (Amick-McMullan et al., 1991; Hertz, Prothrow-Stith, & Chery, 2005); highlighting the intensity of this experience of loss for surviving family members. However, the presence and expression of traumatic stress symptoms among Black, male, homicide survivors have rarely been examined (Bordere, 2008–2009; Smith, 2015).

Posttraumatic Stress in Urban Youth

Previous research has established a strong association between youth exposure to violence and the endorsement posttraumatic stress symptoms (Alegria et al., 2013; Breslau, Wilcox, Storr, Lucia, & Anthony, 2004; Jenkins et al., 2009; Paxton et al., 2004; Rich & Grey, 2005; Roberts, Gilman, Breslau, Breslau, & Koenen, 2011). However, results of recent research examining the prevalence of posttraumatic stress among African American and urban samples have been inconsistent. In a large, nationally representative study of traumatic events and PTSD, Roberts et al. (2011) found that lifetime prevalence for PTSD was highest among Blacks. Similarly, Alegria et al. (2013) found that African Americans are more likely to experience lifetime prevalence of PTSD, exposure to personal violence, and exposure to witnessing violence. Paxton et al. (2004) examined the relationship between exposure to neighborhood violence and PTSD in a sample of African American males attending a high school in the Midwest and found that such exposures significantly predict the endorsement of PTSD symptomology in this group. Although the mechanisms of increased PTSD risk among African American participants are unclear, exposure to community violence is hypothesized to be a key contributing factor.

Research examining PTSD in a socioeconomically and racially diverse sample found rates of PTSD to be highest among White, low-income women in the sample, raising questions about disclosure and assessment of posttraumatic stress symptomology among Black participants (Parto, Evans, & Zonderman, 2011). A recent examination of traumatic events and PTSD among African American adolescents found that nonviolent traumatic events (e.g., accidents, illness, etc.), but not violent traumatic events (e.g., shootings, killings, etc.), predicted PTSD for African American boys (Jenkins et al., 2009). These studies raise questions concerning both the assessment of PTSD symptomology among Black boys and men, and about the processes of coping and resilience among this group.

These data present the need for additional research to clarify the connection between exposure to violence and posttraumatic stress among African American urban samples, with special attention directed at understanding the contexts of violent exposure for Black males growing up in urban neighborhoods. Specifically, research should incorporate qualitative examinations that unpack narratives of trauma and posttraumatic stress symptoms for Black males who have experienced traumatic loss of a loved one to homicide and remain situated in violent neighborhoods. Therefore, guided by the *Phenomenological variant of ecological systems theory* (PVEST; Spencer, Fegley, Harpalani, & Seaton, 2004) this study asks:

1. How do young, Black men describe their exposures to neighborhood violence?
2. How prevalent are traumatic stress symptoms among this sample of young Black men in Baltimore?
3. How do young Black men express their symptoms of traumatic stress in response to neighborhood violence exposure and homicide?
4. How are these trauma narratives informed by their urban contexts?

It is critical that the systems serving this population be informed, equipped, and prepared to respond to the mental health needs of young Black men. Understanding the presence and expression of traumatic stress symptoms among young Black men will improve physical and mental health professionals' ability to assess, diagnose, and treat PTSD among a population whose trauma symptoms may be overlooked or misinterpreted. Early assessment and recognition of trauma symptoms are key prevention strategies critical to facilitating life course health and success for young Black men growing up in contexts of chronic violence exposure.

Phenomenological Variant of Ecological Systems Theory

Phenomenological variant of ecological systems theory (PVEST)—first developed by Spencer (1995) and later redesigned (Spencer et al., 2004), draws heavily on the fields of human development, psychology, and sociology and is empirically grounded in the developmental experiences of youth of color. The model consists of five central components: (a) risk contributors, (b) stress engagement, (c) reactive coping strategies, (d) emergent identities, and (e) coping outcomes. *Risk contributors* are factors that predispose youth to adverse outcomes. *Stress engagement* refers to an individual's actual experience with situations that may challenge identity development and overall well-being. Youth respond to stress engagement with *reactive coping strategies*. These strategies are used to make meaning of, and potentially resolve, conflict-producing situations and are important to understanding factors that promote resilience among Black youth (Gaylord-Harden, Gipson, Mance, & Grant, 2008; Thompson, 2009; Zimmerman et al., 2013). These coping strategies can be either adaptive (e.g., choosing non—gang member friends, engaging in school) or maladaptive (e.g., fighting, hypermasculinity). For example, a Black male's response to community violence might be a tough bravado that protects him emotionally and physically as he navigates the neighborhood (Rich & Grey, 2005).

Recent literature also suggests that distinguishing coping strategies as adaptive or maladaptive among African American youth growing up in neighborhoods of concentrated disadvantage and chronic violence is complex (Gaylord-Harden et al., 2008). For example, avoidant strategies, which are traditionally described as maladaptive, may be protective against violent engagement or victimization for Black youth who must navigate the chronic risk of violence in their neighborhoods. Several studies have identified avoidant strategies as more adaptive for this group (Brady, Gorman-Smith, Henry, & Tolan, 2008; Gaylord-Harden et al., 2008; Rosario, Salzinger, Feldman, & Ng-Mak, 2008). In much the same way, previous studies suggest coping strategies that have been traditionally considered adaptive—such as confrontational or active strategies—may actually place African American youth who have been exposed to community violence at higher risks for violent victimization and delinquent involvement (Stewart, Schreck, & Simons, 2006; Rosario et al., 2008). These studies highlight the ambiguity in qualifying reactive coping strategies of African American youth growing up in economically disadvantaged urban contexts as adaptive or maladaptive. They also highlight the need for contextual considerations as we evaluate Black youth's responses to trauma and urban violence (Thompson, 2009).

When coping strategies such as presentations of toughness are employed over time, they can become an emergent identity. *Emergent identities* develop as individuals move through contextual experiences and their behavior becomes consistent and stable over time across various settings, including family and school. Emergent identities form the background for either productive or unproductive coping outcomes. Together, these factors shape development over the life course.

By conceptualizing how context shapes youth development, PVEST expands on the well-established bioecological theory of human development (Bronfenbrenner, 2005). Bioecological theory focuses on the impact that three key microsystems—family, neighborhood, and school—have on development. PVEST provides a more specific understanding of how development changes over time in social cognition, multilevel social context character, and content. For instance, a Black male who lives in a violent neighborhood may develop a tough identity as an adaptive protective strategy in the neighborhood, but that same presentation of identity may be interpreted as aggressive within the school context. PVEST also provides insight into how meaning-making about phenomena changes over time. For example, how one reacts to the traumatic loss of a peer resulting from homicide in early childhood may look very different than how one reacts in emerging adulthood, given the psychosocial resources and cognitive processes available at each developmental stage.

This study uses PVEST in several ways. As an interdisciplinary model, PVEST provides a context in which to situate and interpret findings and draw implications from a broader psychosocial frame that can be applied at the micro, meso, and macro levels. In addition, we used PVEST to consider the ways in which the chronic risk of violence exposure and trauma influences behavior and adaptation across contexts. The interview protocol posed questions inviting participants to unpack the nature violence in their Baltimore neighborhoods, with the goal of better understanding how young men's responses to traumatic exposures may be informed by their local contexts. As an analytic tool, we used PVEST to consider factors that shape traumatic stress responses and how they are related to the prevalence of violence exposure among young Black men in Baltimore. All together, we used PVEST to understand how life course exposure to violence and homicide death may shape how young Black men situated in economically disadvantaged urban contexts respond to and express posttraumatic stress.

Method

Sample

The data for this project were drawn from a larger qualitative study that examined how traumatic losses resulting from homicide shape the health and well-being of Black males across the life course (See Smith, 2013, 2015 for an expanded description of the parent project). Participants ($N = 37$) for this study were recruited over the course of 18 months at a large organization serving primarily Black youth in a racially segregated, economically disadvantaged neighborhood in Baltimore (Jacob France Institute, 2013). The program is available to youth aged 16 to 25 who are disconnected from the Baltimore City Public Schools

system. This program provided wraparound services to support program participants' academic achievement and job attainment.

The first author partnered with the program's mental health clinicians to identify gaps in center programing to contribute to our field site while building relationships with staff and rapport with program participants. The result was the development of a weekly loss and grief psychoeducational and support group facilitated by the first author for 18 months. This group enabled us to (a) establish a presence in the field site, (b) build relationships with program members, (c) conduct participant-observation, and (d) identify and recruit young men who would be "information rich" (Patton, 2002). This prolonged engagement also offered additional insights into young men's lives, neighborhood conditions, and the ecological contexts in which their exposures to violence, trauma, and loss were situated (Smith, 2013, 2015). Detailed field notes of participant observations were jotted, transcribed, and managed using ATLAS.ti (Emerson, Fretz, & Shaw, 1997).

Study participants were largely recruited from the weekly loss and grief groups facilitated in the center. Occasionally, program staff suggested additional potential participants with whom to explore eligibility for the project. To satisfy study inclusion criteria, participants were required to be (a) male, (b) aged 18 to 24, (c) self-identified as Black or African American, and (d) survivors of at least one homicide death of a loved one. The average age of participants was 20 years. A purposeful sample of Black males aged 18 to 24 was recruited, because this demographic has experienced some of the highest homicide rates in Baltimore, and because the parent project's goals examined the implications of homicide survivorship for the transition to adulthood.

Most participants were enrolled in GED classes at the center; however, some young men had already obtained their GED ($n = 7$) or diploma ($n = 3$) and were engaged in employment services. During the first author's time at the field site, young men's employment status fluctuated significantly. At the time of participant interviews, nearly half of participants ($n = 16$) were connected to full or part-time employment. Of participants, 11 were fathers and 3 were expectant fathers. Over the course of the 18 months, field notes and participant-observations noted the utilization of mental health services such as formal counseling sessions and informal drop-in chats with clinicians by study participants. However, the total number of study participants who used any level of service (e.g., regularly scheduled appointments or informal drop-in chats); specifically met with the center's clinicians for trauma-related symptoms; or had a mental health diagnoses as determined by a formal psychological assessment is unknown.

Data Collection

The University of Maryland institutional review board approved the completion of this study, and a certificate of confidentiality was issued by the U.S. Department of Health and Human Services to protect sensitive participant data concerning violence and homicide death (Smith, 2013). In this study, we used qualitative methods to examine the context of community violence, traumatic loss, and posttraumatic stress symptom expression among young, Black, male, homicide survivors in low-income, urban communities. In-depth, semistructured interviews were conducted with each of the 37 participants. All participants chose or were assigned

pseudonyms. Interviews lasted between 90 and 120 min and participants received a $20 incentive for their participation.

Our interview goals differed from those of mental health practitioners seeking to determine a clinical diagnosis of Posttraumatic Stress Disorder (PTSD) through one-time or repeated diagnostic interviewing; behavioral observations; or mental health questionnaires (National Center for PTSD, 2015). These semistructured interviews aimed to:

1. Understand the nature of violence exposure and traumatic loss resulting from homicide death among young men residing in economically disadvantaged neighborhoods.
2. Identify how prevalent PTSD symptoms were in young men's narratives.
3. Examine how participants' responses to traumatic exposure and violent death were similar or different from PTSD symptomology defined by the *Diagnostic and Statistical Manual of Mental Disorders*, fifth edition (DSM–V).

Semistructured interviews were an advantageous methodological approach in that they allowed for *structured discovery*—an interview approach that ensures the researcher covers all protocol domains during all participant interviews while preserving the flexibility to discover unexpected themes (Roy, Tubbs, & Burton, 2004). This approach provided a focus for the interview while allowing the flexibility to adapt to each participant's experience (Daly, 2007). This approach was particularly advantageous for learning about expressions of traumatic stress among young Black men residing in economically disadvantaged contexts. It allowed participants to openly describe their traumatic exposures and responses beyond the constraints of a questionnaire or structured interview. The research protocol guiding the semistructured interview was built around sensitizing concepts (van den Hoonard, 1997) in the literature on trauma, violence, and loss, and field observations. Protocol domains included questions that examined young men's exposure(s) to community violence, frequency and timing of traumatic loss resulting from the homicide deaths of loved ones, and their responses to traumatic exposures to violent death and loss.

Data Analyses

Interview data and field notes were transcribed and entered into ATLAS.ti for analysis. A modified grounded theory approach, including the technique of constant comparison (LaRossa, 2005), was used, and the data were coded in three waves: open, axial, and selective. During the first wave of coding, a priori codes were compiled based on DSM-V (American Psychiatric Association [APA], 2013) symptom categories and were used to help direct the data analysis (van den Hoonard, 1997). We also developed new codes that emerged from reading the data. For example, grounded in participant language, we adopted the code "on point" to capture participants' descriptions of hypervigilance as both a response to traumatic exposure and a protective strategy used to manage living in neighborhoods characterized by unpredictable violence. In the subsequent wave of axial coding, we compared and contrasted participants' expressions of posttraumatic stress symptoms. For example, young men who witnessed the death of their peers were more likely to exhibit avoidant symptoms than young men who

were not physically present or proximal to decedent at the time of death. Finally, during the last wave of selective coding, we developed a core story of participants' traumatic responses informed by both the DSM-V and the contexts of their urban neighborhoods.

Results

We use the DSM-V (APA, 2013) Posttraumatic Stress Disorder criteria (A–E) as a guide for examining the presence of trauma symptoms in the lives of young Black men in Baltimore. We first describe the nature of violence in participants' neighborhoods in an effort to contextualize this persistent stressor (Criterion A). We then use DSM-V PTSD Criteria B–E (Intrusion, Avoidance, Negative Alterations in Cognition and Mood, and Alterations in Arousal) symptomology as a guide to identify the presence of trauma symptoms in participants' narratives (see Table 1). Finally, we examine participant interview narratives and present findings explaining how this sample of young Black men in Baltimore describe and express posttraumatic stress symptoms.

Criterion A (Stressors of Neighborhood Violence): "It's Baltimore"

Across interviews, participants consistently described neighborhood contexts that included pervasive violence. Young men explained the nature of violence in their communities as unpredictable, indiscriminate, inescapable, and lethal, positioning neighborhood residents vulnerable to violence exposure. When asked to describe their neighborhoods, participants would often begin and end their replies with "It's Baltimore," suggesting an implicit understanding of persistent violence in the city. When we asked Santana (20 years old) to decode "It's Baltimore" he replied, "Guns. Drugs. People getting locked up. People selling weed. People getting shot."

Participants have memories, dating from early childhood, of witnessing neighborhood violence. For many, violence was so frequently a part of daily experience that they could not remember life without its presence. When asked if he could remember the first time he witnessed violence in his neighborhood, Nasia (19 years old) laughed and responded, "like to be truthful with you, I'm sorry but I can't remember . . . I just always witnessed violence, for real. Like I was little . . . Yeah, I always see violence. It's Baltimore." Although descriptions regarding frequency and lethality of violence witnessed varied, 100% of participants reported witnessing a violent event in their neighborhood. Physical fights were most commonly cited.

Table 1. *Prevalence of Posttraumatic Stress Symptoms*

DSM-V PTSD criteria	Symptom prevalence ($N = 37$)
Criterion A: Stressor	$n = 37$ (100%)
Criterion B: Intrusion symptoms	$n = 17$ (46%)
Criterion C: Avoidance	$n = 17$ (46%)
Criterion D: Negative alterations in cognition and mood	$n = 24$ (65%)
Criterion E: Alterations in arousal and reactivity	$n = 25$ (68%)

Participants also described direct exposure to violence resulting from physical fights with other youth, starting in early childhood and continuing into the present. Some fights were enactments of hegemonic masculinity or, as Samir (18 years old) described, a part of "boys being boys." However, as participants approached middle and high school, violence often became more frequent and serious, resulting in hospitalizations for 10% of participants.

Participants reported that, in total, 119 of their friends and family members died from lethal acts of community violence. All participants ($N = 37$) reported experiencing the homicide death of at least one loved one. More commonly, participants experienced multiple homicide deaths of persons in their networks, with an average of three homicide deaths reported per participant (see Smith, 2015). Of this group of homicide survivors, 30% reported witnessing a loved one's murder. Consistent with the unpredictable nature of violence in low-income, urban communities, a peer's death often happened when participants least expected it—preventing them from bracing themselves against the impact of loss. Andrew (21 years old) described the death of his cousin: "I told my cousin I loved him and gave him a hug and walked out and next thing I know, he gone, you know . . . that's crazy." Andrew and his cousin were very close and he considered his cousin to be more of a brother to him. Both were 19 years old when his cousin was shot and killed. Participants struggled to articulate what it was like to see peers alive one minute (often literally), and then experience their death in the next. Words like "disturbing," "scary," and "disgusting" were used in an attempt to explain the intense and painful reality of peer homicide.

Among participants in this sample, the progression of traumatic exposure resulting from neighborhood violence tended to move from witnessing violence, to directly experiencing violent injury, to surviving the traumatic loss of peers resulting from homicide. Irrespective of the specific type of violence exposure, the prevalence of violence in participants' neighborhoods indicates the persistent threat of this stressor in their lives. This group of young men were born, live, age, learn, work, play, pray, and parent in environmental contexts where there is no "post" trauma, no lasting reprieve from the chronic stressor of neighborhood violence.

DSM-V PTSD Criteria B–E: Presence of Trauma Symptoms

Analyses of participant narratives uncovered the presence of DSM-V (APA, 2013) posttraumatic stress symptoms emerging in response to violence exposure in their neighborhoods. Table 1 presents the percentage of participants who reported experiencing each category of the DSM-V traumatic stress symptoms. All participants (100%) reported experiencing at least one DSM-V traumatic stress symptom over their life course. The majority of participants (73%) reported symptoms in two or more categories, with 19% of participants reporting symptoms in all four categories of posttraumatic stress symptoms. Of the four symptom categories (B–E), participants most frequently reported experiencing alterations in arousal and reactivity in response to neighborhood violence-related stressors, chiefly hypervigilance (see Table 1). Negative alterations in cognition and mood were a close second in symptom endorsement across the sample.

Criterion B (Intrusion Symptoms): "I Feel as Though I've Been to Vietnam!"

Intrusion symptoms are traumatic stress responses in which individuals exposed to a traumatic event reexperience that event through involuntary and intrusive memories, traumatic nightmares, flashbacks, and prolonged distress or physiologic reactivity after exposure to traumatic reminders (APA, 2013). Of study participants, 46% reported experiencing one or more DSM-V Category B symptoms. They identified intrusion symptoms as occurring in response to both direct experiences of violent injury requiring hospitalization and to the traumatic loss of peers to homicide.

When Redz was 13 years old, he experienced his first direct, life-threatening, violent injury. Redz went to a club party with friends. He began dancing with a girl, unaware that her boyfriend was watching nearby. The boyfriend drunkenly approached Redz and confronted him about dancing with his girlfriend and they began to fight in the club. Dissatisfied with the fight's end inside the club, the boyfriend found Redz outside after the party and again confronted him, this time with a gun in hand.

> "What's all that tough shit you was talking now?" BOP, BOP, BOP! 3 shots. I didn't know I was hit until I seen it, like I said, I got on the bus, I swiped my card, and the man was like, "Yo, look at your fucking leg!" I looked down and it instantly started burning and hurting. I fainted on the bus. The bus driver basically drove to Johns Hopkins with a full bus.

Even though the physical wounds from his shooting healed six years ago, Redz still reexperiences the trauma of being shot in his leg whenever he hears gunfire. He describes his traumatic reaction:

> When I do hear gunshot[s], I gotta instantly grab my knee cause it hurts [referring to where he was shot]. Every time somebody fire[s] off about 5–6 shots, BOOM, BOOM, BOOM, like my knee gets the throbbing. It hurts so bad I cannot stand it. And it's like I feel as though I've been to Vietnam or something! And it's crazy!

Young men, like Redz, remain situated in neighborhoods of chronic violence, increasing their exposure to trauma triggers that may increase their likelihood of intrusive symptoms. Unlike soldiers deployed to war, there is no return home for participants: Their exposures take place in the communities where they reside. As unpredictable violence intrudes in the daily events of study participants, intrusive posttraumatic stress symptoms may be more likely to disrupt their mental health and ability to recover from traumatic exposure to violence.

Reggie (age 22) was sent to the hospital after being set up by his friend to be banked (physically fought by multiple persons at the same time) as part of a gang initiation. His injuries were so severe that doctors questioned his ability to fully recover. In the months following his injury, Reggie described experiencing distressing dreams about the attack. "I was having dreams that it was happening every night over and over again, like I was going through some stuff like you talking about people with post-traumatic stress disorder, that's what you would have thought I had." For months following his violent injuries, Reggie had nightmares about the event that indeed indicated intrusive traumatic stress symptoms; however, Reggie did not receive treatment to help him manage these symptoms.

Criterion C (Avoidance): "I Just Don't Think About It."

DSM-V Category C symptoms describe attempts to avoid trauma-related triggers after exposure to a traumatic event. Nearly half of participants (46%) reported traumatic stress symptoms categorized as avoidance. A central strategy they articulated was cognitive avoidance. Young men expressed efforts "not to think about" or to "brush off" the homicide deaths of close peers, though they were not always successful in their attempts. Regardless of whether participants acknowledged or worked through how traumatic exposures affected their lives, they emphasized the importance of avoidance strategies for moving beyond violent exposure and traumatic loss.

Raphael (22 years old), a young father, described the importance of "brushing it off" following the death of a friend who was shot immediately after exiting the funeral of another friend: Raphael heard the shots and turned the street corner to find his friend lying dead. Raphael described the cognitive avoidance strategies required to remain mentally and emotionally accessible to his daughter.

> I just don't think about it. I think about me . . . what I want. I don't pay attention or revolve ongoing back to that day or anything. I just move on. I got a little girl so I just look at her and see me and that's all I see. Instead of worrying about what I've been through and everything, cause I don't want her to go through that so I don't worry about it. Mind goes blank. It doesn't go blank, but when it comes to that it goes blank, not something I talk about.

Matt (19 years old) also described cognitive avoidance as a key protective strategy following the homicide death of a peer. Matt struggled to accept the reality of his cousin's homicide, which happened one month before his interview. He did not attend his cousin's funeral. He admitted, "I couldn't do it. Cause I just couldn't believe that it was—that he was . . . gone." To Matt, it still felt like his cousin was around. Therefore, he dismissed any thoughts that forced him to confront the reality that his cousin is deceased. Whenever his mind wandered to his cousin, he would "just do something else." In part, Matt feared that if he allowed himself to really think about his cousin, he would experience intense sadness that he might not be able to shift out of quickly. "Cause if I bring it back up, I think . . . it's just going to have me down for the rest of day, for the rest of the days, or probably just have me down for the rest of this week." Consequently, in an effort to avoid the possibility of lasting sadness, Matt made an effort to avoid thinking or talking about his deceased cousin. Young men's experiencing intense sadness for the rest of the day, or multiple days, could interfere with their ability to properly attend to the unpredictable threat of violence around them. Therefore, Matt's avoidance of thoughts about his cousin might dually serve to protect him emotionally and physically.

Other participants described emotional numbing (avoidance of feelings associated with the trauma) as key to remaining physically and emotionally safe in the future. They referred to this trauma response as process by which they "hardened their hearts." This response was particularly noted among young men who witnessed the murder of a loved one (n = 11). De'Onte (20 years old) witnessed his best friend be killed when he was just five years old.

His friend was caught in crossfire between gang members and police. De'Onte described his emotional numbing:

> It was tough. It was a very tough experience for me. But it kind of hardened me. I felt like it kind of hardened my heart for a minute because I didn't trust anybody afterward and it was like I didn't put anything past no body.

This protective response to witnessing trauma was often accompanied by a heightened sense of distrust that was generally applied to all persons in the community, even family members and friends. Watching friends be killed sent a clear message to young men that no one could be trusted and everyone posed a potential threat to physical and emotional safety.

To facilitate avoidance of trauma-related thoughts and feelings, 23% of participants described using substances—among them alcohol, marijuana, and pills such as ecstasy or Percocet. At age 17, Redz (19 years old) witnessed the homicide death of his best friend who was shot seven times as they stood side-by-side in their Baltimore neighborhood. He frequently had intrusive memories that replayed the gruesome scene in his mind. When we asked Redz how he coped with the trauma and loss of his best friend he shared, "I used to pop pills, like prescription drugs, like Percocets and all that . . . I used pop them. I used pop ecstasy, they would be the e-pills and . . . I used to smoke weed." Similar to Rich and Grey's findings (2005), study participants reported that marijuana was the substance most frequently used to try and avoid trauma-related thoughts and the intense range of emotions experienced connected to exposures to violence and the homicide deaths of loved ones.

Criterion D (Negative Alterations in Cognitions and Mood): "You're Supposed to Be Mad."

Category D symptoms describe negative changes in thoughts or feelings that began or worsened after exposure to a traumatic event. Of all of the symptoms reported by young men, negative alterations in cognition and mood were the second-most prevalent among study participants (65%). The most common symptom reported in this category was "persistent negative trauma-related emotions." Although participants named a wide range of emotions stemming from the grief of losing loved ones to violence, two emotions connected to the traumatic nature of these deaths were central in participant interviews: fear and anger.

Participants' cumulative exposures to violence, both as witnesses and victims, established formative understandings of their vulnerability as young Black men in their Baltimore neighborhoods. However, losing peers to homicide deepened young men's perceptions of their personal vulnerability and affirmed the reality that they were also susceptible to premature death and homicide. This concern was maintained by the continued presence of violence in their communities that did not relent following the death of a peer. The question of "Am I next?" was salient across young men's interviews as they evaluated both their personal sense of vulnerability and lack of outward mobility from their Baltimore neighborhoods. In response, at minimum, most endorsed exercising caution when navigating their neighborhoods.

However, a duality of experience was represented in participants' narratives of fear, particularly for young men who were direct victims of violence or who witnessed close peer homicides. Young men who witnessed peer homicide often experienced intense fear in the immediacy of the event. When J. R. (20 years old) was 15 years old, his older brother was shot and killed in a drive-by shooting as he sat next to J. R. on their front steps. He described his fear in response to the shooting: "He got shot in the chest and the head. I couldn't afford that. So that was like really scary for me. I was feeling emotion like *I'm about to die*!" J. R.'s intense fear persisted for weeks, triggered every time he saw a car that looked like the one the shooter (not found by the police) drove the night of his brother's murder.

In response to peer homicide and direct violent injury, many participants, among them Myles (21 years old) and Howard (23 years old), began to carry guns to increase their personal sense of safety in their unsafe neighborhoods (Rich, 2009). Others responded to their encounters with death by assuming a posture of fearlessness. Redz (19 years old) was standing next to his best friend when a group of young men he had a dispute with approached them and began firing shots. His best friend was shot multiple times but Redz was uninjured. He carried his injured friend on his back to his mother's house to try and get help but his friend died before they could arrive. His friend's death was the second close peer homicide Redz had experienced in two years. For him, this second experience of peer homicide caused him to shed fear and "face facts:"

> I ain't got no fear of dying right now, for real. Cause see, the things I see around my block it's normal now. If you see a body, it's normal. If you hear gunshots, it's normal. . . . Yeah, it is. You see it so much that it start to be getting—it starts to become normal to you. It starts to become a part of your life, and you cannot escape from it so it's just, there's no point in just running away from it, you just might as well sit down and face facts. You're gonna see a murder. And you might be in a murder. You might [be] a murder victim or you might be person that killed a person. So, I'm just saying . . . What can you do about it?

Redz's responses to the traumas of peer homicide highlight the complexity of this experience for young men who remain situated in contexts of chronic risk. They also provide insight into how masculinity may shape response to trauma and loss. Males, generally, are socialized to be tough and fearless, and Black males in urban contexts are often socialized to the code of the street (Anderson, 1999; Brezina, Agnew, Cullen, & Wright, 2004; Kubrin, 2005; Stewart et al., 2006; Stewart & Simons, 2010) and expected to present a persona of toughness to be respected. In response to witnessing his best friend's homicide, Redz goes on to disclose "It aint no fear, no sadness, none of that. It was just an angry emotion." Anger is another accessible, gendered emotion prescribed by masculinity (Mejía, 2005). The expression of anger through violence also sits comfortably within the frames of masculinity, particularly in low-income and urban contexts. The code of the street (Anderson, 1999; Brezina et al., 2004; Kubrin, 2005; Stewart et al., 2006; Stewart & Simons, 2010), partly maintained by young men's longstanding experiences of injustice, distrust, and traumatic encounters with the Baltimore City Police Department, also sanctioned participants' hypermasculine use of violence to achieve justice on behalf of their slain peers (e.g., retaliation). Consequently, trauma-exposed and grieving young men were also

at risk for violent behavioral expressions of pain following peer homicide.

The whirlwind of fearlessness and anger following peer homicide often left participants wanting to take action. The majority reported that police did not actively investigate the murders of their peers. They shared a visceral sense of injustice and anger concerning what they perceived as continued discrimination, even after death. Young men like Antwon (18 years old) confidently believed that if their peers were White males or lived in "the county" (distinguishing between the City of Baltimore and Baltimore County) that a thorough investigation of peers' homicides would have been conducted.

> All they see is another Black man dead. They don't [care]. They see casualties like that just about everyday. That even more so brings out the anger with the police, 'cause it's likely they do not care. Now if it was a White man that got shot in his head and they suspected a Black man, they would have been searching for him up and down every street and every alley. Everywhere. Just like that guy on the news, Trayvon Martin. Prime example.

Across interviews, participant narratives tapped into a collective experience of racial injustice and discriminatory policing targeting Black men in Baltimore. By referencing Trayvon Martin, Antwon extended this shared identification beyond his Baltimore neighborhood, connecting with a national network of young Black men who are treated unjustly by the police. In this instance, by referencing homicide victim Trayvon Martin, Antwon is also tapping into a larger cultural experience of homicide survivorship. Together, these personal experiences and nationally covered incidents of injustice affirmed for Antwon and many participants this same belief that their lives were not valued.

Unable to trust the police to properly investigate the deaths of their peers, many young men decided to investigate the deaths themselves. Neighborhood rumors often narrowed alleged suspects responsible for the deaths of participants' peers. Having collected their own information and evidence, young men were left with choices: Do nothing or seek justice through retaliation. After Santana (20 years old) found out his cousin was killed, the first thoughts that entered his mind were, "I was gonna find him and kill him. Revenge." Santana felt enraged and he began searching his neighborhood for the name of the shooter. "Well, see, I was trying to find him, but I couldn't find him." Although consistent with the code of the street (Anderson, 1999), Santana's hypermasculine eye-for-an-eye ethic of street justice was also an agentic effort to seek justice for his cousin's death in a context where young Black men are often disempowered and are infrequently supported by the formal justice system (Brezina et al., 2004; Stewart et al., 2006; Stewart & Simons, 2010).

Luther's (20 years old) response to his cousin's killing, which occurred one month before his interview, differed from Santana's. He described his process in the context of the broader contextual frame of street justice:

> The police, like, I done found out more than what they found out. Most people would try to avenge it. Avenge his death. Like, it's crazy because what I know, I still don't want to do nothing about. It was not right for them to take my cousin.

Despite knowing more information about the details of his cousin's homicide, he reasoned that it was unacceptable for his cousin's life to be taken away, and in the same regard, it was not right for him to do the same. Luther discussed his perception of a stereotyped response among Black males when a peer is killed:

> Enraged! You're supposed to be mad. You're supposed to avenge his death. You're supposed to, yeah . . . a whole bunch of bull! Cause I don't feel that way. Like moms, females are really the ones that will say, "Catch him. Give him 100 years." *Me*, I just feel like that wouldn't do nothing. That wouldn't satisfy—I mean *it would*, but it wouldn't do nothing. It wouldn't do nothing. It wouldn't. I feel as though my little cousin, he's waiting for me now. He waiting for me now.

Luther resisted enacting his perceived expected response of violent retaliation following his cousin's death. Instead, he focused on his continued relationship with his cousin. He constructed meaning about the loss that helped him to adjust to life without his cousin physically present and began to move forward with life. In this way, Luther's strategies might promote resiliency (Thompson, 2009; Zimmerman et al., 2013).

Criterion E (Alterations in Arousal): "I Stay on Point."

Alterations in arousal were the most common posttraumatic stress symptom category reported by participants (68%) in this sample. Specifically, hypervigilance was most frequently reported among the DSM-V Criterion E symptoms. The unpredictable nature of violence in chronically violent and economically disadvantaged urban neighborhoods creates a context of persistent threat where young Black men learn to remain alert for looming danger. Across participants, young men consistently described the traumatic stress symptom of hypervigilance as being *on point*. Grounded in participant narratives, the strategy of being *on point* can be conceptualized as an intentional state of alertness and heightened awareness in which young men keenly and constantly observe their physical and social environment to anticipate and/or quickly react to danger, specifically the threat of violence. For young men situated in contexts of pervasive, unpredictable violence, the traumatic stress symptom of hypervigilance was also a practical strategy that served to prepare young men for exposures to indirect violence (e.g., witnessing) and protect them from direct exposures to violence (e.g., experiencing). As Tony (18 years old) explained:

> I'm always, like, with it. I'm always on point. . . . I have to be aware of every situation. 'Cause anything can happen at any time . . . you can hear gunshots are happening everywhere, you can be in a close place where somebody has a gun or you can get stabbed. I'm just prepared.

Being *on point* also involves a sophisticated awareness and analysis of body language, voice tone, and social interaction that helps young men discern the likelihood of a violent incident. Chris (18 years old) describes the attentiveness required of this safety strategy:

> Like, I got the point whereas though I know when something's gonna go wrong, or like I can see it, like Yo [he] didn't just look at me like that for no reason or like it's a vibe that people give off, basically. And I don't ever walk with my head down so I catch eye contact with everybody that I walk past, basically.

Participant narratives consistently revealed the requirement of being *on point*—alert, on guard, observant, and prepared for direct or indirect exposures to violence. As Adam (21 years old) expressed:

> I just be mindful of my surroundings, I don't ever be loafing, for real. I stay on point. I never let my guard down. Anywhere you go. Have to stay alert at all times. Doesn't matter where you go, anybody can just go at you for real, and just take your life for real . . . I'm just like, "Adam, you have to stay on point cause anything could happen, for real." I don't want to lose my life. I want to live, you know . . .

Andrew described this strategy of staying *on point* as one that was globally applied regardless of the neighborhood or the setting. Although many young men reported this response to violent exposure as a requirement for negotiating safety in their neighborhoods, Marshall (18 years old) revealed how exhausting and undesirable it is to have to maintain such a high level of arousal:

> I don't like looking over my shoulder and looking at people and just males period. Just walking, like every person, now, like, if I don't know you and I walk past you, I'm looking you directly in your eyes, I'm watching your whole body language to see exactly what you're doing. Yeah, I don't like that feeling. I just like to be on chills and just let life happen.

Although the traumatic stress symptom of hypervigilance had agentic features for the young Black men reporting this symptom, it did not come without cost. Being *on point* requires a lot of focus and energy, but as Matt (19 years old) said, "It's a lot of work to keep your life."

Discussion

This study investigates traumatic stress symptoms among young Black males exposed to community violence and traumatic loss while living in Baltimore. Listening to the narratives of young Black male victims of violence can deepen and extend our current understanding of traumatic stress symptoms among urban Black males exposed to community violence. It can also help us to consider the utility of DSM-V descriptions of symptoms for this vulnerable population. In addition, the presence of trauma symptoms in narratives of this group of homicide survivors deepens our understanding of how violent death can create experiences of both trauma and loss for young Black men. This study points to an increased vulnerability to traumatic stress and traumatic loss among young Black men, given the frequency of homicide death members of this group experience (Smith, 2015).

The nature and prevalence of violence and traumatic stress symptoms as reported by the young men in this sample enhance our understanding of the connection between place and health. Consistent with the literature on urban Black males and violence exposure (see Anderson, 1999; Bell & Jenkins, 1993; Paxton et al., 2004; Rich, 2009; Rich et al., 2009), participants highlighted the unpredictable nature of violence in their communities, referring to such types of violence exposure as witnessing violence, direct exposure (e.g., fighting), and surviving the homicidal death of family members and friends. The concentration of economic disadvantage and the associated determinants of violence in urban neighborhoods (Buka et al., 2001; Peterson & Krivo, 1999; Rivera, Huezo, Kasica, & Muhammad, 2009) identify them as spaces where residents face increased risk of violence exposure, traumatic stress, and traumatic loss resulting from homicide (Smith, 2014, 2015). Therefore, Black youth growing up in these areas may be more vulnerable to traumatic stress resulting from chronic exposure to neighborhood violence than their middle or upper class peers (Way, 1998). Previous research suggests that the levels of violence exposure of Black youth growing up in economically disadvantaged urban contexts are comparable to youth living and growing up in war-torn countries (Bell & Jenkins, 1991; Garbarino, 1995, 1999). Reducing and eliminating this violence exposure and traumatic stress among Black youth in America's economically disadvantaged neighborhoods should be a key public and mental health priority.

In our sample we identified multiple traumatic stress symptoms among Black males exposed to urban violence, which corroborate findings in prior research (Alegria et al., 2013; Garbarino, 1995; Rich & Grey, 2005). All participants met at least one of four DSM-V criteria for traumatic stress symptoms: intrusion, avoidance, negative alterations in cognition and mood, and alterations in arousal. Traumatic stress responses both extend and corroborate those found in Garbarino's (1995) research on Chicago youth exposed to violence and Rich and Grey's (2005) qualitative study of trauma among young Black men. In both studies, the traumatic coping strategies were viewed as maladaptive.

Using PVEST, we suggest that perhaps some responses to traumatic stress offer situational and temporary relief from the physical and emotional pain resulting from a violent experience (e.g., avoidance). In this way, avoidant symptoms ("just don't think about it") and hypervigilance ("stay on point") may be adaptive coping strategies that promote resilience in the context of chronic threats to physical and psychological safety and well-being (Gaylord-Harden et al., 2008; Thompson, 2009). However, this negates neither the more distal, deleterious effects of traumatic stress that may occur once an individual leaves the immediate violent context nor the long term consequences to physical health resulting from constant need to remain "on point" (Mays, Cochran, & Barnes, 2007). This particular set of findings indicates a variation in traumatic stress responses to community violence exposure. It may also suggest the need to develop more holistic treatment plans for direct practitioners working with Black males exposed to community violence in urban settings.

Notably, 73% of participants experienced at least two trauma symptoms. Although individuals who live in chronically violent neighborhoods may view their violence exposure as normal, relative to overall life experiences, this particular finding may suggest that their reaction to violence is not normal. In addition, participant linking of violence exposure in urban neighborhoods to the experiences of soldiers in Vietnam War may serve as a barometer for understanding the severity of the traumatic stress experience. Future research might also directly compare the level of PTSD symptoms reported by young Black men residing in economically disadvantaged urban neighborhoods with those of Afghan or Iraq war veterans to better understand the severity of traumatic exposure and symptoms Black males report.

Our findings also highlight substance use as a potential coping mechanism for violence exposure and trauma. More specifically, participants describe using multiple drugs, not to cope with trauma exposure, but to specifically interrupt intrusive thoughts. This finding is consistent with earlier research findings, which suggest

prior trauma experiences are a risk factor for substance use (Bolton, O'Ryan, Udwin, Boyle, & Yule, 2000; Giaconia & Reinherz, 1995; Kilpatrick et al., 2000).

The trauma symptom participants most commonly reported was *hypervigilance,* alteration in arousal and reaction. This finding is consistent with other studies of Black males exposed to community violence (Harding, 2009; Nugent, Koenen, & Bradley, 2012; Rich & Grey, 2005; Rios, 2011). However, our findings extend our understanding of hypervigilance, highlighting the unique contextual expression of this PTSD symptom (*on point*) and the extent to which one's own body can be an alert system for measuring and assessing potential violence. One important finding not commonly discussed in research on trauma and Black males is the exhaustion attached to "staying on point," a cognitive script used to successfully navigate violence in the community. "Staying on point" extends our understanding of the continuum of hypervigilance in a violent community: Specifically, hypervigilance is not episodic, but a state of being associated with chronic and random violent experiences. Research examining the effect of hypervigilance among racial minority groups in response to persistent discrimination threat identifies this stress response as key mechanism shaping poor health, disease, and mortality (Mays et al., 2007). Future research should examine the physical health implications of hypervigilance in response to persistent threat of violence exposure and ensuing trauma among Black boys and men.

Study participants also reported negative alterations in cognition and mood. Most salient among this group of homicide survivors were fear, fearlessness, and anger—emotions that highlight the importance of examining the role masculinities play in young men's responses to trauma and loss (Mejía, 2005). From a young age, boys are socialized to reject vulnerability, toughen up, and "be a man" (Kivel, 2006). For Black boys and men in urban contexts, personas of coolness (Majors & Billson, 1992) and toughness (Anderson, 1999) are key protective strategies in economically disadvantaged urban contexts. However, these protective strategies and masculinities may mask the presence of trauma symptoms, particularly among young, Black, male homicide survivors who remain situated in contexts of chronic risk. Given the prevalence of trauma symptoms among the narratives of the young Black men in this sample, our findings suggest that violence prevention efforts might do well to direct resources toward young men who have lost a loved one to homicide. By helping young Black men process experiences of traumatic stress and violence exposure(s), mental and public health practitioners may facilitate healing in the lives of Black males exposed to violence and homicide, perhaps preventing vengeance seeking or retaliatory violence.

Our findings also have important implications for developing prevention and intervention strategies. Specifically, young Black males experience multiple traumatic stress symptoms in response to chronic and unpredictable violence in their neighborhood. The ways in which participants cope with traumatic experiences also speaks to the lack of support available to young Black males who experience chronic community violence. Service providers (e.g., public health professionals, mental health counselors, and social workers) may consider developing therapeutic safe spaces and practices that permit Black males to openly process their experiences of homicide without fear of retribution.

Our findings also point to a need for traumatic stress screening, psychoeducational resources, and treatment services or referrals for emergency-room patients who have experienced community violence and are preparing for release to their respective communities (Purtle et al., 2015). Across settings, screening and assessment tools for PTSD symptoms, as well as the clinicians conducting these assessments, should be informed by culturally and contextually specific language used to describe traumatic stress symptoms (e.g., "I stay on point"). In addition, support services for young Black males with community-violence exposure should incorporate substance abuse treatment services for individuals engaged in substance use to cope with untreated trauma.

Although the current study enhances our understanding of traumatic stress symptoms among young Black men, it is limited by several factors. The data presented in this study explore only traumatic stress symptoms among emerging adult Black males living in Baltimore; findings are not generalizable to Black male children, adolescents, or older adults; Black males outside of Baltimore; or those outside violent Baltimore neighborhoods. In addition, our assessment of traumatic stress draws on in-depth life history interviews. Participants did not undergo a formal assessment of PTSD. However, we believe the in-depth life histories gathered provide a nuanced perspective on the development of traumatic symptoms that can be used in the development and enhancement of current trauma-based assessments. Finally, our study is not longitudinal; thus we cannot assess the accumulation of traumatic experiences over the life course that provide deeper insight into how and why participants respond to and cope with chronic violence. Nonetheless, our findings enhance the current knowledge of traumatic symptoms among Black males by deeply examining the context surrounding multiple traumatic events and how young adult Black males cope with traumatic experiences.

Our findings suggest the importance of continued research on the prevalence of traumatic symptoms among young Black men living in chronically violent urban neighborhoods. Future research might investigate prevalence of traumatic symptoms among urban Black males over the life course. In addition, researchers might continue examining the impact traumatic symptoms have on future life course outcomes as education and career. Finally, additional research is needed to determine the link between substance use and traumatic symptoms for this particular population (Rich & Grey, 2005). Understanding the presence and prevalence of traumatic symptoms among Black boys and men in economically disadvantaged urban neighborhoods like those in Baltimore may support development of both individual and community-based prevention and intervention strategies. These efforts should aim to assess trauma symptoms early, provide safe spaces for Black boys and men to process trauma histories and experiences, and partner with informal supports (e.g., parents, peers, mentors, church leaders, etc.) to offer psychosocial assistance that fosters resilience among Black males across the life course. Public health investments of this nature may be critical for supporting the long-term health, well-being, and success of America's Black boys and men.

Keywords: African Americans; males; community violence; trauma; posttraumatic stress disorder

References

Alegría, M., Fortuna, L. R., Lin, J. Y., Norris, F. H., Gao, S., Takeuchi, D. T., . . . Valentine, A. (2013). Prevalence, risk, and correlates of posttraumatic stress disorder across ethnic and racial minority groups in

the United States. *Medical Care, 51,* 1114–1123. http://dx.doi.org/10.1097/MLR.0000000000000007

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.

Amick-McMullan, A., Kilpatrick, D. G., & Resnick, H. S. (1991). Homicide as a risk factor for PTSD among surviving family members. *Behavior Modification, 15,* 545–559. http://dx.doi.org/10.1177/01454455910154005

Anderson, E. (1999). *Code of the street: Decency, violence and the moral life of the inner city.* New York, NY: Norton.

Bell, C. C., & Jenkins, E. J. (1991). Traumatic stress and children. *Journal of Health Care for the Poor and Underserved, 2,* 175–185. http://dx.doi.org/10.1353/hpu.2010.0089

Bell, C. C., & Jenkins, E. J. (1993). Community violence and children on Chicago's southside. *Psychiatry: Interpersonal and Biological Processes, 56,* 46–54.

Bolton, D., O'Ryan, D., Udwin, O., Boyle, S., & Yule, W. (2000). The long-term psychological effects of a disaster experienced in adolescence: II: General psychopathology. *Journal of Child Psychology and Psychiatry, 41,* 513–523. http://dx.doi.org/10.1111/1469-7610.00636

Bordere, T. C. (2008–2009). "To look at death another way": Black teenage males' perspectives on second-lines and regular funerals in New Orleans. *Omega: Journal of Death and Dying, 58,* 213–232. http://dx.doi.org/10.2190/OM.58.3.d

Brady, S. S., Gorman-Smith, D., Henry, D. B., & Tolan, P. H. (2008). Adaptive coping reduces the impact of community violence exposure on violent behavior among African American and Latino male adolescents. *Journal of Abnormal Child Psychology, 36,* 105–115. http://dx.doi.org/10.1007/s10802-007-9164-x

Breslau, N., Wilcox, H. C., Storr, C. L., Lucia, V. C., & Anthony, J. C. (2004). Trauma exposure and posttraumatic stress disorder: A study of youths in urban America. *Journal of Urban Health: Bulletin of the New York Academy of Medicine, 81,* 530–544. http://dx.doi.org/10.1093/jurban/jth138

Brezina, A., Agnew, R., Cullent, F. T., & Wright, J. P. (2004). The code of the street: A quantitative assessment of Elijah Anderson's subculture of violence thesis and its contribution to youth violence research. *Youth Violence and Juvenile Justice, 2,* 303–328. http://dx.doi.org/10.1177/1541204004267780

Bronfenbrenner, U. (2005). *The bioecological theory of human development.* Thousand Oaks, CA: Sage.

Buka, S. L., Stichick, T. L., Birdthistle, I., & Earls, F. J. (2001). Youth exposure to violence: Prevalence, risks, and consequences. *American Journal of Orthopsychiatry, 71,* 298–310. http://dx.doi.org/10.1037/0002-9432.71.3.298

Centers for Disease Control and Prevention. (2011). Factsheet—*CDC Health disparities and inequalities report—United States, 2011.* Retrieved from http://www.cdc.gov/mmwr/pdf/other/su6001.pdf

Centers for Disease Control and Prevention. (2012). Youth violence: Facts at a glance. Retrieved May 26, 2014, from http://www.cdc.gov/violenceprevention/pdf/yv_datasheet_2012-a.pdf

Daly, K. (2007). *Qualitative methods for family studies and human development.* Thousand Oaks, CA: Sage.

Eitle, D., D'Alessio, S. J., & Stolzenberg, L. (2006). Economic segregation, race, and homicide. *Social Science Quarterly, 87,* 638–657. http://dx.doi.org/10.1111/j.1540-6237.2006.00401.x

Emerson, R., Fretz, R., & Shaw, L. (1997). Coding and memoing. *Writing ethnographic field notes* (pp. 142–168). Chicago, IL: University of Chicago Press.

Finkelhor, D., Ormrod, R., Turner, H., & Hamby, S. L. (2005). The victimization of children and youth: A comprehensive, national survey. *Child Maltreatment, 10,* 5–25. http://dx.doi.org/10.1177/1077559504271287

Garbarino, J. (1995). *Raising children in a socially toxic environment.* San Francisco, CA: Jossey-Bass.

Garbarino, J. (1999). *Lost boys: Why our sons turn violent and how we can save them.* New York, NY: Anchor Books.

Gaylord-Harden, N., Gipson, P., Mance, G., & Grant, K. (2008). Coping patterns of African American adolescents: A confirmatory factor analysis and cluster analysis of the Children's Coping Strategies Checklist. *Psychological Assessment, 20,* 10–22.

Giaconia, R., & Reinherz, H. (1995). Traumas and posttraumatic stress disorder in community population of older adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry, 34,* 1369–1380.

Harding, D. J. (2009). Violence, older peers, and the socialization of adolescent boys in disadvantaged neighborhoods. *American Sociological Review, 74,* 445–464. http://dx.doi.org/10.1177/000312240907400306

Hertz, M. F., Prothrow-Stith, D., & Chery, C. (2005). Homicide survivors: Research and practice implications. *American Journal of Preventive Medicine, 29,* 288–295. http://dx.doi.org/10.1016/j.amepre.2005.08.027

Jacob France Institute. (2013). Baltimore neighborhood indicators alliance [data file]. *Vital Signs, 13.* Retrieved from www.bniajfi.org/vital_signs

Jenkins, E. J., Wang, E., & Turner, L. (2009). Traumatic events involving friends and family members in a sample of African American early adolescents. *American Journal of Orthopsychiatry, 79,* 398–406.

Johnson, W. E. (2010). From shortys to old heads: Contemporary social trajectories of African American males across the life course. In W. E. Johnson (Ed.), *Social work with African American males.* New York, NY: Oxford University Press. http://dx.doi.org/10.1093/acprof:oso/9780195314366.003.0001

Kilpatrick, D. G., Acierno, R., Saunders, B., Resnick, H. S., Best, C. L., & Schnurr, P. P. (2000). Risk factors for adolescent substance abuse and dependence: Data from a national sample. *Journal of Consulting and Clinical Psychology, 68,* 19–30. http://dx.doi.org/10.1037/0022-006X.68.1.19

Kivel, P. (2006). Boys will be men: Guiding your sons from boyhood to manhood. Retrieved from http://www.paulkivel.com/component/jdownloads/finish/1/37/0?Itemid=31

Kubrin, C. E. (2005). Gangstas, thugs, and hustlas: Identity and the code of the street in rap music. *Social Problems, 52,* 360–378. http://dx.doi.org/10.1525/sp.2005.52.3.360

LaRossa, R. (2005). Grounded theory methods and qualitative family research. *Journal of Marriage and Family, 67,* 837–857. http://dx.doi.org/10.1111/j.1741-3737.2005.00179.x

LaVeist, T. A. (2005). *Minority populations and health: An introduction to health disparities in the United States.* San Francisco, CA: Jossey-Bass.

Majors, R., & Billson, J. M. (1992). *Cool pose: The dilemmas of Black manhood in America.* New York, NY: Lexington Books.

Mays, V. M., Cochran, S. D., & Barnes, N. W. (2007). Race, race-based discrimination, and health outcomes among African Americans. *Annual Review of Psychology, 58,* 201–225. http://dx.doi.org/10.1146/annurev.psych.57.102904.190212

Mejía, X. E. (2005). Gender matters: Working with adult male survivors of trauma. *Journal of Counseling & Development, 83,* 29–40. http://dx.doi.org/10.1002/j.1556-6678.2005.tb00577.x

Miller, L. (2009a). Family survivors of homicide: I. Symptoms, syndromes, and reaction patterns. *American Journal of Family Therapy, 37,* 67–79. http://dx.doi.org/10.1080/01926180801960625

Miller, L. (2009b). Family survivors of homicide: II. Practical therapeutic strategies. *American Journal of Family Therapy, 37,* 85–98. http://dx.doi.org/10.1080/01926180801960633

National Center for PTSD. (2015). Practical PTSD assessment. Retrieved from http://www.ptsd.va.gov/professional/continuing_ed/practical_assessment.asp

Nugent, N. R., Koenen, K. C., & Bradley, B. (2012). Heterogeneity of posttraumatic stress symptoms in a highly traumatized low income,

urban, African American sample. *Journal of Psychiatric Research, 46,* 1576–1583. http://dx.doi.org/10.1016/j.jpsychires.2012.07.012

Parto, J. A., Evans, M. K., & Zonderman, A. B. (2011). Symptoms of posttraumatic stress disorder among urban residents. *Journal of Nervous and Mental Disease, 199,* 436–439. http://dx.doi.org/10.1097/NMD.0b013e3182214154

Patton, M. Q. (2002). *Qualitative research and evaluation methods*. Thousand Oaks, CA: Sage.

Paxton, K. C., Robinson, W. L., Shah, S., & Schoeny, M. E. (2004). Psychological distress for African-American adolescent males: Exposure to community violence and social support as factors. *Child Psychiatry and Human Development, 34,* 281–295. http://dx.doi.org/10.1023/B:CHUD.0000020680.67029.4f

Peterson, R. D., & Krivo, L. J. (1999). Racial segregation, the concentration of disadvantage, and Black and White homicide victimization. *Sociological Forum, 14,* 465–493. http://dx.doi.org/10.1023/A:1021451703612

Purtle, J., Rich, L. J., Bloom, S. L., Rich, J. A., & Corbin, T. J. (2015). Cost-benefit analysis simulation of a hospital-based violence intervention program. *American Journal of Preventive Medicine, 48,* 162–169. http://dx.doi.org/10.1016/j.amepre.2014.08.030

Redmond, L. M. (1989). *Surviving: When someone you know was murdered*. Clearwater, FL: Psychological Consultations and Educational Services Ltd.

Rheingold, A., Smith, D., Ruggiero, K., Saunders, B., Kilpatrick, D., & Resnick, H. (2004). Loss, trauma exposure, and mental health in a representative sample of 12–17-year-old youth: Data from the national survey of adolescents. *Journal of Loss and Trauma, 9,* 1–19.

Rich, J. (2009). *Wrong place, wrong time: Trauma and violence in the lives of young Black men*. Baltimore, MD: Johns Hopkins University Press.

Rich, J., Corbin, T., Bloom, S., Evans, S., & Wilson, A. (2009). Healing the hurt: Approaches to the health of boys and young men of color. The California Endowment Fund. Retrieved from http://pas.fpg.unc.edu/resources/healing-hurt-trauma-informed-approaches-health-boys-and-young-men-color

Rich, J. A., & Grey, C. M. (2005). Pathways to recurrent trauma among young Black men: Traumatic stress, substance use, and the "code of the street." *American Journal of Public Health, 95,* 816–824. http://dx.doi.org/10.2105/AJPH.2004.044560

Rios, V. (2011). *Punished*. New York, NY: New York University Press.

Rivera, A., Huezo, J., Kasica, C., & Muhammad, D. (2009). *The silent depression: State of the dream 2009*. Boston, MA: United for a Fair Economy website. Retrieved from http://www.faireconomy.org/files/pdf/state_of_dream_2009.pdf

Roberts, A. L., Gilman, S. E., Breslau, J., Breslau, N., & Koenen, K. C. (2011). Race/ethnic differences in exposure to traumatic events, development of post-traumatic stress disorder, and treatment-seeking for post-traumatic stress disorder in the United States. *Psychological Medicine, 41,* 71–83. http://dx.doi.org/10.1017/S0033291710000401

Rosario, M., Salzinger, S., Feldman, R. S., & Ng-Mak, D. S. (2008). Intervening processes between youths' exposure to community violence and internalizing symptoms over time: The roles of social support and coping. *American Journal of Community Psychology, 41*(1–2), 43–62. http://dx.doi.org/10.1007/s10464-007-9147-7

Roy, K., Tubbs, C., & Burton, L. (2004). Don't have no time: Daily rhythms and organization of time for low-income families. *Family Relations, 53,* 168–178. http://dx.doi.org/10.1111/j.0022-2445.2004.00007.x

Sharpe, T. (2008). Sources of support for African-American family members of homicide victims. *Journal of Ethnic & Cultural Diversity in Social Work: Innovation in Theory, Research & Practice, 17,* 197–216. http://dx.doi.org/10.1080/15313200801947231

Sharpe, T. L., Joe, S., & Taylor, K. C. (2012–2013). Suicide and homicide bereavement among African Americans: Implications for survivor research and practice. *Omega: Journal of Death and Dying, 66,* 153–172. http://dx.doi.org/10.2190/OM.66.2.d

Smith, J. R. (2013). *Peer homicide and traumatic loss: A qualitative examination of homicide survivorship among low-income, young, Black men* (Unpublished doctoral dissertation). University of Maryland, College Park, MD.

Smith, J. R. (2015). Unequal burdens of loss: Examining the frequency and timing of homicide deaths experienced by young Black men across the life course. *American Journal of Public Health, 105,* S483–S490. http://dx.doi.org/10.2105/AJPH.2014.302535

Smith, S. S. (2014). Traumatic loss in low-income communities of color. *Focus (San Francisco, Calif.), 31,* 32–34.

Spencer, M. B. (1995). Old issues and new theorizing about African American youth: A phenomenological variant of ecological systems theory. In R. L. Taylor (Ed.), *African-American youth: Their social and economic status in the United States* (pp. 37–69). Westport, CT: Praeger.

Spencer, M. B., Fegley, S., Harpalani, V., & Seaton, G. (2004). Understanding hypermasculinity in context: A theory-driven analysis of urban adolescent males' coping responses. *Research in Human Development, 1,* 229–257. http://dx.doi.org/10.1207/s15427617rhd0104_2

Stewart, E. A., Schreck, C. J., & Simons, R. L. (2006). "I ain't gonna let no one disrespect me": Does the code of the street reduce or increase violent victimization among African American adolescents? *Journal of Research in Crime and Delinquency, 43,* 427–458. http://dx.doi.org/10.1177/0022427806292338

Stewart, E. A., & Simons, R. L. (2010). Race, code of the street, and violent delinquency: A multilevel investigation of neighborhood street culture and individual norms violence. *Criminology, 48,* 569–605. http://dx.doi.org/10.1111/j.1745-9125.2010.00196.x

Thompson, S. N. (2009). *Coping styles of African American youth living in poverty: Understanding the role of coping in resiliency* (Unpublished doctoral dissertation). DePaul University, Chicago, IL.

van den Hoonard, W. C. (1997). Talking distance from the data and constructing sensitizing concepts. In W. C. van den Hoonard (Ed.), *Working with sensitizing concepts: Analytical field research. Qualitative Research Methods Series 41*. Thousand Oaks, CA: Sage.

Way, N. (1998). *Everyday courage: The lives and stories of urban teenagers*. New York, NY: New York University Press.

Zimmerman, M. A., Stoddard, S. A., Eisman, A. B., Caldwell, C. H., Aiyer, S. M., & Miller, A. (2013). Adolescent resilience: Promotive factors that inform prevention. *Child Development Perspectives, 7,* 215–220. http://dx.doi.org/10.1111/cdep.12042

Zinzow, H. M., Rheingold, A. A., Hawkins, A. O., Saunders, B. E., & Kilpatrick, D. G. (2009). Losing a loved one to homicide: Prevalence and mental health correlates in a national sample of young adults. *Journal of Traumatic Stress, 22,* 20–27. http://dx.doi.org/10.1002/jts.20377